THE RELATIONSHIP OF GENDER, AGE, SOCIOECONOMIC STATUS, AND PAST HOSPITAL EXPERIENCES TO EXPECTATIONS OF NURSING CARE IN AN ADULT POPULATION

by

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Somewhat like education and raising children, nursing is work most of us think we know a lot about. We get a mental picture of a compassionate women in white, watching sick people in a hospital, carrying out physicians' orders and easing the tears and pain of illness with soothing words and ministrations. It is not a false picture. But the nursing profession is so much more.

Jean Haley
Editorial Staff Member
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ABSTRACT

The nursing profession has been concerned about nursing's public image since the very beginning of the profession. From a number of research studies it is evident that the public image of nursing is not congruent with the realities of contemporary nursing. Factors such as age, gender, education, and socioeconomic status have been correlated with the perceptions of nursing held by the lay public. The expectations of consumers regarding nursing functions and attributes have not been extensively studied. Therefore, this study was designed to identify the expectations of health care consumers and determine if these expectations were congruent with the expectations set forth by the profession through the ANA Standards of Practice and Code of Ethics. Consumer expectations were examined in relation to the variables of age, gender, socioeconomic status, and past hospital experiences with nursing care. As a convenience sample, 135 consumers, ranging in age from 18 to 62 years and above, chose to participate. These subjects completed an instrument developed by the investigator which was based on the ANA Standards of Practice and Code of Ethics. Descriptive statistics were employed for data analysis. Mean agreement scores for the five nursing function categories

and the five nursing attribute categories were used in addressing the question of congruency between consumer and professional expectations. Chi-square analysis was used to compare consumer expectations with the variables of age, gender, socioeconomic status, and past hospital experiences. The results of this study suggest that consumers generally endorsed expectations of nursing functions and attributes congruent with the Standards of Practice and Code of Ethics. Less congruency was found between consumer and professional expectations of functions related to the category of nursing evaluation. Consumer responses to expectations for the nursing function categories did not bear a relationship to the individual variables. The variables of age and socioeconomic status were significantly related to consumer expectations in three of the attribute categories.

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CHAPTER I

INTRODUCTION

Rationale for the Study

The issue of the professional image of nursing has long been of interest to nurses as evidenced by a review of nursing literature. In fact, Simmons (1962) suggests that nurses have pursued image studies with greater vim and vigor than any other profession. This zealous interest by nurses is not, however, unfounded. It seems the nurse and the nurse's role is misunderstood by nearly everyone. As Grissum states, "To the lay public, to hospital administrators, and to many physicians and other health care workers, a nurse, is a nurse, is a nurse" (Grissum, 1976, p. 54).

The vague image of the nurse as physician's helper in a white uniform who takes temperatures and gives shots is not only inaccurate but old-fashioned (Haley, 1983). In an attempt to enlarge the understanding of contemporary nursing by the lay public, the Missouri Nurses' Association, in recognition of National Nurses' Day, May 6, 1983, invited Kansas Citizens to spend time with a nurse on duty. Much to their chagrin, only a few people accepted the invitation. Jean Haley, editorial staff

member of The Kansas City Star, summarized her experience with a nurse stating that "the need is great for health consumers . . . to understand the kinds of services nurses can and do provide" (Haley, 1983, p. 1G).

In 1970, the Surgeon General's Consultant Group on Nursing recommended a national investigation of nursing responsibilities and skills required for high-quality patient care. In response, The American Nurses' Association and the National League for Nursing established a Joint Committee to study the changing practices in nursing. The committee identified, in part, that defining nursing functions was a major problem in American nursing. They suggested that addressing this problem requires "utilizing the best input from nursing . . . as well as the viewpoint of the patient, the eventual consumer of all health care" ("National Commission," 1970, p. 281).

The American Academy of Nursing conducted a Delphi Survey in 1979 in order to obtain a priority list of critical issues which deserve the profession's attention. Improving the public image of nursing was identified as one of the most critical issues confronting the profession of nursing (Lindeman, 1979). Relative to this global issue were two additional suggestions made by the American Academy of Nursing--that developing a public awareness of the contributions the nursing profession

makes to health care and creating public acceptance of the expanding independent roles of the profession are priority activities for professional leaders (Lindeman, 1979). In order to implement these activities, it seems that an analysis of the public's image of nursing would be necessary; and in the past two decades a number of studies addressing this issue have been conducted. As a more detailed review of the literature will later bear out, many of these studies possess methodological shortcomings; however, a brief description of the existing literature at this point will give direction to this research study.

Study of the public image of nursing has taken a variety of forms. A majority of previous studies have focused on the public image of nurses and nursing in terms of what they perceive to be nursing attributes and functions. These studies suggest that the nurse is seen as the proverbial handmaiden to the physician--thought by many to function more technically than professionally (Beletz, 1974; Lee, 1979a, 1979b; Robinson, 1978; Simmons, 1962). In his own review of the literature, Simmons (1962) pointed out that past studies suggest two popular but competing images of the nurse. At one extreme is the cool-headed, well-trained, and technically efficient person lacking in feeling. At the other extreme is the warm-hearted, sympathetic, altruistic person, endowed with the capacity for compassion and caring but who does not

necessarily possess an inquiring mind. These studies suggest that the ideal image of the nurse should encompass a special blending of these dichotomies; that is, nurses ideally should combine technical and professional skills with the aspects of a humanistic personal approach to nursing care (Simmons, 1962). A review of the literature has revealed a limited focus on the ideal image of nursing from a lay perspective.

Studies have approached the issue of the public image of nursing in terms of the various perceptions held by selected groups. Nursing students queried about their image of nursing held more technically oriented perceptions (Brown, Swift, & Oberman, 1974; Collins & Joel, 1971; Davis & Olesen, 1964). In a study conducted by Woolley (1981), college liberal arts faculty were found to have a positive but nonetheless traditionally technical image of nurses; these faculty members were no more up-to-date in their image of nursing than the lay public about the new and expanding roles of nursing. Interviews with children showed that nurses are perceived as highly technical individuals with the giving of injections, medications, and treatments being mentioned repeatedly as nurses' functions (Turcotte, 1975). Studies concerned with physicians' perceptions of nursing functions reported that physicians in general did not grant professional status to the nurse (Deutscher, cited in Simmons, 1962; Lee, 1979b).

Lee (1979b) found that even those who did recognize nursing as a profession made it clear the profession was a subservient one.

These studies show there are multiple public images of the nurse and, in many cases, these images are incongruent with one another. Dr. Mila Aroskar suggests there is a profound disparity between the public image of nursing and the reality of the contemporary nurse (Spicker, 1980). She contends that if the contemporary nurse is different from what the public thinks the contemporary nurse is, then the public image is incorrect. In other words, imaged characteristics need not actually exist in reality--they may simply be perceived as existing (Simmons, 1962). Simmons (1962) further points out that the validity of an image is not the most critical element, but the significance of an image lies in the firmness which it is held by the individual and the impact it has on subsequent human behavior. Thus, if the public image is in fact incorrect--whether nurses are viewed positively or negatively--then subsequent interaction with nurses may be positively or negatively affected.

Many investigators have capitalized on the notion that culture, social system, sex, occupation, and education are major variables shaping a belief system (Rokeach, 1968). A relationship among the gender, socioeconomic status, and age of the sample respondents, and what the subjects

perceived for nurses and nursing has been documented by several investigators (Alexander, 1979; Beletz, 1974; Lee, 1979a, 1979b). In general, these studies reported inverse relationships among economic class and age and the image of the nurse.

Other studies demonstrated a relationship between personal past experience with nurses and image of the nurse (Lee, 1979b; Woolley, 1981). Respondents in these studies reported that their images of nurses stemmed from their personal experiences in the hospital and with office nurses. These studies suggested that age, sex, socio-economic status, and past experience were associated in both a positive and negative direction with public perceptions of nurses and nursing. These findings hold implications for nursing because efforts at improving the public image of nursing may be more effective if directed at specific groups.

Other studies of the image of nursing have approached the issue from the standpoint of those factors which have, at least in part, shaped the public image. The educational system, the communications media, and major social institutions have been credited (or more correctly discredited) with the perpetuation of the stereotypic subservient picture of the nurse (Gornick & Moran, 1971). Kalish and Kalish have been interested in how various communications media reveal public values of the

profession of nursing. Analysis of novels, magazines, television, motion picture, and newspapers have demonstrated how the nurse has typically been portrayed in a subservient role, divorced from intellectual capacities (Hughes, 1980; Kalish & Kalish, 1981, 1982a, 1982b, 1982c; Muff, 1982; Schorr, 1963). Other investigators have analyzed the content of American Literature and health textbooks (Ham, 1981; Holcomb, 1981; Hott, 1977; Richter & Richter, 1974; VerStegg, 1968). These studies reported that female occupational positions were more frequently portrayed as being subordinate to males who were typically portrayed in higher level roles.

Lande (1966) investigated factors which influence high school students' perceptions about nurses and nursing. His study revealed that a majority of students learned about nursing from nurses and people outside the profession. Still others cited their major source of information as printed nursing materials and television. Students further indicated that, because of the information they had gained about nursing, they were not positively influenced toward nursing as a career choice. Interviews with masters prepared mental health nurses demonstrated that messages from high school counselors were more discouraging than encouraging toward a nursing career (Benton, 1979). These studies show that the image of nursing issue can be related to recruitment of candidates

and, thus, to the future of nursing.

There is a paucity of nursing research on the public image of nursing from the standpoint of consumer expectations. Those studies that have focused on the 'wants' of the public have not actually queried respondents about 'what nurses should do,' 'what are desirable functions of nurses,' or 'what they expected of nurses.' Alexander (1979) asked respondents "what they thought the educational preparation of nurses should be" (p. 655). Lee (1979b) asked respondents "what they liked best about nurses" (p. 35). Robinson (1978) asked sample subjects "what services do you think a nurse could provide" (p. 16). These studies did not directly determine what the lay public ideally expects from nurses and the care they deliver.

Habeeb and McLaughlin (1977) investigated the role expectations of VA professional staff regarding nursing involvement in placement and follow-up. The results demonstrated that nursing role descriptions and expectations held by physicians, social workers, and nurses are inconsistent. Each group envisioned the nurse's role in posthospital placement and follow-up care differently; some supporting the extended role of the nurse more than others. In a pilot study conducted by Nehring and Geach (1973), it was found that, when asked their expectations of nursing care preoperatively, the patients in general did

not expect many of the care items presented to them in the questionnaire. It was concluded that patient respondents were fearful of reprisals for their true responses.

These studies represent beginning research in the area of consumer expectations regarding nurses and nursing. Few research studies have focused on the public image of nurses from this standpoint. We say that nurses are responsible to consumers; we believe that nurses are responsible to inform consumers about their rights, to teach consumers how to stay healthy, to assist consumers in choosing health care resources. But have we asked consumers what they want and expect from nurses? As Kohnke suggests, if advocacy is basic to nursing's responsibility to consumers, then should we not determine what it is that the consumer wants from the nurse (Kohnke, 1978)?

In summary, previous studies have focused on what the consumer 'thinks' about the characteristics of nurses and their functions. Other studies have focused on potential influential factors that have shaped the image of nursing and those variables that are related to consumer perceptions; for example, sex, age, socioeconomic status, educational level, and past experiences. Many authors of both research and nonresearch literature have addressed the issue of how to change consumer's perceptions or

images of nurses and nursing. In considering change, a number of additional questions born out of these studies must be addressed. What is the ideal image to which both nurses and the public aspire? Is the public's ideal image of nursing congruent with the ideal image of the profession as conceived by nurses? Why do consumers hold certain expectations; that is, what has influenced their ideal image of the nurse? These questions, raised in the course of this introduction, give credence to the fact that the public image of nursing is just as much an issue in the 1980s as it has been in past decades, and many questions about the issue remain unanswered.

Purpose of the Study

The purpose of this study was to explore the public image of nursing by focusing on consumer expectations of nursing attributes and functions. To this end, a major objective of this study was to determine what the ideal image of nursing is in the eyes of consumers.

The nursing profession has long been concerned with describing and defining the most elemental components of nursing as a service occupation; the actions performed and wanted. The study proposed to further define and describe these actions in terms of the layman who is the recipient of nursing actions. The study purpose also involved determining if individual characteristics (gender,

socioeconomic status, age, and past hospital experiences as consumers with nurses and nursing care) are related to consumer expectations of nursing attributes and functions.

In addressing the questions of congruency between public ideals and professional ideals of nursing, the study focused on relating the Standards of Nursing Practice, as set forth by The American Nurses' Association, to the expectations of nurses and their functions, as set forth by consumers. If incongruency exists between professional and public standards, then possibly nursing's professional society and professional members could utilize this information to enhance articulation of the social contract that exists between nursing and society. In addition, the study related The American Nurses' Association's Code of Ethics to consumers expectations of nursing attributes and characteristics.

Conceptual Framework

Nursing's primary function, their raison d'etre, is the practice of professional nursing (Kelly, 1975). Many approaches have been taken in efforts at defining professional nursing practice. Despite wide-ranging definitions of nursing, both enacted and proposed definitions of nursing, inevitably, are diverse in language, but the purpose is the same--to permit nurses

to function as they are expected to function [according to practice acts of individual states] (Kelly, 1974).

The diversity of definitions of nursing indicates not only the very complexity of nursing, but the expansion of nursing practice as well (Kelly, 1975). In view of the expanding roles in nursing, and within the context of this research investigation, several questions arise:

1. Is the definition of nursing practice today, as defined by the nursing profession, congruent with the definition of nursing practice as defined by the lay public? In other words, have nursing professionals adequately communicated with the lay public in regard to nursing practice?

2. Is the language of the profession foreign to the recipient of nursing care?

3. Are the Standards of Nursing Practice set forth by The American Nurses' Association communicating the practice of contemporary nursing? Perhaps the profession's scope of practice has extended beyond the range of those perceptions of nurses held by the lay public. As Torres points out, "If nursing is to meet society's needs, there should be further exploration and identification of the functions of the professional nurse, now and in the future" (1974, p. 187). In a word, we need to focus on the 'what' of nursing.

Many individuals have endeavored to define nursing in

terms of what criteria constitute a profession. The classic definition formulated by Flexner (1915) states that a profession (a) involves intellectual operations associated with considerable individual responsibility, (b) is learned in nature, (c) is not only academic and theoretical, but is aimed at practicality, (d) possesses communication techniques as an educationally specialized discipline, (e) is well-organized, (f) is altruistic in nature and is concerned with the interests of the public, and (g) has a definite social and professional status. Subsequent definitions of a profession are similar in principle to Flexner's proposal (Coladarci, 1963).

The American Nurses' Association, since its formation, has endeavored to work constantly toward professionalization of nursing; to this end, The American Nurses' Association has undertaken such major activities as defining professional nursing. The model definition of professional nursing, as suggested by the Association, states, in part:

> The practice of professional nursing means the performance . . . of any act in the observation, care and counsel of ill, injured, or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatments prescribed by a licensed physician . . . requiring substantial specialized judgment and skill and based on knowledge and application of the principles of biological, physical and social sciences. (Kelly, 1974, p. 1314)

While this model definition seems very general, it was intended to be broad in order to allow for the evolution of nursing functions. The American Nurses' Association, however, has aimed at being more specific in identifying the functions of the professional nurse through the development of standards for its practice. The American Nurses' Association's Code of Ethics (1976) and Standards of Practice (1973) establish the social contract that exists between nursing and society. The social policy statement (1980), as well as other American Nurses' Association publications, are designed to "inform other health professionals, legislators, funding bodies, and the public about nursing's contribution to health care" (Nursing: A Social, 1980, p. 30). The purposes of a professional association include establishing, maintaining, and improving standards and educating the public to appreciate standards. The Standards of Nursing Practice (1973) focus on practice and provide a means for determining the quality of nursing a client receives. Ideally, the Standards of Practice, as defined by the nursing profession, should be the same as those identified by consumers. At best, the American Nurses' Association's Standards of Practice should, at least in part, be reflected in the lay public's idealized conception of the nursing profession.

The Standards of Nursing Practice (see Appendix A)

are based on the nursing process and serve as a framework for the vast scope of professional functions and responsibilities; thus, they are applicable to this study which was designed to identify consumers' ideal expectations of nursing practice. The American Nurses' Association's Code for Nurses (1976) (see Appendix B) is based on ethical values and behaviors of individuals who provide nursing services, and thus is applicable to this study which was also designed to identify consumers' ideal expectations of nursing attributes. In representing the nursing profession's definition of ideal or expected nursing practice, these standards and codes served as a framework for developing the consumer questionnaire. The framework facilitated the identification of consumer expectations and served as a means by which professional ideologies could be compared with those of consumers (as evidenced in congruency between professional and public ideal expectations of nursing attributes and functions).

Assumptions

For the purposes of this study, the following assumptions were identified:

1. Individuals can distinguish between what is thought or perceived, what is true or real, and what is wanted or ideal;

2. Individuals will make true responses on the questionnaires;
3. Responses obtained will be a representative sample of consumers' expectations of nursing attributes and functions.

Research Questions

1. Are consumers' expectations of nursing functions and attributes congruent with the profession's expectations of nursing functions, as defined by The American Nurses' Association's Standards of Nursing Practice; and nursing attributes, as defined by The American Nurses' Association's Code of Ethics?
2. Do consumers' expectations of nurses vary with consumers' past hospital experiences with nurses and nursing care?
3. Do consumers' expectations of nursing functions and attributes vary with the individual characteristics of gender and age?
4. Do consumers' expectations of nursing functions and attributes vary with the individual characteristic of socioeconomic status?

Definition of Terms

The definitions of the variables in this research study were as follows:

Consumer: As defined by the investigator, any adult who is a potential or has been an actual consumer of nursing services; within this definition, health care professionals were included with the exception of nurses.

Past Hospital Experience: Those experiences, defined by the investigator, in which the consumer received nursing intervention from a nurse or nurses in a hospital setting. Past hospital experiences were defined in terms of number, recency, and positive versus negative. Past experience was measured by a closed-ended questionnaire developed by the investigator (see Appendix C).

Ideal Image of Nursing Attributes and Functions: A representation of what an individual expects, as defined by the investigator; that is, what an individual believes 'ought or should be' in regard to the attributes and functions of nurses. The ideal image of nurses and nursing care, as described by the consumer, was measured by a closed-ended questionnaire (Consumer Nursing Process and Attributes Questionnaire, see Appendix D). The

ideal image of nurses and nursing, as described by the profession, was operationally defined by the Standards of Nursing Practice (1973) and the Code for Nurses (1976).

Significance to Nursing

An image has the potential for serving several functions. An image, as defined by Webster's New World Dictionary, is a prejudgment--a conception. Rokeach (1968) points out that, based on one's prejudgments or conceptions, an individual formulates certain assumptions which rule that individual's impressions and subsequent beliefs and behavior. Hence, if individuals hold certain preestablished assumptions about nurses and nursing care, their behavior in the health care milieu thus will be ruled by these assumptions. Furthermore, misunderstanding of role and distortions in an individual's perceptions may influence the outcome of nursing care (King, 1981). Thus, a negative public image could affect patient compliance. Incongruent expectations between the recipient and giver of nursing care can affect the degree to which patients comply with nursing care prescriptions (King, 1981).

A negative image of nursing can further affect nursing by negatively altering the success of political and professional goals. And, if the public expects one thing and nurses expect another, the goals for the

provision of health care of neither group will be met. It was hoped that information gleaned from this study would move the expectations of professionals and consumers toward the same goals.

A negative public image of nursing can affect the quality and quantity of individuals making a career choice toward nursing. Perhaps self-images, beliefs, values, and self-confidence of nurses are lowered or changed by negative images held by consumers (Kalish & Kalish, 1983a). A study of this kind, which pursues the clarification of nursing's public image through the identification of ideal nursing functions and attributes, will bolster the personal images of nurses as they pursue and progress through their professional lives.

> Evidence is accumulating that what a person does and who he believes himself to be will in general be a function of what people around him expect him to be, and what the overall situation in which he is acting implies that he is. (Gornick & Moran, 1971, p. 210)

By studying the expectations of the public with respect to the functions of nurses, the profession stands to gain some important insights. Such an analysis would facilitate an awareness of the importance of nursing functions in the health care system and would reveal factors regarding the changing status of nursing (Kalish & Kalish, 1982c). By ascertaining what the desires of the consumer are in relation to nursing services, nurses can determine if,

indeed, they are fulfilling these expectations. Further, this study could shed light on the issue of professional versus technical nursing. The public's desire for simple hands-on, compassionate care may have implications for technical nursing programs. On the other hand, those consumer expectations, which acknowledge professional nurses as having a scientific base of practice and autonomy, may have broad implications for professional nurses and thus impact on nursing education.

The growth of consumerism is clearly related to television, faster and improved communications, and subsequent rising levels of consumer expectations (Quinn & Somers, 1974). Consumers are becoming increasingly knowledgeable and sophisticated in relation to health problems. Quinn and Somers (1974) suggest, as ombudsmen on behalf of health care consumers, nurses should reach out and welcome the consumer who is expecting and demanding a different kind of care from the traditional passive role of the patient in that care. Because consumers are beginning to articulate their concerns for the quality of nursing care they receive, the involvement of the consumer in nursing care will likely be a permanent feature of the nursing professional's working environment. Hence, as Nehring and Geach (1973) state, it seems essential that:

> we not ignore our most valuable source of information about our practice--our patients. We owe it not only to ourselves as professionals but also to the patients as consumers to devise means whereby their views can be taken into account and the information gained from them put to use in planning, carrying out, evaluating, and researching our care. (Nehring & Geach, 1973, p. 321)

By determining consumer expectations and by respecting consumer ideals, we can perhaps anticipate that nurses will have a greater opportunity to practice to their fullest potential and to gain understanding, acceptance, and respect in so doing (Quinn & Somers, 1974). Furthermore, by studying consumer expectations of nursing attributes and functions, as related to the Standards of Professional Practice and Professional Code of Ethics, leaders might be better able to determine if their professional standards adequately cover the scope of expected nursing functions and whether the Association has effectively articulated to the public the practice of nursing.

It was anticipated that findings of this study would increase the profession's awareness of the public image and assist in the ultimate up-dating of that public image. If nurses actually expect to practice in expanded roles then a public image consistent with the profession's goals is imperative. Thus, accurate perceptions of nursing functions and congruent expectations between nurses and the public with respect to nursing functions

and attributes will ultimately be achieved. Through identification of public expectations, the nursing profession may be better equipped to distinguish and sustain the idealized image of the profession.

CHAPTER II

REVIEW OF THE LITERATURE

For the purposes of this study the literature review will be divided into the following major subheadings: Public Perceptions of Nurses and Nursing, Influential Variables Shaping Public Perceptions, and Public Expectations of Nurses and Nursing. The literature review encompassed studies which focused on lay perceptions of nurses and nursing and perceptions held by other groups; for example, high school and nursing students, faculty, and physicians. Literature addressing variables influential in shaping perceptions included individual characteristics (age, sex, education, socioeconomic status), communication media (television, novels, movies, newspapers, magazines, and textbooks), and various effectual individuals (nurses, counselors, and instructors). Literature pertaining to attitudinal and functional 'expectations' of nurses was limited; however, a few studies will be discussed for their relevance to this research study.

Public Perceptions of Nurses and Nursing

The issue of nursing's image has been the subject of much study. A major focus of past research was on public perceptions of the functions and characteristics of nurses.

Discussion of the public perceptions of nurses and nursing will be divided into three sections which consist of lay, professional, and faculty/student perceptions of nurses and nursing.

Lay Perceptions of Nurses and Nursing

The literature suggests that consumers of health care both perceive and prefer nursing services to be traditional in nature (Beletz, 1974; Copp, 1971; Lee, 1979b; Robinson, 1978; Simmons, 1962). Beletz elicited the perceptions of 18 hospital patients (18-39 years of age) utilizing 21 open-ended questions in an interview format. The respondents identified mainly technical nursing functions; for example, aiding doctors, changing beds, washing floors, being a maid, and giving medications (Beletz, 1974). Likewise, using a survey design, Lee (1979b) found that a majority of respondents identified technical functions as those duties performed by nurses on a daily basis: (a) giving shots, 92.3%; (b) giving medications, 92.9%; (c) filling out forms, 88,3%; (d) monitoring equipment, 83.2%; (e) handling emergencies, 55.8% (N = 666). Whether these respondents realized that handling emergencies, for instance, requires utilization of all parts of the nursing process--and thus the scientific method--is questionable. And while these functions represent a fairly realistic conception of a nurse's daily tasks, still other survey

respondents believed nurses clean rooms (8.1%), prescribe medications (7.7%), diagnose illnesses (2.5%), and perform operations (2.5%). Employing a marketing survey approach with 300 consumers, Robinson (1978) found that consumers indicated a preference for conventional types of nursing services such as "providing physical care, administering medications, and teaching patients to care for themselves" (p. 15).

Subjects in Swansburg's interviews reported both positive and negative perceptions of nursing. Responses ranged from "Nurses have a higher level of awareness of their patients than the doctor does . . . the only reason they're subservient is because of social pressures," to "Nursing is the last bastion for women" (Swansburg, 1981, p. 32). This study, however, failed to provide supportive statistical data from which conclusions were drawn. In this study, Swansburg (1981) pointed out that "the human mind perceives what it expects to perceive" (p. 30), an important consideration which was addressed in this study. To gauge consumer's notions of nursing, nurses must assess what consumers expect of nurses (Swansburg, 1981).

Other interesting findings were reported by Turcotte (1975) who interviewed elementary school-age children. When asked, "What do you think a nurse's duties are?", the responses of the children included: (a) taking people's tonsils out and giving big needles (Grade one),

(b) helping with operations and giving things to doctors (Grade two), (c) fixing deep cuts and telling how things happen in cuts and diseases (Grade three), (d) giving directions on how to use medications (Grade four). Turcotte concluded that children are not ignorant of the nursing profession and that perhaps these responses suggest that children are not ignorant of the traditionally held nursing image (Turcotte, 1975). Yet, as some of these responses indicate, there is an awareness--be it superficial--of the nontechnical aspects of nursing; for example, giving directions and explaining diseases.

Typically, these studies showed that the general public perceives nursing largely as a technical field. Nursing's public image, however, has not been wholly based on what nurses do, or do not do. Image studies have shown that nurse attributes or personal traits play a significant role in how consumers view nurses collectively. Utilizing a questionnaire prepared by RN magazine, Lee (1979b) conducted a survey of adults (N = 666) regarding their image of nurses. When asked to check both typical and preferable traits of nurses, 80% of the respondents marked responsible, knowledgeable, caring, competent, and skilled as typical traits while more than half noted kindness, compassion, concern, and patience as preferable traits. Skillfulness and knowledge of medications ranked third as favored qualities.

Professional Perceptions of Nurses and Nursing

A review of the literature reflected similar perceptions held by selected professional groups. As early as 1945, Edward Bernay described the perceptions of leaders in public life with regard to the nursing profession. At the request of the American Nurses' Association, Bernay polled government officials and members of Who's Who in America and Blue Cross subscribers. Recognizing nursing's contributions to World War II, respondents nonetheless were reported to hold a poor understanding of nursing and its functions. Although methodological problems were evident, this study by Bernay represented beginning documentation of nursing's public image (cited in Simmons, 1962).

This beginning was expanded by Irwin Deutscher in the 1950s in his study of registered nurses in the Kansas City area (cited in Simmons, 1962). In an effort to identify the images of nurses held by doctors and the public, Deutscher reported that physician respondents preferred kind and sympathetic nurses to business-like and efficient nurses. In regard to the public's opinion of nurses in Kansas City, Deutscher (cited in Simmons, 1962) reported that people in general, like physician respondents, much preferred kind and sympathetic nurses to those with a more pragmatic industrious nature. When asked to choose from a word list the item that most closely characterized a nurse,

1 physician checked "loose-woman," 22 checked "saint," 6 checked "waitress," 45 checked "Sunday school teacher," and 65% (approximately 140) marked "housewife" (cited in Simmons, 1962, p. 28). While left to wonder what other choices the respondents were given, if any, the data still suggested nursing's subservient image with this group.

In a more recent study, Lee (1979c) conducted a national survey of 536 physicians and their images of the nurse. In this study, 74.1% believed nurses function best as assistants to the physician, 16.7% regarded nurses as colleagues, and 9.2% regarded nursing as an independent profession. Lee's study supported previous findings in as much as, in physician's eyes, nurses held a subsidiary position and virtually none of the respondents perceived nursing care as discrete from medical care. According to Lee, the overall results of the survey suggested that the auxiliary image of the nurse influenced the average doctor's attitude toward other nursing issues. For example, 58.9% of the physician respondents believed that a baccalaureate education is unnecessary. In summarizing the general opinions of the respondents, Lee quoted one physician who stated: "Nurses are supereducating themselves, not to care for patients, but to police doctors without having medical responsibility" (Lee, 1979c, p. 24). On a more positive note, subjects in Lee's study acknowledged the special skills that nursing brings to patient

care. Some of the nursing qualities physicians valued most included the ability to counsel patients, nursing instincts in assessing patient status, the ability to make decisions, the ability to communicate, and the incredible patience and caring attitude nurses possess.

Faculty and Student Perceptions

When investigating the attitudes of university faculty toward nursing, Woolley (1981) found that, as a whole, liberal arts faculty knew very little about what was going on in the nursing program or the nursing profession. Employing an anthropological field work approach, Woolley interviewed 20 men and women (senior faculty) and taped their responses to a variety of questions designed to elicit descriptions of nursing functions and attributes. Functional responses ranged from nurses being adjuncts to the physician, to nurses mediating the patient's experience with medicine. Attitudinal responses included viewing nurses as tough, aggressive, authoritarian, altruistic, and intelligent. Woolley concluded that faculty attitudes in this survey were consistent with the traditional image of the nurse as evidenced by respondents placing high value on nursing's caring function. These faculty members were no better enlightened about nursing's health-oriented, responsible, patient-advocate image than was the general public.

Ironically, these respondents in academia considered traditional hospital based education for nursing quite laudible. Most respondents were not concerned with collegiate education as qualification for the nursing role (Woolley, 1981).

Nursing students have been shown to harbor lay and traditional images of their chosen profession (Brown, Swift, & Oberman, 1974, Collins & Joel, 1971; Davis & Oleson, 1964). In a longitudinal study of baccalaureate students at the University of California School of Nursing (N = 75), Davis and Oleson (1964) discovered that, while there was no appreciable change in the importance students attached to lay images at the end of the first year of education, lay image items did not significantly decline. The most frequently checked attributes at entry were order and routine (93%), hard work (96%), dedication service (80%), and demonstrating care and concern (91%). Originality and creativity (20%) and solid intellectual content (34%) were some of the least frequently marked attributes (Davis & Oleson, 1964). While the longitudinal aspects of this study are not within the context of this research, the results are interesting in that they suggested some reluctance on the part of these nursing students about abdicating many of the lay images they originally held at entry into the nursing program.

In 1974, Brown and his colleagues set out to replicate

the California study with a group of baccalaureate students at the University of Oregon School of Nursing (Brown, Swift, & Oberman, 1974). While there exists a gross discrepancy in the methodological design of the two studies, sophomore students (n = 53) most frequently checked hard work (91%), dedicated service (87%), demonstrating care and concern (87%), and order and routine (89%) as nursing attributes. Solid intellectual content (51%) was checked less frequently but to a greater extent than in the California study. Data in the Oregon study more strongly supported a decrease in lay perceptions following a year of nursing education; however, the sample studied involved two separate groups, 53 sophomores and 21 juniors--the groups representing images at entry and one-year later, respectively. Countertrends and methodological differences notwithstanding, these findings suggested that professional image characterization may be incorporated during the first year of the educational experience; however, the traditional image persisted throughout the study course and coincided with the more advanced professional image (Collins & Joel, 1971).

Collins and Joel (1971) concurred with these researchers in that the lack of a professional image of and commitment to nursing held by students may be attributed, in part, to failure of nurse educators to impart to students such an image and commitment. With an 86%

questionnaire return (N = 231), Collins and Joel found that three-fourths of the baccalaureate respondents disagreed with the statement that nursing entails a lifelong obligation to practice. This data suggests that nursing students themselves, and perhaps nurses, hold strong opposition to a more professional image as they cling fast to the more technical views of nursing.

Melosh (1982) contended that resistance to professionalization represents a major conflict in nursing. Many factors have contributed to this resistance throughout nursing history and nurses today are defending their image as "the physician's hand" (Melosh, 1982, p. 217). Nurses are insisting on acknowledgement of their indispensable contributions to health care. At the same time, however, "nurses continue to resist the traditional connotations of 'the physician's hand,' with all it has implied of passivity, self-abnegation, and subordination" (Melosh, 1982, p. 217).

Image studies clearly have yielded conflicting data. As these studies have indicated, nursing's public image holds both positive and negative connotations. The image is not unequivocally encouraging or discouraging. To some, the nurse is perceived as bossy and dogmatic while others view the nurse as inferior and exploited. At once the nurse is seen as tough and cynical, yet compassionate and forbearing, both intelligent and uneducated,

responsible and careless, upstanding and promiscuous. A nurse's career choice is simultaneously praiseworthy and worthy of disdain. Opinions vary from anyone could be a nurse, to adoration of and respect for those who are, to no esteemed person would be.

Influential Variables Shaping Public Perceptions

Discussion of public perceptions of nursing functions and attributes has been presented. A second major focus of past research was on identification of variables which were influential in shaping public perceptions of nurses and nursing. Discussion of influential variables will be divided into four sections which consist of individual characteristics, influential individuals, communication media, and the relationship of these variables to public perceptions.

Individual Characteristics

When discussing the image issue, a number of researchers have asserted that individual characteristics such as age, gender, education, and socioeconomic status play a role in the formation of public images of the nursing profession (Alexander, 1979; Lee, 1979a, 1979b, 1979c; Robinson, 1978). In their early works on nursing's public image, Birdwhistell and Deutscher (as cited in Simmons, 1962) found an inverse relationship between

positive image of the nurse and economic class (cited in Simmons, 1962). As Birdwhistell reported, upper-class respondents viewed nurses as "skilled menials," middle-class respondents viewed nurses as "semi-skilled," and lower-class respondents viewed nurses as "one of the noblest of all professions" (cited in Simmons, 1962, p. 26). Both investigators reported more favorable responses by females than males.

More recent findings divulge some contrasts to earlier findings. While these later studies addressed the image issue from a less direct perspective (i.e., professional and educational perceptions about nurses versus verbal descriptions of nursing functions and attributes), the findings nonetheless point out some inconsistencies. Employing the University of South Carolina Consumer Panel as a survey sample, Alexander (1979) reported that no significant difference existed between men and women in their perceived and desired educational levels for nurses. However, women did tend to perceive and want nurses to be less technical and more professional. Occupation, income, and education showed no significant relationship to perceived or desired levels of education for nurses, although higher income levels of respondents and greater education of respondents' spouses did correlate with an increased desire for increased nursing education. For older respondents, Alexander found

that the educational level of nurses was less important but the older sample population held higher perceptions of the nurse in regard to professional status. Reflecting on this finding, Alexander (1979) speculated that "the older individual holds the traditional view of the nurse as hospital educated but professional in status" (pp. 655-666). No statistical data were presented in this study and nurses, having been included in the study population, make the results inconclusive.

Robinson (1978), relying on a marketing survey approach with 300 consumers, reported that age, occupation, and education were statistically significant with relation to what services consumers believed nurses could provide, what services consumers sought from nurses, and where they preferred assistance from nurses ($p > .01$). However, the exact nature of these relationships was not clearly described.

In a survey conducted by National Family Opinion, Inc. of Toledo, Ohio, Lee (1979b) reported that the less affluent, nonprofessional segment of the study respondents showed less concern for nurses professional status holding the nurse in greater esteem for her traditional role. On a scale of zero to five, nursing ranked 3.59 with regard to occupational prestige--the highest ratings came from lower income and noncollege respondents--those individuals who at the same time were less likely to regard nurses

as professionals. Data showed that groups in which 20% of the respondents rated nursing highest on the concept of prestige included income under $14,000 (26.3%), noncollege education (24.6%), farmer/laborer (24.9%), under the age of 30 (28.7%). Groups in which less than 20% of the respondents rated nursing highest on occupational prestige included $25,000 plus income (7.7%), college graduates (13.3%), professional occupation (11.1%), 30 to 49 years of age (17.9%) (N = 666, 47% males, 53% females). Based on this data, Lee suggested that the more affluent portions of the study population tended not to rank nursing as a prestigious career but recognized the nurse as a professional. Lee also found that the older the respondent the lower his/her confidence in the nurse to act independently in selected emergences. For example, in the event of a heart attack, 25.7% of the respondents under 30 years of age would feel comfortable with the nurse acting on her own while 16.9% of the over age 50 respondents would feel the same degree of confidence. In a subsequent report on the same study, Lee (1979a) documented strong resistance to nursing's expanded role from individuals aged 50 or over, from middle-income groups, from noncollege respondents, and from women. Data showed that groups in which respondents gave support for nursing's expanded roles included: $25,000 plus income (71.3%), college graduates (71.2%), professionals

(65.7%), under age 30 (63%). A clear majority of respondents believed nurses function best as assistants to the doctor (N = 666, 65.9%). Groups in which respondents said nurses work best as physician's colleagues included: $25,000 plus income (23.5%), college graduates (25.9%), farmer/laborer (25.0%), under age 30 (25.7%). In a similar survey involving physicians, Lee (1979b) found that the younger the physician, the more likely he viewed nurses as colleagues (i.e., respondents aged 35 and under = 22.3%, aged 36-50 = 17.0%, over age 50 = 13.0%).

One theme inherent through most of this work is that, as Lee (1979a) submitted, the public and physicians still want 'handmaidens.' However, the trend is changing, albeit at a snail's pace, toward a more autonomous professional image as evidenced primarily by younger, more educated individuals.

Influential Individuals

Other variables conjectured to influence consumer perceptions of nursing include personal experiences in the hospital and nurse acquaintances. In Alexander's 1979 public survey, 72.7% (N = 641) of the respondents had nurse acquaintances, but no statistical correlations were noted between this variable and their responses regarding their perception of nursing as professional versus technical.

Based on findings with liberal arts faculty, Woolley (1981) pointed out that the birth experience and physician's offices were two sources of poor impressions of nurses. One respondent, for example, stated the worst experience with a nurse occurred in a doctor's office where the nurse was "rude and efficious . . . no human interaction" (p. 465). Another respondent reported his experience with a nurse as "a nurse gave me a shot and she injected a half cc of air before the drug" (p. 465). Yet, on the whole, respondents could think of very few negative experiences and reported very positive experiences. This study however, did not make any statistical correlations between these types of experiences and the respondent's perceptions of nurses and nursing.

Lee (1979a), on the other hand, found that, of those not hospitalized within the past two years, 74% (N = 666) of the study respondents believed nurses were assistants to the doctor while 64% of those recently hospitalized held the same belief. Lee submitted that being in the hospital setting convinced at least some individuals that nurses do function independently and in collaboration with physicians.

With the explicit purpose of identifying influential factors affecting graduating high school females' perceptions of nursing, Lande (1966) found that a majority of the nursing aspirants (N = 177, 68%) believed personal

contacts with nurses had influenced them positively in their career choice. Eighty-six percent (N = 361) of the seniors who never contemplated a nursing career and 66% (N = 396) of the graduates who decided against nursing school felt unaffected by nurse contacts. Of the latter two groups, 9% and 15%, respectively, believed that their personal experiences with nurses had influenced them to reject the career. Reasons included their own limitations, negative features of nursing, and negative behavior of nurses. Speculating on these findings, Lande suggested that the importance of involvement of nursing professionals as sources of positive information for potential nursing students be emphasized in an effort to improve nurses' images of themselves. In a somewhat unstructured yet relevant report by Benton (1979), 10 masters prepared nurses told of having had no vocational counseling. Others reported discouragement from counselors, having been told that "it would be a waste of intellect; . . . it's not genius level work, . . . it fits in well with motherhood (pp. 388-389). Benton charged that such rigid definitions of nursing, whether held by guidance counselors, the consumer, or nurses, only deny the individual and the profession the right to attainment and regard as a respected occupation. Taken alone, these two studies have no special relevance to this research endeavor and its concern for public attitudes; however,

collectively they do serve to support the notion that exposure to nurses and nursing does exert some influence on one's perception of the profession as a whole. Due, however, to the lack of solid design and statistical analysis, these studies do not lend strong support to the hypothesis that past experiences with individuals highly influence perceptual formation of a given occupational sect.

Communication Media

The literature is replete with reports that address the issue of the mass media's influence on nursing's professional image. When discussing this concept, Kalish and Kalish (1980) conveyed that nurses are presented, misrepresented, and underrepresented in the news media and people's ideas on the nurse's place as it is and as it ought to be have been subsequently affected. In their exhaustive analysis of novels (1982c, 1983b, 1983c), movies (1982b, 1983d; Kalish, Kalish, & McHugh, 1982; Kalish, Kalish & Scobey, 1981), prime-time television broadcasts (1981, 1982a, 1983d; Kalish, Kalish, & Clinton), newspapers (Kalish & Kalish, 1981), and stage productions (Kalish & Kalish, 1983c), Kalish and Kalish and others asserted that depictions of nurses by these media sources have perpetuated the outmoded sexual stereotype bringing about a negative image. For example, content analysis of

3,098 newspaper articles about nursing in 1978 revealed that depictions of nurses in "subordinate relationships to physicians occurred 1.7 times more frequently than those in collegial relationships (Kalish & Kalish, 1981, p. 137). Likewise, the customary treatment of nurse characters in most hospital dramas has been far less than desirable, often nurses appeared merely as background scenery propelling wheelchairs and fetching meal trays (Kalish, Kalish, & Scobey, 1981). Similarly, Fernandes (1980) charged that television dramatizations have the power to shape public opinion and that T.V. has effectively established a divine image of the medical profession while simultaneously misrepresenting nursing. To illustrate, Marcus Welby's nurse, Consuelo, was portrayed as a "top-notch secretary . . . but had little to do with health care except for standing in awe of the star miracle worker" (Fernandes, 1980, p. 77). Fernandes is supported by Kalish and Kalish (1982a) through their content analysis of 320 television episodes (28 different series) from 1950 through 1980. In a randon sample of programs, Kalish and Kalish found that nurses scored higher on obedience, conformity, and permissiveness while physicians demonstrated higher levels of intelligence, sophistication, self-confidence, and ambition. In the 1970s, television audiences received highest exposure to technical nursing care. Depictions of nurses giving nursing care have

since declined (Kalish, Kalish, & Clinton, 1982).

This decline of nursing's image also is evidenced in novels and books (Ham, 1981; Holcomb, 1981; Hott, 1977; Kalish & Kalish, 1982c; Richter & Richter, 1974; VerSteeg, 1968). In a review of American literature, dated 19th century through 1981, Ham (1981) found that nurses were shown as peripheral to patient care, often portrayed simply as custodians. The one common denominator in these novels was that "[nurses] are involved with the care of the sick, although not essential to it" (p. 12). According to Kalish and Kalish (1982c), nursing has typically been portrayed as a technical occupation in novels. Through content analysis of 207 novels, Kalish and Kalish discovered that nursing's image improved during World War I, declined in postwar years, and again reached a positive level during World War II. The 1960s and 1970s, however, saw the regression of nursing's image to an all time low as evidenced in such novels as The Interns, Catch 22, and The House of God. Richter and Richter (1974) corroborate with these studies and charged that most books have focused on the allegiance of romance to nursing. They contended that many novels and books "may create expectations in would-be students of a kind of nursing education and nursing practice that does not exist" (p. 1281).

In a review of 54 romance novels centering around nurse characters, Muff (1982) found that the heroine nurse is often the source of many myths about nursing. Among the myths surrounding nursing is the belief that nurses depend entirely on physicians for direction. The "Dumb nurse" stereotype reinforces the public's belief that nurses cannot and should not function without the supervision of the benevolent physician. Muff submitted that popular fiction has consistently portrayed nursing as simplistic, and perhaps the most pervasive message delivered to the public was that "nurses are subservient and deferential" (Muff, 1982, p. 123).

Hughes (1980) also pointed out that "the public has been led to believe that any action by a nurse that had not been approved by a physician could result in harm to the patient" (p. 68). In a historical research study designed to analyze and increase understanding of the public view of the nurse and her role, Hughes (1980) reviewed secular magazines printed from 1896 to 1976. She found that much of the popular literature stressed the importance of a pleasing personality to the exclusion of intellectual requirements of nursing practice. Hughes reported evidence in magazine articles that people believed nurses "are born, not made" (p. 65). This belief led to the assumption by some hospital administrators that no amount of training or education could provide a woman with the

essential qualities of the ideal nurse. Hughes contended that depreciation of the role of the nurse by consumers has resulted from the belief that nurses are subordinate to physicians. The consumer has not realized that, with or without physician supervision, nursing care has always existed (Hughes, 1980).

Relationship of Influential Variables to Public Perceptions

While these investigations show that the media has failed to provide few positive images of nursing for the public to respect, these studies have not determined the relationship between these portrayals and consumer perceptions. Very few studies, in fact, have addressed this potential association. Beletz (1974) found that most of the respondents in her patient sample (N = 18, mean age = 30) felt television depictions were inaccurate. However, Beletz detected some commonalities between what patients had seen nurses doing in the hospital and what they described nurses doing on television. No statistical data were presented, but Beletz concluded that television was influential in a subtle way, sensitizing viewers to certain functions (i.e., taking doctors orders, serving meals, giving medications). When asked what had influenced their views, only 6% of the respondents in Lee's (1979b) survey cited television. The majority of these respondents formed their image of nurses from personal past experiences

with nurses in the doctor's office and the hospital.

Public Expectations of Nurses and Nursing

It is evident in these studies that nurses and nursing have been perceived to act and function in a variety of ways. Many of these conceptions were contradictory and, as Simmons (1962) suggested, a critical element in the reconciliation of image discrepancies is identifying the conflicts that exist between the ideals of nurses and those of the consumer. Moreover, Simmons stated that leaders should "distinguish and sustain the idealized image of its profession" (p. 18). Unfortunately, there have been no serious studies which have attempted to elicit consumer expectations with regard to nurses and nursing. A few studies have touched on this concept and point out some interesting trends and offer guidelines for this study.

Simmons (1962) cited a small study conducted by Jane Holliday on the idealistic image of the nurse. Holliday polled small groups of nurses and lay students, asking for ideal traits of nurses. The top four by rank order were well-trained, empathetic, efficient, and anticipative. Once again, this idealistic image blends two traditionally contrasting views--that of technical competence with personal compassion.

In a 1971 pilot study, Nehring and Geach (1973)

administered a pre and postoperative questionnaire to elective surgery patients (N not reported). The preoperative questionnaire was intended to compare professionals' expectations with patients' expectations regarding items of care. Surprisingly, patients often indicated that they did not expect many of the basic care items listed. Nehring and Geach observed a high degree of anxiety in the sample as they read care items such as "the nurse will check the fluid running into the needle in my arm or she will give me something for pain or discomfort" (p. 318). The investigators abandoned the preoperative study as a result of the anxiety present in their patient sample and due to fears expressed by patients that some item of care might not be administered to them regardless of their expectations. The postoperative questionnaire was constructed to determine if the patient had received items of care. Positive items such as "the nurse would explain X-rays or other procedures to me" (p. 318), were primarily identified as frequently occurring nursing actions and negative items such as "the nurse would seem angry when I asked her to do things for me" (p. 318), were universally identified as never occurring. Nehring and Geach reported that these responses were neither congruent with their observations nor off-the-record comments made by the patients. The investigators again concluded that the patients feared not receiving certain

aspects of nursing care based on their true responses. In light of these methodological limitations encounted by Nehring and Geach, this investigator designed a study which would facilitate open responses from the study participants. This study queried a nonpatient population based on the belief that expectations of nursing functions would be identified with less reluctance and fear of repercussions if respondents were not receiving nursing care.

Interview data, collected from three professional health disciplines at five Veteran's Administration hospitals in northern and central California, showed that there were marked differences among physicians, social workers, and registered nurses regarding the acute care functions of nurses in patient placement into convalescent care facilities (Habeeb & McLaughlin, 1977). Conducting face-to-face interviews, Habeeb and McLaughlin found that each discipline defined the role expectations of registered nurses differently and that expectations of each group tended to reflect their degree of experience and interactions with one another in the professional care setting. Social workers, for example, were more cognizant of the role functions of nurses due, in part, to close reciprocal relationships in developing their respective roles. On the other hand, some physicians (who often divorce themselves from working closely with nurses in

placement activities) revealed fewer expectations, describing placement functions in a traditional sense. Based on recent experiences, other physicians described clearer expectations having worked more closely with nurses in patient placement tasks. Interestingly, study data suggested that social workers supported expansion of the role of the nurse in the acute care setting while physicians supported expansion of the role of the nurse in community placement. One wonders if the expectations of professionals regarding nursing functions perhaps evolved out of their own specific professional role conceptions. For example, certain health care professionals may withhold personally desirable role functions from nurses and relinquish undesirable functions, or, withhold those functions perceived as a certain profession's area of expertise and relinquish those functions perceived as difficult with regard to personal capability. While this particular question was not raised by Habeeb and McLaughlin, the concept may hold some implications with regard to this study's analysis of expectations of nursing care by a variety of consumers including health care professionals.

In a 1978 public survey, Alexander asked a South Carolina consumer panel: "Should nurses be educated and trained to be professionals (to act independently and without direct supervision?" (p. 655). A vast majority

(71.5%) said yes (N = 641). Over half of the respondents (51.3%) believed nurses should have a bachelor's degree (consistent with beliefs of the profession), 41.3% expected two or three years beyond high school, 3.9% believed high school education to be adequate preparation, and 3.4% believed nurses should have a master's degree (Alexander, 1978). These data were, no doubt, colored by nurse respondents in the sample. Interestingly, however, nurse respondents believed in increased professionalism, but not in increased education for nurses. This study focused solely on educational expectations of consumers regarding nursing. No further functional expectations were elicited.

Lee (1979a) found that six out of 10 consumer respondents believed that "nurses should perform some procedures now done mainly by doctors" (p. 37) in order to reduce costs. Respondents believed nurses could do health screening and physical examinations, treat minor illnesses and deliver babies, take patient histories and perform tests, and make referrals. However, only two in 10 respondents conceived of the nurse working as a colleague to the doctor and merely 12% saw nursing as an independent profession. Lee submitted that the public has not recognized the fact that "the nursing process involves assessment, nursing diagnosis, planning, intervention, and evaluation of patient care" (p. 36).

Robinson (1978) found that, while consumers in general indicated a preference for traditional nursing services, a few of the respondents accepted such nursing functions as performing a physical examination, counseling, assisting in locating health resources, and patient advocacy as ideal nursing functions. While severely lacking in statistical presentation of the data, Robinson's study represents one of the few which directly addressed ideal nursing functions as differentiated from actual or perceived functions.

Summary

Nursing's public image has been studied quite amply with respect to perceived functions and attributes of nurses. Likewise, many studies have focused on variables which are thought to play a role in molding these conceptions. However, relationships between these variables and consumer perceptions of nursing care have not been clearly identified. The perceived images of nurses and the effect of certain variables on these images have been conflictual in comparing study findings. It should be pointed out that a number of the studies in this literature review were difficult to interpret because of methodological differences, nature of the sample and data collection, and inadequate statistical documentation.

Although some of the research studies have addressed

singular questions regarding expectations of nursing (i.e., educational expectations) there is no descriptive study available which considers what consumers of nursing care expect from nurses with regard to their functions and attributes. Consequently, the literature review failed to yield a tool for measuring consumer expectations.

Simmons (1962) believed that, essential to a scientific study of images is the identification of attributes and functions accorded to and expectations held toward members of the professional group of interest. Based on the paucity of nursing literature on consumer expectations of nursing attributes and functions, and the fact that former studies appear deficient in scientific methodology, it seemed imperative to this investigator to try to develop a tool which would:

1. delineate consumer expectations,

2. provide a meaningful conceptual framework around which these expectations can be evaluated and compared with those of the nursing profession, and

3. facilitate examination of the relationships between consumer expectations and various influential variables addressed in this literature review.

CHAPTER III

METHODOLOGY

Research Design

This was a descriptive study designed to identify the beliefs of adults regarding ideal nursing functions and attributes. The nursing profession's statements on practice standards and code of ethics were used to describe the nursing functions and attributes in the consumer questionnaire.

The study involved looking at the relationship of consumer ideal expectations of nursing attributes and functions to variables of sex, age, socioeconomic status, and past hospital patient experiences. Because personal characteristics such as the above have been shown to be related to a person's attitudes or beliefs, the study also described subsamples based on these study variables.

Setting and Subjects

The accessible population for this study was defined as potential or actual consumers of nursing services in a community of approximately 144,000. The survey sample consisted of 135 adults involved in a group activity (e.g., religious, community, and/or recreational

activities). The group members in the study ranged in age from 18 to 60 and above. Broad geographical range was sacrificed by the selection of a single midwestern metropolitan community. Individual groups indicated their willingness to participate by signing a letter of permission. Consenting adults indicated their willingness to participate by completing the questionnaires.

The sample technique utilized in this study was of a nonprobability sampling design. The sample subjects, obtained from consenting adult community and/or recreational groups, constituted a convenience sample. To better ensure representativeness, the investigator utilized information regarding the characteristics of potential groups (anticipated sex, age range, and socioeconomic level) in the selection of consenting groups.

The study intent was to describe subsamples consisting of females, males, and persons representing various socioeconomic positions. These variables, plus age, were considered in the selection of adult groups for participation in the study. A conservative interpretation of the results of this study are in order and replication of the study with new samples is recommended due to the representative limitations of a convenience sample.

Development of the Instruments

The study utilized two tools to determine the expectations of adults regarding attributes and functions of nurses and to determine the participants' past hospital experiences and certain demographic data.

Consumer Nursing Process and Attributes Questionnaire

A review of the literature failed to provide the investigator with an instrument designed to measure the expectations of individuals regarding nursing attributes and functions. Therefore, a questionnaire was developed by this investigator which was designed to elicit expectations from the sample subjects. The expectations listed were based on professional standards and codes formulated by The American Nurses' Association. The questionnaire was submitted to a group of graduate nursing students for their input concerning the appropriateness and adequacy of the content coverage as well as the consistency in which the questionnaire reflected the Standards of Practice (1973) and Code of Ethics (1976). These graduate nursing students represented a wide range of clinical specialties and experiential backgrounds. The group assisted the investigator in identifying any inconsistencies in the questionnaire as well as identifying categories of responses based on The American Nurses' Association's Standards of Practice and Code of Ethics.

The categories identified with regard to nursing functions were: (a) nursing assessment, Standard I; (b) nursing diagnosis, Standard II; (c) planning nursing care, Standards III and IV; (d) nursing interventions, Standards V and VI, and (e) nursing evaluation, Standards VII and VIII. The categories identified with regard to nursing attributes were: attributes related to: (a) respect for human dignity and individuality (Code 1); (b) respect for confidential information and the safeguarding of clients against incompetence, unethical or illegal practices (Codes 2 and 3); (c) accountability for nursing judgments and actions (Codes 4, 5, and 6); (d) active participation to improve nursing care (Codes 7, 8, and 9); and (e) respect for consumer rights for correct information and adequate health care (Codes 10 and 11). To assure a balanced representation of the standards and codes, at least three items were developed for each category. Some categories, however, such as nursing interventions, received greater representation in order to cover important aspects of nursing. Six negatively stated items were included as the representative items to validate congruency of respondent answers.

Initially, 27 nursing functions representing the eight standards and 29 attributes representing the 11 code statements were presented to the 10 graduate students who were asked to identify under which category the items

belonged. Responses helped to determine which items were ambiguously worded and problematic in categorizing. Items not reaching a 50% level of agreement between respondents were either discarded or reworded. Newly worded items were then submitted a second time to the same graduate students who again categorized the items. Eight students responded and agreement percentages were calculated. Those items reaching a 50% level of agreement as to categorization were retained for inclusion in the questionnaire. Ultimately, 29 nursing functions and 28 nursing attributes comprised the instrument. Refer to Tables 1 and 2 for the categories and representative items. Tables 3 and 4 show the percent agreement for assignment of each statement to a function/attribute category.

Table 1

Items Representing ANA Standards of Practice

Standard I (Assessment)

1. Give me a physical exam (i.e., check my lungs, heart, vision, etc.).
2. Ask me about my health history (i.e., this includes things like checking how well I sleep, my diet habits, if I'm depressed).
3. Interview my family or significant other people regarding my health.
4. Write a complete report of my health status.
5. Record my health status so that others involved in my care will be informed of my condition.

Standard II (Diagnosis)

6. Based on my physical exam and health history, develop nursing diagnoses (i.e., pain, potential for bed sores).
*7. Determine if I have a certain disease according to my physical problems (i.e., if I have a fever and cough the nurse should determine if I have pneumonia).
8. Identify problems which could develop during the course of my illness (i.e., potential allergic reaction to medication, potential for infection).

Standards III & IV (Planning)

9. Provide a clean and safe environment for my care.
10. Utilize current scientific knowledge in planning and providing my nursing care.
11. Set goals for comforting me if I am in pain.
12. Plan my nursing care so that the goals for my getting well agree with the doctor's orders.
13. Plan my nursing care by deciding which of my health problems need attention first.
14. Decide what kind of nursing care I need in order for me to reach my goals for improved health.

Standards V & VI (Intervention)

15. Plan nursing actions that are individualized for me such as give me a bath in the evening if that's what I prefer.
*16. Let me find my own ways of caring for myself at home.
17. Help me find ways to care for myself at home.
18. Help me learn how to cope with stress.
19. Help me define how I should increase my exercise if need be.
*20. Let me deal with my own emotional and family problems.
*21. Let the doctor teach me about my body and my illness.
22. Provide me with needed information so I can decide how to restore and maintain my health.
23. Utilize opportunities for teaching me how to care for myself.
24. Help me utilize community health resources.

Standards VII & VIII (Evaluation)

25. Determine if I am getting better.
26. Change my nursing care if I am not getting better.
27. Keep me informed about my health status.
28. Determine if I am not making progress with my emotional or family problems and possibly refer me to a counselor.
29. Allow me to determine if the nursing care I am receiving is helping me.

*Indicates negatively stated items.

Table 2

Items Representing ANA Code of Ethics

Code 1

1. Not impinge on my spiritual beliefs which may direct the type of care I accept.
2. Give me care regardless of my ability to pay.
3. Be compassionate, kind, and caring regardless of the nature of my illness.
4. Respect my wishes and personal values when I am faced with dying.

Codes 2 & 3

*5. Share my health information with anyone she/he desires.
6. Report incompetent individuals.
7. Report unethical and illegal products.
*8. Not share information about my health status with anyone.
9. Obtain my consent for other people to review my records for research purposes.
10. Discuss my case with only those individuals involved in my care.

Codes 4, 5, & 6

11. Be able to explain what they do and why.
12. Keep up their knowledge and skills.
13. Use good judgment when assigning my care to others.
14. Be responsible for the care I receive.
*15. Be able to administer my medications properly without ever consulting with the pharmacist.
16. Be able to decide if my doctor needs to be notified of any problems or changes in my health status.
17. Attend classes and workshops in order to keep current with new health developments.
18. Consult with other qualified nurses when my needs are beyond the abilities of the nurse.

Codes 7, 8, & 9

19. Participate in activities which up-grade nursing care.
20. Be involved in research activities which will improve patient care.
21. Be responsible for the education of student nurses.
22. Participate in determining the terms and conditions of employment of nurses.
23. Evaluate one another's performance.

Codes 10 & 11

24. Advise me against the use of dangerous health products.
25. Write to legislators regarding health care issues.
26. Provide me with information regarding a variety of health products or services so I can decide which ones to use.
27. Report advertisements or commercials which misinform the public.
28. Work with others (doctors, social workers, physical therapists) to provide health care to all individuals.

*Indicates negatively stated items.

Table 3

Instrument Categorization of American Nurses' Association Standard Items by Agreement Percentages

Item	% Agreement
Standard I	
1	100.0
2	100.0
3	100.0
4	70.0
5	75.0
Standard II	
6	100.0
7	75.0
8	50.0
Standards III & IV	
9	57.0
10	66.0
11	85.7
12	50.0
13	87.5
14	87.5
Standards V & VI	
15	70.0
16	90.0
17	70.0
18	100.0
19	100.0
20	80.0
21	57.0
22	90.0
23	66.0
24	88.0
Standards VII & VIII	
25	100.0
26	100.0
27	50.0
28	75.0
29	50.0

Note. Cummulative Percentage = 80%

Table 4

Instrument Categorization of American Nurses' Association Code Items by Agreement Percentages

Item	% Agreement
Code 1	
1	90.0
2	90.0
3	88.0
4	75.0
Codes 2 & 3	
5	80.0
6	90.0
7	90.0
8	100.0
9	100.0
10	90.0
Codes 4, 5, & 6	
11	85.0
12	90.0
13	100.0
14	90.0
15	100.0
16	100.0
17	80.0
18	80.0
Codes 7, 8, & 9	
19	100.0
20	100.0
21	80.0
22	100.0
23	50.0
Codes 10 & 11	
24	77.0
25	100.0
26	55.0
27	88.0
28	87.5

Note. Cummulative Percentage = 88%

Once the instrument was devised, the reliability of the tool was established by the test-retest procedure. A description of the study and the questionnaire were presented to 10 adults. Each respondent was instructed to complete the questionnaire and, upon returning the first questionnaire, a second administration of the tool was accomplished. A minimum of 72 hours elapsed from the first administration of the tool before the second tool was delivered. Percentage of agreement between the two tests was calculated for each respondent to determine reliability of the instrument. The responses for the first and second administration of the questionnaire for each subject were then computed into percentages (reflecting the percent of responses marked the same for each test). The results are shown in Tables 5 and 6.

Demographic Questionnaire

The individual characteristics of sex, age, socio-economic status, and past hospital experiences as a patient (with nurses and nursing care) were measured by a demographic questionnaire developed by this investigator. Pretesting the entire questionnaire with 10 adults facilitated establishing the approximate amount of time required to complete the tool (15-20 minutes). Comments from the test-retest group were utilized to improve the comprehensibility of the demographic questions.

Table 5

Test-Retest Reliability for Items Representing ANA Standards of Practice

Item	% of Response Agreement Between Tests
Standard I	
1	70
2	100
3	60
4	90
5	100
Standard II	
6	30
7	70
8	90
Standards III & IV	
9	100
10	90
11	90
12	100
13	70
14	80
Standards V & VI	
15	80
16	60
17	70
18	80
19	50
20	40
21	50
22	80
23	90
24	80
Standards VII & VIII	
25	50
26	70
27	50
28	70
29	80

Note. Cummulative Percentage = 74%

Table 6

Test-Retest Reliability for Items Representing ANA Code of Ethics

Item	% of Response Agreement Between Tests
Code 1	
1	50
2	80
3	90
4	100
Codes 2 & 3	
5	80
6	60
7	100
8	60
9	100
10	90
Codes 4, 5, & 6	
11	90
12	100
13	90
14	80
15	80
16	100
17	100
18	100
Codes 7, 8, & 9	
19	100
20	90
21	70
22	70
23	70
Codes 10 & 11	
24	80
25	70
26	60
27	70
28	100

Note. Cummulative Percentage = 83%

With permission from the author, the variable of socioeconomic status was measured by the Hollingshead Four Factor Index of Social Status (Hollingshead, 1975). This index utilizes the factors of sex, marital status, education, and occupation to determine the social position which the individual occupies. The status score of an individual is determined by multiplying the scale value for education by a weight of three and the scale value for occupation by a weight of five. The Four Factor Index categorizes marital status to include individuals who have never married, divorced persons, and persons who are widowed. The instument also includes methods for calculating the status scores of retired persons. In utilizing the index, "computed scores range from a high of sixty-six to a low of eight" (Hollingshead, 1975, p. 19), and it is assumed that higher scores for individuals or family units represent higher social positions accorded to them by other individuals of our society. Hollingshead has analyzed the index for validity; in part, validity was established by comparing the scores for occupational groups in the Four Factor Index with scores developed by the National Opinion Research Center. Hollingshead reported that the Pearson-r coefficient between the nine-step occupational scale and the National Opinion Research Center scores was $r = 0.927$.

In calculating the status scores of the study

respondents, certain assumptions were made regarding occupation. A number of subjects were vague in stating their specific occupations; thus, this investigator had difficulty assigning these occupational titles to the nine-step scale designed by Hollingshead. Wherever possible, the subjects' occupational titles were scaled according to their educational level. For example, since the scale delineated precise occupations (teacher, college/university versus teacher, secondary school), subjects who did not clarify their teaching positions were assigned to a certain step on the occupational scale based on their years of education.

Computed scores, based on education and occupation, were assigned to one of five major social strata described by Hollingshead. These social strata are illustrated in Table 7 (Hollingshead, 1975). For purposes of analysis in this study, each stratum was assigned a number from one to five--five representing the highest social stratus and one representing the lowest social position (see Table 7).

Table 7

Social Strata Described by Hollingshead

Social Strata	Range of Computed Scores
5--Major business and professional	65 - 55
4--Medium business, minor professional, technical	54 - 40
3--Skilled craftsmen, clerical, sales workers	39 - 30
2--Machine operators, semiskilled workers	29 - 20
1--Unskilled laborers, menial service workers	19 - 08

Procedure for Data Collection

Distribution of the questionnaire was accomplished through face-to-face administration of the instruments to nine adult groups. This method lent itself to greater cooperation of the respondents in that some form of personal contact has been shown to result in higher completion rates than is normally the case for surveys that totally rely on mail contact (Polit & Hungler, 1978). The investigator attended selected group meetings, introduced the participants to the study and questionnaires, and invited group members to complete the assessment tools.

Potential respondents also were introduced to the study through a cover letter attached to each questionnaire (see Appendix E). The cover letter explained the purpose of the study, identified contributions the study would make toward improving nursing care, and included instructions for completing the questionnaire. Participation was voluntary and respondents were assured of their anonymity through coding of the questionnaires. Participants from three of the groups chose to complete the instruments during the scheduled meeting time. The other groups elected to complete the questionnaires at home and return them at the next scheduled group meeting one week later. The completed questionnaires were then collected in manila envelopes to further protect respondent anonymity.

Procedures for Data Analysis

Demographic Data were utilized to describe the total sample and identify socioeconomic status according to Hollingshead's Four Factor Index of Social Status (1975). Information from the Demographic Questionnaire was utilized to categorize consumers with regard to past experiences with nurses and nursing care; that is, the number, recency, and quality of the experience (highly positive/numerous experiences, highly positive/minimal experience, highly negative/numerous experiences, and

highly negative/minimal experience). The data obtained from the Consumer Nursing Process and Attributes Questionnaire were coded into categories of attributes and functions as derived from The American Nurses' Association's Standards of Practice (1973) and Code of Ethics (1976).

Attitudinal and functional expectations were identified using a Likert scale whereby respondents were asked to agree or disagree, on a five-dimension scale, with statements regarding ideal nursing functions and attributes. Percentages, frequency distributions, and mean agreement scores were employed in addressing the question of congruency between consumer and professional expectations. Chi-square contigency tests were utilized to compare the variables of the categories of attributes and functions with sex, age, socioeconomic status, and past experience of the subjects.

Statement of Risk

The study design is such that the investigator anticipated essentially no risks to the participants. The participants gave voluntary consent and were allowed to withdraw from the study at any time. Raw data were reviewed only by the investigator and only group data have been reported.

CHAPTER IV

PRESENTATION, ANALYSIS, AND DISCUSSION OF DATA

The purpose of this descriptive study was to examine the public image of nursing by identifying consumer expectations of nursing functions and attributes, to determine if certain characteristics were related to consumer expectations, and to compare these expectations to those set forth by the nursing profession. The four research questions that were asked were:

1. Are consumers' expectations of nursing functions and attributes congruent with the profession's expectations of nursing functions, as defined by The American Nurses' Association's Standards of Nursing Practice; and nursing attributes, as defined by The American Nurses' Association's Code of Ethics?
2. Do consumers' expectations of nurses vary with consumers' past hospital experiences with nurses and nursing care?
3. Do consumers' expectations of nursing functions and attributes vary with the individual characteristics of gender and age?
4. Do consumers' expectations of nursing functions and attributes vary with the individual

characteristic of socioeconomic status?

This chapter includes the analysis of the data collected for this study and a description of the sample.

Profile of the Sample

One hundred eighty-three consumers were invited to participate in completing the questionnaire. Of the 141 (77%) consumers who responded, 135 (95.7%) met the criteria of the study. Reasons for exclusion of the six respondents from the study were incomplete questionnaire (two) and occupation (four nurse respondents). Criteria for exclusion of incomplete questionnaires consisted of omission of responses to more than two demographic questions or more than four function or attribute statements--other than in cases where omissions were appropriate. Of the total number of questionnaires distributed, 73.8% were utilized in the study. The 135 consumers represented nine groups involved in community, religious, recreational, or employment-related activities.

There were more female respondents (57.8%) represented in the sample than male respondents (42.2%). The greatest number of subjects (34.1%) were between the ages of 29 to 39 years followed by 24% in the 40 to 50 year age range. The least number of subjects (9.3%) were 62 years of age or above followed by 12.4% in the 51 to 61 year age range. A description of the distribution of the subjects by age

and sex can be found in Table 8.

Table 8

Distribution of Responses by Age and Gender

N = 135

Age	n	%	Males/ Age Group		Females/ Age Group	
			n	%	n	%
18-28	26	20.2	9	34.6	17	65.4
29-39	44	34.1	19	43.2	25	56.9
40-50	31	24.0	11	35.5	20	64.5
51-61	16	12.4	9	56.3	7	43.8
62+	12	9.3	6	50.0	6	50.0
TOTAL	129*		54		75	

*N = 135. The total numbers do not equal N due to some respondents not answering the question of age.

The largest percentage of subjects (62.4%) were classified under the social strata of major or medium business/major or minor professionals. Twenty-one percent were classified as unskilled or semiskilled workers while 16.5% of the subjects were classified as skilled workers. Of the five major social strata, the fourth stratum (Medium business, minor professional, technical)

constituted the mode and median points on the strata scale. The mean stratum score was 3.57 and the range of scores was four (highest stratum value = 5, lowest stratum value = 1). Seventy-five percent (upper quartile) of the subjects were classified below the fourth stratum while 25% (lower quartile) were classified below the third stratum (Skilled craftsmen, clerical sales workers). Within the 18 to 28 years age range, the largest percentage (42.3%) of subjects were semiskilled workers. The largest percentage (54.6%) in the 29 to 39 year age range were medium business and/or minor professionals as were the majority of the subjects in the 40 to 50, 51 to 61, and 62 or above age ranges (32.3%, 66.7%, and 36.4%, respectively). Table 9 shows the data on the distribution of respondents by age and socioeconomic status.

There was a wide range of educational levels of the respondents. The largest percentage (29.6%) had completed from one to four years of college while the next largest percentage (20.7%) had completed high school. Of the remaining subjects, 11.9% had a graduate degree, 8.2% had completed one to three years of high school, and one subject (0.7%) had less than a seventh grade education. A summary description of the above demographic characteristics of the sample can be found in Table 10.

Table 9

Distribution of Responses by Age and Socioeconomic Status

(N = 135)

Age	n	Stratum 1[a]		Stratum 2[a]		Stratum 3[a]		Stratum 4[a]		Stratum 5[a]	
		n	%[b]	n	%[b]	n	%[b]	n	%[b]	n	%[b]
18-28	26	4	15.4	11	42.3	7	26.9	3	11.5	1	3.9
29-39	44	0	0.0	2	4.6	5	11.4	24	54.6	13	29.6
40-50	31	2	6.5	4	12.9	7	22.6	10	32.3	8	25.8
51-61	15	0	0.0	0	0.0	1	6.7	10	66.7	4	26.7
62+	11	3	27.3	1	9.1	2	18.2	4	36.4	1	9.1
TOTAL	127*	9		18		22		51		27	

*N = 135. The total numbers do not equal N due to some respondents not answering the questions of age and socioeconomic status.

[a]1 = Unskilled Laborers, Menial Service Workers
2 = Machine Operators, Semiskilled Workers
3 = Skilled Craftsmen, Clerical Sales Workers
4 = Medium Business, Minor Professional, Technical
5 = Major Business and Professional

[b]Represents percentage of respondents in each age group who fall in a certain stratum.

Table 10

Demographic Characteristics of the Sample

(N = 135)

	n	%**		n	%**
Age			**Social Stratum**		
18-28	26	20.2	Major Business and Professional	31	23.3
29-39	44	34.1	Medium Business, Minor Porfessional, Technical	52	39.1
40-50	31	24.0	Skilled Craftsmen, Clerical Sales Workers	22	16.5
51-61	16	12.4	Machine Operators, Semiskilled Workers	19	14.3
62+	12	9.3	Unskilled Laborers, Menial Service Workers	9	6.8
TOTAL =	129*		TOTAL =	133*	
Gender			**Years of Education**		
Male	57	42.2	Less than 7th Grade	1	0.7
			9th Grade	4	3.0
Female	78	57.8	Partial High School (10th or 11th grade)	7	5.2
			High School Graduate	28	20.7
TOTAL =	135		Partial College (at least one year or special training)	51	37.8
			College or University Graduate (4 years)	28	20.7
			Graduate Degree	16	11.9
			TOTAL =	135	

*N = 135. The total numbers do not equal due to some respondents not answering the questions of age and socioeconomic status.

**The total percentages do not always equal 100 due to the rounding of the numbers.

Profile of Consumers' Past Experiences with Nurses and Nursing Care

The past experiences of consumers with nurses and nursing care were addressed in questions one through nine on the demographic questionnaire. A summary of the findings to each of those questions will follow.

The majority (82.2%) of the subjects had never worked as a hospital volunteer. Seven (5.2%) of the subjects were volunteers at the time of the study while 17 (12.6%) had done volunteer work in the past. An overwhelming majority (92.6%) of respondents had been hospitalized at some point in time. Only 10 (7.4%) had never been a patient. Of the subjects in the 18 to 28 year age range, the largest percentage (56.5%) had been a patient two to five times and 43.5% in this age range had been a patient more than five years ago. Likewise, the data in each age range showed the largest percentage of subjects experienced hospitalization two to five times and the largest percentage were patients more than five years ago. Table 11 illustrates the distribution of respondents by age and hospital experiences.

The health care consumers in this study identified the setting(s) in which they had received nursing care as presented in Table 12. Many subjects identified more than one setting; therefore, the percentages were based on a

Table 11

Distribution of Responses by Age and Hospital Experience

(N = 135)

Hospital Experience	n	%	Age Ranges 18-28 n	%	29-39 n	%	40-50 n	%	51-61 n	%	62+ n	%
Number of Experiences												
1	26	21.5	8	34.8	6	14.6	8	25.8	3	18.8	1	10.0
2-5	73	60.3	13	56.5	30	73.2	15	48.4	7	43.8	8	80.0
5+	22	18.2	2	8.7	5	12.2	8	25.8	6	37.5	1	10.0
TOTAL = 121*												
Recency of Experience												
Within past year	27	22.3	6	26.1	6	14.3	7	22.6	5	31.3	3	33.3
2-5 years ago	33	27.3	7	30.4	17	40.5	4	12.9	3	18.8	2	22.2
5+years ago	61	50.4	10	43.5	19	45.2	20	64.5	8	50.0	4	44.4
TOTAL = 121*												

*N = 135. The total numbers do not equal N due to some respondents not answering the questions of age and past hospital experience, and due to 10 respondents never having been hospitalized.

Note. Percentages designated by % represent respondents in each category of past hospital experience who fall in a certain age group.

Table 12

Settings for Previous Nursing Care and Quality of the Experience

(N = 135)

		n	%
Setting			
ICU/CCU		14	8.1
Emergency Room		39	22.7
Medical-Surgical Unit		101	58.7
Home Care Setting		2	1.2
Maternity		13	7.6
Neurology		1	0.6
Radiology		1	0.6
Outpatient Surgery		1	0.6
	TOTAL	172*	
Quality of Experience			
Positive		123	96.8
Negative		4	3.2
	TOTAL	127**	

*N = 135. The total number does not equal N due to multiple responses.

**N = 135. The total number does not equal N due to exclusion of some responses which were contradictory (i.e., "all positive" and "all negative" marked in the same response set).

Note. Percentages do not equal 100 since multiple responses were an option in the response set.

total of 172 responses. The largest percentage (58.7%) of subjects had received nursing care on a medical-surgical unit followed by 22.7% in the emergency room. Other settings included intensive or coronary care (8.1%) and home care (1.2%). Subjects wrote-in the following additional settings: (a) maternity, 7.6%; (b) neurology, 0.6%, (c) radiology, 0.6%; and (d) outpatient surgery, 0.6%. The majority (96.8%) of the consumers viewed their experience(s) with nursing as positive while 3.2% considered their experience(s) as negative.

Of the multiple responses (167) regarding nurse acquaintances, 46.1% of the respondents had one or more friends who were nurses, 36.6% had a relative or immediate family members, and 17.4% had no personal nurse acquaintances. Of the 106 subjects who did have nurse acquaintances, 61.3% believed they had an average understanding of what nurses do followed by 21.7% who believed they knew more than most. Seventeen percent believed they knew nothing, or very little, about the nurse's role.

Of the 126 responses, 61 (48.4%) subjects believed their past experiences as a patient had influenced their image of nurses the most. The second largest percentage (20.6%) believed their nurse acquaintances had affected their image of nurses while 9.5% of the subjects were influenced by television and movies. The hospital experience of family members was a source of information

about nursing for 7.1% of the subjects (see Table 13).

Table 13

Distribution of Responses by Nurse Acquaintances, Knowledge of the Nurse's Role, and Variables Influencing Their Images of Nursing

(N = 135)

Variable	n	%
Nurse Acquaintances		
No personal nurse acquaintances	29	17.4
Immediate family member	23	13.8
One or more friends	77	46.1
A relative (i.e., cousin, aunt)	38	22.8
TOTAL =	167*	
Knowledge of Nurse's Role		
Know nothing to very little	18	17.0
Have an average understanding	65	61.3
Know more than most	23	21.7
TOTAL =	106**	
Influencial Variables		
Television/Movies	12	9.5
Personal Hospital Experiences	61	18.4
Novels/Books	0	0.0
Nurse Acquaintances	26	20.6
Personal Experience Outside Hospital	9	7.1
TOTAL =	126***	

*The total number does not equal N due to multiple responses.

**The total number does not equal N due to some respondents not having personal nurse acquaintances.

***The total number does not equal N due to exclusion of some responses which were not congruent with the instructions to mark "the one most influential" source of information about nursing.

Consumer Expectations of Nursing Functions

To make the comparison of consumer expectations to professional expectations meaningful, it was necessary to examine each nursing function relevant to the ANA Standards of Practice in light of the data collected. The data are presented in Table 14.

Standard I

The collection of data about the health status of the client/patient is systematic and continuous. The data are accessible, communicated, and recorded.

1. Give me a physical exam (i.e., check my lungs, heart, vision, etc.).

The largest percentage (49.6%) of consumers disagreed with this statement while 35.6% would expect nurses to do a physical assessment. Twenty (14.8%) consumers were uncertain.

2. Ask me about my health history (i.e., this includes things like checking how well I sleep, my diet habits, if I'm depressed).

The majority (85.2%) of the subjects expected nurses to do a health history; 7 (5.2%) would not and 13 (9.6%) were uncertain.

3. Interview my family or significant other people regarding my health.

Table 14

Distribution of Responses by Frequency of Agreement and Disagreement with Nursing Functions as Defined by The ANA Standards of Practice

(N = 135)

Nursing Functions	Agree		Disagree		Uncertain	
	n	%	n	%	n	%
Standard I						
1. Give me a physical exam (i.e., check my lungs, heart, vision, etc.).	48	35.6	67	49.6	20	14.8
2. Ask me about my health history (i.e., this includes things like checking how well I sleep, my diet habits, if I'm depressed).	115	85.2	7	5.2	13	9.6
3. Interview my family or significant other people regarding my health .	63	46.7	37	27.4	35	25.9
4. Write a complete report of my health status.	70	51.9	35	25.9	30	22.2
5. Record my health status so that others involved in my care will be informed of my condition.	123	91.1	7	5.2	5	3.7
Standard II						
1. Based on my physical exam and health history, develop nursing diagnoses (i.e., pain, potential for bed sores).	70	54.2	24	18.6	35	27.1
*2. Determine if I have a certain disease according to my physical problems (i.e., if I have a fever and cough, the nurse should determine if I have pneumonia).	17	12.7	91	67.9	26	19.4
3. Identify problems which could develop during the course of my illness (i.e., potential allergic reaction to medication, potential for infection.	106	78.5	13	9.6	16	11.9
Standards III and IV						
1. Provide a clean and safe environment for my care.	127	94.1	5	3.7	3	2.2
2. Utilize current scientific knowledge in planning and providing my nursing care.	109	81.4	6	4.5	19	14.2
3. Set goals for comforting me if I am in pain.	116	86.0	8	5.9	11	8.1
4. Plan my nursing care so that the goals for my getting well agree with the doctor's orders.	120	88.9	7	5.2	8	5.9
5. Plan my nursing care by deciding which of my health problems need attention first.	75	55.5	39	28.9	21	15.6
6. Decide what kind of nursing care I need in order for me to reach my goals for improved health.	87	64.9	18	13.4	29	21.6
Standards V and VI						
1. Plan nursing actions that are individual for me such as give me a bath in the evening if that's what I prefer.	73	54.1	31	23.0	31	23.0
*2. Let me find my own ways of caring for myself at home.	39	28.9	64	47.4	32	23.7
3. Help me find ways to care for myself at home.	110	82.7	7	5.3	16	12.0
4. Help me learn how to cope with stress.	99	74.4	13	9.8	21	15.8
5. Help me define how I should increase my exercise if need be.	96	71.2	12	8.9	27	20.0
*6. Let me deal with my own emotional and family problems.	35	26.1	46	34.3	53	39.6
*7. Let the doctor teach me about my body and my illness.	69	51.5	21	15.6	44	32.8
8. Provide me with needed information so I can decide how to restore and maintain my health.	104	78.2	9	6.8	20	15.0
9. Utilize opportunities for teaching me how to care for myself.	118	87.4	3	2.2	14	10.4
10. Help me utilize community health resources.	106	79.7	6	4.5	21	15.8
Standards VII and VIII						
1. Determine if I am getting better.	55	40.8	41	30.4	39	28.9
2. Change my nursing care if I am not getting better.	98	73.1	23	17.2	13	9.7
3. Keep me informed about my health status.	89	65.9	25	18.5	21	15.6
4. Determine if I am not making progess with my emotional or family problems and possibly refer me to a counselor.	56	41.8	40	29.9	38	28.4
5. Allow me to determine if the nursing care I am receiving is helping me.	77	57.5	16	11.9	41	30.6

*Indicates negatively stated items.

While the majority (85.2%) of the consumers expected nurses to do a health history, only 46.7% expected nurses to obtain information from family members. Thirty-seven (27.4%) consumers would not want nurses interviewing family members and nearly as many (25.9%) were unsure. Several consumers wrote-in "if I am unable" beside the statement. Other consumers may have had similar beliefs which could account for the low percentage of agreement. The data for this statement also corresponded with a low test-retest percentage of agreement (60%).

4. Write a complete report of my health status.

Thirty-five (25.9%) respondents did not expect nurses to document their assessment findings while 70 (51.9%) respondents believed nurses should; 30 (22.2%) were uncertain.

5. Record my health status so that others involved in my care will be informed of my condition.

When stated in a different fashion, the question of documentation received a significantly larger percentage (91.1%) of agreement. Seven (5.2%) consumers still did not expect nurses to record their findings and 5 (3.7%) remained uncertain. Less indecision of consumers regarding this nursing function also was evident in a high test-retest percentage of agreement (100%).

Standard II

Nursing diagnoses are derived from health status data.

1. Based on my physical exam and health history, develop nursing diagnoses (i.e., pain, potential for bed sores).

Seventy (54.2%) consumers agreed with this statement. Twenty-four (18.6%) did not expect nurses to develop nursing diagnoses and 35 (27.1%) of the consumers were undecided--suggesting that nursing diagnosis was either a new concept to these consumers or that 'diagnosing' is a function of the physician. Consumer indecision regarding this statement was also reflected in the low test-retest percentage of agreement (30%).

2. Determine if I have a certain disease according to my physical problems (i.e., if I have a fever and cough the nurse should determine if I have pneumonia).

The largest percentage (67.9%) of respondents did not expect nurses to make medical diagnoses while 12.7% of the respondents believed nurses should determine if a disease were present. Twenty-six (19.4%) respondents were uncertain. Again, these data suggest a diversity of expectations regarding the diagnostic function of nurses and possibly reflect the overall indecision of these consumers on this issue. The data for this statement

also corresponded with a low test-retest percentage of agreement (70%).

3. Identify problems which could develop during the course of my illness (i.e., potential allergic reaction to medication, potential for infection).

When stated in a slightly different manner, the expectation of developing nursing diagnoses elicited a larger percentage (78.5%) of agreement from these consumers. In comparison with statement one, significantly fewer (9.6%) consumers disagreed and 11.9% were undecided.

Standard III

The plan of nursing care includes goals derived from the nursing diagnoses; and

Standard IV

The plan of nursing care includes priorities and the prescribed nursing approaches or measures to achieve the goals derived from the nursing diagnoses.

1. Provide a clean and safe environment for my care.

The majority (94.1%) of the consumers agreed with this nursing function. Five (3.7%) consumers did not expect nurses to provide a clean and safe environment while 2.2% were uncertain. The test-retest percentage of agreement (100%) also indicated less indecision of consumers regarding this nursing function.

2. Utilize current scientific knowledge in planning and providing my nursing care.

The majority (81.4%) of the subjects expected nurses to plan and provide care based on current scientific knowledge. Six (4.5%) subjects did not expect nurses to draw on scientific knowledge while 14.2% were undecided.

3. Set goals for comforting me if I am in pain.

Eighty-six percent of the consumers believed nurses should establish goals for decreasing the consumer's pain. Eight (5.9%) consumers did not expect nurses to set goals for pain relief while 11 (8.1%) could not decide.

4. Plan nursing care so that the goals for my getting well agree with the doctor's orders.

The largest percentage (88.9%) of subjects agreed that nursing care goals should be congruent with the physician's orders while 5.2% disagreed. Eight (5.9%) subjects were uncertain. Less consumer indecision regarding this nursing function was also evident in a high test-retest percentage of agreement (100%).

5. Plan my nursing care by deciding which of my health problems need attention first.

The largest number (75, 55.5%) of consumers expected nurses to prioritize nursing care; however, 39 (28.9%) did not; 21 (15.6%) were undecided. The data for this statements also corresponded with a low test-retest percentage of agreement (70%).

6. Decide what kind of nursing care I need in order for me to reach my goals for improved health.

Eighty-seven (64.9%) consumers expected nurses to determine the type of nursing care needed for the consumers to improve their health. Eighteen (13.4%) consumers did not grant this function to nurses and an even larger number (29, 21.6%) were uncertain. The data suggests that consumers have difficulty deciding if nurses should designate and prioritize nursing care without direction from the physician.

Standard V

Nursing actions provide for client/patient participation in health promotion, maintenance and restoration; and

Standard VI

Nursing actions assist the client/patient to maximize his health capabilities.

1. Plan nursing actions that are individual for me such as give me a bath in the evening if that is what I prefer.

Twenty-three percent of the subjects did not expect their care to be individualized and an equal percentage were uncertain. The remaining subjects (73, 54.1%) did expect their care to be geared toward their needs and preferences.

2. Let me find my own ways of caring for myself at home.

Sixty-four (47.4%) respondents disagreed with this item while 39 (28.9%) agreed that they should be in charge of their care at home. Thirty-two (23.7%) respondents were undecided. Consumer indecision regarding this statement was also reflected in the low test-retest percentage of agreement (60%).

3. Help me find ways to care for myself at home.

When reworded in a positive direction, the above item elicited a much larger percentage (82.7%) of agreement. Few respondents (5.3%) believed home care should be their individual responsibilities and only 12% were uncertain. Stated in this manner, this item appeared to be less perplexing to the respondents.

4. Help me learn how to cope with stress.

The largest percentage (74.4%) of consumers believed that nurses should help them cope with stress while 9.8% did not expect nurses to assist them; 21 (15.8%) were undecided.

5. Help me define how I should increase my exercise if need be.

Ninety-six (71.2%) consumers expected this teaching function of nurses. Twelve (8.9%) consumers did not expect help in defining an exercise program while 20% were uncertain. The agreement percentage (50%) for test-retest also showed greater indecision of consumers regarding this statement.

6. Let me deal with my own emotional and family problems.

Fifty-three (39.6%) respondents were not certain about their expectations regarding the psychosocial aspects of nursing care. Thirty-five (26.1%) respondents agreed that they should cope with their own psychosocial problems; approximately one-third (34.3%) expected nurses to assist them. Consumer indecision regarding this statement also was reflected in the low test-retest percentage of agreement (40%).

7. Let the doctor teach me about my body and my illness.

Slightly more than one-half (51.5%) of the consumers agreed that the nurse should relinquish this aspect of patient teaching to the physician. Nearly one-third (32.8%) were uncertain and 15.6% expected nurses to teach them. The data for this statement also corresponded with a low test-retest percentage of agreement (50%).

8. Provide me with needed information so I can decide how to restore and maintain my health.

The majority (78.2%) of the subjects expected nurses to give health information while 6.8% did not; 15% were unsure.

9. Utilize opportunities for teaching me how to care for myself.

Only 3 (2.2%) consumers did not expect nurses to

teach self-care. Fourteen (10.4%) were uncertain about their expectations, while 118 (87.4%) expected nurses to assume this teaching role.

10. Help me utilize community health resources.

The largest percentage (79.7%) of consumers agreed with this nursing function while 4.5% disagreed. Twenty-one (15.8%) were not certain.

These data possibly suggest that, when teaching involves physiology and pathophysiology, many of these consumers expected the physician to assume the role of teacher while instruction on self-care techniques was a nursing function.

Standard VII

The client's/patient's progress or lack of progress toward goal achievement is determined by the client/patient and the nurse; and

Standard VIII

The client's/patient's progress or lack of progress toward goal achievement directs reassessment, reordering of priorities, new goal setting, and revision of the plan of nursing care.

1. Determine if I am getting better.

Less than one-half (40.8%) of the consumers expected nurses to evaluate the consumer's progress while 30.4% did not; nearly as many (28.9%) were uncertain suggesting

that consumers in this study believed that the physician is the only person capable of such an assessment. The test-retest percentage of agreement (50%) indicated indecision of the consumers regarding this nursing function.

2. Change my nursing care if I am not getting better.

While over 50% of the respondents either were uncertain or did not expect nurses to evaluate patient progress, 73.1% expected their care to be altered if signs of progress were not evident. Still, 17.2% did not expect nurses to instigate change in the nursing care regimen and 9.7% were undecided suggesting that perhaps these consumers believed nursing care orders fall solely under the doctor's jurisdiction.

3. Keep me informed about my health status.

Eighty-nine (65.9%) consumers expected to be kept informed of their condition while 18.5% did not. Nearly as many consumers (15.6%) were unsure regarding the role of the nurse in keeping the patient informed on health status. The agreement percentage (50%) for test-retest also showed greater indecision of consumers regarding this statement.

4. Determine if I am not making progress with my emotional or family problems and possibly refer me to a counselor.

Less than one-half (41.8%) of the subjects expected evaluation of their progress with psychosocial problems. A total of 28 respondents were either unsure or disagreed with this nursing function, a finding consistent with the 88 subjects who either did not want nurses to help them with such problems or could not decide. These data possibly suggest that these consumers, by and large, did not believe nurses should involve themselves with the psychosocial problems of their patients.

5. Allow me to determine if the nursing care I am receiving is helping me.

The largest percentage (57.5%) of consumers expected to be involved in evaluating the effectiveness of nursing care. A large number (41, 30.5%) were uncertain and 11.9% did not expect to be given opportunities for personal input. Perhaps previous lack of personal involvement in evaluating nursing care accounts for this large degree of uncertainty and disagreement.

Consumer Expectations of Nursing Attributes

As in the preceding section, the format for this section includes examination of each nursing attribute relevant to the ANA Code of Ethics and the data collected. Table 15 illustrates the distribution of agreement/ disagreement percentages for each attribute. To make the comparison of consumer expectations to professional

Table 15

Distribution of Responses by Frequency of Agreement and Disagreement with Nursing Attributes as Defined by The ANA Code of Ethics

(N = 135)

Nursing Attributes	Agree		Disagree		Uncertain	
	n	%	n	%	n	%
Code 1						
1. Not impinge on my spiritual beliefs which may direct the type of care I accept.	93	69.4	10	7.5	31	23.1
2. Give me care regardless of my ability to pay.	106	78.6	13	9.6	16	11.9
3. Be compassionate, kind, and caring regardless of the nature of my illness.	130	97.0	0	0.0	4	3.0
4. Respect my wishes and personal values when I am faced with dying.	128	94.9	1	0.7	6	4.4
Codes 2 and 3						
*1. Share my health information with anyone she/he desires.	5	3.7	127	94.8	2	1.5
2. Report incompetent individuals.	120	88.8	3	2.2	12	8.9
3. Report unethical and illegal products.	129	95.6	1	0.7	5	3.7
*4. Not share information about my health status with anyone.	96	71.1	18	13.3	21	15.6
5. Obtain my consent for other people to review my records for research purposes.	119	88.8	7	5.2	8	6.0
6. Discuss my case with only those individuals involved in my care.	123	91.2	4	3.0	8	5.9
Codes 4, 5, and 6						
1. Be able to explain what they do and why.	131	97.1	2	1.5	2	1.5
2. Keep up their knowledge and skills.	134	99.3	1	0.7	0	0.0
3. Use good judgment when assigning my care to others.	134	99.3	1	0.7	0	0.0
4. Be responsible for the care I receive.	121	89.6	3	2.2	11	8.1
*5. Be able to administer my medications properly without ever consulting with the pharmacist.	41	30.4	69	51.2	25	18.5
6. Be able to decide if my doctor needs to be notified of any problems or changes in my health status.	128	95.6	4	3.0	2	1.5
7. Attend classes and workshops in order to keep current with new health developments.	132	97.8	0	0.0	3	2.2
8. Consult other qualified nurses when my needs are beyond the abilities of the nurse.	116	85.9	8	6.0	11	8.1
Codes 7, 8, and 9						
1. Participate in activities which up-grade nursing care.	132	97.8	1	0.7	2	1.5
2. Be involved in research activities which will improve patient care.	116	86.6	4	3.0	14	10.4
3. Be responsible for the education of student nurses.	71	52.6	21	15.6	43	31.9
4. Participate in determining the terms and conditions of employment of nurses.	86	64.2	13	9.7	35	26.1
5. Evaluate one another's performance.	82	60.7	18	13.3	35	26.0
Codes 10 and 11						
1. Advise me against the use of dangerous health products.	123	91.1	4	3.0	8	6.0
2. Write to legislators regarding health care issues.	82	61.6	8	6.0	43	32.3
3. Provide me with information regarding a variety of health products or services so I can decide which ones to use.	98	72.6	10	7.4	27	20.0
4. Report advertisements or commercials which misinform the public.	112	83.0	3	2.2	20	14.8
5. Work with others (doctors, social workers, physical therapists) to provide health care to all individuals.	123	91.1	4	3.0	8	6.0

*Indicates negatively stated items.

expectations, the investigator will first address each code and corresponding nursing attributes.

Code 1

The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

1. Not impinge on my spiritual beliefs which may direct the type of care I accept.

The largest percentage (69.4%) of consumers agreed that nurses should respect the patient's spiritual beliefs. Ten (7.5%) consumers disagreed and 23.1% were uncertain, suggestive perhaps that the ethical nature of the expectation or the negative wording was the source of indecision. The agreement percentage (50%) for test-retest also showed greater indecision regarding this nursing attribute.

2. Give me care regardless of my ability to pay.

The majority (78.6%) of the respondents expected nursing care despite their economic status while 9.6% did not. Sixteen (11.9%) respondents were unsure.

3. Be compassionate, kind, and caring regardless of the nature of my illness.

Nearly all (97.0%) consumers expected compassionate nursing care regardless of the nature of their health problems. The remaining 3% did not hold this expectation.

The data for this statement also corresponded with a high test-retest percentage of agreement (90%).

4. Respect my wishes and personal values when I am faced with dying.

When faced with death, 94.9% of the respondents would expect their wishes to be honored while 4.4% were unsure. One respondent did not hold this expectation. Less consumer indecision regarding this nursing attribute was also evident in a high test-retest percentage of agreement (100%).

Code 2

The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature; and

Code 3

The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.

1. Share my health information with anyone she/he desires.

The majority (94.8%) of the subjects expected nurses to protect confidential health information. Five (3.7%) subjects were not concerned with whom the nurse should share information and 1.5% were uncertain.

2. Report incompetent individuals.

The largest percentage (88.8%) of consumers expected nurses to safeguard the consumer against incompetent people. Three (2.2%) consumers did not expect nurses to report such individuals while 8.9% were undecided.

3. Report unethical and illegal products.

The majority (95.6%) of the respondents hold this expectation while 3.7% were unsure. One respondent (0.7%) did not expect protection from such products.

4. Not share information about my health status with anyone.

The largest percentage (71.1%) of respondents held this expectation of strict confidentiality. Eighteen (13.3%) respondents recognized the need to share information with certain members of the health care team; 21 (15.6%) were unsure. The negative direction of this statement and the use of a double negative could account for confusion of respondents regarding this expectation. The agreement percentage (60%) for test-retest also indicated confusion of consumers regarding this nursing attribute.

5. Obtain my consent for other people to review my records for research purposes.

The expectation of this aspect of confidentiality was held by 88.8% of the consumers. Six percent of the consumers were uncertain and 5.2% did not hold this

expectation of nurses. The test-retest percentage of agreement (100%) also indicated less indecision of consumers regarding this statement.

6. Discuss my case with only those individuals involved in my care.

Of the three items regarding disclosure of patient information, this item was the most clearly stated. Thus, the responses were conceivably the most reflective of the consumer's expectations. The majority (91.2%) agreed with the statement; 3% disagreed, and 5.9% were uncertain.

Code 4

The nurse assumes responsibility and accountability for individual nursing judgments and actions;

Code 5

The nurse maintains competence in nursing; and

Code 6

The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

1. Be able to explain what they do and why.

Nearly all (97.1%) of the consumers expected nurses to know the 'what' and 'why' of their actions. Two (1.5%) consumers did not hold this expectation and an equal number were unsure.

2. Keep up their knowledge and skills.

A clear majority (99.3%) of the consumers expected nurses to maintain competence in nursing. One (0.7%) consumer disagreed with the statement. The test-retest percentage of agreement (100%) also indicated less indecision of consumers regarding this statement.

3. Use good judgment when assigning my care to others.

A clear majority (99.3%) of the consumers agreed with this item. One consumer (0.7%) disagreed.

4. Be responsible for the care I receive.

The largest percentage (89.6%) of respondents held this expectation while 2.2% did not. Eleven (8.1%) could not establish a decision.

5. Be able to administer my medications properly without ever consulting with the pharmacist.

The words "without ever" in this item could make the statement misleading. Slightly over half (51.2%) of the respondents would expect nurses to consult with the pharmacist while 30.4% would not. Twenty-five (18.5%) respondents indicated uncertainty.

6. Be able to decide if my doctor needs to be notified of any problems or changes in my health status.

The majority (95.6%) of the consumers expected nurses to make such decisions while 3.0% did not. Two (1.5%)

consumers were unsure.

7. Attend classes and workshops in order to keep current with new health developments.

Nearly all (97.8%) of the consumers held this expectation. Three (2.2%) consumers did not. Lack of consumer uncertainty regarding this statement was indicated in the high test-retest percentage of agreement (100%).

8. Consult other qualified nurses when my needs are beyond the abilities of the nurse.

Seeking consultation was an expected nursing function by 85.9% of the subjects. Six percent did not hold this expectation and 9.1% were uncertain.

Code 7

The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge;

Code 8

The nurse participates in the profession's efforts to implement and improve standards of nursing; and

Code 9

The nurse participates in the profession's efforts to establish and maintain conditions for employment conducive to high quality nursing care.

1. Participate in activities which up-grade nursing care.

Nearly all (97.8%) of the respondents expected nurses to participate in activities to improve nursing. One (0.7%) did not and two (1.5%) were uncertain. The agreement percentage (100%) for test-retest also indicated less uncertainty of consumers regarding this nursing attribute.

2. Be involved in research activities which will improve patient care.

The largest percentage (86.6%) of respondents expected research activities by nurses. Three percent did not and 10.4% were unsure.

3. Be responsible for the education of student nurses.

Slightly over one-half (52.6%) of the consumers believed nurses should teach student nurses while 15.6% did not believe this to be a nursing responsibility. A large percentage (31.9%) were uncertain about this item. This item possibly inferred that consumers were uncertain about the role of nurses in education for professional practice. The test-retest percentage of agreement (70%) also indicated indecision of consumers regarding this nursing attribute.

4. Participate in determining the terms and conditions of employment of nurses.

The largest percentage (64.2%) of consumers agreed with this statement followed by 26.1% who were indecisive. Thirteen (9.7%) disagreed. The test-retest percentage of agreement (70%) also indicated greater indecision of consumers regarding this statement.

5. Evaluate one another's performance.

A large degree of uncertainty (26.0%) was evident regarding peer evaluation. This data also corresponded with a low test-retest percentage of agreement (70%). Eighty-two (60.7%) consumers believed nurses should evaluate one another's performance while 18 (13.3%) consumers did not.

Code 10

The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing; and

Code 11

The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

1. Advise me against the use of dangerous health products.

The majority (91.1%) of the consumers expected to be

informed of dangerous health products. Three percent did not expect this of nurses and 6% were unsure.

2. Write to legislators regarding health care issues.

A large degree of uncertainty was evident in nearly one-third (32.3%) of the sample regarding nursing's role in health care legislation. The agreement percentage (70%) for test-retest also indicated consumer indecision regarding this statement. Eighty-two (61.6%) consumers held this expectation and eight (6.0%) did not.

3. Provide me with information regarding a variety of health products or services so I can decide which ones to use.

Ninety-eight (72.6%) respondents believed nurses should make health care information available while 7.4% did not. Twenty percent were undecided. The test-retest percentage of agreement (60%) also showed consumer indecision regarding this statement. Perhaps the degree of indecision stemmed from the dual nature of the statement; respondents may have agreed with the nurse's role but withheld the expectation of personal involvement in selecting health care products or services. The reverse also could have occurred.

4. Report advertisements or commercials which misinform the public.

Eighty-three percent of the consumers agreed with

this statement while 2.2% disagreed and 14.8% were uncertain.

5. Work with others (doctors, social workers, physical therapists, etc.) to provide health care to all individuals.

Collaboration with other health care professionals for the good of all consumers was an expectation held by 91.1% of the sample respondents. Three percent of the respondents did not hold the same expectation and 6% were unsure.

Consumer and Professional Expectations of Nursing Functions and Attributes

The findings for each one of the items regarding nursing functions and attributes have been presented. What will follow is a discussion of whether or not consumers' expectations were congruent with the profession's expectations as defined by the ANA Standards of Practice and Code of Ethics. The five categories of nursing functions and the five categories of nursing attributes will be addressed individually.

Nursing Functions

The categories identified from The American Nurses' Association's Standards of Practice were: (a) nursing assessment, (b) nursing diagnosis, (c) planning nursing

care, (d) nursing interventions, and (e) nursing evaluation. The following presentation will be based on mean agreement/disagreement scores for the above categories. Table 16 shows the corresponding data.

Nursing Assessment, Standard I. Seventy-five (55.6%) of the consumers' expectations were in agreement with Standard I. Six (4.4%) consumers did not hold the same overall expectations regarding data collection and documentation in nursing. A large percentage (40.0%) were uncertain about enough of the five Standard I items to establish general uncertainty with the standard. The data suggest that a large percentage of the consumers questioned the role of nurses in patient assessment and/or possibly indicate problems with item construction.

Nursing Diagnosis, Standard II. Based on the three items reflecting Standard II, the largest percentage (68.1%) of the consumers held expectations consistent with the standard. Developing nursing diagnoses was not a function required by 1.5% of the consumers. Nearly one-third (30.4%) of the consumers, however, were unsettled about this function neither endorsing nor rejecting the profession's expectations regarding nursing diagnosis.

Planning Nursing Care, Standards III and IV. Of the five categories, planning nursing care received the greatest acknowledgement from the consumers. Mean scores for the six items reflecting Standards III and IV showed

Table 16

Distributions of Agreement/Disagreement with Nursing Functions Defined by The ANA Standards of Practice (N = 135)

	n	%*
Nursing Assessment		
Standard I		
Agree	75	55.6
Disagree	6	4.4
Uncertain	54	40.0
Nursing Diagnosis		
Standard II		
Agree	92	68.1
Disagree	2	1.5
Uncertain	41	30.4
Planning Nursing Care		
Standards III & IV		
Agree	114	84.4
Disagree	0	0.0
Uncertain	21	15.6
Nursing Intervention		
Standards V & VI		
Agree	92	68.1
Disagree	1	0.7
Uncertain	42	31.1
Nursing Evaluation		
Standards VII & VIII		
Agree	64	47.4
Disagree	8	5.9
Uncertain	63	46.7

*Percentages do not always equal 100 due to rounding of numbers.

Note. Agreement/Disagreement scores were determined by analysis of the responses to the items under each Standard category; Agreement = mean score of 3.5-5.0, Disagreement = mean score of 1.0-2.5, Uncertain = mean score of 2.6-3.4.

that 84.4% of the consumers held expectations in accord with the profession's expectations. Disagreement did not occur in this category. However, 15.6% of the consumers could not define their expectations. The data suggest that the majority of the consumers endorsed the profession's expectations for setting goals and priorities in planning nursing care.

Nursing Interventions, Standards V and VI. The largest percentage (68.1%) of the consumers were in agreement with Standards V and VI which were based on 10 questionnaire items. One (0.7%) consumer did not hold the same overall expectations set forth by the profession regarding provision of nursing care, which includes patient participation. A large percentage (31.1%) of the consumers were by and large indecisive about their expectations. The data suggest that nearly one-third of the consumers questioned the role of the nurse, and/or their own involvement in health promotion, maintenance, and restoration. The data also could indicate problems in item construction.

Nursing Evaluation, Standards VII and VIII. Of the five categories, nursing evaluation received the least acknowledgement from consumers. Mean scores for the five items reflecting Standards VII and VIII showed that less than one-half (47.4%) of the consumers held expectations in harmony with the profession's expectations. Nearly as

many (46.7%) consumers could not establish a decision. Eight (5.9%) consumers did not hold the same overall expectations set forth by the profession. These data suggest that nearly one-half of the consumers questioned the evaluative role of the nurse and/or possibly indicate problems in item construction.

Nursing Attributes

The categories identified from The Code of Ethics were: (a) respect for human dignity and individuality, (b) respect for confidential information and the safeguarding of clients against incompetence, unethical, or illegal practices, (c) accountability for nursing judgments and actions, (d) active participation to improve nursing care, and (e) respect for consumer rights for correct information and adequate health care. The following presentation will be based on mean agreement/disagreement scores for the above categories. Table 17 shows the corresponding data.

Respect for human dignity and individuality, Code 1. Based on the four items reflecting Code 1, the majority (95.6%) of the consumers held expectations consistent with the code. One (0.75%) consumer did not hold the same overall expectations regarding respect for the uniqueness of the individual, and 5 (3.7%) consumers were uncertain. These data suggest that the majority of the consumers

Table 17

Distributions of Agreement/Disagreement with Nursing Attributes Defined by The ANA Code of Ethics

(N = 135)

	n	%*
Code 1		
Agree	129	95.6
Disagree	1	0.7
Uncertain	5	3.7
Codes 2 & 3		
Agree	126	93.3
Disagree	1	0.7
Uncertain	8	5.9
Codes 4, 5, & 6		
Agree	134	99.3
Disagree	1	0.7
Uncertain	0	0.0
Codes 7, 8, & 9		
Agree	111	82.2
Disagree	2	1.5
Uncertain	22	16.3
Codes 10 & 11		
Agree	122	90.4
Disagree	0	0.0
Uncertain	13	9.6

*Percentages do not always equal 100 due to rounding of numbers.

Note. Agreement/Disagreement scores were determined by analysis of the responses to the items under each attribute category; Agreement = mean score of 3.5-5.0, Disagreement = mean score of 1.0-2.5, Uncertain = mean score of 2.6-3.4.

in this study endorsed the profession's expectations for nondiscriminatory nursing care.

Respect for confidential information and the safeguarding of clients against incompetence, unethical, or illegal practices, Codes 2 and 3. The majority (93.3%) of the consumers were in agreement with Codes 2 and 3 which were based on six questionnaire items. One (0.7%) consumer did not hold the same overall expectations set forth by Codes 2 and 3. Eight (5.9%) consumers were uncertain about their expectations for confidentiality and protection from harmful practices. These data suggest that the majority of the consumers corroborated with the profession's expectations of nurses in matters of confidentiality and unethical/illegal practices.

Accountability for nursing judgments and actions, Codes 4, 5, and 6. Of the five categories, accountability for nursing judgments and actions received the greatest acknowledgement from the consumers. Mean scores for the eight items reflecting Codes 4, 5, and 6 showed that 99.3% of the consumers held expectations in accord with the profession's expectations. Mean scores did not show uncertainty in this category. One (0.7%) consumer did not hold the same overall expectations set forth by Codes 4, 5, and 6. These data suggest that nearly all of the comsumers expected nursing competence and accountability as does the profession.

Active participation to improve nursing care, Codes 7, 8, and 9. Of the five categories, active participation to improve nursing care received the least acknowledgement from consumers. Mean scores for the five items reflecting Codes 7, 8, and 9 showed that 82.2% of the consumers held expectations in harmony with the profession's expectations. Two (1.5%) consumers did not hold the same overall expectations set forth by Codes 7, 8, and 9. Twenty-two (16.3%) consumers showed uncertainty in this category. The data suggest that most of the consumers expected nurses to continue improving nursing care through increasing knowledge and betterment of nursing standards.

Respect for consumer rights for correct information and adequate health care, Codes 10 and 11. Based on the five items reflecting Codes 10 and 11, the majority (90.4%) of the consumers held expectations consistent with those of the profession. Disagreement did not occur in this category. Thirteen (9.6%) consumers were uncertain about their expectations of nurses for maintaining the integrity of nursing and collaboration with other health professions and citizens to meet the health needs of the public.

Consumer Expectations and Individual Characteristics

An analysis of the data which addressed the question of congruency between consumer and professional expectations has been presented. This section provides an

examination of the nursing function and attribute categories and their relationships with the variables of age, gender, socioeconomic status, and past hospital experiences with nurses and nursing care. The Chi-square contingency table test was used to see if there was a significant relationship between the variables at the 0.05 level of significance. Although a few relationships did exist, the data from this study should be interpreted with caution since over 20% of the frequency cells contained expected counts less than five, due to many question omissions and, hence, the Chi-square statistic may not be a valid test.

Nursing Functions and Individual Characteristics

Contradictory to findings in past research, the data collected in this study did not show any significant associations between consumer expectations of nursing functions and the variables of gender, socioeconomic status, and past hospital experiences. However, as the consumers in each age group identified their expectations, the Chi-square test indicated a trend toward significance for item five (p = .0518) in the nursing evaulation category (Allow me to determine if the nursing care I am receiving is helping me); as well as for item six (p = .0897) in the category of planning nursing care (Decide what kind of care I need in order for me to reach my goals for improved health) (see Table 18).

Table 18

Chi-Square Analysis of Nursing Functions and the Variable of Age

(N = 135)

	Age Group	n	Agreement		Disagreement		Uncertain	
			Number/Age Group	%	Number/Age Group	%	Number/Age Group	%
Item 5--Nursing Evaluation								
df = 8 p = .0518	18 - 28	26	12	46.2	4	15.4	10	38.5
	29 - 39	44	29	65.9	2	4.6	13	29.6
	40 - 50	31	18	58.1	2	6.5	11	35.5
	51 - 61	16	7	43.8	6	37.5	3	18.8
	62 or above	11	7	63.6	2	18.2	2	18.2
	TOTAL	= 128*						
Item 6--Planning Nursing Care								
df = 8 p = .0897	18 - 28	26	21	80.8	1	3.9	4	15.4
	29 - 39	44	27	61.4	4	9.1	13	29.6
	40 - 50	30	20	66.7	5	16.7	5	16.7
	51 - 61	16	8	50.0	6	37.5	2	12.5
	62 or above	12	7	58.3	2	16.7	3	25.0
	TOTAL	= 128*						

Note. Level of significance = .05.

*N = 135. The total numbers do not equal N due to some respondents not answering the question.

Nursing Attributes and Individual Characteristics

Data showed a greater number of associations of the variables with the attribute items and categories. Consumers expectations for item seven in Category III (Attend classes and workshops in order to keep current with new health developments) showed a significant association with the age variable (p = .0161). Three additional attribute items indicated a trend toward significance with the age variable: (a) item two, Category IV (Be involved in research activities which will improve patient care), p = .0507; (b) item two, Category V (Write to legislators regarding health care issues), p = .0771; and (c) item one, Category II (Share my health information with anyone she/he desires), p = .0886. Table 19 shows the data.

When each variable was examined in relation to the attribute categories, three significant associations emerged: (a) age and Category V (Respect for consumer rights for correct information and adequate health care), p = .0042; (b) socioeconomic status and Category I (Respect for human dignity and individuality), p = .0459; and (c) socioeconomic status and Category III (Accountability for nursing judgments and actions), p = .0077. One additional association indicated a trend toward significance: socioeconomic status and Category IV (Active participation to improve nursing care), p = .0618. The data can be found in Table 20.

Table 19

Chi-Square Analysis of Nursing Attributes and the Variable of Age

(N = 135)

	Age Group	n	Agreement		Disagreement		Uncertain	
			Number/Age Group	%	Number/Age Group	%	Number/Age Group	%
Item 7--Category III								
df = 4 p = .0161	18 - 28	26	23	88.5			3	11.5
	29 - 39	44	44	100.0			0	0.0
	40 - 50	31	31	100.0			0	0.0
	51 - 61	16	16	100.0			0	0.0
	62 or above	12	12	100.0			0	0.0
	TOTAL =	129*						
Item 2--Category IV								
df = 8 p = .0507	18 - 28	26	17	65.4	2	7.7	7	26.9
	29 - 39	43	40	93.0	1	2.3	2	4.7
	40 - 50	31	28	90.3	0	0.0	3	9.7
	51 - 61	16	14	87.5	1	6.3	1	6.3
	62 or above	12	12	100.0	0	0.0	0	0.0
	TOTAL =	129*						
Item 2--Category V								
df = 8 p = .0771	18 - 28	25	9	36.0	3	12.0	13	52.0
	29 - 39	43	27	62.8	2	4.7	14	32.6
	40 - 50	31	22	71.0	1	3.2	8	25.8
	51 - 61	16	9	56.3	2	12.5	5	31.3
	62 or above	12	11	91.7	0	0.0	1	8.3
	TOTAL =	127*						
Item 1--Category II								
df = 8 p = .0886	18 - 28	26	23	88.5	3	11.5	0	0.0
	29 - 39	44	44	100.0	0	0.0	0	0.0
	40 - 50	30	27	90.0	1	3.3	2	6.7
	51 - 61	16	16	100.0	0	0.0	0	0.0
	62 or above	12	11	91.7	1	8.3	0	0.0
	TOTAL =	128*						

Note. Level of significance = .05

*N = 135. The total numbers do not equal N due to some respondents not answering the question.

Table 20

Chi-Square Analysis of Attribute Categories and Individual Characteristics

(N = 135)

	Age Group	n	Agreement		Disagreement		Uncertain	
			Number/Age Group	%	Number/Age Group	%	Number/Age Group	%
Category V								
df = 4 p = .0042	18 - 28	26	22	84.6	0	0.0	4	15.4
	29 - 39	44	44	100.0	0	0.0	0	0.0
	40 - 50	31	27	87.1	0	0.0	4	12.9
	51 - 61	16	11	68.8	0	0.0	5	31.3
	62 or above	12	12	100.0	0	0.0	0	0.0
	TOTAL =	129*						
	Social Stratum	n	Number/ Stratum	%	Number/ Stratum	%	Number/ Stratum	%
Category I								
df = 8 p = .0459	Major Business/Prof.	31	29	93.6	0	0.0	2	6.5
	Medium Business & Minor Prof.	52	50	96.2	0	0.0	2	3.9
	Skilled Craftsmen	22	22	100.0	0	0.0	0	0.0
	Semiskilled Workers	19	18	94.7	0	0.0	1	5.3
	Unskilled Laborers	9	8	88.9	1	11.1	0	0.0
	TOTAL =	133*						
Category III								
df = 4 p = .0077	Major Business/Prof.	31	31	100.0	0	0.0	0	0.0
	Medium Business & Minor Prof.	52	52	100.0	0	0.0	0	0.0
	Skilled Craftsmen	22	22	100.0	0	0.0	0	0.0
	Semiskilled Workers	19	19	100.0	0	0.0	0	0.0
	Unskilled Laborers	9	8	88.9	1	11.1	0	0.0
	TOTAL =	133*						
Category IV								
df = 8 p = .0618	Major Business/Prof.	31	29	93.6	0	0.0	2	6.5
	Medium Business & Minor Prof.	52	43	82.7	0	0.0	9	17.3
	Skilled Craftsmen	22	15	68.2	1	4.6	6	27.3
	Semiskilled Workers	19	15	79.0	0	0.0	4	21.1
	Unskilled Laborers	9	8	88.9	1	11.1	0	0.0
	TOTAL =	133*						

Note. Level of significance = .05

*N = 135. The total numbers do not equal N due to some respondents not answering the question.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Because the nursing profession seeks to serve the public, this study has attempted to broaden the body of knowledge available to the profession with regard to consumer expectations of nursing functions and attributes. This study used the ANA Standards of Practice and Code of Ethics as its theoretical framework for comparing consumer and professional expectations. Conclusions, recommendations for further study, and implications for nursing will be presented in this chapter.

Conclusions

The conclusions of this study will be discussed as they relate to the original research questions.

Research Question 1

Are consumers' expectations of nursing functions and attributes congruent with the profession's expectations of nursing functions, as defined by The American Nurses' Association's Standards of Nursing Practice; and nursing attributes, as defined by The American Nurses' Association's Code of Ethics?

Differences between consumer and professional expectations tended to appear when the individual items reflecting each category were examined. However, when the function items were combined into categories, there was a tendency for the consumers to agree with the overall expectations of the nursing profession. While agreement was not unanimous, over 50% of the consumers expected nurses to assess, diagnose, plan nursing care, and institute that care--functions which are congruent with the ANA Standards of Practice.

Within the assessment category, physical assessment received the least support by consumers while taking and recording a health history received majority agreement. Three-fourths of the consumers expected nurses to develop potential nursing diagnoses, yet less than 50% expected nurses to develop nursing diagnoses based on assessment findings. Planning nursing care received the strongest support; however, many of the consumers questioned the role of the nurse in selecting and prioritizing nursing care. A large degree of uncertainty existed within the category of nursing intervention. Over one-third of the consumers questioned nursing interventions designed to assist the patient with psychosocial problems and nearly the same proportion were uncertain of the nurses teaching role. The least unanimity was found in responses to the statements related to nursing evaluation, where less than

50% of the consumers held expectations congruent with the Standards of Practice; and nearly one-half of the consumers were uncertain about the evaluative role of the nurse. These data suggest that the consumers in this study generally endorsed the nursing functions which reflect the ANA Standards of Practice; agreement, however, was evidenced with greater frequency regarding nursing functions which centered around the provision of safety and comfort measures. Agreement was less frequent regarding nursing functions which involved more advanced intellectual and technical skills; for example, physical assessment and evaluation of patient progress.

When the attribute items were combined into categories, there was a tendency for the consumers to agree with the overall expectations of the nursing profession as defined by the ANA Code of Ethics. In all five categories, over 75% of the consumers agreed they expected nursing care that is based on respect for human dignity, confidentiality, professional accountability, competency, and the rights of the consumer for safe, adequate health care. Some of the consumers, however, were uncertain about the role of the nurse in safeguarding the patient against incompetence and illegal or unsafe products and practices. This data suggested that the consumers in this study expected nursing attributes which were reflective of the profession's Code of Ethics. Agreement was strongly

evident in all of the attribute categories.

The high percentage of uncertainty in many of the categories, however, suggests that it is possible that some of the items were unclear or ambiguous. Several of the statements contained double negatives and qualifiers which possibly confused the respondents and lead to responses which were opposite of their true expectations. In addition, despite efforts at directing the questionnaire toward all groups, the terminology of some statements may have been perplexing to some of the respondents.

Research Question 2

Do consumers' expectations of nurses vary with consumers' past hospital experiences with nurses and nursing?

Analysis of responses to the statements measuring consumer expectations of nursing functions and attributes found no distinguishing differences between consumers with numerous hospitalizations and those who had few or no past hospital experiences. Neither were there significant differences between consumer responses and the quality or recency of their past hospital experiences. It is possible that the disparity of the subsamples could account for the lack of significant relationships.

Research Question 3

Do consumers' expectations of nursing functions and attributes vary with the individual characteristics of gender and age?

No relationship between consumers' expectations of nursing functions and the variables of age and gender was discovered, although there was a tendency for younger respondents to agree more frequently with two specific statements: (a) Allow me to determine if the nursing care I am receiving is helping me, and (b) Decide what kind of nursing care I need in order for me to reach my goals for improved health. A larger percentage of older respondents tended to disagree with these expectations. No relationships between the function categories and the variables of age and gender were found.

Analysis of responses to the individual attribute items showed a significant relationship between age and responses to the statement, "I expect nurses to attend classes and workshops in order to keep current with new health developments." All respondents in each age group agreed with this statement with the exception of the 18 to 28-year age group which showed some uncertainty. No one disagreed with the statement.

The only attribute category showing a relationship with age was Category V (Respect for consumer rights for

correct information and adequate health care). While the direction of these differences was not tested, there was a tendency for the 29 to 39 year age group and the 62 or above age group to agree more frequently with the items reflecting Category V. These age groups also held the least degree of uncertainty.

The data suggests that respondents in these age groups were more concerned about their rights for adequate health care. Perhaps consumers in the 29 to 39 year age group advocated the nurse's role in protecting "consumer rights" based on their attention to equality and justness; public issues receiving increased emphasis during the Vietnam Era. And consumers in the 62 or above age group showed stronger support for the nurse's role in providing adequate health care; attributed perhaps to concerns of older consumers regarding rising health care costs.

Research Question 4

> Do consumers' expectations of nursing functions and attributes vary with the individual characteristics of socioeconomic status?

Analysis of responses to the statements measuring consumer expectations under the attribute categories showed a significant relationship between the variable of socioeconomic status and Category I (Respect for human dignity and individuality) and Category III

(Accountability for nursing judgments and actions). The data showed a tendency for mean disagreement scores to appear only for respondents in the unskilled social stratum. The majority of the respondents in the other four stratum had mean scores indicating agreement with the expectations reflecting these two attribute categories.

The data also showed that support for Category IV (Active participation to improve nursing care) tended to come from the respondents in the extreme positions on the social scale. The largest percentage of agreement was held by respondents in the unskilled and major business/ professional positions. This relationship was not found to be significant, however.

Limitations

The manner of selecting respondents was not truly random and, hence, may have affected the overall results of the study.

Recommendations for Further Study

Like many similar research projects, this study raised a number of questions regarding nursing's public image. Based on the findings of this study, the following recommendations are made for further research:

1. Additional validation and confirmation of the reliability of the Consumer Nursing Process and Attributes

Questionnaire;

2. Modification and clarification of the statements on the Consumer Nursing Process and Attributes Questionnaire, specifically exclusion of double negatives, consistent use of terminology regarding "nursing diagnoses" versus "potential problem," and rewording of items containing two actions;

3. A replication of the study employing a larger number of consumers with greater randomization and percent return to increase the generalizability of the findings;

4. Modification of the Consumer Nursing Process and Attributes Questionnaire for use with older adults;

5. Development of a study using a larger number of consumers representing the lower social strata and a more equal distribution of consumers without hospital experience;

6. Development of a study to examine the expectations of nurses for their role functions and attributes.

Implications for Nursing

The implications for a descriptive study such as this are limited to the study sample in which the data were collected and can be generalized to other consumers only to the extent that they are known to possess similar characteristics with consumers who receive nursing care.

Within these limitations, the findings do have implications for nursing practice and education.

The ability of nurses to provide a unique service to the consumer is dependent on public opinion of the nursing profession. Public opinion of the nursing profession has had and will continue to have an effect on utilization of nursing services by consumers of health care (Hughes, 1980). Consumers in this study indicated that their experiences with nurses and nursing care had been positive and that their image of nursing was influenced most by their past experiences and nurse acquaintances. This implies that nurses are in a position of strength to create images more congruent with reality by educating friends, family, peers, patients, and other professionals. Wherever and whenever possible, nurses should raise the consciousness of others regarding the realities surrounding the role of the nurse. While the majority of consumers in this study believed they had an average understanding of the nurse's role, there were a significant number who had not recognized the potential and actual contributions of quality nursing practice. The fact that these individuals were not knowledgeable of the nursing role perpetuates the misunderstandings surrounding the nursing profession. What is needed is more research to document the effects of good nursing practice, followed by wide dissemination of this information.

A second implication is that the nursing profession needs to continue to articulate the scope of nursing practice to the public. This need was evidenced primarily in the consumer responses to expectations of nursing functions. The data suggested that a number of the consumers questioned the role of the nurse in functions which required intellectual problem-solving. It is the belief of the investigator that this may be due to the common belief that nurses are dependent on the physician and lack the knowledge necessary to teach patients. Nurses have the scientific background as necessary and appropriate; unfortunately, many times, their knowledge and interpretations are regarded as less valid and are less apt to be given credence than those of the physician. From the results of this study, it is evident that the scientific basis for nursing, the autonomy of nursing, and the nursing process are concepts which have not been well-articulated. Furthermore, data showed that consumers' experiences with nurses had influenced their image of nursing. Based on these findings, nurses could use the hospital experience to articulate the scope of nursing practice and orient consumers to nursing terminology. For example, development and distribution of booklets and pamphlets for patient teaching would increase consumer expectations regarding the nurse's teaching role.

A third implication is directed to the traditional

role of the nurse and to nursing education. With the information found in the study, nurse educators could plan a curriculum that focuses on or addresses public expectations. Consumers in this study indicated they still want and need the nurse in the health care setting. The expectations of safe and compassionate nursing care suggested that the consumers in this study may have good reasons to want and keep the traditional nursing role unchanged. If the traditional role of the nurse is functional in the health care setting, corresponding to a real and essential need, then nursing educators must prepare nurses for this role. The nurse can be, and ought to be, an expert at caring for the sick; the study indicates that is what these consumers expected of nurses. However, nursing functions which are directed at illness prevention, assessment, diagnosis, and evaluation were not strongly supported by the consumers. The investigator submits that this data does not mean these consumers, despite their current expectations, cannot be assisted in raising their expectations. Nursing educators must prepare nurses to actualize the role in a manner which encompasses the professional skills and knowledge that are unique to nursing. Nursing educators need to plan curriculae which emphasize to students the importance of orienting the public to the concepts of nursing assessment, diagnosis, and evaluation. If nurses are aware of what consumers do

and do not expect, then they will be equipped to meet and raise these expectations while at the same time moving the traditional role into contemporary nursing.

A fourth implication is directed toward nurses themselves who, before attempting to change public and professional expectations, must examine both individually and collectively their own adherence to unacceptable images and behaviors. The first step to self-respect is for nurses to acknowledge who they are as individuals and professionals and what they expect of themselves. With the results of this study, nurses could examine the expectations of these consumers, comparing them with their own personal and professional expectations. Armed with that knowledge, nurses would have the power to better educate the public about professional standards and codes, or in fact change these standards and codes to meet the expectations of the public. The standards and codes by which nurses practice could be altered to differentiate between the expectations of the traditional nurse in the hospital setting and the expectations of expanded nursing roles.

People often cling to images of the good old days such as the image of the doctor making house calls. Likewise, people often cling to the image of the nurse who is self-sacrificing, though not necessarily highly skilled, and a comforter of the sick. While this image is

not necessarily an undesirable one, nurses want an accurate image of what nursing is really like today. Based on the findings of this study, consumers expected many of the functions and attributes in harmony with standards established by the nursing profession; this suggests that many of these consumers were aware of the changing status of nursing or role of the nurse in providing an autonomous service. While not characteristic of a large number of the consumers, there is evidence that some consumers in this population are receiving correct information. In order to achieve widespread support for the standards of the nursing profession, it would seem clear that the profession must undertake continued efforts to educate the public about the contributions that nurses make to the health care system. The lay public needs to be made aware of what they could and should expect from the professional nurse. Research, in and of itself, can stimulate the minds of consumers; research of this nature also can make consumers aware of health services offered by nurses and, thus, elevate their expectations for quality nursing care.

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APPENDIXES

APPENDIX A

AMERICAN NURSES' ASSOCIATION STANDARDS OF NURSING PRACTICE

American Nurses' Association Standards of Nursing Practice

Standard I: The collection of data about the health status of the client/patient is systematic and continuous. The data are accessible, communicated, and recorded.

Standard II: Nursing diagnoses are derived from health status data.

Standard III: The plan of nursing care includes goals derived from the nursing diagnoses.

Standard IV: The plan of nursing care includes priorities and the prescribed nursing approaches or measures to achieve the goals derived from the nursing diagnoses.

Standard V: Nursing actions provide for client/patient participation in health promotion, maintenance, and restoration.

Standard VI: Nursing actions assist the client/patient to maximize his health capabilities.

Standard VII: The client's/patient's progress or lack of progress toward goal achievement is determined by the client/patient and the nurse.

Standard VIII: The client's/patient's progress or lack of progress toward goal achievement directs reassessment, reordering of priorities, new goal setting, and revision of the plan of nursing care.

Note. From Standards of Nursing Practice, 1973, Kansas City, MO: American Nurses' Association.

APPENDIX B

AMERICAN NURSES' ASSOCIATION

CODE FOR NURSES

American Nurses' Association

Code for Nurses

1. The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

2. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

3. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.

4. The nurse assumes responsibility and accountability for individual nursing judgments and actions.

5. The nurse maintains competence in nursing.

6. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultations, accepting responsibilities, and delegating nursing activities to others.

7. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

8. The nurse participates in the profession's efforts to implement and improve standards of nursing.

9. The nurse participates in the profession's efforts to establish and maintain conditions for employment conducive to high quality nursing care.

10. The nurse participates in the profession's efforts to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

11. The nurse collaborates with members of the health profession and other citizens in promoting community and national efforts to meet the health needs of the public.

Note. From Code for Nurses with Interpretive Statements. (1976). Kansas City, MO: ANA

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

1. Have you ever worked in a hospital as a volunteer?
   1 ( ) Yes, I currently do
   2 ( ) Yes, I have in the past
   3 ( ) No

2. Have you ever been a patient in a hospital?
   1 ( ) Yes (If you check yes, please go to Question Number 3)
   2 ( ) No (If you check no, please go to Question Number 7)

3. Please check how many times you have been hospitalized in the past:
   1 ( ) one time
   2 ( ) 2-5 times
   3 ( ) more than 5 times

4. How long ago was your most recent hospitalization?
   1 ( ) within the past year
   2 ( ) 2-5 years ago
   3 ( ) more than 5 years ago

5. In what type of setting did you receive your nursing care? (✓ as many as apply to you)
   1 ( ) Intensive Care or Heart Unit
   2 ( ) Emergency Room
   3 ( ) Medical or Surgical Unit
   4 ( ) Home Care
   5 ( ) Other_____

6. Has your past experience with registered nurses in the hospital been:
   1 ( ) all negative
   2 ( ) mostly negative
   3 ( ) all positive
   4 ( ) mostly positive

7. Which of the following applies to you?
   1 ( ) I personally have no acquaintances who are nurses
   2 ( ) I have an immediate family member who is a nurse (i.e., sister, wife, son)
   3 ( ) I have one or more friends who are nurses
   4 ( ) I have a relative who is a nurse (i.e., aunt, cousin, uncle, grandchild)

8. Of the registered nurse or nurses you personally know, would you say:
   1 ( ) you know nothing, or very little, about what that person(s) does
   2 ( ) you have an average understanding of what that person(s) does
   3 ( ) you know more than most about what that person(s) does

9. Which one of the following sources of information about nurses and the things they do would you say has influenced your image of nurses the most?
   1 ( ) Television/Movies
   2 ( ) My past experiences as a patient in the hospital
   3 ( ) Novels/Books
   4 ( ) Nurses I personally know (friends, relatives)
   5 ( ) My past experiences with nurses outside the hospital (i.e., office nurses, private duty nurses, etc.).
   6 ( ) Family members and their experiences with nurses in the hospital

10. What is your sex?
   1 ( ) Female
   2 ( ) Male

11. What is your age?
   1 ( ) 18-28
   2 ( ) 29-39
   3 ( ) 40-50
   4 ( ) 51-61
   5 ( ) 62 or above

12. What is your marital status?
   1 ( ) Married and living with my spouse
   2 ( ) Never been married
   3 ( ) Divorced (I support myself)
   4 ( ) Divorced (I receive support payments)
   5 ( ) Widowed (I support myself)
   6 ( ) Widowed (I am living on the income from my spouse's estate)
   7 ( ) Separated (I support myself)
   8 ( ) Separated (I receive support payments)

13. How many years of education have you completed?
    1 ( ) less than seventh grade
    2 ( ) Ninth grade (Junior High School)
    3 ( ) Partial High School (10th or 11th Grade)
    4 ( ) High School Graduate
    5 ( ) Partial college (at least one year) or special training
    6 ( ) College or University Graduate (4 years)
    7 ( ) Graduate Degree

14. How many years of education has your spouse completed? (Even if you are widowed, divorced, or separated, but receive support payments, please answer)
    1 ( ) less than seventh grade
    2 ( ) Ninth grade (Junior High School)
    3 ( ) Partial High School (10th or 11th grade)
    4 ( ) High School Graduate
    5 ( ) Partial college (at least one year) or special training
    6 ( ) College or University Graduate (4 years)
    7 ( ) Graduate Degree

15. What is your current occupation, or what was your occupation before you retired?_____

16. In reference to your current or most recent occupation, if you own a business or farm, what is (or was) its approximate value?
    1 ( ) $250,000 or more
    2 ( ) $100,000 to $250,000
    3 ( ) $75,000 to $100,000
    4 ( ) $50,000 to $75,000
    5 ( ) $25,000 to $50,000
    6 ( ) Less than $25,000

17. What is your spouse's current occupation, or what was your spouse's occupation before he/she retired?

    _____

18. In reference to your spouse's current or most recent occupation, if she/he owns a business or farm, what is (or was) its approximate value?
    1 ( ) $250,000 or more
    2 ( ) $100,000 to $250,000
    3 ( ) $75,000 to $100,000
    4 ( ) $50,000 to $75,000
    5 ( ) $25,000 to $50,000
    6 ( ) Less than $25,000

APPENDIX D

CONSUMER NURSING PROCESS AND ATTRIBUTES QUESTIONNAIRE

Consumer Nursing Process and Attributes Questionnaire

A. The nursing profession has set standards which direct the kinds of things nurses are expected to do. A number of nursing functions are listed below. Please circle the number following each statement which best describes to what degree you agree or disagree with the statement. There are no "right" or "wrong" answers; simply answer according to your beliefs.

I Expect Nurses To:	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. Give me a physical exam (i.e., check my lungs, heart, vision, etc.).	5	4	3	2	1
2. Based on my physical exam & health history, develop nursing diagnoses (i.e., pain, potential for bed-sores).	5	4	3	2	1
3. Provide a clean and safe environment for my care.	5	4	3	2	1
4. Plan nursing actions that are individual for me such as give me a bath in the evening if that's what I prefer.	5	4	3	2	1
5. Determine if I am getting better.	5	4	3	2	1
6. Let me find my own ways of caring for myself at home.	5	4	3	2	1
7. Help me utilize community health resources.	5	4	3	2	1
8. Ask me about my health history (i.e., includes things like checking how well I sleep, my diet habits, if I'm depressed).	5	4	3	2	1
9. Set goals for comforting me if I am in pain.	5	4	3	2	1
10. Help me learn how to cope with stress.	5	4	3	2	1
11. Change my nursing care if I am not getting better.	5	4	3	2	1
12. Interview my family or significant other people regarding my health.	5	4	3	2	1
13. Plan my nursing care by deciding which of my health problems need attention first.	5	4	3	2	1
14. Write a complete report of my health status.	5	4	3	2	1
15. Help me find ways to care for myself at home.	5	4	3	2	1
16. Determine if I have a certain disease according to my physical problems (i.e., if I have a fever & cough the nurse should determine if I have pneumonia).	5	4	3	2	1
17. Keep my informed about my health status.	5	4	3	2	1
18. Help me define how I should increase my exercise if need be.	5	4	3	2	1
19. Record my health status so that others involved in my care will be informed of my condition.	5	4	3	2	1
20. Let me deal with my own emotional & family problems.	5	4	3	2	1
21. Identify problems which could develop during the course of my illness (i.e., potential allergic reaction to medication, potential for infection).	5	4	3	2	1

I Expect Nurses To:	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
22. Let the doctor teach me about my body and my illness.	5	4	3	2	1
23. Decide what kind of nursing care I need in order for me to reach my goals for improved health.	5	4	3	2	1
24. Provide me with needed information so I can decide how to restore and maintain my health.	5	4	3	2	1
25. Allow me to determine if the nursing care I am receiving is helping me.	5	4	3	2	1
26. Utilize current scientific knowledge in planning & providing my nursing care.	5	4	3	2	1
27. Determine if I am not making progress with my emotional or family problems & possibly refer me to a counselor.	5	4	3	2	1
28. Plan my nursing care so that the goals for my getting well agree with the doctor's orders.	5	4	3	2	1
29. Utilize opportunities for teaching me how to care for myself.	5	4	3	2	1

B. The nursing profession has developed a Code of Ethics which nurses are expected to follow. A number of behaviors and nursing characteristics are listed below. Please circle the number following each statement which best describes to what degree you agree or disagree with the statement. There are no "right" or "wrong" answers; simply answer according to your beliefs.

I Expect Nurses To:	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. Give me care regardless of my ability to pay.	5	4	3	2	1
2. Share my health information with anyone she/he desires.	5	4	3	2	1
3. Be able to explain what they do and why.	5	4	3	2	1
4. Keep up their knowledge and skills.	5	4	3	2	1
5. Participate in activities which up-grade nursing care.	5	4	3	2	1
6. Advise me against the use of dangerous health products.	5	4	3	2	1
7. Not impinge on my spiritual beliefs wich may direct the type of care I accept.	5	4	3	2	1
8. Report incompetent individuals.	5	4	3	2	1
9. Use good judgment when assigning my care to others.	5	4	3	2	1
10. Be responsible for the care I receive.	5	4	3	2	1
11. Be involved in research activities which will improve patient care.	5	4	3	2	1
12. Write to legislators regarding health care issues.	5	4	3	2	1
13. Be compassionate, kind, and caring regardless of the nature of my illness.	5	4	3	2	1
14. Report unethical and illegal products.	5	4	3	2	1

I Expect Nurses To:	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
15. Report advertisements or commercials which misinform the public.	5	4	3	2	1
16. Be able to administer my medications properly without ever consulting with the pharmacist.	5	4	3	2	1
17. Be responsible for the education of student nurses.	5	4	3	2	1
18. Provide me with information regarding a variety of health products or services so I can decide which ones to use.	5	4	3	2	1
19. Respect my wishes and personal values when I am faced with dying.	5	4	3	2	1
20. Not share information about my health status with anyone.	5	4	3	2	1
21. Be able to decide if my doctor needs to be notified of any problems or changes in my health status.	5	4	3	2	1
22. Participate in determining the terms & conditions of employment of nurses.	5	4	3	2	1
23. Work with others (Doctors, Social Workers, Physical Therapists, etc.) to provide health care to all individuals.	5	4	3	2	1
24. Obtain my consent for other people to review my records for research purposes.	5	4	3	2	1
25. Attend classes & workshops in order to keep current with new health developments.	5	4	3	2	1
26. Evaluate one another's performance.	5	4	3	2	1
27. Consult other qualified nurses when my needs are beyond the abilities of the nurse.	5	4	3	2	1
28. Discuss my care with only those individuals involed in my care.	5	4	3	2	1

APPENDIX E

LETTER TO PARTICIPANT

Letter to Participant

Dear Research Participant:

I am a nurse studying to complete a Master's Degree in Nursing from The University of Kansas. As part of my studies, I am currently conducting a research study which is designed to describe what the general public expects in regard to nursing care. This study is concerned with what individuals such as yourself believe is the ideal in terms of nurses and the care they deliver. As a respondent, you will be contributing to the overall goal of increased awareness of what individuals expect of nurses and to the clarification of what nursing services are needed and wanted by the public.

I invite you to participate in this study by completing the included questionnaire. The questionnaire has been divided into two sections which will make it easier for you to fill out. It will take approximately 20 minutes of your time to complete both sections. There are no 'right' or 'wrong' answers; I expect a wide range of responses and encourage you to express your ideas freely.

Please do not sign your name to the questionnaire. In this way I can assure you that your responses will be totally confidential. Return of a completed questionnaire will indicate your willingness to continue to participate and serve as consent. If for any reason you do not wish to continue to participate at any time during the study, please return the uncompleted questionnaire to me. At the conclusion of this meeting you will be asked to deposit the questionnaire in a designated box.

The information taken from the completed questionnaires will be reviewed and summarized by myself and my educational advisors. The results of this study will then be compiled in a final report. Should you be interested in the results, please inform your group leader of your interest. I would be glad to send abstracts of the study to the group and/or speak to the group once the research is completed.

Your participation in this study is indeed valuable and greatly appreciated. I thank you for your time and cooperation.

Sincerely,

Penny L. Marshall, R.N.