

ATTITUDES OF REGISTERED NURSES TOWARDS
CONSUMER RIGHTS AND NURSING INDEPENDENCE

by

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ABSTRACT

This study investigated the possibility that registered nurses, working directly with the patient, may hold attitudes towards consumer rights and nursing independence which are different from those in the literature and those of nurse leaders and activists which are reflected in the resolutions on consumer rights passed at the Annual Meeting of the Registered Nurses' Association of British Columbia in 1976.

The Pankratz and Pankratz (1974) Attitude Scale, consisting of 47 statements, divided into three clusters:

- 1) Nursing Autonomy and Advocacy;
- 2) Patient Rights; and
- 3) Rejection of Traditional Role Limitations

was administered by mail to a random sample of registered nurses who were members of one of the Districts of the Registered Nurses' Association of British Columbia, Canada. The sample was stratified by educational level and 99.1 percent of 425 subjects were contacted by telephone prior to the delivery of the questionnaire. A total of 392 questionnaires (92.23 percent of the complete sample) was returned. Analysis of variance techniques were used to test the difference between the means when the three clusters in the Attitude Scale (Pankratz and Pankratz 1974) were analyzed by the six independent variables--administrative position, working hours, experience, work setting, age and education.

Results indicated that nurses in administrative positions, those with advanced education and those who work

in educational or community health settings, are more likely to score highly on the Pankratz and Pankratz (1974) Attitude Scale, than are nurses who have not completed a university degree and who work in a hospital setting as staff nurses. The attitudes expressed suggest that nurses are motivated to accept the patient as a participating member of the health care team but they need support to assume the risks associated with a self-image incorporating professional autonomy and interdependence.

Conclusions reached were that the mean of the total sample, on all three clusters, was sufficiently high to encourage nurse leaders to provide assertive leadership on the issues of consumer rights in health care, informed access to information by the consumer and nursing autonomy. Such leadership would develop role models of consumer advocacy with which staff nurses could identify. It is suggested that by increasing, wherever practical, the patient's participation in decision making and in his own care, a more professional and more consumer oriented staff nurse role could evolve.

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. . . Positive health is not something one human being can give to, or require of, another. In large part, its attainment must include self-directed, intelligent, continuing, personal effort. Absent that effort, the health services can only insulate the individual from the more catastrophic results of his ignorance, self-indulgence, or lack of motivation. Providers of health services must learn increasingly to work with patients rather than to do things to or for them.

J. Douglas Colman
Hilleboe Memorial Lecture (1970)

CHAPTER I

INTRODUCTION

The consumer's influence on the health care system is increasing, necessitating a re-examination of the values and attitudes underlying the planning of health care systems for the future. The expression of attitudes which accept the patient's right to assume more responsibility for the decisions made about his own health care, places emphasis on a need for long range planning in which the influence of the consumer has at least equal priority with that exercised by health care workers. In the past, the health care system:

. . . set the boundaries of its services within the doctor's office or the hospital walls rather than within the best "reach" of the patient. It did not orient itself to serve the patient where the patient was--symptomatically, economically, psychologically, or geographically (Brown, 1974:5).

Dorothy Jean Novello, President of the National League for Nursing, in an editorial published in Nursing Outlook, specifically recognizes that nursing does " . . . a very poor job of long range planning for the profession." (Novello, 1977:243). The main thrust of her argument is that, too often, the planning that is done is structured around what is 'good' for nursing and not what is 'good' for the consumer.

Part of this syndrome has been an attempt by nursing, in common with other sections of the health care bureaucracies,

to define the patient as a passive recipient of their care and attention, in order to process him more efficiently through the system (Goffman, 1961; Taylor, 1962; Freidson, 1967; Straus, 1972; Lorber, 1975). The passivity of the patient role has been further supported by the concept of the professional relationship between the recipient of care and the care-giver, as one in which:

. . . the professional dictates what is good or evil for the client, who has no choice but to accede to professional judgement (Greenwood, 1962:206).

Times are changing. Mechanic has suggested that health care organizations of the future, in addition to striving for a better understanding of the biological and psychological needs that underscore the behavior of the sick person, must pay attention to:

. . . the motivations and perspectives of both patients and health care personnel and the cultural and personal incentives that affect their behavior (Mechanic, 1975:3).

This approach emphasizes the active, interactive and reactive nature of the human components of the organizational system.

Malone (1964:48), Lefton and Rosengren (1966:802), Georgopoulos (1966:15) and Straus (1972) point out that the cult of efficiency, through control and regimentation, which is the core of Weber's (1947) ideal bureaucracy leads to a depersonalizing process for both the staff and the client when applied, unadulterated, to organizations that cater to the physical and psychological needs of individuals.

. . . People do not necessarily think and act rationally; they think, act and perform in terms of their own needs, goals, and motives, whether these be rational or irrational, conscious or unconscious, and organizationally relevant or irrelevant (Georgopoulos, 1966:10).

The social forces which have resulted in the patient exhibiting more assertiveness in his relationships with members of the health care professions are at work also on individual nurses. The likelihood has increased that nurses will respond to these forces by casting aside the last vestiges of their 'handmaiden' role in favor of more independent and interdependent interaction with the patient and with other health care professionals.

Weick (1969:25) in a discussion of organizational behavior, supports this position and that taken by Rosengren and Lefton (1969) by arguing that people carry with them, across organizational boundaries, the attitudes and sensitivities which determine their day-to-day behavior outside of organizations. The attitudes of nurses towards issues surrounding consumer rights in health care will affect their reactions to changes which portray the nurse in a more independent, expanded role (Shetland, 1971; Boudreau Report, 1972; Murata, 1974; Keller, 1975; Bullough, 1976; Kinlein, 1977) and the consumer as an active member of the health care team (American Hospital Association, 1972; Consumers' Association of Canada, 1974; Levin, 1972; Kelly, 1976).

Health care planning, which seeks to provide maximum benefits for the consumer of care and to make optimal use of

the various levels of health care workers, will benefit from changes which define the patient as an active participant in his own care--as far as is practical--once he enters the health care system. Aydelotte's comment that the problems and issues of the nursing profession are intertwined with:

. . . the growing awareness of a need for the professional to practice that which is relevant to the client, rather than that which enhances their own professional image (Aydelotte, 1972:21).

remains as applicable to the situation in the health care system at the end of the decade as it was at the beginning.

Statement of the Problem

The social forces behind the publication of a Patient's Bill of Rights by the American Hospital Association in 1972, have had a definite impact upon the health care system on this Continent. The Consumers' Association of Canada has published a Canadian version of the American document on patient rights which they have titled "Consumer Rights in Health Care" (Canadian Consumer, March/April, 1974).

The Registered Nurses' Association of British Columbia, Canada, at its 1976 Annual Meeting, declared its public support of the consumer rights outlined by the Consumers' Association of Canada (1974). At the same Annual Meeting, members of the Registered Nurses' Association of British Columbia stated their support, in principle, of the consumer's right to have informed access to his own health care record so that he is able to participate knowledgeably in the decisions

made about what happens to him, once he enters the health care system (RNABC News, July 1976:7).

The acceptance of the document "Consumer Rights in Health Care"--by the Registered Nurses' Association of British Columbia (RNABC News, July 1976:7) implies that registered nurses in British Columbia, as represented by their professional association, believe that it is time for the consumer to adopt a more active and independent role in his own health care. The Registered Nurses' Association of British Columbia has taken a position which aligns it with the consumer and which recognizes that:

Care that is dictated no longer suits today's clientele. The right to accept, modify or refuse care is a patient's prerogative, just as it is of any other consumer (Burgess and Burns, 1973:314).

Placing more emphasis on the patient's participation in his own care, forces the health care worker to evaluate the strengths of the person seeking care, along with the physical and psychological weaknesses which precipitated the patient's entry into the system in the first place. Encouraging the patient to participate--to the fullest extent possible--in the decision making surrounding his own health care, carries with it the message:

. . . Growth enhancement begins by letting other persons know that they are capable of assisting in the solutions of their own dilemmas (Chapman and Chapman, 1975:24).

The opportunities for self-growth in this situation are not limited to the person seeking help. Nursing has been described as:

. . . an intersubjective transaction, [which] presents an occasion for both persons, patient and nurse, to experience the process of making responsible choices. Through living this process in nursing situations, the nurse develops her own potential for responsible choosing (Paterson and Zderad, 1976:17).

If the possibility for this sort of growth is accepted, registered nurses who expect the consumer to be more assertive and independent, would themselves expect to assume more autonomy in their relationships with the consumer and with other health care workers. Kramer (1972) believes that if the consumer is to be accepted as an actively participating member of the health care team, attitudinal changes must occur which will lead to a restructuring of relationships between health care professionals and consumers.

By personally reaffirming their nursing commitment to the patient as a person capable of self-direction, individual nurses will demonstrate some of the characteristics of a patient advocate. An advocacy model for the health care system, based on humanistic, patient care:

. . . strongly implies action and interaction of both parties in goal setting: it calls for defining in what circumstances responsibility can and cannot be taken for another. Open communication with patients or their representatives concerning power and mutual expectations is thereby possible within such a framework (Chapman and Chapman, 1975:61).

The adoption of the advocacy role description by nurses, will necessitate their rejection of its mirror image--the traditional nursing role--in which the nurse is loath to challenge directly the physician's omnipotence or to encourage the patient to do so (Stein, 1967).

Collectively, through their professional Association, registered nurses in British Columbia have shown a willingness to accept in principle, consumer participation in matters relating to health care. Whether or not individual nurses, working daily with the consumers of health care, accept the changed attitudes and values highlighted by the concepts behind consumer rights, will affect nursing's future interaction with those it seeks to help.

Purpose of the Study

This study attempts to determine if registered nurses, working directly with the patient, hold different attitudes towards consumer rights and nursing independence than those expressed in the literature and by nurse leaders and activists whose work and efforts are reflected in the resolutions on consumers' rights presented and passed at the Annual Meeting of the Registered Nurses' Association of British Columbia, in 1976.

It has been suggested that, although professional associations are ideally, representative of their membership, in actual fact:

. . . there is a wide divergence of aims between rank and file members and their professional associations. The personnel of such associations may be selected from among the avant-garde, the future-oriented members of the profession. They may demand changes in the profession's status and remain insensitive to those members whose security systems are rooted in the status quo (Smith, 1962:219).

The key note speaker at the 1976 Annual Meeting of the Registered

Nurses' Association of British Columbia, Dr. Elvi Whittaker, discussed the theme "The Oppressed Majority". She suggested:

. . . that nurses--making up the largest group of health care workers--are kept from realizing their full potential as members of the health care team (RNABC News, July 1976:13).

Elizabeth Cahill (a general duty nurse) and a member of a five member panel reacting to Whittaker's presentation, commented that one of the ways that general duty nurses are oppressed is through a lack of representation in the activities of their professional association. Cahill stated that representatives:

. . . are often head nurses or supervisors who don't work shifts and can attend more meetings than general duty nurses (RNABC News, July 1976:16).

This study asks:

- 1) Are the attitudes of registered nurses in British Columbia towards nursing autonomy and advocacy, and consumer rights congruent with the professional Association's public declaration of support for the Canadian Consumers' Association statement on "Consumer Rights in Health Care" and their support, in principle, of the patient's right to have informed access to his own health care record (RNABC News, July, 1976)?
- 2) Does a relationship exist between the personal characteristics and background of respondents (administrative position, hours of work, years of experience, work setting, age and education) and attitudes expressed about nursing independence, patient advocacy, consumer rights and rejection of traditional role limitations, as measured by the Pankratz and Pankratz Attitude Scale (1974) used in this study?

CHAPTER II

REVIEW OF THE LITERATURE

Planned Change: A Theoretical Framework

Planning for change requires an understanding of change as an integral part of existence, recognition of the rapidity with which a need for change presents itself in today's society, and an acknowledgement of the complexity of the interactions that change initiates (Toffler, 1970). It is necessary to achieve a balance in human planning which allows energy and resources to be committed to anticipated changes while, at the same time, maintaining enough leeway so that "unanticipated consequences" do not strain to breaking point, the human ability to cope (Bennis et al., 1976:427).

Nursing leaders who turn to the literature in order to gaze into the crystal ball of the future, must be influenced by:

- 1) the increasing emphasis on the involvement of the public in the responsibility for their own health care (Somers, 1971; Lalonde, 1974; Fuchs, 1974; Little and Carnevali, 1976; Etzioni, 1977).
- 2) the growth of consumerism as a social force (Annas, 1974 A and B; Storch, 1977).
- 3) the changing role of women in society (U.S.A. Department of Health, Education and Welfare. Proceedings of the International Conference on Women in Health, 1975; Polk, 1976; Grissom and Sprengler, 1976).

- 4) the mounting economic toll exacted by the health care system, as it presently functions (Hastings, 1972; Uprichard, 1972; Lalonde, 1974)
- 5) the evolving and expanding role of the nurse practitioner (Mauksch, 1975 and others)
- 6) the need for the delivery of a personalized and acceptable health care service to all the people (Aydelotte, 1972; Howard, et al. 1975)
- 7) the shift away from a preoccupation with illness and a move towards the maintenance of health (Reeder, 1972; Lalonde, 1974)
- 8) the increasing proliferation of knowledge and its more widespread absorption by the various levels of the population (Mussallem, 1970:210; Pettigrew, 1973:136; U.S.A. Dept. of Health, Education and Welfare, publication #HRA-76-14503, 1976:17; Haug, 1976:90)
- 9) the escalating sophistication of medical technology (Brown, 1970:22; The B.C. Professional Engineer, Special Issue: Biomedical Engineering, July 1976)
- 10) the prediction that there will be a disproportionate percentage of people, over the age of 65 years, in the total population by the year 2,000 as well as an overall growth of population (Lalonde, 1974:60).

The list is not exhaustive nor is it arranged in the order of importance but, it contains the possibility of enough uncertainty in the future for the environment in which the health care system operates, to be classified as "turbulent" (Emery and Trist, 1973). In the rapidly changing world in which we live, no one can expect any change to evolve without that change itself being altered by other impinging forces in the environment.

The "turbulent field" environment is unpredictable because of the complex interactions taking place within it, as the result of the rapid rate of change. It is not possible to isolate the turbulence, as coming from this or that point

in the environment but rather the whole 'stuff' of the environment is changing, setting up whirlpools and currents, the effects of which are difficult to predict (Emery and Trist, 1973:171).

Survival in the constantly changing environment may well hinge upon the evolution of a set of common values, which will smooth out some of the uncertainties in the turbulent field. These values become like a life-net strung above the causal turbulence. Provided that the values are representative of other organizations in the field, an individual organization can perfect its ability to adapt, without being threatened with complete destruction, as may happen in an unmodified turbulent field environment (Emery and Trist, 1973:173).

Most of the changes that have taken place in the health care field, over the last 25 years, have been the result of external forces in an uncertain environment.

. . . . If nursing is to maximize its potential effectiveness, . . . , it needs greater knowledge than it has had in the past of how to predict social trends early, and greater skill in planning in alliance, rather than at variance, with these trends as they appear (Brown, 1970:3).

Change, within nursing, usually gains its first seal of approval from the acknowledged leaders of the profession, expressed via pronouncements from the professional organizations, through the medium of the professional literature, by the implementation of innovative programs of patient care in educational settings or in situations which allow nurses to model a new role in pioneer, frontier areas.

Stevens postulates that the time lag between the birth of a new idea and its general acceptance is intrinsically tied up with the attitudes, values and goals of the group affected by the change (Stevens, 1975:25). Recent reports in the nursing literature agree with the position taken by Stevens. For example, Jordan and Shipp describe a program at the University of Florida, in which a registered nurse provided primary health care for diabetic patients. They report that the patients and their families completely accepted the nurse specialist. However, nurses (with the exception of the faculty members) exhibited reluctance to accept the innovation. The authors believe that nursing reacted to a perceived threat to one of the institution's goals--the recruitment of sufficient staff, at a time when the supply was low. At the same time, an existing threat to the individual nurse's ability to provide quality nursing care in already well defined roles, because of the shortage of staff, did not make it easy for nurses to accept the deployment of one of their number into a new and expanded role (Jordan and Shipp, 1971).

Rafferty and Carner who initiated an independent, group nurse-consultant service, also found that some nurses were critical of their innovation--viewing it as a challenge to the established status quo, although other colleagues were enthusiastic about the project (Rafferty and Carner, 1973:235). Andrew and Yankauer confirm these impressions. They state, that:

The freshness, the lack of precedents, and

the lack of definitions of these new roles, however, lead some nurses and physicians to retreat into stereotyped perceptions of themselves and their responsibility for the patient whenever minor problems or flaws arise in the new arrangements (Andrew and Yankauer, 1971:508).

The stereotyped perceptions, to which Andrew and Yankauer refer, include a concept of the patient as a passive recipient of care and the giver of care as the authority figure whose access to knowledge confers upon him the right to make decisions about what is 'good' for the patient without necessarily including the patient in the decision making process (Andrew and Yankauer, 1971). Consumer forces, in this decade, have directed energies towards establishing a new perception of the patient as an active participant in the health care system, based on the philosophy which states:

. . . What patients want is as important in formulating policy as what physicians and nurses think they need (Mullane, 1975:701).

The success or failure of the new image of the patient will depend, to a large extent, upon how successful the consumer is in gaining access to knowledge and information, both about his own health care and about the health care system in general.

Knowledge as a source of power is an underlying theme in the three strategies for change described by Chin and Benne:

- 1) empirical-rational strategies, in which rational self-interest is the operative element. Change is promoted when some group or person can demonstrate to others, that the proposed action will result in gain for those affected by the change.
- 2) normative-re-educative strategies where, in order for change to take place, people have to change their old values and adopt new ones.

- 3) power-coercive strategies, which use economic and political power in order to achieve goals, that are viewed as desirable, by the change agents (Chin and Benne, 1976:23).

Although health care planners are, at present, using all three of these strategies in order to produce change within the health care system, it is the empirical-rational approach which has been more prevalent in face-to-face interactions between the professional provider of care and the consumer of care (Pratt et al. 1957; Kane and Kane, 1969; Wilson, 1963; Freidson, 1972; Powers and Ford, 1976). The professional is described by these authors as formulating a proposed course of action for the patient to follow to ensure a gain in his health status. Powers and Ford say:

. . . At this point, the patient becomes a participant-observer in the affairs of his life.
 . . . He [the patient] is told, or he is instructed, regarding his treatment. The physician teaches or the nurse teaches all the patient needs to know. The catch is, that all the patient needs to know is determined by the provider (Powers and Ford, 1976:54).

Chin and Benne emphasize that power is a vital variable in all three strategies of change. The differences evolve because of the way that the power situation is handled in change processes. In the empirical-rational approach:

. . . men of knowledge are legitimate sources of power and the desirable flow of influence or power is from men who know to men who don't know through processes of education and of dissemination of valid information (Chin and Benne, 1976:39).

Greenwood maintains that the assumption of responsibility for the client, which professional authority confers upon the health care worker, is one of the signs that the client is seeking as he tries to assess whether or not the relationship

will meet his needs (Greenwood, 1962:210). The professional exercises his power to decide what is 'best', in a particular situation, with the consent of the client involved.

. . . Although empirically this consent may be based on fear, ignorance, or habit, in a broader sense it is a consequence of the client's implicit acceptance of the professional's expertise and good will, and the understanding that in accepting the authority of the professional the client in turn will be rewarded (Haug and Sussman, 1969:154).

Zola (1975) and Illich (1976) reject the assumption of responsibility for the patient by the professional. Illich asserts that this strategy has resulted in an intolerable dependency on a medical monopoly--a situation that he has labeled "medical iatrogenesis". He dramatically isolates the unexpected medical consequences of our age and forces society to contemplate the destructive spin-offs of medical technology. For Illich, a self-reliant population in matters relating to health care is positively correlated with a high level of health in the general population. He says:

. . . Medical nemesis is the experience of people who are largely deprived of any autonomous ability to cope with nature, neighbors, and dreams, and who are technically maintained within environmental, social, and symbolic systems (Illich, 1976:271).

If participative patient care, based on the patient's right " . . . to be respected as the individual with the major responsibility for his own health care." (Consumer Rights in Health Care, 1974) is to become one of the goals of the health care system of the next decade, change will need to take place within a framework similar to the one described as normative-re-educative. Chin and Benne have identified two

variants of this change strategy. The first is aimed at helping the client to improve his problem-solving abilities and the second at increasing the possibility that the change process will result in the client becoming more self-reliant, more able to cope with the personal challenges that confront him (Chin and Benne, 1976:34).

The use of the normative-re-educative framework for change requires a philosophical stance which recognizes the consumer as an individual with a store of untapped, personal, resources at his disposal. Christman, in an article discussing the role ambiguity that the patient faces when he enters a hospital, agrees that most people, as patients, are strangers within the hospital system. He believes that nurses have a duty to reduce the environmental uncertainty surrounding the patient, by clearly spelling out the expectations inherent in the nurse and patient roles. This includes an obligation to interpret the technical and professional jargon of the institution, in such a way that the patient is able to function as a participating member of the health care team (Christman, 1967:18).

By establishing free and open communication with the consumer, through careful explanation of all the details which, at present, are only available to the professional staff (including full and informed access to his own health care record) the patient is likely to emerge from his period of hospitalization, more knowledgeable and self-sufficient in matters relating to his own health.

. . . The enhanced abilities he has acquired to manage his own personal health may be sufficient to prevent or reduce the probability of a recurrence of his illness (Christman 1967:21).

Support by the professional Association of Registered Nurses' in British Columbia (1976) of full and informed access by consumers to their own health care record is in accord with Christman's (1967) thesis and it is congruent with the oft repeated statement by nurses that the patient is the center of their concern in the health care system. It affirms the position taken by Rogers (1977:12) that the participatory relationship, between the provider of care and the consumer of care, is considered to be the base upon which therapeutic interventions will yield optimal results. Chin and Benne state, that:

. . . By getting the values of various parts of the client system along with his own openly into the arena of change and by working through value conflicts responsibly, the change agent seeks to avoid manipulation and indoctrination of the client in the morally reprehensible meanings of these terms (Chin and Benne, 1976:33).

Focusing on improving access to information by the consumer in order to increase the probability that joint problem solving will evolve, is an approach which facilitates increased personal growth and actualization in the consumer (Christman, 1967; Chapman and Chapman, 1975; Paterson and Zderad, 1976; Rogers, 1977) as well as continued self-renewal and change within the health care professions. Rogers states:

A person-centred approach, when utilized to encourage the growth and development of the psychotic, the troubled, or the normal individual, revolutionizes the customary behaviors of members of the helping professions (Rogers, 1977:28).

In 1961, Dodge conducted a study using 126 registered nurses, licenced practical nurses and nursing aids working in a 314 bed hospital for the aged and chronically ill, to try to isolate whether or not psychological factors of personal inadequacy, are involved in a person's reluctance to communicate freely and fully with others. Dodge did not try to demonstrate a causal relationship. Her hypothesis stated that, the nurse who believed herself to be psychologically strong, would be more willing to keep the patient informed, than those nurses who perceived themselves to lack such strength. The data supported the hypothesis, although the results are restricted because of the specific type of patient with whom the nurses in the sample were interacting.

The use of normative-re-educative strategies in managing change does not avoid the fact that knowledge is a source of power in consumer/professional interaction but this approach seeks to confirm that the individual to be helped is capable of self-direction. The essence of the strategy revolves around an understanding that:

. . . changes in normative orientation involve changes in attitudes, values, skills and significant relationships, not just changes in knowledge, information, or intellectual rationales for action and practice (Chin and Benne, 1976:23).

If the nursing profession accepts the right of the consumer to have access to what is now treated as classified information, accountability by the professional nurse to the consumer of care, becomes more visible. Change will have to take place in the attitudes, values, skills and significant relationships

of both parties.

Change within the existing health care system is being precipitated by increasing costs, as well as by changing values and technological innovation. In an age where inflation is a household word, it comes as no surprise to find costs cited as one of the primary reasons for exploring different approaches to the delivery of health care services (Berki, 1973). At present, most of the taxpayer's dollars for health care are expended on physician centered, hospital care of already existing illness (Lalonde, 1974:12).

Berki in an analysis of the impact of the introduction of various types of 'physician extenders' on the economics of the health care system, describes the prevailing pattern of health care, with its emphasis on specialization and disease processes as:

. . . a system of functional fragmentation in which the host, the patient, is but a lost wanderer in the strange and complex galaxy of medicine (Berki, 1973:118).

He makes the point that changes in the health care system, resulting from the introduction of new versions of medical manpower, will have similar results to those spelled out by Emery and Trist as occurring in a 'turbulent field environment'.

. . . The consequences . . . lead off in ways that become increasingly unpredictable: they do not necessarily fall off with distance, but may at any point be amplified beyond expectations; similarly, lines of action that are strongly pursued may find themselves attenuated by emergent field forces (Emery and Trist, 1973:171).

Given the complexity of the interactions in the health

care system, the increasing acceptance of responsibility by the Canadian Government for the financing of health care, and the stated objectives of the Canadian Government:

- 1) To reduce mental and physical health hazards for those parts of the Canadian population whose risks are high, and
- 2) To improve the accessibility of good mental and physical health care for those whose present access is unsatisfactory (Lalonde, 1974:66).

it is clear that power-coercive strategies for change will continue to have a significant influence on the future of the health care system in Canada. The power-coercive strategies of change are those which bring the force of economic and political pressure to bear in order to achieve changes seen as desirable by strategists responsible for the delivery of health care.

It is likely that all three strategies of change will continue to be important in the health care system. For instance, Chin and Benne emphasize that:

. . . normative-re-educative strategies must be combined with political coercion, both before and after the political action, if the public is to be adequately informed and desirable and commonly acceptable changes in practice are to be achieved (Chin and Benne, 1976:42).

Changing social values suggest that changes will occur in the incidence of use, within the health care system, of the three strategies of change. Linn, in a study of the care-cure orientation of faculty and students at the University of California Schools of Medicine and Nursing, concludes that the medical practitioners of the future will more readily display interest and concern in the social and psychological

environment affecting the pathology exhibited by persons who come to them for help. This study suggests that the nursing and medical professions are moving away from a clearcut dichotomy between care and cure towards a positive acceptance of both goals by members of each profession (Linn, 1975).

Bliss views this progression positively because she believes that the average consumer of care is " . . . very much in need of both care and cure from a single person" (Bliss, 1976:13).

A display, by young physicians, of a growing interest in areas outside those covered by the exclusive attention to pathology evinced by the medical model, could have far reaching effects on the health care system. According to Cunningham, editor-at-large for the journal Modern Healthcare:

. . . it is possible that a comparatively small number of young physicians in a few centers in a few areas over a few years could acquaint a formidable number of patients with what it means to be a partner, and not a cipher, in their own health care (Cunningham, 1976:72).

Further confirmation that social forces are changing the health care scene can be obtained from the observations made by Haug, suggesting that the acceptance of the use of special knowledge as a source of power by an elite group is on the wane. Data gathered from health care facilities in Great Britain and the U.S.S.R. confirmed that an increasingly sophisticated client population is rejecting the assumption of professional authority by health care workers which excludes the client from the decision making process (Haug, 1976).

Bertram Brown, the Director of the National Institute

of Mental Health, speaking at the 1977 World Congress on Mental Health held in Vancouver, British Columbia, stated that the important thread which orders and supports all our efforts in the provision of mental health services is tied up with the values and attitudes that govern our lives.

. . . An individual may accord primacy to the values associated with any number of personal or institutional identities in his or her life. Ultimately, however, a common thread must link them all lest our lives as well as our institutions become chaotic, our goals fragmented (Brown, 1977:3).

Brown's approach can be extrapolated to other health care services. It is in accord with the suggestion that a set of common values can be utilized to reserve energy for dealing with the uncertainties generated by change (Emery and Trist, 1973:173).

Although the patient, intermittently, is extremely dependent upon the physician's expertise and knowledge, at the same time, a physician without patients loses his reason for setting up in medical practice (Freidson, 1972:214). Patients are precipitating a re-examination of old values by voicing, through the consumer rights' movement, rejection of the passive patient role in favor of one which allows more participation by the patient in the decision making processes that go on once he enters the health care system.

Consumer Rights

The movement towards a more organized demand by consumers for recognition of specified rights in health care has not evolved in a vacuum. It is a part of a general trend in society, which places emphasis on the consumer's 'right to know'. During the last decade, there has been a re-definition, within the North American legal systems, of the balance of power in many legal relationships which were previously held to be sacrosanct--stabilized in favor of the person holding the publicly acknowledged authority in the interaction (Annas and Healey, 1974A:25).

Annas has written at length on the subject of patients' rights, basing his argument that the hospital is a "Human Rights Wasteland" on the:

. . . two fundamental premises: (1) The American medical consumer possesses certain interests, many of which may properly be described as rights, that are not automatically forfeited by entering into a relationship with a doctor or a health care facility; and (2) Most doctors and health care facilities fail to recognize the existence of these interests and rights, fail to provide for their protection or assertion and frequently limit their exercise without recourse (Annas, 1974A:11).

The trend by patients to assert their rights in the health care system has been tempered by a need to retain the goodwill of health care professionals--a fact which is evident in the wording of the American Hospital Association's "Bill of Rights for Patients" (1972) which contains proposals " . . . so vague that they are almost meaningless." (Annas, 1974A:21). The document has been described as paternalistic (Gaylin, 1975:22)

and its authors accused of sidestepping " . . . certain topics that were sure to irritate the medical profession." (Quinn and Somers, 1974:242).

The necessity to co-exist with a powerful other person or organization varies as the ability to 'rock the boat' without increasing the risk of sinking it, improves. The soft pedalling of expressions of discontent, in power balancing operations which involve dependency relationships, is necessary, if:

. . . all the participants in the power game know that they will have to live with each other, whatever the results of their quarrels, [therefore] a minimum of harmony and good fellowship must be maintained, whatever the opposition of roles (Crozier, 1964:167).

Factors which decide how easy it will become for the consumer to replace more economically--or to do without--the services of health care workers, as they presently exist, will determine (in part) how powerful the consumer movement in health care is likely to become in the future.

Following the publication of the American Hospital Association's statement on Patient Rights in 1972 and its circulation to the 7,000 members of the Association, many of these institutions put out statements declaring that they were already operating under a philosophy which incorporated the patient rights outlined in the Bill, (Quinn and Somers, 1974:241). Other responses included that of the Insurance Commissioner of Pennsylvania, Herbert S. Denenberg. Reacting to the carefully worded American Hospital Association's Bill of Rights, Denenberg issued his own "Citizen's Bill of Hospital

Rights". This document displayed no tendency to tread lightly around areas questioning administrative authority. It stipulated that " . . . unnecessary services should be discontinued, and duplicative, unsafe facilities should be closed." (Hospitals JAHA May 26th. 1973:21).

The publication of the American Hospital Association's document--"Bill of Rights for Patients" (1972)--increased the public's awareness of the subject and brought into prominence the role of the patient advocate as one way to improve the powerless position of the patient once he enters the health care system (Annas and Healey, 1974B; Quinn and Somers, 1974; Kalisch, 1975; Kelly, 1976). Annas and Healey analyzed the results obtained when hospitals in the United States of America provided patient representatives and issued pamphlets explaining the rights of patients in their hospitals. They came to the conclusion that most of these efforts failed to provide complete information. For instance, although Massachusetts law allowed patients access to their own records, the brochure given to patients by the Boston Beth Israel Hospital did not mention this fact (Annas and Healey, 1974A:29).

An ombudsman-patient-advocate role was instituted by the Montreal General Hospital in their Emergency Services, on an experimental basis. The advocate, who was a university graduate with special expertise in psychology and sociology, was available as a resource person for patients waiting in the emergency area. The Montreal General Hospital also provided

a suggestion box and an information sheet for their patients, containing details of policies and procedures which might affect the patient as he waited for service. Although the ombudsman-patient-advocate role was discontinued in 1973, it was evaluated positively. At the time that the project was reported, it was stated that continuation of the role was dependent upon the lifting of budgetary restraints (Morgan, 1973:26).

The need for the patient advocate to be paid from a source outside the hospital, in order to avoid the possibility that low priority will be assigned to the role when the budget is being considered, is an important consideration if the role is to become established. External funding would also reduce any tendency that the advocate might have, to give first priority to the maintenance of the status quo--pouring oil on troubled waters--instead of looking for the source of problems in order to try to eliminate them (Annas, 1974B:23). Hospital employees are hampered in the role of patient advocate if their first loyalty is to administration or to medicine. Specifically considering the qualifications of nurses as advocates, Annas came to the conclusion that they have many of the necessary attributes required by the role. However, crucial to the nurse's success as an advocate, is how she sees herself and how she is viewed by others.

. . . For example, the nurse may be seen as more concerned with obtaining information for the doctor than in helping the patient obtain information from the doctor. If so, the nurse cannot function effectively in this role (Annas, 1974B:25).

Annas and Healey list the following powers which they feel the patient advocate must be able to exercise, when necessary, on behalf of the patient. They point out, that:

. . . To a large extent, these powers are rooted in the rights that the patient possesses and include:

- complete access to medical records and the authority to call in, at the direction of the patient, a consultant to aid or advise the patient;
- active participation on those hospital committees responsible for monitoring quality health care, especially utilization-review and patient care;
- access to support services for all patients who request them;
- participation at the patient's request and direction in discussion of the patient's case, especially before decisions must be made and alternatives chosen (Annas and Healey, 1974B:258).

Annas and Healey describe the advocate as exercising " . . . at the direction of the patient, powers that belong to the patient." (Annas and Healey, 1974B:258). These authors do not stipulate that, to the extent that he is able, the patient should exercise these powers for himself. Hughes elaborates, with a simple statement, the consequences of not making it clear that the patient, where he is able and willing, is the pivotal point around which decisions and alternatives evolve. He says:

. . . In many of the things which people do for one another, the for can be changed to to by a slight over-doing or by a shift of mood (Hughes, 1958:70).

The advocacy model put forward by Chapman and Chapman avoids the possibility that the power shift in the advocacy relationship will be in the wrong direction, by incorporating the stipulation that:

. . . an advocacy model of humanistic helping implies that actions are taken in behalf of patients when it has been determined that on their own they or their representatives cannot bring the needed resources to bear on the situation (Chapman and Chapman, 1975:68).

Research in the area of patient rights has not been extensively conducted. An interesting survey, in the form of a nation wide, public poll of 1,513 American households by Louis Harris and Associates, Inc. asked subjects about their feelings on patients' rights and American health care. The majority of respondents (78 percent) agreed that everyone seeking help from the health care system, has a right to be told the nature of his illness as well as the dangers associated with it and the range of help that he can expect to receive from professional health care workers. Seventy-four percent supported the patient's right to refuse medications or treatment, even if the professional sees such behavior as detrimental to the patient's wellbeing. Of those polled, 97.2 percent stated that patients should receive a full explanation of any experiment before they were asked to participate in it. A feeling that hospitals and their personnel were not completely trusted, emerged. Forty-one percent of the sample felt that hospital patients do not get quality care and 11 percent expressed themselves as "not sure" on this issue (Harris, 1973).

The Harris poll agreed, in the areas to do with access to information, with the results obtained by McClure (1975) in a study conducted to investigate the reactions of a group

of patients and nurses to the concepts contained in the American Hospital Association's "Patient Bill of Rights" (1972).

McClure's findings indicate that nurses and patients verbally support the concepts tested. The right to information, explanations before signing a consent, and the right to be advised of any experimental research were all items which were ranked highly in importance and which received strong support from both nurses and patients. The study was conducted in two large metropolitan hospitals with a non-random sample of 172 respondents. One of the hospitals was operated by a Board of Trustees and the other was financed by government funds. Registered nurse subjects were staff nurses employed on medical and surgical units. No information was included about the educational status of the subjects or whether or not the hospitals were used for teaching purposes. The results obtained are restricted by the non-random nature of the sample and by an acknowledged lack of tested reliability and validity of the research tool used. Overall, nurses responded more positively to the concepts than did the patients (McClure, 1975).

Pankratz and Pankratz, in a study which constructed and tested the Nursing Attitude Scale used in the present study, found that:

. . . nursing leaders had by far the most progressive attitudes regarding nursing autonomy and patients' rights (Pankratz and Pankratz, 1974:215).

The sixty-nine item questionnaire constructed by Pankratz and Pankratz measured three sub-scales:

- 1) Nursing Autonomy and Advocacy;

- 2) Patient Rights; and
- 3) Rejection of Traditional Role Limitations.

The questionnaire was administered to 702 nurses representing nursing leaders, nurses working in psychiatric hospitals, university teaching hospitals and community hospitals. The nurses working in community hospitals tended to be the most traditional in their attitudes. The majority of these nurses (90 percent) were diploma graduates. Advanced educational preparation was found to be positively correlated with all three sub-scales ". . . indicating that nurses with advanced education are stronger supporters of the autonomous role." (Pankratz and Pankratz, 1974:214).

A correlation also exists between advanced education and the answers given in the Harris survey to a question designed to probe how people feel about the quality of care in American hospitals. By a small majority, people stated that they did not feel that patients were neglected but, of the people who disagreed, the more affluent, better educated, younger people under thirty, predominated (Harris, 1973).

A review of the circumstances in which the American Hospital Association's Patient's Bill of Rights came into being in 1972, reveals that its authors included hospital administrators, hospital and agency planning chiefs, physicians, attorneys and consumers--but no nurses (Quinn and Somers, 1974:240). It is obvious that the lack of a nursing representative on this committee did not stem from a failure by nursing leadership to support the concepts behind patient rights and consumer participation.

The nursing profession, on the North American continent, has a long history of sensitivity to the needs of the people that nursing serves. The National League for Nursing formally identified itself as an organization concerned with encouraging consumer membership and participation in 1952, when the structure of the organization as we know it today, emerged (Mauksch, 1971:98). Mauksch sees a need to strengthen even further, the consumer's influence on the goals and objectives of the League.

I believe that it would not be difficult to envisage the League of tomorrow as an organization promoting health care rather than only nursing! Thus, it could become committed to the support of all endeavors directed toward meeting the health care needs of the people. As the NATIONAL LEAGUE FOR HEALTH CARE, it would be a unique organization in many ways (Mauksch, 1971:98).

In 1959, the National League for Nursing convened a Committee to draft a statement dealing with the rights of people as patients. This publication was titled "What People Can Expect of Modern Nursing Service." In the statement, recognition was given to the fact that cooperation between the consumer and provider of care enhanced the quality of nursing care that could be provided. However, the committee in dealing with the patient's right to be informed, emphasized the commonly accepted feeling of the day that the physician was the Captain of the ship. The document stated that, " . . . within the limits determined by his doctor. . . " (Carnegie, 1974:561) information about the patient's illness would be relayed to the patient or his family by nursing.

Committee members, reacting to the social climate of the day, failed to identify the philosophical bridge which separates the patient as the passive recipient of the professional health care worker's concerned care and attention, from the patient--or a member of his family, where appropriate--as the ". . . individual with the major responsibility for his own health care." (Canadian Consumers' Association, 1974). As a result, nursing's handmaiden role and the Aesculapian authority of the physician (Kalisch, 1975) were perpetuated.

The attitude that, "The Doctor knows best" is widespread in Western culture. According to Kalisch the physician's Aesculapian authority:

. . . stems from a three-pronged power base: the physician's expertise, the patient's faith in him and the belief that he [the physician] has almost mystical powers (Kalisch, 1975:22).

The behavior of the contributors to the patient/doctor dyad is modified by the expectations each has of the other. The patient usually makes the initial moves which establish the relationship and can, in most instances, terminate the association at will. However, the balance of power in the interaction, is nearly always invested in the professional as the ultimately knowledgeable member of the interaction (Wilson, 1963:279).

Reeder has examined the changing status of people seeking help from health care professionals by an analysis of the labels applied to them in the literature. He maintains that simply by the progressive substitution of 'client' for

'patient' and 'consumer' for 'client', changes occur in the environment which alter the behavior exhibited, depending on the labels used.

. . . The social construction of the relationship becomes redefined by virtue of the realities imposed in the bargaining and negotiating between client-practitioner versus consumer-provider (Reeder, 1972:409).

Little and Carnevali in the second edition of their book--Nursing Care Planning--published in 1976, provide confirmation of Reeder's point. They acknowledge the effect that the changing status of the consumer has had on the format of their second edition. The authors state in the preface to the second edition:

. . . in keeping with our valuing of the consumer as a participant in his health care, at whatever level is possible, we opted to call his role "client". You will note also that we relocated the client and his values from the end of the chapter on values in nursing care plans to the beginning. This also reflects where we are (Little and Carnevali, 1976:viii).

Reeder's thesis suggests that the label 'consumer' is a more powerful cue in inducing change in role behavior than 'client'. The client/professional relationship retains many of the implications of dependency present in the patient/professional roles. On the other hand:

. . . in consumer-provider relationships, caveat emptor implies that the consumer has considerably more bargaining power than formerly. He may . . . be able to shop in the market place of health care (Reeder, 1972:409).

The cues generated in the environment when acute care is the focus of the medical system, result in the establishment of a seller's market, in which the patient is seen as a

supplicant for benefits controlled by powerful professionals. The swing to preventive medicine with more emphasis on the maintenance of health has resulted in the formation of a partial buyer's market. The consumer has to be convinced that the professionals have something to offer him in this area and, consequently, more efforts are made by professionals to attract the client (Echeveste and Schlacter, 1974).

The publication of documents concerned with the rights of patients is a tacit admission of the patients' dissatisfaction with the way their rights are recognized in the present health care system. Rozovsky (1974A:8) has expressed "surprise" and Kelly (1976:26) "sadness" that patients should have to lay claim formally to principles which are already theirs, both legally (based on common-law decisions) and morally (stated in the code of ethics of both physicians and nurses).

Rozovsky presents three suggestions to Canadian hospital authorities which he believes, if implemented, would " . . . safeguard not only the patient's rights but his interests as well." (Rozovsky, 1974A:10). They are:

- 1) the addition to the curriculum in all schools of nursing and medicine, of courses in law as it affects health care
- 2) the creation in all hospital personnel, including members of the medical staff, of a spirit of human responsiveness
- 3) the establishment of systems auditing the standards of medical, nursing and technical care (Rozovsky, 1974A:10).

Curtis in a forum column encouraging physician-readers of Medical World News to express their views, reinforces

Rozovsky's second suggestion. Curtis, a physician, believes that the prevalence of malpractice lawsuits against professional health care workers, is the result of badly managed communication with patients. The physician's apparent lack of concern for them as persons, makes the patients angry enough to sue the physician if " . . . an opportunity or an opportunistic attorney become available." (Curtis, 1975:110).

The viewpoint expressed by Curtis is in agreement with that taken by the U.S. Department of Health, Education and Welfare Secretary's Commission on Medical Malpractice. Their report specifically recognized the link between patient care which ignored the human rights of patients and the incidence of medical malpractice lawsuits. The recommendations of the Commission included one which stated:

. . . that hospitals and other health care facilities adopt and distribute statements of patients' rights in a manner which most effectively communicates these rights to all incoming patients (U.S. Department of Health, Education and Welfare Secretary's Commission on Medical Malpractice, 1973:74).

Kome (1976:18) writing in the magazine Homemaker's, quotes Ivy Dunn--Director of Nursing at the Royal Ottawa Hospital, Ontario, Canada--where a printed bill of rights is distributed to patients, as stating that this innovation resulted in increased involvement and more work for everyone but, she feels that it is a positive step in the right direction. Initially, staff at the Royal Ottawa expressed fears that the Hospital was inviting a rash of lawsuits by informing patients of their rights, but this has not been the case.

The December 7th, 1976 edition of The Medical Post, published in Toronto, Canada, reports that the council of the Ontario Medical Association rejected, by a vote of ninety-six to seventy-nine, a document called "Declaration of Patients' Rights", drawn up by the Ontario Medical Association's Citizens' Advisory Board and submitted to the council after being modified by the Association's executive committee and Board of Directors. Dr. Todd, President of the Ontario Medical Association, described the bill as "innocuous". It contained nothing that is not already accepted by the medical profession and incorporated in the Canadian Medical Association's code of ethics. The risk of malpractice suits was one of the reasons given by the President of the Ontario Medical Association for the refusal of the council to adopt the bill (Medical Post, December 7th, 1976:1, 28).

Consumer rights associations have been formed across Canada. A typical one is the Patients' Rights Association formed in Toronto, Ontario. This non-profit organization has published a booklet called the Patient's Rights Manual which enumerates in detail the grievance procedures available to the patient if he feels that his rights have been ignored or neglected. Listed in the Manual are the following legal rights of patients:

- 1) The right to medical care in an emergency
- 2) The right to control one's own body
- 3) The right to voluntary informed consent
- 4) The right to decide whether or not to be used for research or teaching purposes (Patient's Rights Manual, no date:12).

Along with these rights, the booklet lists three patient responsibilities:

- 1) To fully disclose symptoms or conditions;

- 2) To follow medical instructions;
- 3) To return for treatment (Patient's Rights Manual, no date:14).

The Manual notes that the second responsibility runs counter to the right to accept or reject treatment which is inherent in the second legal right--to control one's own body.

. . . The implication here is that in asserting your right to refuse a particular treatment your physician may decide he can no longer treat you adequately hence ask you to obtain another physician (which action is within his legal rights) (Patient's Rights Manual, no date:14).

The Patient's Rights Manual also names three moral or ethical rights:

- 1) The right to privacy
- 2) The right to normal human courtesies . . .
- 3) The right to a second opinion . . . (Patient's Rights Manual, no date:15).

The Manual goes on to discuss rights which the Patients' Rights Association feels are legally in dispute and points out the conflicts which exist between the basic legal rights originally listed and those rights which the patient most often feels are ignored by health care professionals. For instance, the Association believes that the patient's right to know the truth is disputed and that this conflicts with the basic right of voluntary, informed consent.

The Canadian counterpart of the American "Patient Bill of Rights" is titled "Consumer Rights in Health Care". It was published in 1974 by the Consumers' Association of Canada and identifies four major areas in which Canadian consumers feel that their human rights are in jeopardy, once they enter the health care system.

- 1) Right to be informed.
- 2) Right to be respected as the individual with the major responsibility for his own health care.
- 3) Right to participate in decision making affecting his health.
- 4) Right to equal access to health care (health education, prevention, treatment, and rehabilitation) regardless of the individual's economic status, sex, age, creed, ethnic origin and location. (Appendix A).

The first three areas reflect a concern with the quality of communication between members of the health care professions and the consumer. It is reasonable to assume, therefore, that the public sees a need to improve the communication that presently exists between the parties.

Members of the Registered Nurses' Association of British Columbia, represented by their professional association, have recognized the existence of this communication gap by specifically questioning the right of professionals to declare that information in the consumer's health care record should be withheld from the individual consumer whom it directly concerns (RNABC News, 1976:7). Informed access to information increases the possibility that the consumer (or his appointed representative) will be able to participate intelligently in the decision making processes surrounding his plan of care. Such participation utilizes the principles behind the normative-re-educative strategy of change. In this strategy, individuals are seen as the important unit of the social system and capable of taking self-reliant action towards accomplishing their life potential, provided that the environmental forces foster and support that action (Chin and Benne, 1976:39).

References to the responsibility of the patient for

his own health are increasing in the literature of the social sciences (Lalonde, 1974; Fuchs, 1974; Little and Carnevali, 1976; Illich, 1976) as well as finding expression in the editorials of daily newspapers, for example, The Province, Vancouver, British Columbia, 5th August, 1977. It is, however, not a new concept although the climate in which it is advocated today endows it with the possibility for "unanticipated consequences" missing in previous contexts.

As far back as 1847, when the American Medical Association adopted its first code of ethics, they included a heading of "Obligations of Patients to Their Physicians" which contained the following statement:

. . . The first duty of a patient is to select as his medical adviser one who has received a regular professional education . . . the world ought not to suppose that knowledge is intuitive (New York Medico-Historical Society, 1864:49).

In 1847, the implication behind the statement was that the patient needed to place the entire responsibility for his health and well being in the hands of someone else. The patient's responsibility ended following his choice of a capable, competent, professional person as his physician.

The advice--to select a competent physician--remains good today, 130 years later, but the environment in which the modern patient functions is different. In 1977, the number of persons in health care--outside the medical profession--whose background includes a professional education has widened. The patient himself is better educated and not so inclined to go along, without question, with the idea that "The Doctor knows best" (Wilson, 1963; Quinn and

Somers, 1974; Henig, 1976; Haug, 1976) or with what the hospital dictates (Taylor, 1962).

The viewpoint of the physician on consumerism will, of necessity, be more narrowly molded than that of the organized consumer because of the authority which the physician assumes as a result of his " . . . demonstrated craftsmanship and expertise in the workplace." (Maddox and Stead, 1974:73). Three key elements in the socialization of physicians need to be examined if an understanding of the reaction of most physicians to consumerism is to be reached. These three elements are:

. . . acceptance of ultimate responsibility for the health of the individual patient; the right of autonomy to exercise professional judgment about the management of the individual patient for whom responsibility is accepted; and the related right to control the workplace in the interest of insuring professional autonomy (Maddox and Stead, 1974:74).

Added to these elements is a belief that patient behavior is strongly characterized by dependency, emotionality, irrationality and non-compliance.

. . . These patient characteristics invite if not command authoritative performance by the physician, thus reinforcing a dominant element in his perspective (Maddox and Stead, 1974:75).

In 1976, the Saskatchewan Registered Nurses' Association (S.R.N.A.) presented a brief to the Committee on Rights in Relation to Health Care in Saskatchewan. The S.R.N.A. supported the document published by the Consumers' Association of Canada--"Consumer Rights in Health Care" (1974). The brief emphasized that the individual's responsibility for

health maintenance goes hand-in-hand with rights in health care (News Bulletin, S.R.N.A., May 1976:3). If the health care consumer is to discharge his responsibilities adequately and exercise his rights, as suggested in the S.R.N.A. brief, informed access to information about his health is essential. Counterpoint to this statement is an assumption that there also exists a 'right to inform' which the consumer is asking health care workers to exercise (Fagin, 1975; Kelly, 1976:32; Bandman and Bandman, 1978).

Access to Information by Consumers

One of the most frequent arguments advanced against the suggestion that consumers should have 'full and informed access' to their health care records, is based on the belief that the average person, without a medical background, would be unable to comprehend the information, even if it were freely available. There is a tendency to use the patient's lack of sophistication in medical matters as an excuse to maintain the patient in a position of dependency in interactions between health care professionals and consumers of care.

Moore and Tumin have examined some of the functions which ignorance performs in social and professional settings. They point out that ignorance is an unavoidable part of our social structure, since we do not have access to perfect knowledge. The existing knowledge--and specialized knowledge in particular--is the base, in our society, upon which many

of the accepted power structures depend.

. . . In many instances, of course, the counterpart of ignorance on the part of the consumer is secrecy on the part of the possessor of knowledge (Moore and Tumin, 1949:788).

The maintenance of a privileged status is, to some extent, dependent on the difference that exists between the knowledge and skill of the specialist and those of the consumer. The difference is further magnified when the specialist has access to refined technology not commonly available to the amateur. The work of Crozier (1964) and Pettigrew (1973) emphasizes that status differentiation of this type is not confined to the professions.

Crozier in an empirical study of two bureaucratic organizations in France, describes how the maintenance workers in one of the organizations, exercised power by trading on the need to keep the machines in perfect working order. Their status as the legitimately authorized mechanical experts was jealously guarded and their power, as Crozier depicts it, has many similarities to the power exercised by physicians over the bodily repair of patients.

. . . the one unforgiveable sin of a machine operator is to "fool around" with her machine. Maintenance and repair problems must be kept secret. No explanation is ever given. . . . These and all other tricks of the trade are learned through companionship on the job. Every job is done individually, but there is a great deal of solidarity for learning purposes and whenever there is a difficult problem (Crozier, 1964:153).

Patients are discouraged from consulting practitioners outside the legitimately authorized medical structure--such

action is commonly called 'fooling around' with quacks. Both the maintenance men in Crozier's bureaucratic setting and physicians are utilizing a unique body of knowledge to which they attempt to control access. The practitioners in both situations rely heavily on peer support to solve unusual problems.

Pettigrew in an investigation of the decision making strategies used within a large British retail firm which made extensive use of computers, lists similar devices which the computer programmers resorted to, in order:

. . . to protect their power base and their occupational identity, . . . The programmers used four main strategies:

- (i) norms that denied outsiders' competence
- (ii) protective myths
- (iii) protection of their knowledge base through control over training and recruitment policies (Pettigrew, 1973:150).

The use of these devices designed to maintain a monopoly over specialized knowledge is being questioned (Haug and Sussman, 1969; Haug, 1976). Changes occurring in the environment have enabled the consumer to become more adept at recognizing and dealing with his own problems, with the result that the consumer is less dependent upon the services of the specialist.

In the health care field, the 'do-it-yourself' experience has found expression in the development of women's self-help clinics in large North American cities (Hall, 1974; Dunn et al., 1976) as a by product of the women's liberation movement. These collectives have published manuals, designed to make consumers more familiar with how their bodies work

e.g. A Vancouver Women's Health Booklet (1972), published by the Vancouver Health Collective and Our Bodies, Ourselves, (1973), put out by the Boston Women's Health Collective.

Gussow and Tracy have examined the growth of self-help groups over the last 20-30 years. These authors believe that the emergence of these groups constitutes a social movement whose evolution and growth bridges a gap between the available health services and a need identified at the grass roots level. The gap exists in the areas of communication about support services and access to health education (Gussow and Tracy, 1976:407).

Experience has shown that many people can assume increased responsibility for their own health care when given the opportunity to do so, backed up by adequate access to the appropriate technology and knowledge (Flegle, 1977; Medical World News, April 18th 1977; Kinlein, 1977). The best known example of effective patient participation in their own health care is that of the diabetic patient (King, Spalding, and Wright, 1974:19; Laugharne and Steiner, 1977). Patients, starting at about six years of age can successfully acquire and make use of a body of specialized medical knowledge about diabetes, in order to achieve and maintain physical well-being, with a minimum of professional supervision (Leahy, Logan and McArthur, 1975:18). More sophisticated, technologically oriented examples are the patients who, with the help of their families and a visiting nurse, manage highly technical dialysis equipment at home (Schaffer, 1973; Wheeler, 1977).

A study done at North Central Dialysis Center in downtown Chicago, Illinois, concluded that the disadvantaged minorities living in that area are as responsive to self-care dialysis education as more affluent groups. The difficulties experienced in home dialysis, on this program, were the result of the poor housing conditions in which the patients lived and not because of a low potential for self-care. One approach to correcting this problem has been the establishment of "limited care" dialysis centers in which patients perform their own dialysis under the supervision of trained personnel (Medical World News, April 18th, 1977).

A patient, Yonnie George, who regularly does her own dialysis at New York Hospital Cornell Medical Center, evaluated very positively the "limited care" concept. In describing her experiences as a patient in another unit, where her dialysis was performed by the staff, she says:

. . . I had no control over what was happening. They didn't even tell me my blood pressure. When I asked questions, their attitude was, there's no need for me to know. It would have been better for me emotionally if things had been explained. I really felt I was just a number there (Medical World News, April 18th, 1977:35).

A study of four amputees done by Foort illustrates that the consumer of care is looking for the sort of support which leads to maximal independence at each stage of rehabilitation. These amputees, who were an elite group composed of two physicians, a psychiatrist and a prosthetist, strongly asserted during indepth interviews, that:

. . . What they wanted was support. This support should be in the form of usable information and quite explicit instructions based on facts which they can readily grasp and follow (Foort, 1974:21).

In this study, professionals when transformed into patients, suffered from the same sense of frustration and powerlessness as non-professionals (Kalisch, 1975; Medical World News, April 18th, 1977) when confronted with therapeutic management techniques which denied them the right to be involved in their own care. The plea of Foort's subjects for " . . . useful and reliable information" (Foort, 1974:22) is an endorsement of a statement made by Chin and Benne during an analysis of Lewin's contribution to the theory of normative-re-educative strategies of change. Chin and Benne state Lewin's (1948) position, thus:

. . . Man must participate in his own re-education if he is to be re-educated at all. And re-education is a normative change as well as a cognitive and perceptual change (Chin and Benne, 1976:32).

An empirical investigation in the Netherlands, found that open communication between the nurse and the patient was not a part of the therapeutic behavior built into the nurse's role in nursing units of Dutch general hospitals. When open communication was present between staff members and between staff and patients, it was positively correlated with the prevalence of therapeutic behavior (Cassee, 1975).

Research carried out by Skipper, Tagliacozzo and Mauksch (1964) sought to clarify the reasons for, and the consequences of, limited communication between patients and the people who take care of them in hospitals. A belief exists

among professionals that increased patient involvement in the particulars of his own health care, provokes patient anxiety, causes unnecessary worry and might, in fact, make the patient's condition worse. Skipper et al. (1964) make the point that anxiety is a normal component of illness. Such normal anxiety can be a catalyst in helping professional health care workers explore with the patient, the ramifications of his illness and the probable effects it will have on his future life style. Ignoring the patient's need for information adds a dimension of fear of the unknown to an already anxiety-laden situation.

Skipper et al. (1964) say that nurses are more likely to initiate procedures designed to improve communication with the patient than physicians, because nurses more often find the experience personally satisfying. The authors see the differences between the socio-cultural backgrounds of most physicians and those of their patients, as barriers to satisfying communication. Age, interests, experience and language, combined with an inability to correctly estimate the patient's level of medical sophistication and consequent understanding, all act to inhibit the satisfaction that the physician is likely to experience from personal interaction with the patient.

The conclusions drawn by Skipper et al. (1964) support the findings of a study designed by Pratt, Seligmann and Reader (1957) to explore the communication problems which existed between 214 patients and their physicians (eighty-nine in number) in a medical outpatients clinic, in New York. The

results revealed a bias, which caused the physicians in this study, to under-rate consistently the patient-respondents' knowledge of the etiology, symptoms and treatment of ten common diseases, even though the demonstrated level of medical sophistication among the patients was low.

Pratt et al. suggest, that where professionals seriously under-estimate the consumer's level of medical knowledge, they are less likely to think it worthwhile to spend time explaining to the patient, the facts about his health. The findings do not indicate that the patients were assertive in their search for information, but the researchers cautiously report that " . . . there appeared to be an unformulated, latent desire for more information among the majority." (Pratt et al. 1957:1283). Finally, it emerged from this study, that the patients who had received the best explanation of their condition were more likely to participate in their own care more effectively.

Samora, Saunders and Larson (1962) replicated a part of the study done by Pratt et al. in 1957, using the same thirty-six item questionnaire measuring patient knowledge about ten common diseases, with similar results. Samora et al. found that educational level was the most positively correlated variable associated with knowledge about the diseases tested by the research instrument. These researchers concluded that the level of health knowledge shown by the respondents constituted a " . . . potential barrier to effective physician/patient communication." (Samora et al. 1962:185).

A more recent study in Aberdeen, Scotland, by McKinley which examined the actual and perceived understanding of women of low socio-economic status, using the services of a maternity clinic, produced similar results to those of Pratt et al. (1957). McKinley specifically relates his findings to the fact that physicians impute ignorance to lower socio-economic groups. He identifies this tendency as a function of the social distance between the physician and his patient (McKinley, 1975).

McKinley's observations also showed that patients learn from continued exposure to the medical environment. The women who attended the maternity clinic regularly and those who had had a previous pregnancy, displayed a better understanding of the medical terms tested, than women having their first baby or those who did not attend the clinic regularly (McKinley, 1975). This particular finding might be the result of the teaching undertaken, outside the physician/patient relationship, by other health care workers in maternity clinics.

Linehan interviewed 450 patients to try to find out what patients want to know before discharge from hospital. She provides a list of questions which patients stated that they wanted to ask, ranging from, "What is wrong with me?" "Are they telling me the truth?" to "What does 'take it easy' mean?" and "Will it recur?" (Linehan 1966:1068). Most of the examples of patient's questions are centered around diagnoses, prognoses, self-care following discharge and whom to ask for information. The first three of these categories also emerge in research done by Dodge (1969) based on interviews with 116

patients in a general hospital in New York. The data in this study, showed a relationship between the patient's academic accomplishment and the type of information which he rated as important to him. For example, Dodge suggests:

. . . that while patients want information which will clarify the nature of their situations, they do not concern themselves with things which they are unable to understand. Second, . . . the kind of information sought at various education levels spans a continuum from a desire for simple non-factual assurance that everything will be all right to a desire for information which is needed for arriving at one's own informed decision regarding his true condition (Dodge, 1969:511).

Three years later, in 1972, Dodge reported the results of further study of the same subject. She asked 139 patients and sixty-two nurses (both registered nurses and practical nurses) to rate the importance that they attached to the patient having access to certain types of information. Both the patients and the nurses agreed that knowledge which affected the patient's ability to perform adequately, both his patient role and his usual social role following discharge, was "highly important" (Dodge, 1972).

Disagreement between the two groups emerged in areas concerned with the specific details of the patient's illness. Nurses rated these matters of low importance and the patients indicated that they were anxious to know these details. Nurses stressed the importance of explaining to patients what was going to happen to them as they went through the various tests and procedures dictated by their physicians. Patients, on the other hand, expressed a need to know the results of

their tests and procedures, the names of medications they were taking and what therapeutic results they could expect from the medical and surgical interventions to which they were subjected (Dodge, 1972). All of this information would be available to the patient if he were granted informed access to his own health care record as proposed in the resolution passed at the Annual Meeting of the Registered Nurses' Association of British Columbia in 1976 (RNABC News, 1976:7).

Patient access to health care records is, however, one of the most controversial areas being debated by the proponents of patient rights and health care professionals. In forty States of the U.S.A., the only sure way a patient has of seeing what is written in his medical record, is when the record is subpoenaed by the court, after the patient has filed a malpractice suit (Annas, 1974A:24). A discussion of the patient's property rights in the information contained in his medical record--in the United States of America--is available in an article by Anthony. He states:

. . . it appears that a patient has a qualified legal right to see his own record but must invoke the judicial process of mandatory injunction to clarify this right on a case-by-case basis with the exception of the ten states which allow direct access to records by statute (Anthony, 1976:90).

Shenkin and Warner in 1973 suggested that legislation should be passed in America requiring hospitals to provide the patient with a "complete and unexpurgated" copy of his medical record routinely. They stated that:

. . . The record would serve as an educational tool. Patients would consult books or medical personnel about unfamiliar words, and thus learn professional terminology and concepts. Finally, increased knowledge would lead to more appropriate utilization of physicians and a greater ability of patients to participate in their own care (Shenkin and Warner, 1973:689).

Canadian law stipulates that the hospital owns the physical properties of which the health care record is composed, except in the Province of Quebec, where there is no clear cut decision on the matter (Rozovsky, 1974B:65). Rozovsky (1974B:66) states, that according to the few cases that have been before the courts in Canada, the patient has a right of access to his health care record for the purpose of learning what is happening to him and for the purpose of making a copy of the record. The Province of Quebec is once again, a special case. In that province, a judge may refuse the consumer access to his record, if he (the judge) is of the opinion that the information contained in the record, would be harmful to the health of the consumer (Rozovsky, 1974:66).

The belief that access, by the patient, to the information in his own health care record would be detrimental to his recovery, is commonly advanced as one of the reasons for refusing the patient the right to read his own record. Haug's documentation of her informal interviews with health practitioners in the United Kingdom and the U.S.S.R. revealed that the physicians interviewed, in both countries, were agreed that patients should not be allowed to see their own health care records.

. . . For the patient's own protection, the doctors agreed, there were some things that only they should know (Haug, 1976:92).

There was more emphasis placed on teaching patients about health, in the poly clinics of the U.S.S.R. than was evident in the United Kingdom. The medical staff in the U.S.S.R. recognized the inconsistency which existed in attaching so much importance to patient education in an environment which still expected patient compliance with the physician's orders without too many questions (Haug, 1976). Bloor and Horobin have also identified this dilemma in their observations of the expectations which British general practitioners have of their patients. These authors have described the situation as a "double bind" for the patients, because " . . . the sick person is first encouraged to participate in and then discouraged from the therapeutic process." (Bloor and Horobin, 1975:277).

Despite the conflicting opinions which the topic generates, the literature reports some successful attempts to allow the patient full and informed access to his own health care records (Orovan, 1972; Medical World News, 1975; Rothwell, 1976; Golodetz et al. 1976) and to other relevant medical information (Bartlett et al. 1973; Blair, 1974). The introduction, into the science of medical record keeping, of the Problem Oriented Medical Record developed by Dr. Lawrence Weed (1969) has opened a door which may eventually lead to better access by the consumer to his own health care record. Weed (1975) advocates using the patient's health care record as the

communicating link between the patient and all other members of the health care team. This author suggests that each patient should keep his health care record in his possession because it is possible that he will be the only constant member of the team investigating and dealing with his individual problems over a period of time.

. . . The patient must learn to think of himself as the most important and the most responsible of all the para-medical workers (Weed, 1975:78).

Reports that have emerged from the Medical Center Hospital in Vermont, U.S.A., where the Problem Oriented Medical Record is used, state that the practice of giving patients a copy of their health care records routinely, has increased their cooperation, relieved their anxieties, and has had no harmful side effects (Medical World News, 1975; Rothwell, 1976; Golodetz et al. 1976). One other unit--the Given Health Care Center in Burlington, Vermont--found that, of eight thousand patients given a carbon copy of their complete records, 93 percent felt that free access to the information in the record reduced their anxieties about their health. In a post-discharge evaluation of fifty patients of the practice, about three quarters of the sample reacted positively to the innovation (Medical World News, January 13, 1975:48).

Kitt, speaking to the members of the Canadian Health Record Association at their Annual Meeting, held in Vancouver, Canada on October 14th 1977, about her experience as the Acting Director of the Medical Record Department of a Seattle, Washington, hospital which has instituted a policy for the

release to the patient, on request, of the information contained in his clinical record, noted that:

. . . Surprisingly, most patients who are knowledgeable enough to request their records do not need physician assistance for full interpretation of these records (Kitt, 1977:2).

She feels that most physicians in the hospital already go to considerable trouble to explain to patients what is happening because of the increased emphasis on the need for informed patient consent. As a result, the patients are better educated in matters relating to their own care as well as being academically more prepared to understand the terminology used in the record. Kitt speculates that:

. . . if the physician knows that the patients might have access to the information [in their records] there seems to be more willingness to inform the patients about medical care (Kitt, Personal communication, 1977).

The Registrar of the College of Physicians and Surgeons of British Columbia, Canada--Dr. William McClure--supports the establishment of policies and procedures to allow the patient access to his own clinical record. McClure says that he has recently changed his mind on this issue. He formally spoke against the proposal because he felt that the potential for increased patient anxiety was high and because of the danger of an inflated rate of malpractice suits against doctors.

McClure recognizes that:

. . . doctors are going to have to tell it like it is . . . Society is demanding its 'rights' and decrying medicine's paternalistic stance, often described as the 'arrogance of physicians' (McClure, 1977:457).

A logical progression from allowing patients free access to the information in their own health care records occurs when staff encourage patients to participate in compiling their own records. Orovan describes the successful use of such a program in a small, short-term, psychiatric unit in Montreal, Canada. Patients, in this unit, were asked to contribute to the Kardex Nursing Care Plan and to read and contribute to nursing observations about their behavior. After a year of operation, the program was evaluated as having exceeded the initial, optimistic expectations of the staff. In this program, the doctor's progress notes were not available to the patients, at the time that the article was written (Orovan, 1972).

Authors, writing on the law in the area of the patient's right to have access to the medical information in his health care record, tend to advise hospital administration not to encourage the patient to exercise his rights in the matter (Rozovsky, 1974B; Creighton, 1970; Hayt and Hayt, 1972:1094). Rozovsky in his book Canadian Hospital Law, suggests that " . . . at least while the patient is in hospital his request for access to the record be discouraged." (Rozovsky, 1974B:66).

He explains his advice by maintaining that disclosure of such information may be psychologically detrimental to the patient. Creighton--a lawyer and a nurse--when commenting upon whether or not the nurse should feel free to answer patients' questions honestly, advises against such a trend.

. . . When a patient desires more information about his condition, it is prudent for a nurse to suggest that the patient consult his doctor (Creighton, 1970:131).

She implies that a nurse who believes herself to be an autonomous professional, accountable to the consumer/patient, is likely to find herself in trouble.

. . . If a nurse deports herself with discretion, she will not only avoid legal troubles arising from the wrongful practice of medicine, but she will also make an important contribution to lessening malpractice suits against physicians and surgeons (Creighton, 1970:131).

This advice reflects a perception, commonly held in the past, of the nurse in a hospital setting, acting within the narrow confines of the physician's authority (Brown, 1948:47; Corwin and Taves, 1963; Peplau, 1966; Mauksch, 1966; Stein, 1967; Annas, 1974B; Kalisch and Kalisch, 1977) accountable to the physician and to the institution in which she works and not directly to the patient.

Kalisch in a discussion of her reactions to the passive patient role which she found herself playing when unexpectedly hospitalized, describes a different perception of the nurse.

. . . The nurse is in a key position to help both the patient and his family deal effectively with problems they may be experiencing, either in their relationship with the physician or with the advice he has given (Kalisch, 1975:25).

Kalisch is defining a role for the nurse which comes under the heading of 'patient advocate'. The key ingredients of the successful advocate role include accountability to the consumer of care, combined with the ability to accept the patient as an actively participating member of the health care team and the

acceptance, by health care professionals, of interdependent professional action based on a self image incorporating professional competence and independence (Kosik, 1972; Annas, 1974B; Kalisch, 1975; Chapman and Chapman, 1975; Kelly, 1976).

Nursing Independence as a Factor in Interdependent Professional Action

Nearly thirty years ago, Esther Lucille Brown identified a need for nursing to define its interdependent activities. She ended a chapter, devoted to "The Future Role of the Professional Nurse", in her Report prepared for the National Nursing Council, by quoting the words of a former Surgeon General of the United States Public Health Service, Dr. Thomas S. Parram.

The nursing profession will make its best contribution only when it is organized to work with the public and to find its place in the team of allied professional groups (cited in Brown 1948:100).

Progress has been slow but, in the 1970's, nursing has shown signs of some movement towards this ideal.

A lot of energy and resources have been invested in a struggle to identify the unique contribution which nursing has made to the delivery of health care (Johnson, 1959; 1961; 1968; and 1975; Hall, 1964; Henderson, 1969; Roy, 1970; Wiedenbach, 1970; Mauksch and David, 1972; Rogers, 1975). This need of health care workers to define their specific contribution to the delivery of health care, has been described by Chapman and Chapman as:

. . . an understandable developmental phase for those professionals seeking public identity and autonomy. It is similar to the phase seen in the growth and development of children, of minority groups, and of new countries (Chapman and Chapman, 1975:1).

The nursing literature confirms that nursing is negotiating the developmental stages of dependence and independence. There is increasing evidence that the profession is prepared to accept some of the responsibilities associated with interdependent relationships with the consumer (Norris, 1970; Levin, 1972; Kramer, 1972; Quinn and Somers, 1974; Autrey, 1974; Brandner, 1974; Malkemes, 1974; Kelly, 1976; Kinlein, 1977) and with other health care professionals (Mereness, 1970; Leininger, 1971; Boudreau Report, 1972; Lambertson, 1972; Mauksch and Young, 1974; McCormack, 1974; Moore, 1974; Hellman, 1974; Harding et al., 1975; Elliott, 1977).

At present, nursing's progress towards the establishment of interdependent professional relationships is being recorded on both the plus and minus side of the ledger. For example, the October, 1977 issue of the American Journal of Nursing carries a report from Chicago, about a grant of \$765,765 from the W.K. Kellogg Foundation, to finance a three year project--the National Joint Practice Commission--which will study the problem of establishing joint or collaborative physician-nurse practice in hospitals. The director of this project is reported as saying:

. . . We are convinced that this increased clinical collaboration hinges on, first of all, putting professional nurses in a position where they can be professional colleagues of physicians. And that means that they have full responsibility and accountability to the patient (American Journal of Nursing, October 1977:1543, 1552).

An indication that the objectives of leaders of the nursing profession, as stated by Aydelotte (1972:21) and Novello (1977:243) are similar to those of medicine is contained in a statement by Harold Gardner, the physician responsible for the establishment of a successful nurse/physician joint practice in Rochester, New York. He says:

. . . The important issue is meeting the needs of the consumer, rather than protecting the prerogatives of the medical profession (American Journal of Nursing, September, 1977:1466).

The American Journal of Nursing (August, 1977) contains a negative assessment of nursing's progress towards independent functions. The June (1977) meeting of the American Medical Association House of Delegates:

. . . reaffirmed their position that both kinds of practitioners [physician's assistants and nurse practitioners] should remain under the supervision of the physician and called for continuing reimbursement by third party agencies only to the employing physician (American Journal of Nursing, August, 1977:1244).

A position, in direct contrast to this statement, was taken by Loretta Ford speaking before the House Committee on Interstate and Foreign Commerce's health subcommittee in Washington, D.C.. She stated that the classifications of physician's assistants, physician extenders, paraprofessionals or midlevel practitioners were not acceptable to professional nurses. Ford who was co-director of the first nurse practitioner program at the University of Colorado in 1965, made the point that:

. . . This labeling denies the autonomy, authority, and accountability of the professional nurse . . . With such labeling the physician becomes the center of the universe rather than the patient (Ford, 1976:533).

The nursing profession, in the U.S.A., views the present system of third party insurance benefits--which, in most circumstances, refuses direct payment for nursing care--as a denial of facts which point to " . . . nursing practice [as] a distinctive and unique component of health care." (Welch, 1975:1847). Efforts to remedy the situation are under way (Jennings, 1977). The Rural Health Clinics Bill HR 8422 was signed into law by the American Congress on December 13th 1977. The Bill authorizes direct re-imbursement of rural nurse practitioners and physician's assistants under Medicare and Medicaid, provided that the clinics from which the health care workers operate, meet specific health standards. In the past, nurse practitioners and physician's assistants could only receive payment, through Medicaid and Medicare, if a physician was physically present in the clinic (American Journal of Nursing, January, 1978:8).

As a part of nursing's push towards the establishment of independent status, a need to support increased academic qualifications for professional nurses is apparent (Fagin, McClure and Schlotfeldt, 1976). The New York State Nurses' Association convention in 1975 passed a proposal, by majority vote, calling for a revision of the New York State's Education Law so that, by 1985, a baccalaureate degree in nursing would be required for licensure as a registered nurse and an associate degree in nursing to obtain a license as a practical nurse, in New York State (Sims, 1976).

A counter proposal has been suggested by McGriff in

which she suggests that a new licence be created for already established baccalaureate nurses and those with higher degrees " . . . with a content major in nursing." (McGriff, 1976:932). She proposes that this new licensure should be required of all professional nurses wishing to practice as independent nurses in the State of New York. Greenidge, Zimmern and Kohnke who have established a private nursing group practice in New York City, would obviously be affected by either proposal, if accepted and implemented. These nurses believe that:

. . . a private practice in nursing cannot be equated with either the extended or expanded role of nurses. Rather, we believe our practice is the fulfillment of the basic role of nurses-- providing services directly to the client (Greenidge, Zimmern and Kohnke, 1973:231).

Keller (1975), Lane (1975, Alford and Jensen (1976) and Kinlein (1977) have described the advantages and disadvantages associated with the development of independent nurse practices. Keller specifically asserts that nursing's unique contribution to health care will be recognized when nurses are individually more visible and their professional services are more directly available to the public. She states that independent practice supports the growth and acceptance of a spirit of interdependence among consumers, nurses and other health care professionals (Keller, 1975). The theme of her article agrees with a statement made by Szasz, in his summary of the National Conference on Assistance to Physicians, held in Ottawa, Canada.

. . . Assistance is required not so much to the physician as to the consumer, so that he and his family get more value out of the health care system (Szasz, 1971:87).

Keller describes herself as a "client-extender" rather than a "physician-extender". Her philosophy of care is structured around:

. . . providing the client with specific information and helping him with the task of processing that information into options that are acceptable within his lifestyle and are anticipatory [sic] of daily life events (Keller, 1975:42).

Kinlein expresses a very similar philosophy of care in her definition of nursing as " . . . assisting the person in his self-care practices in regard to his state of health." (Kinlein, 1977:23). Her independent nurse practice is based completely on this concept which allows the client to identify and make therapeutic use of his own self-care practices. Bayer and Brandner have also recognized the value of inter-dependent nurse/patient practice. They point out, that:

As the nurse and the client discover the healthy strengths together--the nurse bringing her special knowledge to the process and the client contributing his own uniqueness and survival ability--the two can pool choices for further health enhancement (Bayer and Brandner, 1977:87).

The philosophies of these independent nurse practitioners are in tune with the emergence of a more assertive, more sophisticated approach by the consumer to his own health care. The consumer of the future will expect to be able to enter the health care system, through a variety of channels, according to his needs. Norris (1970) and Leininger (1973 and 1975A) underline the necessity for this sort of multiple access to

health care and they examine its counterpart--how the system can be changed to accommodate direct access to the consumer/patient by health care professionals, other than physicians. Leininger advocates the development of an open systems model of health care which, in the future, would:

. . . provide for a broadly conceived health assessment plan in which the client may have a choice as to the professional person he and his family wish to have help him with his health problems (Leininger, 1973:174).

The establishment of independent private practice by nurses is one way of providing the alternate access to care envisioned by Norris and Leininger with advantages to both the consumer and the nurse. However, nurses in private practice, although their numbers are growing (Schlotfeldt, 1977:8) are still a minority group. For most nurses, independence is an illusion. Nurses do not find it difficult to extend their role when their activities meet with the approval of their medical colleagues and cover areas rejected by medicine (Shetland, 1975:112). Under these conditions, the nurse is functioning as a 'physician extender' and not as a 'client extender' (Rogers, 1975).

Nurses, especially those remaining within the hospital setting, face a difficult task to differentiate themselves from the stereotyped role imposed by tradition and history (Winstead-Fry, 1977). Accountability to the physician and the institution is deeply imbedded in the hospital environment (Malone, 1964; Johnson, 1971; Anderson et al. 1975). Christman states that the development of autonomous nursing staffs

requires the acceptance of "new-lifestyles" for nurses, including the concept of fee-for-nursing-service within the institutional setting.

. . . Whether the patient pays directly or not is beside the point: the patient can determine from the bill precisely those services which nurses have performed (Christman, 1976:42).

Christman describes an autonomous nursing staff in an institution, as one prepared to accept professional responsibility for their nursing practice directly. In that process, nurses will be expected to accept the risks of legal and professional malpractice which emerge. Nurses seeking autonomy in the institutional setting must organize in order:

- . . . explicitly to permit:
- 1) the expression of clinical self-direction among nurses;
- 2) the fulfillment of their responsibilities to patients; and
- 3) the acceptance of after-the-event sanctions rather than before-the-event controls over practice (Christman, 1976:39).

Implementation of the third point means the abandonment of all ritualized and routinized patterns of care as well as the elimination of the presently prevalent, hierarchial structure used to monitor the quality of nursing care delivered to the patient.

The "new lifestyles" (Christman, 1976) include a system of staff and practice privileges, controlled by nurses, similar to the system used by medicine. Although he acknowledges the difficulties which the change to this system will generate, Christman believes that they will decrease as nurses demonstrate their competence in professional practice. One of

the advantages listed is lowered turnover because of increased work satisfaction.

Status will abide in full staff membership as so much energy is devoted to becoming competent enough to earn full status (Christman, 1976:42).

New life styles imply a new identity. Deloughery and Gebbie, in a chapter devoted to professionalism, agree with Chapman and Chapman (1975) that a developmental process is involved in acquiring professional identity. They make the assumption that nurses have something to contribute to the system:

. . . based on [their] knowledge of and concern for the individual person's health needs. Such a stage of contribution and interdependence can only be reached after proceeding through the stages of socialization (dependence), professionalization (independence) and integration (identity) (Deloughery and Gebbie, 1975:135).

Malkemes in an examination of the resocialization process which accompanies the adoption of an expanded role by the nurse, stipulates that there is more to the transformation than the acquisition of new knowledge and skills. Crucial to the success of the nurse practitioner in reality, is a change in her concept of herself as accountable to an institution, to that of accountability to her client. Malkemes defines the nurse practitioner as a nurse:

. . . who is in direct contact with clients and families; is accountable only to the client; who works interdependently with others in delivering health services to clients; who becomes an advocate for the clients; and who is confident in her ability to practice in the practitioner role (Malkemes, 1974:90).

The last attribute which Malkemes describes--"confidence"--

will influence the perceptions which other health care professionals and the consumers of care have of the expanded nursing role. It is a product of a resocialization model which aims to teach problem-solving techniques in three phases. In the first phase, it is assumed that the practitioner students bring with them into the program, " . . . a degree of motivation for change in themselves and in their nursing practice." (Malkemes, 1974:92). Students are encouraged to examine in depth their previously held attitudes about health services and their role in the health care system. Malkemes refers to this stage as "dependent". She states that it results in a lot of student anxiety and frustration, with an increased desire to try out the new nurse role, even though some of the student anxiety can be attributed to feelings of uncertainty surrounding their own assessment of their ability to function adequately in the nurse practitioner role (Malkemes, 1974).

The second phase begins at the height of the nurse's insecurity. The emphasis changes to interdependent problem solving with families and increasing opportunity to practice, with faculty support, the nurse practitioner role, " . . . helping to establish it more firmly as the nurse's identity." (Malkemes, 1974:92). The third phase consists of a period of experience of the nurse practitioner role under the preceptorship of a physician. Independent problem solving is the nucleus of this phase. The nurse has an opportunity to demonstrate her competence and to experience the satisfaction of

establishing herself as a capable, independent, professional. These experiences stand the nurse in good stead when she moves out of the student role. The nurse, at the end of the program, is " . . . able to function interdependently, while making sound independent judgments about care." (Malkemes, 1974:93).

This developmental approach to the education of nurse practitioners recognizes and attempts to remedy, one of the handicaps imposed by the dependent status of the traditional nurse role. In bureaucratic settings:

. . . The nurse has been delegated administrative authority and accountability, but has not been granted responsibility for her own patients over an extended period of time. Responsibility has been fixed by physical location, routines, and circumstances, with clients as temporary charges (Maas, 1976:39).

It, therefore becomes difficult for the nurse to project herself as a competent, independent, professional giving individualized, quality patient care.

A dilemma exists for nursing which has been described by Freidson (1970:66) as a struggle to escape from the narrow confines of medical domination in a bureaucratic environment. Sheahan supports Freidson's view of the situation in hospitals, by stating:

. . . only the physician, clinically speaking, makes professional decisions in the hospital, and, therefore, he alone functions in a professional capacity (Sheahan, 1972:441).

If nurses are to break free from the constraints of their dependent status, they must first examine closely old attitudes and values and cease to play what Sheahan (1972)

has called "the game of the name". Hospital authorities who play this game delude themselves into thinking that the employment of a nurse wearing a professional label results, automatically, in 'professional nursing care', without recognizing that the environment in which the nurse functions is the other side of the equation.

It is a basic prerequisite for the smooth transition of nursing into areas which require acceptance of increasing professional and consumer interdependence, for nurses in interactions with others, to display attitudes which are conducive to the development of a satisfactory climate for change. The socialization of the student into the nursing profession is profoundly affected by the role models that they encounter in the practice setting. Christman speaking on a panel presentation sponsored by the National Joint Practice Commission at the American Nurses' Convention in Atlantic City, said:

. . . you can't change the socialization of the student into their profession until you change the structure under which nurses practice and the way they practice because that's what students learn. . . . As soon as nurses move into becoming clinicians and do primary care willingly and take these accountability roles, the students will be co-opted by the role of socialization and it's not a problem (Christman, 1976:61).

This statement acknowledges that the service environment contains "consequences" which nursing educators have tended, in the past, to ignore, thus transforming what should have been "anticipated consequences" into "unanticipated consequences".

The Leadership Role of the Professional Association

The professional association is one of the forces in the external environment which has the potential to provide support to the professional nurse as she enacts the professional role within health care facilities or in independent nurse practice (Merton, 1958). Labelle, speaking to the final plenary session of the 16th Quadrennial Congress of the International Council of Nurses, stated:

. . . Collectively nurses at the level of the institutions and professional associations foster accountability through the development of codes of ethics, standards of practice for entry into the profession and evaluation criteria. For individual nurses accountability means answerability and responsibility for outcomes of nursing actions . . . (The Canadian Nurse, August 1977:39).

Aligned with the professional association as trend setters and change agents are those leaders in nursing who are active in the fields of nursing education and nursing service administration. As leaders in their professional associations and in health care facilities they have multiple input into the change process and access to the machinery of power from differing angles.

In an address to the Saskatchewan Registered Nurses' Association Annual Meeting in 1975, in Saskatoon, Marion Jackson--nursing administrator--made the observation:

. . . that the majority of those who serve on Council or its Committees tend to be in management positions in either nursing service or nursing education (Jackson, 1975:1).

Jackson stated that, in her personal experience, as her administrative status increased so did her active involvement in the professional Association. She suggested that the Association should make more effort to recruit grass roots members as representatives on the Council and Committees of the Association. She recommended that staff nurses be given paid time off to attend professional meetings (Jackson, 1975).

The results of a random survey of 7,500 readers conducted by the American Journal of Nursing in 1970, which had a response rate of 40 percent, agree with Jackson's (1975) experience. The survey showed that the respondents believed that their professional association was not representative of a cross section of members or potential members. The published report of the survey, states:

The majority of the respondents believe ANA speaks for the elite groups in nursing--degree holding administrators and educators (American Journal of Nursing, April, 1970:813).

The survey results support a statement by Corwin and Taves in 1963, that the majority of nurses are not actively engaged in their professional organization as members. Corwin and Taves (1963) and Smith (1962) state that, in common with other under-privileged groups, there exists in nursing, a division between persons at the grass roots level and those in leadership positions.

In countries where membership in the professional nursing organization is voluntary, it is obvious to anyone who cares to study the membership figures, that the association

lacks the authority that it might wield, because it represents only a small percentage of the total membership. For example, in 1973, according to the 1976 edition of Facts About Nursing, 14.4 percent of the total number of registered nurses in the U.S.A. belonged to the American Nurses' Association. Even in countries where membership in the professional association is mandatory, if the nurse wishes to practice as a registered professional nurse, the power of 100 percent membership is illusory. Nurse members act as a silent majority on many issues (Zilm, 1969:34).

Bowman and Culpepper have suggested that nursing associations take positions on issues but fail to follow up with constructive, assertive action. Consequently, " . . . they tend to reflect the negative image of their members." (Bowman and Culpepper, 1974:1055). Without the support, commitment and participation of the majority of the members of the profession, the reality of the situation may be that the "taking of positions" is the highest level at which the association can effectively function.

Nurses, in the past, have ignored the potential strength and power inherent in being second only to the patient in numerical strength within the health care system. Bowman and Culpepper describe the beginnings of changes which reflect an awareness of the strength to be found in unity. They say that:

. . . common concerns about patient advocacy, standards of practice, continuing education, certification, accountability and other issues constitute what can be called superordinate goals for the profession (Bowman and Culpepper, 1974:1055).

If the issues identified by Bowman and Culpepper are really a rallying point for change, it is imperative that the professional nursing organizations gain a sense of their members' willingness to support assertive actions in these areas.

Assertive action by nurse leaders is, according to Leininger the variable which is most productive of results in today's society. Leininger's portrait of an effective nurse leader is a counter image of the passive, dependent nurse role. She says that leaders of the nursing profession:

. . . must be not only politically and intellectually astute, but they must be good risk-takers, fairly aggressive, active pursuers of issues, and alert to alternative strategies in pursuit of an objective. They must have strong egos, a positive sense of personal identity, and a determination to preserve desirable professional values (Leininger, 1975B:63).

Leininger says that these leadership qualities are needed to cope with a complex environment in which confrontation and negotiation are increasingly used as techniques of organizational change (Leininger, 1975B). For a leader, such as Leininger describes, to make a significant impact, she must form a coalition with followers whose attitudes and values sustain and renew the energies expended by the leader.

Novello states that nursing is well endowed with strong, innovative leaders but, she believes that there is a need to develop:

. . . an attitude among nurses which fosters such leaders and which welcomes the challenges that they raise. The destiny of our profession is dependent upon such leadership. And destiny is a matter of choice, not chance (Novello, 1977:243).

Even if strong support exists for an assertive, dynamic leader, ripples and waves will be created as change occurs (Leininger, 1975B:67). Opposition from the rank and file membership of professional organizations to situations involving professional change has been examined by Smith who attributes it to feelings of insecurity aroused by the proposed change. He says:

. . . They [members] may feel comfortable having achieved success or recognition on the basis of their present skills. Drastic changes in the system may invite new competition or require new courses of education and training (Smith, 1962:221).

There is a tendency to view resistance to change as a defeatist mechanism. Klein in an effort to isolate the reasons for, and the advantages to be gained from resistance to change, has paid attention to the phenomena. He supports Smith (1962) by stating that resistance to change " . . . may have as its first fundamental objective the defense of self-esteem, competence and autonomy." (Klein, 1976:119). Added to this, Klein cites the " . . . frequent alienation of the planners of change from the world of those for whom they are planning" (Klein, 1976:119) as a prime cause of the resistance to change. Groups who oppose planned change (by radical alternatives or by vigorous support of the status quo) are important forces whose involvement in the change process will, in some instances, lead to:

. . . the development of more adequate plans and to the avoidance of some hitherto unforeseen consequences of the projected change (Klein, 1976:23).

Resistance to change is not confined within the groups whose members are most directly affected by it. Strong

objections may be generated by powerful other groups in the environment who feel themselves threatened by the implications that the change produces (Smith, 1962). The resulting conflict is often viewed as destructive but, in fact, it can be a rallying point for action. Conflict precipitates the use of strategies which will increase the drive towards acceptance of new concepts or the reinforcement of old values (Filley, 1974).

Changes that portray the patient as a more powerful consumer of care, are threatening to the professional's self-concept. Nurses, in particular, are affected because their everyday activities bring them into close proximity to the consumer for long periods of time. Even if the results of the interaction do not imply a negative evaluation of nursing care, they may contain patient behavior that the nurse classifies as "demanding" or "uncooperative" (Vachon, 1976:42). Consumer dissatisfaction expressed in face-to-face interaction is hard to handle. It requires a high level of maturity and ego strength to hear what the patient is really saying.

Vachon reviews some of the repercussions being experienced by nurses because of the increasing stress in the "client environment". She identifies the stress as emerging from new values and concepts relating to the status of people who seek help from health care professionals. This author states that group action to develop mechanisms to deal with stress in the external environment is more successful than individual attempts to cope with situation (Vachon, 1976:42).

Her article suggests that the action taken by R.N.A.B.C. members to endorse the publication "Consumer Rights in Health Care" (1974) and the right, in principle, of the consumer to full and informed access to information (RNABC News, July 1976) will strengthen the attempts of individual nurses in British Columbia, to provide nursing care based on the concept of the consumer as a participating member of the health care team.

Leaders who demonstrate an ability to negotiate successfully the risks involved in political action will influence the self-image the average nurse has of herself, as capable of initiating the change process. Mullane states:

. . . Nurses, who spend 24 hours each day with hospital patients (physicians average about 10 minutes per patient out of 24 hours) and who are the recipients of the fears and concerns patients hesitate to review with their physicians, owe to those patients greater insistence upon being heard (Mullane, 1975:701).

Although collective action is important, there is no doubt that the individual--whether within the collective or outside it--is responsible for translating the ideals of the profession into reality (Merton, 1958; Lysaught, 1970; Levin, 1972; Kramer, 1974; Christman, 1976; Jackson, 1976). Duke concludes the summary of her investigation into the ability of the Registered Nurses' Association of British Columbia to control nursing practice in the Province of British Columbia, by stating:

. . . The power to control nursing practice inherent in the Association or professional role is dependent on the members themselves. When they are actively involved in promoting interests of the profession, the association role is more powerful and influential in controlling nursing practice (Duke, 1976:32).

Indications exist that the interests and values of the nursing profession are interdependent with those of the consumer of health care and that nursing is prepared to structure its future plans, as Brown advised in 1970 " . . . in alliance, rather than at variance, with [the] trend" (Brown, 1970:3). Under these circumstances, the role of the professional associations is to provide leadership which will re-focus and reintegrate the efforts of members to achieve nursing's primary task--the delivery of quality nursing care which is productive of a high index of consumer satisfaction.

Summary

Social values and attitudes which previously supported the concept of a dependent, patient role counterbalanced by that of a powerful, professional, authority figure in the interaction between health care workers and consumers of health care, is being challenged. This change is a part of a general trend which recognizes the right of the individual to have access to information--previously carefully guarded by those with the necessary power--in order that the consumer may exercise more control over the complex decisions that are an increasingly prominent part of our constantly changing environment.

For many patients--especially those who are critically ill--dependency is an inevitable and necessary state which contributes significantly to their chances of survival. Dependency carried to extremes, however, can result in the sick role becoming saturated with feelings of powerlessness.

The trend by consumers to query the stereotype of the passively dependent patient as relevant in today's society is supported by the present political climate in Canada. The spiralling costs of health care have resulted in an increased governmental focus on measures designed to reduce self imposed risks, investigate environmental problems and extend our knowledge of human biology (Lalonde, 1974). There is an increasing emphasis on the prevention of illness (Lalonde, 1974) and on the need to provide care, based on the interdisciplinary health team concept (Hastings, 1972:363).

Levin (1972:2008) has suggested that by deliberately seeking to change the relationship between the consumer of care and professional nurses, the nursing profession could carve a niche for itself--in coalition with the consumer--with benefits to both parties. The hidden danger of this proposal is that it could increase the dependency experienced by the patients once they enter the health care system, unless health care workers are prepared to give high priority to the consumers' right to participate actively in the decisions made about their own health care.

Consumer insights into their personal diseases and health maintenance systems may provide clues with regard to behavior reinforcement that can contribute to the consumer's self-help capability. (Levin, 1972:2009).

Increased public awareness of the issues inherent in consumer rights in health care has highlighted the concept of accountability to the consumer by individual health care professionals. Translating the rhetoric of consumer rights and

accountability from a value position into mechanisms which will become part of professional reality requires commitment to change at all levels of the health care system. Christman says that:

. . . if professional persons desire the rights and privileges of professional status, they also should be willing to withstand the obligations and accountability of that status. (Christman, 1967:21).

One of the professional obligations upon which Christman places emphasis is patient education. Teaching patients how to evaluate the care that they receive from individual members of the health care team allows the patients' expectations of the health workers' role, as well as their own contribution to the therapeutic process, to be more realistic and more appropriate (Christman, 1967:21). Health care workers in direct contact with the consumer have the potential to contribute to the patient's feelings of self-worth in ways which " . . . act as positive influences on accelerating the movement through the rehabilitation phase" (Christman, 1967:20). The reverse is, of course, also true.

Planned change by nursing leaders which recognizes and supports the efforts of individual nurses to reinforce and uphold the rights of the consumer, could develop a model of patient care in which the patient:

. . . will become involved to a great extent as a helpful and knowledgeable person in the planning and management of his illness and the specific elements of his care. (Christman, 1976:18).

Inherent in such a change process is a philosophy which confers increased status on the patient as a person capable of self

direction and a corresponding decrease in the tendency to insist on an omniscient and omnipotent role for health care professionals.

CHAPTER III

METHODOLOGY

The study is non-experimental and exploratory in nature. A questionnaire (Pankratz and Pankratz, 1974) designed to measure the attitudes of registered nurses towards Nursing Autonomy and Advocacy, Patients' Rights and Rejection of Traditional Nursing Role Limitations, was administered by mail. A computer list of the names and addresses of registered nurses, who were members of a District of the Registered Nurses' Association of British Columbia, Canada at the time of the survey, was obtained from the Council of that Association. The list included the basic educational qualifications of members and the highest educational level attained by each person.

The Pankratz and Pankratz (1974) Attitude Scale contains three clusters or sub-scales, isolated by BC TRY System Cluster and Factor Analysis (Tryon and Bailey, 1966). Pankratz and Pankratz (1974) in developing the Attitude Scale, administered it to a total of 702 nurse subjects. They obtained reliability co-efficients for Cluster #1 of .93; for Cluster #2 of .81; and for Cluster #3 of .81 (Pankratz and Pankratz 1974:213).

The data from the 702 subjects in the Pankratz and Pankratz (1974) study, was also analyzed using a principal components factor analytic approach (Pinneau et al. 1966) with

similar results to those obtained by the BC TRY System Cluster and Factor Analysis, thus supporting the validity of the sub-scales (Pankratz and Pankratz 1974:215). The results showed that high scores on the three sub-scales (indicating positive responses to Nursing Autonomy and Advocacy, Patient Rights and Rejection of Traditional Role Limitations) were:

. . . associated with education, leadership, academic setting and non-traditional social climate (Pankratz and Pankratz, 1974:211).

Method of Data Analysis

The data were analyzed using the computer social science program SPSS (Nie et al. 1975). Frequencies were calculated for all subjects from the demographic data supplied by the respondents.

The scores of all subjects were computed according to the method of scoring outlined in Appendix C on page 165 for the Pankratz and Pankratz (1974) Attitude Scale which produces scores on three sub-scales or clusters. The sub-scales are labeled:

- 1) Nursing Autonomy and Advocacy,
- 2) Patients' Rights, and
- 3) Rejection of Traditional Role Limitations.

The sum, mean, standard deviation and variance of the total sample, on each sub-scale in the Pankratz and Pankratz (1974) Attitude Scale, was computed and then the sum, mean, standard deviation and variance according to the scores obtained by six groups defined by the six independent variables:

- 1) Administrative position,
- 2) Full time, part time or inactive status,
- 3) Years of experience,
- 4) Work setting,
- 5) Age, and
- 6) Education.

An analysis of variance was also performed on each sub-scale of the Attitude Scale (Pankratz and Pankratz, 1974) broken down by the demographic, independent variables named above. The F score obtained was interpreted using an alpha of 0.05. The statistical null hypothesis tested was that, when each of the three sub-scales was analyzed by each of the six independent variables:

$$M_1 = M_2 = M_3 \dots = M_n *$$

Data Collection

A random sample stratified by highest educational level obtained, was drawn from the list of members supplied by the Registered Nurses' Association of British Columbia, Canada. Eighty-two percent of the sample held a nursing diploma; fifteen percent held a baccalaureate degree; and three percent held a Master's degree or higher.

An N of 425 subjects was sought, representing 10 percent of the total membership of the district of the Registered Nurses' Association of British Columbia, from which the sample was selected.

* M_1 = mean of first group; M_2 = mean of second group; M_3 = mean of third group and M_n = mean of final group.

Ninety-nine point one percent of the 425 subjects were contacted personally by the researcher through a telephone call, prior to the delivery of the questionnaire by mail, in order to determine their willingness to participate in the study. Subjects for whom a telephone number was not available--with the exception of four subjects--were dropped from the study and a substitute was chosen, at random, from the population. A substitute was also chosen, at random, for those persons contacted who did not wish to be included in the study.

Four weeks after the last questionnaire was mailed, a second telephone contact was attempted to those subjects listed as not returning the completed questionnaire. If this call was unsuccessful because the subject was not at home, it was not repeated. No further effort was made to contact subjects who did not respond to this first reminder. Subjects who returned questionnaires without answering all the questions or whose answers raised queries in the mind of the researcher, were contacted a second time and asked to clarify their answers. Three of these subjects were not available by telephone at this time and their questionnaires were excluded from the analysis of the data.

Response Rate

Thirty-two nurses (or 7 percent of the sample) did not wish to participate in the study. Therefore, a total of 457 completed phone calls was made to obtain the desired number (425) of respondents. The return rate, one month after the last

questionnaire was mailed, amounted to 382 questionnaires or 88.88 percent of the total sample.

Following a telephone reminder to those available subjects who had not returned their questionnaires, ten subjects (or 23.25 percent) out of a total of forty-three non-respondents, returned their questionnaires. The total response rate was, therefore, increased by 3.35 percent to 392 questionnaires, or 92.23 percent of the total sample. Of the four subjects to whom questionnaires were mailed, without a prior telephone call, two returned their questionnaire within a reasonable time, one was returned by the post office because it was not deliverable and one questionnaire was never returned.

Table 1 Response Rate in Percentages According
to Highest Educational Level Attained

Educational Level	Response Rate Percent
Diploma in Nursing	93.45
Baccalaureate Degree	91.8
Master's or Higher Degree	76.92

Definition of Terms

Registered Nurse

A nurse who is a member of the Registered Nurses' Association of British Columbia. His or her basic nursing education may be at the diploma level or the nursing degree level.

Nursing Autonomy

The degree of independence in the work situation that registered nurses perceive that they have or, that they would be willing to exercise, if the opportunity presented itself. It is measured, in this study, by Cluster #1 in the Nursing Attitude Scale (Pankratz and Pankrats, 1974) which is used as the data gathering instrument. High scores on the sub-scale indicate a positive attitude towards assuming an autonomous nursing role.

Patient Advocacy

A measure of how flexibly the nurse responds in interaction with individual patients and of how willing she is to take action on behalf of the patient if his rights are in jeopardy and he (or a member of his family) is unable to remedy the situation. It is measured, in this study, by Cluster #1 in the Nursing Attitude Scale (Pankratz and Pankratz, 1974) in which it co-exists with the measure of Nursing Autonomy. High scores on this sub-scale suggest a willingness on the part of the nurse to adopt a patient advocate role and to accept the right of the patient to be included in the

decision making processes surrounding his health care so that his self-care potential is implemented to the fullest extent possible.

Patient Rights

Refers to the concepts contained in the document titled "Consumer Rights in Health Care", published by the Consumers' Association of Canada in 1974 (Appendix A). In this study, attitudes towards Patient Rights are measured by Cluster #2 in the Nursing Attitude Scale (Pankratz and Pankratz, 1974). This sub-scale taps the degree of independence that the nurse is prepared to concede to the consumer, in matters relating to his own care and treatment. Statements such as: "I believe a patient has a right to have all his questions answered for him." are designed to probe the nurse's attitudes towards the consumer's right to have informed access to information about his condition. High scores on this sub-scale, reflect acceptance of the consumer's right to be an active participant on the health care team, when decisions are being made that involve his health and wellbeing.

Traditional Nursing Role

The traditional nursing role places the nurse in a position in which she is dependent upon the physician for direction in her interaction with the consumer and, in which, she is unwilling to disagree with the physician's decisions. It is measured by Cluster #3 in the Nursing Attitude Scale (Pankratz and Pankratz, 1974) in this study. High scores on this sub-scale indicate attitudes which reject the traditional

nursing role and its associated behaviors. Nurses scoring highly on this measure would be expected to see themselves as an extension of the patient's interests and not simply at the patient's bedside to carry out the physician's orders.

Assumptions

- 1) Consumers of health care can adopt a responsible and knowledgeable role in their health care and they are willing to do so.
- 2) The quality of nursing care will improve as nurses recognize and support the patient's potential for therapeutic self-care practices.
- 3) Nurses are capable of adopting more independent roles in health care with the emphasis on accountability to the patient/consumer.
- 4) A select minority of the total membership of any professional organization is active in formulating and promoting the strategies which determine the direction in which the profession will move.

Limitations

- 1) Subjects may not express their true reactions to the statements listed in the Nursing Attitude Scale (Pankratz and Pankratz, 1974).
- 2) Subjects' attitudes, as expressed in this study, may not correspond to their behavior when confronted with actual situations requiring a behavioral response.
- 3) The survey approach, used in this study to collect data, allows limited control over extraneous variables.
- 4) The population sampled, in this study, is comprised of registered nurses living and working in a metropolitan area of a large city. Their attitudes towards the questions asked may differ from those of registered nurses living and working in less urbanized areas.
- 5) A time lag, of approximately one year, exists between the acceptance by R.N.A.B.C. members of the resolutions put forward at the 1976 Annual Meeting of R.N.A.B.C. and the

collection of data for this study. It is likely that attitudes have not remained static in this period.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Educational Level of Respondents

The random sample to whom the questionnaire was sent was stratified by the highest level of education obtained. Of the nurses in the stratified sample 82 percent held a diploma in nursing; 15 percent held a baccalaureate degree, and 3 percent held a Master's degree or higher. The discrepancy between the percentages, according to the educational level of the subjects who returned their questionnaires and the stratified sample to whom the questionnaires were sent, is the result of two things.

- 1) Subjects who held a diploma in nursing had a higher rate of response (Table 1) than either of the other two groups.
- 2) The computer list from which the random stratified sample was selected, contained the names of some nurses who were described as having a baccalaureate degree when, in fact, they were still pursuing that objective. They had obtained registration after the first two years of the baccalaureate program in nursing at the University of British Columbia. One subject who was listed as holding a baccalaureate degree had completed a Master's degree. The returned questionnaires were checked against the computer list in this area. Whenever a discrepancy was noted, the situation was clarified with the nurse in question by telephone.

Table 2 Respondents According to Educational Level

EDUCATIONAL LEVEL	NUMBER (N=389)	PERCENT	
		Sample	Population
Diploma in Nursing	323	83.0	82.0
Baccalaureate Degree	56	14.4	15.0
Master's or Higher Degree	10	2.6	3.0
Total	389	100.0	100.0

Demographic Data

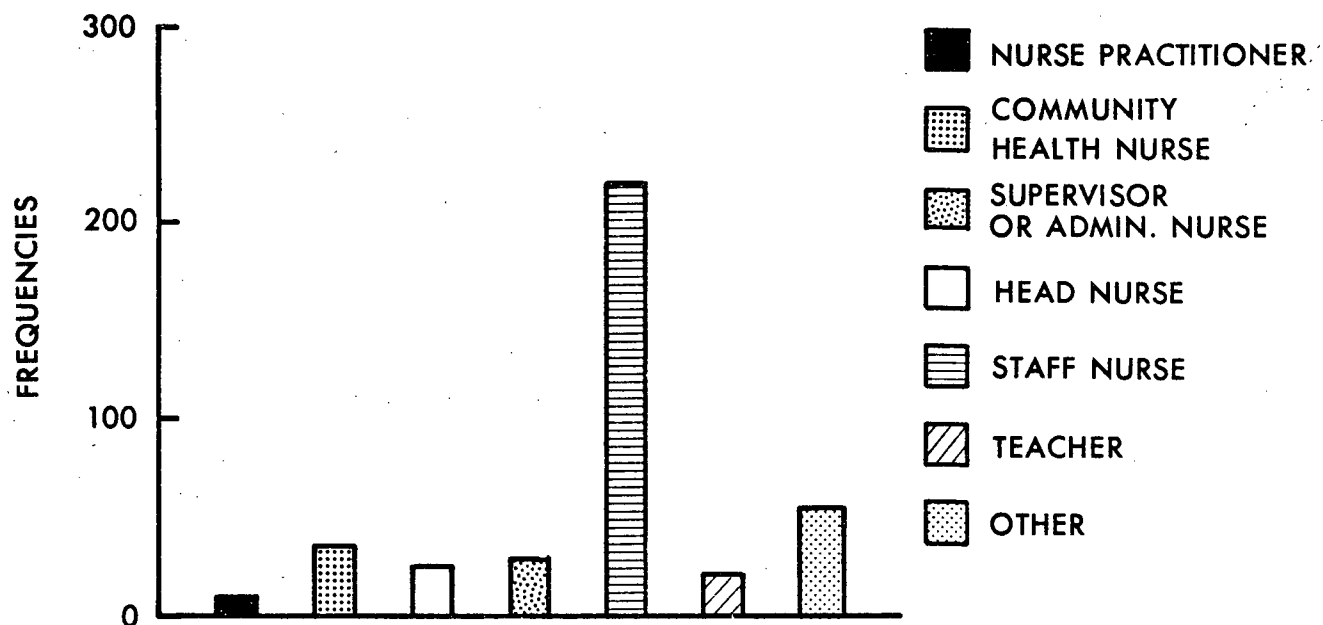


Figure 1 Frequencies by Administrative Position N = 389

The demographic data obtained from the sample is displayed in Figures one to six. The eight nurses who responded to the category "Nurse Practitioner", in Figure 1, were a self-selected group. No formal definition was attached to the category by the researcher in this study and nurses may define the nurse practitioner role in a variety of ways. The category "Other", in Figure 1 includes thirty-six inactive nurses as well as nurses engaged in Private Duty Nursing and those not presently working in nursing, all of whom retain their registration as nurses.

The majority of nurses in this sample (55.8 percent) were employed as staff nurses. Canadian statistics show that in 1973, 118,897 nurses were employed in nursing and of these nurses, 75 percent were working as staff nurses (Countdown, 1974:8).

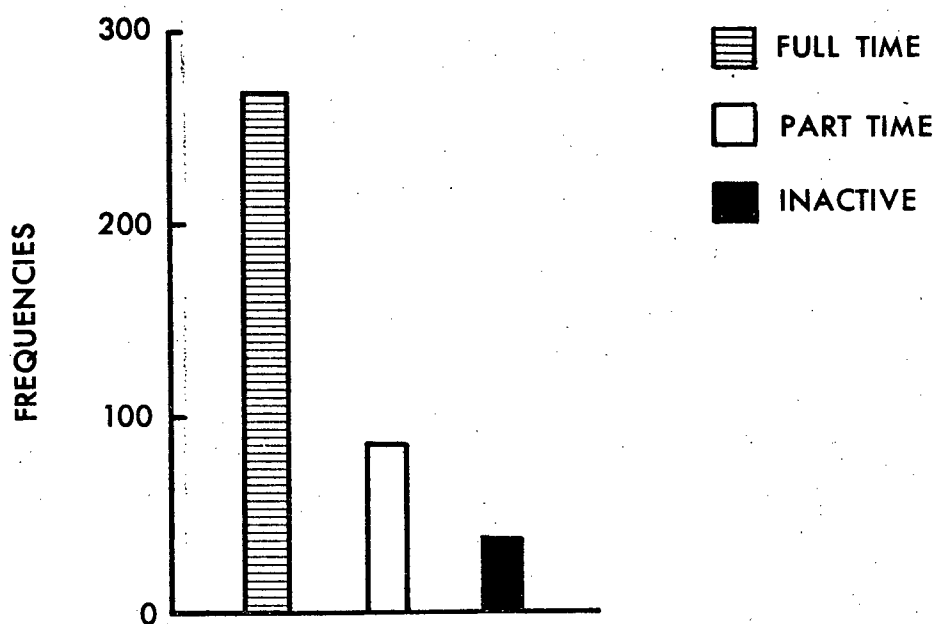


Figure 2 Frequencies by Hours of Work N = 389

In this sample 21.6 percent of the respondents were employed part time. Of the 118,897 nurses employed in Canada, 28 percent were employed part time. The greatest proportion of nurses who work part time in Canada are employed as staff nurses.

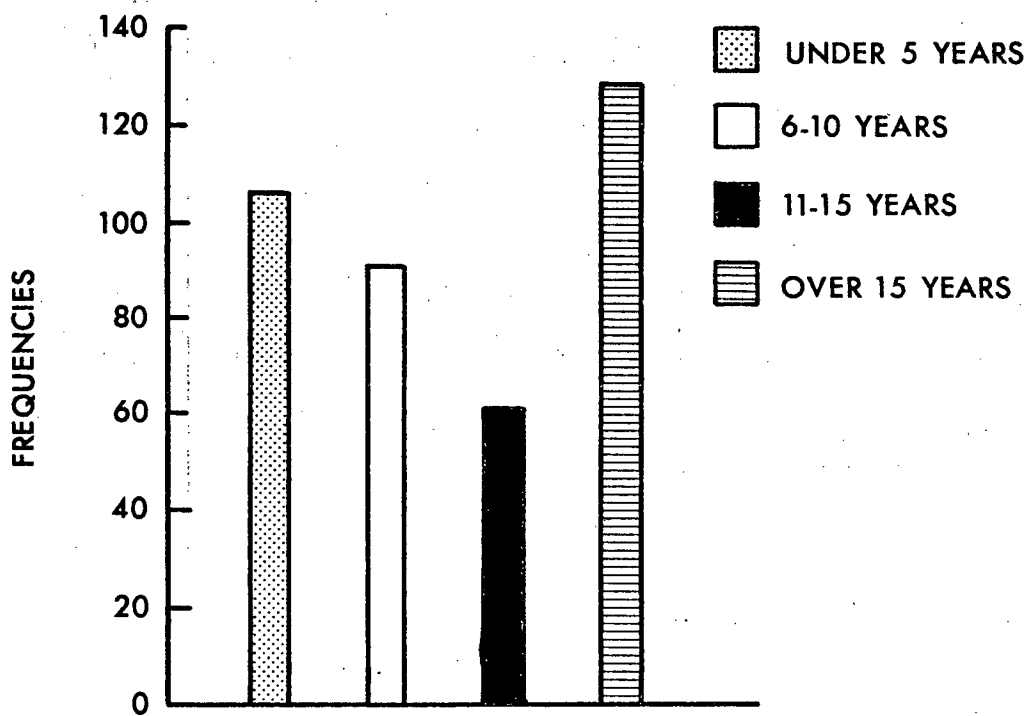


Figure 3 Frequencies by Years of Experience N = 389

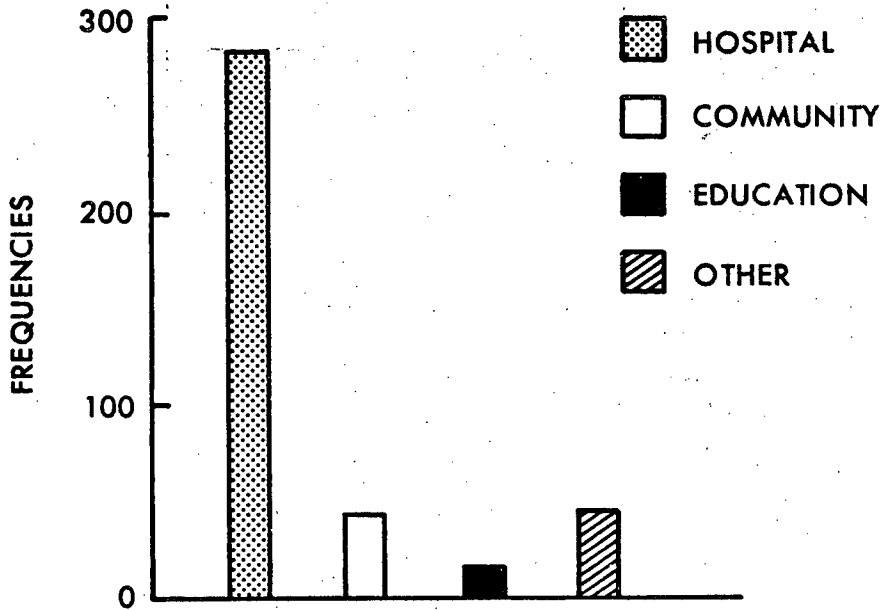


Figure 4 Frequencies by Work Setting N = 389

Most of the registered nurses in this sample worked in a hospital setting (72.5 percent). The statistics collected by the Canadian Nurses' Association in 1973 showed that 83 percent of the nurses working in Canada were employed in hospitals or other institutions (Countdown, 1974:8).

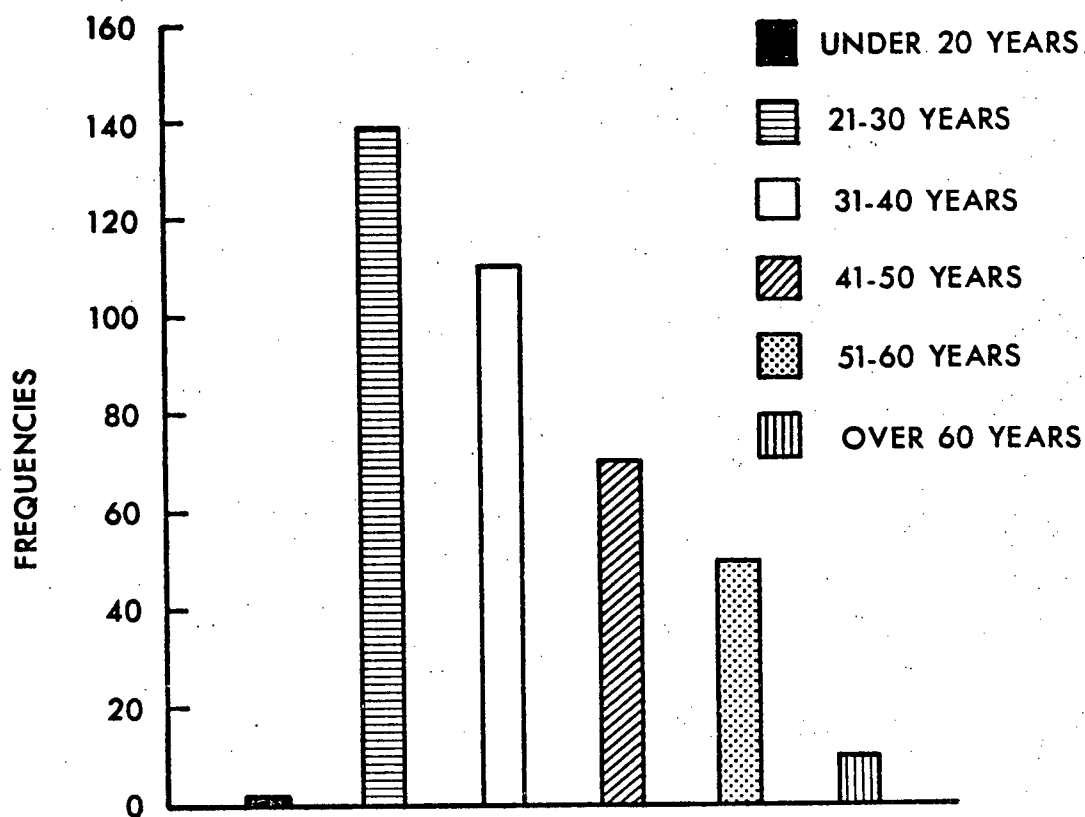


Figure 5 Frequencies by Age of Subjects N = 389

The category "Under 20 years" in Figure 5, which contained only three subjects was merged with the category "21-30 years" for the purposes of analysis. The number of subjects in each age group in this study, is approximately equal to the number of nurses in similar age groups in the total population of nurses in Canada (Countdown, 1974:17).

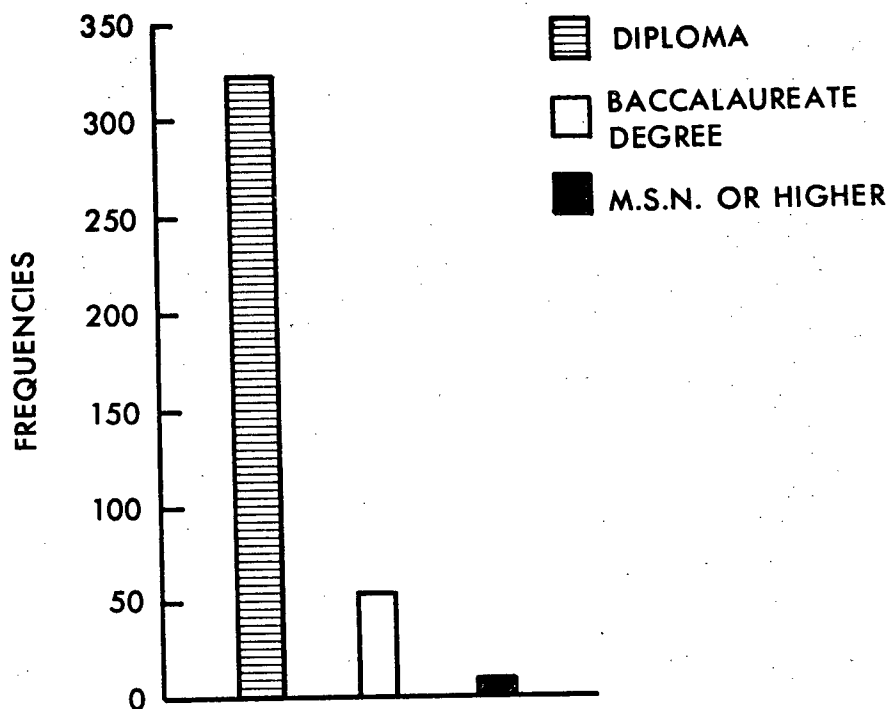


Figure 6 Frequencies by Highest Educational Level Completed
N = 389

The category "Other" which appeared in the questionnaire used in this study under the heading "Highest Educational Qualification Completed", was merged with the category "Diploma" in Figure 6, for the purposes of analysis. The category "Other" contained eighteen subjects or 4.6 percent of the total sample. By reference to the computer list from which the sample was drawn, it was found that the majority of subjects in the category "Other" had credits in continuing education but did not hold a University degree. One subject who marked "Other" was reclassified as "Masters or Higher Degree".

Data Analysis

Cluster #1 "Nursing Autonomy and Advocacy"

The analysis of Cluster #1 "Nursing Autonomy and Advocacy" by the independent variable "Administrative Position" (Table 3) produced means which ranged from 93.13 (teachers) to 81.13 (staff nurses) reflecting a tendency for nurses holding leadership positions to profess positive attitudes towards nursing autonomy and advocacy, as measured in this study. The result is congruent with the results obtained when the Cluster "Nursing Autonomy and Advocacy" was analyzed by the independent variable "Highest Level of Education Completed" (Table 13:109).

Although most of the groups were too small to allow conclusions to be drawn about individual groups, the largest group (staff nurses N = 217) was the only group with a mean below the mean of the total sample. This finding confirms that of Pankratz and Pankratz who found that nurses in leadership positions were very positive in the expression of their attitudes towards nursing autonomy and patient rights (Pankratz and Pankratz, 1974:215).

Teachers, community health nurses and staff nurses-- within which group occur both the highest and the lowest means-- had the lowest variation within the groups (standard deviations of 10.79, 10.98 and 10.88 respectively). Nurses within these groups were more agreed in the attitudes that they hold, about the amount of independence that they--and their patients-- should exercise within their individual roles, than was the case with other categories.

Nurses who placed themselves in the category of "Nurse Practitioner" had the second highest mean of 89.13 but showed the widest variance in their scores. The size of the group (N = 8) and the fact that the term "Nurse Practitioner" may have a wide variety of meanings to individual nurses, meant that it was difficult to draw meaningful conclusions from the data obtained from this group.

Table 3 Cluster #1 "Nursing Autonomy and Advocacy" analyzed by "Administrative Position", arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.*	VAR.**	N	%
Teacher	2142.00	93.13	10.79	116.39	23	5.9
Nurse Practitioner	713.00	89.13	18.76	351.84	8	2.1
Supervisor or Administrative Nurse	2201.00	88.04	13.83	191.29	25	6.4
Head Nurse	2244.00	86.30	11.52	132.62	26	6.7
Community Health Nurse	3015.00	86.14	10.98	120.66	35	9.0
Other	4556.00	82.84	13.56	183.92	55	14.1
Staff Nurse	17606.00	81.13	10.88	118.45	217	55.8
Total Sample	32477.00	83.49	12.14	147.27	389	100.0

*Standard Deviation

**Variance

An analysis of variance (Table 4) performed on the two variables "Nursing Autonomy and Advocacy" and "Administrative Position" produced an F of 5.561. The result indicated that a relationship existed between the two variables which was significant at well below the 0.05 level. The hypothesis that

the means were different in this sample was accepted.

Table 4 Analysis of Variance Cluster #1 "Nursing Autonomy and Advocacy" analyzed by "Administrative Position"

SOURCE	SUM OF SQUARES	DF*	MEAN SQUARE	F	SIG.**
Between Groups	4590.278	6	765.046	5.561	0.0000
Within Groups	52548.920	382	137.563		
ETA = 0.2834		ETA SQUARED = 0.0803			

*Degrees of Freedom

**Significance Level

The analysis of Cluster #1 "Nursing Autonomy and Advocacy" by "Hours of Work" resulted in a logical ordering of the means (Table 5). Nurses working full time produced scores with the highest mean (84.91) and inactive nurses scored the lowest mean (79.72). Nurses engaged full time in nursing can be expected to respond more positively to statements which portray the nurse as an independent professional, because such status is more productive of work satisfaction and feelings of self esteem (Bullough, 1974; Maas et al. 1975; Brandner, 1974). Both part time and inactive nurses produced scores which resulted in means below the mean of the total sample (83.49). These nurses are less likely to be as exposed to the concept of nursing autonomy and advocacy and its possible influence on the future of the nursing profession, than nurses working full time in the profession.

Table 5 Cluster #1 "Nursing Autonomy and Advocacy" analyzed by "Hours of Work" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Full Time	22840.00	84.91	11.92	142.17	269	69.2
Part Time	6767.00	80.56	12.02	144.42	84	21.6
Inactive	2870.00	79.72	12.28	150.78	36	9.3
Total Sample	32477.00	83.49	12.14	147.27	389	100.0

An analysis of variance on Cluster #1 "Nursing Autonomy and Advocacy" and the independent variable "Hours of Work" showed that the obtained F of 6.179 was significant at the 0.0023 level (Table 6) and therefore, the hypothesis that the means of the sample were were different was accepted. The results suggested that a relationship existed between the two variables, "Nursing Autonomy and Advocacy" and "Hours of Work" in this study.

Table 6 Analysis of Variance: Cluster #1 "Nursing Autonomy and Advocacy" analyzed by "Hours of Work"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	1772.597	2	886.298	6.179	0.0023
Within Groups	55366.601	386	143.437		
ETA = 0.1761		ETA SQUARED = 0.0310			

Subjects with 11-15 years experience obtained the highest mean when Cluster #1 "Nursing Autonomy and Advocacy" was analyzed by the variable "Experience" (Table 7). These subjects completed their basic nursing education, prior to

the time that the expanded role of the nurse was beginning to receive attention in the nursing literature (Ford and Silver, 1967; Skinner, 1968; Silver and Duncan, 1969; National Conference on Assistance to the Physician, 1971). This result reflects the fact that, within certain limits, accumulated experience leads the nurse to acquire a self concept based on her ability to function with confidence and assurance in her role. As her expertise and self confidence increase, she is more likely to support positive attitudes towards statements portraying the nurse as an autonomous professional accountable to the client, especially as this attribute has become more valued in the nursing culture. Such a nurse has progressed, at least part way, through the resocialization process described by Malkemes (1974) as a prerequisite for the successful adoption of the nurse practitioner role.

At the same time, this group of nurses have been exposed to forces in the environment which have placed increasing emphasis on the need for continuing nursing education. Confirmation of this statement is contained in the fact that the group included five out of the ten people in the total sample who held a Masters degree or higher. Variance within the group with 11-15 years experience was wider than that in the groups with less experience, in accord with the transitional profile of the resocialization process (Malkemes, 1974).

The two groups of nurses in the sample, with under 5 years experience and from 6-10 years experience, had very similar means of 84.96 and 84.67 respectively. The standard

deviation of these groups indicated that their scores were more closely clustered than either of the groups with more experience. A change in the basic socialization of the nurse to her role--both as a nurse and as a woman--has occurred in the last ten years. More emphasis is now placed, in basic nursing educational programs, on the role of the nurse as a member of the health care team. This is reflected in the attitudes of the groups with less than 10 years experience towards statements which portray the nurse as exercising independent judgement in her interactions with patients and other health care professionals.

The group with over 15 years experience showed the widest variation in scores and the lowest mean of 80.60 which was below the mean of the complete sample. The group consisted of 126 subjects (32.4 percent of the sample) and included 110 diploma nurses, twelve baccalaureate degree nurses and four nurses holding a Masters or higher degree. Because the group with over 15 years experience was twice as large as the 11-15 year group the effect of academic preparation was diluted. The group with over 15 years experience contained 12.7 percent with a baccalaureate degree or higher as compared to 20.3 percent in the group with 11-15 years experience. Added to this, the group with the most nursing experience has been exposed, for a longer period of time, to a nursing culture which accepted the traditional role of the nurse as the norm.

Table 7 Cluster #1 "Nursing Autonomy and Advocacy" analyzed by "Experience" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	Variance	N	%
11-15 years	5441.00	85.02	13.09	171.48	64	16.5
Under 5 years	9006.00	84.96	10.30	106.04	106	27.2
6-10 years	7874.00	84.67	10.00	100.05	93	23.9
Over 15 years	10156.00	80.60	13.98	195.52	126	32.4
Total Sample	32477.00	83.49	12.14	147.27	389	100.0

The analysis of variance performed on the Cluster "Nursing Autonomy and Advocacy" by the variable "Experience" (Table 8) resulted in an F of 3.596 which is significant at below the stated alpha for this study (0.05). Therefore, the hypothesis that the means were different in this sample was accepted. The indications are that a significant relationship exists between Cluster #1 "Nursing Autonomy and Advocacy" and the independent variable "Experience".

Table 8 Analysis of Variance, Cluster #1 "Nursing Autonomy and Advocacy" analyzed by "Experience"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	1557.539	3	519.180	3.596	0.0138
Within Groups	55581.659	385	144.368		
ETA = 0.1651		ETA SQUARED = 0.0273			

The ordering of the means when Cluster #1 "Nursing Autonomy and Advocacy" was analyzed by the independent variable "Setting" (Table 9) lends support to the findings of Pankratz and Pankratz

(1974) that academic and non-traditional settings foster the growth of attitudes which value nursing autonomy and advocacy. The group, working in an educational setting in this sample, was composed of eighteen nurses, evenly divided between nurses holding diploma, baccalaureate and master's degree or higher. The nurses holding master's or higher degrees working in educational settings represented 60 percent of the ten nurses in the master's and higher group in the stratified sample.

The nurses working in a hospital setting were the largest group--282 or 72.5 percent of the complete sample. The mean of this group (82.62) was below the mean of the total sample. The bureaucratic structure of the modern hospital health care facility does not encourage independent nursing action (Malone, 1964; Mauksch, 1965; Stein, 1967; Kramer, 1974; Bullough, 1976). People find it hard to tolerate inconsistency between their attitudes and their everyday behavior. Research has shown that people tend to alter their opinions and attitudes to conform with their behavior especially if the behavior is rewarded (Festinger and Carlsmith, 1959).

Nurses working in a community setting in this study, had the second highest mean of 86.74. The forty-three subjects in this group represented 11.1 percent of the total sample. They included seventeen nurses with a baccalaureate degree and one with a masters or higher degree (41.86 percent of this stratum of the total sample). The basic nursing education of twenty-five nurses (or 58.1 percent) in this group was at the diploma in nursing level. Reference to the original computer

list from which the sample was drawn, indicated that nine of these twenty-five nurses held a basic nursing diploma only and seventeen held a diploma/certificate in a specialty area or university credits in continuing education. It was not possible to define the educational status of the group more precisely from the available data. The results suggest that the setting in which the nurse practices is an important variable in determining how the nurse will react to statements designed to probe her attitudes towards the dependent variable "Nursing Autonomy and Advocacy" in this study.

Table 9 Cluster #1 "Nursing Autonomy and Advocacy" analyzed by "Setting" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Education	1668.00	92.67	11.46	131.41	18	4.5
Community	3730.00	86.74	12.55	157.39	43	11.1
Hospital	23301.00	82.62	11.77	138.52	282	72.5
Other	3778.00	82.13	12.57	157.89	46	11.8
Total Sample	32477.00	83.49	12.14	147.27	389	100.0

The indication that a relationship existed between Cluster #1 and the independent variable "Setting" was confirmed by an F of 5.299 which was significant at the 0.0014 level (Table 10). The hypothesis that the means obtained in this sample were different was accepted.

Table 10 Analysis of Variance: Cluster #1 "Nursing Autonomy and Advocacy" analyzed by "Setting"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	2265.890	3	755.297	5.299	0.0014
Within Groups	54873.308	385	142.528		
ETA = 0.1991			ETA SQUARED = 0.0397		

The means of the groups showed decrease with age when Cluster #1 "Nursing Autonomy and Advocacy" was analyzed by the independent variable "Age" (Table 11). The under 30 years group had the highest means of all groups (85.64). The next two groups--aged 31-40 and 41-50 years--produced very similar means (84.41 and 84.32) to each other and to the group preceding them in Table 11. Then there was a six point drop in the mean of subjects between 51-60 years to 78.12 and a twelve point drop in the mean obtained by subjects over 60 years of age.

The pattern is consistent with changes which have occurred over time in the education of nurses. Social forces in the external environment, such as the liberalizing effect of the women's movement on a predominantly female work force and the increasing exposure of nurses--who are both consumers and providers of health care--to the arguments of the patients' rights movement, are also reflected in the ordering of the means according to age group.

The standard deviations in Table 11 show that the group with the highest mean and the group with the lowest mean (i.e. the youngest and the oldest age groups) have the lowest variation in scores--10.24 and 10.36 respectively. Of the eleven nurses in the "over 60" bracket, five (45.5 percent) were inactive. Although the group was small, the figures show that the majority of the "over 60" subjects in this study have retained active membership in the work place.

Table 11 Cluster #1 "Nursing Autonomy and Advocacy" analyzed by "Age" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Under 30 years	12161.00	85.64	10.24	104.98	142	36.5
31-40 years	9285.00	84.41	11.73	137.51	110	28.3
41-50 years	6240.00	84.32	12.14	147.32	74	19.0
51-60 years	4062.00	78.12	13.97	195.20	52	13.4
Over 60 years	729.00	66.27	10.36	107.42	11	2.8
Total Sample	32477.00	83.49	12.14	147.27	389	100.0

A sharp division in the attitudes expressed by those subjects under fifty years of age and those over fifty was evident in this study. The analysis of variance produced an F of 10.357 which was significant at well below the 0.05 level (Table 12) indicating that a relationship exists between the attitudes expressed by subjects on the topic of "Nursing Autonomy and Advocacy" (as measured in this study) and age group. The hypothesis that the means were different was accepted.

Table 12 Analysis of Variance: Cluster #1 "Nursing Autonomy and Advocacy" analyzed by "Age"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	5564.218	4	1391.055	10.357	0.0000
Within Groups	51574.980	384	134.310		
		ETA = 0.3121	ETA SQUARED = 0.0974		

The category "Other", which was merged with the category "Diploma" when the variable "Nursing Autonomy and Advocacy" was analyzed by the independent variable "Education" (Table 13), contained eighteen subjects with a mean of 78.78 and a standard deviation of 13.06.

The results depicted in Table 13 support the findings of Pankratz and Pankratz (1974) that exposure to programs of higher education makes nurses more positive in their attitudes to statements portraying the nurse as an autonomous professional. The impact of education as a socializing process has also been demonstrated in a study by Bullough and Sparks (1975:691) which indicated that students are socialized to accept the values of faculty members, curriculum content or both. Schmahl, 1966; Torres, 1974; Malkemes, 1974 and Januska et al. 1974 all stress that education is one part of a complex re-socialization process which must take place before nurses can function comfortably as independent health care professionals.

Support for the findings in the present study is also forthcoming from a review of the backgrounds of nurses who have translated their attitudes about nursing independence

into very visible behavior by setting up independent nurse practices. Those nurses who have published accounts of their experiences in independent practice have all pursued their education beyond the baccalaureate degree in nursing (Greenidge et al. 1973; Lane, 1975; Keller, 1975 and Kinlein, 1977).

The means were ordered in step with the highest level of education attained by the subjects in this study. Those persons holding a master's degree or higher scored the highest mean (97.20) and those with a diploma in nursing, the lowest (81.46). The standard deviations revealed that nurses with increased education are more agreed within their group on the subject of attitudes towards "Nursing Autonomy and Advocacy" as measured by this study, than are nurses who hold a diploma in nursing. The wider standard deviation among diploma nurses (11.67) may reflect a state of transition in attitudes within this group.

Table 13 Cluster #1 "Nursing Autonomy and Advocacy" analyzed by "Education" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Masters or Higher Degree	972.00	97.20	7.96	63.29	10	2.6
Baccalaureate Degree	5192.00	92.71	9.30	86.46	56	14.4
Diploma in Nursing	26313.00	81.46	11.67	136.17	323	83
Total Sample	32477.00	83.49	12.14	147.27	389	100.0

The F which resulted from the analysis of variance was 31.283 (Table 14) significant at the 0.0000 level. It has therefore been demonstrated that a relationship exists between the Cluster "Nursing Autonomy and Advocacy" and "Education" in this study. The hypothesis that the means were different, when Cluster #1 was analyzed by the independent variable "Education", was accepted.

Table 14 Analysis of Variance: Cluster #1 "Nursing Autonomy and Advocacy" analyzed by "Education"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	7969.829	2	3984.914	31.283	0.0000
Within Groups	49169.369	386	127.382		
ETA = 0.3735			ETA SQUARED = 0.1395		

Cluster #2 "Patient Rights"

The means of the Cluster "Patients' Rights" were arranged in the same order as the Cluster "Nursing Autonomy and Advocacy" on the variable--"Administrative Position". Teachers had the highest mean of 62.87 and staff nurses the lowest of 58.32 (Table 15). The standard deviations were much smaller and closer together in the analysis of this cluster, than was the case in Cluster #1. The highest and the lowest means are within 4.55 points of one another in Table 15, whereas, in Table 3:98 -Cluster #1 "Nursing Autonomy and Advocacy" broken down by "Administrative Position"-- there was a difference of 12 points. Therefore, there was more overall agreement on the subject of attitudes towards the

Cluster "Patient Rights" compared with the agreement expressed about "Nursing Autonomy and Advocacy" on this variable.

It is argued that the variance was smaller on this Cluster because the nurse is exposed to discussion of the topic from several sides--from the nursing culture and from the external environment in which she is both a nurse and a consumer. The concepts behind the Patients' Rights movement are not in conflict with the image, which nursing fosters, of the nurse as a professional who specializes in individualized patient care. There is apt to be less conflict involved in expressing attitudes that are valued by the profession--and which concern a less powerful other--than is inherent in a situation calling for a declaration of independence from powerful authority figures.

Table 15 Cluster #2 "Patients' Rights" analyzed by "Administrative Position" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Teacher	1446.00	62.87	3.97	15.75	23	5.9
Nurse Practitioner	500.00	62.50	5.88	34.57	8	2.1
Supervisor or Administrative Nurse	1539.00	61.56	4.55	20.67	25	6.4
Head Nurse	1563.00	60.12	4.84	23.39	26	6.7
Community Health Nurse	2101.00	60.03	5.26	27.68	35	9.0
Other	3232.00	58.76	5.77	33.26	55	14.1
Staff Nurse	12656.00	58.32	5.41	29.29	217	55.8
Total Sample	23037.00	59.22	5.44	29.62	389	100.0

The analysis of variance with an F of 4.503 is significant at below the 0.05 level (Table 16) which confirms that the relationship indicated between the Cluster "Patients' Rights" and "Administrative Position" is not a chance one and, therefore, the hypothesis that the means were different was accepted. The F obtained on this Cluster is smaller, with the same degrees of freedom, than the F of 5.561 obtained for Cluster #1 on the same independent variable (Table 4:99).

Table 16 Analysis of Variance: Cluster #2 "Patients' Rights" analyzed by "Administrative Position"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	759.247	6	126.541	4.503	0.0002
Within Groups	10733.741	382	28.099		
ETA = 0.2570			ETA SQUARED = 0.0661		

The analysis of Cluster #2 by "Hours of Work" produced means that were close together over the three categories with standard deviations which showed that the scores were closely clustered around the mean, within each category, as well as within the complete sample (Table 17).

Table 17 Cluster #2 "Patients' Rights" analyzed by "Hours of Work" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Full time	15973.00	59.38	5.58	31.18	269	69.2
Part Time	4948.00	58.90	5.03	25.34	84	21.6
Inactive	2116.00	58.78	5.38	28.92	36	9.3
Total Sample	23037.00	59.22	5.44	29.62	389	100.0

The analysis of variance with an F of 0.374 (Table 18), confirmed that any differences which emerged were the result of chance and the hypothesis that the means were equal was accepted. Eta squared is approaching zero (0.0019) which supports the result of the obtained F. This result does not support the suggestion made by Storch, that:

. . . Because of the increased opportunities for lay contact which part time nurses generally have, they are frequently more attuned to lay-thinking (Storch, 1977:158).

The force of consumerism overrides the occupational barriers created by the nursing role. At the same time, modern nurses working full time, have rejected the suggestion that they have a cloistered, restricted viewpoint, by actively seeking community involvement (Freeman, 1970:111; Robischon, 1971:410-413; Leahy et al., 1972:4-5).

Table 18 Analysis of Variance: Cluster #2 "Patients' Rights" analyzed by "Hours of Work"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	22.203	2	11.102	0.374	0.6885
Within Groups	11470.784	386	29.717		
ETA = 0.0440			ETA SQUARED = 0.0019		

Conformity of attitude was once again evident when Cluster #2 "Patients' Rights" was analyzed according to the variable "Experience" (Table 19). There was only 0.37 difference between the highest and the lowest mean.

Table 19 Cluster #2 "Patients' Rights" analyzed by "Experience" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Under 5 years	6296.00	59.40	5.19	26.91	106	27.2
6-10 years	5515.00	59.30	5.41	29.32	93	23.9
11-15 years	3788.00	59.19	5.40	29.17	64	16.5
Over 15 years	7438.00	59.03	5.74	32.99	126	32.4
Total Sample	23037.00	59.22	5.44	29.62	389	100.0

The F of 0.094 (Table 20) suggested that no relationship existed between the attitudes expressed about Cluster #2 "Patients' Rights" and the independent variable "Experience". This result was significant at the 0.9632 level, well above the alpha of 0.05 set for this study. Therefore, the hypothesis that the means were equal was accepted. The eta squared was near to zero (0.0007) and it confirmed the finding.

Table 20 Analysis of Variance: Cluster #2 "Patients' Rights" analyzed by "Experience"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	8.436	3	2.812	0.094	0.9632
Within Groups	11484.551	385	29.830		
		ETA = 0.0271	ETA SQUARED = 0.0007		

When the Cluster "Patients' Rights" was analyzed by the variable "Setting" (Table 21), the two highest means of 62.72 and 60.33 were respectively obtained by nurses working in educational and community settings. The educational setting is usually expected to provide opportunities for trend setting activities in response to social forces such as the patients' rights movement. The community setting places more emphasis on the patients' self care activities and it is therefore more productive of nursing attitudes which value the patient's decision making powers, than is usually the case in the hospital setting.

The standard deviations obtained indicate more uniformity in the attitudes expressed by respondents to this Cluster "Patients' Rights" than was apparent in Cluster #1 "Nursing Autonomy and Advocacy" when analyzed using the same variable "Setting" (Table 9:105). The result may reflect the fact that the rights of patients have always been given at least lip service, in such concepts as 'patient centered care', whereas, nurse autonomy is a conflict ridden innovation implying that the nurse must accept more risks than she has been socialized to accept.

Table 21 Cluster #2 "Patients' Rights" analyzed by "Setting" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Education	1129.00	62.72	4.43	19.62	18	4.5
Community	2594.00	60.33	5.25	27.56	43	11.1
Hospital	16625.00	58.95	5.46	29.81	282	72.5
Other	2689.00	58.46	5.39	29.01	46	11.8
Total Sample	23037.00	59.22	5.44	29.62	389	100.0

The F of 3.677, which was significant at below the 0.05 level (Table 22), suggested that a relationship does exist between the setting in which a nurse practices and the attitudes that she expressed on the subject of patients' rights. The hypothesis that the means were different in this study, was accepted.

Table 22 Analysis of Variance: Cluster #2 "Patients' Rights" analyzed by "Setting"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	320.120	3	106.707	3.677	0.0123
Within Groups	11172.867	385	29.020		
ETA = 0.1669		ETA SQUARED = 0.0279			

Cluster #2 "Patients' Rights" analyzed by the independent variable "Age" produced very similar means for groups up to 60 years of age (Table 23). The scores of subjects over 40 years of age resulted in means which were below the mean of the total sample (59.22).

Table 23 Cluster #2 "Patients' Rights" analyzed by "Age"
arranged from highest mean to lowest mean

CATEGORY LABEL						
Under 30 years	8507.00	59.91	5.10	25.97	142	36.5
41-50 years	4377.00	59.15	5.64	31.80	74	19.0
31-40	6495.00	59.05	5.44	29.60	110	28.3
51-60 years	3045.00	58.56	6.01	36.13	52	13.4
Over 60 years	613.00	55.73	4.61	21.22	11	2.8
Total Sample	23037.00	59.22	5.44	29.62	389	100.0

The obtained F of 1.943 (Table 24) indicated that no relationship existed between the two variables "Patients' Rights" and "Age" as measured in this study. The computed F was significant at above the 0.05 level. The hypothesis that the means were equal was accepted. An Eta squared of 0.0198 supported the result of the obtained F.

Table 24 Analysis of Variance: Cluster #2 "Patients' Rights" analyzed by "Age"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	228.031	4	57.008	1.943	0.1026
Within Groups	11264.956	384	29.336		
ETA = 0.1409			ETA SQUARED = 0.0198		

The category "Other" which was merged with the category "Diploma" in Table 25, contained eighteen subjects with a mean of 58.89 and a standard deviation of 6.61. The means displayed in Table 25 ranged from 62.20 for respondents with a Master's degree or higher, through 61.79 for nurses with a

baccalaureate degree to 58.68 for those subjects with a diploma in nursing. The fact that the means were close together and the standard deviations were within ± 6 points of the mean indicate that there was a considerable amount of conformity in the attitudes expressed by subjects about statements contained in the Cluster "Patients' Rights", when analyzed according to the variable "Education". The ordering of the means from lowest to highest with increasing education supports the findings of Pankratz and Pankratz (1974).

Table 25 Cluster #2 "Patients' Rights" analyzed by "Education" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Master's or Higher Degree	622.00	62.20	5.96	35.51	10	2.6
Baccalaureate Degree	3460.00	61.79	4.60	21.12	56	14.4
Diploma in Nursing	18955.00	58.68	5.42	29.38	323	83.0
Total Sample	23037.00	59.22	5.44	29.62	389	100.0

Although the means are close together, they are significantly different at well below the 0.05 level. The analysis of variance resulted in an F of 9.703, significant at 0.0001 (Table 26). A relationship has, therefore, been demonstrated between the Cluster "Patients' Rights" and the variable "Education" in this study. The hypothesis that the means were different was accepted.

Table 26 Analysis of Variance: Cluster #2 "Patients' Rights" analyzed by "Education"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	550.169	2	275.085	9.703	0.0001
Within Groups	10942.818	386	28.349		
ETA = 0.2188			ETA SQUARED = 0.0479		

Cluster #3 "Rejection of Traditional Role Limitations"

The order into which the groups fall is slightly different in the analysis of Cluster #3 by "Administrative Position" (Table 27) from the order which emerged when the previous two Clusters were analyzed using the same variable (Tables 3:98; and 15:111). However, the category "Teacher" had the highest mean and "Staff Nurse" the lowest mean on all three Clusters, so that, overall, the groups are congruent. The means of the groups "Other" (49.82) and "Staff Nurse" (49.58) are both below the mean of total sample which was 50.47 in Table 27.

The ordering of the means displayed in Table 27 is logical and supports the results obtained by Pankratz and Pankratz where the three Clusters were correlated with " . . . advanced education, leadership, academic setting and non-traditional social climate . . . " (Pankratz and Pankratz, 1974:215).

Staff nurses practising in a hospital setting are, by the nature of the environment in which they work, less likely to be able to take innovative approaches to patient care outside the role definitions established by the hospital.

The finding that the groups "Supervisor or Administrative Nurse" and "Head Nurse", in this study, scored the third and fourth highest means respectively, may indicate that the potential for change exists in the hospital environment. Although the "Staff Nurse" group had the lowest mean, that does not necessarily suggest that their attitudes towards the Cluster "Rejection of Traditional Role Limitations" are negative. On the contrary, the mean score of 49.58 represented approximately 77 percent of a total possible score of sixty-five.

Table 27 Cluster #3 "Rejection of Traditional Role Limitations" analyzed by "Administrative Position" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Teacher	1260.00	54.78	5.24	27.45	23	5.9
Community Health Nurse	1830.00	52.29	6.01	36.09	35	9.0
Supervisor or Administrative Nurse	1299.00	51.96	5.27	27.79	25	6.4
Head Nurse	1340.00	51.54	5.93	35.22	26	6.7
Nurse Practitioner	406.00	50.75	9.21	84.79	8	2.1
Other	2740.00	49.82	6.54	42.74	55	14.1
Staff Nurse	10758.00	49.58	5.97	35.68	217	55.8
Total Sample	19633.00	50.47	6.18	38.18	389	100.0

The analysis of variance, with an F of 3.759 (Table 28), suggests that the relationship between Cluster #3 and "Administrative Position" is not one that occurs by chance. It is significant at below the 0.05 level and therefore, the

hypothesis that the means in this study were different was accepted.

Table 28 Analysis of Variance: Cluster #3 "Rejection of Traditional Role Limitations" analyzed by "Administrative Position"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	825.755	6	137.626	3.759	0.0012
Within Groups	13987.155	382	36.616		
ETA = 0.2361			ETA SQUARED = 0.0557		

Analysis of Cluster #3 by the independent variable "Hours of Work" (Table 29) produced means that were all very close together. Standard deviations of within ± 6.18 of the mean of the total sample indicated that subjects' scores were clustered around the mean fairly closely.

Table 29 Cluster #3 "Rejection of Traditional Role Limitations" analyzed by "Hours of Work" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Full Time	13704.00	50.94	6.15	37.87	269	69.2
Inactive	1790.00	49.72	5.40	29.12	36	9.3
Part Time	4139.00	49.27	6.44	41.50	84	21.6
Total Sample	19633.00	50.47	6.18	38.18	389	100.0

The analysis of variance, with an F of 2.653 (Table 30) showed that the difference between these means is not significant at the 0.05 level. The hypothesis that the means were equal was accepted indicating that no relationship exists between Cluster #3 and the variable "Hours of Work".

Table 30 Analysis of Variance: Cluster #3 "Rejection of Traditional Role Limitations" analyzed by "Hours of Work"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	200.822	2	100.411	2.653	0.0718
Within Groups	14612.088	386	37.855		
ETA = 0.1164			ETA SQUARED = 0.0136		

The means in Table 31 when Cluster #3 was analyzed by the variable "Experience" decreased as years of experience increased. The first three groups--from under 5 years up to 15 years experience--were similar with a 0.61 difference between the highest and the lowest mean. Then a wider gap of 2.64 points separated the group with below 15 years experience from the group with over 15 years experience. This grouping indicates that the changing educational and social scenes are having some impact on the attitudes of nurses when they are asked to define the nursing role.

Although the order which emerged in Table 7:103 when Cluster #1 "Nursing Autonomy and Advocacy" was analyzed by the variable "Experience" was different, there was the same pattern as in Table 31--very similar means for the groups under 15 years experience and then a drop of 4.07 points separating the under 15 years from the over 15 years experience group.

Table 31 Cluster #3 "Rejection of Traditional Role Limitations" analyzed by "Experience" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Under 5 years	5479.00	51.69	5.39	29.05	106	27.2
6-10 years	4779.00	51.39	5.66	32.07	93	23.9
11-15 years	3270.00	51.09	6.00	36.05	64	16.5
Over 15 years	6105.00	48.45	6.79	46.14	126	32.4
Total Sample	19633.00	50.47	6.18	38.18	389	100.0

The analysis of variance produced an F of 7.070 (Table 32) which was significant at well below the 0.05 level and resulted in the acceptance of the hypothesis that the means obtained were different. The indication exists that a relationship between the variable "Experience" and Cluster #3, in this study, does not occur by chance.

Table 32 Analysis of Variance: Cluster #3 "Rejection of Traditional Role Limitations" analyzed by "Experience"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	773.467	3	257.822	7.070	0.0001
Within Groups	14039.443	385	36.466		
ETA = 0.2285			ETA SQUARED = 0.0522		

The order in which the means emerge when the Cluster #3 is analyzed by the independent variable "Setting" (Table 33) supports the suggestion that the environment in which the nurse practices is an important variable in shaping attitudes about the nurse role. Nurses working in an educational setting scored the highest mean, followed by those nurses working in a community health setting. Nurses who practiced in the hospital setting produced scores with a mean below that of the total sample of 50.47. Support for rejecting traditional roles was, however, strong. The mean of the total sample (50.47) in Table 33, represents 77.6 percent of the possible score for Cluster #3. All three clusters produced the same ordering of the means when analyzed according to the independent variable "Setting".

Table 33 Cluster #3 "Rejection of Traditional Role Limitations" analyzed by "Setting" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Educational	955.00	53.06	6.28	39.47	18	4.5
Community	2245.00	52.21	6.01	36.12	43	11.1
Hospital	14168.00	50.24	6.02	36.22	282	72.5
Other	2265.00	49.24	6.85	46.94	46	11.8
Total Sample	19633.00	50.47	6.18	38.18	389	100.0

The F obtained from an analysis of variance (Table 34) performed on these data is 2.968 which was significant at below the 0.05 level. Therefore a relationship has been suggested in this study, between the Cluster "Rejection of Traditional Role Limitations" and the variable "Setting". The hypothesis that the means in this sample were different was accepted.

Table 34 Analysis of Variance: Cluster #3 "Rejection of Traditional Role Limitations" analyzed by "Setting"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	334.877	3	111.626	2.968	0.0319
Within Groups	14478.033	385	37.605		
ETA = 0.1504			ETA SQUARED = 0.0226		

The means displayed in Table 35 depict the scores obtained when Cluster #3 "Rejection of Traditional Role Limitations" was analyzed by the independent variable "Age". The pattern is similar to the one that emerged (Table 11:107).

when Cluster #1 "Nursing Autonomy and Advocacy" was analyzed by age groups. In Table 35, the means of groups under 50 years of age show a difference of 1.79 points. Then a gap of 3.88 appears between the lowest mean of the under 50 group and the mean of the 51-60 age group, followed by a further drop of 5.88 points in the mean of the over 60 group. There was, therefore, a definite division between the under 50 and the over 50 age groups. The pattern is an expected one since most of the stress on the need for nursing to adopt a more independent image has emerged over the last 10-15 years.

Table 35 Cluster #3 "Rejection of Traditional Role Limitations" analyzed by "Age" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Under 20 years to 30 years	7420.00	52.25	5.22	27.30	142	36.5
31-40 years	5590.00	50.82	5.75	33.07	110	28.3
41-50 years	3734.00	50.46	5.37	28.85	74	19.0
51-60 years	2438.00	46.88	7.14	51.01	52	13.4
Over 60 years	451.00	41.00	7.29	53.20	11	2.8
Total Sample	19633.00	50.47	6.18	38.18	389	100.0

The analysis of variance (Table 36) supports the suggestion that a relationship was present between the Cluster "Rejection of Traditional Role Limitations" and "Age" in this study. An F of 16.034 was obtained which was significant at well below the 0.05 level. The hypothesis that the means obtained were different was accepted for this sample.

Table 36 Analysis of Variance: Cluster #3 "Rejection of Traditional Role Limitations" analyzed by "Age"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	2119.987	4	529.997	16.034	0.0000
Within Groups	12692.923	384	33.054		
ETA = 0.3783			ETA SQUARED = 0.1431		

The category "Other", which was merged with the category "Diploma in Nursing" (Table 37) for the purposes of analysis, contained eighteen subjects with a mean of 48.00 and a standard deviation of 6.50. Cluster #3 "Rejection of Traditional Role Limitations" analyzed by the independent variable "Education" resulted in an increase in means with increasing educational status. This result was in accord with the results obtained in the analysis of all three Clusters with the variable "Education".

Standard deviations displayed in Table 37 showed that nurses with a Master's or higher degree were more agreed in their attitudes about the nature of the nursing role than were nurses with less educational preparation. The results agree with those obtained by Pankratz and Pankratz (1974) who concluded that education was a powerful variable in shaping the attitudes that nurses expressed about the traditional nursing role.

Table 37 Cluster #3 "Rejection of Traditional Role Limitations" analyzed by "Education" arranged from highest mean to lowest mean

CATEGORY LABEL	SUM	MEAN	S.D.	VARIANCE	N	%
Master's or Higher Degree	546.00	54.60	4.03	16.27	10	2.6
Baccalaureate Degree	3047.00	54.41	5.08	25.77	56	14.4
Diploma in Nursing	16040.00	49.66	6.10	37.26	323	83.0
Total Sample	19633.00	50.47	6.18	38.18	389	100.0

The F obtained when an analysis of variance was performed was 17.825 (Table 38). This result was significant at well below the 0.05 level and confirms that a relationship existed between the variable "Education" and Cluster #3 "Rejection of Traditional Role Limitations" in this study. The hypothesis that the means obtained were different was accepted.

Table 38 Analysis of Variance: Cluster #3 "Rejection of Traditional Role Limitations" analyzed by "Education"

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	SIG.
Between Groups	1252.418	2	626.209	17.825	0.0000
Within Groups	13560.492	386	35.131		
ETA = 0.2908		ETA SQUARED = 0.0845			

Summary

The majority of the results obtained in the series of analysis of variance tests, performed in the present study, were significant at below the 0.05 level. The results which were not significant at the 0.05 level were those obtained when the Cluster #2 "Patients' Rights" was analyzed by the independent variables "Hours of Work", "Experience" and "Age" and when Cluster #3 "Rejection of Traditional Role Limitations" was analyzed by "Hours of Work".

The present study indicated that nurses in administrative positions, those with advanced education and those who work in educational or community health settings are more likely to score highly on the Pankratz and Pankratz (1974) Attitude Scale--designed to measure attitudes to the three Clusters:

- 1) Nursing Autonomy and Advocacy;
- 2) Patients' Rights; and
- 3) Rejection of Traditional Role Limitations;

than are nurses working in a hospital setting as staff nurses and who have not completed a university degree.

Years of nursing experience was shown to produce two separate groups in relation to Cluster #1 "Nursing Autonomy and Advocacy" and Cluster #3 "Rejection of Traditional Role Limitations". Subjects with 15 years or less experience had the highest means in both Clusters and formed one group. Subjects with over 15 years experience had lower means and formed another group. No such grouping of the means occurred

when Cluster #2 "Patients' Rights" was analyzed by the variable "Experience"

The results obtained when Cluster #1 "Nursing Autonomy and Advocacy" and Cluster #3 "Rejection of Traditional Role Limitations" were analyzed by the variable "Age" demonstrated a dichotomy between the attitudes expressed by subjects under 50 years of age and those over 50 years. The result is congruent with the results obtained when these two clusters were analyzed by the variable "Experience". Analysis of the Cluster #2 "Patients' Rights" and the variable "Age" showed very little variation among the means.

The majority of respondents in this study profess positive attitudes towards all three clusters tested by the Pankratz and Pankratz (1974) Attitude Scale. However, a comparative examination of the means and standard deviations obtained on the three clusters (Table 39) revealed that the attitudes of the respondents were more homogeneous on Cluster #2 "Patients' Rights" than on either of the other two clusters.

This result is illustrated when the responses to individual statements in the cluster are examined. For example, in response to the statement, "I believe a patient has a right to have all his questions answered for him." 91.5 percent of the total sample marked either STRONGLY AGREE (60.9 percent) or AGREE (30.6 percent). Question number 19, which stated, "I feel patients should be told the medications they are taking." drew a response of STRONGLY AGREE, of 54.5 percent and AGREE, of 40.1 percent from the total sample. At the same time,

the Cluster "Patients' Rights" produced the lowest mean for the total sample when means were expressed as a percentage of the highest possible score on each Cluster (Table 39).

Cluster #1 "Nursing Autonomy and Advocacy" contains statements which tap the nurse's attitudes towards her own right to independent professional action and her willingness to support the patient's efforts to gain more control over what happens to him within the health care system. An examination of the means and standard deviations in Table 39, provides evidence of a comparatively wide variance in responses, to statements in Cluster #1. This is an expected result in an area undergoing dramatic changes as a result of shifting societal attitudes towards the importance of consumer behavior in health care and the need to make more efficient use of available health care workers.

The third Cluster--"Rejection of Traditional Role Limitations"--produced means and standard deviations which show that nurses, in this study, reject attitudes reminiscent of the dependent, traditional nurse role. For example 88 percent of the total sample agreed that, "If I am not satisfied with the doctor's action I would pursue the issue." This statement implies that nurses are prepared to take assertive action on their own or on the patient's behalf, if necessary. Subjects were prepared to support this statement where the emphasis is on their sense of dissatisfaction with the physician and they were not prepared to give a similar statement majority support, when the emphasis was placed on the

patient's dissatisfaction with the physician and the state-
ment was specifically linked with the patient advocate role.

Table 39 Scores for Total Sample (N = 389) on each Cluster

CLUSTER LABELS	MEAN	S.D.	MEAN AS A % OF HIGHEST POSSIBLE SCORE ON EACH SUB-SCALE
Nursing Autonomy	83.49	12.14	64.3
Patients' Rights	59.22	5.44	60.4
Rejection of Traditional Role Limitation	50.47	6.18	77.6

The findings in this study support the results reported by Pankratz and Pankratz (1974) and the means expressed as a percentage of the total possible scores (Tables 39 and 40) are very similar in both studies.

Table 40 Scores obtained by Pankratz and Pankratz (1974) on the three Clusters for total sample with N = 702

CLUSTER LABELS	MEAN	S.D.	MEAN EXPRESSED AS % OF HIGHEST POSSIBLE SCORE ON 3 SUB-SCALES
Nursing Autonomy	84.6	16.6	65.1
Patients' Rights	56.6	6.1	57.8
Rejection of the Traditional Role Limitation	50.2	7.3	77.2

CHAPTER V

CONCLUSIONS

The results of this study suggest that, although nurses in administrative positions, educators and those nurses working in educational and community health settings, scored highest on all three clusters in the Pankratz and Pankratz (1974) Attitude Scale, the mean of the total sample on the three clusters is sufficiently high to provide firm support for assertive leadership on the issues of consumer rights in health care, informed access to information by the consumer, and nursing autonomy, and advocacy. At the level of the professional association, nursing leaders who promote the rights of consumers in health care by assertive interaction with consumer groups, government representatives and other health care workers could develop role models of consumer advocacy with which the individual nurse, working with the consumer of care, can identify.

The findings indicate that the hospital setting is the least productive of positive attitudes towards the three clusters and that the status of staff nurse within the hospital setting reflects a similar situation. If nurses value the concepts inherent in nursing independence, consumer rights and advocacy and, if the nursing profession is to give substance to the myth that the patient is their 'reason for being',

these facts merit serious consideration.

The nursing profession, as a part of the revolt against the apprenticeship system of nursing education, transferred the major responsibility for the socialization of the nurse to her role, to nursing educators. Responsibility for the work place as a socializing force was abdicated, although it is well known that the work place exerts a powerful influence upon workers (Goffman, 1961:4; Christman, 1976:61; Treat and Kramer, 1977; Miller, 1977:28).

The reality that the nursing profession must face is that most nurses work in hospital settings which are " . . . work centered and action oriented" according to Theis and Harrington (1968:1481) and which Haase describes as:

. . . bureaucratic structures organized around the performance of tasks and based peculiarly on an industrial model that deals in products and profitable outcomes (Haase, 1976:807).

Change within these settings requires a " . . . clarification and reconstruction of values . . . " (Chin and Benne, 1976:33) which is the fulcrum upon which the normative-re-educative change process rests.

This researcher agrees with Hassenplug who has stated that it is necessary to concentrate on the problems that the staff nurse faces in delivering nursing care to the consumer, in order to insure that the primary task of nursing is accomplished to the satisfaction of both nurses and consumers.

. . . It seems imperative that we help [staff] nurses strengthen their preparation, shift their accountability from physicians and institutions to clients, and become contributing members of their professional organization, whose goals include improvement of nursing practice and nursing education and greater say in the delivery of health care services (Hassenplug, 1977:436).

The emergence of the consumer rights in the health care movement carries with it a message that the consumer considers himself and his reactions to be important in the processes of "cure and care". From it arises a need to clarify the value that the professional health care worker places on the patient. How the patient thinks, feels and acts--his strengths as well as his weaknesses--provide a basis for change within the health care system. At present, the system values techniques and interventions external to the patient which can be applied, administered or otherwise manipulated by someone else.

It is rare for the health care worker to examine carefully the potential for health that the patient brings with him, along with his diseased organ or system, into the hospital setting. Even when the patient enters the hospital in desperate need of acute care, a potential for health continues to exist, although it may have to be expressed by the thoughts, feelings and actions of family members or, in extreme cases, by the actions of professional health care workers.

Shelagh Rose, a social worker, writing about her experiences as a patient, suggests that the differing attitudes expressed by community health nurses and hospital nurses have their origins in the patient profile. The hospital patient

is typically accepted as dependent whereas, the person seeking help in the community setting more often retains his mobility and independence and he is treated as more intelligent than his hospital counterpart (Rose, 1970).

A hospital environment which encourages the maximum possible participation by the consumer (or, where appropriate, his family) in his own care would encourage change within a framework of normative-re-educative strategies (Chin and Benne, 1976). The change would create a more demanding, professionally oriented staff nurse role. Resocialization, on a large scale, is needed to make such a role a reality. Interactions aimed at exploring the consumer's potential to contribute to decision making and to self-care, assessing accurately when responsibility must be assumed by the health care worker, would become as important as the skills necessary to perform highly technical tasks.

The staff nurse role would expand to include that of health educator working with the consumer to set realistic self-care goals, teaching the skills necessary to achieve those goals and offering support and feedback as the patient tries out his new skills and responsibilities. The concept recognizes that there comes a time in the evolution of the patient's progress towards health when the need for interdependent patient/nurse interaction assumes priority over the need for patient/physician or physician/nurse interaction.

At one end of a continuum in Cluster #1 of the Pankratz and Pankratz (1974) Attitude Scale are statements about nursing

autonomy, which specifically tap the subject's attitudes towards independent nursing practice and the assumption by nurses of legal responsibility for professional nursing actions. At the other end of the continuum is a statement, which portrays the nurse as a professional health care worker accepting the responsibility for the initiation of public health referrals on behalf of the patient. In the latter case, the vast majority of respondents (98.5 percent) had no difficulty in accepting the statement (49.4 percent marked STRONGLY AGREE and 49.1 percent marked AGREE).

As might be expected, responses to, "I should be able to go into private practice like a doctor if I wish." resulted in 44.2 percent of the total sample rejecting the statement (15.4 percent STRONGLY DISAGREE and 28.8 percent DISAGREE) and 27.5 percent marking UNDECIDED. This result is probably partly due to the lack of behavioral models in this area.

Levin has stated:

. . . attitudes are difficult to change in a vacuum. Some actual behavior, a practical activity, will have to take place--some trials which will reduce embarrassment and replace it with trust based on experience with practical and mutual benefits (Levin, 1972:2010).

Most nurses do not know colleagues who have set up in independent nursing practice and their familiarity with the model is confined to reports in the literature. However, the fact that 28.3 percent of the total sample accepted the statement, shows that nurses have given thought to the model as a future possibility for some members of the nursing profession.

The statement that, "Nurses should be held solely legally responsible for their own actions and not expect to come under the umbrella of the doctor or hospital in a mal-practice suit." is the ultimate in accountability to the consumer. It describes a situation which is closer to the reality of nursing practice in the 1970's in Canada than is the model of independent nurse practice. However, it asks for a reaction to a situation which would have to be accepted before independent nurse practice could become a reality. Results indicate that the majority of nurses in this study are not ready to accept legal responsibility for their actions. Forty-four point five percent of the respondents rejected the statement (13.1 percent STRONGLY DISAGREE and 31.4 percent DISAGREE). The number of persons who were UNDECIDED dropped to 21.9 percent as compared to 27.5 percent who expressed uncertainty in response to the statement about independent nurse practice.

Role models of independent nurse practice in the literature place great emphasis on the role of the nurse as a patient advocate (Keller, 1975; Kinlein, 1977). Nurses, in this study, did not identify with the role of patient advocate if it specifically contained a rejection of the physician's authority. More respondents disagreed (39.6 percent) with the statement, "I am the best person in the hospital to be the patient's advocate if he disagrees with the doctor." than agreed (34.9 percent). Twenty-five point four percent marked UNDECIDED for this statement which may be indicative of the transitional state of attitudes about the physician as the

symbol of ultimate authority in the health care system.

When the subjects were asked to respond to the simpler statement--"Patients can expect me to stand up for them."--indecision dropped to 8.2 percent. Eighty-eight point nine percent of the respondents checked agreement with the statement (31.6 percent marked STRONGLY AGREE and 57.3 percent marked AGREE). The first statement places two values in competition with one another and creates dissonance for the nurse who has been socialized to value the individuality of the patient and at the same time to accept the physician as the person "who knows best" what is good for the patient. Recognition by nurses, of this sort of dissonance ". . . among their most cherished values" (Pankratz and Pankratz, 1974:212) may result in the discarding of old value systems in favor of values more in accord with autonomous roles.

The nurse-advocate role needs careful examination by leaders of the nursing profession. Chapman and Chapman's model of humanistic advocacy, contains--as an intrinsic part of the helping process--an emphasis on health worker/patient participation in decision making which is in tune with an approach to planned change based on Chin and Benne's (1976) normative-re-educative strategies for change. Chapman and Chapman say:

. . . Helpers deserve high value and respect, just as do patients. They must be listened to as individuals as well as groups and assisted in every growth-enhancing way to know and actualize themselves more broadly (Chapman and Chapman, 1975:49).

The adoption of the advocacy role by nurses carries with it specific risks for individual nurses. Kelly has faced the reality of the situation by commenting:

. . . We have encouraged the nurse to be autonomous, to make independent decisions within her scope of practice, to consider herself as accountable to the patient. But, if she does indeed practice in this fashion and, as a result, finds herself in personal and professional difficulty, are there support systems available to her? (Kelly, 1976:32).

The attitudes expressed in this study indicate that nurses are motivated to accept the patient as a participating member of the health care team but they need support to assume the risks associated with a self-image incorporating professional autonomy and interdependence.

Suggestions for Further Research

Recognition of the antecedents of change which are enmeshed in the present emphasis on consumer rights in health care has to be melded with a recognition that " . . . human behavior is like a centipede, standing on many legs." (Bennis et al. 1976:6). Attitudes, although important elements in planning for change, are not necessarily transformed into corresponding behavior in given situations.

The results obtained in this study suggest the need to investigate the nature of the interactions that occur, in reality, between the consumers of care and health care workers and to isolate the effect that various environments in the health care system have upon these relationships. Inherent in this approach is a need to define the support systems that are

available to registered nurses who, in the process of activating the ideals of the profession, find that the realities of the work place exert powerful influences which can prove to be overwhelming to the individual nurse.

Increased emphasis on the consumer's evaluation of the health care system could result in innovative approaches to the delivery of health care. Research is needed to develop insight into how to foster the patient's self-care potential as a therapeutic resource while still supporting the patient's legitimate need for dependency as it occurs. Studies demonstrating the effects of an environment which develops the patient's abilities to actively participate in his own health care compared to one in which the patient is expected to be compliant and passive would provide clarification of environmental influences and direction in long range planning for the future of the health care system.

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APPENDIX A

CONSUMER RIGHTS IN HEALTH CARE
CONSUMERS' ASSOCIATION OF CANADA

1974

CONSUMER RIGHTS IN HEALTH CARE

I Right to be informed

- 1 - about preventive health care including education on nutrition, birth control, drug use, appropriate exercise
- 2 - about the health care system including the extent of government insurance coverage for services, supplementary insurance plans, the referral system to auxiliary health and social facilities and services in the community
- 3 - about the individual's own diagnosis and specific treatment program including prescribed surgery and medication, options, effects and side effects
- 4 - about the specific costs of procedures, services and professional fees undertaken on behalf of the individual consumer

II Right to be respected as the individual with the major responsibility for his own health care

- right that confidentiality of his health records be maintained
- right to refuse experimentation, undue painful prolongation of his life or participation in teaching programs
- right of adult to refuse treatment, right to die with dignity

III Right to participate in decision making affecting his health

- through consumer representation at each level of government in planning and evaluating the system of health services, the types and qualities of service and the conditions under which health services are delivered
- with the health professionals and personnel involved in his direct health care

IV Right to equal access to health care (health education, prevention, treatment and rehabilitation) regardless of the individual's economic status, sex, age, creed, ethnic origin and location

- right to access to adequately qualified health personnel
- right to a second medical opinion
- right to prompt response in emergencies

APPENDIX B

PANKRATZ AND PANKRATZ (1974) ATTITUDE SCALE

PANKRATZ AND PANKRATZ (1974) ATTITUDE SCALE

NURSING QUESTIONNAIRE

IDENTIFICATION

I would like to know what you think about these statements. For each opinion statement, place a number in the box to the right of the question that corresponds most closely, to how you react to the statement.

STRONGLY AGREE = 1; AGREE = 2; UNDECIDED = 3; DISAGREE = 4; and STRONGLY DISAGREE = 5. Please answer every question. There are no right or wrong answers.

-
- 1) I feel that patients should plan their own activities.
 - 2) I have fulfilled my responsibility when I report a condition to a physician.
 - 3) I would feel free to try new approaches to patients' care without the "permission" of an administrative nurse.
 - 4) I feel free to recommend non-prescription medication.
 - 5) If I requested a psychiatric consult for a patient, I would feel out of bounds.
 - 6) I believe a patient has a right to have all his questions answered for him.
 - 7) If I am not satisfied with the doctor's action I would pursue the issue.
 - 8) I am the best person in the hospital to be the patient's advocate if he disagrees with the doctor.
 - 9) If a patient is allowed to keep a lot of personal items, it becomes more trouble than it is worth.
 - 10) I don't answer too many questions of the patient because the doctor may have another plan in mind.
 - 11) I feel the doctor is far better trained to make decisions than I.
 - 12) I would never call a patient's family after discharge.

- 13) Patients should not have any responsibility in a hospital.
- 14) Patients should be permitted to go off their unit and elsewhere in the hospital.
- 15) If a patient asks why his medication is changed, I would refer him to his doctor.
- 16) If a policy change affects patient care, I want to understand why the change is necessary.
- 17) Patients should be encouraged to show their feelings.
- 18) I should be able to go into private practice like a doctor if I wish.
- 19) I feel patients should be told the medications they are taking.
- 20) I should have a right to know why a change is necessary before it is accepted.
- 21) Patients should be told their diagnosis.
- 22) If I make conversation with the patient, there is no need to explain procedures and treatments before they are started.
- 23) I generally know more about the patient than the doctor.
- 24) Patients in a hospital have a right to select the type of treatments or care they wish.
- 25) If I disagree with the doctor, I keep it to myself.
- 26) I feel the patient has a right to expect me, as a nurse, to effectively utilize my time in improving my skills by taking advantage of educational opportunities offered.
- 27) I would feel comfortable in authorizing a patient to leave the unit to go to another part of the hospital.
- 28) The patient has a right to expect me to regard his personal needs to have priority over mine.
- 29) I feel the patient has a right to refuse care.
- 30) It should be the doctor who decides if the patient can administer his own drugs.
- 31) I would never refuse to carry out a doctor's order.

- 32) I feel that patients should be informed as to what constitutes quality health care.
- 33) The patient has a right to expect me to accept his social cultural code and to consider its influence on his way of life.
- 34) Patients should be permitted to wear what they want.
- 35) I would never interact with a patient on a first name basis.
- 36) I rarely give in to patient pressure.
- 37) Nurses should be held solely legally responsible for their own actions and not expect to come under the umbrella of the doctor or hospital in a malpractice suit.
- 38) Doctors must decide what nurses can and cannot do in the delivery of health care.
- 39) It is the prerogative of the nurse to decide whether or not to wear a uniform.
- 40) I would give the patient his diagnosis if he asks.
- 41) It should be the nurse's decision when to talk to the terminal patient about his condition.
- 42) I think that it is my responsibility to initiate public health referrals on patients.
- 43) I feel that I should suggest to patients, family, and doctor any community resources that I know are available.
- 44) Patients can expect me to speak up for them.
- 45) I would never ask a patient about his or her sexual life.
- 46) I would talk very little to patients about their past.
- 47) I rarely ask a patient a personal question.

FOR THE REMAINING QUESTIONS, PLEASE PLACE THE CODE NUMBER IN THE ANSWER BOX, WHICH CORRESPONDS TO THE CORRECT ANSWER TO THE QUESTION. EXAMPLE - If you are a Community Health Nurse, Place the number 2 in the box.

CODE

48) Are you a -

Nurse Practitioner?	1
Community Health Nurse?	2
Supervisor or Administrative Nurse?	3
Head Nurse?	4
Staff Nurse?	5
Teacher?	6
Other?	7

49) Do you work -

Full time?	1
Part time?	2
Inactive?	3

50) How many years of experience do you have as a Registered Nurse?

Under 5 years?	1
6-10 years?	2
11-15 years?	3
over 15 years?	4

51) Do you work in -

a Hospital?	1
a Community setting?	2
Educational setting?	3
other?	4

52) Age -

under 20 years?	1
21-30 years?	2
31-40 years?	3
41-50 years?	4
51-60 years?	5
over 60 years?	6

53) Highest educational qualification completed -

Diploma?	1
Baccalaureate degree?	2
Graduate degree?	3
Other?	4

APPENDIX C

SCORING FOR PANKRATZ AND PANKRATZ (1974) ATTITUDE SCALE

Scoring for the Pankratz and Pankratz (1974) Attitude Scale

Each subject was given one to five points on each statement. The points were assigned so that 'Strongly Agree' = one point up to 'Strongly Disagree' = 5 points. Some statements contributed positively and some negatively to the scale scores. Therefore, some items were reversed by subtracting from a given constant--that constant being six points for each reversed statement. EXAMPLE--on Scale III, the subject's score on statement number seven contributed only one point, if the subject checked 'Strongly Disagree' (six minus five = one).

The procedure to obtain scores on the three scales is as follows:

SCALE I - Highest possible score is 130.

- 1) Add the scores on the following 15 items:

1, 3, 4, 8, 14, 18, 23, 24, 27, 34, 37, 39, 40, 41, 42

Subtract the total score on these items from 90.

- 2) Add the preceding results to the total score on the following eleven items:

5, 9, 10, 11, 12, 15, 30, 36, 38, 45, 46

SCALE II - Highest possible score is 98.

Add the scores on the following 14 items:

6, 16, 17, 19, 20, 21, 26, 28, 29, 32, 33, 34, 43, 44

Subtract the total score on these items from 84.

SCALE III - Highest possible score is 65.

- 1) Subtract the subject's score on item number seven from six.

- 2) Add the preceding results to the total score of the following twelve items.

2, 5, 10, 11, 13, 22, 25, 31, 35, 45, 46, 47.