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COMPARISON OF THE PROFESSIONALIZATION OF NURSING IN CANTON, HONG KONG, AND MACAO

The University of North Carolina at Greensboro ED.D. 1983

COMPARISON OF THE PROFESSIONALIZATION OF NURSING IN CANTON, HONG KONG, AND MACAO

by

Ellen D. Tabor

A Dissertation submitted to
the Faculty of the Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
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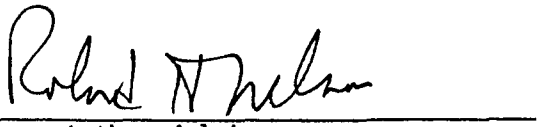
Approved by



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APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of the Graduate School at the University of North Carolina at Greensboro.

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January 17, 1983
Date of Acceptance by Committee

January 17, 1983
Date of Final Oral Examination

TABOR, ELLEN DENNIS. Comparison of the Professionalization of Nursing in Canton, Hong Kong, and Macao. (1983) Directed by: Dr. Roland H. Nelson, Pp. 156.

The purpose of this comparative field study was to compare the professionalization of nursing in three Chinese-populated cities--Canton, Hong Kong, and Macao--on Moore's (1970) professional characteristics, Mintzberg's (1973; 1979) manager roles of professionals, and the professional operating core characteristics advocated by Mintzberg (1979). Each nursing system was evaluated on its degree of the characteristics, and the nursing systems were also compared in the development of their professionalism. Historical development of nursing in the three cities and a brief description of traditional medicine and the western medical model were also presented.

The convenience sample, comprised of 33 nurse subjects, provided professional and organizational data. Two quota samples of one nurse from Canton, Hong Kong, and Macao in each sample responded to the perceptual items on professional nursing and Mintzberg's professional manager roles. Nurses in the first quota sample were professional association officers; the second quota sample was comprised of nurse managers in government units.

Researcher-designed interview schedules and Likert-type perceptual items were used to collect the data. Analyses of data were performed by use of coding tables, summed scores, rank-ordered scales, and chi-square for significance. The results for the three nursing systems were compared.

Three study questions were formulated to obtain measures of the development of professional characteristics. The first question measured Moore's six characteristics. Of these, Canton, Hong Kong, and Macao exhibited occupational status, and Hong Kong also demonstrated calling. Macao's data were significant by chi-square analysis.

The second research question examined nurse managers on Mintzberg's (1973; 1979) ten manager roles. The Canton manager claimed figurehead, liaison, leader, monitor, and spokesman roles; Hong Kong's manager identified figurehead, liaison, leader, and monitor roles; and the Macao manager reported figurehead, leader, monitor, and negotiator roles. The chi-square analyses were significant for the three subsamples.

The last question obtained measures of the professional operating core characteristics of Mintzberg (1979). However, Canton, Hong Kong, and Macao nurses did not demonstrate any of these professional operating core characteristics.

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Many people and organizations have provided support and assistance to this research.

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I thank the staffs of the Biblioteca Nacional in Macao and the University of Hong Kong Libraries, also M. Lovegren and Dr. and Mrs. W. R. Swan of Macao for making available many rare documents and publications.

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I am under obligation to many others: professors, professional colleagues, and friends who have made contributions to this study.

Finally, a special word of appreciation is given to my husband, Charles, whose patience, understanding, interest, and support made the completion of the study a reality.

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CHAPTER I

INTRODUCTION

Professionalism has become a universal concern of occupations in general (Abbott, 1981; Carr-Saunders & Wilson, 1933/1964; Goode, 1969; Hughes, 1960) and of nursing in particular (Chaska, 1978; Corwin, 1961; Gamer, 1979; Jacox, 1973; Stuart, 1981). This study ascribed to Moore's (1970) definition which states that professionalization is the process of developing professional characteristics. At the lowest level conceptually, a checklist approach may show that many occupations are developing professional characteristics. "Characteristics by their dynamic nature, can take the form of goals for a professionalizing occupation" (Houle, 1980, p. 27). The goal of professionalization is autonomy of work for the professionals who are controlled by the profession (Goode, 1969; Greenwood, 1957; Moore, 1970). Wilensky (1964) and Goode (1969) cautioned that there are limits to how far occupations may move toward the ideal professions, medicine, clergy, law, and university teaching, in their quests for autonomy. When predictions were made that nursing would probably remain outside the inner core of the ideal professions (Corwin, 1961; Etzioni, 1969; Goode, 1969; Katz, 1969), nurses turned to the assessment of the professional development of nursing.

The theoretical concepts of Moore concerning the characteristics of professionalism (1970), Mintzberg's manager roles of professionals (1973, 1979), and his professional operating core design (1979) were

chosen as measurements of professionalization of nursing in Canton, Macao, and Hong Kong.

The professionalization process of nursing worldwide is interrelated in proportion to the continuing interaction of nurses on an international level. In 1899 the International Council of Nurses was founded by Fenwick of England to assist in elevating and maintaining high professional standards (Dolan, 1968; Fenwick, 1920). Diers (1981) assumed that nursing issues are not much different worldwide. Henkle (1979) questioned whether international nursing should be a specialty area. Hockey (1981) called for studies of nursing on an international level to promote greater international understanding of nursing as a global discipline. After a two-week visit in China, Donley and Flaherty (1982) declared that nursing will be advanced through international exchanges in which nurses seek to learn from each other.

Moore (1970) noted that members of a given professional group may be less valued in different economic, social, and geographical settings. Mintzberg (1973) called for studies of job differences regarding the role emphases and influences of cultural, situational, and societal changes. Since the nursing systems of Canton, Macao, and Hong Kong fulfill many of these qualifications, they were selected for the settings of this investigation.

Theoretical Orientation

Hughes (1958) introduced the concept of professionalization as a process of developing professional characteristics. The theoretical concepts were enlarged upon by Bucher and Strauss (1961) and Vollmer and Mills (1966). Hughes was the first to suggest that the question

should be "how professionalized is an occupation?" Moore (1970) proposed that professionalism is composed of characteristics which may be placed on a scale or continuum moving from less to greater professional status according to the degree of the characteristic exhibited. He described six characteristics:

1. Occupation: practice of a full-time, income-producing work
2. Calling: commitment to the occupation's requirements and behavioral expectations
3. Organization: formalized interaction of the professional peers
4. Education: minimum entry requirements equivalent to those for a baccalaureate degree
5. Service orientation: practice guided by rules of competence, rules of conscientious performance, and rules of service
6. Autonomy: use of own judgment to provide the service or perform the work

Professionalism may also be approached from the point of view of the roles of the professionals who serve as managers of their professional peers. Mintzberg (1973, 1979) identified ten roles of managers:

1. Figurehead: serves in routine social and legal activities
2. Leader: motivates and activates the peers or subordinates
3. Liaison: maintains network of outside contacts essential to the manager activities
4. Monitor: collects internal and external information
5. Disseminator: controls the flow of information
6. Spokesman: releases information to the external environment

7. Entrepreneur: initiates and supervises change and new projects

8. Disturbance handler: initiates corrective actions when disturbances and crises occur

9. Resource allocator: makes or approves all significant department or organizational decisions

10. Negotiator: represents the department or organization in major negotiations (pp. 91-92).

These roles are essential activities of all managers who serve as the links of organizational units and the environment.

What happens to professionals who work in complex organizations? Marshall (1939) recognized that organizations and professions interact in such ways that each is altered by the other's presence. Mintzberg (1979) classified organizations in which the main work force is an operating core of professionals of one or more disciplines as professional bureaucracies. To him the essential characteristics of these professionals in the operating core are:

1. Standardized skills acquired through education
2. Specialty areas of practice
3. Limited vertical management
4. Autonomy of practice (p. 379).

Organizational designs and manager roles of professionals have been found to be interrelated (Clark, 1963; Kornhauser, 1962; Mintzberg, 1979; Scott, 1966; Stevens, 1981; Vollmer, 1966; Wilensky, 1964). Mintzberg identified hospitals as professional bureaucracies.

Nursing is practiced chiefly in hospitals, and since its beginning physicians and leaders have acknowledged its professional aspects (Burdett, 1877; Lewis, 1895; Nightingale, 1859 / 1946; Stoker, 1896). Bixler and Bixler (1945) asserted that nursing in the United States began with a higher degree of autonomy than it was able to preserve. Researchers such as Braito and Prescott (1978), Stevens (1981), and Stuart (1981) have applied the theoretical concepts of Moore (1970) and Mintzberg (1973, 1979) to nursing in the hospital settings of the United States. In the belief that these professional concepts are appropriate for cross-cultural study in nursing, the researcher selected them as the theoretical foundations of this investigation.

Purpose

The purpose of this study was to compare the professionalization of nursing in Canton, Macao, and Hong Kong on Moore's (1970) continuum of professional characteristics, Mintzberg's (1973, 1979) professional manager roles, and the professional organizational design of the operating core according to Mintzberg (1979). Each nursing system was compared to the specified characteristics, and the nursing systems were compared to each other on the measurements of the criteria of Moore and Mintzberg.

Statement of the Problem

How professionalized is nursing in Canton, Macao, and Hong Kong? Are there differences in the development of nursing in these three cities

in Kwangtung[1] or Guangdong[2] Province, China? Canton is under the governmental system of the People's Republic of China, while Hong Kong has been a part of the United Kingdom since 1842, and Portugal has claimed control of Macao since the 1530s. In order to study the professionalization of these three Chinese nursing populations, three questions were formulated:

1. At what level on Moore's continuum of professional characteristics (1970) do professional nurse subjects identify their respective nursing systems in Canton, Macao, and Hong Kong?

2. Do professional nurse managers in government hospitals in Canton, Macao, and Hong Kong identify Mintzberg's professional manager roles (1973, 1979) as components of their job activities?

3. Is nursing practice in general government hospitals in Macao, Canton, and Hong Kong organized as the operating core in a "professional bureaucracy" organizational design as measured by Mintzberg's criteria (1979)?

Definition of Terms

Operating core: those who carry out the basic work of input, processing, and output of a product or service--the heart or essential part of every organization (Mintzberg, 1979, pp. 19, 24).

Professional Bureaucracy: an organization which relies "on the skills and knowledge of their operating professionals to function...it

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[1]Mandarin -- official language of The People's Republic of China

[2]Cantonese -- language traditionally spoken in Canton, Hong Kong, and Macao

hires duly trained and indoctrinated specialists-professionals for the operating core, and then gives them considerable control over their own work...highly specialized in the horizontal dimension...works relatively independently of colleagues, but closely with the clients served" (Mintzberg, 1979, p. 349).

Professional manager: a manager of the peer professionals under his administration in the organization (Mintzberg, 1979, p. 358).

Professional nursing: a subsystem of the professional operating core in the hospitals of the study.

Professionalization: the process of developing professional characteristics which include occupation, calling, organization, education, service orientation, and autonomy (Moore, 1970).

Role: organized set of behaviors belonging to an identifiable office or position (Sarbin & Allen, 1968) and used to mean one of the ten activities of managers: figurehead, leader, liaison, monitor, disseminator, spokesman, entrepreneur, disturbance handler, resource allocator, and negotiator (Mintzberg, 1973).

Sampling - convenience: a group of available subjects.

Sampling - quota: subjects selected according to specified controls.

Traditional medical model: a complex system of health resources which include

1. Magical and demonological practices;
2. Medical systems based upon theories made up of concepts of Yin-Yang, Five Phases, and Pulse Diagnosis which are

treated by acupuncture, moxa, materia medica, and diet in combination or separately;

3. Popular practitioners (self, family, or immediate community), folk healers (non-professional sacred or secular healers), and the expert physicians (practitioners who are regulated by the ruling political structure) (Unschuld, 1979a).

Western medical model: a system of health care organized on scientific principles of the germ theory of disease causation; health restoration by surgery, medication, or scientific treatments, in combination or separately; preventive measures aimed at maintaining health.

Research Design

This investigation was designed as a descriptive field survey based on interview schedules for two quota samples and one convenience sample of nurses in Canton, Macao, and Hong Kong.

Quota sampling subjects were desired for the two samples because comparable professional responsibilities and roles were being investigated. Convenience samples were used when possible due to the difficulty in obtaining approved nurse interviews. The quota samples responded to perceptual items. The first sample responded to Moore's professional characteristics data (1970), and those in the second quota sample were interviewed regarding their roles as identified by Mintzberg (1973; 1979). Convenience-sampling subjects provided data to be used in the assessment of Moore's professional characteristics and Mintzberg's characteristics of the professional operating core.

The interview instruments were designed by the researcher using Hall's Professional Inventory Scale (1967) as a guide, because a usable standardized tool was not available. A test-retest reliability (Borg & Gall, 1976) was obtained by administering the interviews to a Chinese nurse and a Cantonese-speaking American nurse at three-month intervals. Extensive investigations were made of the environmental presses on each of the nursing systems which might influence the data obtained and the interpretations made by the researcher.

All data were collected by the investigator through personal interviews assisted by interpreters in the respective work settings of the informant.

Likert-type summed rating and rank-ordered rating scales, coding tables, and chi-square for significance analyses were used on the descriptive data.

Assumptions

Basic to the purpose of this study are the following assumptions regarding nursing and its professionalization:

1. Accepting Unschuld's concept (1979b) that each society has developed a distinctive health care system over time according to its available resources, it was assumed that Canton, Hong Kong, and Macao had developed western model health care systems requiring nurses. This is supported by Balme (1921), Poon (1979a; 1967b), Simpson (1926), and Teixeira (1975).

2. An assumption based upon the first one was that each of these nursing systems has a professional organization which has played a vital role in the professional growth of nursing. This assumption is supported by the concepts of researchers who proclaim that an association of professionals is essential in the process of professionalization (Carr-Saunders & Wilson, 1933/1964; Hall, 1948; Monnig, 1978).

3. It was assumed that the nursing systems of Canton, Macao, and Hong Kong are developing professional characteristics, and that these characteristics are identifiable by the characteristics of professionalism as defined by Moore (1970) and Mintzberg (1979).

Limitations

In addition to the ex post facto weakness which is common to all field studies, the following limiting factors are probable:

1. The investigator's limited knowledge of Chinese and Portuguese languages and cultures may have introduced biased interpretations.

2. Controlled and limited subject-researcher interaction was a weakness.

3. Novelty effect may have influenced the responses given.

4. The nonstandardized tools were only tested for test-retest reliability.

Significance of the Study

The findings of the Chinese nursing samples in Canton, Hong Kong, and Macao should enlarge the critique of Moore's (1970) professionalism characteristics and Mintzberg's (1973, 1979) professional manager roles and professional operating core organizational design concepts.

This study should contribute to a better understanding of nursing in Canton, Hong Kong, and Macao by providing data on the present state of nursing practice and the professional status of nursing.

Formal and informal exchanges of nursing data on international nursing between the sample subjects and the researcher promoted awareness and increased understanding for both.

Summary

This descriptive field survey of the professionalization of nursing in Canton, Macao, and Hong Kong according to Moore's (1970) continuum of professional characteristics, Mintzberg's (1973, 1979) professional manager roles, and his (1979) professional operating core in hospital organizational design employed interview schedules to collect data from two quota-samples and one convenience-sample subjects in each of the cities.

Test-retests of the interview questions designed by the researcher were given to a Chinese nurse and to a Chinese-speaking American nurse at three-month intervals.

Likert-type and rank-ordered rating attitude scales, coding-tables, and chi-square tests for significance measurements were used to analyze the descriptive data.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

Professionalization has become a concern of many occupations including nursing. In this study, nursing was conceptualized as a complementary and interdependent professional subsystem in organizations of health care delivery. The development of professional characteristics and the professional's autonomy of practice in organizations were the measures chosen to investigate in nursing in Canton, Hong Kong, and Macao. Moore's (1970) professional characteristics and Mintzberg's professional manager roles (1973, 1979) and his professional operating core in organizations (1979) provided the theoretical foundations for this study of nursing in the three Chinese populations. Since the theories of Moore and Mintzberg are applied to this cross-cultural investigation, the review of the literature is divided into Part I, The Review of Professionalization, and Part II, Historical Data.

Part I. The Review of Professionalization

Historical Perspective of Professionalization

During the nineteenth century, a growing number of occupations received professional recognition in western society; at the same time, the prestige of the older professions of medicine, law, clergy, and university teaching increased. Medicine was especially favored as complex medical care systems evolved which demanded greater physician expertise. During this century, foundation grants enabled

the medical profession in the United States to be propelled to the pinnacle of professionalization guided by the plans formulated from the 1910 Flexner studies.

Flexner identified the components of a profession as these:

1. Work based upon intellectual judgments
2. Advancements made through theory and research development
3. Unique body of knowledge which is imparted to new recruits through a special discipline of education
4. Organization of full-time workers with practical aims serving the good of society
5. Professional status accorded by society (Flexner, 1915, p. 576).

As the occupational quests for professionalization grew, social scientists began to study the process of professionalism. Carr-Saunders concluded that:

> Professions evolve and in consequence their organizations are modified, but on the whole they change less rapidly than do the institutions in which men practice their crafts...groups are always in process of formation for the carrying out of certain specific objects. When those purposes have been achieved, the organizations are superceded or transformed. Those who collaborated to achieve these objects seek for opportunities to practice their crafts in other organizations ...the growth of professionalism is one of the hopeful features of the time (Carr-Saunders, 1928, reprinted in Vollmer & Mills, 1966, pp. 7, 9).

Vollmer and Mills (1966) concluded that professionalization is stimulated by technological changes and that analysis of occupations according to the development of professionalism gives meaning to many of these technological changes. They called for a rank ordering

of the professional characteristics which are required for professional growth.

Theoretical Orientation of This Study

Moore's characteristics of professionalism. At the lowest conceptual level, a checklist approach may show that many occupations are developing professional characteristics. Wilensky (1964) and Goode (1969) cautioned that there are limits to how far occupations may progress in their professional development. To measure the degree of professional growth, it has been suggested that a continuum or scale of the professional characteristics be used (Goode, 1969; Greenwood, 1957; Moore, 1970; Vollmer & Mills, 1962). On that continuum ideal types are placed at the upper end of the scale and occupations without professional characteristics are clustered at the opposite end. Moore's characteristics (1970) begin with the full time occupational factor, move through calling, professional organization, educational requirements, service orientation, and arrive at the highest point, autonomy.

Moore suggested that the dichotomy of professional or non professional focus obliterates the process of professionalization; therefore, occupational status growth struggles are not played out upon an open stage. He postulated that more accurate concepts of professionalization are presented when attributes are placed on a continuum scale rather than in attribute clusters. He maintained that the characteristics are interrelated social relationships which move along a continuum toward professionalization.

Moore gave the following definitions for his professional characteristics:

Occupation means a full-time, income-producing activity which is demanded by society to fulfill personal needs of individuals.

Calling is demonstrated when the professional commits himself to the norms and standards of education and continued competence, and identifies with his professional peers in a continuing relationship to advance the profession. Being called or set apart conveys a dedication of the entire self to the profession, according to Greenwood (1957); therefore, one is readily socialized to embrace the professional cultural norms, values, and symbols.

Professional organization is a natural development by members of an occupation with common interests who wish to promote the development of the professionals and the occupation. The association of those members is expected to establish professional standards, regulate entry into practice, and monitor the ethical and professional activities of the members.

Educational requirements become an essential qualification, and are increased as the profession's theoretical foundations develop into a specialized body of knowledge. This is a distinguishing characteristic of professions (Greenwood, 1957). Moore suggested that the baccalaureate degree or its equivalent should be the minimum requirement for professions in the United States. However, he cautioned, this is probably too low since the ideal professions require education and training beyond the baccalaureate degree. The purpose

of the education and training is to impose the profession's required theory, skills, and cultural socialization upon a broad educational foundation.

Service orientation implies that the professional accepts the premise that he will practice according to the rules of competence, rules of conscientious performance, and rules of loyalty (Moore, 1970, p. 13). Entry requirements, certification by examinations, license renewals, and continuing education are manifestations of competence demands. Conscientious performance is deemed necessary by society which has granted a monopoly of service to a given profession. To insure that the public is served well, the professional association establishes ethical and moral codes and methods of discipline for those who do not meet the standards. The ideology of service that is accepted not only by the professionals but also by the clients, who thus are able to follow the physical and mental treatments which the professionals prescribe, is that the professionals' work must take priority over their personal needs and commitments (Wilensky, 1964).

Autonomy is the highest value point on the continuum and can only be reached after the other characteristics have been developed. Society is reluctant to grant independent or collective judgment decisions to any select group and does so only when it has been deemed essential for the well-being of the society (Moore, 1970). Freidson (1970) declared that "the single zone of activity in which autonomy must exist in order for professional status to exist is in

the content of the work itself. Autonomy is the critical outcome of the interaction between political and economic power and occupational representation" (p. 82). Goode (1969) supported this concept when he stated that professionals may work within organizations if they and their fellow professionals retain control of the professional roles in the organization.

Summary. Moore (1970) claimed that his "proposed criteria of professionalism warrant the asking of common questions, even if the answers turn out to be different from one case to another" (p. 17). These professional characteristics are interrelated social relationships of rights and obligations between professionals and society which make professional development very difficult for any occupation. However, occupational assessment is critical for the development of professional characteristics.

Mintzberg's Manager Roles of Professionals. Roles are important in the professional concept, because work roles and services are designed to move the system toward goal attainment within the organization. In the definition of roles that complement other roles within complex organizations, it is required that each person be socialized to the culture of his/her profession. Maturity in professional identity enables one to move into collaborative roles of practice in organizations. Employees are expected to practice their professions and maintain professional role identities while participating in a fusion process of organizational socialization and goal attainment

(Bakke, 1955; Hart & Herriott, 1977; Katz & Kahn, 1978; Kovner & Neuhauser, 1978; Miller, 1965; von Bertalanffy, 1956).

Roles may be viewed as either functional or interactive. In the functionalist theory, society develops roles to fulfill needs, and socialization is required to prepare one for the role (Caplow, 1954; Durkheim, 1958; Parsons, 1960). Interactionists emphasize that roles are taken or made as a response to the interpretation given to symbols of others as they interact (Biddle & Thomas, 1966; Blumer, 1962; Turner, 1968). Mintzberg (1973) defined his approach with these words:

> We use the concept of role, a term that has made its way from the theatre to management via the behavioral sciences. A role is defined as an organized set of behaviors belonging to an identifiable office or position (Sarbin & Allen, 1968). Individual personality may affect how a role is performed, but not that it is performed (Mintzberg, 1973, p. 56).

From his observational studies of managers, he concluded that roles are really just a categorizing process of what managers do and that the activities of managers may be grouped into ten roles.

1. Figurehead: serves as a symbolic and ceremonial head of the unit or organization.

2. Leader: directs subordinates toward goal achievement.

3. Liaison: establishes communication networks.

4. Monitor: scans external and internal environments for information.

5. Disseminator: releases or withholds information according to his/her judgments.

6. Spokesman: speaks externally for the organization or department.

7. Entrepreneur: initiates new activities and developments.

8. Disturbance handler: mediates and resolves problems of the organization or department.

9. Resource allocator: determines the distribution of resources.

10. Negotiator: bargains as demanded for the organization (Mintzberg, 1973).

These roles could be subgrouped into three divisions: interpersonal including figurehead, leader, and liaison; informational including monitor, disseminator, and spokesman; and decisional including entrepreneur, disturbance handler, resource allocator, and negotiator.

When Mintzberg (1979) looked at manager roles in organizations which employ professionals at their core, he found a parallel administrative structure. The nonprofessional support staff was managed with a top-down, chain-of-command hierarchy, while the professionals had a member of their profession serving as manager of the bottom-up democratic work design. In this new design Mintzberg stated that:

> ...full-time administrators who wish to have any power at all in these structures must be certified members of the profession, and preferably be elected by the professional operators or at least appointed with their blessing...the professional administrator may not be able to control the professionals directly, he does perform a series of roles that gives him considerable indirect power...managers of the professionals may be the weakest... but...individually, they are usually more powerful than individual professionals (Mintzberg, 1979, pp. 358, 361, 363).

The professional manager engages in all the ten roles; but spokesman, liaison, figurehead, and negotiator demand a major part of the

manager's time. Moore (1970) pointed out that organizations often invest the enduring responsibilities of administration in a professional. Even though professionals have mixed feelings about their administrators, they usually display greater confidence in the administrative professional than they do in a lay administrator.

Mintzberg's Professional Organizational Design. Organizational design was also a focus of Mintzberg in 1979. Guided by the assumption that organizations must operate with coherent components, Mintzberg argues that:

> ...the characteristics of organizations fall into natural clusters, or configurations. When these characteristics are mismatched--when the wrong ones are put together--the organization does not function effectively,....If managers are to design effective organizations, they need to pay attention to the fit...five clear configurations emerge that are distinct in their structures, in the situations in which they are found, and even in the period of history in which they first developed. I call them the simple structure, machine bureaucracy, professional bureaucracy, divisionalized form, and adhocracy (Mintzberg, 1981, pp. 103-104).

One of these organizational designs or configurations usually predominates as the distinguishing structural design of a given organization. A configuration is developed by the arrangement of the dominant group of basic workers, of the control design, and of the coordinating means as shown in Figure 1.

The dominant group of basic workers--strategic apex of top managers, technostructure of formal planners and job designers, professional operating core, middle line of intermediate managers, and support staff--is different for each configuration. The five groups are all required for the function of a complex organization,

Structural Design	Key Part (Basic Workers)	Control Design	Key Means of Coordinating
Simple Structure	Top Management (Strategic Apex)	Centralized	Gives direct order
Machine Bureaucracy	Technostructure (Formal planners and job designers)	Decentralized Horizontal (limited)	Standardized Work Processes
Professional Bureaucracy	Operating Core (Professionals)	Decentralized Horizontal Vertical	Specialized Skills
Divisionalized	Middle Line (Intermediate managers)	Decentralized Vertical (limited)	Standardized Service/Product
Adhocracy	Support Staff	Decentralized (certain areas)	Mutual Adjustments

Figure 1. Mintzberg's Organizational Configurations

but in a "simple structure" for example, the strategic apex and operating core may be all that are needed. A single line of authority typically connects the apex, the middle line, and the operating core. The technostructure and support staff may be separated from the line authority as demonstrated in Figure 2. The interrelationships of these groups of workers in formal and informal work groups and ad hoc decision processes determine how the organization functions. Structure is provided to accomplish the goals of the organization.

Since the focus of this study was in the area of an occupation's professional development, the professional bureaucracy configuration was addressed in the third research question. The professional bureaucracy assumes that the professional of the operating core serves as the key part as presented in Figure 3. The operating core of professionals supplies the required standardized skills which

are essential for attaining the goals of the organization. The distinguishing characteristics of a profession--expertise, training, and indoctrination--are under the control of the professional discipline.

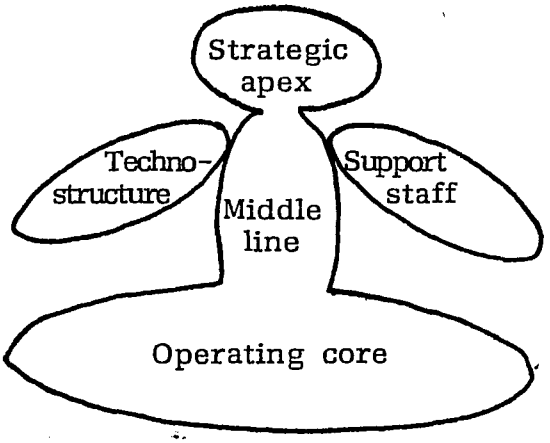


Figure 2. The Organization's Five Basic Parts

The professional body can continue its control over the professional by censuring malpractice or deviations from ethical codes. Professionals maintain a higher loyalty to the profession and its associations than to the organizations in which the skills are practiced.

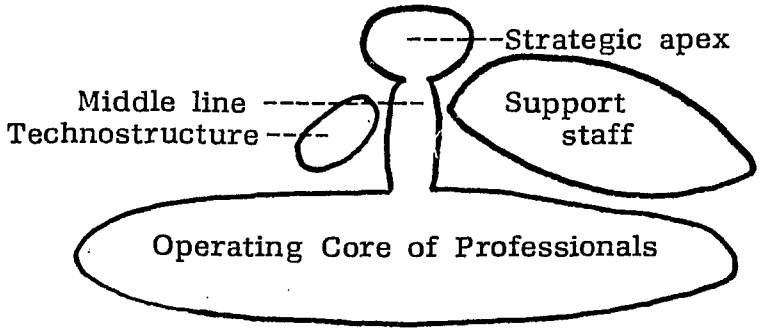


Figure 3. Configuration of a Professional Bureaucracy

Mintzberg (1979) suggested that professionals join organizations in order to share resources, train new recruits, have mutual exchange of knowledge and expertise, get clients, and provide collective care. In organizations, professionals are granted a wide range of autonomy in practice as they determine client needs and execute programs to provide for those needs. Power comes to the professionals through the societal demand for their services and from the complexity of their roles which cannot be supervised by non professional managers. Operating core professionals who work independently in the organization provide a wide horizontal specialization base which often controls the organization. It is economically expedient to provide support staff to do the routine work and thus free the professionals to practice their professional skills.

The professional characteristics of this operating core include educational and skills requirements, specialties in practice, limited managerial control, and autonomy of practice. Education and skills are determined by the professional association. The knowledge required for a professional grows so complex that it is impractical for all the professionals to be expert in everything; therefore specialties are created. The independent work pattern does not need coordination which results in only a peer professional manager. Professionals are free "to serve the clients in their own way, constrained only by the established standards of (the) profession" (Mintzberg, 1979, p. 371). A professional bureaucracy is very democratic for the professionals in

the operating core. This organizational design is common in universities and general hospitals.

Moore and Mintzberg's Professional Orientation Applied to Nursing.

Many occupations became associated with hospital systems as people in medical occupations pressed for professional status. The title of medical professional has been accepted to mean any health care provider given legitimate status by the power structures of the society (Kleinman, 1978; McQueen, 1978). Nurses as health care providers must interact with boundary systems of agency organizations, politics, economy, and other professionals in a competing environment of plural medical models (Kunstadter, 1974; Mendelsohn, 1974; Porkert, 1974; Unschuld, 1979a, 1979b). Historically, the secular occupation of nursing has been influenced and controlled by other professionals to the extent that the question asked continually was: "Is nursing a profession?" Changes in concepts of health care and patients' rights have caused nurses to ask a different question: "How professionalized is nursing?" (Stuart, 1981, p. 18). This question is based upon concepts of professional development as a process (Caplow, 1954; Goode, 1969; Greenwood, 1957; Moore, 1970).

Moore's professional characteristics. Moore's concepts were cited in the studies of Braito and Prescott (1978), Jacox (1973), Monnig (1978), and Stuart (1981). Three of Moore's characteristics, specialized education, service orientation, and autonomy were considered major characteristics of a profession by Jacox (1973).

She called for basic nursing education to be responsible for socialization of the nursing student to be autonomous and self-directive in practice. Others supported the importance of the socialization of the nursing student into the professional culture (Benne & Bennis, 1959; Corwin, 1961; Davis & Olesen, 1963; Etzioni, 1969; Katz, 1969; Kramer, 1966, 1968, 1969a, 1969b, 1970; Taves, Corwin & Haas, 1961; Williams & Williams, 1959). Greenwood (1957) assessed that the most critical differentiating characteristic of a given profession is a unified professional culture. In Monnig's (1978) study of Professionalism of Nurses and Physicians, the professional characteristics were measured on Hall's Professional Inventory Scale which measured attitudes concerning use of a professional organization as a major referent, belief in public service, belief in self-regulation, sense of calling to the field, and feeling of autonomy. Comparison of the baccalaureate graduate nurses and the diploma nurses' characteristics showed that baccalaureates measured higher only in autonomy. The physicians manifested a higher degree of professionalism than nurses in all areas except service orientation.

Braito and Prescott (1978) found that nurses employed in three hospitals which were engaged in conflict resolution did not relate job dissatisfaction and demands for increased autonomy in patient care.

Stuart (1981) applied Moore's professional characteristics to nursing in the United States and concluded that while it is making progress in its movement on the continuum, nursing still falls below the ideal professional types. Its weakest areas, according to Stuart,

are those of professional association role, educational requirements, and autonomy of nursing practice. No research was found on professionalization of nursing in Canton, Macao, or Hong Kong.

Mintzberg's manager roles of professionals. Mintzberg's roles have been used as a guide in the assessment of managers in health care organizations. Working under the assumption that managers in all fields are not much different, Sheldon (1975) found that managers in health care organizations do have an overall purpose of providing efficient service while fulfilling the mandates of the controlling body of the organization. The ten roles of managers can be observed. Sheldon agrees with Mintzberg that managers in hospitals choose which roles to alter or expand in order to accomplish the organization's goals. Choices made in role priorities often determine the effectiveness of the manager in a given organization.

Since health care managers have less control of professionals in their organizations than business managers have over their professionals, and since health care requires "almost 9 percent of the gross national product," Kovner and Neuhauser (1978) advocated the analysis of the health care manager's job in order to apply appropriate management theory and teachings. They formulated these questions for study:

1. What is the amount of discretion or autonomy he and his position have within the organization?

2. On what tasks and with which groups and programs does he spend most of his time and energies?

3. To what extent is the manager involved directly in the production process? (p. 23).

They pointed out that no studies were found on the education of health care managers or their tasks.

Nursing departments are usually designed as a top-down, chain-of-command, organizational design as depicted in Figure 4.

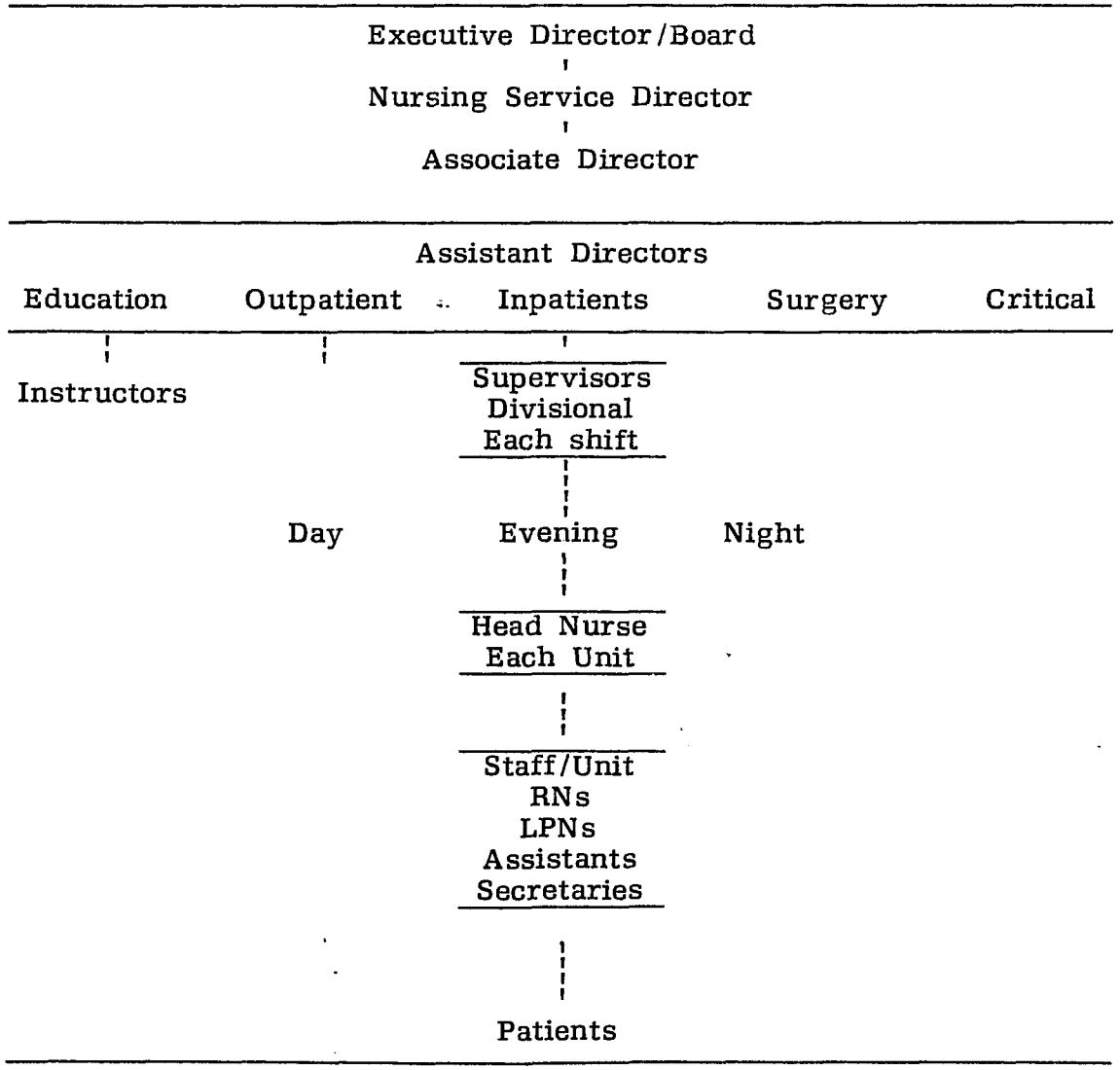


Figure 4. Organization of Nursing Service in a Complex Hospital

These hierarchical managers' roles are often overlapping and ill-defined which results in confusion for the managers and those with whom they interact. In one work setting, the highest nurse manager in the organization--who may be known as director of nurses, chief nurse, superintendent of nurses, or nurse administrator--is given administrative decisions involving nursing budget and policy. However, this same manager may find that in another organization these administrative decisions are made outside the domain of nursing (McQuillan, 1978; Stevens, 1979a). The hospital "sets limits to the amount and kinds of interaction, communication, responsibility, and discretion that are appropriate for...the professional roles of physicians and nurses" (Georgopoulos, 1972, p. 17). Christman (1979) argued that "organizational arrangements powerfully influence role behaviour."

A survey of over 100 nurse executives by Stevens (1981) revealed that these professional managers recognize Mintzberg's roles in their work. Stevens found that nurse managers distribute the time given to their various roles according to their individual theoretical approaches to management. Five dominant professional manager role patterns were identified:

1. Innovator - Focusing on starting new programs, new methods, new ideas.

2. Expander - Promoting growth and expansion of nursing mainly through political moves.

3. Refiner - Formalizing policies and practices; providing for what nursing service is and does.

4. Stabilizer - Maintaining harmony and equilibrium within and at boundary levels of the environment.

5. Revolutionary - Replacing old structures with radically different ones.

Relationships have been found between the organizational design and the dominant manager roles of professional nurses. Stevens (1981) examined the relationships using Griener's (1972), Katz's (1955) and Mintzberg's (1973) concepts of manager roles and organizations and hypothesized that

> organizations have stages of growth and development that correspond to the executive roles: innovation, expansion, refinement, stabilization and revolution. Directors of nursing tested under this model were able to identify stages both for their respective organizations and for their divisions...the success of the nurse executive might be a reflection of the match or mismatch (Stevens, 1981, pp. 21-22).

Georgopoulos (1972) observed:

> ...Traditionally, nursing has served as a repository of residual and supportive functions in the system--functions that are essential to coordination but not necessarily to professional practice. As nurses specialize further...(They are) no longer willing or able to carry out coordinative (duties)...and still discharge professional responsibilities to the patient and the organization (pp. 24-25).

Nurses are largely prevented from exercising professional judgments by the restrictions of policies, administrative directives, and physician orders (Jacox, 1973; Kramer, 1970; McQuillan, 1978; Roemer & Friedmán, 1971). The nurse leaders who advocate that there is a science of nursing independent of and different from

medical science are calling for nurses to facilitate the professionalization of nursing by creating a new system of nursing based upon a unique body of nursing knowledge and theory (Chaska, 1978; Diers, 1981; Ford, 1979; Jacox, 1973; Monnig, 1978; Stevens, 1979; Winstead-Fry, 1977).

No studies were found on nursing as a professional operating core in a professional bureaucracy. The review of the literature supports the concerns of professionalization of nursing in western cultures. However, this investigation was concerned with the development of professionalism in nursing in Canton, Macao, and Hong Kong.

Part II. Historical Data

Historical Settings

Canton, Macao, and Hong Kong. Canton, Macao, and Hong Kong are located on the Pearl River in the southeast province of Kwangtung, China. Macao is situated on the west bank where the river joins the South China Sea. Forty miles across the mouth of the Pearl River on the east bank is the British colony of Hong Kong. Canton is 90 miles inland. The map of the area is presented in Figure 1.

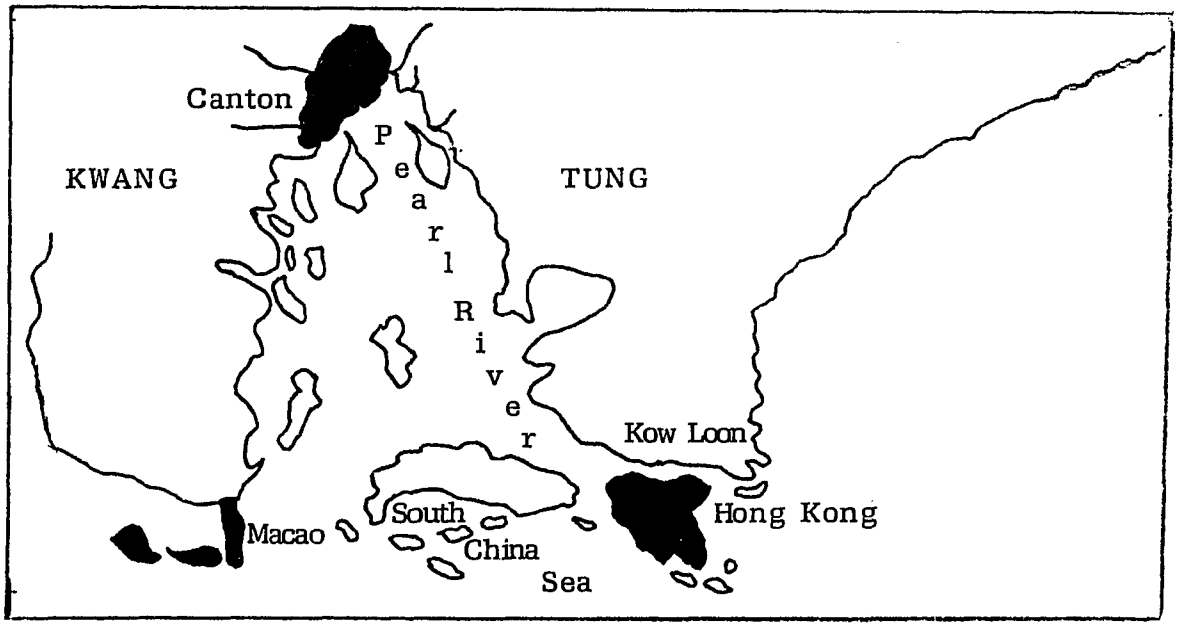


Figure 5. Map of Canton, Macao, and Hong Kong

The crowded cities of Canton and Hong Kong have mainly Cantonese populations of over 4,000,000. The six-square-mile Portuguese territory of Macao has a population of about 400,000 with less than one percent of these being Portuguese. Over 98 percent of the people of Hong Kong and Macao are Chinese (King, 1981a, 1981b; Lawrence, 1980).

Canton, which was founded during the reign of Nan-wang in the period of 314-255 B.C., has been under continuous Chinese rule except for brief periods during wars with Japan and England. Canton leads the cities of China in the number of contacts with the outside world (Gray, 1875; Lawrence, 1980; Russell, 1922). By 700 A.D. a regular market for foreign commerce was in operation. Local warfare and unrest resulted in the demise of this market for 500 years. Hong Kong and Macao were still devoid of permanent dwellers when Canton was enclosed by a wall in 1067 A.D. When the Portuguese first settled in Macao in 1557, they found only a few fishermen living there. In 1842 the British reported that:

> on taking possession of Hong Kong it was found to contain about 7,500 inhabitants scattered over twenty fishing hamlets and villages...less than 1,000 women and children (Martin, Vol. 2, 1847, p. 833).

A Portuguese, Fernao Peres de Andrade, is credited with opening Canton to European commerce in 1517. Spanish, Dutch, Russian, English and American traders followed. English trade began in 1635; and by 1890, it was greater than the trade of all other nations combined (Ball, 1900; Crow, 1921; Gray, 1875; Martin 1847; Mayers, Dennys, & King, 1867; Morrison, 1817; Volpicelli, 1895; Williams, 1871).

Western ideas concerning health and illness entered Kwangtung Province from the time the Portuguese established themselves on the China coast despite the efforts of the Chinese to prevent the introduction of such ideas into China (Ball, 1905; Boxer, 1948, 1974;

Braga, 1948; Coates, 1966; de Jesus, 1902; Gray, 1875; Hughes, 1968; Martin, 1847; Shuck, 1840; Teixeira, 1975). Their presence had penetrating significance:

> Macao's historical importance lies in the fact that she was the bridge to the almost hermetically sealed city of Canton. Had Macao not belonged to a foreign country, it is safe to say that Christianity and western medicine would not have come into China until a much later date. Because Macao had enjoyed the benefits of medicine for two centuries, western doctors and dispensaries were permitted....Canton has proved to be the commercial gateway of China, but Macao has been the back door at which have stood Pearson who introduced vaccination into China...and Colledge, who started an ophthalmic dispensary first in Macao and then in Canton...(Cadbury & Jones, 1935, pp. 5, 6, 7).

The western medicine of the sixteenth century in Macao's Saint Rafael Hospital, like that of Saint Thomas' in London, did not embrace the germ theory, antisepsis, or anesthesia; medical care was based upon the concepts of symptom alleviation (Hamilton, 1920; Kollard, 1935).

Philosophical Basis of Traditional Chinese Medicine

The health care systems of the Chinese are based upon plural medical models which are integrated in some areas but separate and competing in others. Twentieth-century Chinese health practices are influenced by the early philosophers of China; therefore, an understanding of these philosophers is basic to this study. Confucius and Lao Tzu, sixth-century B.C. philosophers, are celebrated as the compilers of the Classic and Taoist thought, respectively. Their teachings have been influential in shaping the Chinese thought systems. Their precepts were based upon the legendary teachings

of the three emperors, Fu Hsi, Shen Nung, and Huang Ti. Shen Nung developed a pharmacodynamic system of plants, animals, and minerals; Fu Hsi is credited with being the inventor of writing, fishing, and trapping; and Huang Ti, the Yellow Emperor, founded the diagnostic, prognostic, and therapeutic aspects of the traditional medical system (Bridgman, 1974; Couling, 1917; de Bary, 1960; Henderson, 1864; Meadows, 1856; Morrison, 1817; Veith, 1972).

In the second century B.C., the Classics of Confuscius became the principal foundation of the educational system of China and later that of the civil-service examinations.

The I Ching or the Book of Changes provided the interpretations for bone and tortoise-shell divinations. Appendices have been added as new cosmology and medical doctrine developed. The basic concept acknowledges the Supreme Ultimate which generates two primary forces, opposing yet interlocking, the Yin and Yang. These two forces generate the eight trigrams which determine good and bad fortune (I Ching, Hst Tz'u in de Bary, 1960). The design of the concept is presented in Figure 2.

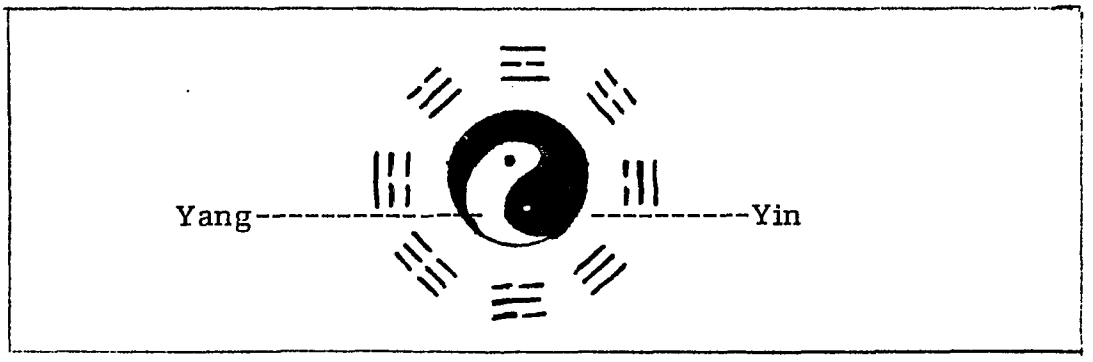


Figure 6. The Eight Trigrams Encircling the Yin-Yang Principle.

Rules for living are presented in the Book of Rituals or Li Chi. Confucius cautioned about the dangers of rebellion in the following passage:

> (The) sick will go untended and the aged and tender, the orphaned and solitary, will find no place. Such is the great disorder that will ensue...the former kings set up rites and music that men might be controlled by them (de Bary, 1960, p. 168).

Other classics include the Book of History, Shu Ching; the Book of Poetry, Shih Ching and Spring and Autumn Annals, Ch'un Chiu. In addition to the Classics, Confucius is associated with the Four Books: Analects, Great Learning, The Mean, and Mencius. These were to the school boy what the Classics were to the scholar (Chang, 1901; Legge, 1861). Since the second century B.C., Confucian teachings have been the most widely accepted doctrine in China (Couling, 1917; Edkins, 1860; Mei, 1960; Weber, 1951).

The competing complementary doctrine of Taoism is credited to Lao Tzu and his followers. Lao Tzu proclaimed that a simple life guided by the principles of Tao would result in harmony in the individual, the nation, and the universe. Huang Ti is reputed to have exclaimed:

> Tao is that which supports Heaven and covers earth; it has no boundaries....It fills all within the Four Points of the compass; it contains the Yin and Yang; it holds together the Universe and Ages, and supplies the Three Luminaries with light...no action is visible outwardly, and yet the work is completed (Balfour, 1880, pp. 312-313).

The doctrine of Tao or the Way became the starting point of all the early philosophical thoughts of China including Confucianism and

Buddhism (de Bary, 1960; Weber, 1951). Down through the centuries the doctrines that embrace harmony, Yin-Yang, the five elements, and changes have been developed into a complex belief system.

What is the Yin-Yang theory? In the earliest records Yin and Yang are mentioned, but during the Han Dynasty (200 B.C. - 220 A.D.) the correspondence concepts were greatly enlarged. In developing the theory of harmony, the complementary forces of Yin and Yang took on both metaphysical and physical significance. The Chinese character for Yang (陽) originally meant the bright side of a bank or hill, and Yin (陰) was the opposite force. Expanded meanings for Yang include male, Heaven, sun, fire, heat, creation, dominance, spring, and summer. Yin became associated with female, earth, moon, cold, water, nourishing, recessive, autumn, and winter. Both forces are essential for harmony and life. Through constantly changing relationships, these forces subdivide in such ways that Yin is found in Yang, and Yang is found in Yin. Yin-Yang concepts are basic to the practice of traditional medicine (Bridgman, 1974; Palos, 1971; Unschuld, 1979a; Veith, 1972).

The Yin-Yang theory is interwoven with the five elements: wood, fire, earth, metal, and water. These elements are so structured that they can exist in a complementary relationship:

> Fire is fed by wood; after the fire has burned itself out, there remains ashes which become earth, in which metals are found and from which water springs, the water feeds the trees which produce wood. Thus, the endless cycle goes (Palos, 1971, p. 28).

Like the permutation of Yin and Yang, the five elements rearrange themselves in their dominating influence. Yin is most powerful at midnight and in the winter season, but its force is never completely gone. The complexity of the correspondences developed over time is illustrated in Figure 7. Man who came from the interaction of Yin and Yang is made up of the five elements. The harmony of a person's life and health is continually influenced by the correspondences (de Bary, vol. 2, 1960; Palos, 1971; Veith, 1972; Wallnofer & Rottauscher, 1965).

Correspondences	The Five Elements				
	Wood	Fire	Earth	Metal	Water
Taste	sour	bitter	sweet	acrid	salty
Organ	spleen	lungs	heart	liver	kidneys
Tissue	ligaments	arteries	muscles	skin/hair	bones
Fluid	tears	perspiration	mucus	saliva	
Orifice	eyes	ears	nose	mouth	genitals

Figure 7. The Five Elements Correspondence System

The evolution of medical concepts in China is difficult to trace, because the basic treatises were accepted as absolute truth. All new ideas and concepts were incorporated into commentaries and revisions of the originals. Huang Ti's Treatise on the Interior, and the two works, Treatise on the Pulse and Fundamental Herbarium, appear in most of the medical writings of early periods (Bridgman, 1974).

Sze-ma Ts'ien's Historical Records of the second century B.C. deals with the concepts of Yin-Yang, correspondence relationships of five solid viscera, five elements, five colors, body meridian lines in which the "pneuma" circulates, and the regulation of energy flow by acupuncture, and diagnosis of diseases by palpation of the pulses. After 200 A.D., the Taoist influence increased, and during that period Taoist thought became preoccupied with "witchcraft and the observation of natural phenomena." Medicine did not escape this influence (Bridgman, 1974; Unschuld, 1979a). The chief Taoist concern became the quest for elixirs of life to promote longevity. Buddhist disciples brought in formulas for elixirs and practices which made that new religion attractive to the Chinese. As dynasties waxed and waned either supporting or suppressing the doctrines of Confucianism, Taoism, and Buddhism, the teachings of the three systems became more and more eclectic in competing for the peoples' support (Needham, 1954/1956; Reischauer & Fairbank, 1962; Unschuld, 1979b).

Various methods were developed to diagnose and treat imbalances of Yin or Yang. One of these was the pulse theory. Palpation of the three sets of pulses on either hand which are connected to a designated body part is reputed to enable the diagnosis and prognosis of diseases by the skilled examiner. When the pulse diagnosis indicated an excess of either Yin or Yang in an area of the body, either acupuncture, moxa, or medicines were prescribed to restore balance (Bridgman, 1974; Henderson, 1864; Kerr, 1872).

Acupuncture is the art of inserting needles of various shapes and materials in one or more of the 365 designated points of the body along the twelve channels which are deeply imbedded in the muscles. Six of the ducts are related to Yang and six to Yin. Acupuncture is administered for conditions that require a stimulation of Yin to overcome the excessive Yang (Bridgman, 1974; Veith, 1972).

Moxa, ignipuncture, is the application of heat to conditions in which Yang must be increased. Combustible substances--commonly used is artemisia vulgaris (mugwort)--are placed on predetermined points in either a cone or stick form and ignited to produce heat (Palos, 1971; Veith, 1972).

The use of diets and medicines was guided by the principles of the five flavors--sour, bitter, sweet, acrid, and salty. Each has a defined usage. Preparation of the diets and medicines were family duties. In the Nei Ching is recorded the following admonition:

> If people pay attention to the five flavors and blend them well, their bones will remain straight, their muscles will remain tender and young, breath and blood will circulate freely, the pores will be fine in texture, and consequently breath and bones will be filled with essence of life (Veith, 1972, p. 55).

It was during the Ming Period (1368-1644) that western medical thoughts and practice began to infiltrate China. Padre Pereira, a Jesuit priest in Peking in 1737, evaluated Chinese medicine in the following words:

> As regards the medicine of China, they cannot be compared with those of Europe; all these here are very weak, and they have not got the force and strength which ours have (Boxer, 1974, p. 28).

In general, the early western reaction to Chinese medicine was negative, because scientific foundations were absent.

There is a shortage of traditional practitioners in China today; therefore, the government sponsors education and research. One researcher reported:

> The principle of Chinese medicine and its four standard methods of diagnosis--looking, listening, questioning and feeling pulse--are dealt with in detail in the literature. Predominating in the therapies is the prevention of old age, a subject which has fascinated people for centuries (Wei Wen, 1982).

Summary. Traditional medicine had a client-physician interaction outside an organized institutional system. Family and servants provided the care needed in the home setting; therefore, the practice of nursing as a profession was unknown in the traditional system. As the western medical model began to develop in China, the traditional and western models opposed each other. Adaptations were made. Traditional medicine not only developed hospitals with nursing systems but also became a component of the western models in China. Today, the western model has 70 percent western and 30 percent traditional care, and the traditional model has 70 percent traditional and 30 percent western care (Shumacker, 1980).

Western Medical Model Professionalization

Prior to the time of Hippocrates in 400 B.C., western medicine was nonscientific in its concepts. Hippocrates combined philosophy, reasoning, observation, and experience and developed medicine into a science and art. During the 1400s-1700s, research in anatomy

and physiology resulted in valuable contributions which included Harvey's theory of blood circulation. In 1798 Edward Jenner reported his work on smallpox vaccination. The period following Jenner is known as the Golden Era in western medicine. Between 1838 and 1876 Schwann developed his animal cell theory, Mendel produced his genetic theory, and the Pasteur and Koch germ theory of disease causation was developed. Health conditions improved rapidly as applications of these new theories were made. In England alone, the death rate from parturition was reduced from one woman in thirty-six in 1660 to one in 150 in 1860 (Henderson, 1864; Horsfall, 1967). The western world turned to the new model.

The new system required hospitals for the most effective care. As hospital usage increased, so did the demand for personal services by trained nurses. Very few hospitals existed before 1830 in Europe or the United States for general care. Religious groups came to the rescue and established the needed institutions after the 1840s (Shryock, 1959). The complex medical care systems accepted the responsibility of training the nurses. Hall (1948) observed that

> medicine like other professions, is practiced in a network of institutions, formal organizations, and informal relationships... the successful practice of medicine involves participation in the hospital system (pp. 327, 330).

In the western model of hospital systems, the physician took the role of autonomous practitioner giving orders to all other health care workers. The nurses worked in a support staff role.

Western physicians sought means of sharing the advances of health care. Opportunities came to a few physicians and surgeons

who took employment in trading companies stationed abroad. The East India Company established by the British was the most famous of these companies (Coates, 1966; Martin, 1847; Mayers, Dennys, & King, 1867; Morse, Vols. 1-4, 1926; Shuck, 1840).

On the China Coast. Since China regarded herself as the self-sufficient center of the universe, efforts were made to protect her citizens from the encroachment of foreigners whom she regarded as uncivilized barbarians. Foreign interaction was restricted to the area of Portuguese Macao, and further restricted to selected Chinese merchants in Macao who were given the responsibility for keeping the "foreign devils" out. The Emperor's Edict of 1760 was illustrative of the feelings of the time and contained the following restrictions:

1. Trade must be done through the Hong Merchants only
2. Money must not be loaned to shopkeepers and country merchants
3. Chinese must not serve as servants to foreigners
4. When the traders' ships are dispatched to Europe, the traders must go to Macao
5. No foreign women are permitted to come to China (Morse, 1926, vol.2, p. 56).

One contributing factor to the anti-foreign feelings was the opium trade which continued in spite of the Emperor's Prohibition in 1800. The Chinese found it difficult to understand that the traders could bring opium and benevolent medical care at the same time (Shuck, 1840; Williams, 1871).

Physicians and surgeons began to reach out to the Chinese medical needs when they were stationed on the China Coast. One of these, Dr. Alexander Pearson, successfully introduced smallpox

vaccination in 1805. Other medical efforts were so successful that appeals were made to Christian groups in the United States and England to send medical missionaries to establish hospitals in China (Bridgman, 1832, Colledge, 1835; Colledge, Parker, & Bridgman, 1838; Morse, 1926; Williams, 1871).

Canton's first western medical institution was opened by Peter Parker, an American missionary physician, in November, 1835. In his first annual report, it was stated that he had treated 2152 patients. He called for continuation of the institution and the establishment of new departments (Parker, 1836, p. 332). By 1838 the work had become so demanding that the East India Company physician, Colledge, joined with Parker, and other interested foreigners residing in Macao and part-time in Canton to form a Medical Missionary Society to project the work on the China Coast. They justified their interest in giving western medicine to the Chinese in this manner:

> When we reflect upon the present state of surgery and medicine in China...and advert to the time when similar ignorance was the misfortune of the nations of Europe; and we consider the rational basis upon which science is now established, and our facilities for imparting it to others; the obligation...imperative ...of imparting...the incalculable benefits received from application of chemistry and natural and inductive philosophy to the subject of health....Men belong not merely to the nation that gave them birth, but to the whole world (Colledge, Parker, & Bridgman, 1838, p. 43).

Hospitals were established in Macao and Hong Kong. In 1838, Dr. Parker established a branch of the Canton Hospital in Macao which was later moved to Hong Kong. Hong Kong's military hospital was established from the time that the British troops were stationed

there in 1841. Two more important hospitals in Macao--Kiang Wu for the Chinese, and the Conde de S Januario Government Hospital--were established in the 1870s. These are Macao's only two hospitals in existence today (Ball, 1905; Teixeira, 1975). The Tung Wah Hospital in Hong Kong, a voluntary endeavor for the Chinese was authorized in 1870 (Austin, 1870). Nurses had not been introduced to the hospital systems, and in 1878 Dr. Kerr of Canton Hospital reported that male and female trained nurses were essential in order to improve the hospital (Cadbury & Jones, 1935).

Development of Professionalism in Nursing

Historically, the care of the sick has been a family function in the home. The germ causation of disease theory with its resultant aseptic requirements contributed greatly to the expansion of the hospital system to care for the sick. It became evident that trained skilled nurses were needed in this new system, and training was begun in several places. Theodore Fliedner of Kaiserswerth, Germany was a pioneer in the training of nurses. It was in his school that Florence Nightingale received three months of training in 1851 (Abel-Smith, 1960; Cook, 1914; Dolan, 1948; Fenwick, 1920; Miller, 1947; Seymer, 1932). Various cultures have participated in the professionalization of nursing since Nightingale set forth the principles of the profession in her writing:

> The every day management of a large ward, let alone of a hospital--the knowing what are the laws of health for wards...are not these matters of sufficient importance and difficulty to require learning by experience and careful inquiry, just as much as any other art? (Nightingale, 1859/1946, pp. 79/75).

United Kingdom. Upon Nightingale's return from the Crimean War, the British credited her with saving their army and bestowed their loving gratitude by contributing funds to establish a training school for nurses. The Nightingale School at Saint Thomas opened in 1860, under the control of Mrs. Wardroper, the matron. Nightingale chose to play her role in the transformation of nursing from her home (Abel-Smith, 1960; Burdett, 1877; Fenwick, 1920; Mongan, 1905).

With the developing social consciousness of the late 1800s came efforts to improve the conditions and rights of women. At first, ladies of the upper class were permitted to visit the sick poor in their homes; and later, they were able to enter nursing. The Nightingale School Fund Committee stated in their 1862 report:

> Ladies are not to be excluded. Where sufficient evidence is shown that they intend to pursue the calling as a business, and have the qualifications which will fit them to become superintendents, their admission would be considered an advantage (Dunbar, 1936, pp. 34-35. Quoted in Abel-Smith, 1960, p. 22).

By 1869, physicians were being told to allow nurses discretion in patient care along with written directions for diet and medicine, and to expect nurses to provide reports of the patients' condition and activities as observed during their time of duty (Guy & Harley, 1869). In less than twenty years nursing was being advocated as a

> profession of skilled nursing...a pleasant means of gaining a livelihood...a competency. Were...Nightingale and...Jones of Liverpool both ladies of birth, education, and position, ashamed to devote the best part of their lives....Is there a more honoured name amongst the women of England, or one that carries greater weight in all philanthropic enterprises than...Nightingale? Surely, every young woman who has nothing specially to keep her at home will come forward (Burdett, 1877, pp. 120-121).

Physician Lewis in his theory of nursing and practice textbook proclaimed that

> Nightingale created the art of nursing; invented, in fact what may be called a new science of which people before had no notion, no more than they had of the phonograph before Edison invented it (Lewis, 1895, p. 2).

The President of the Royal Surgeons of Ireland in addressing a surgical meeting in 1895, asserted that he had learned how to manage postoperative patients only through the assistance of the watchful intelligence and careful skills of trained nurses (Stoker, 1896).

The assimilation of trained nurses into the existing health care systems, at times, created conflict and change. Some institutions expelled the nurses, but the majority yielded to the new system. The Select Committee for Hospitals (1892) acknowledged that voluntary hospitals in England had a matron in charge of an independent department of nursing. The matron reported to the hospital committee independently from the lay administration. Nursing had been transformed into a suitable vocation for upper-class women, and training schools had been established throughout the nation by 1895 (Abel-Smith, 1960).

The quest for professionalization was reported to have begun in 1887 when

> The British Nurses' Association was formed...upon the invitation of Mrs. Bedford Fenwick...to unite all qualified nurses in membership of a recognized profession and to provide for their registration (Fenwick, 1920, p. 5805).

From the very beginning, Ethel Fenwick's professionalization plans were opposed by leading people including Nightingale who believed

that a unified body would set forth examinations as entry requirements and a nurse's professional competence could not be judged by examination. During the thirty-year battle that followed, many nursing organizations were formed. These organizations fought openly. In 1919, Parliament enacted a bill introduced by the Minister of Health calling for a Register of Nurses. The battles continued. The professionalization process was hampered by the absence of a united associational voice. However, Carr-Saunders and Wilson, 1933/1964) claimed that nursing was becoming professionalized, and Miss Nightingale might even accept that her 'calling' concept is applicable to a skilled and dignified profession (Able-Smith, 1960; Carr-Saunders & Wilson, 1933/1964).

United States. The upheavals of the Civil War prevented the nurse programs of the United States from keeping pace with those of England in the 1860s. When the nursing schools of the United States were begun, they were influenced by the Nightingale philosophy since she had served as a consultant to the American health leaders during the war. The first Nightingale type of nursing program was established in 1872 at the New England Hospital for Women and Children located at that time in Boston. Linda Richards was the first graduate of that one-year course in 1873. From the very beginning of organized nursing in the United States, nurses expressed professional concerns. In London this concern was condemned by Sidney Holland when he admonished the British Select Committee on Registration:

> We want to stop nurses thinking themselves anything more than they are, namely, the faithful carriers out of the doctor's orders. The other side are always talking about nursing being a profession and 'graduates' in nursing, just as they do in America (Abel-Smith, 1960, p. 66).

The American nurses organized the American Nurses' Association in 1896 as an outgrowth of a general meeting of nurses at the World's Fair in Chicago in 1893. Isabel Hampton (Robb) was appointed chairperson, and she provided innovative leadership in the areas of administration, education, and professional organization. The American Nurses' Association is the official organization of professional nurses in the United States, serving as the voice in interaction with the public and other professional organizations (Dolan, 1968; Donnelly, Mengel & Sutterley, 1980; Freeley, Shine & Sloboda, 1980; Nutting & Dock, 1907; Richards, 1911; Seymer, 1932; Stewart, 1944).

From the time that the education of nurses was established in the hospitals, nurse leaders began to push for public support to separate the education of nurses from their hospital sponsorship. A study of nursing in the United States sponsored by the Rockefeller Foundation called for nursing to establish its educational foundations in colleges and universities (Goldmark, 1923). Following this report, the Rockefeller Foundation financed the establishment of Yale University School of Nursing in 1923. Annie W. Goodrich, the Dean of this school, claimed that nursing education belonged in the university "where all educational expressions have been increasingly placed" (Goodrich, 1932).

The demand for nurses was so great during World War II that in 1941-42 the United States Congress appropriated almost seven million dollars for nursing education (Dolan, 1968). Nursing studies reported:

> The new nursing began in this country...with a degree of autonomy which it was not long able to preserve....The early schools...produced a group of highly intelligent, courageous, and foresighted young leaders, who early assumed and held positions of great influence, carrying nursing through the critical organizing years between 1893 and 1913 (Bixler & Bixler, 1945, p. 733).

> Careful consideration should be given to the fact that professional schools in most other fields have already come within degree-conferring institutions to such an extent that possession of a degree is fast becoming a criterion of a person's having received professional as contrasted with vocational training (Brown, 1948, p. 77).

Studies in nursing continued, and one of the outcomes was the creation of a technical nurse role with its educational preparation given to the junior and community colleges. A dilemma arose in the ranks of nursing when clear role differentiations were not established for the associate, diploma, and baccalaureate graduates. The professional base of nursing was eroded. In spite of the problems, some advances were made as baccalaureate programs increased and a Code of Ethics was adopted in 1950 (American Nurses' Association, 1950; 1976; Montag, 1951).

Nurses were classified into three groups by Habenstein and Christ (1955). Professionalizers were those who ascribed to the application of rational knowledge as the basis of nursing. The foundation of nursing was a bedside practice of tender loving care

to the traditionalizers, and the utilizers concerned themselves with the organization and task performance of the duties. Sociologists reminded nursing that professions must provide a distinctive service flowing from a distinct body of knowledge which is recognized by society. Nursing continues its quest for professional status in a changing health care environment.

Canton as a subsystem of China. Before trained nurses arrived in China in 1884, physicians were trying to train Chinese to assist in patient care. In Canton Dr. John Kerr, Dr. Mary Niles, and Dr. Mary Fulton began their training of nurse helpers in the early 1880s. Dr. Boone, a physician in Shanghai since 1847, reported that he had one man and one woman in training in 1886 (Boone, 1887, p. 42).

An English physician, dean of a medical school in Tsinian, China described the introduction of nursing with the following complimentary words:

> The pioneer nurse must have found it no easy task to decide just where to begin! With a hospital already established on primitive lines, with patients suspicious of strange innovations... she approached it with that cheerfulness and tact and patience which has been characteristic of the trained nurse all the world over (Balme, 1921, p. 137).

Early poineers included Elizabeth McKechnie, Esther H. Butler, Ella Johnson, and Frances Johnson who came between 1884 and 1889. Many of the early nurses were not only trained nurses but also college educated which facilitated their efforts to establish a nursing system for China. As early as 1909, these nurses had translated outstanding nursing textbooks including Hampton Robb's Principles

and Practice of Nursing (Balme, 1921; Cadbury & Jones, 1935; Lin, 1938; Simpson, 1926; Stephenson, 1946; Wong & Wu, 1932).

Canton's nursing program was advanced in its professionalization process when the Christian Association of the University of Pennsylvania sent four physicians and a nurse to work in the Medical Department of Canton Christian College in 1904. It was reported that an excellent and able group of nurses were taught. The University of Pennsylvania professionals moved to Shanghai after a short time in Canton (China Medical Commission of the Rockefeller Foundation, 1914). Canton's Turner School for Nurses was established in 1902 and was associated with the David-Gregg Hospital and Hackett Medical College under the sponsorship of the American Presbyterian Mission (Anderson, 1943; Bischoff, 1925).

China's customs on the care of the sick by servants and the restrictions placed upon the nursing care of males by females were changed with great difficulty. Hospital systems were organized separately for the two sexes. Female physicians and nurses cared for the women, and male physicians and nurses staffed the men's hospitals and departments. In the China Medical Commission report (1914), it was exclaimed that the time would come when all the nursing could be done by women.

One of the most significant events in the nursing history of China occurred in 1908 when the November issue of the China Medical Journal presented the following pleas of Cora Simpson, a nurse:

> We have never trained any nurses in this part of China. We have always trained medical students instead, but now I think the time is ripe for medical students to take their training in the medical colleges, and give place to the hospitals for the training of nurses as we do in the home lands.
>
> I would like to know what has already been done along the line of training nurses. Have we any textbooks or course of study marked out? Is there any nurses' association in China? If so, I would like to become a member. I realize that this is new work, and many of the Chinese look down upon nurses' work as work only fit for coolies, but it must be time to change that idea...(Simpson, 1908).

Dr. Cousland, the editor of the China Medical Journal, supported the inquiry by stating that the time had come for nurses to be organized and requested that any responses be mailed to him. He encouraged Miss Simpson to pursue the idea until nurses did become organized. When the Nurses Association of China was organized in 1909, the members were all foreigners or foreign-trained Chinese. This group of professionals looked at the most progressive developments in Europe and the United States and formulated a pattern of high professional organization and education. Two courses of study were developed--the three-year diploma course in hospitals and the five-year degree program for those who desired positions in the educational and administrative areas of nursing. An examination was prepared for the graduates who wished to be recognized by the Association. National conferences began in 1914; a quarterly journal was published in 1920; and in 1922 graduates of the Chinese schools were ready for membership in the association. Cora Simpson was elected to serve as a full-time General Secretary of the Association in 1922. The Nurses Association of China became a member

of the International Council of Nurses that same year. Within twenty years of the Association's founding, all the officers were Chinese. Foreign nurse membership peaked in 1927 at 700, but anti-foreign sentiment and political unrest reduced the foreign membership to 200 only three years later (Balme, 1921; Bischoff, 1925; Bowers, 1974; Cadbury & Jones, 1935; Hollister, 1932; Lam, 1934; Rauch, 1925; Simpson, 1926; Todd, 1919; Wong & Wu, 1932).

The nursing occupation became official in China when the Association Secretary, Mary Shih, was invited to organize the Department of Nursing Affairs in 1930. It was recorded that

> Miss Shih, a nurse, the first woman appointed to a government position...giving half time to the government and half to the Nursing Association...has charge of the certificating of all nurses, and supervises the education of nurses for all China... upheld the standards for which the Nurses Association has fought, refusing in the face of heavy pressure to shorten the course or lower educational standards (Hollister, 1932, p. 122).

As the government saw the value of the health projects of the private medical endeavors, it began to create provincial hospitals and centers. Graduate nurses from the private foreign-sponsored institutions were called upon to begin the nursing systems of the new government programs. In 1933 the Canton Health Center and the Canton Hospital cooperated in establishing its successful program. Credit was given in the following manner:

> Miss Kwok Fung Lut, the trained health nurse, is due not a little of the success of this venture...the Canton Hospital had anticipated these rural programs and established a model... consists of the following units: (1) The village dispensaries to which the doctors pay visits three days a week, and the health nurses follow up cases in the homes. (2) More serious cases are referred to the Branch Hospital for more careful

> treatment and (3) Those requiring major operations, special diagnostic study, x-ray, etc., can be sent to Canton Hospital (Cadbury & Jones, 1935, p. 260).

Nursing continued to progress; new training schools were established and by 1949 there were 317 nursing schools. After the Communists came to power in 1949, forcing the Nationalist Government to flee to Taiwan, nursing, like other professions, faced a time of reorganization. The adjusted curriculum for nursing was continued as part of the increased emphasis on meeting the medical needs of the rural and urban common people. Orleans (1969) calculated that China had 186,000 nurses in 1966 when all educational programs were suspended during the 1966-1970 Cultural Revolution period. As education resumed during the 1970s, nursing was shortened to a two-year course with a greater emphasis on practice. The association was inactive from 1966 to 1978. Professional concerns of nurses have been manifested in their return to a three-year educational program, continuing education for the nurses, and the reappearance of the journal of the Association. Forums sponsored by the Association are calling for a restoration of the university-based educational programs, higher professional regard, and better conditions for nurses. Canton nurse educators reported that less interest is shown in nursing as a profession to enter by students since the return to order in the 1970s, because a wider range of occupations are open to women (Chen, 1961; Cheng, 1974; Chinese nurses, 1981; Garfield, 1978; Kennedy, 1979; Shumacker, 1980; Sidel, 1974; Vogel, 1974).

Hong Kong. England's trained nurses took employment abroad in the Civil Hospital in the colony of Hong Kong as indicated by the following report:

> For the Nursing Staff of Sisters whose services are generally acknowledged and so much appreciated, ladies who are received with pleasure into the best society, the Colony is indebted to Dr. Atkinson whose knowledge of the nursing institutions at home enabled us to procure them soon after his appointment as Superintendent. They have earned the respect and good-will of the whole Colony...have through the Matron (Miss Eastmond) undertaken the tuition of nurses for the public benefit (Atkinson, 1897, p. 74).

Qualified nurses were being introduced into the private hospitals also. In 1891, Mrs. Stevens of England came to work in the Alice Memorial Hospital and trained the first Chinese woman nurse there in 1893 (Ashton, 1957). Nursing developed very slowly in Hong Kong, because the Chinese woman was limited by cultural biases and educational restrictions. Girls were not admitted to government middle schools or universities before 1920 (Anderson, 1943; Childe, 1980; Mollendorff, 1895; Simpson, 1926; Soothill, 1913).

Nursing in Hong Kong continued to be an extension of that in England until 1931, at which time the Colony legislated into being a Nursing Board to regulate the practice and education of nurses. The Japanese occupation of Hong Kong from 1941 to 1945 reduced nursing activities and suspended the educational programs. Since the resumption of the nursing activities in 1945, Hong Kong has progressed steadily. The first qualified Chinese nurse educator entered the government nursing system in 1953.

Even though an Association for Nurses and Midwives was organized in 1940, a professional association restricted to registered nurses' membership was not founded until 1964. That same year the Association joined the International Council of Nurses (Childe, 1980; Iu, 1979; Nurses Registration, 1931; Poon, 1967b).

A two-level nursing system was inaugurated in 1964. The two-year, second-level graduates qualify as Enrolled Nurses when they pass the Nursing Board examination. The first-level nurse is a graduate of a three-year training program and is known as a Registered Nurse. Registered nurses and enrolled nurses are educated in the hospital system of training. The educational requirements and licentiate examinations are mandated by the government. Over 7,000 of Hong Kong's 10,000 nurses are employed in the government sector of health care. Nursing staffs have been transformed from all foreign to chiefly Chinese in 1981. The nurses in the government sector established a separate association in 1977 which is registered as a trade union. The professional association, open to all nurses, is committed to a service ethos which excludes strikes and bargaining (Ashton, 1957; Balme, 1921; Childe, 1980; Iu, 1979; Jones, 1969; Martin, 1967; Nurses given, 1982; Nurses Registration, 1931; Poon, 1967b).

Macao. The founding of Hong Kong in 1842 proved disastrous to Macao's social systems, which were disrupted because schools and hospitals which had been established by westerners in Macao were moved to Hong Kong. Portugal's home government was unstable.

Periodic suppression of the religious orders in Portugal caused additional disruption of Macao's social systems which were largely provided by these religious groups (Ball, 1905; Coates, 1978; Nowell, 1973; Teixeria, 1964; Williams, 1871).

In Macao, nursing continued as an untrained service administered by males until 1918. At that time the governing body called for the establishment of a female military nursing division to correct the deficiencies in health care provision for women and children. When the Health Department was reorganized in 1919, a course in nursing to train both male and female second-class nurses was established (Teixeira, 1964, 1975).

From the time that the Chinese in Macao established a private hospital for the Chinese in 1870, the medical care in Macao developed a dual system in which the government provided care for the Portuguese and permitted the Chinese to care for themselves. The Chinese hospital maintained close relationships with medical work in Canton; therefore, a school of nursing for Chinese in the Macao hospital was authorized in 1923 keeping pace with nursing development in Canton. In 1939 the Franciscan Missionaries were granted permission to establish a three-year school of nursing with the students training in a religious and in a government hospital.

Nursing for the Portuguese remained under the religious orders until 1942 when a secular technical occupation was created (Enfermaria, 1943; Hospitals, 1943; Teixeira, 1964, 1975).

Macao's government nursing and that of the Chinese hospital operated in separate independent programs with each providing nurses for their respective programs. Following the establishment of secular nursing in 1942, the Department of Health created a government school of nursing. However, the Portuguese language requirement has resulted in a limited enrollment. In 1975 there were 5 students in the government-sponsored school, while 38 diplomas were issued to those completing the Chinese-language curriculum of the Franciscan missionaries in the government hospital. By 1981 both programs were inactive. The non government nursing school of the Chinese medical care system was still in operation (Anuario, 1964, 1976, 1981).

Nursing in Macao was organized on three levels. The third-class nurse had on-the-job training only. Second-class nurses qualified by graduating from a two-year middle school program, and the first-class nurse was a graduate of a three-year, high-school training program located in a hospital (Anuario, 1924, 1964, 1981; Braga, 1963).

After the 1974 revolution in Portugal, nurses working in Macao's government hospital took their demands for an independent nursing organization to the authorities in Portugal. Finally, in 1981 the Macau Nursing Association charter was granted and the official organization ceremonies were held on July 1, 1981. Nurses from both the Chinese and the government health care organizations have joined. Macao's nurses have had limited contact with other nursing systems (Gabriel, 1981; Macau Nursing Association, 1981a;1981b; Page, 1981; Silva, 1981).

CHAPTER III

METHODOLOGY

This investigation of the professional development and practice of nursing in Canton, Hong Kong, and Macao was conducted through a descriptive field survey. The criteria for such a survey--a research design, preparation for the study, instrumentation, samples, settings, procedures, and data analysis--are presented in this chapter.

Research Design

Field survey personal interviews were used to collect the data from the subsamples in each of the three cities on schedules devised by the researcher. Quota-sampling subjects provided the data for the perceptual scale of professional nursing and Mintzberg's professional manager roles. Convenience-sampling subjects' data were used in the assessment of Moore's professional characteristics and Mintzberg's professional operating core organizational design of nursing.

Preparation for the Study

Permission and approval to conduct the study were obtained from the researcher's doctoral advisory committee at the University of North Carolina at Greensboro. An introductory letter (Appendix A) from the nurse member of the doctoral committee was sent with each request for permission to conduct the study (Appendix A). Upon approval from the health care systems and professional organizations involved, the study was initiated.

Instrumentation

No instruments were found that had been designed to give a measure of Moore's professional characteristics (1970), Mintzberg's professional manager roles (1973; 1979) or the degree of professionalism of Mintzberg's professional operating core in organizations (1979); therefore, instruments were developed from professional concepts derived from review of the literature, Hall's Professional Inventory Scale (1967), Stuart's (1981) findings on the professional development of nursing in the United States according to Moore (1970), suggestions from professional peers, and the investigator's professional experience.

Schedule I. Tabor's Nurse Leader's Perception Questionnaire. Originally, twelve items were constructed for the questionnaire; but the evaluation of the content validity by professionals in nursing education and practice resulted in a revision with the completed instrument having one item addressing each of the professional characteristics of Moore (1970) (Appendix B). A test-retest administration of the schedule to a Chinese nurse and an American nurse at three-month intervals resulted in identical responses on the two testings.

Coding was done to assign value points to the responses with the range of values assigned as follows:

3 - indicated the most progress toward professionalism

2 - indicated moderate progress toward professionalism

1 - indicated beginning progress toward professionalism

0 - indicated no progress toward professionalism.

Schedule II. Part A: Tabor's Scale for Moore's (1970) Professionalization Interview Data. Representative criteria as defined by Moore were selected for each of Moore's professional characteristics and coded to provide a scale to obtain measures of the development of each of the characteristics (Appendix B).

Part B: Professional Nursing Interview Questions. A mix of open-ended and structured interview questions concerning professionalism were designed and validated as in Schedule I (Appendix B) (Borg & Gall, 1976; Brink & Wood, 1978; Kerlinger, 1973).

Schedule III. Tabor's Perceptual Scale for Mintzberg's (1973; 1979) Manager Roles of Professionals. Part A: One perceptual item for each of Mintzberg's manager roles (1973) was constructed in a coded form to obtain measures of the role activity by interview technique (Appendix B). The test-retest validation experience alerted the researcher to avoid questions regarding individual salary and disciplinary matters in interviewing Chinese nurses.

Part B: Five activity items were prepared for rank ordering on an ascending scale according to the time spent in the activity. The scale moved from least managerial to the most autonomous role function (Appendix B).

Schedule IV. Tabor's Scale for Mintzberg's (1979) Professional Operating Core. Items were designed and coded to obtain measures of four characteristics essential for Mintzberg's (1979) operating core of workers to be considered professional (Appendix B). Test-retest interviews revealed that autonomy concepts were weakly developed in

the Chinese nurse subject; therefore, discussions of professionalism were planned for the interviews before administering the questions.

Schedules I and II were developed for data gathering for the first research question. Data on Schedule III concerned study question two, and that of Schedule IV addressed the third question of the investigation.

Samples

This study investigated two quota samples and one convenience sample comprised of three subsamples each. Quota sampling was chosen for Schedules I and III data collection to enable the researcher to select the subjects desired. Schedule I items were administered to only one professional nursing association officer in Canton, Hong Kong, and Macao, because only one subject was available in Hong Kong.

Characteristics of Quota Sample I. The Canton subject was an English-speaking Chinese female nurse educator and administrator about 60 years old who had studied at Columbia University. Hong Kong's subject was also an English-speaking Chinese female nurse administrator, about 30 years old. Her education was based in the Hong Kong government nursing system. Macao's subject was an English-speaking Macanese (Silva, 1979) male second-class nurse with about 10 years of staff nurse experience in the government-operated hospital. All three subjects were serving as officers in their respective professional nursing associations.

Characteristics of Quota Sample II. Nurse managers were required to supply the professional manager role data.

Government hospital managers were stipulated, because that was Canton's hospital design. Macao had only one government hospital; therefore, each subsample had one subject. Canton's non-English-speaking Chinese female manager nurse communicated her data through an interpreter. The Hong Kong subject was an English-speaking, Chinese associate manager who worked in a 1300-bed government general hospital. A non-English-speaking, Portuguese, female nurse educator with graduate study in Canada, who was serving as the nurse manager in the government hospital, provided the Macao data. This second quota sample supplied the data for Schedule III.

Characteristics of the Convenience Sample The data used for the assessment of Moore's professional characteristics (1970) and Mintzberg's (1979) professional design of a professional operating core of nurses were obtained from 33 convenience sampling subjects. Canton's 20 Chinese female nurse subjects were managers and educators from six large hospitals and two educational programs. Hong Kong's six female subjects were two American and four Chinese nurse educators and managers serving either in private or government health care systems. Macao's seven subjects were two Portuguese, female nurse educator / managers and five Macanese staff nurses from the government hospital. Three of the Macanese staff were men.

Settings

The three nursing system settings were very different. Nurses in Canton comprised about 5 percent of China's 500,000 nursing work

force in 1981 (Chinese Nurses, 1981). All of China's nurses were employed in government health care programs. Canton, with a population of four million, is located in Kwangtung Province on the south coast of China within 100 miles of both Macao and Hong Kong.

Hong Kong, a British-governed colony, had about 10,000 Chinese nurses employed in government and private health care organizations serving the 98 percent Chinese population of four and a half million. Hong Kong and Macao were open to tourists, but Canton travel was controlled.

The Portuguese territory of Macao's 400,000 population was served by 300 nurses in both the government and the nongovernment Chinese health care systems. Macao's government health care was managed by a nurse and a physician from Portugal who did not speak Chinese, the language of over 98 percent of the people.

Procedures

Canton. Canton data were collected during a week's visit in September 1981. A group of about 15 nurse managers from the Provincial Hospital met with the researcher at that institution on one day for several hours to provide data. The managers would often conclude an answer to an interview question with a question on nursing in the United States which was answered by the researcher. At times, the managers gave a consensus answer after group discussion. Later, two nurse educators and five managers from the Chun Shan Medical Center--which was composed of five teaching hospitals, a medical school and a nursing school--responded to the

researcher's questions at their university. At that session special attention was given to questions that needed clarification or further information. In addition, the interview with the second group was used to verify data obtained on the first interview. Interpreters were used in both of the interview periods with the convenience sample.

Individual perceptual responses for Moore's professional characteristics were given at a dinner party as the researcher and the subject sat together, because private interviews were not a common practice at that time in China. The interview with the nurse manager took place in a group at her hospital work site and was later reviewed with the respondent at the researcher's hotel. Historical data were checked for validity through a review of the literature.

Macao. A telephoned invitation was extended to the researcher to meet with the Minister of Health and Social Affairs of Macao upon receipt of the request-to-study letter. During the interview the researcher was informed of the government's role in the dual medical system operating in Macao and was given introductions to the government hospital nursing personnel and to the officers of the newly established nursing association. The data were collected between June and October, 1981.

A group of five associational officers met with the investigator in a tea garden for the first interview, and the second interview followed at the site of the nursing association inaugural ceremony. The President of Direction was the subject who responded to Moore's perceptual data, and the other subjects participated in answering the historical

questions on nursing as a profession and its organizational design. The responses were communicated in English.

Three interviews took place with the Nurse Manager and her assistant in the nursing office of the government hospital. Nurse manager role data responses were those of the Nurse Manager. Both responded to the professional and organizational questions after receiving the written interview questions to study. The assistant interpreted the Portuguese answers of the Nurse Manager into English for the researcher. Limited written data on Macao nursing were constraints in checking the validity of the survey data.

Hong Kong. Officer changes in the professional nursing association and government organizational design for Hong Kong's medical systems were severe constraints in gaining approved access to nurses there as seen by the correspondence in Appendix A.

A two-hour interview on August 5, 1981 was granted with an associate nurse manager at an office in the Princess Margaret Hospital in Kowloon. The Chinese subject was very cooperative in giving answers in English to the schedule questions concerning the professional, organizational design and manager roles.

Interviews took place in a private hospital with three subjects on Hong Kong's professional and organizational design in nursing during the summer of 1981.

Three interviews took place during the summer of 1981 at the nursing headquarters in Hong Kong with a professional officer and another nurse who responded to questions concerning the development

of professional nursing. The association officer responded to the opinionnaire on Moore's professional characteristics (1970).

Validity checking was facilitated by the well-documented records of Hong Kong's nursing development.

Data Analysis

Likert-type summed rating, rank-ordered rating scales, coding tables, and chi-square for significance analyses were applied to the descriptive data.

Schedule I data were Likert-type summed rating items which were coded for comparisons.

Schedule II coded-table data were summed and compared to the perceptual data in Schedule I. Chi-square distribution analysis using a .05 level of significance with 2 degrees of freedom was calculated on the summed scores of the combined perceptual and survey data for Moore's professional characteristics (1970) (Gibbons, 1976; Hays, 1973).

Schedule III data analysis consisted of coding and chi-square distribution measurements on the summed scores for Mintzberg's (1973, 1979) professional manager roles using a .05 level of significance with 2 degrees of freedom.

Schedule IV. Coded data results on Mintzberg's professional operating core (1979) design of nursing were tabulated, scored, and compared on the summed scores.

CHAPTER IV

DATA ANALYSIS

The purpose of this study was to compare nursing in Canton, Macao, and Hong Kong on three dimensions. The first addressed the professional development of nursing according to Moore's professional characteristics (1970). Identification of Mintzberg's (1973, 1979) manager roles among professional nurses in Canton, Macao, and Hong Kong was the concern of the second question. The third research question was designed to obtain a measure of the organizational design of nursing in Canton, Macao, and Hong Kong according to the professional operating core of Mintzberg (1979). The analysis of data was developed according to these three questions.

Moore's Professional Characteristics

Data obtained on Schedule I and II were used to compare the three nursing systems on the first research question: At what level on Moore's continuum of professional characteristics (1970) do professional nurse subjects identify their respective nursing systems in Canton, Macao, and Hong Kong?

Moore stipulated that the six characteristics of occupation, calling, service, professional organization, education, and autonomy were essential for a work endeavor to be identified as professional; therefore, data for the three samples were coded (Appendix B), summed,

and compared for each characteristic. Chi-square distribution was also done. Each professional characteristic was treated separately.

Occupation. Professional practice in a full-time position which provides the principle portion of a person's earned income is Moore's definition of occupation. Nursing was first developed in the 1860s as a secular occupation requiring training in the British health-care systems (Burdett, 1877; Lewis, 1895). This study based the assessment of occupational status upon three measurements: government recognition, retirement with a pension, and laws or requirements governing the entry to practice. Each measure had a value of 1 point, and a score of 3 points was considered to signify occupational status. Canton, Hong Kong, and Macao met these criteria. A perception item asked nurses in each city if they worked full time in a paid position. On a scale ranging from "never" to "routinely," the answers given accorded to nursing in these three cities occupational status, as shown in Table 1.

Calling. "Commitment to a calling involves acceptance of the appropriate norms and standards, and identification with professional peers and the profession as a collectivity" (Moore, 1970, p. 8). The career or calling concept conveys a dedication of the entire self to the professional endeavor, according to Greenwood (1957). The feeling of being called is powerful enough to hold a practitioner in the profession when opportunities for advancement are available by leaving. Calling can only be exercised in societies where there is freedom of

Table 1

Occupational Status

Assessment criteria	Canton	Hong Kong	Macao
	Survey Data		
Government recognition	1	1	1
Retirement with pension	1	1	1
Government stipulated training for entry to practice	1	1	1
Totals	3	3	3
	Perceptual Data		
Full-time paid positions	3	3	3
Summed totals	6	6	6

choice in professional selection. Commitment is seen when the new professional accepts the profession's norms and standards and identifies with peers in advancing the growth of the profession (Moore, 1970).

Three measurements for the concept of calling were defined: voluntary choice in becoming a member of professional organization, professional organization membership eligibility for all qualified professionals from the time of qualification, and open access to apply for entrance to the educational programs for all citizens. Each factor was given a value of 1 point. The survey revealed that Hong Kong scored 3 out of 3 possible points, but Macao and Canton scored only 1 point each. Perceptually, all three samples rated their nursing

at 3 on the possible score of 3 scale which was a measurement of the practice of nursing being a lifelong career as the usual pattern for nurses. Data results appear in Table 2.

Table 2

Calling/Commitment

Assessment criteria	Canton	Hong Kong	Macao
	Survey Data		
Voluntary membership in association	1	1	0
Membership open upon qualifying	0	1	0
All society members free to apply for educational preparation	0	1	1
Calling Totals	1	3	1
	Perceptual Data		
Lifelong career	3	3	3
Summed totals	4	6	4

Professional Association. Historically, common interests of practitioners in a given profession have resulted in the formation of an association. The association over time develops the criteria for entry and practice, which include not only ethical codes and methods for advancement but also means of dealing with breaches of conduct and practice. A professional culture is maintained through the interaction and controls mutually and voluntarily supported by the membership. Collectivity is encouraged through the professional journal and meetings which are devoted to peer sharing, support,

and advancement of the individual and the group (Carr-Saunders, 1928; Carr-Saunders & Wilson, 1933; Freidson, 1970; Goode, 1969; Moore, 1970; and Stuart, 1981).

The associations' beginnings covered a wide period. Canton's (China) association was organized in 1909, Hong Kong's in 1964; and Macao's was not official until 1981. The assessment criteria used to measure this professional characteristic included membership restricted to professional nurses, a journal published at least yearly, and four stated purposes for the association: to promote peer relationships, to set standards, to formulate ethical codes, and to promote professional advancement. Each of the purposes had a value of .25 assigned, and the membership and journal criteria were valued at 1 point each. On a scale of 0 to 3 the scores were 2.75 for Canton, 3 for Hong Kong, and .5 for Macao. In the perception question the nurses were asked to give the percentage of nurses who have membership in an association which was restricted to professional nurses. In Canton and Hong Kong less than 50 percent of the nurses joined the association which gave Hong Kong and Canton a score of 2 on a 3-point scale. Macao did not register any points. The tabulations are presented in Table 3.

Education. Qualifying educational programs demand more knowledge and theory learning than is usually required in practice. According to Goode (1969), this overtraining is designed to guarantee retention of enough knowledge by the practitioners to easily solve the routine problems encountered. The learning process for the

Table 3

Professional Association

Assessment criteria	Canton	Hong Kong	Macao
Survey Data			
Membership restricted to professional nurses	1	1	0
Journal published at least yearly	1	1	0
Purpose			
promote peer relationships	.25	.25	.25
set standards	.25	.25	0
formulate ethical code	0	.25	0
promote professional advancement	.25	.25	.25
Totals	2.75	3	.50
Perceptual Data			
Percentage of nurses with associational membership	2	2	0
Summed totals	4.75	5	.50

fully qualified professions has passed through stages from apprenticeship to university-based general to specialty education. The length of the educational program is dependent upon the amount of knowledge deemed necessary for entry into the occupation. On Moore's scale of professionalism (1970), it was stipulated that the college baccalaureate degree should be the minimum point for a profession in the United States.

Questions were asked concerning the levels of nursing practice and the educational requirements for entry into nursing practice.

Since Moore's scale specified the college baccalaureate degree as the minimum entry for a profession, this factor was given the value of 3 on the 3-point scale of measurement. Hong Kong had a three-year post-high-school training program and a two-year high-school-based program in nursing which provided two credential categories of nurses. Prior to the Cultural Revolution, Canton had two programs in nursing education: a three-year high school program and a five-year degree program. When training programs were resumed after the Cultural Revolution, only a two-year technical high school course was permitted. In 1981 the three-year hospital-based programs for students who had completed 10 years of schooling prior to entry were the routine. Macao's mode of preparation had a two-year middle school track and a three-year high school training program. Macao's Chinese hospital had a three-year high school program. The data summations for the educational requirements were 1 point for Canton, 2 points for Hong Kong, and 1 point for Macao on a summed scale of 6 as revealed in Table 4.

Service. The professional characteristic service comprised competence, conscientious performance, and service. In addition to minimum educational entry requirements, the rules of competence provide for certification by examining boards, monitoring of continuing competence through license renewals and continuing-education requirements. Standards of education and practice must be kept current to meet the demands of society (Moore, 1970).

Table 4

Educational Entry Requirements

Assessment criteria	Canton	Hong Kong	Macao
Survey Data			
1-level high school basic nursing	1	0	0
2-credential-levels below college	0	1	1
1-level post-high-school basic nursing	0	0	0
College-level basic nursing	0	0	0
Totals	1	1	1
Perceptual Data			
Education requirement -- Define high school, post high school, college	0	1	0
Summed totals	1	2	1

Society, at large, recognizes the service characteristic and believes that professionals are guided by moral and ethical codes in conscientious performance. Believing this enables clients to subject themselves to the prescribed mental and physical treatments given by the professionals even though the treatments are painful and embarrassing at times (Wilensky, 1964).

Greenwood (1957) defined service as the concept of work's being a social good for the community to such an extent that the activity becomes an end in itself and commands priority over the personal aspects of the professional's life.

The measurement items for service included credentials issued by a licensure board, continuing education provided by the association, credentials revoked for malpractice, and the nursing system organized in such a manner that nurses must work shift rotations. The survey data results were scored on a 3-point scale, and the scores were 2.5 for Canton, 3 for Hong Kong, and 2 for Macao. Responses to the perceptual item, high community regard for nursing, were scored as 2 for Canton, 2 for Hong Kong, and 1 for Macao. The analysis is illustrated in Table 5.

Table 5

Service Orientation

Assessment criteria	Canton	Hong Kong	Macao
Survey Data			
Competence			
Licensure Board to issue credentials	0	.5	0
Continuing education provided by association	.5	.5	0
Performance			
Credentials can be revoked	1	1	1
Service			
Norm work patterns irregular	1	1	1
Totals	2.5	3	2
Perceptual Data			
Community regards nurses as special	2	2	1
Summed totals	4.5	5	3

Autonomy. Professionals are called autonomous when they have "authority and freedom to regulate themselves and act within their spheres of competence" (Wilensky, 1964, p. 146). Autonomy is

regarded as the most critical characteristic required for an occupation to be designated a profession on the continuum scale. It is the highest and most difficult characteristic to acquire. The autonomous position may be withdrawn when the service is no longer regarded as essential for the well-being of society (Freidson, 1970; Moore, 1970).

"Most nursing takes place inside the hospital, where nursing has not achieved autonomy" (Freidson, 1970, p. 63). Even the autonomous professional labors under environmental constraints that alter the professionals' roles:

> When professionals are employed by organizations, there is a fundamental change in their situation. They must sacrifice some of their autonomy and conform to certain organizational rules for a simple reason: they do not possess all the basic skills for doing the work but are part of a larger and more complex system in which they perform only some of the required activities (Scott, 1966, p. 270).

In seeking to obtain a measure of nursing autonomy, the question became: Do nurses carry out the physicians' orders as their primary function?

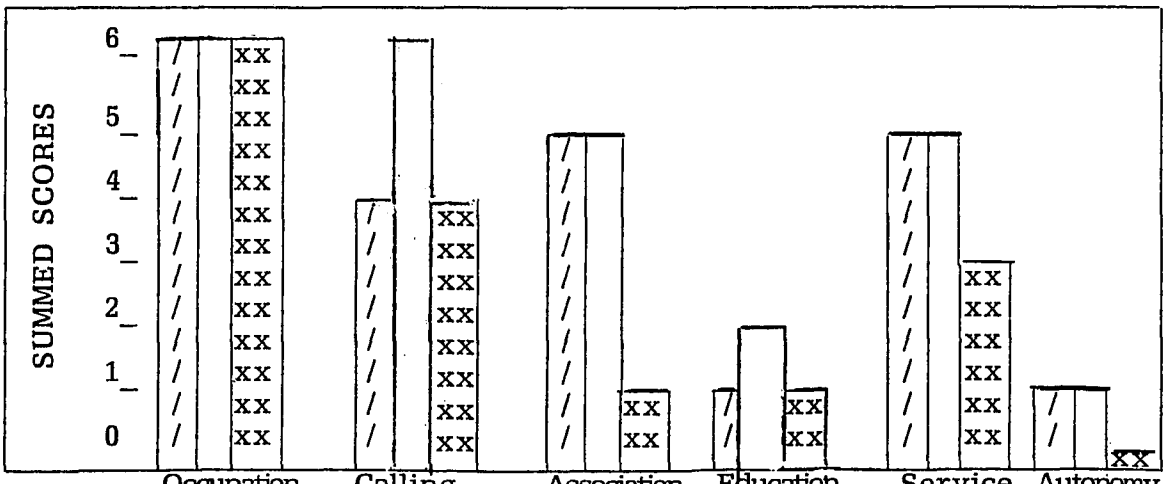
The level of autonomy was measured by whether a general independent nurse practice was permitted, and whether over 10 percent of nurses engaged in private practice. On a 3-point scale, Canton, Hong Kong, and Macao failed to score. The perceptual question ascertained the frequency of independent nursing care given on a routine basis. Canton and Hong Kong scored 1 point, but Macao did not score. The autonomy tabulations are demonstrated in Table 6.

Table 6

Autonomy

Assessment criteria	Canton	Hong Kong	Macao
	Survey Data		
General independent nurse practice permitted	0	0	0
Over 10% of nurses are engaged in private practice	0	0	0
Totals	0	0	0
	Perceptual Data		
Frequency of nursing care independent of doctors' orders	1	1	0
Summed totals	1	1	0

Figure 8 provides a visual comparison of the development of Moore's (1970) professional characteristics in the nursing systems of Canton, Hong Kong, and Macao as depicted by the summed scores of the survey and perceptual data.



Note. ///--Canton; white--Hong Kong; xx--Macao

Figure 8. Comparison of Professional Characteristics (Moore, 1970) of Nursing in Canton, Hong Kong, and Macao in 1981

The summed scores for the combined survey and perceptual data concerning Moore's professional characteristics (1970) were compared by chi-square distribution analyses using a $p < .05$ level of significance with 2 degrees of freedom. The results are demonstrated in Table 7. Nursing in Macao scored 12.25 on the development of professional characteristics, and the score was significant when compared to the critical value of 5.99 at $p < .05$ in the tables of Gibbons (1976) and Hayes (1973). Thus, factors other than chance must have been in operation at least 95 percent of the time.

Table 7

Chi-square Analysis of Moore's (1970) Professionalization Characteristics Development in Nursing

Professional Characteristics	Frequency observed	Frequency expected	x^2	df
Canton	22	36	5.44	2
Hong Kong	25	36	3.36	2
Macao	15	36	12.25*	2

*$p < .05$

Summary. Canton and Macao demonstrated the characteristic occupation, and Hong Kong was identified as having occupation and calling. Chi-square analysis of the data for Macao's nursing was significant at $p < .05$ with 2 degrees of freedom.

Mintzberg's Manager Roles of Professionals (1973, 1979)

The second research question focused on nurse managers' roles in government hospitals to obtain a measure of the professionalization

of nursing in Canton, Hong Kong, and Macao. In 1973 Mintzberg identified 10 roles common to all managers, and claimed that professionals who managed other professionals in organizations engaged in the 10 roles but devoted more time to the roles of spokesman, liaison, figurehead, and negotiator (1979). He stipulated that the observable roles had to be filled but that the manager could exercise some interpretative control. Roles are not isolated components in that they

> form a gestalt in an integrated whole. In essence the manager is an input-output system in which authority and status give rise to interpersonal relationships that lead to inputs (information) and these in turn lead to outputs (information and decisions). One cannot arbitrarily remove one role and expect the rest to remain intact (Mintzberg, 1973, p. 58).

Organizations design work roles to facilitate goal attainment, and those of managers include figurehead, leader, liaison (interpersonal roles), monitor, disseminator, spokesman (informational), entrepreneur, disturbance handler, resource allocator, and negotiator (decisional roles) according to Mintzberg (1973).

A two-part schedule (Schedule III, Appendix B) was designed by the researcher. One perceptual item for each of the 10 roles of Mintzberg was constructed in a coded form to obtain measures of the role activity by interview technique. The second part of the instrument contained five activity items for ranking in order of the time devoted to the activity. The ascending scale moved from least managerial to the most autonomous role function. Data analyses included tabulations, coding, chi-square, and comparisons of the results for the three subjects.

Interpersonal Roles

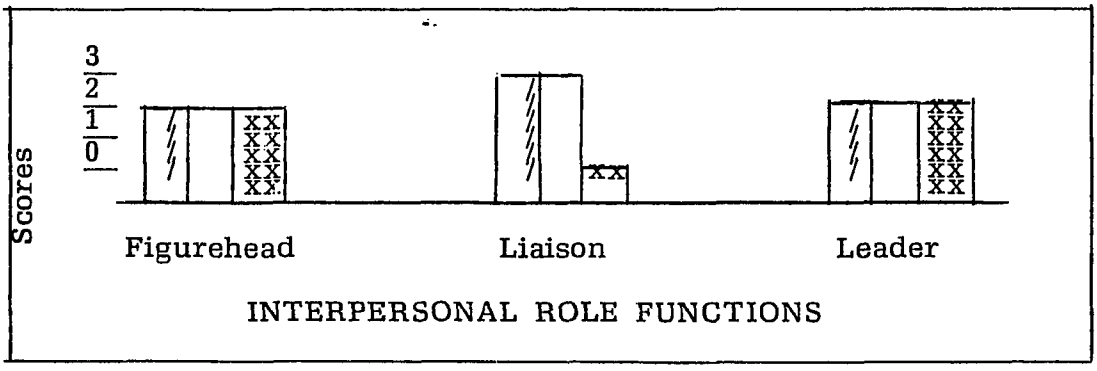
Management ideology ascribes to a hierarchical arrangement of roles in organizations with authority and status bestowed upon the higher levels, the managers. The authority and status serve as a basis for the three roles which relate to interpersonal relationships--figurehead, liaison, and leader.

Figurehead. As the authority symbol, the manager represents the department or organization at both legal and social functions. Traditionally, this role has been ignored or called a nonmanagerial function (Drucker, 1954). In the survey the nurse managers were asked to relate how often and under what circumstances they served as the nurse representative for the hospital. On a scale of 0-3 the managers reported that only "Sometimes" (2 points) did they serve as the figurehead.

Liaison. Outgoing and incoming external contacts flow from and to the manager due to the status invested in the liaison role (Mintzberg, 1973). An active liaison role is observable as the manager interacts in community, government, and professional organizational activities. The managers were asked to evaluate their nursing roles as representative of their hospital nursing system in government, professional association, and community functions. The scale of 0-3 ranged from "never" to "routine" representative (3 points). Canton and Hong Kong scored 3 points, but Macao's manager denied any liaison role functions.

Leader. Leadership, the third role, is the most widely acclaimed function for it permeates the organization. Incumbent managers are usually selected on this perceived leader role activity requirement in the organization. Staffing, motivating, and trouble shooting are leadership responsibilities. Nurse managers in Canton, Hong Kong, and Macao scored 2 points on a scale of 3 on their leader roles in designing the nurse jobs in their hospitals.

The three interpersonal role scores were presented in Figure 9. Scores were measured on a scale of 0 to 3 which ranged from no -(0) to complete- (3) role function.



Note. ///--Canton; white--Hong Kong; xx--Macao

Figure 9. Comparison of Interpersonal Role Functions in Nurse Managers in Canton, Hong Kong, and Macao

Informational Roles

Three roles -- monitor, disseminator, and spokesman -- are performed in dealing with information (Mintzberg, 1973).

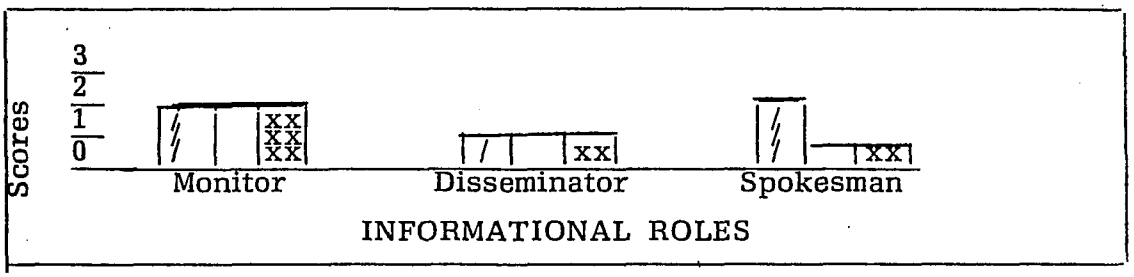
Monitor. Monitoring produces five categories of information which include pressures, ideas and trends, analyses, external events and internal operations. Little of this information is obtained through

formal channels; therefore, each manager must develop his own monitoring contacts (Mintzberg, 1973). Managers responded to a question on their control of gathering information from varied sources. A score of 3 indicated that the manager was in full control of her information gathering. Even though each manager scored 2 points on the 3-point scale, each responded that she had limited use of her information in the restricted organizational design.

Disseminator. This role concerns the flow of information to subordinates or peers. In the disseminator role, the manager's leadership style and power control tactics are displayed. The channels used and the timing of the information release need to enhance the manager in the eyes of those in her division (Mintzberg, 1973). Canton, Hong Kong, and Macao managers scored 1 on a 3-point scale on the control of information flow in the nursing departments under them.

Spokesman. As the functional head of the organization or department, the manager has the authority and status to speak externally; therefore, all statements made by the functional head are accepted as that of the organization. Thus, the spokesman role must be judiciously exercised (Mintzberg, 1973). Only the Canton nurse manager, with a score of 2 points, reported spokesman activity.

Data results of the three informational roles--monitor, disseminator, and spokesman--are presented in Figure 10.



Note. ///--Canton; white--Hong Kong; xx--Macao

Figure 10. Comparison of Informational Role Functions in Nurse Managers in Canton, Hong Kong, and Macao

Decisional Roles

Interpersonal relationships and information processing lead to decisions or strategy-making which range on a continuum from innovative to reactive. The decisional roles--entrepreneur, resource allocator, disturbance handler, and negotiator--are evaluated as the most crucial of the 10 roles; however, Mintzberg (1979) pointed out that professional managers spend more time in the negotiating role than in the other three.

Entrepreneur. The entrepreneur role embraces initiating and designing new activities or restructuring existing ones to facilitate the department's function in the organization's goal attainment. In this role the manager may operate in a delegating, authorizing, or supervising capacity (Mintzberg, 1973).

Nurse managers in this study demonstrated little opportunity to initiate, design, or restructure nursing functions. In Canton all decision-making was committee-centered. Hong Kong and Macao nurse managers rarely engaged in entrepreneurial activities because

this was a function located outside the nursing department. The scores were Canton: 0, Hong Kong: 1, and Macao: 1.

Disturbance handler. Disturbances occur in all organizations. Emergencies arise in interpersonal relationships and in the need for reallocation of resources. Community, government, other agencies, and clients initiate unexpected environmental constraints. Unsolicited informants reveal the problem to the manager who usually responds with immediate attention and priority to provide a short-term solution. Precedents set in handling one emergency may result in greater crises in another situation or alter planned strategy (Mintzberg, 1973, 1979).

In the American setting, managers in nursing systems are confronted with disturbances routinely. Patient overflows in emergency, labor, and surgery wards, personnel shortages, and exhausted supplies demand immediate attention. Societies with extremely limited resources, which are always in short supply, are often forced to work guided by the principle of collective welfare rather than that of individual case needs. The immediacy, therefore, in disturbance handling is reduced or often removed from the role of the managers. The survey subjects scored 1 point on a scale of 3 for their input into the situations of disturbance handling in nursing management.

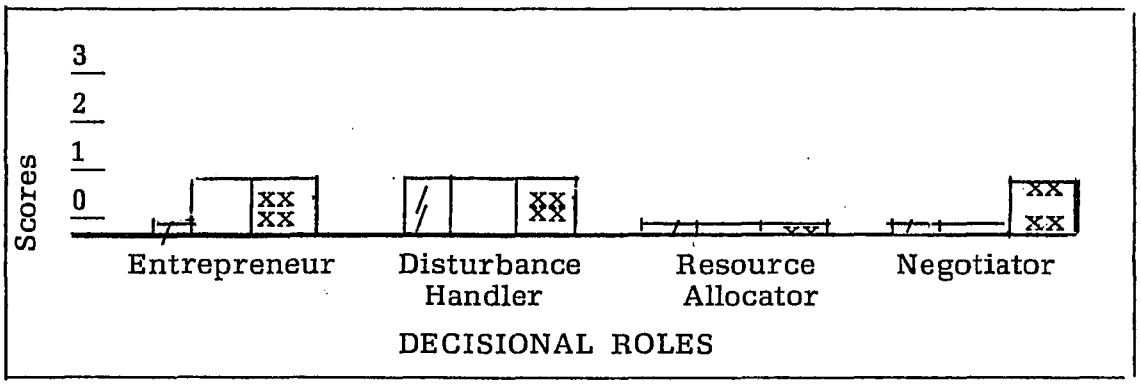
Resource allocator. The heart of the decision roles is the distribution of personnel, time, finances, and materials. In the allocation of resources the manager may conserve or expend. Three activities are seen in the resource allocator role: scheduling time,

programming work, and authorizing the use of resources. The role of the professional manager is altered in that "much...time is spent in linking the unit to the broader environment, notably to ensure adequate financing" (Mintzberg, 1981, p. 109). The measurements of the role--responsible for budget request and distribution, increasing and decreasing nursing personnel responsibility, and responsible for nursing salary decisions--were used to obtain the scores for the resource allocator activities on a scale ranging from 0 to 3 points. Each nurse manager received a score of 0.

Negotiator. The role of negotiator is defined as participating in nonroutine bargaining transactions. Figurehead, spokesman, and resource allocator roles demand that the manager participate in negotiation. Mintzberg viewed this function as a resource trading in real time (1973, p. 91).

Nursing often employs the largest number of hospital employees; therefore, the need for the department to negotiate with those in control of resources arises both internally and externally.

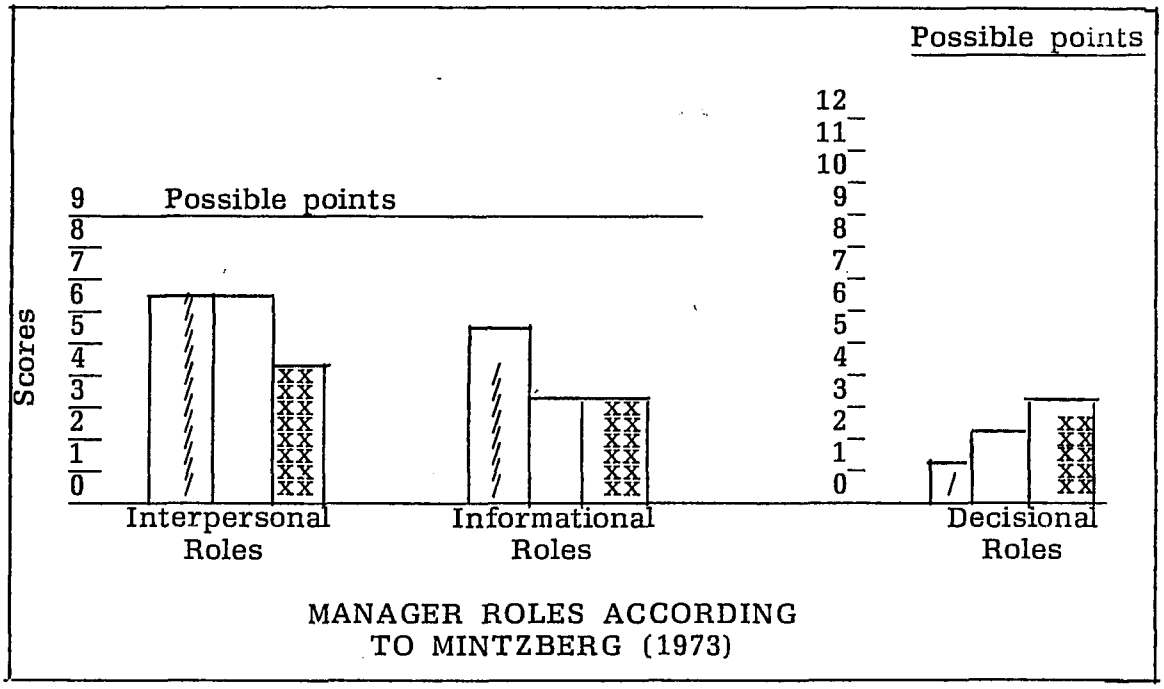
The Macao manager scored 1 on a scale of 3 in bargaining, and Canton and Hong Kong managers did not score any points in this area. The findings are presented in Figure 11.



Note. ///--Canton; white--Hong Kong; xx--Macao

Figure 11. Comparison of Decisional Role Functions in Nurse Managers in Canton, Hong Kong, and Macao

When the individual scores of the nurse managers' roles of figurehead, liaison, and leader were summed for a measurement of interpersonal roles, the scores were 7 points for Canton, 7 for Hong Kong, and 4 for Macao on a scale of 9 points. The summed scores for the informational roles of monitor, disseminator, and spokesman were Canton - 5, Hong Kong - 3, and Macao - 3 on a scale of 9 points. Since the decisional roles were four in number, their summed scores were on a scale of 12 points; and they were 1 for Canton, 2 for Hong Kong, and 3 for Macao. Summed score results are presented in Figure 12. Nurses' participation in reduced manager roles resulted in low scores which were significant at $p < .05$ with 2 degrees of freedom by chi-square analysis for the individual nurse managers in Canton, Hong Kong, and Macao. Therefore, there is a 95 percent probability that factors other than chance are in operation in these environments which influenced the roles of managers. The chi-square values are presented in Table 8.



Note. ///--Canton; white--Hong Kong; xx--Macao

Figure 12. Comparison of Manager Role Activities of Nurse Managers in Canton, Hong Kong, and Macao in Government Hospitals in 1981

Table 8

Chi-square Analyses of Mintzberg's (1973) Manager Roles

Roles	Frequency observed	Frequency expected	x^2	df	critical value
Canton	13	30	9.62*	2	5.99
Hong Kong	12	30	10.8*	2	5.99
Macao	10	30	13.3*	2	5.99

*Significant at $p < .05$

Ranking of Time in Role Activities. Managers were given five activities to rank order on an ascending scale according to the time

spent in the role: (1) giving patient care; (2) keeping relationships running smoothly; (3) improving the programs and jobs already going; (4) increasing the divisions of nursing or promoting growth of the nursing department; and (5) starting new jobs, methods, programs. The scale moved from least autonomous to the most autonomous function. Canton's manager identified the roles of her work to be number 2, keeping relationships running smoothly, and number 3, improving the programs and jobs already going. Number 3, improving the programs and jobs already going, was the major activity of the Hong Kong manager. Macao's manager chose number 2, keeping relationships running smoothly, as her major activity. The two most autonomous roles, increasing the divisions of nursing or promoting growth of the nursing department and starting new jobs, methods, and programs, were not identified in their major activities.

Summary. The nurse managers of this study identified only some of Mintzberg's roles as job activities. The Canton manager reported her roles to be those of figurehead, liaison, leader, monitor, and spokesman. The roles of figurehead, liaison, leader, and monitor were described as job components of the Hong Kong manager. The Macao manager identified figurehead, leader, monitor, and negotiator role functions in her work.

Mintzberg's (1979) Professional Operating Core Characteristics

The last research question was formulated to examine the organizational design of government hospitals in Canton, Hong Kong, and

Macao according to the characteristics of a professional bureaucracy. The key part of a professional bureaucracy is an operating core of professionals. Since professional salaries require a high percentage of the organizational resources, support staff performing less professional activities are established to increase the output of the professionals. Professional characteristics of this operating core include education / skills, specialty practice requirements, limited managerial control, and autonomy of practice (Mintzberg, 1979, 1981). The research concern was whether nurses function in the operating core as professionals or support staff.

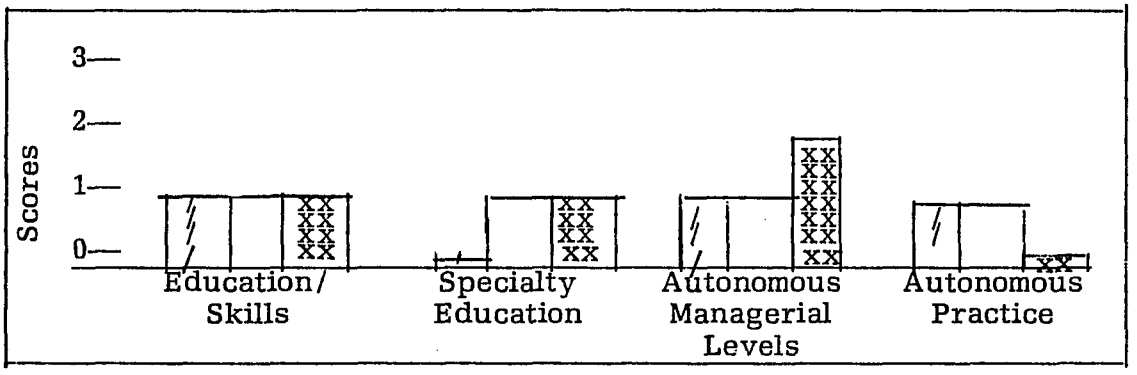
Education / Skills. Mintzberg (1979) identified a professional in a professional bureaucracy as one who has standardized skills acquired through education and socialization as determined by the professional association prior to job entry. Four items--on the job training only, special noncollege education, college degree required, and postcollege education were placed on a 3-point scale with the postcollege education valued at 3--the most professional. Nurses in the samples in each city were identified in the special noncollege education characteristic at point 1 on the scale of 3.

Specialty Practice Requirements. In complex professional work, specialties are developed over time as the need arises for a high degree of expertise in a given area. It becomes impractical for everyone to be expert in all areas. Educational programs are designed to insure that standardized skills are developed for the specialty (Mintzberg, 1979; 1981). Nursing specialties include education,

administration, and clinical areas of practice. The 3-point scale values ranged from 0 for on-the-job training to 3 for all specialties requiring education. The scores were 0 for Canton, and 1 for Hong Kong and Macao.

Managerial Patterns. One of Mintzberg's postulates (1979) stated that operating core professionals work independently; therefore, little coordinating is required which results in a thin middle line (Figure 7). A professional who serves as the manager is the most common type of management seen in the operating core design. To obtain a measure of autonomy as depicted by the levels of management, the nurses described the manager levels. Canton and Hong Kong's three or more levels of managers gave them a score of 1 on a 3-point scale. Macao's two-level design had a value of 2 points.

Autonomy of Practice. Mintzberg (1979) stated that "The professional bureaucracy...disseminates its power directly to the professionals...(who is) free to serve his clients in his own way, constrained only by the established standards of his profession" (p. 371). In this autonomous role the professional is able to perfect his skills; therefore, he is devoted to his work and serves his clients well. The nurses in the samples responded to items concerning nursing's control of the work of nurses in the hospitals. Macao scored no points, and Canton and Hong Kong scored only 1 point on the 3-point scale on the autonomy of practice. A comparison of the developmental scores of the operating core professional characteristics for the three cities is presented in Figure 13.



Note. ///--Canton; white--Hong Kong; xx--Macao

Figure 13. Comparisons of Mintzberg's (1979) Operating Core Professional Characteristics Development in Government Hospital Nursing Design in Canton, Hong Kong, and Macao in 1981

Summary. Nurses in government hospitals in Canton, Hong Kong, and Macao were not identified at the professional operating core level in the professional characteristics of education/skills requirements, specialty practice educational requirements, autonomous managerial levels, and autonomous practice. In view of this finding, nursing was identified as being at the support-staff level in the government hospitals surveyed in this study.

CHAPTER V

SUMMARY, DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This descriptive study compared nursing in Canton, Hong Kong, and Macao in the areas of development of professional characteristics (Moore, 1970), manager roles of professional nurses, and the organization of nursing as a professional operating core in hospitals (Mintzberg, 1973, 1979).

The study population included a quota sample of three professional nurses who were associational officers, a quota sample of three professional nurse managers, and a convenience sample of 33 employed nurse subjects. The quota sample subjects were evenly represented from the three cities. The convenience sample subjects were 20 from Canton, six from Hong Kong, and seven from Macao.

Data were collected by researcher-designed interview schedules and Likert-type item perception opinionnaire and scales. The professional conceptual base of the instruments was derived from review of the literature, Hall's Professional Inventory Scale (1967), Stuart's (1981) findings on the professional development of nursing in the United States according to Moore (1970), suggestions from professional peers, and the investigator's professional experience. The instruments were evaluated by professionals in nursing education and

practice for clarity and content validity. A test-retest of the instruments by a Chinese nurse and a Cantonese-speaking American nurse at three-month intervals resulted in identical responses on the two testings. Likert-type summed rating, rank-ordered scales, coding tables, and chi-square for significance analyses were applied to the descriptive data.

Three questions were formulated to investigate the three-fold purpose of the study:

1. At what level on Moore's continuum of professional characteristics (1970) do professional nurse subjects identify their respective nursing systems in Canton, Macao, and Hong Kong?

2. Do professional nurse managers in government hospitals in Canton, Macao, and Hong Kong identify Mintzberg's professional manager roles (1973, 1979) as components of their job activities?

3. Is nursing practice in general government hospitals in Macao, Canton, and Hong Kong organized as the operating core in a professional bureaucracy organizational design as measured by Mintzberg's criteria (1979)?

The comparative analysis of the professional characteristics yielded summed scores on a scale of 6 possible points:

	Canton	Hong Kong	Macao
Occupation	6	6	6
Calling	4	6	4
Professional Association	4.75	5	.5
Education	1	2	1
Service	4.5	5	3
Autonomy	1	1	0

Canton and Macao had attained the occupation characteristic, and Hong Kong demonstrated the occupation and calling characteristics.

The examination of Mintzberg's manager roles (1973, 1979) of professional nurses showed that the interpersonal roles of figurehead, liaison, and leader were identified as the most prominent of the ten roles in their job functions. The Canton manager reported her roles to be that of figurehead, liaison, leader, monitor, and spokesman; figurehead, liaison, leader, and monitor were described as job components of the Hong Kong manager; and the Macao manager identified figurehead, leader, monitor, and negotiator role functions in her work. When the summed scores for each manager on all ten roles were analyzed by chi-square, the results were significant at $p < .05$ with 2 degrees of freedom. Therefore, there is a 95 percent probability that factors other than chance are in operation in the environments which influenced the managers' roles.

Nurses in the government hospitals of Canton, Macao, and Hong Kong were not identified as being at the professional operating core level. That is, according to Mintzberg's measure, they had not attained certain essential professional characteristics: education/skills requirements, specialty practice education requirements, autonomous managerial levels, and autonomous practice. In view of this finding, nursing, in the government hospitals surveyed in the study, was determined to be at the support staff level.

Discussion

The results of this study must be viewed in light of the stated limitations and the small sample sizes. Data discussion is presented as it relates to the three research questions.

Moore's Professional Characteristics. It has been stated that progress in attaining and maintaining professional characteristics requires tremendous effort on the part of the aspiring occupational group (Goode, 1969; Stuart, 1981). Socio-ethnic, political, and economic conditions may promote or impede the development of professional characteristics by an occupational group. Both positive and negative environmental presses were evident in Canton, Hong Kong, and Macao.

1. Occupational status: Nursing was recognized and regulated by the governments from 1930 in Canton, from 1931 in Hong Kong, and from 1942 in Macao. Administrative environments differed in the three samples. Canton's nursing was a subdivision of an occupational force of almost 500,000 nurses employed in the government health services. The 10,000 nurses in Hong Kong were in both private and government health care systems. Over 7,000 nurses were employed by the Medical and Health Department. Even though some government servants were English, the nursing personnel had been transformed from an all-English to a completely Chinese staff by 1980 (Childe, 1980; Nursing given, 1982). There were about 300 nurses listed in the Anuario De Macau, 1981. The nurse manager in Macao's general government hospital was a Portuguese appointed from Portugal and

did not speak Chinese, the language of the majority of her Macanese nursing staff.

Even though nursing was a foreign concept introduced by foreigners about 100 years ago, by 1980 it was vital to the delivery of health care in the three cities.

2. Calling: The concept of calling is limited in its operation if a society has imposed restrictions on entry and exit to an occupation. If job opportunities are nil, the concept is restricted or altered. This was true for the citizens of Canton who lived in a controlled work environment, and the nurses' association membership was restricted. These environmental impositions might have influenced the discrepancy between the factual and perceptual measurements of calling in Canton. Macao's differences in perceptual and factual measurements could have been influenced by the newness of the nurses' association and limited job opportunities in general. Hong Kong's data indicated that calling was a characteristic of nursing there.

3. Professional Association: The three cities varied more in the development of this characteristic than any other. Canton's nursing became a part of an organized body from 1909; Hong Kong nurses founded their association in 1964; but Macao's was not official until 1981. It is possible that the small number of nurses present in Macao and their continuing interaction in a common work environment enabled them to function as an informal organization. Historically, the association in China played a major role in the development of the occupation of nursing. When the government saw the nursing

profession progressing under the able leadership of the professional association, it invited the president of the nursing association to determine the requirements and standards of nursing education and practice that the government should endorse (Hollister, 1932; Wong & Wu, 1932). The nursing association's influence was greatly reduced when all the health care systems became government organizations during Mao's reign. During the Cultural Revolution the association and its journal were banned as revealed in the following words:

> The Nurses Association revived its activities three years ago, after 12 years' suspension, and now publishes a periodical--"Chinese Nurses Journal" which has a circulation of 170,000 (Chinese Nurses, 1981, p. 528).

Continuing education, national and regional meetings, re-publication of the journal, and interaction with international nurses were manifestations of the association's present professional activities. However, government restraints appeared to be delimiting to the professional association's developmental process.

In 1960 the twenty-year old organization, the Hong Kong Nurses and Midwives Association, was denied membership in the International Council of Nurses which was begun in 1899 by Mrs. Fenwick of England, because the midwives were not all registered nurses. Four years later the Hong Kong Nurses Association was formed with a beginning membership of 533. When the new association leaders brought the nurses of Hong Kong together in peer activities which included publishing a journal, providing continuing education, holding meetings, and establishing membership in the International Council

of Nurses, progress was made in developing professional characteristics. The conflicting beliefs of the Association of Government Nursing Staff, founded in 1977, appeared to decrease the older general association's influence on nursing in 1981. Other delimiting factors on the Hong Kong Nurses' Association were increased government-sponsored health care and nurses-training programs and the location of post-basic nursing education elsewhere in the British Commonwealth (Childe, 1980; Dolan, 1968; Iu, 1979; Pinkstone, 1982; Poon, 1967a, 1967b; Veevers, 1977).

Nurses in Macao whose association was relatively new, and in Canton where their association was newly resurrected expressed optimism about the effectiveness of their professional associations in the next few years.

4. Education: One of Moore's professional characteristics is an educational requirement of a college baccalaureate degree for entry into the occupation. This characteristic was not demonstrated in any of the samples; however, the elite professions also had reduced educational requirements. Hong Kong's three-year post-high-school basic program was the most advanced of the educational requirements. Association leaders in Canton and Hong Kong recommended college-level nursing courses (Chinese nurses, 1981; Wong, 1966; Working Party Report, 1968). Notwithstanding, the college baccalaureate degree entry requirement appeared remote for all three samples in 1981.

5. Service Orientation: All three nursing systems were progressing toward a high service orientation. Hong Kong had attained this characteristic as measured. In 1979 the former president of the Hong Kong Nurses Association promoted service in this way:

> ...some nurses have opted to adopt the tools of trade unionism to arouse community conscience...demeans the nobility of the profession...casts aside all notions of service in preference for monetary gain...as long as we retain public esteem...we will always have public opinion on our side (Iu, 1979, p. 4).

The most common slogan in China was "Serve the people." Canton's nurses had attained 4.5 on a 6-point scale of the service measure. Nurses were being enculturated that professional nurses are known by the way that they sacrifice themselves for the country. A professionally socialized nurse was expected to remain in nursing even though she might have an opportunity to advance to the role of a physician, which had been a common practice for China's nurses during the Mao period (Song, 1981).

Macao measured three out of six points on the service characteristic. In the inaugural address of the Macao Nursing Association, nurses were admonished to serve the citizens of Macao in such a way that health for all the people will be advanced.

Nurses in the three samples were dedicated to the rule of loyalty or service as demonstrated in their willingness to provide patient care either day or night or on holidays. Both professionals and clients expressed confidence in the service orientation of nurses.

6. Autonomy: Nurses in Canton, Hong Kong, and Macao demonstrated the least degree of professional development in the area

of autonomy. Socialistic and colonial governments with their socialized health care systems appeared to hinder the development of professional autonomy in all three samples. In general the nurses interviewed in each city did not appear to expect to be autonomous in their collective organization or in their individual work roles in nursing. It is true that working conditions, quality of health care, and salary were real concerns. The concept of an individual nurse providing care outside the organized health care delivery system was foreign to all those interviewed except the nurse manager in Macao who was Portuguese.

Mintzberg's Manager Roles of Professionals (1973, 1979). The data collected in response to the second question concerning nurse managers' roles in the ten activities of Mintzberg suggested that nurses in Canton, Macao, and Hong Kong were given broad responsibilities, but limited control and authority were bestowed upon the professional nurse managers. These factors restricted the managers to supervisory roles. Sheldon (1975) identified limited manager authority as an increasing problem for managers in complex organizations such as hospitals. The managers in the samples identified the interpersonal roles of figurehead, liaison, and leader as their strongest role activities. This supported the findings regarding the lack of autonomy accorded nursing on Moore's (1970) professional characteristics scale. Interpersonal role functions found in the study can be exercised within a restricted decision or policy-making environment which was characteristic of the health care systems under

Canton's Communist government, Hong Kong's modified socialized system, and Macao's government-sponsored program. Leader role activities of job supervision and promoting harmonious relationships were the highest perceived functions on a ranking of autonomous characteristics by the nurses.

The managers responded in the following manner to the question of how the professional association can improve the professional manager role in nursing. The Canton manager indicated that the professional association had an important role to play in the advancement of nurse manager roles. The nurse manager in Hong Kong regarded the Association of Government Nursing Staff as the important organization to improve nursing and the roles of manager nurses in the government health care systems. The view of the manager in Macao was that major changes in the nursing system would be required to advance professionalism there. Her postgraduate education in Canada probably provided her with the most understanding of autonomy in professional nursing roles as advocated by more advanced nursing systems in the world.

Reduced manager-role activities reported by the three nurse managers were significant in a negative direction when analyzed by chi-square at $p < .05$ with 2 degrees of freedom. This means that there is a 95 percent probability that factors other than chance influenced the roles of managers. These influencing factors were probably government control of occupations and job designs, limited job opportunities, reduced influence of the professional associations, and cultural restrictions and socialization of women.

Mintzberg's Professional Organizational Design (1979). The responses to the questions formulated to determine whether nurses operate as professionals in the core of the hospital revealed that nurses work in supporting staff roles instead of being accorded professional status. These findings support the data on Moore's professional characteristics and Mintzberg's manager roles of professionals. The organizational design of a hospital is influenced by the work roles and the professional characteristics of the workers employed.

Conclusions

Nursing in Canton, Macao, and Hong Kong was developing professional characteristics as defined by Moore. Hong Kong had developed the highest degree of professionalization as measured in 1981, and Canton had developed a higher degree than Macao. However, the degree of professionalization in the three samples did not meet the standards for a profession as identified by Moore. Etzioni (1969) and Katz (1969) claimed that nurses with these charactristics are semi-professionals. According to Stuart (1981), nursing in Canton, Hong Kong, and Macao would be labeled as an emerging profession. The assessment of nursing in the United States made by Bucher and Strauss (1961) is that nursing is striving to become a profession, and to convince society that this label is legitimate and deserved. Nurses in Canton, Hong Kong, and Macao were less concerned about professional status than Bucher and Strauss indicated was true of nurses in the United States.

Evidence from this investigation supported the concept of measuring professionalization by the degree of professional characteristics present in a given occupation. The samples provided data that nurses have been active in developing professional characteristics whether they were aware of the process or not. Since Moore cautioned that comparative studies could not expect to find professionals equally valued in different situations, it was surprising that the three nursing systems were very similar in their development of professional characteristics. However, nurses were observed in the three samples who had moved from one system to the other to work. The investigator concluded that, unless many unexpected happenings influence future developments in nursing in the three cities, it is unlikely that nursing there will attain professional status.

The managers in nursing described limited role involvement and absence of many role activities. Canton's manager reported that her roles included figurehead, liaison, leader, monitor, and spokesman. The roles of figurehead, liaison, leader, and monitor were described as job components of the Hong Kong manager. The Macao manager identified herself with minor figurehead, leader, monitor, and negotiator role functions. This study supported Mintzberg's conclusion that "managers' jobs are remarkably alike" (1979, p. 4) to the extent that situational conditions, job environments, job level and functions, and socialization of the managers are similar. Government differences appeared to have less effect than cultural influences upon the roles of managers in these three nursing systems.

The researcher repeatedly questioned whether the roles were not present because the managers had not been educated in management enough to identify themselves in the role activities, and therefore had not reported them. It was concluded that this lack of education in manager roles in combination with the situational and environmental influences probably was responsible.

The professional operating core characteristics--the standardized skills acquired through education, specialty areas of practice education requirements, limited vertical managerial levels, and professional autonomy of the nursing work--were not developed. Therefore, the investigation supported the nurse support-staff role-function concepts as identified by Mintzberg (1979), Freidson (1970), and Georgopoulos (1972) through the findings for Canton, Hong Kong, and Macao. The hospital patient care design was that of professional cores of physicians who directed the care.

Autonomy, the highest professional characteristic and the most essential in the attainment of professional status, was the least developed characteristic in nursing in the three samples according to the measurements of Moore's characteristics, of Mintzberg's decisional roles, and of the characteristics of professionals in a professional bureaucracy. Thus it was concluded that nursing in Canton, Hong Kong, and Macao will continue to develop higher degrees of professional characteristics, but in all probability will not gain professional status in the foreseeable future.

The foregoing conclusions about the Chinese nursing subsamples support the validity of the study of professionalization of occupations according to the criteria of Moore (1970) and Mintzberg (1973, 1979).

Finally, it is concluded that the extensive historical and theoretical analysis of the professional development of nursing in Canton, Hong Kong, and Macao will contribute to a better understanding of nursing there. The comprehensive bibliography should be useful to researchers and nurses on an international basis.

Recommendations

1. A replication of this study involving larger samples of nurses in Canton, Hong Kong, and Macao by a Chinese nurse researcher to test the validity of the findings and to test the validity of a foreigner's interpretation of the data is recommended.

2. It is recommended that a comparative study of the conceptual bases of the major nursing systems of the world be done by an international organization and that the findings be made available to nurses who are involved in cross-culture nursing.

3. Since the study results support the use of Moore's and Mintzberg's professional concepts, it is recommended that standardized instruments be developed for the measurement of Moore's (1970) professional characteristics, Mintzberg's manager roles of professionals (1973, 1979), and his professional operating core characteristics (1979). Standardized measurements applied to larger samples in many countries should provide a more comprehensive data base on which to evaluate nursing nationally and internationally.

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APPENDIX A

LETTERS OF INQUIRY, INTRODUCTION, AND CONSENT

(Translation from Chinese) June 15, 1981

My dear respectful Principal:

Please let me address you this way. I was in the 1959 class of Canton First People's Hospital Nursing School. I still remember that it was the only open nursing school in Canton, and you were the principal. Teachers included... These were intelligent teachers, and I miss them very much. I miss the happy life of nursing school. Even though it has been more than twenty-years, I remember everything deep in my heart. Thank you for caring for us like your children and making it possible for us to become nurses to serve the people.

In...1979, I went with the Fushan nursing leaders to the Canton Scientific Museum to attend a nursing lecture given by a Chinese-American nurse who had her doctorate. You were in charge of the meeting. I was lucky to see you healthy again after all the troubles of the Cultural Revolution.

Since I left China in 1979, I have been working in a clinic in Macao which is operated by Americans. It is modern and follows the American system. The doctor's wife is a nurse who is a very knowledgable doctoral student. She is anxious to study Chinese nursing practice and wants to go to Canton to visit hospitals and nursing schools. It would be good if she can understand and exchange mutual experiences and become friends. It would be good to improve American and Chinese friendship by building blocks of experience such as this. Please join me in using your influence to let my American friend's plan come true.

Please advise us what we should do and what procedures to follow.

We shall anxiously await your reply. Shake your hand tightly.

Your former student,

(Translation of Response to Letter on Page 124)

_____,

I received your letter and am happy that you have an American nurse friend who wants to come to Canton to visit. We shall welcome her.

The easiest way to come is to come at her own expense. While she is here, we can arrange for her to see the hospitals and to speak, and to have discussions with us.

...When would she like to come? What is her speciality? What is her main interest in coming? Please inform the committee or me of these matters in order for us to arrange for her visit.

...

Signed

_____

1981/6/24

(Translation from Chinese)

(Name),

How are you? I was happy to receive your letter when I went back to the hospital emergency room for a case this morning. This afternoon, I communicated with the Director of Nursing, (Name), concerning the request. Fortunately, the Director is Vice President of the Canton Branch-China Nurses Association. She has many responsibilities in this position; therefore she welcomes the visit of Mrs. Tabor...

Mrs. Tabor should give us the title of her speech. Which hospital does she wish to visit? The Director said that she is willing to organize and direct the visit.

The simplest way is to join an international tour to Canton. If you go through formal invitation, it is very difficult. If you arrange through a tour agent for hotel, transportation, and food, then you can move about independently.

Please write to the Director and tell her your purpose for the visit. Her address is...

If you need any further help, please write me again. Canton is very hot now, 35-36^{o} Centigrade. Maybe Macao is better.
(Personal message not translated).

(Name)

22/6/81

Ellen D. Tabor
RN. M. ED.

Doctoral Research Student
University of North Carolina-Greensboro
Greensboro, NC, USA

Hoover Ct. D-12
1, Travessa do Colégio,
Macau
Telephone: 89000

June 29, 1981

Canton Branch-Chinese Nursing Association
Vice President _____

Dear Vice President _____,

I am an American nurse, Ellen D. Tabor, who would like to visit your nursing work in Canton. My doctoral research topic is concerned with comparing nursing in Canton, Macao, and Hong Kong. After getting to know some nurses who have been educated there, I am very impressed with your programs.

Would it be possible for you to assist me in getting to visit your nursing department, a nursing school, and your nursing association.

My husband who is an internal medicine physician, one other American nurse, and I are the ones interested in visiting you.

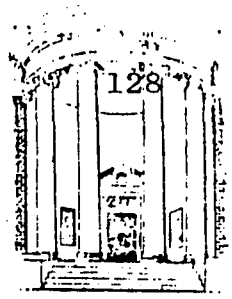
I will be happy to talk with you about nursing in the United States, but my interest is in learning about your work.

Please suggest the number of days we should plan to stay and what to tell the China Travel Agent in Hong Kong to arrange for us in addition to our travel, hotel, and food.

Thank you for your assistance.

Sincerely,
Ellen D. Tabor
Ellen D. Tabor, R.N., M. Ed.

THE UNIVERSITY OF NORTH CAROLINA
AT GREENSBORO



School of Nursing
Graduate Program

May 20, 1981

President
Kwangchow Nursing Association
Kwangchow, China

Dear Sir:

I am very pleased of this opportunity to write Mrs. Ellen D. Tabor a letter of introduction. I have known Ellen as a student for the past two calendar years; consequently, it is appropriate that I speak to some of her academic abilities and potentials.

Ellen is pursuing a minor in nursing in partial fulfillment of the doctorate degree in education at the University of North Carolina at Greensboro, Greensboro, North Carolina. As the Director of the Master of Science in Nursing Program, I am a member of her Graduate Committee and serve as the key professor in setting-forth the academic requirements for the minor in nursing.

Ellen's tentative dissertation title is: Comparison of the professionalization of nursing in Hong Kong, Macao, and Canton. I, as one of her graduate committee members would appreciate your cooperation in allowing her to collect data in your institution, necessary for this study. She will give you specific details of her instrument and research procedures.

Sincerely,

Ruby G. Barnes

Ruby G. Barnes, R.N., Ed.D.
Professor
Director MSN Program

RGB/sg

(Translation)

My respectful_____,

It is our desire that Mrs. Tabor introduce to us the advances in nursing in the United States. These include: (1) Administration of hospital nursing, (2) New techniques and business in nursing, (3) New instruments and equipment in nursing, (4) Qualifications for becoming a nurse, (5) The future development of nursing, (6) Education in nursing, (7) Specialities in nursing, (8) Other situations about nursing.

We are going to arrange five days of activities which will include visits to three hospitals, two nursing schools, and then invite you to give one big lecture, one medium lecture, and have discussion meetings. Is this suitable with you?

The best time to come to Canton is in September instead of October. In October the trade conference makes hotel booking very difficut. When you decide on a date, please call or write us.

China Nurses Association-Canton Branch

Vice President _____

81/7/16

(Translation)

KWANGTUNG PROVINCIAL PEOPLE'S HOSPITAL

My respectful Mrs. Tabor:

How are you? Thank you for your letter. I am very glad to represent Canton Branch-Chinese Nurses Association in welcoming you to give a lecture.

We are, also, anxious to know about the American nursing situation. We desire that you give us all the details in your presentation, especially the details of hospital management and nursing.

It is better if you can use slides or movies or written information. We will arrange for you to give some special topic reports.

We will give you all the details of the Chinese nursing situation, so that we can learn from each other and exchange our experiences. Also, we want to improve the friendship between American and Chinese nurses. We will keep in touch.

We wish you continual happiness.

China Nurses Association- Canton Branch

Vice President_____

81/7/16

Ellen D. Tabor

RN. M. ED.

Doctoral Research Student
University of North Carolina-Greensboro
Greensboro, NC, USA

Hoover Ct. D-12
1, Travessa do Colégio,
Macau
Telephone: 89000

August 25, 1981

Vice President Choe Sae Sum
Canton Branch-China Nurses Association
Nursing Department- People's Hospital
Canton, Kwangtung Province

Dear Vice President Choe:

I am excited about the prospects of visiting you and your work. My desire is to learn about Canton's nursing, and I am sure you have many interesting things to teach me.

The first three pages of my presentation are enclosed for your review. As you can see, I plan to discuss the nursing process, hospital nursing organization, and independent nursing practice. Please inform me if there is a better approach for your nurses. I am sure you will have someone to interpret for me.

Please guide or advise me as to the best use of our time to be helpful to you and to me.

Thank you.

Sincerely,

Ellen D. Tabor

Ellen D. Tabor

(Translation)

Dear Mrs. Tabor:

First of all, I extend my greetings to you and Dr. Tabor. We trust that you are happy living in Macao.

We received the letter and pictures. The pictures were very good. I shared them with the other nurses, and they were happy to receive them. They asked me to express their appreciation.

The fifth issue of Chinese Journal of Nursing has just been published. It is now possible for you to subscribe to it, if you desire to do so.

We hope to keep in touch, and you are more than welcome to come to give another lecture, visit, or tour. We hope to come to Macao, Hong Kong, and the United States so we can exchange our nursing experiences which will improve the development of the nursing profession.

Please forgive my late response to your letter. I went to Shanghai for a visit from October 6-28. On getting the pictures on my return, I felt that we were together again.

We really want you to keep writing in order to exchange our nursing experiences and develop our friendship. We trust that we will meet again soon.

Your friend,

_____

October 31, 1981

Ellen D. Tabor

RN. M. ED.

Doctoral Research Student
University of North Carolina-Greensboro
Greensboro, NC, USA

Hoover Ct. D-12
1, Travessa do Colégio,
Macau
Telephone: 89000

June 11, 1981

Ms Sheila Iu, President
Hong Kong Nurses' Association
221 Gloucester Road
Hong Kong

Dear President Iu:

I am a nurse from the United States. At the present I am living in Macao.

For my doctoral research I want to compare the organization of nursing in Hong Kong, Macao, and Canton. To do this I want to interview the leading nurse in the association concerning the development of nursing. In addition, I need to interview a chief nurse in a government hospital in each city on the organization of the work patterns and relationships to other workers.

Would it be possible for me to have an appointment with you sometime during the dates of July 14-17? I will be in Hong Kong then. If this is not convenient, please suggest another date.

Thank you for your kind consideration to this matter.

Sincerely,

Ellen D. Tabor

Ellen D. Tabor, R.N.,M.Ed.

THE HONG KONG NURSES ASSOCIATION

香港高士打道221-226號
海聯大廈十二字樓A-D座

221-226 GLOUCESTER ROAD
HYDE CENTRE
FLAT A-D 12TH FLOOR
HONG KONG
TEL. 5-729255

香港護士會

PATRON
LADY MACLEHOSE
贊助人：港督麥理浩夫人

20th June 1981.

Miss Ellen D. Tabor,
Hoover Court Apt.12-D,
No.1 Travess Do Colegio,
Macau.

Dear Madam,

With reference to your letter of the 11th instant regarding nursing organisation in a government hospital in Hong Kong, I would advice you to write to the Principle Nursing Officer, Medical & Health Department, Lee Gardens 3/F Hysan Avenue, Hong Kong for further information.

Yours faithfully,

Amy Kwan
Hon. Secretary
Hong Kong Nurses Association

HOPE MEDICAL GROUP

1-A Praca de Luis de Camões, Edificio Formosa, Apt. G. R/C, Macau

澳門協同醫務所

澳門白鴿巢前地美麗大廈壹號A G座地下

June 25, 1981

Amy Kwan, Hon. Secretary
Hong Kong Nursing Association
221-226 Gloucester Road
Hong Kong

Dear Ms Kwan:

Thank you for your kind response to my letter of June 11. I shall write to the Principle Nursing Officer as instructed.

I would like to have an appointment with some one in the association to learn about your organization. I will be in Hong Kong July 14-17, and would appreciate an interview during that time if possible. If not possible, I will come when you suggest. I became interested in your organization through reading the International Nursing Review.

If The Hong Kong Nursing Journal is available for sale outside your association, I would like to subscribe to it this year while I am in Macau.

Thank you again for your assistance.

Sincerely,

Ellen D. Tabor

Ellen D. Tabor RN, M. Ed. (Mrs.)
Hoover Court, D-12
1 Travess Do Colegio
Macau

HOPE MEDICAL GROUP

1-A Praca de Luis de Camoes, Edificio Formosa, Apt. G. R/C, Macau

澳門協同醫務所
澳門白鴿巢前地美麗大廈壹號A G座地下

June 25, 1981

Principal Nursing Officer
Medical and Health Department
Lee Gardens 3/F Hysan Avenue
Hong Kong

Dear Sir:

I am an American nurse who is interested in comparing nursing in Hong Kong, Macau, and Canton for my doctoral research. Government Hospitals offer the best setting for comparisons; therefore would you please permit me to interview your chief nurse in one of your government hospitals?

I will be in Hong Kong July 14-17. Would one of these days be convenient? If not, I shall be happy to come when you suggest.

Do you have information on your health care system that would be helpful for me to know before I visit?

Thank you for your assistance.

Enclosed is a letter of introduction from one of my professors.

Sincerely

Ellen D Tabor

Ellen D. Tabor, RN, M. Ed. (Mrs.)
Hoover Court, D-12
1 Travessa Do Colegio
Macau

香港政府
醫務衛生處
香港銅鑼灣希慎道利園大厦五樓

HONG KONG GOVERNMENT,
MEDICAL & HEALTH DEPARTMENT,
LEE GARDENS, 4TH FLOOR,
HYSAN AVENUE, CAUSEWAY BAY,
HONG KONG.

本署檔號 OUR REF:

電話 TEL: 5-762311

Date : 8th July 1981.

Mrs. Ellen D. Tabor, RN, M. Ed.,
Hoover Court,
D-12,
1 Travessa Do Colegio,
MACAU

Dear Mrs. Tabor,

I acknowledge receipt of your letter of 25-6-1981 and note your intention of visiting a Government Hospital in Hong Kong for your research study in nursing.

May I suggest you contact the Chief Nursing Officer of Princess Margaret Hospital while you are in Hong Kong during the period from 14th - 17th July 1981 for arrangement of a convenient time for your visit. The Chief Nursing Officer or her deputy could be contacted at Tel. K-7427111.

Yours faithfully,

L. SUM (Miss)
for Principal Nursing Officer

c.c. Chief Nursing Officer,
Princess Margaret Hospital.

Ellen D. Tabor
RN. M. ED.

Doctoral Research Student
University of North Carolina-Greensboro
Greensboro, NC, USA

Hoover Ct. D-12
1, Travessa do Colégio,
Macau
Telephone: 89000

July 17, 1981

Chief Nursing Officer
Princess Margaret Hospital
Kowloon

Dear Madam:

I did not receive the letter from Miss L. Sum for the Principal Nursing Officer of the Hong Kong Government Medical and Health Department suggesting that I could contact you regarding my research study in nursing during July 14-17 before I left Macao for Hong Kong. I regret therefore that I did not contact you.

Would it be possible to have an appointment with you on August 4 or 5, 1981? If these dates are not convenient to you, I could come on September 8 or 9.

I am looking forward to learning about nursing in Hong Kong. Thank you in advance for your contribution to my learning experience.

Sincerely,

Ellen D. Tabor

Ellen D. Tabor, R.N., M. Ed.

香港上環郵箱三八六八號

THE HONG KONG NURSES ASSOCIATION

香港護士會

P. O. BOX 3868 SHEUNG WAN
HONG KONG

9th July, 1981.

Mrs. Ellen D. Tabor, RN, M. Ed.,
Hoover Court, D-12,
1 Travess Do Colegio,
Macau.

Dear Mrs. Tabor,

Thank you for your letter dated 25th June 1981 indicating that you would like to have an appointment with us to learn about our Association. I am glad to inform you that one of our Executive Committee members Miss Ella Chan will be pleased to see you on Wednesday, 15th July 1981 at 2:30 p.m. Please come to the Grantham Hospital at 125, Wong Chuk Hang Road, Aberdeen, Hong Kong, at which Miss Chan is the Acting Assistant Matron. If the date is not convenient to you, please do not hesitate to contact Miss Chan directly at telephone number H-524321 to arrange for another date.

I sincerely hope that the interview will be helpful and informative to you and look forward to meeting you.

Yours sincerely,

Dora Wei

Dora Wei,
Hon. Secretary

c.c. Miss Ella Chan
DW/yol/ywn

Ellen D. Tabor

RN. M. ED.

Doctoral Research Student
University of North Carolina-Greensboro
Greensboro, NC, USA

Hoover Ct. D-12
1, Travessa do Colégio,
Macau
Telephone: 89000

July 17, 1981

Miss Ella Chan, Acting Assistant Matron
Grantham Hospital
125 Wong Chuk Road
Hong Kong

Dear Miss Chan:

I deeply regret that the letter from Honorable Secretary Dora Wei did not arrive in Macao before I left to go to Hong Kong; therefore I was not aware of the appointment for July 15.

Would it be possible to have an appointment with you on August 4 or 5, 1981? If these dates are not convenient to you, I could come on September 8 or 9, 1981.

Again, I am very sorry that I was not aware of the appointment.

I am looking forward to learning about nursing in Hong Kong. Thank you in advance for your contributions to my learning experience.

Sincerely,

Ellen D. Tabor

Ellen D, Tabor, R.N., M.Ed.

香港政府
瑪嘉烈醫院
九龍荔枝角荔景山道

HONG KONG GOVERNMENT
PRINCESS MARGARET HOSPITAL
LAI KING HILL ROAD,
LAI CHI KOK, KOWLOON.

設文編號 OUR REF.:

收文編號 YOUR REF.:

電話 TEL. 3-727111 Ext. 226

22nd July, 1981

Mrs. Ellen D. TABOR
Hoover Court,
D-12,
1 Travessa Do Colegia.
MACAU

Dear Mrs. Tabor,

With reference to your letter dated July 17 regarding an appointment of visiting Princess Margaret Hospital. We are very pleased to meet you on August 5 if possible at 9.30 a.m. Please phone the Chief Nursing Officer by Tel. 3-7427111 if necessary or contact the undersigned on your arrival in the hospital.

Looking forward to see you.

Yours faithfully,

(UE Wai-tak)
for Chief Nursing Officer
Princess Margaret Hospital

c.c. P.N.O. (Attn.: Miss L. SHUM)

M.D. 1110 AX

Ellen D. Tabor

RN. M. ED.

Doctoral Research Student
University of North Carolina-Greensboro
Greensboro, NC, USA

Hoover Ct. D-12
1, Travessa do Colégio,
Macau
Telephone: 89000

August 6, 1981

Chief Nursing Officer (Attn. Miss L. Shum and Mrs. Tjon)
Hong Kong Government Princess Margaret Hospital
Lai King Hill Road
Lai Chi Kok, Kowloon

Dear Miss Shum and Mrs. Tjon:

Thank you for your informative interview which should assist me in understanding nursing in the Princess Margaret Hospital in Hong Kong. I am very much interested in being able to make a valid comparison of nursing in Hong Kong, Macau, and Canton.

I congratulate you both on what you are giving to the development of the professionalization of nursing.

Sincerely,

Ellen D. Tabor

Ellen D. Tabor

THE HONG KONG NURSES ASSOCIATION

香港護士會

香港高士打道221-226號
海聯大廈十二字樓A-D座

221-226 GLOUCESTER ROAD
HYDE CENTRE
FLAT A-D 12TH FLOOR
HONG KONG
TEL. 5-729255

PATRON
LADY MACLEHOSE
贊助人：港督麥理浩夫人

10th August 1981.

Mrs. Ellen D. Tabor, RN, M. Ed.,
Hoover Court, D-12,
1 Travess Do Colegio,
Macau.

Dear Mrs. Tabor,

I understand from our Administrative Assistant, Miss M.Y. Kam, that you contacted her on 5th inst. at the Nursing Centre. I do hope that the informations on our Association which you obtained would be helpful to you.

With best wishes,

Yours sincerely,

Amy Kwan
Hon. Secretary

THE HONG KONG NURSES ASSOCIATION

香港護士會

香港高士打道221-226號
海聯大厦十二字樓A-D座

221-226 GLOUCESTER ROAD
HYDE CENTRE
FLAT A-D 12TH FLOOR
HONG KONG
TEL 5 729255

PATRON
LADY MACLEHOSE
贊助人：港督麥理浩夫人

26th August, 1981.

Mrs. Ellen D. Tabor,
Hoover Ct. D-12,
1, Travessa do Colegio,
Macau.

Dear Mrs. Tabor,

I write on the behalf of the Hong Kong Nurses Association to thank you for your very generous donation of US$25.00 to the nurses Association. Our official receipt is enclosed for your record.

Your kindness will long be remembered and we thank you most sincerely.

Yours sincerely,

.....

Gloria Kam,
Administrative Assistant.

à S.ª D. Guilhermina, para como
superintendente do serviço dar as facilidades necessárias
26.06.81

Hoover Court Apt. 12-D
No. 1 Travess Do Colegio
Macau
June 22, 1981

José Da Paz Brandão Rodriques Dos Santos
Director dos Service de Saude de Macau
Macau

Dear Director Santos:

I am an American nurse (o americano a enfermeira) who would like to request your permission to study the history of nursing in Macau.

Would you introduce (introduzir) me to your nursing department (a enfermeira o departmento)? I shall be waiting for your reply and look forward to learning about nursing in Macau. My telephone number is 89000.
Thank you for your kind assistance.

S. R.
PRESIDÊNCIA DO CONSELHO DE MINISTROS
GABINETE DE MACAU

Rua Prof. Gomes Teixeira
1300 LISBOA

Sincerely,

Ellen D. Tabor, RN

Ellen D. Tabor, RN, M. Ed.
Doctoral Research student
University of North Carolina-Greensboro
Greensboro, North Carolina, USA

ENFª GUILHERMINA

Associação de Pessoal de Enfermagem
de Macau
澳門護理人員協進會

Hospital C. C. S. Januario
Macau, July 14, 1981

Dear Mrs.

Ellen D. Tabor, Mr, M. Ed.

Doctoral Student

1. We want to thank you for your kinds words and your contribution of US- $100.00 to assist us in our work in the association.

2. We hope we can help you in your dissertation work about nursing "Comparison of the Professionalization of Nursing in Hong Kong, Macau, and Canton".

Sincerely

Mario A. Gabriel

Mario Alberto Gabriel

President of Direction

Macao Nursing Association

APPENDIX B

RESEARCH INSTRUMENTS

TOOL I

TABOR'S NURSE LEADER'S PERCEPTION OPINIONNAIRE

Directions: Please check the answer to the following statements which you feel best describes nursing

1. Nurses in your association work as nurses full time in paid positions.
   _____ Not applicable
   _____ Rarely
   _____ Sometimes
   _____ Most of the time
2. Nurses in your association remain in nursing through out their work life.
   _____ Not applicable
   _____ Rarely
   _____ Sometimes
   _____ Most of the time
3. Nurses believe that others in the community see them as special workers.
   _____ Not applicable
   _____ Rarely
   _____ Sometimes
   _____ Most of the time
4. Nurses join a special association which is restricted to registered nurses.
   _____ Not applicable
   _____ Less than 25% do
   _____ Between 25% - 50% do
   _____ Over 50% do
5. The educational requirements to enter nursing are:
   a_____ Hospital based nursing course for high school students for ___years
   b_____ Hospital based nursing course post high school for ____years
   c_____ College program for ____ years
   _____ Mixture of ____ and ____ above
6. Nurses decide a care plan for patients without doctor's orders of direction.
   _____ Not applicable
   _____ Rarely
   _____ Sometimes
   _____ Most of the time

TABOR'S SCALE FOR MOORE'S (1970) PROFESSIONALIZATION INTERVIEW

1. Occupation

Totals_____

(1) Government recognized as an organized work

(1) Laws to control education and entry

(1) Retirement with pension in government health care systems

2. Calling Totals_____

(1) Voluntary choice regarding membership in association

(1) All registered nurses permitted to join on becoming registered

(1) All society members free to choose nursing as a profession

3. Professional Organization Totals_____

(1) Membership restricted to professional nurses

(1) Journal published at least yearly

Purpose

(.25) Promote peer relationships

(.25) Set standards

(.25) Formulate ethical code

(.25) Promote professional advancement

4. Education for Practice Totals_____

(1) One level high school basic nursing course

(1) Two levels of nursing below college with separate credentials

(2) One level of nursing basic post high school course

(3) College basic nursing program

5. Service Orientation Totals_____

(.5) Licensure Board to issue credentials

(1) Credentials can be revoked

(.5) Continuing education provided by association

(1) Norm work pattern irregular (shifts)

6. Autonomy Totals_____

(1) General independent nurse practice permitted

(2) Over 10% of nurses are in independent practice

Application of Perception Opinionnaire

One item was constructed to measure each of Moore's characteristics of professionalization. Coding was done to assign value points to the responses. The range of values were assigned as follows:

3 - indicated most progress toward professionalism
2 - indicated moderate progress toward professionalism
1 - indicated beginning progress toward professionalism
0 - indicated no progress toward professionalism

Application of Professionalization Interview Data

Data questions were formulated to provide information regarding nursing's movement along Moore's continuum of professionalization. Each of the six characteristics of occupation, calling, professional organization, education, service orientation, and autonomy were given the possibility of measuring 3 value points on the ordinal continuum.

QUESTIONNAIRE-INTERVIEW

PROFESSIONAL NURSING

Moore's (1970) Professional Characteristics Identification

1. Occupation: When was nursing first recognized as an occupation_____

When were educational entry requirements established_____

Do nurses have retirement benefits in the government service?

Explain:

2. Calling: How does one become a member of the nursing association?

Is membership mandatory? Dues?

Membership-job relationships? Life members?

Percentage of nurses in association?

Do students select nursing as an occupation?

Does government select and assign job entry?

What are the age, sex, and other restrictions on entry into nursing?

3. Professional Organization: Is the membership restricted to professional nurses? What are the stated purposes of the association?

Name the organizational design of association?

Officers? Term of service?

How elected? Speciality Divisions?

Name them.

Does the association publish a journal?

Name? How many issues per year?

4. Education for Practice: Types of educational programs

Hospital based schools--Middle school _____

high school_____Post high school_____College

based programs--describe

Percentage of male students

Does study include traditional medicine and western medicine? Explain

Length of programs Licensure Examination?

Who controls it?

5. Service Orientation: Is there a Nursing Board to issue credentials?

Can credentials be revoked?

Do you require and provide continuing education?

What is the work design? shifts?

Do nurses continue to work after marriage?

Has there been changes in women's work activities in recent years?

6. Autonomy of practice: Are nurses permitted to practice and give care

independently? Types of practice?

Percentage doing independent practice? Discuss the physician-

nurse relationships in health care delivery.

Do nurses function as assistants or support to physicians?

What is the relationship desired by you as a leader in nursing?

Are nurses equal to physicians in the professional regard of the community?

What is the greatest progress of nursing as you see it?

TABOR'S PERCEPTUAL SCALE FOR MINTZBERG'S (1973; 1979)
MANAGER ROLES OF PROFESSIONALS

Interpersonal Roles

Figurehead

Represent Nursing

0 Never
1 Substitue
2 Sometimes
3 Routinely

Liaison

Outside Interaction on Behalf of Nursing

0 Never
1 Substitute
2 Sometimes
3 Routinely

Leader

Organize Nursing Jobs within the Hospital

0 No control
1 Input into decision
2 Lower decisions
3 Complete control

Informational Roles

Monitor

Gather Information for Nursing

0 No control
1 Downward
1 Upward
1 Horizontal

Spokesman

External Flow of Information on Nursing

0 Never
1 Lower levels
2 Sometimes
3 Routinely

Disseminator

Flow of Information in Nursing Department Control

0 No control
1 Downward
1 Upward
1 Horizontal

Decisional Roles

Entrepreneur

Creating new Activities in Nursing

0 Never
1 Committee input
2 Sometimes
3 Routinely

Disturbance Handler

Nursing Personnel Problem Control

0 Never part of job function
1 Refer only
2 Part of committee
3 Power to solve

Resource Allocator

Responsible for

0 None
1 Budget request/division
1 Increasing/decreasing nursing personnel
1 Nursing salary decisions

Negotiator

Bargaining Role for Nursing

0 No control
1 Minor role
2 Part of committee
3 Complete control

Please divide your time given to the following activities. Rank them by placing a (1) by the most time given to a (5) for the least amount.
_____Starting new jobs, methods, programs _____Increasing the division of nursing-growth of department _____Improving the programs and jobs already going _____Keeping relationships running smoothly ___Giving patient care

QUESTIONNAIRE-INTERVIEW

TABOR'S TOOL FOR IDENTIFICATION OF MINTZBERG'S MANAGER ROLES IN NURSES

1. Figurehead: How often do you represent nursing in your organization?

2. Liaison: What responsibility do you have outside the organization in regard to nursing? Do you routinely interact for nursing?

Are you permitted to attend nursing meetings outside the organization on hospital time?

3. Leader: What control do you have in organizing the nursing department and its work?

4. Monitor: What do you do with information regarding nursing that you gather in the course of your work?

5. Spokesman: Do you have control of releasing nursing information to the organization and to the public?

6. Disseminator: Do you determine the flow of organizational information to the nurses whom you manage?

7. Entrepreneur: Describe your part in designing new programs and jobs in nursing.

8.Disturbance Handler: Describe your role in handling nursing personnel problems.

9. Resource Allocator: Are you responsible for budget requests and division of it? Can you increase or decrease nursing personnel? Do you control nurses' salaries?

10. Negotiator: What part do you play in bargaining for nursing?

TABOR'S SCALE FOR MINTZBERG'S (1979)

PROFESSIONAL OPERATING CORE

Education and Skills

__0__ On the job training only

__1__ Special noncollege education

__2__ College degree required

__3__ Post college required

Nursing Specialities Require Additional Education Before Taking Job

__0__ None

__1__ Some do and some do not

__2__ At least two specialities required

__3__ All required

Nursing Managerial Patterns

__0__ Non nurse managers

__1__ 3 or more levels of nurse managers

__2__ 2 levels of nurse managers

__3__ 1 level of nurse manager

Autonomy of Practice

__0__ All work under orders or directions of others

__1__ Can make suggestions regarding work

__2__ Co-decisions on work

__3__ Diagnose and treat independently according to professional standards set by peers

QUESTIONNAIRE-INTERVIEW

TABOR'S TOOL FOR MINTZBERG'S PROFESSIONAL OPERATING CORE (1979)

1. Education and Skills required: Describe these for nurses in this hospital? Do you have levels of nursing? Are the requirements for nurses increasing?

2. Nursing Specialities Require Additional Education Before Taking Job: How many specialities do you have? Describe requirements? Do nurses select or are they assigned to the specialities?

3. Nursing Managerial Patterns: Is the chief manager of nursing a nurse? How is the position filled? Discuss the levels of nurse managers and their responsibilities.

4. Autonomy of Practice: Describe the nursing design and responsibilities. Do you give nursing care by the nursing process design? Who develops the procedures for nursing care? Do physicians give orders for nurses to follow?

Is nursing changing? How? Is nursing more highly regarded by physicians and the patients in the last two years? Explain your answer.

When was the hospital first begun? How many nurses work independently of physicians in giving health care? Is nursing becoming more professional?