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1991-01-27

PERCEIVED IMPACT OF WORK-RELATED ROLE SETS:
Nurses' Experiences With Their Colleagues

by

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B.S.N., University of Victoria, 1983

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF SCIENCE

in the School of Nursing

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ABSTRACT

**Perceived Impact of Work Related Role Sets: Nurses'
Experiences With Their Colleagues.**

A qualitative study was conducted to examine the perceived impact work-related role sets have on distance education learners' ability or willingness to apply concepts or skills acquired in a post-RN baccalaureate program.

The Critical Incident Technique was used to elicit 106 incidents from 30 general duty nurses working in acute care hospitals. These incidents were categorized according to the role set, the emotional tone of the interaction, (the incidents were reported as positive, negative or neutral), the concepts or skills initiated and the impact on subsequent behaviour as a result of the interaction.

An examination of the incidents showed the greatest number to involve other RN's; with half positive and half negative incidents. In the category of supervisory personnel (head nurses, supervisors and director's of nursing), all the incidents were negative. Physicians provided more negative than positive incidents and incidents involving patients were almost exclusively positive.

Acquired concepts or skills identified as being new by the subjects included: nursing process, understanding of physiological processes, interpersonal skills, empowerment,

patient advocate, understanding of the elderly and teaching abilities.


The most significant finding was that of the effect negative sanctions had on subsequent behaviour. Despite the fact that almost half the incidents were viewed as negative, in only ten incidents did the nurse report she stopped the behaviour.


Since the distance education learner experiences some problems not encountered in traditional face-to-face interactions, some strategies are examined: support systems, role models, mentors, and periods of immersion.

Future studies might be undertaken to determine how widespread is the phenomenon and how distance education learners cope with the negative interactions they experience.

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TABLE OF CONTENTS

| | |
|--|-----|
| Abstract..... | ii |
| Table of Contents..... | iv |
| List of Tables..... | vi |
| Acknowledgements..... | vii |
| CHAPTER ONE - INTRODUCTION..... | 1 |
| CHAPTER TWO - LITERATURE REVIEW..... | 7 |
| Professional Socialization..... | 7 |
| Distance Education..... | 12 |
| CHAPTER THREE - METHODOLOGY..... | 17 |
| Critical Incident Technique..... | 17 |
| Procedure..... | 20 |
| Subjects..... | 21 |
| Analysis..... | 22 |
| Limitations..... | 25 |
| CHAPTER FOUR - RESULTS..... | 26 |
| Overview..... | 26 |
| Work-Related Role Sets and Emotional Tone..... | 28 |
| Concepts and Skills Practised..... | 31 |
| Impact on Subsequent Behaviour..... | 33 |
| Acquired Concepts and Skills..... | 33 |
| Nursing Process..... | 33 |
| Physiological Processes..... | 35 |
| Interpersonal Skills..... | 36 |
| Empowerment..... | 37 |
| Patient Advocate..... | 38 |

| | |
|---|----|
| Understanding of the Elderly..... | 39 |
| Teaching Abilities..... | 40 |
| General Reaction to the Program..... | 41 |
| CHAPTER FIVE - DISCUSSION..... | 43 |
| Incidents Involving Other RN's..... | 43 |
| Supervisory Personnel..... | 46 |
| Physicians..... | 47 |
| Effect of Negative Sanctions..... | 49 |
| Concepts and Skills Acquired..... | 50 |
| Implications..... | 55 |
| Suggestions for Further Research..... | 59 |
| Summary..... | 60 |
| BIBLIOGRAPHY..... | 61 |
| APPENDICES | |
| Sample Consent..... | 66 |
| Consent For Human Subject Research..... | 68 |
| Glossary..... | 71 |
| Letter..... | 72 |

LIST OF TABLES

| | | |
|---------|--|----|
| Table 1 | ROLE SET, EMOTIONAL TONE, CONCEPTS AND SKILLS ACQUIRED..... | 27 |
| Table 2 | WORK-RELATED ROLE SETS AND EMOTIONAL TONE..... | 29 |
| Table 3 | ACQUIRED CONCEPTS AND SKILLS AND EMOTIONAL TONE..... | 30 |
| Table 4 | IMPACT AND EMOTIONAL TONE..... | 32 |

ACKNOWLEDGEMENTS

I would like to extend my deepest appreciation to my advisor, Dr. Carolyn Attridge for her limitless patience, advice and support during this process. I also thank the other members of my committee Dr. Isobel Dawson, Dr. Geoffrey Potter and Dr. Frank Cassidy.

To a dear friend, Jocelyne Boulanger, who also supported me through the process, I thank you.

To those nurses who gave unstintingly of their time and shared their experience with me, I also give thanks.

Special thanks to Laura Go for typing this document.

Finally, to my patient, supportive and loving family Eric, Lisa, Lynda and Leah, I express my love and my thanks.

CHAPTER ONE - INTRODUCTION

The Canadian Nurses' Association has adopted a position that a baccalaureate degree will be the required educational level for entry into the practice of professional nursing by the year 2000. This position, subsequently endorsed by the Registered Nurses' Association of British Columbia, has had a ripple effect throughout the nursing profession (Attridge and Gitterman, 1988; Kerr, 1988).

Increasing numbers of registered nurses in British Columbia are returning to school to complete post-basic baccalaureate degrees. The post-basic baccalaureate program, or post-RN as it is sometimes called, is designed for those nurses who were educated in a diploma or hospital-based program and gives them university credit for that program towards a degree in nursing. Most require at least an additional two years to complete baccalaureate requirements. However, as one author states, "today's traditional educational system is inadequate in meeting the demand for available and accessible nursing courses" (Rodger, 1986). The traditional post-basic program may be inaccessible to some students for a variety of reasons: they may be unable or unwilling to leave families, homes or jobs. In British Columbia the universities are located in the Lower Mainland and Vancouver Island in the major cities of Vancouver and Victoria, far from a portion of the population. Innovative programs, such as the B.S.N. distance education program at the University of Victoria

have made it possible for registered nurses in British Columbia to overcome the geographic barriers of a province containing three mountain chains, a land area more than half covered by dense forests and with disparate population distribution (Kaufman and Sweet, 1983) and complete baccalaureate degrees. This is accomplished without ever leaving their community or jobs and without face-to-face interaction with teachers and classmates. Distance education is a form of education that has been around for about one hundred years and is characterized by the fact that the learner has varying degrees of face-to-face interaction with teacher and fellow students but it is typically less than traditional education (Rodger, 1986).

Distance education has been defined as an educational approach in which the learner is separated from the institution by time and/or space. Communication in distance education is usually non-contiguous but interactive. Courses involve various media rather than face-to-face teaching (Osborne, 1985, p. 145).

While the outreach nature of distance education is viewed as extremely positive and convenient for many students, it has been suggested that some aspects of the educational process are not well addressed by this format. One such concern is the professional socialization of the student into the baccalaureate role (Rodger, 1986).

According to nursing literature, baccalaureate nurses, or professional nurses as they are sometimes designated, provide a more complete type of care for patients in varying

stages of health and illness (Davis, 1986) than the graduates of diploma nursing programs. The baccalaureate nurse is expected to use a theory base for practice; support the nursing process by the use of nursing research; focus on the family and community rather than just on the individual; practice in a wider variety of settings; focus on the maintenance of wellness not just illness; be responsible for teaching, management, health promotion, counselling and to function in multidisciplinary teams (Nurse Administrators Association of British Columbia, 1989). The learning of such a professional role takes place through the process of professional socialization, (Bucher & Stelling, 1977; Cohen, 1981).

Professional socialization is the "complex process by which a person acquires the knowledge, skills and sense of occupational identity that are characteristic of a member of that profession." (Attridge, 1989). Professional socialization is primarily an interpersonal process where the learner interacts with teachers, peers, and significant others for example role sets. "Role sets" is defined as all the individuals the subject interacts with in the course of developing and practising a role. It is through these series of interactions that the learner acquires the behaviours appropriate to the profession. As Attridge (1989) states "it is also very important to note that the process involves not only cognitive content but attitudinal,

value and other affective learning." The socialization process is said to be facilitated in part by: sustained exposure to teachers who role model the expected behaviours; congruence between educational and practice role models; congruence between desired behaviours and personal values; an environment supportive of and fostering the desired behaviours; and, the positive responses of peers (Cohen, 1981; Simpson, 1979; Bucher and Stelling, 1977). One factor, the congruence between the messages sent by teacher-role models those sent by others, and interactions with work colleagues is known to significantly influence the socialization process for learners (Cohen, 1981). For example, a study by Dodds, Lawrence, and Guiton (1984) found that interactions with colleagues in the work setting was important and affected the student's ability to process new information. It should be noted, that though several studies have found that work colleagues have a significant impact on learners, no study has been done to determine what the impact on distance education learners might be. In traditional educational settings, teachers can mitigate the negative messages sent by those in the work environment but, for the distance learner, the personal influence and socialization effect of the teacher is limited or non-existent.

Additionally, there is evidence that peers can have an impact on behaviours and that distance education learners

may have limited or no contact with a student peer group. However, they do have contact with their work peers and, since they may integrate new skills or behaviours into their present practice, the work related role sets become important.

For instance, currently, the University of Victoria reports that 90% of its distance education post-RN baccalaureate students are working while taking courses (Attridge, 1989). Therefore, it is important to attempt to ascertain what influence the work setting has on the distance education learner. Work colleagues (other nurses, doctors, head nurses, administrators, etc.) may influence the distance education learner with respect to what is learned, what is valued, what learners choose to practice. This, therefore, may significantly impact on the professional socialization process.

The term role sets as stated previously has been used to describe "the constellation of relationships with the role partners of a particular position. A role set is comprised of all of an actor's role senders" (Hardy & Conway, 1978). That is, they are all the individuals the subject interacts with, in the course of developing and practising a role. The importance of the impact of role sets in how learners develop roles is posited by a number of theories. For example, according to one perspective, symbolic interaction, reality is defined by each individual

as he or she perceives the situation. Subsequent behaviour is acted out based on these perceptions and the initiation of new behaviour is influenced by the reaction of others to that behaviour. Social learning theory also suggests that an individual's learning of new behaviour is affected by role models and the expectation of others. Since we know that role sets affect face-to-face learners there is a need to determine how distance education learners are affected by work related role sets. Because it is anticipated that more and more R.N.'s will return to school to obtain a baccalaureate degree and many will choose the option of distance education, it would seem important to determine just what impact work related role sets have on individuals as they strive to develop their professional nursing roles. The question which this study will address therefore is, "what perceived impact do work-related role sets have on the distance education student's ability and willingness to apply concepts or skills acquired in the post-RN baccalaureate program?"

CHAPTER TWO - LITERATURE REVIEW

A computer search of the literature failed to generate any reports of research utilizing the dual concepts of professional socialization and distance education. However, several studies are available on the two as separate concepts. These concepts will now be discussed individually.

Professional Socialization

Professional socialization is built upon socialization theory. Socialization has been defined as "the complex process directed at the acquisition of appropriate attitudes, cognitions, emotions, values, motivations, skills, knowledge and social patterns necessary to cope with the physical, cultural and social environment" (Hardy and Conway, 1978, p. 79). Professional socialization is

the complex process by which a person acquires the knowledge, skills, and sense of occupational identity that are characteristic of a member of that profession. It involves the internalization of the values and norms of the group into the person's own behaviour and conception. The end product of professional socialization must be a person who has both the technical competencies and the internalized values and attitudes demanded by the profession and expected by the public at large. Professional socialization is a part of, and a responsibility of the formal educational process (Attridge, 1989, p. 28).

An early analysis of professional socialization is that done by Merton (1957) in which medical students were followed through their training. Merton conceptualized the medical school as part of the medical profession and the

medical student as a student physician already accepted and gradually becoming acculturated into the professional role - a junior doctor. Simpson (1979) refers to this as the induction model of socialization. In the induction model, failures or variations in socialization may come about because of "inconsistent expectations of different teachers, from incongruencies of classroom teaching and students' experience of professional role-sets or from views brought by students to their education that are incompatible with what they are taught" (Simpson, 1979, p. 8).

In contrast to Merton, Becker and his colleagues (1961) did not conceive of a professional school as a subsystem of the parent profession but rather as a separate entity. The students and faculty were viewed as separate groups. Students developed their professional identity through interaction with the educational system. They were successful because they learned how to work within the system. They learned how to pass examinations and developed effective coping patterns. Simpson (1979) calls this the reaction model of socialization.

Bucher and Stelling (1977) also dealt with students in medical school settings. The aim of their research was to link the characteristics of the socializing institutions and the kinds of experiences provided to "the kinds of professionals they produced" (Bucher and Stelling, 1977, p. 20). Their model held that outcomes of professional

socialization such as identity, commitment and sense of career would be largely determined by the realities of the socializing process. Bucher and Stelling originally hypothesized that the students were passive vessels shunted through the system, but as their research progressed they came to agree with Becker that the students were selective in identifying role models and taking cues from role sets, and concluded that institutional constraints and personal intent were both important in the socialization process.

Oleson and Whittaker (1968) examined the professional socialization of nurses in a baccalaureate program and found a similar phenomenon; an interactive process with role sets. Through the process students learned to "play the game" in order to be successful in the program "and integrate the multiple aspects of roles and selves" (Donner, 1986, p. 12).

Simpson (1979) also examined the socialization of nursing students and found the process to be a multidimensional and dynamic one. Her study showed that professional socialization involved learning skills and knowledge of the occupation, the development of orientations to occupational roles and to a place in the occupation, and relating the person to the occupation (Simpson, 1979, p. 225). Simpson's findings,

support a view of development of orientation through the school's equipping students for the occupational role ... Controls within the program but outside the student regulated the nature and degree of acceptance of orientations and

behaviours observed in potential role models (Simpson, 1979, p. 227).

In the Simpson model both attachment to significant others in the environment for example role sets, and the identification of incongruencies in the system played a role in the professional socialization process.

Kramer (1974) examined another facet of professional socialization of nurses, that of socialization into the work force. In this critical period of professional socialization, she found that "reality shock" caused many nurses to exit from the profession because they could not reconcile the reality and demands of the role with their personal self. Others, however, were able to more or less work through the professional - bureaucratic conflict and remain in the profession and reconcile personal values with the professional role.

Ondrack (1975) examined the entry and leaving characteristics of student nurses in three schools of nursing with a view to determining if an environment of relatively consistent attitude and role model cues for students encouraged "more pronounced socialization among students in a particular direction than an environment of low consistency cues" (Ondrack, 1975, p. 97). The hypothesis was supported by the study that "the more consistency among cues from significant others, the more pronounced the socialization effect" (p. 102).

Cohen (1981) analyzed the professional socialization of nursing students with a view to identifying what helped or hindered the process. She postulated a developmental model to explain the stages in professional socialization. These four stages consist of: 1) unilateral dependence in which the individual relies on external control; 2) negative/independence where individuals attempted to free themselves of external controls by a cognitive rebellion; 3) dependence/mutuality with the beginning of empathy and commitment to others; and 4) independence in which the conflict between independence and mutuality are resolved. In each of these stages, behaviours by faculty and practising nurse role models affected the professional socialization process.

Caretto's 1986 study tried to determine if the nursing performance of RN's changed after these nurses returned to school and acquired a baccalaureate degree. She measured leadership, teaching/collaboration, planning and professional development. She used a self-test and report by immediate supervisors of twenty-four staff nurses. She concluded that "staff nurses perceived significant changes in nursing behaviours related to leadership, teaching/collaboration, and planning evaluation. The supervisors did not perceive any significant changes in nursing performance." Cattle (1986) in examining professional socialization also concluded that peer influences are

important to the behaviour of the person being socialized. It is clear, therefore, there are a number of factors that have a significant impact on professional socialization, not the least of which is work place role sets.

The studies cited previously dealt with professional socialization in traditional educational settings. It is not clear how professional socialization is affected if the educational mode is by distance education. Further, there are indications that the work place role sets might also conflict with the distance education learner's desire to apply new skills, behaviours, and concepts. Therefore, it would seem that in examining professional socialization one needs to be aware of the impact the environment, faculty, practising role models, peers and role sets particularly have upon the process. Distance education will now be discussed in light of these factors.

Distance Education

There are a variety of approaches taken within distance education. In some instances there is some student-teacher face-to-face contact. There may be telephone or written contact or there may be contact with course tutors rather than teachers. Since this research examined a sample of nurses enrolled as distance education post-RN baccalaureate students at the University of Victoria, Keegan's definition is used. For the purpose of this study, distance education is defined as limited or non-contiguous or non-face-to-face

interaction or situations with no, or limited, interactions between teacher or teacher surrogate and learner (Keegan, 1984).

Distance education, in a one-hundred year history (Baath, 1985), has produced some research studies but none in nursing. The principal content of distance education literature centres around factors influencing students' course completion (Taylor et al, 1986; Schell and Thornton, 1985; Roberts, 1984; Scales, 1984; Coldeway, 1980; Dodds, Lawrence, and Guiton, 1984). The consensus is that early regular and personal contact from course tutors or teachers positively influenced course completion rates.

Characteristics of the distance learner and the applicability of adult learning theory have been examined by Moore, (1986 & 1983). A research study was undertaken where independent study programs were classified according to learner autonomy and distance; and, learner's attitudes to various aspects of distance education were analyzed. Moore used the term 'field independence' to describe the personality characteristics of successful independent distance education learners. These characteristics included: an ability to define own needs independent of others; an individual who maintains his/her own direction; prefers self-evaluation to evaluation by others; more task oriented and less affected than others by social stimuli. His findings showed that learners were affected by the lack

of teacher contact but the more successful the student the greater degree of independence and motivation.

Clyde et al (1983) investigated the different ways students used distance education teaching materials and concluded that often the students did not use course materials as the course designer had intended. Students often did not complete additional readings. As in the Becker study, students found their own ways of coping with the system.

A 1984 study by Dodds, Lawrence, and Guiton examined pressures influencing the distance learner. This research study examined 51 on-campus and 53 distance education students and their perceptions of factors influencing their studies. Both groups identified family, job and life circumstances as major influences. This study also found that "any person's processing of new information is affected by two distinct types of pre-existing factors; their own preconceptions and features of their work environment" (p. 174). Similarly Wedemeyer, in describing the distance education student (1983) states "the non-traditional learner knows loneliness; not so much in a social sense as in the identity as a learner".

Finally, Attridge (1989) examined distance education at the University of Victoria. She looked at factors influencing professional socialization and the implications for program delivery arising out of those factors:

1) the clarity, consistency and congruence of the views of nursing/nursing roles/nursing work/values/beliefs and other related phenomena depicted in various parts of the program and the rationales behind them; ... 2) the visibility to learners of role models who are practising the desired role; ... 3) the length and depth of exposure of learners to what is to be learned; ... 4) the degree to which learners' role sets i.e. those with whom they come into contact in the course of learning and practising their nursing work; agree with and practise the views of nursing, etc. espoused in the program ... 5) the degree to which differences in the views espoused by the program and those evident in the 'real world' practice settings can be successfully accommodated; ... 6) the visibility to learners of 'messages' which contradict the views of the program and the effectiveness of program methods of dealing with these; ... 7) the degree to which the workplace social system, both during the program and after graduation, supports and does not block the practice of nursing according to the views the program espouses, and; ... 8) the characteristics which learners bring to an educational program. (Attridge, 1989, p. 29 - 34).

In addressing the characteristics of the distance education student enrolled in the School of Nursing at the University of Victoria, Attridge points out that work-related role sets are important since almost 90% of distance education students are employed mostly in hospitals and in their work setting are "surrounded by a variety of examples of nursing behaviours and positive and negative sanctions which influence their own ways of nursing" (p. 36). Since we know that professional socialization is influenced by the exposure to teachers role modelling the desired behaviours and by the effects of a peer groups, and we know that these two factors may be limited or absent for the distance

education learner, it seems pertinent to examine how work place role sets impact on the learner.

So, it is the work environment and work related role sets that are of interest to this writer as she seeks to answer the question "What perceived impact do work related role sets have on the post-RN baccalaureate distance education students' ability and willingness to apply concept or skills acquired from their post-RN baccalaureate program?"

CHAPTER THREE - METHODOLOGY

Method: Critical Incident Technique

The qualitative research method of the Critical Incident Technique was chosen to collect the data. "The Critical Incident Technique is an exploratory qualitative method of research that has been both reliable and valid in generating a comprehensive and detailed description of a content domain" (Woolsey, 1986, p. 242) and because this method is useful in the understanding of perceptions. The method consists of a set of simple interview procedures for collecting information from people about their direct observations of their own behaviour (Polit and Hungler, 1988). "The critical incident technique outlines procedures for collecting observed incidents having special significance" (Flanagan, 1954, p. 327). The Critical Incident Technique was chosen because "it is well known that extreme incidents can be more accurately identified than behaviour which is more nearly average in character" (Flanagan, 1954, p. 338). It was posited that it would be probable that a subject would recall those incidents when new skills or concepts were initiated, how others reacted to the new behaviour and the subsequent impact of that reaction on the subject.

An incident is defined as

"any observable human activity that is sufficiently complete in itself to permit inferences and prediction to be made. To be

critical, an incident must occur in a situation where the purpose or intent of the act seems fairly clear to the observer and where its consequences are sufficiently definite to leave little doubt concerning its effects" (Flanagan, 1954, p. 327).

Since the researcher was interested in the perceived impact work-related role sets have upon distance learner's ability and willingness to apply concepts or skills presented in the post-RN baccalaureate degree program at the University of Victoria in clinical practice, the Critical Incident Technique was considered appropriate.

Flanagan (1954) emphasized that rather than a rigid set of rules, the Critical Incident Technique procedure consists of a flexible set of principles which may be modified and adapted to meet the specific situation. He outlined the following steps using it:

1. The selection of a general frame of reference for describing the incidents.
2. The use of plans and specifications to meet the following guidelines:
 - a. clear delimitation of the situations to be reported.
 - b. checking to see if specific behaviour is relevant to the aim of the study.
 - c. deciding how important an effect the observed incident has on the general aim, both positively and negatively.

- d. the observers should be trained and familiar with the aim of the study.
3. The collection of the data. "If full and precise details are given, it can usually be assumed that this information is accurate" (p. 340).
4. The analysis of the data which includes the induction of categories from the basic data and the submission of tentative categories for others for review.
5. The interpretation and reporting of the data. Flanagan suggests that each of the preceding four steps must be studied to see what biases may have been introduced.

Based on these suggested steps, this researcher asked the subjects the following questions:

1. "Think back to a time which stands out in your mind when you wanted to or you did initiate some concept or skill taught in your baccalaureate program into your clinical practice."
2. "What was the incident? What were the general circumstances surrounding the incident?"
3. "Who else was involved?"
4. "What was the reaction of work colleagues?"
5. "How did you feel as a result of this incident?"

6. "What impact did this have on your ability or willingness to initiate further concepts or skills taught in your baccalaureate program? In what way did the incident facilitate or hinder your work performance?"

These specific questions focused the subject on actual, concrete incidents rather than opinions or speculations. Subjects were asked to report as many incidents as they could recall. The interview was tape recorded, transcribed onto cards and identified only by a code number.

Procedure

Once transcribed, a trial classification scheme with clear definitions for the categories was constructed. After the tentative categories had been established and defined, the need for redefinition or development of new categories was examined. The last step was to "determine the most appropriate level of specificity-generality to use in reporting the data" (Flanagan, 1954, p. 345). The following considerations were kept in mind when establishing headings major categories: 1. clear cut and logical organization of headings; 2. titles that convey meanings; 3. list of statements that are homogeneous; 4. headings of a given type are at same level of importance; 5. headings used permit findings to be easily applied and useful; 6. list of headings are comprehensive.

Once the data were analyzed and categorized, the next step was to place the incidents under the major categories until all incidents were placed. Finally, inferences were drawn about the incidents and their effect on the distance learner's ability or willingness to apply concepts or skills learned in their program.

Subjects

The sample for this study consisted of 30 general duty registered nurses drawn from three Vancouver Island general hospitals: Cowichan District Hospital, Nanaimo Regional General Hospital, and West Coast General Hospital. The sample was 30 although, as Woolsey (1986) suggests, the sample size may be smaller if all the categories chosen are saturated with the incidents collected. It is suggested that a running count of incidents be kept ... at the estimated halfway point, of the number of new critical behaviours added to the classification scheme. When only two or three new critical behaviours are added by 100 incidents, data collection can be discontinued (Woolsey, 1986, p. 246). Criteria used for inclusion in the sample were all those subjects willing to participate who were enrolled or had been enrolled as distance learners in the post-RN baccalaureate program at the University of Victoria within the last three years and are working or were working at the time as general duty registered nurses in the three acute care general hospitals. The time frame of three years

was set since Woolsey (1986) suggests that recency is of significance for remembering, and time blurs the information. Volunteers were obtained by approaching Directors of Nursing for permission to put up posters in each hospital and by asking a contact person in each agency to solicit for volunteers.

Volunteers were assured of confidentiality and number codes were used in transcribed materials. All raw data was discarded once the analysis phase was completed. Subjects were free to withdraw at any time and, if they chose to do so, could retain the transcribed material. No subject chose that option. A written consent prior to data collection was obtained (See Appendix A).

Analysis

"The purpose of the data analysis phase is to summarize and describe the data in an efficient manner so that it can be effectively used for many practical purposes" (Flanagan, 1954, p. 344). The first step in the analysis concerned the general frame of reference (Flanagan, 1954) on the nature of the classification schemes. During the data collection process, four general frames of reference evolved. The fact that the questions were asked in a specific way probably led to the frames of reference. They included the tone of the incident (whether perceived as positive or negative by the subject); the other person involved in the incident (other RN's, doctor, etc); the new behaviour put into practice by

the subject; and the perceived impact on subsequent practice.

The second step in the process was the formulation of a trial classification scheme for "the new behaviours category". Flanagan (1954) suggests that this is an inductive process that is subjective in nature, and that one should submit the tentative categories to others for review. The trial classification scheme was tested and judged by a college instructor who was familiar with the content and qualitative research. Categories were resorted, redefined and clarified until the college instructor and the researcher agreed. "Although there is no guarantee that results agreed upon by several workers will be more useful than those obtained from a single worker, the confirmation of judgements is usually reassuring" (Flanagan, 1954, p. 344).

The third step in the process consisted of placement of the incidents under the major classification scheme. Andersson and Nilsson (1964) suggest that reliability is more likely if independent judges can consistently place incidents in the same classes as the researchers. "One criterion for the necessity and sufficiency of a categorical set is its reproducibility by another competent judge" (Lincoln & Guba, 1985, p. 122). For this step an external judge was approached. This judge is a college instructor in nursing, who is educated at the Master's level. The judge

was given the classification scheme, with a brief definition of each category, and was asked to place the incidents in the appropriate categories. The percentage of agreement was 75% which Andersson and Nilsson (1964) suggest an acceptable level of agreement.

Andersson and Nilsson (1964, p. 399) suggest that an important question "is whether or not the collection of data has been sufficiently comprehensive to include all types of behavioral units". A test for comprehensiveness was made by randomly sorting the incidents and placing them under the appropriate headings. When only 59 of the 106 incidents were placed, no new categories emerged. Therefore, it was felt that the data collection had not been stopped too soon.

An aspect of content validity that must be taken into consideration is "whether the incidents collected are really critical" (Andersson & Nilsson, 1964, p. 401). Categories are formed because of the similarity of a group of incidents reported by different people. The likelihood that a category is well-founded occurs when several people report the same kind of incident.

Since there was only one interviewer and one data collection method, a tape recorder, there is not the problem of inter-observer reliability. A set format for asking questions was followed and every effort was made to keep the similarity of questioning between subjects. Additionally, validation occurred at the time of the interview when the

researcher checked with the subject the accuracy of the perceptions. Finally, once the incidents were transcribed, the interviewer asked the subject to check the information to see if it accurately portrayed the events and feelings described by the subjects.

Limitations

Due to the nature of this study, several limitations appear. The small convenience sample used means that findings can not be readily generalized to include all distance education nursing students.

All the data are subjective from the viewpoint of the respondents. The Critical Incident Technique depends upon self-report and this may be considered suspect although Mischel quoted in Lindsey (1989, p. 26) notes that "people are the best experts on themselves". Woolsey (1986) suggests that the "factual accounts of behaviour [as subjects describe the incidents] are preferable to ratings and opinions based on general impressions" (p. 244).

The data was reviewed and interpreted by the researcher who brings her bias into the process. While every effort was made to control for bias, it is recognized that some exists.

CHAPTER FOUR - RESULTS

Overview

The thirty nurses interviewed generated 106 incidents with the range of one to seven per nurse and an average of 3.5 per nurse. Using the steps in the Critical Incident Technique as devised by Flanagan (1954) the incidents were then grouped into categories. The incidents were classified in four different ways. The following questions were used as organizers:

1. With whom did the incident take place? i.e. which of the work-related role sets were involved in the interaction?
2. What concepts or skills did the nurse initiate or attempt to initiate into her clinical practice?
3. What was the emotional tone of the incident? i.e. did the nurse perceive the incident to be positive, negative or neutral?
4. What was the perceived impact on the nurse? i.e. did the incident affect the nurse's subsequent behaviour in that the behaviour was either continued or extinguished?

Table 1 provides an overview of the role set category, emotional tone and concepts and skills put into practice. Appendix C provides a glossary of terms used in Table 1.

TABLE 1

Role Set, Emotional Tone, Concepts and Skills Acquired

| Role Set and Emotional Tone | Nursing Process | Physiological Processes | Interpersonal Skills | Empowerment | Patient Advocate | Elderly | Teaching | General Reaction |
|--|-----------------|-------------------------|----------------------|-------------|------------------|-------------|-------------|------------------|
| RN's positive negative neutral | 7 8 2 | 7 7 1 | 6 | 2 | 2 2 | 1 1 1 | 3 1 1 | 1 2 |
| Physicians positive negative neutral | 2 | 1 2 1 | | 1 3 | 3 | 2 2 | | |
| Patients positive negative neutral | 1 | | 7 1 | 1 | 1 | | 2 | |
| Supervisory Personnel positive negative neutral | 2 | | | 2 | 2 | | 2 | 1 |
| RN/Physician positive negative neutral | | | | 1 | 1 1 | 1 | | |
| Visitors positive negative neutral | | 1 | 1 | | | | | |
| Mixed positive negative neutral | 2 | | | | | 1 | | |
| Other Health Care Workers positive negative neutral | 1 | | 1 | 1 | | | | |

N = 25

N = 20

N = 16

N = 11

N = 12

N = 9

N = 9

N = 4

Work-Related Role Sets and Emotional Tone

The first classification scheme applied to the incidents was that of work-related role sets. The reader will recall that role sets include all the individuals with whom the subject interacts in the course of developing and practicing a role. It should be noted that some incidents involved more than one individual so these have been classified as either 'RN/Physician' since that is who was involved or 'mixed' since some incidents involved people such as RN/LPN or RN/Head Nurse.

Additionally, the work-related role sets were classified as to emotional tone. Subjects were asked how they felt as a result of the interaction. In each case the nurse identified how she would characterize the incident as to emotional tone. Statements such as "I felt terrible" or "I was really happy" were also used to characterize the incident by emotional tone.

From Table 2, it can be seen that the bulk of the interactions involved other RN's: a total of 55 incidents. It is interesting to note that whereas incidents involving other RN's were somewhat more positive (53%) than negative (38%), the reverse is true for physicians. Also the majority of interactions involving patients was overwhelmingly positive (92%) and interactions with supervisory personnel were exclusively negative. Further

TABLE 2

Work-Related Role Sets and Emotional Tone

| | Positive | Negative | Neutral |
|----------------------------------|----------|----------|----------|
| Other RN's | 29 | 21 | 5 |
| Physicians | 6 | 10 | 1 |
| Patients | 12 | 1 | 0 |
| Supervisory Personnel (HN/ADON)* | 0 | 9 | 0 |
| RN/Physician | 1 | 2 | 1 |
| Visitors | 1 | 1 | 0 |
| Mixed | 0 | 3 | 0 |
| Other health care workers | <u>2</u> | <u>1</u> | <u>0</u> |
| TOTALS | 51 | 48 | 7 |

* HN = Head Nurse

* ADON = Assistant Director of Nursing

TABLE 3

Acquired Concepts and Skills and Emotional Tone

| Acquired Concept or Skill | Positive | Negative | Neutral |
|--|----------|----------|----------|
| nursing process | 11 | 12 | 2 |
| understanding of physiological processes | 8 | 10 | 2 |
| interpersonal skills | 15 | 1 | 0 |
| empowerment | 4 | 7 | 0 |
| patient advocate | 4 | 8 | 0 |
| understanding of the elderly | 3 | 4 | 2 |
| teaching abilities | 5 | 3 | 1 |
| general reaction | <u>1</u> | <u>3</u> | <u>0</u> |
| TOTALS | 51 | 48 | 7 |

discussion of the implications of these findings will be dealt with in Chapter 5.

Concepts and Skills Practised

The second component in the classification scheme is that of the learning focus or the acquired concepts and skills that the nurse attempted to initiate or did initiate into her clinical practice. One category did not quite fit the classification of acquired concept and skill - that of 'general reaction to the nurse being enrolled in a post-RN baccalaureate program'. However, it was felt that these incidents might impact on the nurse's subsequent practice so the category is included.

In Table 3 one can note that the interpersonal skills category is much more positive than negative in tone. Also it is noted that where the nurse acted as patient advocate or behaved in an empowered way, there were almost twice as many negative incidents as positive incidents. What is interesting to note here are the concepts or skills acquired by the nurse and put into practice. Those noted are those that are singled out by the subjects. It is clear from looking at them that this cannot comprise all the concepts or skills taught in a post-RN baccalaureate program. For example, the concept of family is taught in the University of Victoria's program but subjects did not indicate that they put into practice anything to do with family as the

TABLE 4

Impact and Emotional Tone

| Impact and Emotional Tone | Positive | Negative | Neutral |
|---------------------------|----------|-----------|----------|
| Behaviour Continued | 51 | 38 | 7 |
| Behaviour Extinguished | <u>0</u> | <u>10</u> | <u>0</u> |
| TOTALS | 51 | 48 | 7 |

focus of care or that this concept did not translate into a critical incident.

Impact on Subsequent Behaviour

The third component examined was that of the impact on the nurse as a result of the incident.

The nurses were asked if the recalled incident had had an impact on their subsequent behaviour. Table 4 shows an interesting phenomenon: that is, that despite the fact that 48 incidents were perceived as negative, in only 10 cases did the nurses admit to stopping the behaviour. Negative sanctions do not appear to have impacted significantly on the nurse's practice.

Acquired Concepts and Skills

In this next section, each of the acquired concepts and skills is examined more closely for work-related role sets and emotional tone. In addition, a prototypical response is presented. An example of a positive and a negative incident for each category is given. Since the impact from incidents viewed as neutral is negligible, examples of these are not presented.

1. Nursing Process

The largest category identified by nurses as a concept acquired in a post-RN baccalaureate program is that of the nursing process, with 25 incidents reported. This category includes the use of a conceptual model, the nursing process incorporating the use of physical assessment skills and care

plans. In this category the number of positive interactions was 11; the number viewed as negative was 12; and there were 2 neutral incidents. For logical reasons the principal role-sets involved were other nurses; 17 incidents, (eight negative, seven positive, and two neutral). Two incidents involved supervisory personnel (Head Nurses, Assistant Directors of Nursing), (both of which were negative) and one incident involved a patient (which was positive). There were only two incidents involving physicians and in both these cases the physician commented positively on the increased assessment ability of the nurse. It would seem reasonable to assume that nurses probably do not discuss nursing models or nursing care plans with physicians.

One positive and one negative example are cited here:

Incident 49. Subject P - 5

When I took 302 I talked to people about nursing models. I didn't realize that _____ (agency) used a nursing model. I finally found out that it was Virginia Henderson's. None of the other nurses I worked with knew about the model. I talked to a group of RN's about how a model guides your practice, forms, etc. We compared the nursing admission forms we used to the model. They [other RN's] asked questions and seemed interested. They could see how the form was derived from the model. I knew how they were feeling since I had been there.

Incident 46. Subject P - 5

I had a lady who was hospitalized with a very swollen ankle; tight, shiny, hard. I made a nursing care plan to include bed cradle, etc. I did try explaining the rationale for having a care plan to other RN's - you just can't assume everyone is doing it. They laughed and said "We

do those things anyway - why do we have to write it down?" I felt a little angry and then I realized that I had been there, too, a few years ago. I think it made me more conscientious to prove that the education was worth it. It was a challenge.

2. Physiological Processes

The second largest category of concepts emerging in critical incidents identified by nurses as concepts acquired in a post-RN baccalaureate program is that of physiological processes: 20 incidents reported. Here nurses identified information from an advanced physiology course as having contributed to their nursing practice. This could also include pathology and pharmacology. Again the most common role set interacted within that of other RN's with seven incidents viewed as positive, seven viewed as negative and one viewed as neutral.

Additionally, four incidents involved physicians with one positive, two negative and one neutral. Two incidents involved a visitor which was negative. Two examples of incidents follow:

Incident 6. Subject N - 2

One thing I learned was understanding of COPD. Another nurse didn't know why oxygen is not given. I explained. I had learned about this in Basic Health Science update. She was pleased to have the information and I felt great.

Incident 48. Subject P - 5

After learning about the risks of massage with decubitus ulcers, I remember talking to some other nurses about it and how rubbing might not be

good for it. They just laughed at me and said "We've been doing that for 50 years and it works. I felt uncomfortable but it didn't impact on my practice.

3. Interpersonal Skills

This category has sixteen incidents and involved communication skills with both individuals and groups. All but one incident were viewed as positive; 16 incidents reported. The largest number of interactions were with patients (eight) and all but one were positive. Six positive incidents were with other RN's. One interaction involved a visitor and one incident involved another health care worker. It appears that communication skills can be easily incorporated into clinical practice. Two examples follow:

Incident 36. Subject N - 9

A patient had Caesarian section for partial abruptio. She had been in hospital for a while then started to hemorrhage. Baby was stillborn. Having taken the 'Helping Relationship' gave me the skills to just listen - just be there. The patient expressed her grief and anger - she cried. She found it easier and easier to talk. I felt really good and I've found it easier to deal with this. It's made these situations easier to deal with.

I had this 38 year old woman who miscarried. She was angry and critical. She stayed behind curtains. I did go and talk to her. She aborted in the toilet. I felt I had an understanding of what she was going through. She was hard to deal with and I found myself getting angry. She was negative. I felt angry - a little bit. I think I look at things differently - I look broader.

4. Empowerment

In this category nurses indicated that as a result of their courses in the post-RN baccalaureate program, they felt greater confidence in their own abilities and so would speak up more readily on issues or concerns. Two incidents involved RN's and both of these were positive. The greatest number of incidents (5) involved physicians with only one incident being positive and three being negative. Supervisory personnel had two negative incidents. In the other health care workers category, there were two positive and one negative incident to bring the total to eleven incidents. Two examples follow:

Incident 38. Subject N - 10

I feel I've increased my problem-solving ability. An incident occurred on the floor; we were busy, staff being pulled to other parts of the hospital, water supply not working properly. I asked for help and didn't get it and ended up working overtime. I sat down and detailed the problems in writing and possible solutions. I forwarded this letter to Administration. I talked about this to other RN's on the floor. They were positive. One was especially exuberant. Administration was positive. I felt pleased with myself. I received a positive complimentary letter from Administration. There is now a change in water supply and the inception of a portering service in the hospital. I felt empowered and vocalized to others how to go about the process.

Incident 77. Subject N - 15

I think professional issues helped me feel like an equal member of the health team. We had this kid who was really sick - status asthmaticus. We didn't feel the orders for the kid were adequate. The doctor said he'd be up in 20 minutes but the kid didn't have 20 minutes. We

bypassed the doctor and got another doctor. The first doctor got to the floor and started screaming at me. I knew we were right. I have more confidence now. I'm a peer. I would do it again.

5. Patient Advocate

Incidents in this category involved the nurse being aware of patient's rights, ethical issues and speaking out on behalf of the patient. There were twelve incidents in this category with RN's with four incidents. In the RN category there were two negative and two positive. In the physician category there was three negative incidents while in the RN/Physician group there were one positive incident and one negative incident. One incident involved a patient and was a positive interaction. Two incidents involved supervisory personnel and both of these were negative. That resulted in a ratio of 2:1 for negative to positive incidents. It would appear that where patient's rights are concerned, there may be more resistance from supervisors and physicians when nurses speak out on the patient's behalf.

Two examples follow:

Incident 72. Subject P - 6

I brought up at a meeting that nurses shouldn't be having patients sign consents. This came out of ethics, patient's rights and informed consent - but the person doing the procedure should be explaining it. There was general support from other RN's. "That's the way it should be." I felt good about bringing it up. No changes have taken place but I'd still speak up.

Incident 31. Subject N - 6

A patient came into hospital for hysterectomy. Hadn't seen doctor for six months and had forgotten about surgery - didn't recall details of what doctor was going to do. I supported the patient when patient refused to sign consent until doctor explained surgery. I contacted the doctor who was angry. I felt more stubborn to support patient. I didn't feel intimidated. I'd do it again.

6. Understanding of the Elderly

There were nine incidents in this category which dealt with the special problems of nursing care of the elderly. While some of the incidents in this category could be cross referenced with Physiological processes and Patient Advocate, it was felt that these incidents should be separated because the nurses themselves identified how their knowledge of the elderly had changed. Nurses were able to point to a specific course, Sociology of Aging, and identify concepts from this course as specifics they had learned. Four of the nine incidents were with physicians with two negative and two positive. Three of the incidents involved other RN's with one negative, one positive and one neutral. One neutral incident from the RN/Physician category was noted. The final incident was one negative from the 'mixed' category.

Reading through the incidents, one is struck by the number of times, five, that medications were involved. In addition, two of the incidents involved the use of restraints and the elderly. The examples are:

Incident 28. Subject P - 4

An elderly patient (lady) on Erythromycin was showing toxic levels. She was confused - complained of ringing ears. This was my fourth shift with her so I knew how she had changed. I contacted the doctor who discontinued the drug. I felt really good that I could pick it out.

Incident 3. Subject N - 1

An elderly patient, 12 - 14 medications, some of which were contraindicated or incompatible. I made a note to doctor about meds and left it on the chart. I had learned about medications and the elderly in sociology of aging. The note was torn up and no changes were made. I felt frustrated. I would do it again and I would confront the doctor.

7. Teaching Abilities

This category contains those incidents where the nurse felt that her teaching abilities had improved. There were nine incidents in all. Five incidents involved RN's with three being positive, one negative and one neutral. Two positive incidents involved patients and two incidents involved supervisory personnel and both incidents were negative. In the two negative supervisory incidents, the nurses identified teaching tools that were needed by the ward and suggested teaching tools but in both cases were turned down. The examples are:

Incident 68. Subject P - 6

Recently I had a patient who needed cardiac teaching. He was in the first stages of asking questions and instead of just telling him what he needed to know, I asked him to tell me what he already knew. I wouldn't have done that before -I would have just told him. His reaction was quite

good - he was able to tell me what he knew. It made me feel good.

Incident 95. Subject N - 17

I work on "Mat" and half the newborns develop physiological jaundice. I brought up to the Head Nurse that we should develop a sheet of information to teach the mums about it. She wasn't interested. She said, 'No, we don't do that.' It was awful. You get so many 'No's' that you can't work anymore. You lose creativity. The things you went into nursing for are crushed. It affects your soul.

8. General Reaction to the Program

This category does not fit with the preceding categories as concepts and skills acquired in a post-RN baccalaureate program but nurses did identify these incidents as impacting on their subsequent behaviour. There were four incidents in this category; three involving other nurses and one negative incident involving supervisory personnel. Of the three involving other RN's, one was positive and two were negative. It is interesting to note that of the incidents related by the nurses that three times as many negative incidents as positive were recalled. It may be that negative incidents are remembered more than positive or that there are some general negative reactions to a post-RN baccalaureate program. This will be dealt with further in the Discussion section.

There are two examples: one positive and one negative.

Incident 39. Subject N - 10

One woman I worked with always asked me about the program. She was very much against the

program but I always talked to her about it. Over the years we talked many times. She actually started the program and thanked me for my input.

Incident 88. Subject N - 16

I remember taking my books one night shift and other staff saw them. The conversation died. There were non-verbal cues of disapproval. One nurse said, "Oh, good! Another one we won't understand." I felt sorry for them. I stopped taking my books. You see, when you work part-time you don't belong all that much and by taking my books I belonged even less. If I didn't take my books then I could fit in as much as any part-time person.

This concludes the summary presentation of the critical incident results. Further discussion of the findings follow in the next section.

CHAPTER FIVE - DISCUSSION

In this section, devoted to discussion of the findings, there is evidence of the myriad shades of human relations and the all too human reluctance of people to accept change. The research also speaks, in no small way, of the courage of those armed with new skills and concepts to continue the struggle against narrow thinking and intransigence, and to press for the changes they believe in. Explanation for the reasons why negative sanctions did not extinguish behaviour are explored. Some strategies are suggested here that might help to mitigate the effects of negative sanctions as are some suggestions for future research.

Incidents Involving other RN's

First, because of their prevalence, the reasons for the most commonly generated category, that of incidents involving other general-duty RN's, will be examined. From Table 1 it can be seen that, of the 106 incidents generated by the subjects, more than half (57) involved other RN's. This number becomes 61 when the combined category of RN/Physician is included. Nurses come into contact with a variety of other health care professionals and patients, that is their role sets, during the course of their work. Why would more than half the incidents involve other RN's? It is the nature of nurses' work that they work in teams with their colleagues. It is also true that the most common health care worker is a nurse. Another explanation might be

that other RN's are in a better position to observe and comment when a post-RN baccalaureate distance education student attempts to incorporate into her practice some concepts or skills acquired in her program.

However, that does not explain why almost half the incidents involving other RN's were negative. Why don't RN's support one another? One explanation might lie in oppressed group theory. Attridge and Callahan (1989) explored this concept when examining power and powerlessness in nursing. Nurses, being predominantly female in number and in a service industry, have long been relegated to a subordinate role in the health care system. Physicians and hospital administrators are usually male and have worked to retain the power they hold.

Nurses, failing to recognize the oppression process do not unite to change the view of reality imposed by these more powerful groups [doctors and hospital administration]. Instead, they adopt the adaptive strategies of oppressed groups and direct their dissatisfaction inward toward themselves and toward those less powerful than themselves, responding in a predictable fashion to a system which has, for the most part, excluded them from the power structure. (Attridge & Callahan, 1989, p. 47).

In directing their dissatisfaction inward, nurses devalue their own work and sometimes oppress members of their own group. This might explain the behaviour of some RN's: they are disciplining those members of the group who are different, who have gone back to school to obtain a baccalaureate degree.

Cragg (1990) found a similar phenomenon of nurses not supporting one another, when she interviewed distance education students. "The informants reported that they frequently encountered lack of understanding or hostility from the nurses they worked with. Having less in common with their former peers, they found more congenial company with nurses who were students or had degrees" (p. 123).

Davis (1986) suggested that there is no grass roots support for the entry to practice issue and that "nurses like any other group of people are reluctant to change previously held beliefs especially when there is much dissent among the co-workers". In addition to this lack of support for the entry to practice issue, it may be that nurses who are pursuing a baccalaureate degree are a threat to their colleagues. They are the proof of a change that is coming and other nurses may be afraid to expose themselves to the educational process - much the same as a divorced woman acts as a threat to married women. This, too, could happen to you. Many times this researcher heard comments like, "When I started my degree people would say, 'so now you're going to take over'", or "I had to be careful not to flaunt my new knowledge", or "I found my peers jealous and resentful of what I was doing". This is particularly distressing to hear when nurses look for and appreciate the support of peers.

Attridge and Callahan (1987) state, "emotional support derived from collegial relationships with peers, co-workers

and superiors is so important to nurses ... support provides reward, value, respect and caring to professional Nurses who feel supported can handle many distressing circumstances" (p. 35). They found in their study of quality of work life, that "participants in the study ranked supportive and competent colleagues as the single most important ingredient in a quality work environment for nurses", (p. 46) but they also found that "most frequently persons or groups considered non-supportive were nurse colleagues" (p. 46).

Supervisory Personnel

In the same vein, one can see that the other group of nurses that the respondents encountered (supervisory personnel consisting of head nurses, supervisors and assistant directors of nursing) were exclusively negative in the incidents collected. Attridge and Callahan (1987) found that along with the nurse colleagues who were unsupportive were also head nurses. In a study reported by Lindsey and Attridge (1989) it was found that "higher nursing administrators (i.e. nurse administrators and supervisors) were reported to be two and a half times more unsupportive in their actions" (than supportive), (p. 20). The actions of head nurses and supervisors can impact greatly on a nurse. Landstrom, Biordi and Gillies (1989) found the most common factor and source of conflict contributing to a nurse leaving a ward or hospital "was conflict between the nurse

and nursing manager. Differences in philosophy and style and manager's inattention to the nurse's need were significant stressors for the departing nurse" (p. 25). In two of the incidents collected by this researcher, the subjects had noticed a need for patient teaching tools on the ward. Perhaps the identification of this need implied a criticism that the head nurse was not doing her job by failing to design these tools.

Physicians

The next finding for discussion is that of the number of negative incidents involving physicians (a total of ten negative, six positive and one neutral). Perhaps some explanation of this can be found in the nature of physician-nurse relationships.

Physicians have long insisted on maintaining the dominant role in the health care scene. The physician regards other health care professionals as mainly serving him in his so-called captain of the ship role. The nurse, on the other hand has accepted the position of deference to the physician and other authority figures. She has been described as docile, subordinate and deferent and has traditionally had the reputation of fulfilling a role of blind obedience to orders rather than that of an autonomous professional (Kalisch and Kalisch, 1982, p. 223).

Therefore, if nurses were to demonstrate some of the concepts or skills acquired in a baccalaureate program, this may be threatening to a physician. As Kalisch and Kalisch (1982, p. 228) state, "physicians in general have not been enthralled with nurses becoming better educated". This

may be especially so when nurses speak out about physician's orders, behaviours, etc. In the category of empowerment, the greatest number of incidents involved physicians (four) and all but one of these was negative. In the patient advocate category the figures also reveal that three incidents involving physicians were negative. It appears that when nurses speak out in an empowered way or speak up for patient's rights, there may be considerable resistance from physicians. It may be that physicians expect to play the doctor-nurse game, first described by Stein, "In playing this game, the nurse is to be responsible for making significant recommendations while at the same time appearing passive. The physician in requesting the advice or assistance of a nurse must do so without it being noticed" (Kalisch and Kalisch, 1982, p. 225). Stated another way, "the essence of the game is how the nurse who knows gets the doctor to play the role of rightful knower" (Baumgart in Attridge and Callahan, 1987, p. 79). The doctor-nurse game involved the nurse wanting to make suggestions to the doctor about the patient but approaching the topic carefully. It must seem as if the decision to make some change in the patient's regime must come from the physician. The nurse cannot ask outright for an order as this may threaten the physician's ego or autonomy. Why are nurses deferent? Why do nurses play the doctor-nurse game? It has been suggested that the fact that nurses are predominately female, are less

well-educated, come from a lower socio-economic group, are socialized into a "good Samaritan" role and have these behaviours reinforced by faculty who were also socialized this way, all contribute to the reason why nurses defer to physicians. Another explanation lies in oppressed group theory where the oppressed tend to perpetuate the status quo and continue to subordinate themselves to the more powerful group.

Effect of Negative Sanctions

The next finding for discussion concerns the relatively little effect the negative incidents had on the subjects. While almost half the incidents were viewed as negative, in only ten incidents did the nurse admit to stopping the behaviour. Some explanations suggest themselves. While years of experience was not controlled for in this study, the range of experience was from one to twenty-five years with the majority of subjects having had more than ten years experience in the nursing role. Perhaps the subjects felt so confident in their own abilities that the comments of others had little effect on them. Another explanation might be that the courses they had taken towards a BSN (range was from one course to program completion) gave them confidence in their own skills or abilities. Caretto suggests that graduates of a BSN "are prepared to accept responsibility and be accountable for the choice of nursing interventions and to utilize leadership skills in influencing the

behaviour of others" (Caretto, 1986, p. 16). In a study by Murray and Morris (1982, in Caretto, 1986) it was found that "BSN graduates scored higher (than other graduates) in the area of nursing autonomy and patient's rights" (p. 28).

While this study is about graduates of a generic BSN program, it is hypothesized that those enrolled in a post-RN baccalaureate program would begin to acquire those traits seen in graduates of a BSN program. An alternative explanation might be that those students who enroll in a baccalaureate program have more confidence in their skills and abilities and would, therefore, be more willing to speak out about patient's rights or other issues.

Concepts and Skills Acquired

Finally, a review of each category is presented. It is interesting to note that the subjects themselves identified the concepts and skills they felt they had acquired. The ones identified do not comprise all of the concepts or skills taught. For example, in one course taught in the post RN-baccalaureate program at the University of Victoria, there is a greater emphasis on families, yet no subject identified a concept about families that was incorporated into her practice.

The largest category, (with 23 incidents) developed from the study was that of nursing process. This category included assessment, the use of care-plans and other aspects of the nursing process including the use of conceptual

models. As is to be expected, the largest number of incidents involved other RN's. The use of nursing care plans is an issue that came up frequently and was viewed negatively. It would appear that there is some resistance among practising nurses toward the writing of nursing care plans. Reasons for this usually centre around the amount of time it takes to write out a nursing care plan when nurses already feel their time with patients is too limited. As one nurse stated, "I've been more aware of care plans. Now I update them and amend them rather than leave them even though other staff don't keep them up to date. There's very little time to do them". Although some respondents found them positive, they met with negative sanctions in the workplace. Only two of the incidents in this category of nursing process involved physicians and in both cases these involved increased assessment abilities of the nurse in which physicians commented favourably.

The second largest category (with 20 incidents) concerned an increase in the understanding of physiological processes. The course clearly identified as having an impact on the learners was an advanced physiology course. Since this course deals with concepts not necessarily taught in nursing schools and helps nurses speak intelligently with physicians about physiological concepts, it is hard to explain why half the incidents (two) involving physicians were negative. Perhaps it is as Kalisch and Kalisch (1982)

contend that physicians are not enthralled with more education for nurses. The increased education enables the nurse to challenge the physician, something he may not feel comfortable with.

The third largest category with 16 incidents, was that of interpersonal skills, where all but one incident were positive. An increased ability to communicate can only be an asset in the clinical setting. The greatest number of incidents involved patients. The examples included incidents where the nurse had just listened, really listened, and patients were grateful. Other examples included an increased ability to function in groups. As Caretto (1986) states, "baccalaureate students did score significantly higher in the areas of communication and leadership" (p. 24). There appears to be no difficulty in incorporating improved communication skills into one's practice. However, it could be argued that improved communication skills may act to the nurse's detriment. For example, a nurse with good communication skills may be assertive in speaking with a physician or supervisor and this may precipitate a confrontation (Cossom, 1990).

The fourth and fifth categories with 11 and 12 incidents each were incidents where the nurse spoke up either for herself or for patients. As to be expected the majority of incidents were negative. Physicians figured prominently and again it may be due to the fact that

physicians have come to expect subordination from the nurses. As Attridge and Callahan (1989) state in describing powerlessness "In most instances the reporter found herself confronted with work colleagues more powerful than she who limited her ability to act on her best judgment, i.e. control her own work". In the incidents collected by this researcher, nurses had spoken out against work colleagues who did try to limit the nurse's ability to work. As one nurse reported when she had gone over the attending physician's head, "I knew we were right. I have more confidence now. I'm a peer". The category "Understanding of the Elderly" was a category kept separate because the nurses themselves identified a change in their knowledge base about the elderly. One is struck by the number of incidents (five out of nine) that involved the use of medications and the elderly. It may be that nurses are finally beginning to understand and speak up about the medication of elderly patients. The consciousness level of nurses has been raised and the plight of the over-medicated elderly has been recognized. Since the greatest number of hospital beds are occupied by the elderly, it seems especially important that nurses have a greater understanding of the elderly. In the incidents where physicians were involved, on each occasion the nurse spoke up about inappropriate or incompatible drug usage. Some physicians responded by withdrawing or changing the dosage

while in another case, the note left for the physician alerting him to the incompatible nature of two drugs was torn up. However, that nurse affirmed that she would continue to notify physicians of drug problems. She did not, however, indicate whether or not she would refuse to give the drugs. Perhaps nurses are not ready for that step yet.

Another category was that of "Teaching Abilities". Only three of the nine incidents were negative and two of these came from supervisory personnel. As stated previously, perhaps these head nurses felt threatened when the nurse pointed out teaching tools that were needed on the ward since the head nurse is responsible for the care on the ward.

The final category was that of "General Reaction" where nurses reported how their work colleagues viewed the nurse returning to school to obtain a baccalaureate degree. Half the incidents were negative although the number of incidents was small (four). Even though only four incidents were cited more than half the subjects commented on how their work colleagues viewed the baccalaureate program negatively. Comments such as, "Nurses ask me why I'm doing this at my age" or "People say you'll never get your money back" and "This (the degree) won't make you a better nurse" were common statements. It would appear that there is not much support for the returning BSN student. As stated

previously, this may be because the baccalaureate student is seen as a threat to working RN's who fear they too may need to take this step. It may be that the Entry to Practice issue is misunderstood and nurses think that all RN's will be required to have a degree, not just the beginning practitioner. Or it may be tied to the feeling of powerlessness. It may be that nurses seek to discipline those who would act differently from the norm; they "devalue and sometimes oppress members of their group" (Attridge and Callahan, 1989, p. 47).

Implications

The findings lead to the proposal of some strategies for dealing with the negative sanctions encountered by the nurse. The strategies and recommendations provide a variety of topics for further research in the areas of supports for distance students, the effects of improved communication skills, and the political consequences of distance education.

If nurses who return to school meet with this many negative reactions, it is interesting that more of them are not discouraged from putting into practice the concepts and skills acquired in post-RN baccalaureate programs. Although the respondents in this study continued behaviour despite reactions from work-related role sets, it seems important to provide support and encouragement for a distance education BSN student. This may be more so since the distance

education student may lack the peer support normally found when the courses are taken face-to-face. The distance education student may not have the peer support found in the classroom setting.

What can be done for the distance education student? As Cragg (1990) found in her study of distance education students, the students themselves looked for other students or those nurses who had degrees, for their support. Attridge (1989) states that it is important to have the "visibility to learners of role models who are practising the desired role If learners see nurses thinking about, talking about and practising nursing in ways which are congruent with the program and which are valued and rewarded by others they are more likely to aspire to do the same" (p. 29). Therefore, it would seem prudent for the School of Nursing to find contact people in the acute care hospital (or other work milieu) who would be willing to be available to the distance education student and provide the support so needed.

In addition to selecting suitable support people, there needs to be dissemination of information about the program; its beliefs, intentions and content. Several subjects indicated to this researcher that peers were surprised at certain content taught in the program. "I didn't know you learned that" and "I thought it was all airy-fairy theory" were comments made by these peers.

Given that there is support in numbers there should be opportunities for learners to relate to one another. Class lists sent to each distance education student is one way that presently exists for learners to find others in the same situation. This should be continued. Students are encouraged to form study groups and student initiated study groups are another mechanism for dealing with the negative interactions since talking about these events may be helpful. As well, names of graduates from the program could (with their permission) be given to the distance education student so that they might discuss experiences and ways of dealing with the negative sanctions. Peer counselling has often been employed with success in these areas.

Since the learners meet with negative interactions, there should be a mechanism in place so that these issues can be discussed. Perhaps the School of Nursing could address the problem during an immersion period. (Discussed below) Recognition that the problem exists is a first step. Ways of dealing with these incidents as well as discussion of the feelings the incident evoked could be offered to the student.

Although distance education teachers do not have face-to-face contact with their students, they can help too. Teachers should be clear and consistent about the messages they send. These messages should be congruent with the course material. Also teachers need to be aware that some

students face negative sanctions so that the teachers could offer support and assistance.

Often distance education courses make use of field guides or tutors for students. These tutors need to be supportive and understanding of the problems faced by the distance education student. Tutors need to model the behaviours that the program intends the learner to have. Additionally, Attridge (1989) suggests that "clinical areas should be selected/developed/evaluated with role model potential ... in mind" (p. 30).

It has been suggested that the School of Nursing offer a "survival course" for distance education students (Dawson, 1990). The course might offer insights into why the negative sanctions exist and what the distance education learner could do to counteract their effect.

Finally, the use of periods of immersion in face-to-face "learning environments designed to communicate, reinforce and otherwise influence program messages about nursing" (Attridge, 1989, p. 30) might also provide support for the distance education learner. These periods of immersion would allow for discussion about how others see the learner and how to deal with negative sanctions. The availability of role models or mentors, increased dissemination of information, encouragement of student support groups, clear messages from teachers, supportive tutors, appropriate clinical facilities, and periods of

immersion are all strategies that might assist the distance education post-RN baccalaureate student to better weather the negative sanctions she experiences when she attempts to incorporate into her practice concepts and skills acquired in the program.

Suggestions for Further Research

The findings of this study show that this sample of post-RN baccalaureate distance education students frequently met with negative interactions when they attempt to initiate some concept or skill acquired in their program. However, because of the sample size and type (convenience) these results can not be generalized to a larger population. Samples from other sites in the province are necessary to generate more data. Since only three sites of acute care hospitals were used, further sites need to be examined to determine if similar phenomena occur. Additionally, other work sites such as long term care settings or nurses working in home care need to be addressed.

It would be important to control for a variable such as length of time in nursing practice to see if nurses with more experience are less influenced by negative sanctions. It would also be interesting to see if position in the post-RN baccalaureate program (i.e. number of courses completed toward a BSN) has any impact on how the nurse responded to negative sanctions.

In addition to the studies already suggested, a study might be done by asking those nurses why the negative sanctions did not deter them from continuing their newly acquired behaviour. A survey of general duty nurses might be conducted to determine why they react negatively when colleagues incorporate new concepts or skills into their practice.

Summary

Many B.C. nurses are returning to University distance education learning program to complete post-RN baccalaureate degrees. Many of these nurses work as general duty staff nurses in acute care hospitals where they come into constant contact with other health care professionals and patients. As part of the degree program new concepts and skills are acquired and incorporated into the nurse's practice. The response of work-related role sets does seem to be a critical event in the eyes of the subjects even though it did not deter nurses in this sample from putting into practice concepts and skills acquired in a post-RN baccalaureate program. Nurses who enrol in such a program report that they continue to incorporate new knowledge and skills into their practice.

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APPENDIX A**CONSENT FORM**

**To Participate in a
Study of What General Duty Staff Registered Nurses
Perceive to be the
Reactions of Peers when they are Enroled in the
post-RN baccalaureate program as a Distance Learner
October, 1989**

I _____ hereby consent to participate in the University of Victoria study on my perceptions of peers responses to my implementation of new knowledge, skills or values from my baccalaureate program.

I give my permission for this interview to be audio-taped and used as part of the data in this study. I understand that reasonable measures will be taken by the researcher to protect the confidentiality of the research data and my anonymity within the research project. I have been informed that code numbers will be used for those participating both in the interview transcriptions as well as the final report of the research project. The final report will be drafted so as not to reveal the identity of myself and other volunteers or any employing agency. Taped interviews will be erased once the data are transcribed. I have been further assured that all interview data will be kept in complete confidence and will not be viewed by

persons other than the researcher, faculty advisor, committee members, and members of a research group without my prior written consent. I also understand that I may withdraw from the study at any time and data collected will be destroyed or retained by myself. I have been informed that I may view the results of study once completed.

Signature _____

Date _____

Witness _____
(Researcher)

APPENDIX BUNIVERSITY OF VICTORIAREQUEST FOR APPROVAL OF PROPOSED RESEARCH INVOLVING HUMAN SUBJECTS

TO: Committee on Research and Other Activities Involving Human Subjects, Office of Research Administration, University Centre.

FROM: _____ (name) _____ (date)
 _____ (department) _____ (phone number or local)

- (i) **Short title of proposed research:** Perceptions of Peer Responses to Distance Education Clinical Course

Please attach an outline of the proposed research, with emphasis on the procedures involving human subjects. That is, what are the subjects going to be doing? Include copies of questionnaires, test, interview schedule, etc.

- (ii) **Who are the Subjects?**

Registered Nurses working as general duty staff nurses in acute care (regional and general) hospitals who are enroled in a post-RN baccalaureate program as a distance education student.

- (iii) **How will the subjects be obtained?**

Agencies through DON's will be asked to display posters and contact person in each agency will be approached will ask for voluntary participants from their general duty staff.

- (iv) **To what extent is the participation of the subjects voluntary? How is this assured, procedurally?**
- Strictly voluntary. Signed consent form. Subjects are able to withdraw at anytime and retain data.
- (v) **To what extent are appropriate guarantees of anonymity or confidentiality given to the subjects? How is this implementation (e.g. will data records contain names or other means of identifying individuals)?**
- Code numbers for agencies and individuals will be used for participating volunteers. No mention of employing agency will be made on tape or in transcribed data.
- (vi) **Is there any possibility of physical, psychological, or other risk in the research? If so, explain in detail, on or hazard and the potential value of the research justifying it.**
- No.
- What safeguards for the subjects, the researcher, and the University are part of the research plan?**
- Confidentiality. Results will be made available to participants. Tapes will be erased following transcription. Raw data will be heard by researcher and research team only.
- (vii) **When, and to what extent, is the nature and purpose of the research or study explained to the subjects?**
- Through telephone and/or personal communication and consent form which explains the nature and guidelines of the study.
- Considering this question and question iv. (page 1), when and how is informed consent obtained?**
- Prior to beginning the interviews.

- (viii) **Please list any institutions, or organizations involved in the research (e.g. by providing subjects, facilities, or access to data). Also, indicate whether their written permission is attached or is to be forwarded to the Committee.**

Acute care regional, general, and district hospitals on Vancouver Island.

- (ix) **Person designating him/herself as in charge of the research:**

(name)

(signature)

Supervisor (if any):

(name)

(signature)

(date)

- (x) **Additional information, required before final approval can be issued:**

Dates of research from September to December, 1989.

Researcher is Pat Robinson.

APPROVED BY COMMITTEE ON RESEARCH & OTHER ACTIVITIES
INVOLVING HUMAN SUBJECTS:

(Chairman's signature)

(date)

APPENDIX CGLOSSARY

Emotional Tone - identified by the subject as having an affective component and classified as positive, negative or neutral.

Elderly - a group of individuals who by virtue of their age (over 65) require nursing care.

Empowerment - The ability to speak out freely and act independently of others. When nurses took control of a situation.

General Reaction - How work-related role sets viewed the BSN program in general.

Interpersonal Skills - those aspects of verbal and nonverbal interacting with others and includes group process.

Nursing Process - the systematic set of actions which includes assessment diagnosis, planning, implementing and evaluation of care.

Patient Advocate - where nurses spoke up on behalf of clients who were unable or unwilling to speak for themselves.

Psychological Processes - an understanding of human anatomy of physiology.

Role Set - all the individuals the subject interacts with during the course of learning and practising a role.

Teaching - a specific process designed to provide learners with information they can learn.

APPENDIX D

3027 Landmark Crescent
Nanaimo, BC
October 4, 1989

Sharon Prediger
Assistant Executive Director
Nanaimo Regional General Hospital
1200 Dufferin Crescent
Nanaimo, BC

Dear Sharon:

As part of my Master's program, I am conducting research on the effect of work-related role-sets on the distance education learner.

I am aware that, on staff at Nanaimo Regional General Hospital, you have many nurses who are completing post-basic baccalaureate degrees by distance education. I am anxious to interview these nurses. Would you, therefore, display this poster on an appropriate bulletin board in your agency? I also intend to use "word-of-mouth" to contact willing subjects.

I would be happy to discuss any aspect of my research and share the results with you.

Yours truly,

Pat Robinson

Enclosures

VITA

Surname: Robinson Given Names: Patricia Helen

Place of Birth: Witley, Surrey England

Date of Birth: October 21, 1942

Educational Institutions Attended:

| | |
|--|----------------|
| Vancouver General Hospital School of Nursing | 1961 - 1964 |
| University of Victoria | 1976 - 1983 |
| University of Victoria | 1985 - Present |

Degrees/Diplomas Awarded

| | |
|--|------|
| Graduate Nurse Diploma Vancouver General Hospital School of Nursing | 1964 |
| Instructors Diploma University of British Columbia | 1980 |
| Bachelor of Science in Nursing University of Victoria | 1983 |

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Title of Thesis/Dissertation: _____

PERCEIVED IMPACT OF WORK-RELATED ROLE SETS: Nurses' Experiences With
Their Colleagues

Author



(Signature)

PATRICIA HELEN ROBINSON
(Name in Block Letters)

December 12, 1990
(Date)