MCNEAL, LINDA JEAN. A Comparative Study of Nurse Role-Conceptions Held by Nursing Faculty and Nursing Service Personnel. (1977) Directed by: Mrs. Gracia McCabe. Pp. 69.

It was the purpose of this study to identify and compare the nurse role conceptions of the faculty of a baccalaureate nursing program and those of the nursing service personnel in two hospitals that employed May, 1976 graduates of the nursing program. It was hypothesized that there would be a difference between the nurse role conceptions held by the nursing faculty and the nurse role conceptions held by the nursing service personnel.

The subjects were 102 nurses, all female. Sixty-five subjects were nursing service personnel of the two hospitals and thirty-seven were nursing faculty of the baccalaureate school of nursing.

The data were collected using the Nurse Role Conception Scales adapted from the Corwin Role Conception Scales (1961). Analysis of variance by the F-test was computed on the total scale scores for the role conception of each respondent with the significance level set at .05.

The hypothesis, that there would be a difference between the nurse role conceptions held by nursing faculty and nursing service personnel, was accepted. The nursing faculty had a significantly higher professional role conception score and the nursing service personnel had a significantly higher bureaucratic role conception score.

A COMPARATIVE STUDY OF NURSE ROLE-CONCEPTIONS HELD BY NURSING FACULTY AND NURSING SERVICE PERSONNEL

by

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CHAPTER I

INTRODUCTION

Members of the nursing profession have long recognized a contradiction in the new graduate nurse's expectations of her role and the realities of the work situation. Many new graduate nurses employed in hospitals express feelings of helplessness, powerlessness, frustration, and dissatisfaction. These feelings are manifestations of a phenomenon Kramer (1974) has labeled "reality shock." One major source of this role-conflict has been identified as the discrepancy in the nurse role conceptions, as measured by values, promulgated by the socializing agents of nursing (Corwin, 1961; Smith, 1964; Kramer, 1974). Nurse educators and nursing service personnel, as the most visible role models, represent chief socializers of student and graduate nurses.

Role conceptions, the cognitive component of role, is not directly measurable. Role conception includes values, beliefs, attitudes, and behavioral expectations perceived to be appropriate to a role. It is by measurement of stated values and expectations that role conception is inferred (Corwin, 1961; Smith, 1964; Kramer, 1966, 1974).

Professional and bureaucratic role conceptions are two chief value systems in nursing (Corwin, 1961). The professional role conception refers to occupational principles which transcend the location of employment and suggests primary loyalty to the nursing profession. The bureaucratic role conception refers to the administrative rules and regulations which describe the nurse's role in a specific organization and suggests primary loyalty to hospital administration. This theory of the existence of two subcultures in nursing with disparate value systems has been labeled the "professional-bureaucratic work conflict" (Corwin, 1961; Johnson, 1971; Kramer, 1974). It assumes a discrepancy in the nurse role conceptions, as measured by values, promulgated by nurse educators and nursing service personnel.

The nurse educator serves as a role model while discussing and clarifying theories and demonstrating skills. Nursing service personnel serve as role models while setting the standards and climate of the unit where students and graduates practice nursing care. The influence of the role model extends beyond the transmission of knowledge and the teaching of skills to the transmission of values (TenBrink, 1968). Each model transmits values to the neophyte according to his own nurse role conception by selecting and

communicating appropriate values consciously or unconsciously through verbal or nonverbal means (Smith, 1964).

This study focused on the identification and comparison of the nurse role conceptions of selected nurse educators and nursing service personnel to determine if a significant difference exists between the groups.

The Problem

Investigators in the last two decades have studied the role-conflict of professionals in bureaucratic organizations. As nursing programs have increasingly located in collegiate settings, many of these studies have focused on new graduate nurses employed in hospitals. Several studies have identified disparate role conceptions promulgated by primary nurse socializers as one major source of "reality shock" in the new nurse (Corwin, 1961; Smith, 1964; Kramer, 1974).

The present research was a comparative study of the nurse role conceptions, as measured by values, held by the faculty of one baccalaureate nursing program, and those held by nursing service personnel in two hospitals that employed graduates of the nursing program. Nurse role conceptions of the selected nurse educators and nursing service personnel were identified and compared for statistically significant difference.

The purpose of the study was to determine if disparate nurse role conceptions were promulgated by the two groups. The research question asked was "Is there a statistically significant difference between the nurse role conceptions held by this specific nursing faculty and those held by the nursing service personnel?" Based on previous research (Corwin, 1961; Smith, 1964; Kramer, 1974), findings of such differences in this particular population would have relevance for the nurse educators and nursing service personnel involved. Other findings not specifically addressed by the research question but of research interest are discussed.

Hypothesis

There will be a significant difference between the nurse role conceptions held by nursing faculty and those held by nursing service personnel.

Importance of the Study

Previous studies of nurses have identified disparate nurse role conceptions held by primary nurse socializers as a predisposing factor to role-conflict in new graduate nurses. Although such findings have implications for nursing in general, most studies have greater meaning for the specific sample population. Information in the present study may provide more impetus for action in the sample

population of nurses than do studies conducted elsewhere. If there is a significant difference in the nurse role conceptions of nurse educators and nursing service personnel of this study, role-conflict may be predicted in graduates of the nursing program.

The present study may be useful in conveying an awareness of the stated values so that modeling may be more conscious and controlled. Such an awareness may influence the role models to portray those role conceptions best suited to the changing scene of today's nursing, while discarding those that become obsolete. The present study may identify an area in nursing, role-conflict, that could benefit from collaboration between nurse educators and nursing service personnel to promote a unified climate for the practice of nursing.

In summation, information from the present study in regard to nurse role conceptions of the selected groups is useful in the possible modification of modeling behavior of nurse educators and nursing service personnel.

Assumptions and Limitations

Assumptions

Major assumptions of this study include:

1. Role conception can be inferred by measurement of stated values.

2. Role conceptions of nurse educators and nursing service personnel are those promulgated to student and graduate nurses.

3. Nurse educators and nursing service personnel are chief role models for new graduate nurses.

4. Modification of Corwin's instrument has not altered its validity.

Limitations

Several limitations of the study are acknowledged. These include the following.

1. The sample population is thought to be representative of nurses in the Southeastern United States but generalizations beyond that are not possible.

2. An important limitation may have been incurred because it was impossible to administer the questionnaire during the faculty meeting due to time limitations and urgent faculty matters. Faculty participants were instructed to return the completed questionnaires within twelve days to a designated collection point while nursing service participants completed the questionnaires within an allotted twenty minutes of a meeting and returned them directly to the investigator.

3. Sample size was diminished by one hospital's refusal to participate in the study. Other participants were not sought due to limitations of time imposed on the study.

Definition of Terms

The following definitions of key terms are provided for clarity:

1. Role Conception - role conception is the cognitive component of role; the internal representation of the role expectations held by an individual, including and measured by stated values at a specific time (Corwin and Taves, 1962).

2. Nurse Role Conception - the nurse role conception includes those values, attitudes, beliefs, and behaviors perceived to constitute the role of the professional nurse (Kramer, 1970).

3. Professional-Bureaucratic Work Conflict - the professional-bureaucratic work conflict refers to the discrepancy between what the new graduate nurse learned was good and valued in the pre-work socialization period and what she finds is the way things are actually done in the work situation (Kramer, 1970).

4. Reality Shock - reality shock is the phenomenon of the startling discovery and reaction to the discovery that pre-work values conflict with work-situation values (Kramer, 1974).

5. Values - values refer to that which an individual or group believes they "ought" or "should" desire; these involve choices and instigate behavior (Smith, 1964).

CHAPTER II

REVIEW OF RELATED LITERATURE

Individuals aspire to a status within a social system; cultural patterns of attitudes, values, and behavioral expectations are associated with each status. The cultural patterns constitute the specific role conception which defines behavior (Smith, 1964).

Socialization is the process by which individuals develop the knowledge, skills, and attitudes suitable to the active member of society (Brim and Wheeler, 1966). The goal of socialization is to bring the individual to a definition of himself that is congruent with how he is defined by other members of society.

Socialization to the nurse role is complex and requires consideration of (a) preparation for the performance of specific tasks which is role socialization and (b) preparation for the occupation of a generalized status in life with associated life styles which is status socialization. Adult socialization is necessary because childhood socialization cannot prepare an individual for all the roles he will be expected to fill in later years (Brim and Wheeler, 1966).

The scope of the literature as reviewed here includes an overview of important theoretical views of socialization. This section is followed by a discussion of role-conflict and nurse socialization. The final sections deal with supporting studies and the measurement of role conception.

Theoretical Views of Socialization

Studies of the effect of society on behavior and attempts to describe the mechanisms of social learning have provided at least three major theories of socialization. These are the psychoanalytic orientation, the reinforcement orientation, and the cognitive orientation. The psychoanalytic orientation emphasizes the parent-child relationship and describes sequential stages of development. It supports a unidirectional effect of society on the individual and the long range consequences of childhood experiences (Estok, 1977).

The reinforcement orientation is based on the idea of stimulus and response, where behavior is either rewarded or punished. It emphasizes imitation and the influence of models (Estok, 1977). Miller and Dollard (1941) advanced an early social learning theory on imitation as instrumental conditioning: subjects reinforced for making the same response as a model would come to imitate that model. In

more recent years, Bandura (1966) and others (Bandura and Walters, 1963; Bandura, Ross and Ross, 1963) focused on the behavioral effects of models. Research revealed that vicarious, as well as direct, reinforcement of the model influences the modeling behavior of the socializee.

The cognitive orientation toward socialization assumes a cognitive mechanism as the initial step in a chain of events from stimulus to response. It emphasizes goal-directed behavior and central processes such as attitudes, ideas, and expectancies in the explanation of behavior (Baldwin, 1969; Shaw and Constanzo, 1970). This supports a concept of socialization in which an individual learns

> behavior appropriate to his position in a group through interaction with others who hold normative beliefs about what his role should be, and who reward or punish him for correct or incorrect actions. (Brim and Wheeler, 1969, p. 9)

An explanation of adult socialization requires a combination of the three orientations. Adult socialization builds upon attitudes and skills acquired earlier, using them as a foundation for later learning. Personal characteristics, social interaction, ahd the influence of reference groups are major factors in later socialization (Brim and Wheeler, 1966). Socialization requires that cognitive and,

at least minimal, internalization of appropriate norms occurs (Moore, 1967).

The most important aspect of adult socialization is role acquisition and the emphasis is on the acquisition of beliefs, values and attitudes appropriate to the position. Sarbin (1954) proposes that for a person to be socialized into any role he must have the vicarious experience of identifying himself with someone who feels, thinks and does what he will be expected to feel, think and do when he is in that role. This fundamental mode of socialization is referred to as modeling or imitation of a role model (Bandura, 1969; Caplow, 1971).

Members of a social group share a system of values which patterns behaviors. The transmission of these cultural values appropriate to the role expectations is a basic component of socialization and is partially accomplished by modeling. According to his own personal value system, the culture bearer or role model selects or filters out appropriate values and communicates them to others consciously or unconsciously through verbal or nonverbal means (Smith, 1964).

The family is the primary agent for childhood socialization in all societies. Parents and close relatives are

the role models. In contemporary American society, the educational system has been identified as a major secondary socializing agent that has increasingly greater influence as the child progresses through adolescence and into adulthood (Williams and Williams, 1959). The role models of the educational system are the faculty members, whose special purpose is to transmit many of the social values and behaviors held to be ideal by the larger society. Some of these systems also train young adults in certain technological skills and knowledge and are often termed "professional."

Organizations, educational or service, have the effective means of influencing role behavior because the individual behaves in such a way as to achieve rewards and/or avoid punishment. These means include providing norms for performance, opportunities for learning and practicing the required performance, and by selectively rewarding the behavior of its recruits (Brim and Wheeler, 1966).

Role-Conflict

There will be some cultural discontinuities so that successive roles to be learned do not build upon each other and may even conflict with what was learned earlier. In a rapidly changing society, the discontinuities between what is expected in successive roles are greater; the inabilities

of the socializing agents to do an effective job rise as the rate of change increases (Brim and Wheeler, 1966). Lippitt (1968, p. 337) also stated that "conflicting messages received from authoritative sources" may cause confusion; values of the socialization agents can be the source of conflicting messages. These discontinuities manifest as role conflict, an incompatibility of values or norms that creates emotional tension for individuals (Caplow, 1971).

Educational institutions and employing agencies may be defined as organizations, complex human systems of culture and values that orient and regulate behavior among members in pursuit of special goals (Kramer, 1974). A common goal of organizations of higher education and employing agencies is socialization into an occupation. This socialization requires learning the work role; the skills and knowledge needed are usually practiced on the job. Successful mastery of the job requires learning a new set of values, attitudes, and behaviors (Corwin, 1961). Role-conflict occurs when educational and work organizations founded on different principles attempt to socialize an individual into a common occupation.

Such conflict has been labeled the "professional-bureaucratic work conflict." This is an outgrowth of the

combination of increased bureaucratization and professionalization and increased employment of professionals in bureaucratic organizations (Kramer, 1974; Corwin, 1961). Studies have shown conflict exists in a variety of professionals in bureaucratic organizations, e.g. teachers in schools, social workers in health agencies, and scientists in industry. These studies substantiate the premise that inter- and intra-personal role conflict will result from the combination of two loyalties, either within the same individual or between the individual and the work setting (Corwin, 1961).

Characteristics of the bureaucratic work organization include a part-task orientation, emphasis on efficiency and effectiveness, and a hierarchical authority structure. The bureaucratic role conception refers to administrative rules and regulations which describe a job in a specific organization and suggest primary loyalty to the employing agency. The professional system of work organization is characterized by a whole-task orientation, judgment and decision-making based on knowledge, and autonomy of control. The professional role conception refers to occupational principles which transcend the location of a specific employing agency and suggests primary loyalty to the profession.

Socialization of the Nurse

Nursing education, increasingly located in collegiate settings, meets many of the criteria for the professional work organization. The hospital qualifies as a bureaucracy and is the work setting in which most nurses practice. These conditions predispose the nurse to the professional-bureaucratic work conflict.

Professional socialization contains elements of both child and adult education (Olmsted and Paget, 1969). Whereas childhood socialization is directed to the learning of values (what a person "should" do), adult socialization emphasizes the acquisition of behaviors. Olmsted and Paget contend that professional education is an extension of childhood socialization because (a) the student is provided with a core of "shoulds", the attitudes, values and norms of faculty, and (b) the student plays the role of learner in a situation where there is a considerable authority differential. A major portion of professional socialization occurs in the work setting after schooling is completed. Work demands adult socialization, which involves those role specific behaviors based upon a value system somewhat different than that found in the school.

Investigators (Corwin, 1961; Smith, 1964; Kramer, 1974) have identified two subcultures of nursing in which the two chief role models for neophyte nurses, nurse educators and nursing service personnel, promulgate two divergent nurse role conceptions. The values deemed appropriate for transmission to the neophyte nurse are included in the model's own role conception (Corwin, 1961). According to Kramer (1976), the dominant values transmitted in schools of nursing are: comprehensive, total patient care; individualized care; and family involvement. Judgment, autonomy, cognitive skills and decision making are emphasized. In the work subculture values of organization, efficiency, cooperation and responsibility are stressed with the goal of providing safe care for all patients. Therefore, the resultant role-conflict is due to the discrepancy between what the nurse learned was good and valued in the pre-work socialization period and what she finds out is the way things are actually done in the work-world.

Supporting Studies

The professional-bureaucratic conflict is not limited to nurses. It has been found in studies of business school graduates (Schien, 1968), social workers (Scott, 1969), and high school teachers (Corwin, 1970).

Schien (1968) investigated "reality shock" in business school graduates. The study described a psychological conflict between the graduate's expectations and values, and the company's values.

Scott (1969) studied the professional-bureaucratic problems of 90 social workers in a county agency. The study concluded that the professional system, through a peer control structure, supported its members in their resistance to bureaucratic rules with a resultant increase in role conflict.

Corwin (1970) studied the relationship between professionalism and conflict resolution of 1500 public high school teachers. The study found that most measures of conflict increased with the average professional orientation of a faculty.

Other studies of the problem have major relevance to nursing. Corwin's (1960) cross-sectional study focused on the relationship between type of nurse socialization pattern and magnitude of conflict. Role conception scales were administered to 296 graduate and student nurses from seven hospitals and four nursing schools in a midwestern metropolis. The study found that degree nurses maintained higher professional role conceptions more frequently than diploma

nurses. This resulted in a higher intensity of role-conflict in the degree nurses.

Smith (1964) conducted a study of the value climate confronting student nurses in collegiate nursing programs. Thirteen head nurses' written evaluations for 42 staff nurses and 14 teachers' evaluations for 56 student nurses were analyzed to ascertain the differences between head nurses and teachers in conceptions of valued nurse behaviors. The study concluded that discrepancies in nursing role values between head nurses and nursing faculty did exist. These created a climate in which the student nurse was continually exposed to two disparate and positively sanctioned sets of patterned behavior.

Kramer (1966) conducted a longitudinal study to determine the effect of exposure to bureaucratic employment on the professional values of new collegiate graduate nurses. A sample of 79 neophyte nurses from three California State College nursing programs were administered the Corwin professional-bureaucratic role conception scales at stated intervals. Results indicated a significant increase in bureaucratic role conception after exposure to the employing organization accompanied by a decline in the professional role conception. This supports a theory that the

professional and bureaucratic systems are inherently antithetical and that loyalty to both systems simultaneously is associated with role-conflict (Kramer, 1974).

The Measurement of Role Conception

The components of role conception are the attitudes, beliefs, values, and expectations for behavior specific to the role. Concepts are not directly measurable and must be inferred from the measurement of one or more of the components as stated by a respondent. Scales of the Likert-type, devised by Rennis Likert in 1932, are the most frequently used in the study of social attitudes. These fixed alternative, summated scales are appropriate for eliciting expressions of opinion about issues on which people hold clear opinions. The questionnaire can obtain only that information that the respondent is willing and able to report (Selltiz, Wrightsman, and Cook, 1976).

The Corwin Role Conception scales were developed by Corwin, a sociologist, in 1960 to measure role conception and role deprivation. The three Likert-type scales measure the respondent's loyalty to ideals and values implied in service, bureaucratic, and professional concepts. Items on each scale were selected on the basis of their relevance to these ideals and values. The service scale includes items

about the desire to do "bedside" nursing and to serve humanity. The items representing loyalty to the hospital bureaucracy include such characteristics as punctuality and strict rule-following. Items in the professional scale pertain to the ability to use judgement and the power to make suggestions about nursing care, and to a commitment to knowledge as a basis of the profession (Corwin, 1961). The scales do not necessarily represent all dimensions of each concept.

Items on each scale are stated in the form of hypothetical situations in which the nurse might find himself. Respondents are asked to indicate the extent to which the situation <u>should</u> be the ideal for nursing, and also the extent to which it actually <u>is</u> practiced. The respondents are instructed to check one of the alternative responses ranging from "strongly agree" to "strongly disagree." Responses are scored on a 5 point scale. The arithmetic sum of the responses to items in each scale constitutes the total score for each of the role concepts of each respondent. Responses to the "should" question constitute the role conception scores. The role deprivation scores are obtained by the numerical difference between the way things should be and actually are.

In developing the scales, items were analyzed for discriminatory power by computing critical ratios between upper and lower quartiles based on the total scale scores. Only items attaining the .05 level of significance were retained. Some items were deleted on the basis of respondents criticisms of ambiguity and irrelevance (Corwin, 1961).

Objections were made by Korber (1959) to the use of hypothetical situations because they are often so abstract that they omit essential qualifying criteria upon which actual judgments are made. Corwin (1961) replied that this objection is directed against the fundamental advantage of the method, which allows a simplification of complex situations and focuses on variables of interest to the investigator by elimination of random details. He states:

> That a nurse would (or would not) read articles in a nursing journal rather than keep a diary on patients if she were to make that decision does provide evidence about her loyalty to patients, even though it allows no inference about whether she does or does not keep a diary. (p. 74)

Therefore, the statement does not predict the actual behavior but is of interest because it is relevant to the respondent's value system.

Validity studies on the scales were done by both Corwin (1961) and Kramer (1970). Corwin focused on face and

content validity in developing the scales. Kramer conducted a series of tests to validate the scales against the external criterion of "known groups", i.e. nurses known to have high bureaucratic or high professional orientations. Critical ratios between the mean scale scores of these "known groups" (PR $<$ .05) was accepted as satisfactory validity.

Kramer also did test-retest studies on a sample of 52 senior baccalaureate nursing students before and after a three week Christmas break. These studies yielded reliability coefficients of .88 on the professional scale, .89 on the bureaucratic scale.

Summary

It is concluded, based on the theories and studies in this review of literature, that acquisition of the nurse role evolves through a process of professional socialization which is a unique combination of child and adult socialization. A basic function of this socialization process is the transmission of values appropriate to the behavioral expectations of the nurse role. The transmission of values is partially accomplished through modeling by two primary socializing agents, nurse educators and nursing service personnel. There is indication that these two role models promulgate disparate nurse role conceptions, as measured by values, promoting role conflict in the neophyte nurse.

CHAPTER III

METHODS AND PROCEDURES

Sample Selection

The sample for the study was composed of nurse educators, members of the baccalaureate faculty of a state university school of nursing, and nursing service personnel of two hospitals. The university and hospitals were located within a 75 mile radius of one another in the southeastern United States; both hospitals employed May, 1976 graduates of the selected school of nursing. One hospital was a 500-bed acute care community hospital affiliated with the medical teaching services of a state university and the baccalaureate nursing programs of two state universities. The second hospital was an 890-bed acute care facility located within a university medical center having a large variety of medical, nursing, paramedical, and research teaching facilities. A third hospital declined to participate in the study because of commitments to other researchers.

Subjects participating in the study included: nursing school faculty members directly involved in the classroom and clinical education of undergraduate nursing students

and nursing service personnel involved in the supervision of staff nurses. The nurse educators included professors, associate professors, assistant professors, instructors, and teaching assistants. The nursing service personnel included directors of nursing service, assistant directors, supervisors, head nurses, and assistant head nurses.

Data Collection

The initial contacts for permission for the study were made with the dean of the school of nursing and the directors of nursing of the hospitals and permission was obtained (Appendix A). The surveys were scheduled on the agendas of a faculty meeting and two supervisor-head nurse meetings. At the designated meetings, the investigator made a request of the members for participation in the study. There was an indication of general agreement and the instruments were distributed. Members of the sample population were asked to read the face sheet for an introduction to the study and instructions to the instrument (Appendix B). This activity was followed by an invitation for questions related to the mechanics of completing the instrument. Instructions for the return of the instrument were given. Participants were advised that the results of the study would be made available to them.

A total of 117 respondents participated in the study. These included 48 nurse faculty members and 69 nursing service personnel. The rate of response was 100 percent for service personnel and 87.5 percent for faculty. Six faculty instruments were not returned for unknown reasons. Instruments used in the study included 37 faculty instruments and 65 service personnel instruments. The five faculty and four service personnel instruments found to be unusable in the study were deleted because items were omitted or were responded to with more than one alternative.

The Instrument

The overall research instrument was a self-administered questionnaire which consisted of three parts: (a) a face sheet with an introduction to the study and instructions for recording responses to the items, (b) Nurse Role Conception Scales adapted from the Corwin Role Conception Scales (Appendix C) for the measurement of professional and bureaucratic role conceptions, and (c) a Personal Data sheet for the recording of demographic data (Appendix B).

The Nurse Role Conception Scales contained several modifications of the Corwin Scales. The service items were deleted because they were not relevant to the interests of this study. The "b" portion (what actually <u>is</u>) of each item

in the professional and bureaucratic scales were omitted because no measure of role deprivation was desired. Further, Corwin's instructions made reference to the response items as "statements" but presented them in question form. Because of this ambiguity, the "a" portion, "should be", was changed from question to statement form.

The alternative responses ranging from "strongly agree" to "strongly disagree" were scored from 1 to 5. This resulted in low mean scores indicating high orientation scores on the conception scale represented by the item. For example, a "strongly agree" response to a bureaucratic item was coded with the lowest number possible, "1", but indicated a high bureaucratic orientation. The arithmetic sum of the item responses constituted the total score for each respondent. An equal interval was assumed between adjacent scale points. It was not assumed that the scoring method elicited an actual measure of the intensity of agreement since this would require a standard unit of measurement and common knowledge of the existing agreement in the general nurse population. The scale scores were a measure of the respondent's judged relationship to other respondents.

The phrasing of the situation attempted to avoid a response set. The items of the two scales were integrated

and the order of response alternatives was reversed in items 10 and 11 to guard against the possibility of a set.

A Personal Data sheet was designed to elicit demographic data such as sex, age, work history, and specific nursing education (Appendix B). Because persons are sometimes reluctant to give personal data, these were requested after the scales. Respondents were advised verbally, as well as through written instructions, to omit any items on the Personal Data sheet that they believed might have too closely identified them. This was done in an attempt to avoid threatening the respondents' anonymity and to insure a higher rate of return of completed scales.

Procedures

After receiving permission from the dean and directors of nursing service for conducting the research, meetings were scheduled with each group. Approximately 30 minutes was allotted in the head nurse-supervisor meetings for the presentation of the study and for administration of the instrument. In the nursing faculty group, the instruments were taken home, completed and returned to a designated place within 12 days. Participants were requested to refrain from discussing the instrument with each other and with other nurses in the community.

Data Analysis

Responses to items on the questionnaire were numerically coded according to a predetermined scheme. Data were transferred to coding sheets in order to facilitate data card preparation and these sheets were checked against the original questionnaires. All data cards were verified against the data sheets. Analysis of variance (ANOVA) by the F-test procedure available through The Statistical Analysis System (SAS) (Barr, Goodnight, Sall and Helwig, 1977) was utilized because it provided two independent estimates of the changes within the population. The first estimate was based on the dispersion within each sample (within group variance); the second estimate was based on the variance between the means of the sample (between-groups variance). This method corrected for the variation in the number of respondents in each of the two groups (Treece and Treece, 1973). A probability level of .05 was selected for rejection of data as statistically significant.

CHAPTER IV

ANALYSIS OF THE DATA

The purpose of this study was to identify and to compare the nurse role conceptions held by nursing faculty and those held by nursing service personnel. Nurse Role Conception Scales were used to measure role conceptions inferred by stated values. It was hypothesized that there would be a significant difference between the nurse role conceptions held by nursing faculty and those held by nursing service personnel.

Demographic Data

Omission of responses to items on the Personal Data sheet was an option given each respondent and the omissions did not interfere with the purpose of the study. The data supplied were summarized with the following findings.

In the faculty group, all respondents were female with an age range of 25 to 53 years. Thirty-three were caucasian, one was black, and three did not designate their race. All faculty respondents held a baccalaureate or higher degree in nursing. Twenty-nine of the faculty respondents had a minimum of one year of experience as a hospital staff nurse or a

first-level community health nurse; three had less than one year of such experience; one indicated no such experience; one did not respond to the item.

Of the nursing service personnel, all respondents were female with an age range of 24 to 60 years. Fifty-two were caucasian, two were black, and eleven did not designate their race. Thirty-eight respondents had diplomas in nursing, one had an associate degree, fourteen a baccalaureate degree in nursing, five had a master's degree in nursing, and seven did not respond to the item. Six of the nursing service personnel indicated previous experience as a nurse educator, 49 indicated no such experience, and fourteen did not respond to the item.

Nursing service specialities represented by both faculty and nursing service personnel included: community health, maternal-child health, medical-surgical, psychiatry, pediatrics, maternity/obstetrics/gynecology, intensive care, coronary care, ambulatory care, intravenous therapy, and clinical research.

Role Conception Scores

The total scale scores were analyzed for the role conception of each group. Results indicated that: (a) the nursing faculty, with a mean score of 18.32, held a

stronger professional role conception than did the nursing service personnel, with a mean score of 21.04; and (b) the nursing service personnel, with a mean score of 16.94, held a stronger bureaucratic role conception than did the nursing faculty, with a mean score of 20.05 (Table 1).

Table 1

Mean[(a)], Range, and Standard Deviation for Professional and Bureaucratic Role Conceptions by Group

Source	N	Role Conception	Mean	Range	SD	SED	Variance
Nursing Faculty	37	Prof[(b)]	18.32	12-27	3.39	0.56	11.50
		Bur[(c)]	20.05	13-26	3.10	0.51	9.61
Nursing Service Personnel	65	Prof	21.04	14-29	3.47	0.43	12.01
		Bur	16.94	9-25	3.25	0.40	10.56

(a) Low mean indicates strong orientation to the conception

(b) Professional

(c) Bureaucratic

Tables 2 and 3 show analysis of the variability between groups and within groups on the professional and bureaucratic role conceptions. The resultant F-value for

Table 2

Analysis of Variance for Professional Role Conceptions by Group

Source	DF	Sum of Squares	Mean Square	F-value	PR > F
Between Group	1	174.68	174.68	14.77**	0.0002
Within Group	100	1182.97	11.83		

**Significant at the .01 level

Table 3

Analysis of Variance for Bureaucratic Role Conceptions by Group

Source	DF	Sum of Squares	Mean Square	F-value	PR > F
Between Group	1	228.87	228.87	22.40**	0.0001
Within Group	100	1021.64	10.21		

**Significant at the .01 level

professional role conceptions was 14.77; that found for bureaucratic role conceptions was 22.40. The F-values indicated a highly significant statistical difference ($PR < .01$) between nursing faculty and nursing service personnel in both role conceptions. This supported the hypothesis that there is a significant difference between the nurse role conceptions held by nursing faculty and those held by nursing service personnel.

Total scale scores were further analyzed for role conception within nursing faculty. This analysis yielded a statistically significant difference ($PR < .05$) in the bureaucratic role conceptions of faculty by position. The mean bureaucratic scores by position were: teaching assistant, 18.29; instructor, 19.18; assistant professor, 22.00; and, associate professor, 18.50. No statistically significant difference was found in the professional role conceptions of faculty members by position. The mean professional scores of faculty by position were: teaching assistant, 19.14; instructor, 17.73; assistant professor, 18.41; and associate professor, 24.00 (Table 4).

The analysis for variability between positions and within positions of faculty on the professional and bureaucratic role conceptions is shown in Tables 5 and 6. The

Table 4

Mean[a], Range, and Standard Deviation for Professional and Bureaucratic Role Conceptions Within Faculty by Position

Source	N	Role Conception	Mean	Range	SD	SED	Variance
Teaching Assistant	7	Prof[b]	19.14	16-23	2.19	0.83	4.81
		Bur[c]	18.29	13-21	3.09	1.17	9.57
Instructor	11	Prof	17.73	12-22	3.38	1.02	11.42
		Bur	19.18	14-25	3.09	0.93	9.56
Assistant Professor	12	Prof	18.41	15-27	3.34	0.96	11.17
		Bur	22.00	18-26	2.63	0.76	6.91
Associate Professor	2	Prof	24.00	21-27	4.25	3.00	18.00
		Bur	18.50	18-19	0.71	0.50	0.50
Position Not Indicated	5	Prof	16.00	12-19	2.74	1.22	7.50
		Bur	20.40	17-25	2.97	1.33	8.80

[a] Low mean indicates strong orientation to the conception

[b] Professional

[c] Bureaucratic

Table 5

Analysis of Variance for Professional Role Conceptions Within Faculty by Position

Source	DF	Sum of Squares	Mean Square	F-value	PR > F
Between Position	3	68.92	22.97	2.27	0.10
Within Position	28	283.96	10.14		

Table 6

Analysis of Variance for Bureaucratic Role Conceptions Within Faculty by Position

Source	DF	Sum of Squares	Mean Square	F-value	PR > F
Between Position	3	80.44	26.81	3.27*	0.04
Within Position	28	229.56	8.20		

*Significant at the .05 level

ratio of the "between position" to "within position" variabilities resulted in an F-value of 2.27 for the professional role conception. This was not significant at the .05 level. The ratio of the variabilities for the bureaucratic role conception resulted in an F-value of 3.27, which was significant at the .05 level.

No statistically significant difference was found, by position, in either role conception scale for nursing service personnel. The mean professional scores by position were: assistant head nurse, 21.75; head nurse, 21.09; supervisor, 20.38; assistant director of nursing, 18.00; and, position not indicated, 21.57. The mean bureaucratic scores by position were: assistant head nurse, 13.75; head nurse, 17.42; supervisor, 17.15; assistant director of nursing, 20.00 (Table 7).

Tables 8 and 9 show the analysis of the variability between position and within position for the nursing service personnel on the professional and bureaucratic role conceptions. The computed "between position" to "within position" ratio resulted in F-values of 0.41 and 1.94 for professional and bureaucratic role conceptions, respectively. These results indicated no significant difference at the .05 level.

Table 7

Mean[a], Range, and Standard Deviation for Professional and Bureaucratic Role Conceptions Within Nursing Service Personnel by Position

Source	N	Role Conception	Mean	Range	SD	SED	Variance
Assistant Head Nurse	4	Prof[b]	21.75	19-24	2.63	1.31	6.92
		Bur[c]	13.75	12-17	2.36	1.18	5.58
Head Nurse	33	Prof	12.09	14-28	3.78	0.66	14.27
		Bur	17.42	10-25	3.15	0.55	9.94
Supervisor	13	Prof	20.38	14-24	3.23	0.90	10.42
		Bur	17.15	12-24	3.21	0.89	10.31
Assistant Director of Nursing Service	1	Prof	18.00	8-18			
		Bur	20.00	20-20			
Position Not Indicated	14	Prof	21.57	16-29	3.34	0.89	11.19
		Bur	16.29	9-23	3.43	0.92	11.76

[a] Low mean indicates strong orientation to the conception

[b] Professional

[c] Bureaucratic

Table 8

Analysis of Variance for Professional Role Conceptions Within Nursing Service by Position

Source	DF	Sum of Squares	Mean Square	F-value	PR > F
Between Position	3	15.96	5.32	0.41	0.74
Within Position	47	602.55	12.82		

Table 9

Analysis of Variance for Bureaucratic Role Conceptions Within Nursing Service by Position

Source	DF	Sum of Squares	Mean Square	F-value	PR > F
Between Position	3	56.79	18.93	1.94	0.14
Within Position	47	458.50	9.76		

An analysis of the role conception score for difference within the two subgroups of nursing service personnel by place of employment was conducted. No statistically significant difference was found in the professional or the bureaucratic role conceptions. The mean professional scores were: community hospital, 20.76; and medical center hospital, 21.18. The mean bureaucratic scores were: community hospital, 16.38; and medical center hospital, 17.20 (Table 10).

Table 10

Mean[a], Range, and Standard Deviation for Professional and Bureaucratic Role Conceptions Within Nursing Service by Employment

Source	N	Role Conception	Mean	Range	SD	SED	Variance
Community Hospital	21	Prof[b]	20.76	16-29	3.59	0.78	12.89
		Bur[c]	16.38	9-23	3.76	0.82	14.15
Medical Center Hospital	44	Prof	21.18	14-28	3.44	0.52	11.83
		Bur	17.20	12.25	2.99	0.45	8.91

[a] Low mean indicates strong orientation to the conception

[b] Professional

[c] Bureaucratic

An analysis of the variability on both role conceptions between place of employment and within place of employment for the nursing service personnel is shown in Tables 11 and 12. The ratio of "between employment" to "within employment" yielded an F-value of 0.21 on the professional role conception and 0.91 on the bureaucratic role conception. These F-values were not significant at the .05 level.

The findings and analysis of the data in this chapter are followed by the discussion and summary of the results. Conclusions are drawn and recommendations made for further research.

Table 11

Analysis of Variance for Professional Role Conceptions Within Nursing Service by Employment

Source	DF	Sum of Squares	Mean Square	F-value	PR > F
Between Employment	1	2.51	2.51	0.21	0.65
Within Employment	63	766.35	12.16		

Table 12

Analysis of Variance for Bureaucratic Role Conceptions Within Nursing Service by Employment

Source	DF	Sum of Squares	Mean Square	F-value	PR > F
Between Employment	1	9.64	9.64	0.91	0.34
Within Employment	63	666.11	10.57		

CHAPTER V

SUMMARY AND CONCLUSIONS

This investigation attempted to identify and to compare the nurse role conceptions of the sample nurse educators and nursing service personnel to determine if a significant discrepancy does exist.

Discussion

The reviewed literature described role conception as the cognitive component of role, constituted by cultural patterns of values, attitudes, and behavioral expectations. Socialization was identified as the process by which role acquisition occurs, with values transmitted through the technique of modeling.

A unique combination of child and adult socialization with components of psychoanalytic, reinforcement, and cognitive orientations has been proposed as the process by which professional nurses become socialized. Primary socializers of nurses were identified as nurse educators and nursing service personnel. The present study is based on this theoretical framework.

Many studies have investigated the professional-bureaucratic work conflict (Scott, 1966; Johnson, 1971), nurse role conception (Corwin, 1961; Kramer, 1974), and the socialization of nurses (TenBrink, 1968; Williams and Williams, 1959). Few studies, however, have sought to investigate the role conception, as measured by values, of the two chief role models of new graduate nurses (Smith, 1974).

A main purpose of this study was to identify and to compare the nurse role conceptions of the two groups to determine if a significant discrepancy did exist. A major assumption of this study was that the selected nurse educators and nursing service personnel were primary socializers of graduates of the nursing program. Central to the purpose of the study was the notion that, given the results, nurse educators and nursing service personnel can modify their modeling behavior to consciously portray those role conceptions best suited to today's nursing. This information is especially valuable for nurse educators and nursing service personnel as they collaborate to promote a unified climate for the practice of nursing.

Studies with high reliability and validity have utilized measurement of values to infer role conception (Corwin, 1961;

Corwin and Taves, 1962; Kramer, 1968, 1970). One study (Smith, 1964) revealed a significant difference in the nurse role conception held by nurse role models. Data from the present study support the findings of these investigators with respect to the difference and direction of difference between professional and bureaucratic role conception. A related finding of this study was the significant difference in bureaucratic role conception according to position, within the faculty group itself.

Summary of the Findings

The hypothesis that there will be a significant difference between the nurse role conceptions held by nursing faculty and those held by nursing service personnel was supported by the data. A statistically significant difference in both role conceptions, as measured by values, was found between the groups of nurse educators and nursing service personnel. These differences were also in the same direction as findings from previous studies: (a) the nurse educator held a stronger professional orientation than did the nursing service personnel, and (b) the nursing service personnel held a stronger bureaucratic orientation than did the nurse educators.

Other Relevant Findings

The data in this study indicated a significant difference in the bureaucratic role conception within the nurse educator group by position. Influencing factors could be the variables of age, length of time in position, and level of education. This finding warrants further examination in future research. Other findings indicated no significant differences in the professional role conception of faculty and the professional and bureaucratic role conceptions within or between nursing service personnel groups.

Conclusions

The following conclusions were drawn from the analysis of the data:

1. Discrepancies in nurse role conception were found to exist between this sample of nurse educators and nursing service personnel.

2. Intragroup differentiations were not sufficient to conclude significant differences between subgroups according to specialty, length of time in position and level of basic education.

3. Discrepancies in the bureaucratic nurse role conception were found to exist within the sample of nurse educators.

4. No significant differences in the professional nurse role conception were found to exist within the sample of nurse educators.

5. No significant differences in the nurse role conception were found to exist within or between the two subgroups of the sample of nursing service personnel.

Implications for Nursing

Based upon the conclusions and theoretical framework of this study, the following implications for nursing are suggested:

1. The discrepancies of nurse role conception found to exist between this sample of nurse educators and nursing service personnel could be expected to create a climate of role-conflict for the student and graduate nurse of the selected nursing program.

2. Nurses in role-conflict may divert energy from the provision of quality patient care toward adjustment and adaptation.

3. The nurse educators and nursing service personnel of this study need to be aware of the nurse role conception they convey and to recognize the influence they have, as primary socializers of nurses, on the future of nursing practice and the nursing profession.

4. There is a need for active colloboration and appropriate compromise within the sample of nurse educators and nursing service personnel for the purpose of:

a. acquiring a greater understanding of the nurse role conceptions of each other and of the internal and external constraints under which each group operates;

b. providing nurses with the tools of and practice in constructive conflict resolution;

c. providing support to students and new graduates to maintain their innovativeness as they practice in the realities of the work situation.

5. The nurse educators need to portray role models who have themselves learned to maintain the professional nurse role conception within a bureaucratic work organization.

6. The nursing service personnel need to reevaluate the existing structure of the work situation in search of modifications to encourage and stimulate full use of today's nurse graduate capabilities.

Methodological Implications

Results of this investigation have several implications for future research in nurse role conceptions.

1. Future research should determine the reliability and validity of the instrument used in this study. Items eliciting a high rate of "undecided" responses should be closely examined for possible rephrasing or omission.

2. Future studies using role conception scales might look closely at the use of the term "should" in an attempt to avoid threatening those respondents who have difficulty expressing their opinion on a forced-choice questionnaire.

3. Future research should pursue a single approach to administration of the questionnaire to better control extraneous variables and prevent possible contamination of the study.

These implications evolved from strengths and weaknesses of the present study. Taken together, they should combine to enhance future large studies of nurse role conception.

Implications for Future Research

Based upon the procedures, findings and conclusions of this study, the following implications for further research are suggested:

1. Research should be conducted to determine the prediction ability of this study by:

a. investigating the role-conceptions of student and graduate nurses of the nursing program in this study, and

b. determining if role-conflict does exist in that population.

2. The finding of significant differences in the bureaucratic role conceptions of the faculty indicates a need for further research of role conception in nurse educators to identify the areas and direction of the discrepancies. Of particular interest are the variables of position, level of education, length of time in position and age.

3. More research is needed on the importance of the role model-modelee relationship between nursing educators/ nursing service personnel and student/graduate nurses.

4. More studies are needed to determine the specific areas of nurse role conception in which nurse educators and nursing service personnel are most discrepant.

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APPENDIX A

Form Letters

FORM LETTER SAMPLE

(Date)

Dr. _____
Dean
School of Nursing

Dean _____:

This is a request for permission to conduct a survey by questionnaire of your faculty members directly involved in the education of undergraduate nursing students. The survey is intended to collect data for my master's thesis--"A Study of the Nurse Role Conceptions Held by Nursing Faculty and Nursing Administrators."

The instrument requires approximately fifteen minutes to complete. All data collected would remain anonymous. The results of this study will be made available to those who wish to see them.

Please notify me whether or not you will permit this survey. If so, I would prefer to personally conduct the survey to minimize discussion among participants and to answer any questions that may arise. Could the survey be scheduled on the agenda of the January faculty meeting?

Sincerely,

Linda J. McNeal, R.N.

FORM LETTER SAMPLE

(Date)

Mrs. _____
Director of Nursing
Hospital

Mrs. _____:

This is a request for permission to conduct a survey by questionnaire of nursing service personnel in your hospital. This survey is intended to collect data for my master's thesis--"A Study of the Nurse Role Conceptions Held by Nursing Faculty and Nursing Administrators."

Your hospital and two other hospitals employed a total 33% of the May, 1976 graduates of one school of nursing. This is the reason your nursing service personnel were selected to participate in this study. Participants would include: director of nursing, assistant directors, supervisors, and head nurse personnel.

The instrument requires approximately fifteen minutes to complete. All data collected would remain anonymous. The results of this study will be made available to those who indicate a wish to see them.

Please notify me whether or not you will permit this survey. If so, I would prefer to personally conduct the survey to minimize discussion among participants and to answer any questions that may arise. Could the survey possibly be scheduled on the agenda of the February head nurse's meeting?

Sincerely,

Linda J. McNeal, R.N.

APPENDIX B

Nurse Role Conception Scales

The following instrument was administered to all participants in the study. The only variation in the instruments distributed to nursing faculty and nursing service personnel was the first introductory paragraph.

This is a survey to collect data for my master's thesis: "A Study of the Nurse Role Conceptions Held by Nursing Faculty and Nursing Administrators." Those faculty members directly involved in the education of undergraduate nursing students in the School of Nursing at . . . were selected to participate in the study.

The attached questionnaire requires approximately fifteen minutes to complete. All data will remain anonymous. If you choose to participate, please ask any questions you may have after reading the following instructions:

The first section of this questionnaire consists of a list of hypothetical situations in which a nurse might find herself. You are asked to indicate the extent to which you think the situation should be the ideal for nursing. Give your opinions; there are no "wrong" answers. Please answer all questions.

Indicate the degree to which you agree or disagree with the statement by checking one of the alternative answers, ranging from "strongly agree" to "strongly disagree."

STRONGLY AGREE --- indicates that you agree with the statement with almost no exceptions.

AGREE ---------- indicates that you agree with the statement with some exceptions.

UNDECIDED -------- indicates that you could either "agree" or "disagree" with the statement with about an equal number of exceptions in either area.

DISAGREE --------- indicates that you disagree with the statement with some exceptions.

STRONGLY DISAGREE- indicates that you disagree with the statement with almost no exceptions.

Here is an example:

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
Some graduate nurses in New York hospitals believe that doctors are more professional than nurses. On the basis of the facts, graduate nurses <u>should</u> believe that doctors are more professional.					

Suppose that, almost without exception, you agree that nurses should regard doctors as more professional. Then check (✓) the first column (STRONGLY AGREE) for the question as shown. Be <u>sure</u> you place a checkmark (✓) after each question.

SECTION I:

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
1. One graduate nurse tries to put her standards and ideals about good nursing into practice even if hospital rules and procedures prohibit it. This is what graduate nurses <u>should</u> do.					
2. One graduate nurse does not do anything which she is told to do unless she is satisfied that it is best for the welfare of the patient. This is what graduate nurses <u>should</u> do.					
3. One graduate nurse, an excellent nurse except that she is frequently late for work, is not being considered for promotion even though she seems to get the important work done. This is the way it <u>should</u> be in nursing.					
4. All graduate nurses in a hospital are active members in professional nursing associations, attending most conferences and meetings of the association. This <u>should</u> be true of all nurses.					

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
5. A head nurse in one hospital insists that the rules be followed in detail at all times, even if some of them do seem impractical. This is the way head nurses and supervisors <u>should</u> act.					
6. A graduate staff nurse observes another graduate staff nurse, licensed practical nurse, or aide, who has worked in the hospital for months, violating a very important hospital rule or policy and mentions it to the head nurse or supervisor. This is what graduate nurses <u>should</u> do.					
7. All graduate nurses in a hospital spend, on the average, at least six hours a week reading professional journals and taking refresher courses. This <u>should</u> be true of all nurses.					
8. Some nurses try to live up to what they think are the standards of their profession, even if other nurses on the ward or supervisors don't seem to like it. This is what graduate nurses <u>should</u> do.					

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
9. When a supervisor at one hospital considers a graduate for promotion, one of the most important factors is the length of experience on the job. This is what supervisors <u>should</u> regard as important.					
10. Some graduate nurses believe that they can get along very well without a lot of formal education, such as required for a B.S., M.S., or M.A. college degree This is what graduate nurses <u>should</u> believe.					
11. In talking to acquaintances who aren't in nursing, a graduate nurse gives her opinions about things she disagrees with in the hospital. This is what graduate nurses <u>should</u> do.					
12. A graduate nurse is influenced mainly by the opinions of hospital authorities and doctors when she considers what truly "good" nursing is. This is what graduate nurses <u>should</u> consider in forming their opinions.					

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
13. At some hospitals, when a graduate nurse is considered for promotion, one of the most important factors considered by the supervisor is her knowledge of, and ability to use, judgment about nursing care and procedures. This is what supervisors <u>should</u> regard as important.					
14. Some hospitals try to hire only graduate nurses who were educated in colleges and universities equipped to teach the basic theoretical knowledge of nursing science. This is the way it <u>should</u> be in nursing.					

Please turn the page to the second section of this questionnaire.

SECTION II:

Personal Data Form:

Please respond to the following items as completely as possible. If you believe that any of the items may too closely identify you, please omit those items but respond to all others.

Date:

Age:

Sex:

Race:

Place of employment:

Length of present employment:

Position presently held:

Length of time in present position:

Positions held prior to present one:

Length of time employed as
hospital staff nurse, or :
first level community health nurse, :
if applicable

Current area of specialty:
(psychiatry, medical-surgical, etc.)

Year of completion of highest
level of nursing education:

Thank you for your participation in this study? If you wish to know the results of this research, please indicate

with an appropriate checkmark: yes____; no____; and the completed study will be made available to you. Again, may I assure you that all information in these forms will remain anonymous.

Linda J. McNeal, R.N.

APPENDIX C

Adaptation of Instrument

Permission was obtained from Professor Corwin to use and to modify the Corwin Role Conception Scales. Initially, verbal permission was obtained via telephone on November 23, 1976. Following the study, verbal approval to publish an adapted version of the Corwin Scales was obtained via telephone on April 18, 1977. Written approval to publish the adapted instrument was received by the investigator on April 25, 1977.