BECOMING A NURSE --
SOCIALIZATION INTO AN OCCUPATIONAL ROLE

by

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ABSTRACT

This is a study on becoming and being a nurse. The nursing role involves role-anticipation, role-taking, role-playing and role-abandonment; it involves the moulding, by specific process, of an occupationally-undefined individual into a professional person. These processes, if successful, consist of a commitment to nursing norms by discipline, identification, and rites de passage. They are accompanied by increasing group unity, increasing adoption of institutional norms and a decreasing ability to play other roles and to identify with outsiders. Role-taking could also be seen in terms of distinct phases such as the theoretical phase, the practical phase, the phase of disillusionment and the phase of acceptance and routine. There is a change in attitudes between the first and the final phase.

The role of the nurse can be clarified by the use of a method of occupational analysis. The five variables of the scheme are: images of the role, character of the obligations, rewards, strains and relation to others.

The methods and techniques that were used for this study were questionnaire, guided and unguided interviews, and participant observation.
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Introduction</td>
<td>1</td>
</tr>
<tr>
<td>II A Frame of Reference</td>
<td>9</td>
</tr>
<tr>
<td>1. General Orientation to Role</td>
<td>10</td>
</tr>
<tr>
<td>2. Relevant Work by Others</td>
<td>20</td>
</tr>
<tr>
<td>3. The Major Questions of This Study</td>
<td>39</td>
</tr>
<tr>
<td>III Research Methods and Experiences</td>
<td>45</td>
</tr>
<tr>
<td>IV The Training Setting</td>
<td>70</td>
</tr>
<tr>
<td>V The Choice of Nursing and Role-Anticipation</td>
<td>104</td>
</tr>
<tr>
<td>1. Making the Choice</td>
<td>104</td>
</tr>
<tr>
<td>2. Role-Anticipation</td>
<td>118</td>
</tr>
<tr>
<td>VI From Probie to Grad -- Processes</td>
<td>134</td>
</tr>
<tr>
<td>VII From Probie to Grad</td>
<td>161</td>
</tr>
<tr>
<td>Phases</td>
<td>161</td>
</tr>
<tr>
<td>Changes</td>
<td>178</td>
</tr>
<tr>
<td>Suggested Typology</td>
<td>191</td>
</tr>
<tr>
<td>VIII Playing the Role -- Being a Nurse</td>
<td>197</td>
</tr>
<tr>
<td>1. Images of the Role</td>
<td>203</td>
</tr>
<tr>
<td>2. Character of Obligations</td>
<td>215</td>
</tr>
<tr>
<td>3. Rewards</td>
<td>225</td>
</tr>
<tr>
<td>4. Relation to Others</td>
<td>228</td>
</tr>
<tr>
<td>IX Strains and Conflicts</td>
<td>237</td>
</tr>
<tr>
<td>1. The Nature of Strains in Nursing</td>
<td>238</td>
</tr>
<tr>
<td>2. Institutional Means of Releasing Tension</td>
<td>265</td>
</tr>
<tr>
<td>3. Functions of Strain</td>
<td>267</td>
</tr>
<tr>
<td>X Conclusions and Implications</td>
<td>270</td>
</tr>
<tr>
<td>Findings</td>
<td>270</td>
</tr>
<tr>
<td>Recommendations</td>
<td>289</td>
</tr>
<tr>
<td>Suggestions for Future Research</td>
<td>293</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>296</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>301</td>
</tr>
</tbody>
</table>
TO FORTY YOUNG NURSES --

THE CLASS OF AUGUST '58
CHAPTER I

INTRODUCTION

The Nature of the Problem

The role of the nurse could be considered from two perspectives. The first is concerned with nursing as the process of "taking on" an occupational role. It provides the answer for the following questions: How and why does one become a nurse? What changes occur? How does the training period function in the development of professional people? What characteristics are noticeable in this development? As these questions indicate, the "taking on" of a role is a dynamic thing, involving the leaving behind of one state of "being" and the adoption of another. It signifies the learning of new modes of action and the forgetting of the old. Growing into an occupational role, such as nursing, and learning to predict the expectations of this role, and to act according to these expectations, is a process which sociologists call socialization. It is change in a socially-defined direction by a person acquiring a new role. The role of the nurse, therefore, could be looked at as the result of fashioning the particular "role-incumbent" from an occupationally-undefined individual. This could be taken further so that the process of becoming a nurse could also be looked at as the process of becoming a professional person.
The second perspective provides an answer for the question: what is a nurse and how does she differ from other roles? It assumes that the individual has passed through the process of "becoming," that she is involved in the actual playing of the role. The role lends itself to discussion with the help of selected concepts, which allow for the comparison of this role with others. This is by nature a descriptive and static perception in that it looks at nursing at a given time and not during a period of time.

I have tried, therefore, in this study, to give equal attention to both aspects of the role: the process of "taking on" a role and the "playing" of that role.

Reasons for Selection

At the beginning of my graduate year, in September 1955, I had to choose a topic for a thesis. Out of the many areas of sociology in which I could do a study, I felt attracted to the area which is often termed "medical sociology." I feel obliged to add that my initial interest was not in the subject matter of "medical sociology" per se. Rather I wanted to see what sociology, which seemed, at the time, rather abstract and theoretical, could contribute to the practical, action-oriented medical milieu.

After reading the contributions of sociologists, such as Hall, Hughes, Stanton and Schwartz, I became convinced that their work was not merely an intellectual exercise or
merely a piece of scientific research. They could also have practical applicability. Their main virtue was in being able to present a new, analytical point of view, which would permit the medical sub-culture to view itself from a different perspective. This perspective would have the added advantage of being disengaged from nursing. The result could be different interpretations of nursing problems and possibly new programs of action.

I was at this time vaguely aware of certain public images of the nurse. I had heard it said that nurses were "angels of mercy" and at the same time I had heard comments to the effect that girls changed when they became nurses and that they became callous. I was enthusiastic about knowing what really happened when girls became nurses; what were nurses like; and what it was like to be a nurse.

A study of this kind promised interesting findings and it had the added advantage of being a convenient choice as far as field work was concerned. On the campus of the University of British Columbia there is a School of Nursing, where in the fall of each year approximately forty girls begin their careers as student nurses. As at this time I was taking courses at the university, the initial stages of the study would be facilitated if I could study these students. The teaching staff of the School of Nursing was approached on this matter. They consented and I was encouraged by their approval and interest. The necessary arrangements were made and I began to attend nursing
lectures and to formulate questions that could be posed.

The instruction for these students involved attention to both practical and theoretical areas. Conveniently for me, the instruction given during the university term, and on the university campus, was primarily theoretical. The students were given a taste of practical training in laboratory periods when they "pretended" that they were working as nurses on a hospital ward. It was not until the university term had expired that the girls were introduced to hospital work, to residence life and to the practical aspect of their training. I was very fortunate in obtaining permission from the university school and the hospital school to join the students at the hospital in order to participate in the practical training they were given. This gave me the opportunity to construct a first-hand picture of students adapting to the hospital milieu and to formulate a self-conception of "what it felt like to be a student nurse," when one had to sleep in a residence with five hundred other girls, to give a bed bath for the first time, to do the first dressing, and to learn how to work harmoniously with head nurses, instructresses and doctors.

Nature of Investigation

This study, initially carried out as a partial requirement for a degree in the Department of Anthropology, Criminology and Sociology, was begun in the fall of 1955. During the winter that followed the field work that I could do
was somewhat meagre as I was trying, at the same time, to complete six university courses. I did, however, during that time attend nursing courses, formulate a rather lengthy questionnaire, do some interviewing, and go every second week to a discussion among nursing students as part of a course in Sociology. From the nursing lectures I was able to collect information on the nature of the formal instruction given to the students, as well as on instances of the transmission of relevant attitudes. Many of these attitudes were also displayed in the nursing discussions. The questionnaire, consisting of approximately fifty questions, was constructed to indicate the beginning self-conceptions and the expectations of the students. This was administered in March, 1956. My intention was to administer the same questionnaire after the period of practical training and thus to specify change. At the same time I conducted interviews designed to enquire into: 1) what students believed motivated them to "take on" the nursing role; 2) how strong their wish for nursing was.

The months of May and June, 1956, were the students' first contact with the hospital. At this time I took on the role of "participant observer," becoming involved in their learning, work and "off duty" activities. At the end of the two-month period, before the girls left for a month's holiday, I once again asked them to complete the questionnaire and gave each girl an interview. The interviews focussed primarily on change. At this point I believed that the field work for my
thesis was over. During the month of August and early September, when the students were once again on the university campus, taking courses from the university School of Nursing, I encountered them frequently. This interaction was not in terms of observer and observed, but rather on the basis of one student to another.

During the period from September, 1955 to June, 1956, I was receiving support and encouragement from three sources. Firstly, I was given constant help and guidance by Dr. K. D. Naeglele and the department in which I was writing my thesis. Secondly, I had the benefit of the interest and co-operation of the Schools of Nursing at the university and at the hospital. Finally, of utmost importance was the favorable reaction and acceptance given me by the members of the nursing class that I was studying.

Having devoted nine months to studying the "making" of a nurse, seven months of which the prospective nurse, was, in reality, a university student, I began to feel an increasing dissatisfaction with the length of time that had been devoted to the study. The students were to graduate in August, 1958, more than two years after I had stopped studying them for changes and self-conceptions. It seemed to me that I had studied one branch and could not conceive of the whole tree. I became aware of the segmental character of my work. At this time I was very fortunate in being given a grant by the Koerner Foundation to enable me to continue the research.
Therefore, in October, 1956, I returned to the hospital milieu and took up where I had left off. The staff of the department of nursing education was most co-operative and gave me the use of a room in the Nurses' Residence, and permitted me to follow the students through all the departments of the hospital where their work took them.

In January, 1957, I conducted another set of interviews, questioning each girl with my objective being to bring out indications of change. This was done during their last weeks as junior students, before they entered on the intermediate phase of their training. Again in May, when the students returned for a two-week period to the university campus, I interviewed them in groups. Between each set of interviews I assumed the role of participant observer, becoming involved in as many aspects of their life as possible.

Presentation of Data and Conclusions

My findings and conclusions are to be recorded in two ways. Firstly, this thesis shall cover in full the first phase of the study, presenting the conclusions from the questionnaire, the first three interviews and the data collected by means of participant observation. The nature of this data is both qualitative and quantitative. It shall also draw on evidence from the work that was possible only through the support of the Koerner Foundation.
The second phase of the work shall be presented in the form of a report to the Koerner Foundation. It shall emphasize the material collected between October, 1956, and July, 1957, but shall also rely on the data from the first phase.
CHAPTER II

A FRAME OF REFERENCE

To enable me to collect data in a consistent manner and to organize it effectively I looked for a framework. In order to understand the problem I was to study more fully, I found it necessary to examine three areas:

1. General Orientation to Role. This involves a consideration of the phenomenon of "role," the organization and structure of roles and the stages in the taking of a role.

2. Relevant Work by Others. Studies by others played a part in helping me to perceive and organize my problem.

3. The Major Questions of this Study. With regard to role-playing and role-taking I had formulated certain hypotheses, and a framework by which these could be investigated.

These three considerations helped me to conduct interviews and field work, to formulate appropriate questions and to systematize my data. This chapter shall briefly explain the significant contents of each of the three areas.
1. General Orientation to Role

A role is a pattern of behaviour and thought indulged in by individuals. Each role is distinguished by a set of norms and values which the individual adopts as his own, and according to which he patterns his actions. A role, therefore, defines the performance of an individual in a situation.

Roles arise out of interaction. The meaning of any one role can only be ascertained in relation to other roles. In this way the expectations of a role, and the manner of fulfilling these expectations, are made known. The definition of any role, therefore, depends upon the definition of the other relevant roles. That is to say, roles are never alone, they imply a reciprocity.

It can also be said that roles imply some manner of organization. As the social relationships of any one individual are multiple, that individual has many roles. Hence one individual can be a woman, a nurse, a daughter, the member of a church, a friend and a wife. Her performance in a social situation depends upon the definition, given by her, to the roles of the others involved. Her behaviour in the presence of her mother differs from her behaviour in the presence of her husband and differs, again, when she is with a patient. When the situation becomes more complex, involving, for example, her mother, a friend and a nursing instructress, her performance is organized on a combination of the expectations of each. If the
situation becomes so complex that she is unable to integrate her behaviour on the basis of the combined expectations involved, a conflict occurs. Such an incident of conflicting or widely-varying role-expectations arises only when the system of organization employed by the individual to integrate his varying role-performances is no longer adequate. The reactions to such a situation are numerous. For example the individual may react according to her most frequently performed role or in terms of the expectations of the role she defines as "the most important" in the situation. This implies, therefore, that when an individual plays many roles simultaneously, a system of organization of role-expectations and performances is employed. When this organization is no longer functional, a situation of conflict arises.

Similarly in the social system at large there is an organization of roles. Each role is organized with others to make a meaningful whole and the interaction between roles is socially defined. Within the social system itself there are sub-systems and institutions consisting of some of the roles that are evident in the larger system. These roles are once again organized in a functional manner. The institutional expectations of a role have some elements in common with the social expectations of the same role and some elements differing from it. In other words the role of the nurse as defined by the hospital approximates the definition by the public, but at the same time the expectations are more precise and include
institutional aspects of which the public may not be aware. Both the public and the hospital expect a nurse to be both efficient and sympathetic, but in general, the public is not aware that the nurse must wear short hair, must never tell a patient what she knows of the patient's condition and must stand when a doctor comes into the room. Similarly the relationship between a doctor and a nurse in a hospital differs from their relationship outside of the hospital. There is a complex organization in each case. In the former case it is organized to a large extent in terms of the relationship of a superordinate to a subordinate, irrespective of other roles played by either. In the hospital, therefore, a young intern assumes the role of the superordinate, even though the nurse may be his mother. Outside of the hospital it is organized primarily in terms of the socially defined mode of interaction between men and women. There their roles would be reversed, the young intern would stand when the nurse entered the room. So complex at times is the organization of role-expectations that contradictions occur even between a social system and segments of it.

The concept of role could be considered a link between the concept of personality and the concept of social system. As the preceding two paragraphs have shown, role is the property of both. It is important in understanding the social system as it is inherent in every social relationship and in every interaction. Likewise it is important in the understanding of personality, for it develops an awareness of self as opposed to
others. Furthermore the processes of role-taking and role-playing introduce values and norms which are integrated into the personality. It is in the concept of role, therefore, that connections between personality and the social system can be found.

Classification of Roles

There are many methods of classifying the numerous kinds of roles that can be observed in our society. A frequent method is to divide all roles into "general" or "specific" categories. The former refers to the wider area which covers age and sex, the latter to the more specific affiliations such as nurse, father-confessor or immigrant. Often also, the categories of "achieved" and "ascribed" are used. An ascribed role, such as age and sex, or a chief of a tribe, are assigned to the individual on the basis of biological facts over which the individual has no control. An achieved role, such as that of a wife or a stenographer, is one that is acquired by a wish to acquire it. The desire to acquire the role may be positive when the values and aims of the role are similar to those held or desired by the aspirant; or it is negative, when an individual is forced into taking on a role because doing so is less uncomfortable than resisting. Hence a girl may become a nurse because she likes the kind of people that nurses are, or because she wants to please her mother who wants her to become a nurse. It should be pointed out that what a girl may claim as a motive for
becoming a nurse does not necessarily influence her performance in the role.

For the purpose of this thesis I would like to suggest two possible ways of categorizing roles: "permanent" and "changing." Permanent roles are those which are the result of the social use of biological facts and of membership in a kinship group. Permanent roles, therefore, imply age, sex and traditional status such as exists among royalty and aristocracy. Furthermore every individual plays the permanent role of son or daughter, and often of brother, sister, mother or father. All of these roles can be played simultaneously. "Changing" roles, on the other hand, correspond more to the achieved roles, in that they can be consciously "taken on." Examples of this are group memberships and occupational roles. Some of these can be played simultaneously, others cannot. One individual can be a lawyer, a member of a political party and an adult, but he cannot be a member of a kindergarten group and a member of a law class at the same time. This case implies a process whereby the attributes of one role are unlearned or modified and the attributes of the new role are learnt. The role of the law student is exchanged for that of a lawyer. This idea of the acquisition of new roles will be utilized in this paper.

Attachment to a Role

There are four phases to the acquisition of a role: role-anticipation, role-taking, role-playing and role-abandonment.
The first, role-anticipation, refers to the abstract image of role held by the aspirant. The future incumbent conceives of herself as fulfilling the functions of that role, receiving the rewards and being exposed to the strains. A future nurse, hence, sees herself clad in a white uniform, flitting about a ward, administering help to patients, who in return give her their gratitude. She sees herself as the object of public esteem. At times, however, she sees herself in positions of strain, such as administering the wrong medication. Thus in the image the prospective nurse foresees the satisfactions and anxieties of her future role. Needless to say the anticipation takes a simplified form of what could be termed "reality."

The second, role-taking, refers to the process of socialization which occurs when a new role is learnt. The role of a nurse is comprised of an organized pattern of expectations of behaviour and thought, as well as functions and techniques which she must perform. Until the appropriate knowledge and attitudes are acquired, she is considered only a candidate for the role. She is "taking on" the role. It consists of a process of direct teaching and learning, whereby the appropriate values and techniques are internalized. It also consists of a process of unconscious learning during which the trainee learns attitudes, values and techniques that are not held out to her.

The third, role-playing, implies the acceptance of the trainee into the role. The incumbent now performs the actual functions of the role and fulfils the expectations and
requirements. She can claim the privileges and duties of the role, and at any specific time she is identified with others who play the same role.

The fourth phase, role-abandonment, can occur at two instances in the acquisition of a role. It can occur before the process of role-taking when the attachment to the previous role is relinquished and the requirements of the new role are learnt. It can also occur when the new role is, in its turn, discarded. It is the prerequisite, in each case, to the acquisition of a new role. Thus a nurse abandons her role as student to become a nurse, and unlearns or modifies the attributes of the former role in order to learn the latter. Similarly the role of a nurse is relinquished for the role of a wife or mother.

Work Roles as Aspects of Society

Work is an integral part of our society. Every individual is expected to assume a work role on the basis of which he takes a meaningful position in the social structure. One of the first questions in defining a strange individual is: what does he do? This implies that values internalized in a work role tend to flavour his whole behaviour even outside of the work situation.

Work is an obligation to all and idleness is considered an avoidance of obligations. Work, therefore, has unpleasant
connotations. To counteract this feeling of distaste there is a social desire for every man to enjoy his work. This gives rise to a contradiction. As soon as man begins to enjoy his work, he begins to perform it for its own sake; instead of for the results it brings, and it takes on the attributes of play. He then feels that he is shirking his obligations, for he feels that he is not working, but rather, playing.

The motivation to work arises out of a need to maintain one's livelihood and to do this in a socially acceptable manner, namely by acquiring an occupation. The rewards of an occupational role, therefore, are income, status and psychological security.

The Self and the Professional Conscience

The "self" is a product of both permanent and changing roles. It is a combination of the innate qualities of the individual and the attitudes and norms that are acquired through playing "changing" social roles. In this way a man and a member of the English upper class combines with these characteristics the attitudes and norms of a doctor, a husband, a politician and a staunch follower of the church. These qualities make up the internalized structure of the self.

The meaning of the "self" to the individual arises out of communication with others. The individual, so to speak, steps out of himself, and sees himself as others in the social
situation see him. These others in the social situation are often referred to as the "generalized other." The attitudes of this "generalized other," therefore, are adopted by the individual as his own, and are the basis for his sense of identity. His behaviour is fashioned on this, and on the "conscience" that develops from it. His actions follow this self-image and are controlled by the "conscience" that is connected with it, even during the absence of the "generalized other."

Even as social roles and the internalized attitudes that accompany them are in a constant state of change, the "self" is never constant. The self-image changes with the changing attitudes of the "generalized other." A nurse's conception of herself changes when she realizes that the other nurses on her ward regard her as incompetent and unreliable. This undoubtedly also affects her behaviour. Similarly her self-conceptions and behaviour would change if she knows that the others regard her as a "good nurse."

Conflicts also disturb the equilibrium of the self. There can be conflict between basic human wants and the norms of socialized roles. A tired nurse wishes only to rest, but the requirements of her social role demand that she perform her duties. There can also be conflicts between the norms of two social roles which the self has integrated. Hence a man has often to combine shrewdness with professional trustworthiness as in the case of a doctor, who must also be a business man.
The Professional Self

It is a cultural norm in our society to acquire an occupational role. Involved in this is the "taking on" of the relevant techniques and attitudes and an ability to identify oneself with other selves playing the same occupational role. A special type of occupational role is the professional role. An incumbent of this role must adopt the qualities that pertain to all occupational roles, plus the added qualities that pertain to all professional roles. In this way there develops the conception of a "professional self," together with the existence of a "professional conscience." It seems, therefore, that all individuals who assume an occupational role take on two sets of characteristics: those they have in common with "other men who work"; and over and above this they assume the added characteristics of the type of occupational role they fulfill, whether it be artistic, manual or professional.

A professional self in our society conceives of himself as being trustworthy and discreet with all matters that come into his area of competence. He sees himself as being in possession of a specialized body of knowledge, which he defines as being indispensable for the function of society. He feels himself to be under the obligation to dispense this knowledge whenever it is needed. He must be altruistic and show utter disregard for his personal benefits. On the other hand, he is aware that he must have the respect and the trust of prospective clients. This depends on the picture of "success" that he can portray.
One important method of showing success is to present a relatively high standard of living, which, in turn, depends upon self-interest.

Certain personality characteristics are desired in professional selves. Among other things, they are expected to be reliable, courteous, competent, and sympathetic. All professional trainees attempt to internalize these expected traits, often making them an integral part of the personality. In such a case the individual is not aware of consciously utilizing these characteristics, but sees them as being part of himself "as he really is." In other cases there is a doubt on the part of the individual in his sincerity in using these traits, and a belief that he is "only acting." Consequently there is a tendency towards cynicism.

The role-taking of student nurses, which is one major concern of this thesis, could also be described in terms of the development of professional selves. The other major aspect, role-playing, could be the actual performance of "being" a professional self.

2. Relevant Work by Others

The theoretical framework in terms of which I have viewed the problems of this study was, to some extent, stimulated by the works of others. I intend, therefore, to give credit to those works which have had some part in fashioning my ideas.
The Idea of "Role"

As far as the analysis of "role" is concerned, I found the suggestions of Parsons particularly enlightening. He has succeeded in integrating vast amounts of data about roles and in developing a method whereby the elements of a role can be separated and then reorganized in a more meaningful whole.

To Parsons a role depends on social relationships and should be viewed in terms of its functional significance to the social system. The fact that roles differ is evident and Parsons proposes that this difference is a function of the cultural expectations of each role. This led me to believe that an understanding of the institution within which a role functions is essential to an understanding of the role.

All roles, Parsons suggests, can be defined in terms of five variables. These he calls "pattern variables." Firstly, a role can be described in terms of its relationship to another role. On one hand it can be a relationship which is personal, informal and has emotional connotations. This occurs in the case of a mother and her child, as compared to a lawyer and his client, and is termed by Parsons as "affective." On the other hand, it can be impersonal, formal and of an unemotional, objective nature. This is an "affectively neutral" role as with the lawyer and his client, and in direct opposition to the

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relationship between the lawyer and his wife. Secondly, Parsons suggests that the role may follow "self-oriented" or "collectivity-oriented" interests. By this he means that an individual may direct his activities with the wish of achieving private ends or the individual may be altruistic in his outlook and direct his actions towards the "common good." The child may tend to be "self-oriented," whereas his mother and the lawyer are "collectivity-oriented." The third "pattern variable" of Parsons' scheme is "universalism" vs. "particularism." The former refers to a relationship that is governed entirely by a prescribed set of standards and norms. A lawyer's relationship to his client is defined by a set of prescribed norms for interaction with all clients, and is devoid of emotionality. The latter refers to a relationship where the other is evaluated in terms of an emotional connotation based on a special relationship, such as would exist between a lawyer and his wife. Fourthly, he suggests the duality of "achievement-ascription." This he later changed to "performance" and "quality." A role that is attained through conscious effort is one that falls under the "achievement" or "performance" category, while one that is inherited or attained without effort is "ascribed" or given because of "quality." The fifth "pattern variable" defines the scope of interest in the other role. It can be either "specific," where the interaction between the roles is limited within defined boundaries, for instance, the lawyer's interest in his client is limited only to the area of his legal problem; or it is "diffuse" where the lawyer's client is also his friend.
To exemplify the use of his scheme, Parsons analyses the role of the physician. The role is an "achieved" one, requiring intensive education and increasing technical efficiency. It is "universalistic," in that the actions of the physician are governed by a generalized objective criteria, known as medical science. It is "specific" in that his legitimate authority is confined to areas of health and illness. The activities of the role are not governed by personal preferences, but are "affectively neutral." Finally, the physician is interested in the common good above his own personal desires. Therefore, the "professional" role in our society is distinctive because it is achievement-oriented, universalistic, functionally specific, affectively neutral and collectivity-oriented. As far as the nature of the performance goes, Parsons' proposition for professional roles is valuable. It distinguishes professional roles from other occupational roles.

The Idea of Occupational and Professional Roles

The literature on occupational roles is increasing. The quantity of the material is dependent on the nature of our society. The growing interest in occupational roles in our society is connected with the growing complexity of occupations which accompany scientific and industrial development. The need for understanding this phenomenon has become evident, and the

2 Parsons, Social System, p. 454.
need to find a method for its analysis is defined as a "problem."

Reference is often made to Hughes for his work in the area of occupational analysis. A few of his postulations on "Personality Types and the Division of Labour," I found stimulating and relevant to my area of interest. He suggests that personality changes and effective performance are achieved by isolation. I found that this is also applicable to the nurse. Secondly, he proposes that roles can be placed in positions on an occupational scale according to: 1) the manner of entry into the role; 2) the attitude of the incumbent towards his occupation; and 3) the status of the occupation in the community. On the basis of these he differentiates the missions, the professions and "near-professions," the enterprises, the arts, the trades and the jobs. These three variables do not cover the whole occupational picture, because they omit too much that is relevant, yet they should definitely be considered in any scheme for role analysis.

His elaboration of the professional role is very enlightening. He suggests that a profession is a culture and a technique. It builds a set of attributes, which is the property of the group, and incomprehensible to outsiders. A code governs interaction within and without the group. These various

attributes become personality traits within the individual. Hughes' main thesis is, therefore, that divisions in labour affect the individual by developing distinctive personality types.

This idea of the culture and the community of professionalism is also exemplified by Goode. He terms it a "community of profession" because of the sense of identity of the members, the common values and language, its continuity, and the power that is exercised over its members. The limits of the community are clear and its members and outsiders are well defined. The next generation is produced socially by a controlled process of adult socialization. Goode suggests that an occupation approaches professionalism when it begins to show the characteristics of a community.

Marshall also clarifies the professional way of life. The professional creates around himself an atmosphere of trustworthiness upheld by his professional ethics. He feels that he has the responsibility for a specific knowledge, which he must use in the interests of society. His decisions are made on the basis of being right, not of being profitable. Yet at the same time they "are respectable because they do not strive for money, but they can only remain respectable if they succeed in


spite of this pecuniary indifference, in making quite a lot of money, enough for the needs of a gentlemanly life.\textsuperscript{6} This shows a dual, yet conflicting, expectation from a professional role, on the part of both the public and the professional himself.

Caplow, in his study of work, touches on the various aspects of professional and occupational roles.\textsuperscript{7} Occupational institutions, he proposes, reflect the occupational culture. Like Goode, he considers the structural characteristics of institutions: recruitment, evaluation of seniority and merit, the control of occupational and non-occupational behaviour, folkways of the occupation, formation of relevant attitudes and the stereotyped view of the occupation. He also deals with the increasing trend towards professionalization, which he proposes involves the establishment of a professional association designed to oust the unqualified, a break with previous status by change of name, the development of a code of ethics, political agitation designed to influence opinion and the improvement of training facilities. In this he presents a more concrete way of measuring professionalization. I have found his suggestions very useful when considering the role of the nurse as a professional.


\textsuperscript{7} Theodore Caplow, \textit{The Sociology of Work}, Minnesota, University of Minnesota Press, 1954.
Hall, by his work on the internal organization of the medical profession, contributed significantly to my understanding of the organizational patterns within the nursing professional group. He conceives of these relationships in the same terms as Goode, Marshall, Hughes and Caplow — in terms of institutions, formal organizations and informal interaction. He suggests that the study of a professional role should include five basic areas of interest: the essential activities of the group, the services they render, the manner of recruitment, the manner of acquiring clients and the means used to oust intruders. These factors should all be considered in role-playing and role-taking.

He makes an enlightening contribution by suggesting that there could be a typology of roles. He defines medical careers according to whether they are "colleague," "individualistic" or "friendly." I have tried to achieve a similar segregation among the nurses, although the variables differ. The value of Hall's postulations lie, not in the particular typology he uses, but rather in the suggestion that such an analysis would be worthwhile.

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As there are numerous occupational roles, it is important to organize them in terms of status in order to perceive them more clearly. "It is doubtful whether any society ever had so great a variety of statuses or recognized such a large number of status-determining characteristics as does ours," writes Hughes. He claims that the "struggle for achievement" brings individual traits into relief and their peculiar combinations lead to contradictions. He postulates that many statuses are legal and formalized, while others are ill-defined with regard to both identifying traits, rights and obligations. Many such contradictions and dilemmas I found well exemplified in the role of the nurse.

Statues, he claims, give rise to the expectations of "auxiliary" characteristics which are associated with them. For example, there is the expectation that the majority of doctors, engineers, lawyers and supervisors in industrial plants should be men. The combinations of such auxiliary characteristics take on the appearance of stereotypes which are transmitted by mass communication. Within the occupational group, the expectations for the appropriate characteristics control recruitment. They are manifested in sentiment and behaviour and ensure free communication among members. This informal brotherhood, the author proposes, ousts any individual who is the first of his

kind to attain a different status. He remains a marginal man. This I have tried to point out in the role of the nurse.

The status of the nurse I consider to be somewhat marginal to that of a doctor. Wardwell, in his work on the chiropractor, considers the attributes of the marginal professional role. The individual involved seeks and wants acceptance and has only partly been accepted. Marginality of status is characterized by: less technical competence, limited scope of practice, lower legal status, less income and prestige. The status of the nurse certainly seems to have these characteristics.

One of my hypotheses was that many of the dilemmas of the nursing status arose out of their being "women." It was interesting to note that Caplow defined the occupational status of women as "a problem." He is inclined to dwell on their discontinuity, their small wages, immobility, lower status and the pressures aimed to reduce their ability to qualify. He writes: "It may not be far-fetched to speak of a generalized cultural resistance by men to action initiated for them by women to whom they are not related emotionally." As far as nursing is concerned, this suggestion is worthy of consideration.

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These, briefly, are the findings that I found relevant to my work as far as the understanding of occupational and professional roles is concerned.

The Idea of Role-Taking

I began with the hypothesis that a nurse becomes increasingly aware of institutional structure and function. Parsons supports this in his conceptions of the socialization of a child. He suggests that the "affective" attitudes would be acquired first because of their direct relationship to dependence and emotional attachment to the mother. This is also liable to happen in a hospital, where the nurse, prior to the adoption of the proper attitudes, is liable to form "affective" orientations, or emotional attachments to patients. Its opposite polarity, "affective neutrality," Parsons continues, is more difficult to acquire. A nurse finds it difficult to assume an unattached manner towards some patients. "Universalistic" patterns would be the hardest to acquire. This is true in the hospital setting, where it is difficult for a nurse not to express preferences for certain types of patients above others. Parsons opens up this valuable area of interrelationships, between socialization and "pattern variables."

This introduces a concept of stages in socialization. Parsons sees it, not as a linear process, but rather as a
discontinuous, spiral pattern. He introduces the terms "socializer" and "socializee." The former could be taken to be the teacher, the latter the learner. Of these two the former is the more powerful and is a participant in two stages: the higher one, which the socializee has not yet reached and the lower, in which he is being socialized. Hence the socializer serves a levering function.

This concept of stages is further supported by Parsons' ideas on the socialization of the child. He sets out the process in five phases. Phase one is a stable state. The socializer, in this case the mother, gives instrumental care and love, acts as a disciplinarian, yet does not "expect too much." The second phase displays a change in several areas: there is a greater capacity on the part of the socializee to perform more skilfully; the socializer is responsible for representing institutional expectations to the socializee, and at the same time the socializee is expected to meet these new expectations; the socializer is more permissive and tends to withhold punishment; the socializee is frustrated and often aggressive, regressive or anxious. The third phase is characterized by a graduation into a disturbed state where the socializee has no positive basic desire to define objects in this stage. The socializer now gives support


14 Ibid., pp. 202-216.
which is related to her acceptance of the socializee, despite his inadequacies; and the socializer relies heavily on the latter's attachment to her. This support motivates positive action by the socializee. The fourth phase is one in which the elementary adjustments have been made, and the socializee is concerned with the internalization of the new values. When this goal is attained the fifth phase begins. In this fourth phase the agents of socialization, in Parsons' example, the family, are conceived by the socializee as being significant and are expected by him to act appropriately. He is now in a higher-level system and his attachments to the lower must dissolve. The chief socializer directs this process. "This takes the form of consistently holding the relevant cognitive cues before the child, and gradually, according to his capacity to 'take it' without undue anxiety, withdrawing the lower-level support, and substituting for it support or 'acceptance' on the 'parental' level and specific gratifications as rewards for adequate performance in the new context."  

11 Phase five, is a stage of reorganization after the acceptance of new recruits. These contributions of Parsons', where the family, mother and child could correspond to the hospital, the school of nursing and the student nurse, are valuable. Particularly enlightening are his concepts of desocialization from the old state of equilibrium and his reference to a "disturbed state" where there is no motivation

or positive basis for defining objects.

Becker also focusses attention on these two phases of socialization and suggests that the training period is limiting as well as expanding, in that it prepares the recruit for new duties, but at the same time incapacitates him for others.\(^\text{16}\) This is another useful insight for the understanding of the socialization of nursing students.

This disturbed state of Parsons' scheme, and the limiting as well as expanding concept of Becker, could also be called a period of disillusionment. Supporting evidence is supplied by Hughes, who writes of the discrepancy between anticipation and realization, and that expectations are usually simpler and even distorted and stereotyped.\(^\text{17}\) This is also the "reality shock" of Dornbusch, which accompanies the disparity between expectation and reality.\(^\text{18}\)


As far as the training of nurses is concerned, Parsons and Bales have suggested two types of "role activity" which have proved helpful in analysing the phenomenon. The first type has to do with the inhibition of emotions, the formation of rational views towards social situations and finally, with the handling of objects. In short these activities could be described in Parsonian terms as "affectively neutral," "functionally specific," "universalistic" and "achieved." It corresponds to the area of nursing education that transmits technical skills and their application. The second type deals with internal situations and emotionality. This corresponds to the area of role-learning that concerns the transmission of the ideas behind the skills that are used. Parsons implies that the first type leads to a "going apart," while the second type leads to a "coming together." This is relevant to the role-taking of nurses where impersonal scientific techniques are not conducive to a feeling of "togetherness" among students, but lead rather to social isolation; while the transmission of attitudes and beliefs, in so much as it involves transmission by group interaction, leads to integration.

Therefore as has been suggested by Parsons, Becker, Hughes and others, socialization, or role-taking, as I have termed it, could be seen as stages, and rites de passage. It

19 Parsons and Bales, Family, Socialization and Interaction Process, pp. 309-312.
involves a period of formal training and learning and informal transmission of attitudes. The socializee learns, but he also forgets. He becomes integrated with his group, but segregated from others. These facts have encouraged me into asking similar questions of the nursing role.

Works on the Role of the Nurse

Within the immediate past much has been written on the role of the nurse. There are, however, only three studies which could be considered of immediate relevance to this thesis.

The first is one which emphasizes the changes occurring in the nursing role during the process of role-taking. It is suggested that first year students enjoy their classes, like the head nurses and have ambivalent feelings towards the supervisor. They believe nursing is an ideal service for the welfare of man. Second year students are highly sensitive, easily hurt, have feelings of inferiority to other students, graduate nurses and other medical staff. They find it harder to study because of boredom with their cloistered existence and the monotony of routine. Third year students feel less secure in their status as active team members and feel that their work is directed by doctors. They tend to look at their work as a "job," "a never-ending job." These variations seem to indicate a "reality

20 Alice E. Ingmire, "Attitudes of Student Nurses at the University of California," Nursing Research, 1:2, October 1952.
shock," or the sudden realization of the disparity between the way a job is envisaged before beginning on the learning process and the way it is conceived in the work situation.

The second study of importance, as far as this thesis is concerned, compares the personality characteristics of nursing students, of graduate nurses and of a norm group. The results showed that the students and graduate nurses were more introverted than the norm; that graduate nurses were more cheerful, optimistic, emotionally stable, controlled, conscientious, cooperative, agreeable, objective, self-confident and more inclined to overt activity than either of the other groups; that graduate nurses showed more favourable results with regard to inferiority, nervousness, depression and generally a more fortunate adjustment; that nursing students were less favourable than the norm in social extroversion, depression, social ascendancy and cooperation. For me the importance of this study does not lie in the actual characteristics attributed to the students as much as in the implication that these attitudes change after acceptance into the occupational group. This seems to indicate that Alice Ingmire's results could have taken a complete change had she continued her study after graduation. It seems likely therefore that the training process engenders frustrations and depression which can be dispelled with acceptance and full role-status in

the hierarchy.

The third relevant piece of work was conducted by Ann Morrison and Mary Breed. They explored the impressions held by student nurses at two stages in their education, the senior and the freshman phases. Firstly, the juniors had no impressions or plans as to where they would work, what positions they would hold, nor the type of work they would like to do. Seniors on the other hand, were rather definite about this. Secondly, the younger girls showed preferences and pleasant expectations towards pediatrics and obstetrics. They expressed fears of surgery, but were drawn by its drama. The older girls, however, showed wide variation, preferences often being influenced by the school they attended and the personnel of the department. Thirdly, freshmen on the whole thought the public image of the profession was good, while the seniors had a more differentiated idea. Fourthly, the younger girls wanted to marry husbands with sensational occupations, the seniors placed more emphasis on education level. Fifthly, the authors found further evidence for the disillusionment process. The younger nurses were more optimistic, they discovered; the older ones were more cynical. The former thought the administration was attempting to help them, the latter displayed resentment at being "treated like babies." Sixthly,

the beginner could envisage an ideal nurse and an ideal patient. Their training they anticipated as being harder than it actually was. The girls, ready to graduate, had difficulty in conceptualizing the ideal nurse and queried the existence of an ideal patient. They felt that they had been unprepared for the training they received. The seventh point mentioned by the authors was the expected differences in verbalization, in the use and understanding of terminology, in concepts of status and professionalization. As expected, the seniors were more sophisticated in this area. The authors, therefore, have amassed a great body of data. The clearest indication is that change in attitudes and conception of self occurs. The more senior the students are, the more cynical they seem to become. This supports Alice Ingmire's findings. All three studies point out a difference between initial conception and final experience. The study by Morrison and Breed, however, indicates that acceptance into the profession is liable to dispel cynicism.

As far as these studies are concerned it should be noted that there is a discrepancy between what is said and what is meant. However, the findings of the above three studies are valuable in showing that students in different phases of role-taking say different things about the attitudes they hold. What actually is meant and why they say what they do, can only be inferred.
Some of the ideas put forth in this study have grown out of the works mentioned above. Sometimes works by others have directed my thoughts into new channels, other times they have stimulated further enquiries, and often they have served to support hunches.

3. The Major Questions of this Study

The data collected and the questions answered by this study could be organized under two primary areas: role-taking and role-playing. By using these two concepts I found that I could pose the problems and present the answers more systematically. Only through using these two arbitrary categories did I feel I could do justice to the material I had gathered.

Role-taking

As far as "role-taking" is concerned, I have tried to answer the following questions:

1. Are there stages to becoming a nurse? What are they? This query presupposes that socialization is not an undifferentiated linear process, but is of such a nature that division into stages is possible.

2. What reasons do nurses give for going into training? How strong is their wish for nursing as an occupation? By what means are they recruited and what qualifications are
desired? The area of motivation and recruitment is an integral part of any consideration of role-taking and is touched on in this study.

3. How, and what, are the students taught? How and what do they learn? An investigation of the education and training involved is important, not only in so far as formal and direct teaching and learning occurs, but also as students often learn what they are not taught. There should also be an answer to the question: how are the relevant attitudes and techniques transmitted? Is there a mould into which the recruit is to be fitted?

4. What changes are there in conceptions? What are they? These questions delve into the area of changing self-conceptions and attitudes. There seems to be an indication of this change in the very nature of socialization, which is a dynamic process, subject to constant change. This leads to the major question: what types of changes are there?

5. Is there an increasing institutionalization? Do the students show an increasing awareness of the hospital as an integration of other roles with their own? This implies that a nurse, in the process of role-taking, develops an increasing ability to place herself in a context.

6. Is there a changing categorization and attitude towards the other roles with whom the student nurse interacts? This involves the possibility of changing views towards people
such as instructresses, administrators, doctors and so on.

7. Do the students have a period of disillusionment or a "reality shock"? The occurrence of this phenomenon has been pointed out in several of the works reviewed in an earlier part of this chapter and it would be interesting to discover whether there is evidence of its occurrence among the subjects I studied.

8. What are the manifest and latent functions of the system of isolation used in the training of nurses? Does the learning of the nursing role also imply the unlearning of other roles? Is there a decreasing ability to identify with outsiders and an increasing solidarity within the nursing group? How are nursing groups organized?

9. What types of nurses seem to be evolving? This presupposes that there are differences between the nurses after the process of role-taking.

These seem to be the major questions that are involved in socialization, and I have tried to provide answers to these in the context of this thesis.

**Role-playing**

In role-playing there is one major question that has to be answered: What is it like to be a nurse? The problem lies in how to look at the role of the nurse and how to present all
the aspects of the role. I intend therefore to use five variables, which seem to cover all the important areas of a role:

1. Images of the Role
2. Character of the Obligations
3. Rewards
4. Strains
5. Relation to Others

The use of such a scheme of variables has a twofold advantage. Firstly, the role of the nurse can be taken apart, studied, and then put together into a more meaningful whole. Secondly, the scheme is such that it is applicable to other occupational roles. In this way the role of the nurse can be compared to other roles.

The meaning of the five variables should be briefly explained. A more detailed explanation will be given in following chapters.

1. Images of the Role. This covers two possible perspectives on the role of the nurse. It refers, firstly, to the public image, or the expectations and evaluations of the role held by the public. Secondly, it concerns the occupational self-image. This self-image is constructed on the basis of the public image and the image held forth by the occupational group. It is a system of beliefs, ideals, expectations and myths to which the members are committed, and which defines their course of action. It is an idealization of the values of the group and shows a disregard for reality. The nurse is moulded partly by the public image and partly by the ideal self-image held out to her.
2. Character of the Obligations. The obligations of the nurse refer to the tasks she must perform and the manner in which she must perform them. Her tasks are both impersonal, dealing with instrumental activities, such as doing dressings and giving medications, and personal, dealing with her interaction with others. Both varieties of obligations are governed by a set of standards which are to be upheld as part of the obligations of the role.

3. Rewards. For any individual to continue playing a role there must be adequate rewards to balance the weight of the obligations. Rewards could come in many forms. They could be in terms of remuneration, prestige or security. As long as the satisfactions received outbalance the dissatisfactions and strains, the motivation to continue playing the role is reinforced.

4. Strains. Conflicts and strains are aspects of every role and serve both positive and negative functions. When the strain becomes too oppressive attempts are made to relinquish the role or to redirect activities into a more satisfying channel. Often inner desires and social expectations are in conflict, at other times rewards do not balance obligations and strains and in still other instances there are divided responsibilities. Each role acquires ways of coping with strains that are an institutionalized part of the role and are acquired with all the other aspects of the role.
5. Relation to others. There are three possible relations that could be discussed in this context. There is the question as to how the role is defined in relation to other roles in society and what status it occupies. This, because of the lack of a set of criteria by which each role could be allocated, must be a matter of speculation. Secondly, there is the question of the position of the role in the occupational world. In this instance it could be considered a general work role, a female role and a medical role. Thirdly, there is the question of the relation of the nursing role to other roles within the context of the medical institution of the hospital. These categories of role relationships should take into consideration both the conceptions on the part of the nurse and the conceptions on the part of the "others" involved.
CHAPTER III

RESEARCH METHODS AND EXPERIENCES

This is a study on the making of a nurse. Its leading actors are forty student nurses enrolled in the university course leading to the degree of Bachelor of Science in Nursing. They are to be differentiated from their sisters in the hospital course, who terminate their studies by acquiring the status of Registered Nurse. The main differences lie, firstly, in the duration of their training which exceeds the other by a year; secondly, in their affiliation with the university; and thirdly, in that their training enables specialization in public health agencies or in administrative and instruction positions in the hospitals. Of this four year period, two years are spent at the hospital where occupational training is received in conjunction with the hospital class and the girls experience residence life. The instruction for the remaining two years, in fact the first and fourth years of the program, is given on the university campus.

Data for the study was collected during an eighteen month period from October, 1955 to April, 1957. The intensity of the research ranged from the observation of a two-weekly campus discussion group, composed of student nurses to a day-to-day two month participation, involving lectures, ward
routines and residence life—in short, "becoming a student nurse." During the time that I had to devote to lectures, examinations and data analysis, contact with the group was retained.

It may prove feasible at this point to focus attention on this group, institutionally identified as the "class of August '58" and for the purpose of this research often referred to as "the class." Several of the girls have grown up together, have had their elementary education together and have been friends for many years before entering university. All of them have had the common experience of taking the first year in the Faculty of Arts and Science and a few have taken two years in this faculty. (Appendix A 9). After seven months in the University School of Nursing the majority were nineteen years of age, a few were a year younger or a year older. (Appendix A 1). Some belonged to sororities and most were affiliated with one or several athletic, social, political or religious campus organizations.

Although birth places included such neighboring localities as New Westminster and countries as distant as Japan, twenty-five students gave their home address as Vancouver and adjacent areas, fourteen mentioned other British Columbian points, while three claimed homes in other provinces. All, however, were in residence either in parental homes or temporarily boarding in dormitories or private dwellings. (Appendix A 2, 5).
The majority had parents of what would be considered middle class socio-economic status and predominately of Canadian nationality and Protestant religious affiliations. (Appendix A 3, 4, 6, 7). Mothers had, in the majority, been employed before marriage in either a semi-professional or white collar capacity and had retired after marriage to the occupational status of "housewife." (Appendix A 7, 8).

To conclude this survey of the significant actors who made up the core of this study, a brief mention of the hospital should not be omitted. The institution with which the university school is affiliated is a large metropolitan general hospital, often defined as a "teaching hospital" because it functions as a training post for medical students, student nurses, dietetic internes, hospital administration aspirants and others. Because of its size and diversity it is potentially able to offer superior knowledge and training material for all nursing specialities. Thus it is widespread in both area and experience, and shows a promise of still further expansion.

Such then is the social milieu within which the research was carried out. More detailed descriptions will be utilized where method or interpretation make it necessary.
The Collection of Data

After the formulation of a hypothesis, however uncertain or exploratory it may seem, the next step is research. This is the testing of the hypothesis by logical scientific procedures with the aim of either proving or disproving it. This I intended to do, but soon discovered that this verification became only a secondary function of the research. Primarily, it served in posing questions which had been unknown at the outset and in redirecting attention to other areas, which now became equally important. Whereas initially my interest had been centred on occupational analysis and role expectation, I soon became aware of the value of considering the complex and embracing concepts of role and socialization. Whereas I had intended to concentrate on the student nurse, I found, in due course, that this was not feasible unless I placed her in the context of the institutional patterns, and at least contemplated a brief look at certain cultural traits which influenced her socialization into the role. Thus I was forced to realize that a general exploration of the field of study would be valuable. Only in this way could the work be flexible and fluid enough to permit unexpected and perhaps new inferences. I soon expanded my aim from seeking a validation of my hypothesis to that of gaining a more intimate view of the training, life and perception of the student nurse. I wanted to develop two perspectives. Firstly, I wanted to view the situation from the position of an outsider, the
objective view of an onlooker who is able to see behavior and attitudes as if they were measurable objects. The second viewpoint was that of the situation as it would be perceived by the actor, an insider. This would be subjective and achieved largely through the process of empathy. Of course, to describe these two areas as being subjective and objective is a gross understatement. Where the process of interpretation is involved, objectivity is unavoidably marred. All interpretation is subjective to some degree, and to say that the researcher should strive for the greatest degree of objectivity possible, would be closer to the truth.

The collection of data was to be conducted in a direct manner by participant observation, an ill-defined method which seems to have become a constant tool of the social scientist as a result of repeated use, rather than critical evaluation. This enabled me to gain first-hand knowledge, to observe behaviour and attitudes, and to collect non-quantitative material. In addition it gave me the opportunity of conducting unguided interviews and of paving the way for other research techniques. To supplement this method, I used the guided interview and a questionnaire.

Participant Observation

I think I should clarify what I understood the concept of participant observation to mean and how it was used in reference to this study. The observer becomes part
of the situation in either an active or passive manner. At one time or another I utilized both of these roles by either increasing integration and interaction or by interacting as little as possible. This enabled me to gain impressionistic knowledge, which although it was neither quantitative nor statistical, proved valuable in supplying situations for questioning, interpreting actions, collecting case materials, rendering certain behaviour predictable, comparing attitudes and generally in familiarizing myself with the context and the actors within it. In this way, also, I was able to note details which otherwise would have remained unrevealed—such as the remark that accompanied an action, facial expressions and other behaviour which was apparent to me, as an observer and as an outsider. This is a method, then, wherein the dynamics of behaviour and attitude can be observed and explored within its context.

Participation in the life of the group led me into diverse situations. These included not only sleeping in residence and attending lectures, but also talking to various staff personnel from all levels of the hierarchy; sitting in the nursing station observing interaction among nurses, patients, visitors and doctors; partaking in conversations at the dinner table; standing unobtrusively in the corner of the operating room; attending movies and beach parties with student nurses; listening to complaints by and about various people; carrying out bedpans and carrying in lunch trays; watching
various nursing procedures; talking to patients; and just drinking coffee. There were also the numerous personal contacts which this method made possible. Thus I was able to develop conceptions of behavioral patterns and identify sufficiently with the sub-system of the hospital to predict action. In other words, I gradually developed a knowledge similar to that of the hospital personnel, or an insight which enabled me to judge what should be done, what was expected and what should not be done. This allowed me later to often discount the face value of statements made to me in interviews and questionnaires and to examine them in terms of what their real meaning could be. Such statements were often formulated in terms of what the girls conceived as group expectation, and their exact meaning was evaded.

At the outset I was made aware of the necessity for the adoption of a role. To be accepted by the group, I had to be defined, to be placed within the standards and values upheld by them. My aim was to diminish social distance. I wanted to approach them on an informal, human level and this was facilitated by the status that we had in common. I refer to our status as students. Early in the research I was forced to decide on either the role of appearing experienced and worldly, or of being a learner, eager for new knowledge. In other words, was I to adopt a superordinate or a subordinate status. I decided on attempting an equal status, wherein I allowed the nurses to be mentors within their own area of
specialization. Although I made efforts to keep the role on this level, I was soon to find that it could never remain so simplified. It was to change and to be perceived differently from different status levels and in general to become quite complex. This I shall try to point out later in this chapter.

I was aware, through the reading of field accounts, that an observer can never be objective, although the full implications and complexities of this fact did not strike me until later. I realized that I could not observe a situation without being a part of it and redefining it. The ideal solution, it seemed to me, would be to remain as objective as possible. I made it a rule, therefore, to try to avoid influencing the group, to refrain from suggesting action and to eradicate any tendencies to make moral judgments. It soon became clear to me, however, that there would be a reaction to my very presence and methods, over which I could register little or no conscious control. Nevertheless I attempted to abide by my initial rules whenever I could. This abstention from the passing of value judgments and even from the formulation of clearly discernible private ones, often proved a weapon of self-defence and a form of ensuring freer interaction. In that way the behaviour that I observed could not disturb or redirect me when it conflicted with my own system of values. Thus it tended to stop the formulation of prejudices and strong values and enabled me to interact in a far more unrestricted manner with people possessing diverging
and varying characteristics. Once again this is an ideal form of action, and as it deals with my attitudes, which are subjective, it is doubtful whether reliable control over them could be exercised. Perhaps it may suffice to say that these were the intentions to which I attempted to conform.

Even though I consider the facility of the interaction and of my acceptance by the group to be the most satisfying aspect of my research work, I could never expect to be so well accepted that my role as an outsider would be entirely forgotten. The very tasks I performed prevented this. I did not spend eight hours on wards, washing utensils, bathing patients and charting; rather I was on a ward for half an hour and then disappeared elsewhere and was not seen again for the rest of the day. I went to coffee whenever I wished and stayed as long as I wished. The group was subjected to authority and discipline. I was not affected. My position was both desirable and undesirable. "Gee you're lucky being able to go when you want to!" or "I really feel sorry for you, you must work horribly long hours." Although the desirability of my position fluctuated from one extreme to the other, it was never the same as that of the student nurses. It was that of an outsider—in short, I was not a student nurse. Thus although I was perhaps unable to acquire information which was the inherent property of the group, I was, on the other hand, in a position of advantage, the value of which I came to appreciate. I could not identify completely
with their sets of values and sentiments, and hence I was able to take a more unbiased view, something that would have been impossible had I been a student nurse. Also information would become perceptible to me simply because I was an outsider. Had I been a student nurse, interaction with others in the hospital would have provided me with certain attitudes and expectations. I was at times to be quite thankful for the rather undefined nature of my role, for it exposed me to varying kinds of contacts and enabled the collection of information, which would not have been possible had I had a stereotyped, well-defined role to play. This I shall point out later.

Interviewing

The research method referred to above as "participant observation" provided the setting for much of the interviewing, especially that of the unguided or non-directive variety. I had certain theoretically formulated hypotheses; I was eager to know how the group perceived their life. Often questions that were unconceptual at the outset would arise. In participating and observing I had the opportunity, enhanced by a face-to-face contact, to explore some of these areas. Whereas my attention was directed mainly toward the kind of material I was seeking, I discovered that this direction was often changed by field experiences and that the limits of the interview or conversation were defined by the
interviewee. In other words, I may initiate a conversation by a query such as "How is it going?" knowing that a patient attended by this student had died that morning. I would intend to probe further in an effort to find out how death had affected her. Often these questions could not be raised as the student may insist on telling me of an argument with a private duty nurse or a mistake in technique that she had made. New questions would arise and the whole interview would be directed away from death and would often be productive of valuable data, otherwise unavailable.

I also conducted guided interviews, for which I invited each student to see me privately and to be interviewed on tape. For this I had constructed, before-hand, a set of questions which showed promise of providing answers for hypotheses that I hoped to explore. During this I attempted to limit my talking to the minimum, saying little beyond asking the question and reassuring the interviewee where necessary. Needless to say, with my increasing familiarity with the group, it became more difficult to limit my own contributions. In some of the earlier interviews, the accumulated factors of the tape recorder, the ill-defined role of the interviewer and a caution at being interviewed, caused some respondents to appear uncertain. Often, in such cases, much time was spent in reassuring the student. Towards the end of the study I was very pleased to note that many of these symptoms seemed to have disappeared, and on occasion it
seemed that the interviewee benefitted as much from the interview as I did. Members of the group often expressed the opinion that they enjoyed the interview, that it made them think, or that they were glad to "beef" to someone.

During the eighteen month period I conducted three separate sets of interviews. The first occurred after seven months of campus training and was aimed primarily at the area of motivation and recruitment. At this time the majority of girls were unaware of my intentions, or of the role I was playing and knew me only as "the girl who goes to the Friday morning lab" or "the girl who marks our Sociology 200 papers."

The second disadvantage was that the interviews had to be arranged formally through teachers in the School of Nursing and thus became identified with the teaching hierarchy and entirely divorced from student activities. Thirdly, uncertainty and suspiciousness was increased by the fact that the interviews were carried out in the formal, academic environment of Dr. Naegele's office. Needless to say, I felt obliged to give long explanations and reassurances in each case before the interview. Fortunately the questions did not impinge too heavily on private sentiments and wishes, and lasted on the average for one quarter-hour. After further acquaintance with the group, however, I realized how these three factors must have influenced the answers given.
The second interview, this time formulated to reveal their perception of the role of the nurse in terms of my proposition for an occupational analysis and to emphasize any change of their self-perception. This was given in June after two months of intensive field work during which time I had familiarized the group with my work, and they had developed a clear definition of my role. I tried to act as a friend to each and invited each one privately to an interview in my room at the residence. Although the interview averaged over one half-hour and the questions seemed more difficult to answer, the respondents seemed more at ease, showed acceptance of the recorder and were willing to volunteer more information. Needless to say interviewing conditions were much better.

The third set of interviews, of an average of a quarter of an hour each, was conducted in the following January. The questions were designed to show their perception of change. The procedure for arranging them was again more informal, as I asked each member of the group whenever they were available and unoccupied. This allowed any interview to continue for an unlimited period. This arrangement seemed more satisfactory to both parties.

During any interview, when any hesitancy was shown, or I felt that I perceived any uncertainty, I would not pursue the question further. Any hostility I felt to exist, would have proved most detrimental to the research. Often in the case of the informal, unguided interview the respondent would
be approached while she was working in the service or hopper room or on the ward. The work situation thus frequently led to the termination of an interview when the student had to continue her work elsewhere, as I had no desire to disrupt work routines.

Questionnaire

Statistical quantitative data was acquired through the administration of a questionnaire, the same set of questions, with slight variations, being given again after a three month period. It was originally given to explore the hypothesis for the analysis of the occupational role as the experience of the group at this stage was limited to campus training, with only slight differences from training received in other academic schools and faculties; it could be said to explore also role-expectation at its initial stage. The second administration came after an intensive two month hospital experience, and the questionnaire was written in four different instances corresponding to the four laboratory periods. To test the influence of the questionnaire on the interviews, both of which were being done concurrently, half of the interviews were conducted before the administration of the questionnaire and the remainder after its administration. The purpose of the questionnaire and the nature of the project was explained to each of the four groups before the questionnaire was handed out. Nevertheless, the questions,
being answered during a university laboratory period, tended to have examination-flavoured answers, and seemed to cater to what the group thought their attitudes and reactions should be. In the second case the answers were undoubtedly affected by the fact that the group had defined my position, were more familiar with my expectations and wrote the answers on their "off-duty" time. There were good-humoured complaints about the length of the questionnaire and such remarks as the following were made:

"Not the same thing again?"

"I forget what I put the first time."

As would be expected the answers were shorter and a few "nonsense replies" were in evidence.

The questions themselves were of several types. They ranged from multiple-choice, in terms of hypothetical, structured situations which posed problems and numerical attitude scales, to open-ended questions.

Recording and Interpretation

During the research period I systematically kept a diary. After the occurrence of an event I recorded it in the form of a mental or a written note. At the first opportunity I recorded everything that I could remember as having occurred, whether it seemed relevant at the time or not. This often proved very difficult. I would take refuge in the corner of the hopper room, or perch myself on the stool in the washroom
to quickly make sketchy notes of what had happened. A special luxury was note-making over a coffee cup in the cafeteria. When attending lectures, many of these difficulties were solved. I was able to take notes on the spot. This often aroused the curiosity of my neighbor who upon demanding "What did he say?" would look at my paper to glean the relevant information and would be confronted with irrelevant material. Often, however, she would be able to get the missing links from my paper, for frequently I found myself making notes on the material being presented.

When I recorded unguided interviews I attempted to put down in so far as possible, the exact words that were said. This I found to be a skill which developed with practice. In interpreting situations I found it necessary to develop the technique of differentiating the specific from the general, to become aware of the discrepancy between what is said and what is thought, between what is thought to have happened and what, in factual terms, did happen. Also I had to overcome my desire to ignore the obvious, which I often forced myself to record as if it were new and able to yield fruitful information.

Ethics

After I had been engaged in research for some time I became aware of the fact that I had constructed a system of
ethics. This I must have built without conscious intent, to alleviate the guilt feelings which inevitably arose when I asked myself certain questions. What right have I to probe into such matters? This information is confidential and personal, how can I use it? Was I being deceptive in trying to seek acceptance? Was it dishonest to later record conversation carried on in a casual manner? I recognized in these many of the queries that have often been directed at field work techniques by social scientists. Yet on reconsidering I became convinced that I had a certain faith in what I was doing and I hoped that my service orientations would be satisfied and I would be "of help" by providing what information I could.

I resolved, therefore, to remove the identifying elements from quotations, without distorting facts. The interviews, questionnaire and reports on observations were to be held in strict confidence, their contents being utilized only in an anonymous manner. When reassuring respondents prior to interviews, the intention was not to press information from them. At no time were any of the group or other individuals involved, ignorant of the purpose and nature of the study.

In June, at the end of my two months of intensive "participant observation" I briefly discussed field work techniques and aims with members of the group. They expressed
concern as to "how you can get anything when we have no answers to the questions or say 'I don't know.'" I assured them that this could be just as valuable, although its connotation was different. This particular talk I later regretted when I was fortunate enough to be able to return and further my study. I changed my opinion, however, for this imparting of knowledge to the group seemed to be instrumental in relaxing tension, in aiding rapport and in dispelling some of the unpleasant feelings that accompany the awareness that one is being observed.

Limitations to Research

As with most research in the social sciences this study has its limitations, some being ones that are held in common with other studies, others peculiar to this particular one. Firstly, the researcher is biased and there is no known correction for this inaccuracy. I tried at all times to be consciously aware of my biases with the belief that only in such a manner could I hope for the greatest degree of objectivity. Secondly, there is the difficulty of attempting to keep the situation pure and hence ensure procedural clarity. My presence in the group influenced them and only rarely could it be determined how it influenced them. Thirdly, interview and questionnaire answers are liable to be inaccurate because of the tendency to supply answers that conformed with expectation and the suppressing of answers that deviated.
Fourthly, I could not assume that the respondent was not dramatizing, withholding relevant information, describing inaccurately or distorting. This is not meant to imply that such actions were intentional, but rather unanalyzed and transmitted without conscious awareness of their implications. Fifthly, there is the interfering consideration of discomfort, arising from personal sensitivities. I felt this occasionally in positions where my role was ill-defined as often under ward conditions, which carried the added threat of the possibility of being caught in a situation where lack of knowledge would lead to severe predicaments. When I experienced this I reacted by withdrawal, for it seemed that where my concentration was focussed entirely on personal discomfort, other, potentially rich, situations would escape me. Sixthly, the consideration of observer empathy and involvement proved of prime importance. I found that on occasion my morale would vary with that of the group in a manner too intense for comfort. To this I reacted by withdrawing for the afternoon or the day, until I regained what I considered a reasonably objective perspective.

These, in my opinion, were the salient features of the research methods that I used and some of the limitations and their connotations.
Socialization and Evolving Role

The role of the researcher is instrumental in determining the nature of the data he is to collect. Being unfamiliar with the traits of the small community into which I was to go and having no standard role to adopt, I was uncertain as to what position I should fill and how I should represent myself to the people involved. Through the passage of time, however, I found that I was being fitted into a context, which was easily defined by the individual or occupational group concerned. My own actions, consequently, were primarily guided by the expectations of the group with which I was interacting. The complexity and integration of varying occupational and social roles that made up the hospital, accounted for the variety of roles given me.

I Play Many Roles

Robert Merton suggests that the images of an interview were: as a democratic channel for the expression of opinion; as an intellectually demanding experience; as a moral inventory in that "I've got nothing to hide"; as a part of an institutionalized pattern of social surveys; as having an ego-building and status conferral function; as catharsis.¹

All of these images I felt at one time or another. 1) I was also treated as if I were a direct channel to persons of influence in the nursing hierarchy and through whom the individual could bring about reform. Material given was often weighted in this direction. 2) I was made to feel like a spy. "Look out, Elvi's analyzing us." But fortunately for my personal comfort this occurred very seldom, always from the same individuals, and presented in a teasing manner which implied their awareness of my sensitivity in this area. 3) I was used to eradicate feelings of insecurity and uncertainty by portraying myself as a sympathetic listener, and by making it apparent that I was not only observing the members of the group, but also other personnel. Regret was often expressed that I had not been present during a very trying situation. It reached me via the grapevine that I had been defined thus: "She sort of looks after us. She comes around to see how we are getting along." This was a role with which I was to become quite familiar in the latter part of the study. Sometimes I found it somewhat distracting when head nurses and supervisors regarded me as a tool whereby the problems of the students could be aired. It seemed as if I constituted a threat to them, with the added likelihood that I could illuminate on their inefficiencies and mistakes. 4) To the patients I was a supervisor who came around to examine the techniques of the student nurses, with whom the patients identified. At approaching the bed where one of the group was working, I was once greeted with: "She's doing fine. It's all right." 5) To those that had no closer knowledge of my project, the nature of my work
from the point of view of an action-oriented culture must have determined my status. They would see me walk around, talk to students, graduates, head nurses, yet do no "work." I appeared to be free to organize my own program. This would place me in some position of authority and on occasion I was very embarrassed to see a head nurse or student nurse stand when I approached the nursing station. This conception changed, however, when they were able to observe my interaction with the class of August '58. Conversation was friendly and could only be defined as such, for I had at the outset, feeling myself to be outside the institutional hierarchical system, adopted the use of Christian names in a culture where an index of "professionalization" was the use of "Miss Smith" as a form of address. Conversation of the informal nature that was reserved for personnel low on the status hierarchy and the pleasure the group members seemed to express on seeing me, contradicted the previous definitions of authority, confusing the role assigned to me. I was sought for clarification. "Just what do you do?" "Are you a graduate nurse?" After a process of trial and error I adopted an answer that was both satisfying and brief. I resorted to the explanation that I was studying the August '58 class, or that I was trying to understand nursing education or that I was studying the making of a nurse. This quenched questioning for a while for it did explain my existence there. An action-oriented culture turned to the next area of puzzlement. "Do you do any work?" "Do you ever do any nursing or things like that?" To these questions, which arose mainly with reference to my
activities on wards, I replied that I often volunteered elementary nursing duties and that I had fed patients, washed and dried utensils, taken TPRs and carried bedpans. In lectures and during informal lounge groupings my activities were more easily definable. All of these roles were radically different from my initial position as "the girl in the Friday morning lab" and "the girl who marks Sociology 200 papers." The difference is a direct result of increasing acceptance and more intensive participation.

Increasing Socialization and Acceptance

My initial contacts with my research field were made with those in positions of authority, such as professors and instructors at the university and hospital schools. After entering on this level, contacts with the students were greatly facilitated through the cooperation and efforts of the former. As time went on, however, I found that I began to lose the first affiliation in favour of the second. At all times, however, I had the security of feeling that the study was supported by those in control. I had the impression that they were interested in the information that I sought, and were willing to aid in its collection by cooperation and by contributions of their own.

Empathy can play an important part in the instigation of social values and standards. With increasing involvement with the life of the group I began to feel a growing
identification with them and the development of sentiments and attitudes that resembled their own. At the outset I attended social functions, meals and informal bull sessions because of their value as observational situations. I became aware of the fact that soon I was attending them primarily for my own pleasure and only secondarily to observe. With increasing identification and as I became more and more socialized, I adopted hospital slang and occupational terminology. "Peds" referred to Pediatrics, "Mat" to Maternity and so on. I became conscious of having hair on my collar, or of a uniform that did not meet the standards of "professionalization."

Although my initial reception measured up to my expectations of suspiciousness, unresponsiveness and coolness, I was to be pleasantly surprised. I was given increasingly varied and detailed information, the interviews became of greater duration, and I was often made to feel that people wanted to impart information. "Here's something for your thesis." From giving me the kind of information that is displayed to outsiders to maintain the prestige and public image of the nurse, they showed their acceptance of me by including me in "gripe sessions."

On the other hand I became often deeply involved with their problems and often felt disposed to take sides. When this occurred I withdrew for a day or so.

Over and above my position as a participator, there were several typical incidents that could be emphasized as ones
which heightened my acceptance with the group. Among these could be mentioned instructors asking me questions in class because of their unawareness as to my reason for being there, matrons scolding me because they identified me with a student nurse, small mistakes made in nursing procedures, my willingness to help them with small chores and my evident pleasure with their company. Above all I believe that my initial step of accepting their invitation to coffee on the first day of my attendance at the "Friday lab" and thus identifying myself with the students rather than the teachers, proved of great value.

Thus these two processes worked hand in hand, and were mutually interdependent. Increasing acceptance came with increasing identification.
CHAPTER IV

THE TRAINING SETTING

There is within our culture a distinct type of sub-culture, which could be called the "medical sub-culture." The nursing part of this sub-culture shall be discussed in this chapter from three perspectives. I shall describe it with information from my observations, from the interpretations of members of the sub-culture and from inferences and speculations derived from both of these. It shall be a presentation of what I saw, what others told me and how I interpreted both of these.

The medical sub-culture depends for its existence on the general cultural interpretation of illness. Without the cultural isolation of "illness" and the behaviour that is socially expected in every case of illness, there would be no medical sub-culture. In other words our culture defines a certain state of being as "being ill," which involves an obligation to leave this state and "become well." The process of passing from one state to another takes place through the medical sub-culture, which is structured in such a way as to make cure possible. In this way there is an interdependence between the general culture and the medical sub-culture. The general culture depends on its medical sub-culture to cure illness and the medical culture can only survive if there is
such a phenomenon as illness. The cultural norm of curing illness becomes the dominant value of the sub-culture and is responsible for its function and structure.

The sub-culture is involved with all the processes by which an individual, who when he becomes part of the medical world is defined as "patient," is returned to his former status as "person." During his time as "patient," the individual adopts the relevant attitudes and norms that are held out to him by the sub-culture. The complex organization of the sub-culture functions for the prevention and treatment of illness and defines this function as being "to do the utmost for the welfare of the patient."

The structure of the medical world is organized around techniques and skills, behaviour and attitudes, and the interrelationship of many roles. It consists of hospitals, clinics, pills, doctors, nurses, operating rooms, medical and nursing schools, research laboratories and all the other phenomena concerned with illness and its cure. The nursing role, and all that it symbolizes, is one part of the medical culture.

As far as the nursing portion of the medical sub-culture is concerned, it can be said that the training of nurses functions to fit them into their appropriate position in the sub-culture. Once in the sub-culture they are expected to perform in the defined manner. This defined manner is learnt in the process of training where the student acquires the subject
matter of her occupation and the relevant norms and attitudes. By this method the nursing community within the medical culture is perpetuated and maintained.

The Kind of Training Given

Nursing education and training is the process by which laymen are made into nurses. This process is managed by specialized members of the nursing profession, who are considered experts on the kind of nurse that is desired by the occupational group. Instructresses, as they are called, are in possession of the knowledge of how a nurse should be made and how and what she should be taught. These instructresses, therefore, begin with a preconceived image of what every nurse should be, and channel their energies into moulding every student into this form. Each generation of students is fitted into the cultural mould prepared for it. This fitting process involves two things. Firstly it is the duty of the instructresses to teach the student the particular type of skill that is the property of her prospective role. This could be termed the "instrumental, technical" aspect of what has to be learnt, and is usually transmitted directly in straightforward teaching and learning, supplemented by practice. Secondly, instructresses try to impart the correct attitudes and behaviour which befit the role of the nurse. Such a form of teaching is abstract, and hence more difficult to transmit. It could be described as the "expressive" aspect of role-learning.
After observing what students are taught and what they seem to have learnt, I came to the conclusion that learning and teaching are not always direct, but often also indirect. Direct learning and direct teaching occur when instructresses consciously teach and students consciously learn. It occurs in the classroom where instruction is didactically given and students are, by definition, under the obligation to learn. Under other circumstances, however, students may learn indirectly and often in opposition to what has been directly taught. They learn "short cuts," such as giving enemas without the use of stands and clamps, which they are taught to use. This is the result of learning two other things: that they must balance time and their ability to perform and that enemas can be given without conforming to the taught procedure. Similarly, attitudes not appropriate to the desired outlook of nurses and in opposition to what has been taught, are acquired. An instructress may teach the students to always show tolerance and kindliness towards patients despite their feelings of exasperation. Yet indirectly the students often learn to refer to patients as "old bags" or "lumps of fat." This form of indirect learning, which is beyond the control of instructresses, occurs through interaction with more advanced generations of students, or with other graduate members of the occupational group. It can also occur through distortion of the material presented for direct learning as in situations of conflict, where the student is unable to interrelate what she has been taught with other factors. These, then, are cases of indirect learning.
Indirect teaching occurs when instructresses, who are defined as models of appropriate behaviour, teach one thing, yet practice another. An instance of indirect teaching occurs when an instructress implies directly that nurses should not display anger, and if a desire to do so becomes uncontrollable, they should simply withdraw and walk away. Yet at the same time students are in contact with angry instructresses, head nurses and graduates. It appears, therefore, that direct teaching and direct learning occur more frequently in the traditional classroom situation and indirect teaching and indirect learning occur more frequently in the actual work situation.

The learning of the nursing role, however, whether it is direct or indirect learning, is concerned with two distinct aspects -- the "instrumental, technical" and the "expressive." "Instrumental" knowledge shows what should be done, "expressive" knowledge shows how it should be done. Adequate command of both aspects enables a student to play the nursing role well. The end result of the training of these aspects is a distinct gap between nurses and outsiders.

The Instrumental, Technical Aspect

This aspect refers to the vocational skills of nursing. Students are taught scientific techniques and how to give physical care. They are taught the theoretical knowledge behind these procedures. To quote an example, students, having once acquired an understanding of the circulatory system in a
theoretical sense, put this into practice in such things as hot fomentations to increase circulation. For this a definite procedure is implied. The necessary equipment is assembled and the flannel that is used is placed in a wringer folded lengthwise and is then placed in the fomentation basin. It is then covered with a plate and hot water until the basin is two-thirds full. It is boiled on the gas, from whence it is removed after five minutes and carried to the sink where sticks are adjusted and the flannel is wrung as dry as possible. Finally placed on the plate, it is covered with a towel and carried to the bed-side with any other equipment that is required. The covers are folded down, the body exposed and the binder is put in position. The fomentation is removed from the wringer, the moisture is shaken off and the fomentation is tested on the nurse's wrist. It is applied gradually in such a manner as to be tolerable to the patient. Quickly a Venetian cloth and flannel are used to cover it and the binder is fastened. A hot water bottle is applied. The procedure seems to have been completed, but it has a follow-up. A second flannel is put in the stupe wringer ready for the next treatment. When the fomentation is changed, the condition of the skin is reported to the head nurse and vaseline is applied if necessary. When the treatment is finally discontinued, the area is dried and covered with dry flannel and the binder is again fastened. The instrumental, technical aspect is concerned with this type of knowledge. It also involves nursing lectures.
in bacteriology, anatomy, chemistry and physiology. The student is taught to give bed-baths, to prepare patients for operations, to understand the intricacies of a sterile field in opposition to a clean one, to do wet and dry dressings and to measure correctly in giving medications.

At all times emphasis is placed on speed and precision. Students are impressed with the "importance" of giving the correct medications, of applying the correct amount of heat and of keeping instruments and areas sterile. An anxiety about accuracy is fostered by the instructresses, who often relate disturbing anecdotes. One instance was when the students were told of the nurse who gave a patient a bad burn by leaving the hot water bottle on too long. "The illness was cured, but the boy had to see his doctor six months afterwards because of the burns. Never leave a hot water bottle unchecked." Or the students are told of the nurse who administered the wrong medication and of the complications that set in. The urgency of the medical sub-culture is stressed. Speed and the ability to act quickly are considered valuable assets.

There seem to be three types of instruction for imparting the instrumental, technical knowledge. Firstly, they are didactically taught theoretical knowledge. This they are expected to master and to prove this mastery in objective examinations. Secondly, they are taught to participate in an imaginative ward in the laboratory and are aided in applying their learnt knowledge. Here it is no longer purely
theoretical learning, but has become practical. Thirdly, the knowledge is applied in the "real" situation. The knowledge is thereby elaborated and reinforced by experience when the student meets the demands of her work situation. Here the teaching is incidental and occurs only in cases of uncertainty. Didactic teaching gives way to correction, support and reinforcement.

The Expressive Aspect

Students are also taught the appropriate attitudes and norms that accompany the skills they perform. The moral beliefs and the social mannerisms of the occupation are pointed out. Students are taught to be altruistic, to place the welfare of the patient above their own desires. "A nurse does everything possible for her patient within her range of responsibility" they are told. Ideally, every action should be oriented towards the betterment of the patient.

The nature of her relationships with others in the medical sub-culture is clearly defined. Towards the patient the nurse is expected to be discreet, kind, helpful and tolerant. She is reminded that she, more than any other in the medical sub-culture, has closer and more frequent contact with the patient, and hence she is responsible for the physical, as well as the psychological well-being of her patient. She is even led to believe that she, in reality, is in full control of the reparative process.
The nurse is the only person in a position to see changes. This baby, who looks OK, the nurse can see that he isn't the same as he was an hour or three days ago. She is the only one to see the change. A lot of faith is put in what the nurse says.

In such a way the "importance" of her work is emphasized. The comparative "importance" of her work to that of others, for instance, that of the doctor, is not pointed out, but is something of which she becomes aware when she comes into the hospital context.

She is also taught how to react towards superordinates. To professional people, such as doctors, supervisors and so on, she is told to show full respect by standing when they enter. She has to be cooperative to graduate nurses and to students above her. She is asked to carry out orders without argument or discussion, the importance of this obedience being reinforced by reference to emergency situations where argument would waste valuable time. She is to accept the idea that her superiors have a greater command of the techniques and knowledge of the medical culture and hence can act more appropriately in the milieu into which she is still being socialized.

The nurse's behaviour outside of the medical sub-culture is also controlled. Her behaviour within the sub-culture is expected to be repeated when she is away from it. She is to carry over her occupational mannerisms and to conduct herself as a member of a "service" profession. Instructresses imply that students are to be confidential about information and to
guard their knowledge and skills and not to allow them to pass into unqualified hands. Yet she is under the obligation to administer her skills whenever the occasion calls for it. All of these requirements function to keep outsiders out. In general nurses are expected to uphold the "reputation" of their group. They are asked not to frequent beer parlours, to use obscene language or to conduct themselves in other unprofessional and untrustworthy ways. Thus the continuation of a favourable public image is entrusted to each member of the group.

These expressive aspects of role-playing are taught didactically or by the use of models. They are transmitted in classrooms by instructresses in the form of traditions, ideals or facts. Students are told that this is the way it was always done by "good" nurses, or that this is the best way to do it, or that this is the way it is done. To these images of the right behaviour for nurses the instructresses themselves try to conform, and in turn to mould their students. In a certain sense, therefore, they try to make students in their own image, and certainly the behaviour of all students is controlled to some extent by the teachings of their instructresses. Sometimes other nurses, defined as "good" nurses, serve as models, and students try to identify with them and to imitate their actions. These examples, as taught by instructresses and set by model nurses, become adopted as ideals, which the students try to uphold. As such the ideals also take on the functions of controls, by exercising guilt feelings when students deviate.
Indirect learning of "expressive" material also takes place. It usually does not comply with the demands of the occupational group, and often is in direct contradiction to the behaviour and attitudes desired. It takes place through experience and is beyond the control of teachers. Although students are taught to respect head nurses and instructresses and to approach them with their problems, their reactions to these people may be altogether different. In actual practice they may come in contact with instructresses or head nurses with whom they are incompatible, whom they cannot respect and to whom they cannot take their problems. The definition of head nurses and instructresses, which has been taught, becomes changed. The student feels that they are deviating from nursing norms and hence cannot respect them. She is placed before the conflicting expectations, namely the norm of respecting superiors and the actual situation. Thus ideal "expressive" behaviour is taught in a didactic manner by instructresses, and factual "expressive" behaviour is the result of the balance between the ideal and the demands of the "real" situation.

Whereas the "instrumental" aspect deals with "things," the "expressive" aspect deals with "people." As children at an earlier age become more accustomed to "people" than they do to the specific "things" of nursing, it can be said that the "expressive" aspect could be acquired at an earlier age. This is especially true of nursing where the occupational norms are very similar to the cultural norms attributed to middle-class
women with humanistic ideals. Thus even as children, students are beginning to acquire the relevant norms, whereas often the "instrumental" knowledge is not gained until the prospective nurse has been accepted as a student and is introduced to dressing equipments, hypodermics and so on. One student remarked with insight: "Actually your training started a long time before you even took nursing. Even as a child you learnt what people are like." Nursing training, therefore, merely supplements and clearly indicates these norms. The student is now under a greater obligation to "express" these norms as a member of the nursing group.

Organization of Training Milieu

There are several contexts within which the student nurse is trained. The subjects of this thesis, being university program nurses, are trained, in the beginning, in a university environment. Secondly, they are introduced to a hospital environment where they are confronted with the reality of ward experiences. At the hospital also, they are given lectures and laboratory demonstrations. Finally, residence life, with its emphasis on group associations, plays its part in the making of a nurse. The total training process is not chronologically presented in these stages, but alternates between the four. It begins with university classes, then switches to ward experiences, then to hospital classes, then back to university classes and so on.
The University

Located on the campus of the University of British Columbia is a School of Nursing. It is housed in a building which also contains a student health centre, a small hospital, class rooms and laboratories for students in bacteriology and oceanography. The section of the building where the School is situated is supplied with offices, classrooms, a library, a laboratory and common rooms.

The School of Nursing is formally defined as a school within the Faculty of Applied Science, administered by a council nominated by the Dean of the Faculty. The courses presented by the school are structured to meet the professed purpose of the school:

...to assist students to become competent professional nurses, capable of participating with other individuals and groups in a comprehensive health programme designed to assure to all citizens a high quality of nursing service in sickness and in the promotion of health; to help them develop the concepts that nursing is concerned with the promotion of mental and physical health, as well as the care of the sick; that it is a service to the family as well as to the individual, and is given in homes, hospitals and other community agencies.  

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During the first year of the degree course in nursing, students are given lectures on the campus, and except for short periods of a few weeks, the students do not return to the campus until their fourth year when they have graduated as registered nurses. Before entry into the School, students are expected to have completed their Senior Matriculation or their first year in the Faculty of Arts and Science. In the first nursing year courses in English, Biology, Bacteriology, Psychology, Anatomy and an introductory course in Nursing are given. Often when Psychology is taken in the Senior Matriculation year, a course in the social sciences is substituted. This arrangement brings nursing students into constant contact with students aspiring to other occupational goals. Except for lectures in the rudiments of nursing, the classes are intermingled.

The laboratory for the introductory course in nursing techniques is set up like a ward. It has beds, bedside tables, sinks and a service room, all equipped with the necessary utensils. Even a patient is supplied. This comes in the form of "Mrs. Chase," a life-like, life-sized doll, "who has everything." Using the available apparatus and "Mrs. Chase," the students "practice" and "pretend" by "giving" the "patient" everything from bed baths, to mustard plasters to enemas. Often, however, when the procedures to be practised are not of a difficult or embarrassing nature nursing students use each other as patients, taking turns at playing that role.
The nature of the teaching given the students in nursing courses, as well as in the general science courses, seems to follow the tradition of university instruction. General education and a broad outlook are considered "good things" and the primary function of university education is ideally defined "to stimulate thought and encourage enquiry." Questioning is traditionally welcomed and discussions among students and between students and faculty are deemed advisable. The obligation to condone these practices is placed on all teaching personnel. The students, on the other hand, expect such attitudes and consider themselves justified in expecting a right to contradict professors and to query what has been taught to them.

In extra-curricular activities nursing students often collaborate with engineering students, being members of the same faculty. "Mixers" or "dos" are organized. There are also sororities and campus clubs with which nursing students become affiliated. High School companions and friends made during the first year in the Faculty of Arts and Science are among the other attachments. Added to these contacts is the fact that the majority of lectures in the first year in the School of Nursing are taken in conjunction with non-nursing students. Therefore the interaction with other students is usual and frequent.

Despite these diverse contacts, however, the first year nursing class begins to show signs of an inner solidarity. Although they attend classes in other parts of the campus, they
congregate around their own building. The students spend much time together, develop friendships within the group, make field trips together and participate in campus affairs as a group. They begin to see themselves as a group and as being different from outsiders. They develop notions of "we" as opposed to "they," who consist of all other faculties and schools. Even though they participate generously with non-nursing students, they already have a self-image of being nurses, and they prefer to identify themselves with other nurses, rather than with other university students.

This image becomes a reciprocal thing. Not only do nursing students identify themselves with nurses and with each other, but non-nursing students also classify them as "nurses" as opposed to engineers or artsmen. When speculating on the image of student nurses that prevails among the campus groups, it seems that they are diverse and often contradictory. Nurses are often considered to be "not really" university students in that they have only a few years there and then withdraw to the hospital, where they are not able to make themselves felt as full participants in campus activities. Artsmen often give them the kind of disdain that is accorded to those that apply, or those that practice, by those who consider themselves "pure" scientists. In that way it is not considered as much an educational course, as a vocational course. It is considered by outsiders to be "easy" to be accepted into nursing, and an acceptable career for those girls who are not able to take a
more academic role. On the other hand nursing students are considered as self-sacrificing and humanitarian in taking on work that is "hard" and receives little remuneration and prestige. Along with Home Economics it is considered a woman's profession and hence students of the profession are often defined as the "feminine type."

The faculty of the School of Nursing also induces feelings of solidarity and identity with the nursing group. Unlike the members of the Faculty of Arts and Science, they are familiar with the personalities and backgrounds of all their students. They keep a check on their attitudes towards the occupation by interviews, which are recorded and then become part of the picture of the student. They are thus able to understand their students, to predict their behaviour and thus, to guide them. From the beginning they begin to introduce the idea of "professional self" to the class, and to indicate the norms of the occupational culture. In this way they help to develop a professional personality in each student and a feeling of sameness in the group and a difference from outsiders.

The Hospital

From the university campus the students move into an entirely different type of milieu. They enter the hospital, or their work environment, where they expect to spend the next two years as well as unlimited time after they graduate.
The hospital could be viewed as an organization of specific roles which are stratified in such a manner as to enable the most efficient fulfillment of a common goal. The common goal is the cure of illness, and this phenomenon is the core of the whole structure, for without it there would be no such structure. Besides being harmful to the physical organism, illness is considered socially undesirable. It is treated almost as a form of social deviance which isolates the individual from others and hence is unpleasant. This role of isolation involves one obligation, that is, to get better. The role of the patient is hence a "changing" role. The patient is expected to get better both by his own efforts and also through the efforts of others who are experts in the ways of returning to health.

The hospital is the structure into which these experts are fitted. The hospital has four groups of such roles. Firstly, there is the group which includes the patients, the central figures. Secondly, there is the nursing group, which is highly stratified according to competence. It ranges from the director of nursing, through supervisors, head nurses, graduate nurses, student nurses to nurses' aides and ward aides. The higher on the scale, the greater are the privileges such as authority and its associate factors of prestige and income. The greater also are the duties and responsibilities. Thirdly, there is the medical group which consists of the medical administrator, heads of departments, visiting specialists, general practitioners,
senior and junior residents and interns. Fourthly, the hospital administration group, headed by the hospital administrator and controlled by a board of trustees, includes the office staffs, the admittance and discharge departments, statistics, medical records and so on. There are other roles which play auxiliary parts in the hospital milieu, where the rehabilitation of the patient is the central concern. This means roles in the social service division, in the laboratories, in dietetic departments and in public health agencies.

This formal structure is made up of sets of hierarchies, where each status in each hierarchy has its own well-defined responsibilities. Thus it is the duty of the head nurse to accompany the doctor when he visits the ward. Similarly it is the duty of the ward aide to supply the ward with the required linen. The functions of each role are specialized, and being traditionally defined, are stable. Because of these traditional expectations each role becomes socially predictable. These expectations are passed on to all who "take on" specialized roles in the structure. Therefore, before their arrival at the hospital, student nurses are made aware of their traditionally-defined expectations. To a certain extent, then, the functions of a hospital depend on tradition.

Secondly, training into a medical milieu is based on discipline. Although students know what is required, they are not sure of how this can be learnt. It is achieved in an authoritarian system, which demands immediate obedience and
precision. This rather dictatorial method is rationalized by stressing the importance of speed and direct following of orders in an emergency situation where lives hang by a thread. For this an elaborate set of rules is set up and enforced. All criticism is discouraged. In these respects, the hospital milieu resembles a military institution. Such training results in giving control to authorities and in fostering efficiency.

The continuation of the efficient functioning of the hospital depends on a third principle. This is routinization. A prerequisite of this behaviour becoming the routine behaviour is some acceptance of the system and of what is required of the nurse in this system. When this is accepted the student becomes conditioned to acting in the prescribed manner in all situations. In this manner discipline, obedience and consequently efficiency are ensured.

When the student leaves the university to come to the hospital, she is subjected to a different type of teaching situation. The greatest change lies in her learning apprenticeship-fashion on the ward, where she is placed. It is a form of in-service training. The girl is no longer only a student, she also becomes a worker. She is expected to perform certain duties and is under the obligation to "learn by experience." Her teachers are her superiors on the ward. She receives instruction from head nurses, graduate nurses and other students who have been there longer. Occasionally she is helped by an
instructress. In general, however, her teachers are experienced nurses, not trained teachers.

I have been up here for two weeks, but I haven't yet seen the instructress.

Her teachers, therefore, are numerous and of differing statuses, and her rotations send her frequently to new wards where she meets more teachers. What she is to learn is standardized. Yet her learning is diffuse. What she learns on one ward she often has to unlearn and then relearn when she goes to another, so that she can fit into the requirements imposed by the new head nurse.

In this way, after theoretical instruction at the university, the students are able to experience their role in action for the first time. She is now called upon to give the mustard plasters and the enemas that she performed on "Mrs. Chase." She actually makes a bed in which a "real" patient will sleep. She gives a back rub to a "real" patient and not to a doll. She sees what happens in emergencies, and does not merely hear about them. There is no longer an opportunity to ask questions and to discuss the advantages and disadvantages of different techniques. The student is expected to act. Any individual initiative is definitely discouraged. Tradition, discipline and routine condition the student to the norms of the hospital. She is conscious of the need for precision and speed.
Another aspect of the new teaching is hospital nursing lectures. These are conducted by instructresses from the hospital teaching staff and by doctors who lecture in their special area of competence. These lectures serve several functions in the new training milieu. Besides presenting new subject matter, they serve to break the routine and give relief from the monotony of ward experiences. They reinforce the interest of students by giving them a taste of what is coming. They function also in solidifying attitudes that already exist and in introducing new ones. Such attitudes are introduced by requiring students to rise when a lecturer comes in the room, something that was not enforced at university. They also serve to remind the girls of their role as "students," when they are beginning to define themselves as "workers."

The atmosphere of university lectures, however, is not present. A stricter control is kept on the students by constant roll-calls and by placing restrictions on what can be done between lectures. Degree students resent this as an infringement on their freedom, and as a regression from their university training:

I've just been told by one of the kids in the university class ahead of us that all our classes will be on this level until we graduate . . . That's hard to take after the level of university classes . . . and then to top it all, we have to return to university level in our final year.

They begin to feel as if they were being treated like children. This they feel to be in contradiction to the responsibility and leeway that is given to them on the ward.
The Residence

When the students leave the university and become part of the hospital program, they also change their place of residence. They are given a room in the Nurses' Residence adjoining the hospital, where they lead a communal life. This life is led within a system of rules which allows the nursing profession to control their initiates in the most appropriate manner. The ultimate purpose of this control is to subject the students to the kinds of experiences which are liable to develop the required type of nurse.

The students, therefore, are controlled by strict time boundaries. They must be in the residence at a required time each night, and are allowed a certain amount of time for which they do not need to account. Even "sleep out" nights are controlled by residence rules, and such privileges are only afforded the student when the place of the "sleep out" is her home, or is at a place approved by her parents and by resident authorities. If students do not leave the residence, all common or group activity must cease at a specified hour, and all girls must retire to their own rooms. Then again bedtime is well-defined and strictly enforced by matrons who patrol the corridors to punish deviants.

At ten o'clock on winter evenings and at eleven o'clock on summer evenings the doors of the residence are shut. All students are allowed one "sleep out" every week, on the night
before their day off, and all students, with the exception of preliminary students are granted a "late leave," which means that they are able to stay out until midnight. Under special circumstances an extended "late leave" may be permitted by the matron in charge. The students are not allowed, however, to accumulate "sleep outs" and "late leaves" and to take them during the one week.

This system of isolation and strict control compares to that exercised in a military institution. The residence is often referred to as a "nunnery" or a "prison." Both terms are significant in their functional similarities. With nursing students residence life separates them from outsiders and forces them into the constant company of their own group. This makes it doubly easy to transmit the relevant norms. The aspirants are freed, to some extent, from outside influences, and placed further under the control of the system that makes them into nurses. They are, therefore, more often available and in the hospital milieu, and hence exposed to the attitudes that prevail and to the expectations that are placed on them. At the same time they have less time to acquire or practice norms that do not apply specifically to the medical sub-culture. Thus they are constantly listening to the views of other students, nurses and matrons. They eat with hospital personnel, and their world seems to be made up of nursing functions, of study, of patients, instructresses and doctors. They see other students capped, graduated and examined. They listen sympathetically to the
troubles of their friends, and are among the first to hear and transmit hospital news. They begin to know what actions are the beginnings of trouble and what punishments could occur. They know which instructresses, head nurses and doctors to avoid long before they meet them.

There are two distinguishable attitudes towards residence life. One sees this form of isolation as a "good thing," and a very necessary part of nursing training. It is considered a disciplinary form which provides the correct milieu in which the appropriate kind of nurse can be moulded. She is prevented from becoming over-tired, and from exposing herself to the wrong influences. Instead she leads a strictly regulated existence and thereby maintains the desired public image. This is the view held by members of the profession who are in a position of training the students. It is also considered "the only way" by some students, even though they express displeasure at the imposed limitations. Only by this method can they become "good" nurses.

The other view, held mostly by students, is that residence life is an unpleasant phase that "must be put up with." It is considered unjust and the controls exercised are considered pointless. Students refuse to admit that there is any value in such a life and eagerly look forward "to the day we can get out of here." Their behaviour in the residence follows institutionalized forms of deviance. They complain about the
rooms, the lack of privacy, the unimaginativeness of the food, the hours and the rules. They develop ways to outwit and avoid controls. They keep quiet while the matron examines the halls, thus giving the impression that each girl is in her own room, while four or five are in the one room. They stuff the mat under the door so that the light does not show into the corridor. They eat meals in the residence even when only snacks are allowed. They even work out ingenious methods of staying out all night. In these ways they can channel aggression indirectly at residence authorities, who limit their behaviour.

Group Affiliations

The frequent association of working, studying and living together serves several significant functions in the role of the student nurse. It can be assumed that the life that is led plays a major role in moulding the social identity of the student. As the life of all students is similar, their mode of existence serves an assimilating function. The result is that each nurse is somewhat similar to every other nurse.

This assimilation begins with co-habitation. This common existence is emphasized by the isolation imposed by residence rules, which force the student into the company of her fellows and less into the company of outside friends. They are also bound together by common work and common study. The process ends with the establishment of internal bonds. Students now are no longer in the company of their fellows because they
are forced to do so, but because they want to do so. They tend to have fewer friends outside of the residence, and more within the residence.

A common identity becomes evident. There is an increasing solidarity. Other classes are referred to as "they," their class is "we." When asked how many friends they have within their class, they answer that all of the girls are their friends. Only when asked to qualify, do they show any preferences. Thus to outsiders they show this front of solidarity. Only among themselves and in their informal activities is it dropped. To outsiders, however, they emphasize the fact that they are equal and that they are a group. This is shown by the way in which they understand each other's difficulties and become insulted and enraged when one of their members is insulted or enraged.

Psychological support is derived from such solidarity. They exchange confidences about their feelings towards others, about their inadequacies in their work, as well as about their personal problems outside of the medical milieu. In this way they understand each other without elaborate explanations and share burdens by "talking shop." Each member of the class is under the unspoken obligation of listening, offering support, and of not repeating to outsiders.

This solidarity leads to the reinforcement of standards and of attitudes. The group registers either approval or
disapproval of an individual member's actions by giving or withholding support. Attitudes become so strongly controlled that if a student has deviated from expectations, she does not discuss this deviation for she is well aware that the group would not approve. Thus if a student loses her temper towards a patient and is consequently apprehended by authority, she may not discuss it. She relieves her guilt by withdrawing and forgetting the situation. If, however, she feels the punishment unjust, she complains to the group.

The establishment and transmission of local myths are also the results of this solidarity. Hence the behaviour of a head nurse or instructress is criticized and passed from member to member, long before any contact has been made. In this way group members are prepared for certain experiences. They are able to predict the behaviour of the head nurse involved, and to react in the most desirable manner.

Listen to everything she says, but for goodness sake, don't argue with her.

Each class in the residence develops such solidarity. Intellectual and recreational interests do lead to cross-class affiliations. The initial bonds, however, are not overcome, the feelings of "we" are restricted to one's own class, and generally in times of stress, support is sought among one's own class members. Regarding her class, one student commented:
You could go and talk to anyone really. I think our class is quite close. And I think it is really a good idea to move all the classes together. Except that you don't get to know the other kids in the other classes. Actually it doesn't make too much difference because you have enough friends in your own class.

Over and above the divisions among classes, there is a well-defined division between students in the university degree course and the students in the hospital nursing course. The subjects of this study often complained that they were identified as "university girls" and were often scorned by the other students. They felt that the attitudes of hospital personnel towards them changed when they discovered that they were "university girls." Often they felt more was expected from them in the way of skills and knowledge. The university students had varying explanations for the feelings that existed between themselves and the hospital class. They believed the others thought them "stuck up." They often defined this attitude as unjust, but on occasion they laid blame on a few of their members for engendering this image. They often commented that the antagonism existed because the hospital students thought the university students "had it easy" and were required to spend less time in the residence and to give less service. Or the hospital girls believed they were "given favors," as they were allowed to spend a two-month period at the provincial mental hospital as a part of their training, while the hospital girls were deprived of this. University girls, furthermore, were considered privileged because of their affiliations with the
university and their opportunity to partake of campus social activities. Generally, however, it appears that both groups laid the blame on the other. The hospital girls were considered unjust in their antagonism, and the university girls were considered unjustly privileged.

**Sequences**

The nature of the training period can be clarified by dividing it into stages. Each stage is an advancement on the one before. Instrumental skills and expressive knowledge become increasingly internalized. So that at the beginning of the first stage the aspirant is a layman, her only claim on the nursing role being a desire to "become" a nurse. At the end of the last stage, she is a fully accepted member of the occupational group.

The School of Nursing of the hospital has declared formal phases to divide the role-taking process. They are named the "probie," "junior," "intermediate" and "senior" terms, each one signifying an increasing command of the instrumental and expressive knowledge of the role. Each stage means more authority and more responsibility. This is visibly symbolized in the dress of the student, each of the four phases being characterized by a distinctive uniform. This way of indicating the stage of a student's knowledge functions to enable others in the medical subculture to expect from her, upon sight, a certain amount of skill and understanding.
1. The "Probie" Phase. The probationary period begins with the issuing of a uniform, consisting of the "blues," the narrow bib and apron, black shoes and stockings. It ends with "capping." This orientation into the medical sub-culture consists mainly of lectures, with short periods of two to four hours on the ward. The university class has this preliminary period for two months, the hospital class for four months. After this period, there are exams and successful candidates are then eligible for a cap, cuffs and hospital pin.

2. The "Junior" Phase. Capping is a rite of initiation marking acceptance by the nursing profession of another member. It presupposes that the initiate has fully met the requirements of the profession and is hence worthy of learning to play the role. With "capping," the junior term begins. This means a six month period for university girls and an eight month period for the others. They spend time on the ward and become familiar with more complex procedures. They are now qualified to catheterize, to give bladder irrigations, to chart doctor's orders, and to administer medications. They begin to work shifts. Exams mark their entry into the "junior block" of lectures where they receive instruction on junior specialties. After classes their knowledge is tested once more before they are allowed to begin on their specialty training. While juniors, the students work in dietetics, orthopedics, ophthalmology, on the ear, nose and throat ward, the genito-urinary wards and in the operating room. Junior students are
considered to be "the ones that really work, the intermediates and seniors sit around answering the telephone and charting."

3. The "Intermediate" Phase. Students graduate from narrow to broad bibs, and thereby enter onto the longest single phase of the training process. They will be "intermediates" for twelve months. The local myth of the monotony of the intermediate phase has circulated among the students and they have formed their expectations of what it entails. They have heard of the "intermediate slump," and expect to go through it. Intermediate specialties are obstetrics and pediatrics, each department taking three months of the student's time. Exams terminate each period, and formally signify the student's ability to progress to the next period.

4. The "Senior" Phase. After "capping," a major ritual, entry into the senior phase could be considered a minor rite de passage. The fact that students are now close to graduation is symbolized by the wearing of white shoes and stockings. To prevent examination of shoes and stockings, the training stage that has been reached is made immediately noticeable by a black band attached to the cap. When the student graduates this black band and the "blues" disappear and are replaced by an all-white uniform. During this period of twelve months for the hospital students and eight months for the university students, instrumental skills are acquired in the specialties of gynaecology, infectious diseases, psychiatry and neurology. Exams follow each specialty.
The process of role-taking, therefore, is divided into four well-defined phases. Each phase signifies the didactic presentation of more difficult technical and instrumental material. With increasing experience, however, interpersonal relations and expressive skills become more familiar. Attitudes and norms, which are appropriate to the nursing role, also are increasingly internalized. This results in the student reacting in the required manner.

The acquisition of the material presented is measured at the conclusion of each phase. This is done objectively by examinations. The manner in which this knowledge is applied, as well as the nature of interpersonal relations is evaluated. This, therefore, is subjective and is presented in the form of ward reports by head nurses. A close check is kept on the progress of the student by these means. Ward reports and the results of examinations tend to check any deviance from the required course of training.

The four phases serve several important functions. From the point of view of others involved in the medical sub-culture, the extent of a student's knowledge can be immediately estimated by the nature of her apparel. Therefore, no doctor would approach a "probie" to give a medication, or any student, other than a senior, to insert a lavine tube. In a culture of such urgency as the medical sub-culture, this device is time-saving as it avoids the arduous and time-consuming process of asking each student whether she is able to perform the
procedure required. From the point of view of students the system serves a psychological function. The students feel secure in knowing that they will not be called upon to perform services that they have not yet mastered. This undoubtedly gives them greater confidence on the ward. They are also equalized with other students of equal abilities, not only in knowledge, but also in appearance. The four phases, marked by the visual means of apparel, function also in the distribution of privileges and status.
CHAPTER V

THE CHOICE OF NURSING AND ROLE-ANTICIPATION

This chapter is based on the assumption that an occupational role in our society is an acquired role, being "taken on" because of a wish to enter the role. With this wish to take on the role there goes a series of anticipations and self-images, which will be discussed in the second section of this chapter.

Student nurses were interviewed during their university training with questions on their choice of nursing and their beginning anticipations. They were asked why they took up nursing, what else they would consider as an occupation, what was their model occupational role and what initial self-images they had.

1. Making the Choice

When considering "role-taking" and "role-playing," it does not suffice to reflect on the process of "how men become lawyers" or "how women become nurses." This omits one significant question: Why lawyers and not policemen? Why nurses and not school teachers? There are, therefore, reasons for choosing one occupational role from numerous possible roles.
Any enquiry into why the subjects of this study wished to become nurses brought forth a certain type of information. It did not delve into the complicated factors that are involved in motivation, but rather showed the students' conceptions of what turned them towards nursing. Their answers are indicative of their initial self-image and it is possible these answers could change with their changing self-images. In other words, before taking on the role, they may give dedication to helping others as their reason for wanting to become nurses, but after having been student nurses for some time, they may say that they went into nursing for reasons of security or personal satisfaction. This chapter, therefore, shall discuss the images they had, at the beginning, of why they went into nursing, and not what really motivated them into becoming nurses.

Types of Reasons Given

When asked how they came to take up nursing, numerous reasons were given. These reasons, however, fell into two distinct classes: the "ascribed" and the "acquired" modes of orientation.

1. The Ascribed Orientation

These students see the nursing role as a part of the self and as a manifestation of one's inherent self. They believe they are meant to be nurses, and there is no conflict of having to choose an occupational role. No other role would be suitable
for them, and the taking and playing of the nursing role is merely a continuation of the development of their selves. There is no stage of weighing the duties and privileges of occupational roles and no evidence of the necessity of making an occupational choice. These individuals did not consider other roles, as the nursing role was inherently suitable and other roles were not.

In interaction with these students I found that their "expressive" knowledge was well-developed and nursing norms and attitudes had been internalized and acted upon before they became nursing students. They show that they have humanitarian, altruistic ideas and that they are eager to help others. They are quiet and reserved and willing to carry out orders. Some of these attributes are evident before they take on the "practical" aspects of their work. Hence for them the process of becoming nurses is greatly facilitated.

These individuals do not refer to the rewards and privileges of the profession, but rather to what they can do for others. They show little concern for remuneration, prestige and security, and if they are concerned with these, they do not mention them. In this way they conform to the image of a professional self, namely, the image of altruism. This does not necessarily mean, however, that they are oblivious of these rewards, but simply that they have adopted the occupational norm to such an extent that they do not refer to aspects of self-interest.
Within this broad category of those who consider themselves nurses because of ascribed reasons, there are sub-types of orientation:

**Born a Nurse**

Well, actually, I never wanted to be anything else. You know, when you're a little girl you set an ideal for yourself.

Statements such as this occurred with marked frequency, and should, therefore, be considered as a distinct category. The implication in each case is that the student is aware of a well-defined goal, that is, of wanting to be a nurse, from a relatively early age, and is, therefore, able to direct her energies towards that goal. Where the initial wish came from is lost to the subject and cannot be discovered in an interview situation. She believes, however, that the role is inherently appropriate to her. Therefore, she is never placed in the conflicting situation of having to make a choice.

**In Mother's Image -- Positive Identification**

I decided that I would take up nursing simply because my mother had been a nurse and I always admired her . . . . Well naturally my mother is interested. She's always telling me what to do. She kind of has the inside story. When I'm confused she's the person I go to.

The occupations of parents and other family members undoubtedly positively affect the occupational choice made by
children. This could be explained in terms of emotional and physical dependency, which are involved in child socialization. The child is sensitive to the influence of others, especially her parents. Because of her flexibility she is molded through the process of interaction with these parents. She continuously adopts the values and attitudes of parents and these become parts of her personality. In this way parents with personalities resulting from the playing of occupational roles transmit their values and attitudes to their children. Thus mothers who were, or are, nurses are liable to have daughters who have characteristics similar to members of that occupational group. It is significant to note that the occupational group to which the largest number of mothers belonged was nursing. (Appendix A, 7.) This does not take into account other kinship members, who are also nurses. Subjects of this sub-type have, therefore, adopted personality factors as a result of identification with the mother or other member of the kinship group.

In Mother's Image — Negative Identification

It's funny . . . my mother was a nurse . . . and I know that she always wanted me to be a nurse, and I didn't want to be, mainly because I think she wanted me to be. And so did father.

Some of the students interviewed were influenced towards nursing in a negative manner. In the case cited above it seems likely that the values of the mother, as a nurse, have been transmitted to the child. The child, however, is not
conscious of a desire to take on the nursing role. The values she has internalized, however, finally influence her to choose nursing.

It is interesting to note that these individuals, who have chosen the nursing role at an early age, are seen by their peers as having a longer and a prior claim to the role of the nurse. This led to their often assuming an authoritative position within the group as having possession of the knowledge of the subject matter of nursing. Early in the training period I noticed that questions on the nature and subject matter of nursing were often directed at these students.

2. The Acquired Orientation

Individuals of this type of orientation see the nursing role as something separate from themselves, which they must choose and then acquire. It is a role into which they must place or mould themselves, whereas individuals of the ascribed type see the role as a continuation of themselves. Unlike the first type, they go through a stage where they weigh the attributes of occupational roles, a stage of indecision which culminates in the making of a choice.

Consideration is given to the demands made by the role and the rewards that compensate for them. On the one hand, they know that nurses work on their feet and that they have undesirable hours. On the other hand, they are aware that
nurses have prestige within the community, that they are well rewarded for their work and that they can find employment anywhere. They are aware that nurses are shown respect because they fulfill an altruistic function. Whereas individuals of the ascribed type do not mention these rewards, individuals of the acquired type outwardly show their awareness of them and thereby deviate from the professional image of lack of self-interest.

The professions, in other words, are respectable because they do not strive for money, but they can only remain respectable if they succeed, in spite of this pecuniary indifference, in making quite a lot of money, enough for the needs of a gentlemanly life.¹

There are more elements of rational choice in these reasons than there are in the preceding group, which had developed an early emotional attachment to the role.

There are again several modes of orientation evident in this group:

Nursing as a Means

It offers employment, and it will be practical if you get married and it offers a job. Say something happened to your husband you would have a job . . . so it's quite useful.

Well, I came into it for several reasons, mainly because I wanted a job to work with people. And I wanted a job that afforded lots of opportunity when I finished. And one I could travel with.

The desired end for this sub-type of orientation is not being a nurse, but rather what nursing offers as a means to a desired end. Whereas the first types mentioned above give other-oriented reasons, this type gives self-oriented reasons. Nursing is a form of security and a way of acquiring attractive goals. An occupational role for these individuals is only a means, and the nursing role is the most appropriate one available. Nursing as a means is possibly a consideration in all cases, but only in a few is it given as the prime reason for the choice of the role.

Traumatic Experiences

Well, when I was very little -- I think it is all personal experience. Well, when I was very little, I had very serious ear trouble. And through the doctors and the nurses they fixed it up O.K. and I'm all for different operations. And I found out later that if they hadn't fixed it, I would have been deaf, and I figured that I owed so much to it, I would like to help other people. Being little and being in hospital, the whole thing intrigued me . . . the whole atmosphere of the place.

Here nursing is chosen because of a personal experience involving high emotionality. Besides being harmful to the organism in the physical sense, illness is socially isolating and undesirable. Others, who help the patient to
leave this unpleasant state, are defined as "good," "necessary" and "important." They are afforded prestige on this basis. A dependency between the patient and the nurse develops. This is similar to the mother-child relationship where emotional attachment is involved. In the above case, and in similar cases of sickness or death in a family, the student had developed an attachment and identified with an admired and socially desired model. Therefore, they choose nursing as their occupational role. Thereby they also can be "good," "necessary" and "important."

Crystallization

After I graduated I came to university.
Well, after I graduated from high school, I thought that I would go into nursing then, before that . . . I hadn't really thought about it from my childhood or anything like that. It sort of grew upon me.

. . . . . . . .

I went into nursing . . . well, because medicine is interesting and people are interesting and you learn at the same time as caring for people . . . oh, I don't know. Just people . . .

These statements are vague and show that the student is not really aware of a clear cut reason why she went into nursing. Certain values and norms are part of the personality. They are also compatible with those native to the nursing role. The student, however, is not aware of this and is placed in a position of frustration when she is expected to indicate a
preference for some occupational role.

Finally in such a situation of crisis, when pressure is applied to decide on an appropriate occupational role, the existence of these values and norms is forced into awareness. She finds that the nursing role is most suited to her, although she may not be able to identify reasons why this is so. I found that they have values of "liking people," of "helping others" and of "being of service," but had never thought of exercising these in the role of a nurse.

It's not something I wanted to do all my life . . . . I decided in one afternoon that I wanted to take it . . . . I was going through for a lab technician. And I wanted to major in Chemistry. I was studying Arts last year, you see . . . . and I didn't like it at all . . . . and I decided that this wasn't for me, so I decided to try nursing.

This quotation shows the existence of a value system which is similar to that found in nursing. Yet the student was not aware of the similarity and made another occupational choice. The role which had been chosen did not provide the necessary satisfactions and was, therefore, abandoned.

A Way Out -- and Into Nursing

It's something different from taking a B. A. and I wanted to be a doctor before . . . . and then I decided that it was too long and too involved, and nursing was the next best thing.

Many students implied that they did not initially want to be nurses, but as their first preferences had to be
cancelled for one reason or another, they had to resort to nursing as an alternative choice. It would be safe to assume that the taking and playing of the nursing role would prove a greater strain to students of this group than it would to students who "always wanted to be a nurse," or who became nurses "in mother's image." They have become nursing students simply because they could not take on another occupational role that they preferred. It seemed to me later in the study that these girls were more dissatisfied with their role than the others, and entertained more doubts about whether they were in the right profession or not. I felt that nursing to them was something "they had to take."

These modes of orientation show the kinds of reasons given and indicate the nature of the initial self-image. They are only valuable in showing that my subjects gave these reasons, and in suggesting that possibly all nursing students could be seen in terms of these orientations.

Strength of Wish for Nursing

In order to discover the strength of their wish to become nurses, the students were asked what other occupation they would consider, what was their ideal occupation and what opinions were held about nursing by parents and friends.

During the interview the students were presented with the problem of what occupational choice they would make if for
some reason they did not go through with nursing. Some answered with two possible alternatives. Laboratory technicians and social workers were the most frequent choices, followed by school teachers, physiotherapists, dietitians, secretaries, doctor's nurses, air stewardesses and academic professions, in that order. These answers indicate a marked preference for what could be traditionally termed "women's professions." They also show a continuing interest in the medical sub-culture, and in occupations involving "dealing with people."

Some respondents had a difficult time, on the whole, to think of a possible alternative. As one student put it:

I don't really know. That's the trouble with having one idea in mind, you just sort of automatically exclude everything else.

It is interesting to note that this student would be classified in the "mother's image" type of orientation. She had not considered other occupational roles and could not conceive of herself as not being a nurse. On the other hand a student who sees nursing as "a way out," gives this answer:

Well right now that was what I was wondering about, because I don't like nursing. I was thinking of Med, but . . . .

Of those who had no clearly defined alternative, two were oriented to nursing "in mother's image," one was of the "born to be a nurse" sub-type, one wanted to be a nurse because of traumatic experiences and one saw nursing as a means as well as a crystallization of her values.
The nature of the alternatives mentioned indicates, generally, that nursing was chosen initially because of its humanitarian values, because it is traditionally a woman's profession and because of its demands on altruism and service. It is also apparent by alternative choices that the medical subculture holds a fascination for the students. It should be remembered, however, that these are initial self-images and are liable to change with role-taking.

To find out if the students had any hidden desires for any other occupational role they were asked to imagine that they could change anything about themselves that they wished. They were then asked what occupational role they would choose. This, I assumed, would allow them to indicate their ideal or their model occupation. Their answers were:

<table>
<thead>
<tr>
<th>Ideal occupational choice</th>
<th>% choosing it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>40</td>
</tr>
<tr>
<td>Nursing</td>
<td>40</td>
</tr>
<tr>
<td>Creative occupations, e.g. painting, designing</td>
<td>10</td>
</tr>
</tbody>
</table>

Also mentioned were the field of philosophy, of commercial occupations and airline piloting. Thus there is an overwhelming majority in favour of the medical professions. It indicates that many nurses would have ideally preferred to have been doctors, if circumstances had been more favourable. It is interesting that 40 per cent of the students would still choose nursing, thus showing that these individuals had been able to "take on" their model occupational role.
I'd still do nursing. If I could change my sex I think I would be a doctor ... I don't know, it's just the only thing that appeals to me, and I can't really think of anything in the world happening that would really change my ideals.

Students were asked what their parents and friends thought of their choice of occupation. The answers showed that 85 per cent of the students believed that both parents were pleased with the choice, and 15 per cent indicated that there had been an initial dislike or desire to redirect their preference. A majority of the students claimed that either their feminine friends approved of their choice of role, or were nurses themselves. A few mentioned that their girl friends were of the opinion that "anyone can be a nurse," or could not "see why I wanted to be a nurse," or considered the pay too low and the work too hard. When their ideas on the opinions of men were asked, the answers were more varied. The majority believed that their male friends approved of the choice. Some indicated that their friends expressed no opinion, thought nursing a waste of ability, did not show partiality, or thought that nurses were cold, too specialized and limited in abilities. One student seemed somewhat uncertain of the attitudes of men:

It seems to have quite an effect on boys. They seem to prefer to take out nurses. When you say that you're going in for nursing, they sort of perk up.

On the whole, therefore, most students seem to have the support of friends and parents. Such approval undoubtedly
influences them to express stronger desires in becoming a nurse.

2. Role Anticipation

I suggest that the choice of an occupational role is accompanied by some kind of image of the future role and of oneself playing that role. Thus if an individual desires to take on a specific role, I assume that she has a pattern of thoughts as to what the playing of the role would mean. That is to say, I expect that student nurses, before embarking on their period of training, have some conception of what the functions of a nurse are, what kinds of behaviour would be expected from her, how they would fit into the hospital, and what kinds of rewards they could expect. I assume that they have some conception, however vague, of what the role-playing would involve. It is possible that they conjure up a picture of themselves as they would appear during different phases of the learning of the required skills and techniques, and as they would appear once they are fully accepted members of the group. It seems likely that they have fears and doubts about some of these phases and look forward eagerly to others. It has been pointed out how aspirants dreaded the training period believing that it was difficult. They found it much easier than they had expected.2

The function of public images in role-anticipation are pointed out by Morrison and Breed in other findings. They discovered that freshmen seem to anticipate with interest their work in the operating room, while at the same time they expressed doubts as to whether they would be capable and quick enough for the required tasks. The initial interest could arise out of a public image which conceives of the operating room nurse as the "glamour girl" of the profession, and hence as a desirable role. The extent by which role-anticipations are affected by public images, however, is a matter for future research.

As students become more familiar with the various details of their future profession, these anticipations may change. The images that the students had of themselves in the desired role when they made their choice of occupation, would differ from the self-images that would arise once they were involved in the taking and the playing of the role. They would become more familiar with the patterns of behaviour and the values of their role, and these would be gradually accepted and fitted into their personality. It could be said that the difference lies in the definitions of the two images. One could be termed "anticipation," and the other "interpretations of reality." Obviously there is a difference in the self-image

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where, on the one hand, a student pictures herself proudly standing at the elbow of a surgeon, skilfully and deftly handing him the correct instruments even before he has expressed his needs in words, and on the other hand the self-image of the girl that actually stands at his side, nervous, distraught, fumbling with the instruments and aware of the increasing impatience of the surgeon and the intense, accusing gaze of the instructress. Of course it is also possible that the student may have a pessimistic initial self-image, and later become an efficient, skilful operating room nurse.

Leaving aside the problem of the derivation of initial images, it should be pointed out that there is a difference between "anticipations" and "reality," as there is between the thoughts of handling an instrument and the actual handling of it. The former is in terms of abstract, immaterial concepts, the latter in terms of very concrete actions. The former is subject to control by the individual, who can, if he so pleases, change an unpleasant image to a pleasant one. The latter, however, is in a context where the image is controlled to a large extent by actors and objects outside of the individual. The individual has little control over "reality" over and above the control they have over their own behaviour in the context of this "reality." One is simple, in that the awareness of detail that arises with experience is absent; the other is complex in that the individual becomes increasingly involved with both the aspects of the work that he had anticipated and
with the details, of which he was not aware.

This chapter shall present the initial role-anticipations and self-images as they were revealed through questionnaire and through interview.

**Images of the Role**

Students were questioned early in their university training period about what they considered to be the characteristics of an ideal nurse. Above all they believed that a nurse should have the ability to get along with people. She should enjoy her work, have a pleasing personality, a neat appearance and the ability to follow orders and to have a command of the technical skills of the occupation. Of the qualities listed, they considered it least important that a nurse have scientific curiosity and a high level of intelligence. To be successful, they thought, a nurse should devote herself to the welfare of the patient without over-concern for the rules. The patient should be the centre of the nurse's interest. They believe that they, as nurses, should be overwhelmingly patient-oriented and not illness-oriented. That is, they thought that they should concern themselves with the patient, rather than with his illness. They were greatly in favour of a human relations approach, as opposed to an efficient, mechanical one. When, however, a problem of personal attachment to a patient was posed against her obligation towards other patients, the
students showed that they were faced with a conflicting situation. They were asked how they would behave if their mother was one of their patients and whether they would spend more time with her than with the others. They suggested that, although during their working hours they would not devote more time to her, they would spend time with her during off-duty hours. Some thought that they would explain the situation to the mother. Others would not like to have their mother as a patient at all and would ask to change wards or would let another nurse tend to her.

Students were aware of certain expectations directed towards them by others in the medical culture and by the public. As far as patients were concerned, all the subjects thought that patients expected them to have a sympathetic, personal attitude towards them, and to have feminine, almost motherly characteristics. Mechanical skill and efficiency was next in importance, followed by professional characteristics such as trustworthiness, reliability and authority. Intelligence and an ability to converse were also mentioned but were not considered as important.

A large majority of the subjects thought that the prime expectation of doctors was that nurses fill a subordinate status position, and hence be able to take and fulfill orders. Nurses should show deference, and generally be there for the doctors' convenience and to further their work with the patient.
Secondly they expect a nurse to be a technician and to have mechanical and nursing skills. A few thought that the doctor saw the nurse as a person, a co-worker, and placed importance on her personality and appearance. Still fewer students mentioned that the doctor expected the nurse to have professional characteristics. On the other hand they showed, in a great majority, that they believed the doctor saw them only as instruments for carrying out orders.

Their co-workers, other nurses in the hospital, they believed would, above all, expect them to be cooperative and to place emphasis on human relationships. They would expect them to show a humanistic approach to the patient and to be independent, to have initiative and to be endowed with professional characteristics such as trustworthiness and reliability. In other words, other nurses would expect them in future to stand on their own feet and to cooperate with them. Efficiency and the ability to perform mechanical feats were mentioned as being expected, but were not deemed as important as the other factors.

Before any contact with the hospital milieu, students thought that the hospital expected the nurse to have a technical, instrumental and efficient approach to the patient and to his illness. They wanted skill, neatness, cleanliness, an ability to give good nursing care with thoroughness, speed, and a full knowledge of what she was doing and why. It would also expect
them to maintain the structure and function of the organization by appropriate behaviour. They would have to be obedient and loyal; to know and follow the rules; to uphold the hospital's reputation of high standards; and to show pride in being a member of the institution. They would have to cooperate with others, to be dependable, respectful, and pleasant.

The non-medical community would also direct expectations towards them and have images of what a nursing role should be. Initial anticipations of students showed that they thought their family and friends placed the greatest emphasis on a personal, humanistic type of nursing care. Skills and efficiency were also thought important, followed by their expectation for the nursing student to retain individual qualities of friendliness, cheerfulness, and good grooming. At the same time they would be expected to assume the air of a professional being. Parents and friends would expect them to be responsible, intelligent, respected and to have high ideals. In this way the students thought they would be expected to advise, help and guide, not only patients, but their family as well.

Nursing initiates see the public as demanding a personal, human touch with patients, but, at the same time, the ability to give good, efficient care. They believe the public sees nurses as leaders in the community and as people who have a "good education." They are seen as being willing to serve others and as doing it in a skilful, reliable way. They want
a nurse to be sympathetic, pleasant and morally beyond reproach.

Character of Obligations

The first obligation of a nurse, as conceived by students at the beginning of their training period, is to give kindness and understanding to her patients. Next she must be skilful in her work. Less emphasis is placed on obedience to the head nurse, to hospital rules and to the expectations of the public. Their most important task, they believe, will be to give good, efficient physical care to the patient, and secondly to establish good relationships with him or her. When asked what they thought was least important, many answered that they thought everything was important, while others answered that routine jobs, which they would have to do, would be the least important. They expected to enjoy most their contacts with the patient and the "working with people" aspect of their role. Also they thought that they would enjoy making people comfortable, watching them recover, working with cheerful people and with children. In other words they expect to enjoy their work if their patients showed reciprocity. They also mentioned that they would enjoy learning new techniques and specialties. Least of all they would enjoy "dirty work," such as routine jobs and bedpans. This is obviously status-lowering and thus can easily be explained as not being enjoyable. They also point out that they would not expect to like patients who
do not reciprocate and hence give the nurse no satisfaction. In this context they mention patients with chronic complaints and patients with annoying habits. They also feel that they will not enjoy bookwork.

They have developed certain views of illness. They consider it a thing of bad luck, and a few see it as a thing of negligence. It is above all to be cured as quickly as possible. It is a thing which they should accept without fuss and from which they can learn. The greatest misfortune in illness they think would be shown in a case of nervous breakdown, cancer, tuberculosis, skin disease, and venereal disease, in that order. They all think patients are ashamed more of venereal disease than of any other complaint. This is followed to a lesser degree by their belief that patients are ashamed of skin disease and nervous breakdowns. Venereal disease, skin disease and stomach ulcers are, in that order, considered to be results of negligence. The most repulsive illnesses are, in the following order, skin diseases, venereal disease, cancer and asthma. It should be noted that students generally did not like to show discrimination among the illnesses listed, but were forced to do so by being asked to answer all the questions on the paper.

In their tasks they were also concerned with what they, as nurses, would be able to contribute to the welfare of the patient that the doctor could not. In the initial
self-image they thought that they would be able to contribute nursing skills and expertise, and other comforts resulting from their closer contact with the patient. They could administer to small physical needs and give "total nursing care." They feel that they, as nurses, would be able to give a more personal touch. Many mentioned that they thought this would be possible as they were women. On the other hand, they thought that the doctor, as a result of greater education and skill, could contribute his broader knowledge of medicine. He is in a position of authority, and the nurse is really a subordinate. When asked to estimate the indispensability of the other roles to the medical sub-culture, they thought that the doctors would be the most valuable, followed by nurses, dietitians, instructresses and student nurses. The least valuable were visitors and nurses' aides.

Rewards

When asked what they thought other nurses found most attractive about the profession, they mentioned security first, followed by the thought of being able to help others, and the idea that nursing is a profession suited to women. They were overwhelmingly in favour of the thought that other nurses were attracted by security. They themselves, however, thought that they had been attracted, firstly, by the opportunity to be altruistic and only secondly, by security. They project security on others, altruism on themselves. Nevertheless they think
that people are first attracted to nursing by the glamour of the work, the drama and the emergency. The motivation of service to others is also considered important, but by fewer students. Still fewer students think utilitarian reasons such as security and a practical preparation for marriage are considered as important.

On the other hand, however, they think nursing is a good profession for women because above all, it offers security and tenure. It has similarities to the role of a mother, and hence is practical for women, and a good preparation for marriage. "A woman can give good care and love to a patient -- she may approach 'motherliness'," wrote one student. Other reasons such as personal satisfaction, the opportunity to learn and to see reality, the chance to work with people, and the variety of the work were also given. Some suggested that women were "naturally" good nurses.

The chief reward of the role they thought would be personal satisfaction, chosen by a large majority over and above security, income and prestige. Income and prestige were not mentioned at all, while security was indicated in only three instances out of the possible forty.

Nursing, they thought, was not a very difficult profession to get into, and many thought it was "fairly easy." Most of the students thought that nurses were paid too little, or just enough. They felt that they were "not too well
prepared" for hospital experiences, or just "fairly well prepared."

Most girls showed a preference for nursing leading to a career as public health nurses. The next role chosen was that of a "nurse," closely followed by the role of "mother."

Status and prestige is also an occupational reward. The girls grouped themselves with the medical team, with women's professions, with traditional professions like medicine and law and with professions which work with people. Thereby they saw themselves in groups of occupations that enjoy prestige in the community.

**Strains**

Students were asked to write of what aspects of nursing they thought the general public was ignorant. They thought that the public did not see the side of nursing that lacked glamour and drama and that was hard work and monotony. They thought that the public was not aware of the training and education of a nurse and thereby tended to underestimate her. Some thought that the public was ignorant of the psychological care and the human approach given the patient. Nursing, some maintained, was not merely a dirty job. There was more to it. They thought that the public did not see the nurse as a part of the hospital, and thereby was ignorant of some aspects of her responsibilities and work.
When asked what professions they admired, the students answered, with the exception of only three people, that they admired medicine. This was followed by the mention of traditional professions like law and the clergy by fourteen people, and nursing by ten. Eleven students referred to the professions of their parents and the same number to educational professions, such as school and college teaching.

Relation to Others

Within the occupational world, prospective nurses grouped themselves most frequently with social workers. This was followed by doctors, psychologists, laboratory technicians, school teachers, engineers, lawyers and architects, in that order. Their reasons for these choices were given as being the similarity of the work, education and interests, as well as their professional status and their role in helping and working with people.

Within the medical sub-culture they especially looked forward to their work with other nurses. They also anticipated pleasantly their work with doctors. They thought that least of all they would like their work with medical interns, head nurses and orderlies. Many showed no anticipated dislikes.

They indicated that they would like to nurse in a semi-private ward, followed closely by a staff ward. Very few showed a preference for a private ward. There was also a
marked preference for the emergency unit, the operating room and pediatrics. Least of all they would like a mental hospital.

Illnesses that they would prefer to nurse are: surgical cases, children's diseases, illnesses where the patient recovers and is not suffering extremely, obstetrical cases and heart diseases.

Among patients they thought that they would prefer children. They would like to nurse cheerful patients, patients who are grateful and who follow orders. They dislike people who swear, who are obviously economically privileged and patients who cannot express themselves in English. They would find patients who constantly complain, and who tell them what to do, very disagreeable.

They mention that they had not given too much thought, on the whole, to the problem of getting too attached to patients, but they were fairly sure that they could deal with it. They had given no thought to the possibility of patients getting attached to them. They believed, however, that they could deal with the problem, but they did not show as great a degree of confidence at their ability to deal with this problem as they did with the first. On the other hand, they had given quite a lot of thought to the question of feeling the right amount of concern for patients and thought that they could deal with it.
Conclusions and Implications

The answers given by nursing initiates show a marked "other-oriented" interest. They are entirely patient-centered, and place the welfare of the patient above all their future responsibilities. This ability to help others they feel to be the greatest attraction of the nursing role. They imply that they, as women, are able to do this more effectively and to give the human, personal touch that is so important. Thus personal satisfaction in being "altruistic" or "other-oriented" is their greatest reward.

They show a disregard for rewards of the monetary and prestige type, but feel that they are not paid sufficiently for their obligations. In this way they conform to the norms of all professions, especially as professions claim a "service" ideal. Their reward comes through the status of association with the medical profession, a high-status position, and with their "altruistic" motives.

They expect to be rewarded by the reciprocity of patients. They like patients who depend on them; thus they like children, and patients who give them satisfaction by showing improvement and recovery. They want to be able to communicate with their patients, this being one form of satisfaction that they will expect.

Although they feel that they have public respect,
one strain of the role is that they believe the public is not aware of the full extent of their abilities and responsibilities. Hence they show a dislike for status-lowering tasks, such as bedpans, and bookwork.
CHAPTER VI

FROM PROBIE TO GRAD -- PROCESSES

Between the time when the student begins her probationary term and the time when she graduates, socialization into the nursing role occurs. Primarily this is concerned with the internalization of new norms. These are the norms characteristic of the nursing role; the sum total and organization of these norms distinguish nurses from other occupational groups.

The Norms of Nursing

Nursing offers a set of norms, both instrumental and expressive, which become part of the obligation of each student. These norms cover areas of performance and conduct.

1. Norms of Physical Performance. Nurses learn the techniques and procedures of nursing such as the giving of hypodermics and treatments, the correct way to change dressings and so on. How these are performed, in other words the expressive norms, are governed by values of optimum skill, accuracy and attention to minute details. For example in giving sterile dressings great care is given to the possible existence of germs and extra tasks are performed for the sake of
these invisible threats. Here skill, accuracy and attention to detail are emphasized as obligations, even though the need for them is understood, but not visible.

2. Norms of Institutional Behaviour. The nurse is expected to be obedient towards superiors, helpful with her equals and understanding towards her subordinates. At all times, a norm of cooperation governs her actions. Once in the hospital, she is introduced also to norms of loyalty towards those of the in-group, in other words the hospital personnel, and a norm of discretion about her knowledge of techniques and patients is enforced. Generally, the norm is that each individual nurse should feel it her responsibility to foster the good reputation of the hospital.

3. Norms of Behaviour towards Patients. The chief obligation of the nurse is to transfer a patient once more into a person. It is emphasized that she nurse the patient and not the sickness. She is expected to comprehend the patient's needs and to understand his point of view. At the same time she is told not to get involved.

It is important that she feel for her patient, not with him. Important she accept his condition despite her reaction . . . . If she feels with him, she would be exhausted at the end of the day.

Instrumentally her behaviour towards the patient must be oriented entirely towards the safety of the patient, and expressively her norm is to place the patient before all other interests.
Norms of Behaviour towards Colleagues. Once again, in her interaction with her equals, the norm of cooperation is stressed. She is expected to live harmoniously with others, to understand their problems, and to help them whenever possible. The norm is that any one individual is not to expect extra privileges or to be subjected to extra duties. In other words, they are to feel equal to their nursing colleagues, at least once they have become accepted members of the group.

Internalizing Nursing Norms

The norms of nursing are internalized through several processes. Some of these processes function manifestly, others function latently. Thus discipline is a process which is consciously imposed on students by the training school, while the function of rituals is of a more latent nature. This chapter shall deal with the processes by which instrumental and expressive knowledge is adopted and integrated.

Internalizing of Instrumental Norms

The student is taught basic nursing techniques at the beginning. Emphasis is placed on safety and accuracy as being the main criterion of worth in these instrumental aspects of her work. The anxiety that she appears to feel at the beginning about these unfamiliar tasks is reinforced by the telling of anecdotes by instructresses and other students of what could
follow if a nurse does not give attention to skill and accuracy. Her initial anxiety when she comes in contact with patients takes the form of doubting whether she can give bedbaths and whether she has the ability to rub a back correctly. By observing students, I noticed that this anxiety is lessened when her ability to perform these tasks is ensured by constant successful repetitions. When this knowledge is thus established by continuous repetition, accompanied by increasing confidence, anxiety and doubt are attached to newer and more difficult techniques. The end result is that nurses show little recollection of their initial doubt and anxiety and their tasks become part of their everyday actions, performed with the same self-assurance as cleaning their teeth.

The functions of anxiety could be seen in two ways — positive and negative. Anxiety functions in a positive manner to give extra impetus to processes of learning. The student devotes more energy towards being accurate and skilful if she feels anxious about her work. If, however, anxiety becomes too great, its functions become negative and the student may be inhibited in her learning. On the other hand, if anxiety disappears altogether, the student may become over-confident and thereby inefficient. Therefore, for anxiety to function efficiently it is maintained at a satisfactory level.
Internalizing of Expressive Norms

At first the expressive expectations of the nursing role are learnt in the same manner as the instrumental ones. They are transmitted as lecture-material or informally by instructresses and superiors. These norms appear to be learnt intellectually, but they do not become solidified as the norms of behaviour until their meaning becomes apparent in student nurse contacts with patients. Students may be taught the expectation that they direct all their activities towards the welfare of the patient, but they are not fully aware of what this implies until they begin their ward experiences and find that everything is oriented towards the patient.

Before long, students become aware of contradictions between the expressive aspects of their work and the instrumental requirements. On the one hand, they must carry out the prescribed techniques. These may often involve inflicting pain. On the other hand a prominent norm is the orientation towards curing pain. In other words, instrumentally they must cause pain, but expressively they must at all times try to alleviate pain. This conflict is overcome by rationalizing pain-giving as "medical treatment" and defining it as legitimate and necessary. At the same time they begin to ease their anxiety at inflicting pain, which they should instead be easing, by defining patients as cases rather than people.
You hear people talking about nurses being callous. Well, I find myself becoming like that. And I have to fight against it.

There is, therefore, a change in their expressive norms. In the beginning they saw patients as people and individuals, and their outlook was therefore "particularistic." Each patient was defined as an individual, as different from the patient in the next bed, and not to be treated by the nurse in a manner used for all patients. The problems of each patient were seen as special and as requiring the personal attention of the nurse. The students' continuing interaction with patients, however, begins to resemble an orientation to "patients" rather than to "people." They are less able to see the differences between patients and to define each one's problems as special. They become increasingly more "universalistic."

The Assessment of Learning

The learning of norms is evaluated objectively by examinations and subjectively by ward administrators in the form of ward reports. High marks are on occasions rewarded by prizes, and "good" ward reports bring praise. In theory this supposedly strengthens the wish to learn. Elevation to higher authority is another way by which learning is encouraged. If a junior passes her examinations she is rewarded by a promotion to the new status of intermediate. Probies perform subordinate tasks, such as carrying trays and running errands, with the promise that if they persist and perform well, both in the
instrumental and expressive aspects of their tasks, they will be rewarded by a new status.

Maintaining Student Interest

Training is a combination of routine, special events and changes to new specialties. Manifestly special events and changes to new wards are defined as the learning of new material. Latently they function to break the monotony of routine. With changes students show new interest. Thus a trip to the operating room is morale-boosting to students, relieving them from the routine of ward duties. At the same time it implies to the student that there are future areas of interest to which she is eligible if she learns the required material and endures the sameness of routine. Specialty training, such as pediatrics and obstetrics alternate between periods of ordinary medical or surgical ward experiences. In this way learning is encouraged and interest is reinforced.

The Nature and Function of Ritual in Training

Rituals and ceremonies traditionally mark the passage from one stage of training to another. Latently, they also function to confirm attitudes and to stimulate interest and learning in students. Oaths, vows and ceremonies appeal, not as much to the intellect, as to the emotions. Capping ceremonies, performed with lighted candles held high to the
singing of hymns such as "Take my Life and let it be, consecrated Lord to Thee . . ." function not only to imply that students have successfully passed their period of probation. They imply to students and to other participants that nursing is a sacred, devoted profession. Any doubts about nursing that may previously have occurred to students are dispelled. My subjects sometimes implied that they were very similar to maids or cleaning women, but during and after the ceremony the attitude was that the work of the nurse was somehow sacred and important.

It was a solemn crowd . . . but then capping is rather a sad occasion -- all those young girls dedicating their lives.

When students saw their profession in a light where it had greater prestige, it seemed to me that a greater security was gained, and original motivations to become nurses were renewed or strengthened.

Each rite de passage, whether it is capping, graduation or merely the change in uniform signifying an increased status, functions to confirm the students' abilities to perform more difficult tasks. They symbolize a transition to a higher status. They imply that training is not an evenly continuous process, but a disjointed one, where each stage is marked by abrupt beginnings and endings. One day, therefore, a student wears "blues" and a black band and is not permitted to insert lavine tubes. The next day she wears a white uniform and is allowed to insert lavine tubes.
Ceremonies function also as expressions of group solidarity. Graduation ceremonies, for instance, are attended by all the students in the school who are not "on duty." This is defined as a requirement. Under dramatic circumstances they are able to observe a large group of white-uniformed girls, to smell the scent of bunches of roses, to hear the Florence Nightingale pledge (see Appendix B) and to listen to the compliments and praise given to the graduates by outsiders. After such a ceremony the subjects of this thesis implied that they were "inspired to go straight home and study." The importance and the desirability of the nursing role is reinforced.

The Abnormal becomes the Normal

The medical sub-culture, characterized by urgency, concerns itself with life and death. These matters, in our society, are defined as somewhat abnormal, and matters about which the majority of individuals feel little responsibility. From the beginning students are taught to develop habits that are adapted to potential emergencies. Tours of the operating room are conducted on Sunday, implying that the importance of this emergency transcends even the sacredness of Sunday. Facts such as this play a significant part in indoctrinating the attitude towards emergency. As their instrumental skills develop, however, students become more competent in dealing with it. They become more aware that emergency is permanent and something could go wrong at any time. They begin to expect
emergencies as the normal course of events. Students cease running wildly down the corridor when Mrs. Smith turns blue or Mrs. Brown has a natural abortion. Alarm, which accompanies situations where individuals do not know how to react, disappears gradually. Students begin to learn that prompt, quiet action is the desired norm. Therefore, what is abnormal for society at large becomes normal for nurses.

A Process of Growing Up

We've become a lot more serious about things . . . you're quieter and I think you're a little older, and you think things through more clearly.

Students often claim that nursing has given them more self-confidence and a different outlook on life. They feel that they have an increasingly greater knowledge of life and, at the hospital, they are "closer to the very essence of life." Intermediate and senior students define the probies as "innocent little things" and reminisce how inadequate they themselves were and how little they knew. They claim that their knowledge of people has increased, together with their understanding of the illnesses which they are treating. They consider non-nursing students as immature and light-hearted in comparison. In this way they feel that nursing has helped them to "grow up."

This process of "growing up" could be understood in terms of the process of increasing responsibility. Students
are beginning to internalize norms where they subject what the self wants to do, to what the self must do. They have passed from stages where they, as children and adolescents, were protected to stages where they are responsible for giving increasingly greater degrees of protection to others. It seems likely that their association of nursing with a process of "growing up" stems from an internalized norm of responsibility towards others, which is part of their occupational role.

The Process of Disciplining

The internalizing of the new norms depends also on the disciplinary nature of the bureaucratic structure of the training setting. The required mode of behaviour, whether it is the correct procedure for dry dressings or the ability to tolerate all patients, is enforced. This is done until the students act in the required manner and until such behaviour has been accepted to the extent that deviations from it become matters of guilt. There is a distinct process of methodical training in obedience and the subjection of a student's individuality to hospital and nursing requirements. In this way they are taught the boundaries of their responsibilities, what they are allowed to do and what work must be left for the doctor. Individual action and decision are definitely discouraged. This type of training is rationalized by the nursing occupation as being "necessary" for the structure and function of the hospital. They ask: what would happen in an
emergency if a nurse stopped to query a doctor's decision and to suggest alternatives? Conformity to discipline is defined as "duty." Nonconformity, therefore, is defined as "not doing one's duty" and is subject to disapproval by superiors and by peers who have been successfully disciplined. Hence a student who has not followed orders is seen by her peers as "not doing her duty." Duty is, needless to say, a strong norm of the nursing group.

Disciplining, as I observed it, appeared almost militaristic. Obedience was emphasized. One lecturer commented on his own attitudes: "I never ask why, I just do it." The attitude is that students should not exercise personal criticisms or deviations.

You copy exactly what the doctor writes . . . you do not interpret his abbreviations, but copy them exactly . . . I know sometimes they are difficult to read, but you copy as close as you can to what it looks like.

At the beginning of their practical experiences, all their paper-work is checked. Each new procedure is first observed by the student, then she performs it under supervision, and only if she can do this appropriately, is she permitted to perform it alone.

There is an equalizing process which is similar to military discipline. The behaviour of students on a particular level of competence is expected to be predictable, and similar to that of other students on that level. Their responsibilities
are well-defined. Furthermore, their individuality is concealed by uniforms. Any deviation, such as hair on the collar, is immediately brought to the student's notice.

Unlike the army, however, nursing does not reject certain cultural norms. In other words, where the army encourages aggression, nursing retains the norms of gentleness, sympathy and helpfulness attributed to middle-class womanhood.

There tends to be a contradiction of norms. On the one hand, norms instilled by a process of militaristic discipline serve to emphasize such militaristic qualities as methodical performance of duties, heightened efficiency, and hostility between ranks. Thus nurses often refer to each other by surnames, show dislike for superiors and fall easily into a routine. This functions to increase efficiency and impersonality. On the other hand, their ability to give personal, individualistic care is limited by this very process. Thus if they have internalized the norm of "treating patients as individuals" and giving psychological care, they are liable to experience a conflict.

Discipline begins at the probie period. Probies feel, in comparison to more advanced students and graduate nurses, that they are the "scum of the place," or "the lowest of the low." Theoretically, this makes them submit easily to disciplinary measures. They feel subordinated and intimidated
sufficiently to refrain from asserting their charismatic qualities and their individuality.

The Process of Imitation and Identification

Each student has been taught the criterion of worth in nurses. She is thus able to evaluate the worth of each nurse with whom she comes in contact. Students admitted that they admired some nurse whom they considered to be a "good nurse." They commented on how she performed her tasks, her manner towards the patients and "how nice she is." They showed a desire to become and to act like her.

Empathy, as it occurs in identification and imitation, plays a major role in the inculcation of social values. Students are aware of values in nursing, but these values become solidified when they are able to observe and interact with those that have internalized these values and are defined as "good nurses."

Gee, did you see that tall girl? Did you see how fast she was?

On the other hand, "bad" nurses also function to reinforce positively the norms of nursing.

They are all graduates on that floor. No students. But everything is so sloppy, you don't feel proud of being a nurse. The patients call the head nurse "mother" and offer alcoholic refreshments to the nurses at the nursing station in the middle of the afternoon.
Students begin to identify with those nurses that they admire and attempt to act as they do. Role-taking and conformity to nursing norms and values is thereby stimulated. Individual deviations are somewhat controlled. A similarity and equality among nurses is also strengthened.

Unlearning the Old Norms

New norms are sometimes internalized at the expense of old ones. The old norms, if in disagreement with the new, are either suspended or changed. Nursing has its own norms and values, and often the persistence of old norms and learned habits can lead to strains in the nursing role. Consequently, if an individual is motivated to take on the nursing role, she must integrate or supplant her old norms with the new. An example of this is the two norms concerning death. The cultural definition is where death is regarded as sacred and condoned with the reverence given to the supernatural. Respect is shown for the dead and for the bodies of the dead. The medical subculture, however, defines death as a "natural" thing and nurses are expected to behave in accordance with this and to perform such tasks as washing the corpse in preparation for the morgue. In such a case, the old norm would have to be unlearned and replaced with the new.

Another example is the norm concerning pain.¹

Culturally, pain is defined as undesirable and inflicting pain is considered a symptom of an abnormal personality. In the course of performing their tasks, nursing students are often expected to inflict pain. Thus they must learn to define this abnormal symptom not only as normal, but even as desirable. The change was noticeable among the subjects of this thesis. When I first met them they were gasping in anxiety when other students, merely acting as patients in practice laboratory period, were rolled over in bed. Toward the end they were moving patients in great pain, giving hypodermics and doing dressings on gaping wounds -- all of which were painful, yet necessary, for the patient. One student described her reactions:

My first colostomy! I thought that I was going to pass out . . . I've never been squeamish in my life . . . but I find that when you have to do it yourself it is not as bad as standing and watching.

Students, for their own comfort, therefore have to learn to overcome their previous attitudes and to be able "to take it." At the beginning they rationalize for themselves that these unpleasant steps have to be taken for the benefit of the patient. The need to rationalize appeared to decrease with the increasing internalization of values that define "medical care" as important, necessary and the only way by which a cure can be attained. The old norm regarding the inflicting of pain is therefore unlearned.
Culturally learnt norms regarding knowledge of the body have also to be disregarded. Taboos on sexuality have to be modified. Students have to learn to care for the bodies of others, both male and female, without feeling the social norm which governs sexuality. New norms in which knowledge of the body is accompanied by disinterest have to be learnt. A student who had just begun to work in the urology operating room stated:

Well, if you had any modesty, you wouldn't have any once you get out of there.

Social secrecy on the processes of elimination and on the genito-urinary tract have to be unlearnt in a sub-culture where urine analysis and the recording of excretions are emphasized. Probies feel the embarrassment of listening to nursing conversations on such matters. They commented with some surprise that nurses stop to talk, while still holding a bed pan in their hand. Before very long, however, probies begin to discuss enemas at the breakfast table and stop to converse in the corridors themselves, when on their way to the hopper room.

These rejections of social norms in favour of nursing norms go through a period of conflict, where the individual is still guided by the persistence of learned habits. As nursing norms begin to win out, however, and become accepted and increasingly defined as the desired norms, nursing students find it increasingly more difficult to identify with outsiders and there is a widening gap of common experience between them.
Increasing Group Solidarity -- Peer Group Pressures and Conflicts

The processes involved in the internalization of norms, such as the rituals, the identification, the discipline and the loss of social norms for nursing norms serve another function. The ability of students to identify with outsiders diminishes. The training setting, the residence life and the sub-cultural isolation aid this process and strengthen the solidarity of the nursing group. I found that my subjects became aware of the existence of common experiences, problems and understanding. Each member of the group identified herself with the others and was able to empathize with them.

Isolated as they are by the prescribed method of training, they identify with the people with whom they interact. This undoubtedly makes the internalization of the necessary norms much easier. This identification with each other is simplified by the fact that most students admit that the majority of their friends are also nursing students or are in their nursing class. Frequent close contacts further stimulate these friendships, and encourage the making of more friends in the nursing class. Thus not only frequent interaction and peer group pressures, but also friendships, lead to the reinforcement and transmission of attitudes.
Nursing Group "Ethnocentricity"

The nursing class develops an "ethnocentric" attitude. Individuals outside the group are referred to as "they," and this extends to non-medical people, to personnel in the hospital, to other nurses and even to other student nurses. Efforts are made to keep outsiders out. In the class studied this was done by turning the conversation to common experiences, such as university life, in which other nursing classes could not participate. Intra-group antagonism develops. This is especially evident between the university-program nurses and the hospital program nurses. The extent of this hostility has been mentioned.

There is some friction. You have to go more than 50 per cent of the way to be friendly. They think you are university girls, you know, rich, snobbish and so on . . . .

Yet although nursing norms demand friendship between the two groups, few close friends are made with students in other classes. Role-taking, therefore, is enforced by both inter-group interaction and intra-group conflict.

Each group develops its own system of sanctions and norms, and this system of morality is defined as "good." University students valued initiative and complained more about their loss of individuality, than did the hospital nursing students. They also value the nature of university lectures and consider the hospital lectures to be somewhat simpler.
Each group has its own myths. Foreknowledge of a matron or instructress is the property of a student before she comes into personal contact with her. One student, following a situation of conflict with an instructress, transmits to the others that this instructress has a little animosity for university trained nurses. Members of the group now know how to react with the instructress in question and what to expect from her.

Similarly each group has its own cues and signs. They have warnings for the approach of matrons; they cast meaningful glances at each other during significant situations; they cease talking or quickly change the topic of conversation on the approach of an outsider. These are all cues and signs to keep outsiders out. There are also signs used within the group in relation to each other. Thus open doorways signify that the student desires others to come in and converse, whereas closed doors indicate a desire for privacy.

Acceptance as a member of a social group implies that the individual has psychological support. Tension is released by complaining to members of the group, who are considered to understand because of their ability to identify and empathize. The group also attempts controls in that it reacts negatively against departure from in-group ways. Thus group members who do not help others on the ward situation become outcasts and subject to group disfavour.
The Secret Cult of Nursing

Once they become nursing students, girls become aware of two distinct groups: the members of the nursing group and outsiders. Within the nursing group students also become members of smaller groups, such as the group of student nurses, the group of degree-program nurses and finally the particular nursing class. This nursing class could in its turn be divided into friendship groups.

The nursing group has many of the characteristics of a secret cult. Prospective members are selected or rejected on the basis of a set of criteria controlled by the group, and alterable only by members of the group. Their progress, personality reports, medical examinations, exam marks, and letters are filed for future reference. Interviews with the student are recorded and their personalities are evaluated. Thus the occupational group is in possession of complete knowledge regarding aspirants. It keeps a constant watch on those that are accepted and rejects those that do not qualify for professional standards.

Language

Students begin gradually to acquire the characteristics of the "secret cult." They begin to use the distinct language that is assigned to their group. They talk of colostomies, trichyotomies and gastro-intestinal
nourishments. They refer to the operating room as the "O. R.," to the pediatric department as "Peds" and to temperature, pulse and respiration as "T. P. R." These words signify their acquired level of knowledge and of competence. They also function to keep outsiders out. At the same time they stimulate subordinates who have as yet not learnt certain aspects of the language and cannot participate in conversation, to learn the language more fully. The use of a common language, therefore, also stimulates the internalization of group norms.

Acceptance through Rites de Passage

A probie, when accepted as an aspirant and as worthy of assuming the status of a member of the "cult," assumes the status of "nurse" to outsiders while to the occupational group she is still on trial, and defined as "student." Prior to acceptance in the group she has to perform appropriately and to pass the tests set by the members. Then after rites de passage and rituals of initiation, such as capping and graduation, she becomes a fully-fledged member of the group. Until that time she maintains a subordinate status and shows respect to accepted members, by obeying their orders.

Once accepted they guard their knowledge and gain prestige by being in possession of mysterious methods of controlling life and death. They feel moral indignation towards unqualified people performing nursing duties. They
keep a barrier between themselves and those unqualified.

Widening Gap from Outsiders

Accompanying increasing group solidarity and increasing acceptance into the occupational group, there is a decreasing ability to partake in the experiences of outsiders. Many of the cultural norms have been rejected and outsider interaction, because of lack of time or interest, has come to a minimum. The students' knowledge becomes more specialized and there is a widening distance between a student nurse and her patient in knowledge of what can be done for the welfare of the patient. There is an inability to feel comfortable in the presence of outsiders; this leads to feelings of inadequacy when with these outsiders.

Once you get past the stage of "Hi! How are you? What's new?" you're stuck, because you've got nothing to talk about.

Therefore nurses find that they are both more knowledgeable than outsiders and yet less knowledgeable. In other words they legitimately claim a greater knowledge of the subject matter of nursing; to this they add their varying contacts "with all kinds of people." On the other hand, however, they complain that their knowledge of non-nursing matters is meagre and causes them to feel isolated in non-nursing groups.
Increasing Institutionalization

Mention should be made of the context within which these processes occur. The context is the hospital, an institution, consisting of roles interacting for a well-defined purpose -- the curing of illness. This institution has all the aspects of the medical sub-culture, such as the norms, the values, the techniques, the personnel and so on.

The hospital could be considered to be the main socializer, and in this milieu the student is slowly converted into the required image of a nurse. Communication with this institutional socializer, together with the processes of discipline, imitation, increasing group solidarity and norm internalization, which all operate within this context, bring this image into effect. The manifest function of being in the institutional milieu is the development of nurses from students. The latent function is that the development of nurses, as well as other institutional processes, serves to perpetuate the existing nature of the institution.

Initial entrance into the hospital plays a large part in changing the self-images of students. I found that at the university the self-images of student nurses involved the interaction between doctors, patients, and themselves as nurses. Once in the hospital, however, they become aware of hospital costs, of the need for service, the importance of knowing rules,
and of the fact that the hospital is also concerned with numerous roles above those of doctors, nurses and patients. The simplified image which they had at university becomes enlarged by contact with the "reality" of the context.

I would say that you don't learn anything really until you're in the hospital and faced with the practical situation.

They become involved with norms of which they were only vaguely aware. Firstly the norm of filling a position on a hierarchy, where obedience is the major expectation. They become aware of the waning of individual importance, the discouragement of initiative and the growth of quick obedience. Obedience is uniform and is achieved by appeals to nursing norms and ethics with regard to fulfillment of duty. Duty comes to include strict obedience and the display of respect for those higher on the hierarchy. The individualist is a deviant, not only in the institutional sense, but also a violator of nursing norms. Institutional expectations and nursing norms, therefore, support each other.

We have to do it, the doctor ordered it. We are going to do it.

This comment was made with regard to the giving of a skin preparation to a patient, who needed an operation, but was quite strongly against both the operation and the "skin prep." Obedience is defined as duty, and in this case, this institutional norm of obedience replaces loyalty to people as individuals.
Secondly, they become aware of a process of depersonalization. Their personal feelings and opinions are not condoned. This impersonality is maintained, on the superficial level, by the insistence on the formal, impersonal form of address: Miss Brown. Boundaries are placed on the nature of the personal objects permitted in residence rooms. Matrons, therefore, regularly check rooms for indications of such articles; and magazine racks and potted plants are removed. Students are not encouraged to visit patients, especially never in visiting hours. Emphasis is placed on the maintenance of hospital supplies, that the corners of the bed are neat, that the casters are turned in and that the thermometer water is changed. They are taught to use the word "appears" in reports, because "who are you to know" whether this is fact or merely hypothesis. Students in reports, therefore, write statements like the following: "The patient appears to be disoriented." Individual deviations from these institutional rules are open to reprimand. All of these undoubtedly serve to perpetuate the state of the hospital that is in existence. There appears to be a tendency that while becoming more institutionalized, more professional and more familiar with the role of the nurse, there seems to be an increasing indication that nurses become less individualistic, less personal and less creative.

The third norm is the engendering of a feeling of equality that accompanies the loss of identity and the taking
of a position on the hierarchy. Their dislike of authority is eased by the support received from their equals. This feeling of sameness is generated by a system of institutional isolation where all associations are limited to one's peers. The private life of all student nurses becomes an institutional responsibility. Their free time is divided by the institution into what must be spent in the residence and what can be spent outside. A head nurse at any time can telephone the residence and enquire from a student why she is late for work. Students, even on time off, can be reached at any time, as they leave the telephone numbers of the places where they "sleep out." Students have a common bond in sharing the image of being "confined."

Students become gradually accustomed to these norms in the same way as they become accustomed to the physical structure of the hospital. For instance, they find it hard to sleep when they first enter the hospital. Ambulance sirens and crying children keep them awake. Before long, however, these cease to affect them. In a similar way they become accustomed to norms of obedience, impersonality, equality and subjection to authority.
CHAPTER VII

FROM PROBIE TO GRAD -- PHASES, CHANGES AND TYPOLOGY

This chapter shall follow the process by which a probationary student changes into a graduate. It could be seen from three perspectives. 1) Certain changes, whether in the training setting or in student attitude, permitted the division of the whole continuous process into easily definable phases. 2) Questionnaires and interviews provided data on concrete changes that occurred in the attitudes of students. These will be discussed and illustrated by the use of tables. 3) During the socialization process certain distinctive types of nurses seemed to evolve. Therefore, a typology of nurses will be suggested. It should be stated that because of the limitations of my data in this area, the typology will be merely a proposition.

Phases

There are two ways of dividing the process of role-taking into phases: firstly, as it is seen by the subjects of the study and secondly, as I see it.

The students studied were asked how they visualized their training period, and whether they would suggest any dividing lines or stages. All the students made clear
distinctions between the theoretical and the practical parts of their learning. One stated simply: "Just divide it into two, I guess. The theory at university and the practical here." It should also be considered significant that not one student mentioned the hospital divisions of "probie," junior, intermediate and senior. The phases of theory and practice were the most distinguishable.

On the other hand, I see the process of role-taking in four phases: 1) the theoretical preparation, which occurs at the university and in early hospital lectures; 2) the first practical experiences, where students have their preliminary contacts with hospital and patients; 3) a reality shock, where students find that role-anticipation, and previous role-playing, does not always correspond to the new role-playing; 4) a pattern of routine, setting in after the period of initial disillusionment. The two phases referred to by the students correspond to phases one and two of my scheme.

1. **Theoretical Preparation**

The theoretical university period is characterized by teaching and discussion. The subject matter is the presentation of an idealized view of the medical sub-culture. Instrumental knowledge is transmitted as theoretical material, and the application of this knowledge is taught by asking the students to "pretend." Enemas are given to Mrs. Chase with
the use of a beer bottle, or a mustard plaster is applied to her arm. Students themselves pose as patients and thereby have some indication of how it feels to be a patient. Expressive knowledge is also taught. They are made aware of the culturally prescribed behaviour, and are placed under the obligation to adopt it.

During their initial preparation students are in the university culture and subject to its norms. They are inspired to be charismatic, and to show initiative. They are expected to evaluate and criticize all the material that is presented to them, and questioning and discussion are encouraged. Emphasis is placed on each as being an individual, and non-conformity is approved and considered creative. Within this environment they have their introduction to nursing.

A source of strain to the students at this stage is the lack of a means to apply this purely theoretical type of knowledge. They feel that being members of an occupation, which is characterized by action, they should have more "practice" and thus prepare themselves for the different calibre of training that they know they will be given at the hospital. There is a general impatience with theory and a failure to see its connection to the work they will be doing. They feel that they are "not doing anything" and query how the theoretical training they are having is concerned with "doing nursing."
I don't think we have enough practical work. I think we have too much theory. There is too much to absorb and you cannot put it to use all at once. And it just seems as if what you are learning is going to waste. If you could practice the procedures and the principles as you go along a bit more . . . like if you had more trips down to the hospital. I know that would be difficult to arrange. We just go down twice to work with actual patients. If you could go down more times, it would be better.

They indicate a fear that they will come to the practical phase and not have the ability to carry out their tasks. They complain that as they are nursing students they should be learning "nursing." They feel that in their position they are neither university students, as they feel isolated both physically and academically from other students, nor nursing students, as their work involves academic courses and not nursing.

2. First Practical Experiences

The second phase begins with the students' entry into the hospital, and into residence life. They move into the context in which they will play their future role. This is the "real" situation as they see it. They are now in a position, they are told, to apply the theoretical knowledge that they acquired in the first phase. What was taught to them at the university is reinforced in hospital lectures.
Whereas in the first phase much emphasis was put on instrumental norms, expressive norms are now more forcefully confirmed through ritual and discipline. They participate in and observe ceremonies performed in candlelight. They take vows and oaths of dedication. They are emotionally impressed with the sacredness of these acts, and with belonging to the group. The meaning of nursing becomes more significant and is filled with added importance. They begin to feel a greater desire to be like other nurses. Thereby the commitment to nursing norms becomes easier, and the students begin to fit into the medical sub-culture.

For the first time, nursing services are required from them, and they begin to be defined, not only as students, but also as workers. They are no longer learning about ward duties -- they are performing them. A new set of expectations, therefore, is imposed on them.

They now have to contend with the institution and with other roles therein. There is an eagerness to learn new duties and to progress to a higher level on the hierarchy. They feel that they are the least knowledgeable of all the students and try to conceal their ignorance. They have an anxiety about wasting hospital equipment, and feelings of guilt about taking coffee breaks when the ward is busy. They are uncertain of how to behave in the presence of superiors and of older students.
Their major concern in the new phase is their interaction with the patient. They begin by showing great concern for the patient's condition and by identifying with him in his discomfort. They show preferences for patients who are improving, or who are well enough to respond to them. There is much concern at first for the patient's privacy and a tendency to define their obligations towards him in terms of his role of "patient" in the medical sub-culture. They find they are not prepared to perform many of the unexpected duties that fall to their lot. One instructress commented: "Doing little things for the patient is the hardest thing to put across at first."

The attitudes of the students at this stage of their training could be looked at in terms of Parsons' "pattern variables." He analysed the professional role as achievement-oriented, universalistic, functionally specific, affectively neutral and collectivity-oriented.¹ In other words he suggests that a professional role is achieved, as opposed to ascribed; that it is oriented towards a client or a patient in terms of their specific role as such, rather than in terms of the organization of the many roles that they play; that the duties of the professional are confined to the specific area of his profession; that the professional does not develop an emotional attachment to his client or patient, but remains affectively

¹ Parsons, The Social System, p. 454.
neutral; and finally, that a professional person is altruistic and interested in a collectivity rather than in self-gratification. (These suggestions of Parsons have been paraphrased more fully and with reference to the role of a doctor in a preceding chapter.) With this scheme in mind, it could be said that at the time of phase two, the student is affectively-oriented, for she tends to develop a personal concern for her patient. She is particularistic as she interests herself in as many aspects of the patient as possible, and not merely in his illness. She is functionally specific in that she is too inexperienced and unsure of her tasks and the boundaries of these tasks to perform small duties such as "doing little things for the patient."

Operating simultaneously, or immediately after their first practical experience, the students feel some anxiety. The gap between phases one and two is so great that this anxiety occurs. In other words, role-anticipation differs from actual role-playing. This could be called a "reality shock."

3. **Reality Shock**

I remember thinking you go right in and everything's right there. An ideal situation. And you find out it isn't.

---

2 Cf. ante pp. 21-23.
Reality is something outside of the self to which the self must adjust. Prior to coming into contact with reality the self entertains images of what reality would be like. The effect is disillusioning when initial expectations are frustrated or dissolved on meeting the demands of the real situation. The reality shock, therefore, is the result of a discrepancy between phase one and phase two. It is also the result of a discrepancy between previous role-playing and the new role-playing. Reality shocks are incurred in the following:

Overcoming Old Norms

When students come into contact with the practical aspects of their training, some of their old norms have to be unlearned or modified. Whereas the university fostered charisma and individuality, the hospital tends to frown on these and to consider them dysfunctional. Instead precise obedience is rewarded, and equalizing, depersonalizing processes are instigated. Students begin to feel the influence of these processes, together with the growing knowledge that they are unable to do anything about this. This change from one extreme to another takes the form of a shock.

As I have already pointed out, they have to overcome such social norms as the norm governing attitudes towards death, towards inflicting pain and towards contacts with the human body. They have also been unprepared for such factors
as objectionable smells, to which they are forced to accustom
themselves. Also, they were not aware of the strains that
would occur during operations, when a person is converted into
a nondescript combination of arteries, muscles, flesh and bone.
They experience great anxiety when in contact with amputated
limbs. These remind them of previous social norms where such
a limb is "part of a person," and any separation from the
totality is a matter of horror. There is, therefore, a
sensation of shock when a student has to overcome previously
internalized social norms.

Imperfections of Institutional Life

As far as the hospital is concerned, students are
disillusioned in finding that often institutional rules do not
make sense. They query why in the case of an emergency they
should phone the supervisor who will then summon the intern.
They ask why both could not be summoned at once, thereby saving
time. They are surprised at finding that routine, which has
long become traditional, is still maintained, even though it
has become dysfunctional. For instance, they do not see why
they should use a clamp in giving enemas, when they can do it
just as well without.

Because of the constant reference that was made to
them, I gather that students were not prepared for what they
began to define as shortcomings on the part of the hospital.
They were shocked to discover that there is a shortage of supplies in the hospital, and that an individual on the operating table has to be "sewed up" because a lack of blood supply does not permit the required operation to be performed. Contrary to expectations, they find that they are not able to leave duty at the correct time, or are forced to do without coffee-breaks because a shortage of personnel places extra demands upon them. They are also unprepared to find that many graduate nurses do not conform to nursing norms and perform acts of unkindness, of indifference to patients, or are inefficient in nursing techniques.

Contradictions to Previous Learning in Nursing

Students find that what they were taught in phase one of their training is often disregarded in phase two. For example, they were told that patients with staphylococcus aureus boils should be segregated, yet they find them wandering in the ward corridors. Students were taught that when giving back rubs, they should always rub hard, yet they find that this has to be adapted to the individual patient, as often patients object. They may find that they are forced to finish a man's bath, when they had been told, during their theoretical training, that this would not be expected from them. They were told to take their problems to instructresses, but in reality they may be afraid of them, and feel that they are not able to please
them with their work. Hence, they are discouraged from approaching them with problems. Such contradictions place them in a position of conflict, where they do not know which course to adopt.

In addition to such obvious contradictions in technique and the performance of nursing duties, there is a feeling that prevails that there is little connection between the theoretical training and its practical counterpart. Students often mentioned that they were unable to apply the theory that they learnt, and in fact gave no thought to it during the various aspects of their work. At the same time they felt they should be using this theory in their work. One student emphasized:

There's no similarity between what we learnt at Varsity and what we're doing here. It's a completely different stage.

Feelings of Inadequacy

At one time or another all my subjects indicated the presence of feelings of inadequacy, whether they are the result of frustrated self-images, which had consisted of images of the student ably and promptly carrying out her duties, or whether they are the result of mistakes or the lack of knowledge. They claim, for example, that although they knew the work of a nurse was "hard," they had not been able to realize just how "hard." They complain of aching arms, tired
feet and backs, and "housework" hands. They find that bed-making is not as easy as they had thought, especially when there is a "live" patient in it. They find that on giving the wrong thermometer to a patient, they are faced with the humiliation of being corrected by the patient. They had not been prepared for the possibility of well-informed patients, and the controls that could be exercised from this area.

They find that often their knowledge is inadequate. They begin work in Pediatrics and realize that they are not able to change diapers, and, in fact, find that they are not able to perform many of the basic duties that non-nursing people can perform. Or, during their first weeks in the hospital they are faced with the emergency of a natural abortion, and are asked to take charge. They have never, however, learnt or observed the correct procedure.

Not only do they feel inadequate within the context of the hospital, but there is an increasing feeling of inadequacy with the non-medical culture. They find that they are isolated and are not able to talk of anything but nursing. Consequently, they complain that they often feel ousted in non-nursing groups.

Routine Replaces Drama and Glamour

Changes in self-images often lead to reality shocks. Many students imply that they had seen the nursing role as
socially desirable for it was ideally feminine, somewhat
glamourous, mysterious and self-sacrificing. They find,
however, that many symbols of femininity are disguised behind
such equalizing, militaristic fronts as uniforms and short hair.
They invariably indicated that they pictured themselves,
glamourously attired in white, bending over ailing patients.
They realize, however, that they perform this task seldom, but
most of their time goes into tasks that involve treating the
patient, often in an unpleasant manner, cleaning up "messes"
and charting. They even find that often their work is of such
a nature that it has little relevance to nursing and seems
unnecessary.

The DK is fine for one week, but after five,
it's terrible . . . I don't think we should
go down to the DK. That's one part of the
training that isn't necessary.

They feel they are violating the image that defines their
occupation as "important." This feeling arises very strongly
when they are in the diet kitchen putting butter and sprigs of
parsley on the potatoes on patients' plates.

Therefore, what was once dramatic, glamourous and
attractive because of its abnormality, becomes normal and a
part of every day's work. The monotony of routine, which had
not been part of the role-anticipation, sets in and a persistent
feeling of disillusionment occurs.
Feeling of Depersonalization

Students indicate that they feel a loss of freedom, a loss of responsibility for directing their own lives and a loss of ability to control their development into an image which is often distasteful to them. They feel restricted in their behaviour in not being able to partake of outside activities, in being isolated into the company of other nurses and in living in residence; they begin to feel exploited as institutional scapegoats, when they think both superiors and patients often "take it out on them"; they think that working in the diet kitchen serves the function of removing them from what is "important" and what is the work of a nurse; they have heard of callous nurses and have intended to prevent themselves from becoming so, yet they feel that they are becoming increasingly so, and are unable to control the process. This process of depersonalization is met with defeatist attitudes on the part of the students. They recognize its presence, but can do nothing to stop it.

Reality shocks, therefore, arise from two sources: 1) the discrepancy between what students expected and role-playing as it actually exists; 2) contradictions to previous role-playing. Reference to reality shocks is not meant to imply that I have resorted to the hypothesis that "reality" is unpleasant. Future chapters will indicate that contact with "reality" can also be an experience of satisfaction, as well
as an experience of strain.

4. Acceptance and Routine

Phase four is the result of the adjustment between phase one, two and three. This adjustment, I observed, took the form of alternating between sincerity and cynicism, between satisfaction and depression. The tenseness and anxiety which arises when the students come in contact with the practical situation is quelled by acceptance of the circumstances as they exist. The result is the formation of appropriate habits of conduct to cope with the existing state of role-playing. Finally, routine is established.

In the beginning, the only reason that students gave for their leaving nursing was failure to meet the required standards. This changes to a question of "do I really want this?" and the doubt whether some other role would have been more appropriate. They indicate, however, that it is too late to withdraw. The initial desire of students to be successful nurses is replaced by a resignation to the existing state of performance.

I think I'm losing my initiative. I never really exert myself to do anything. You get to the point where you can't be bothered to do anything.

There seems to be a decreasing ability to experience contentment with their work, and there is little evidence of the feelings of optimism that occurred in the beginning.
The curiosity for the abnormality of illness has passed through practical experience and reality shocks to where it becomes normal, everyday and routine. "Probies," when they first went to the hospital, had serious attitudes towards their duties; this changes to the less serious attitudes of intermediates, who are able to joke about their work. An example of this difference in attitude occurred at the party given by intermediates for the "probies." A skit, ridiculing hospital personnel, nursing techniques and patients, was created for the "probies" by the older students. The latter were often amused by the dialogue or actions of the actresses, while the former remained unmoved and somewhat surprised at the attitude presented to them. "Probies" also regard nursing as fascinating and boast about it being "hard work." Aching limbs are referred to as if they were indications of self-sacrifice. This changes to complaints about genuine fatigue, with no indications of pride. Work proves to be, not the reward that they estimated in phase one, but rather a punishment. They no longer feel guilty about taking coffee breaks, but grumble when this is not possible.

They become more competent in organizing time and in performing procedures. They manipulate prescribed methods of performance by adapting them to their own use.
I think that most of us after we know the basic procedure will go ahead. We know that a certain 1, 2, 3, 4, 5 is the way it's written in the book, but we do it 1, 2, 4, 3, 5 because it fits better.

Students gradually begin to lose their ability to identify with patients, and this they often interpret as a process of becoming callous. They are becoming more affectively neutral. They become less concerned with the patient's individuality, and more concerned with defining them as "patients," and in converting them into "people." When a patient begins to respond to treatment and to improve they refuse to perform tasks that they would for "patients." One student remarked: "I see no earthly reason why she cannot wash her own back . . . if she complains once more I'll scream." Thus they are becoming more universalistic. Their tasks also are becoming more diffuse, because they become aware that they are expected to perform such duties as buying cigarettes and candy or listening to personal problems. Students then become affectively-neutral, particularistic and functionally diffuse, all of which, with the exception of the last, correspond to Parsons' criteria for professionalism. Therefore, phase four could also be referred to as the phase where role-playing takes on professional characteristics.
Changes

The students studied were given a questionnaire prior to their entry into the hospital as probies, the results of this questionnaire being designed to indicate beginning self-images and role-anticipations. They were questioned again after they had experienced phases two and three of their training. The differences between the two questionnaires is an indication of the change that had occurred. In order to give a systematic view of the results, I shall use my five-variable scheme for occupational analysis.3

Images of the Role

Students were asked what they thought attracted people to nursing. At first they thought that people were attracted primarily by the drama, the glamour and the urgency of the profession. This was followed by a desire to help others, and then by utilitarian reasons such as security and an ability to prepare for marriage. At the second time, when they were asked they implied that helping others was the most important, followed by the glamorous aspects of the work.

The importance of a favourable public image and the function

3 These results shall be examined in more detail in the joint report written with Dr. K. D. Naegele, for the Koerner Foundation.
of curiosity have taken a rise in importance, while utilitarian reasons have diminished.

Characteristics Which Became More Important

<table>
<thead>
<tr>
<th>Role Characteristic</th>
<th>% Who Considered It Important</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Time 1)</td>
</tr>
<tr>
<td>Favourable public image, prestige</td>
<td>13</td>
</tr>
<tr>
<td>Curiosity</td>
<td>5</td>
</tr>
</tbody>
</table>

Characteristics Which Became Less Important

<table>
<thead>
<tr>
<th>Role Characteristic</th>
<th>% Who Considered It Important</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Time 1)</td>
</tr>
<tr>
<td>Drama, glamour, urgency</td>
<td>51</td>
</tr>
<tr>
<td>Being able to help others</td>
<td>46</td>
</tr>
<tr>
<td>Utilitarian, security etc.</td>
<td>38</td>
</tr>
</tbody>
</table>

This shift from images which show the students as being attracted by egocentric reasons such as glamour and security are diminishing and being replaced by other-oriented reasons. This leads to the suggestion that nursing norms of devoting one's energies and loyalties to the patient are being increasingly internalized.

Increasing commitment to hospital norms becomes apparent when students were asked what they thought the public expected from a nurse. Emphasis on skill and efficiency increased, while attributes of individuality and femininity decrease. The prime expectation of personalized, humanitarian care retains its importance. Institutional demands were also brought out, in the second instance, to a greater degree when students were asked what they thought their family and friends expected from nurses. Professional attitudes became more important. On the
other hand, however, they thought that their family would also expect them to retain their individuality. This became more emphasized at the time of the second questionnaire, when contact with the medical sub-culture occurred.

<table>
<thead>
<tr>
<th>Characteristics Expected</th>
<th>% Who Considered It Important</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Time 1)</td>
</tr>
<tr>
<td>Personal, humanitarian care</td>
<td>66</td>
</tr>
<tr>
<td>Mechanical skill &amp; efficiency</td>
<td>62</td>
</tr>
<tr>
<td>Nurse as Individual</td>
<td>49</td>
</tr>
<tr>
<td>Professional attitudes</td>
<td>41</td>
</tr>
<tr>
<td>Ability to help own family</td>
<td>21</td>
</tr>
<tr>
<td>Desirable institutional qualities</td>
<td>18</td>
</tr>
</tbody>
</table>

This suggests that students may indicate their family's desire for their individuality as a result of their own feelings of strain, occurring as a result of the depersonalizing process of role-taking.

Character of Obligations

In answer to a question which asks what a nurse can contribute to the welfare of a patient that a doctor cannot, there was an overwhelming majority in favour of efficient, scientific nursing care in the first instance. This was not considered so important in the second instance.

<table>
<thead>
<tr>
<th>Exclusive Contributions of Nurse</th>
<th>% Who Considered It Important</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Time 1)</td>
</tr>
<tr>
<td>Technical nursing skills</td>
<td>80</td>
</tr>
<tr>
<td>Psychological care</td>
<td>59</td>
</tr>
</tbody>
</table>

This decline in the importance of the technical care given by
the nurse indicates a source of strain when the nurse feels marginal to the doctor. It also implies a tendency on the part of probies before entrance to the hospital to define illness in terms of physical and not mental abnormality.

Students were asked for their opinion of what made a successful nurse. The answers were as follows:

<table>
<thead>
<tr>
<th>Form of Behaviour</th>
<th>% Who Considered It Important (Time 1)</th>
<th>% Who Considered It Important (Time 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devoting oneself to the welfare of the patient without over-concern for the rules</td>
<td>77</td>
<td>66</td>
</tr>
<tr>
<td>Carrying out the orders of superiors at all events</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>Obeying strictly the rules of the hospital</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

These figures show a distinct awareness of the institution and its expectations in the second instance, and the loyalty that a successful nurse should show. Nursing norms, on the other hand, put nurses under the obligation to devote themselves entirely to patients. Therefore, institutional norms seem to gain in importance over nursing norms.

When asked to mention the characteristics that the hospital would expect from nurses, the answers were the following:
### Characteristics Which Became More Important

<table>
<thead>
<tr>
<th>Characteristic Expected</th>
<th>% Who Considered It Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 1</td>
<td>Time 2</td>
</tr>
<tr>
<td>Technical approach to patients</td>
<td>82</td>
</tr>
<tr>
<td>Adoption of institutional norms</td>
<td>33</td>
</tr>
<tr>
<td>Economy</td>
<td>23</td>
</tr>
</tbody>
</table>

### Characteristics Which Became Less Important

<table>
<thead>
<tr>
<th>Characteristic Expected</th>
<th>% Who Considered It Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smooth interaction with other roles</td>
<td>Time 1</td>
</tr>
<tr>
<td>Humanitarian approach to patients</td>
<td>77</td>
</tr>
<tr>
<td>Independence, charisma</td>
<td>26</td>
</tr>
</tbody>
</table>

The suggestion is that students become increasingly aware that the hospital requires them to fit into the institutional context and to help to maintain it in its required state. Individuality and humanitarian attitudes are not considered as being important.

On the other hand when asked where their loyalties belonged, students answered that they belonged, firstly, in kindness and understanding to the patient, and, secondly, in the skill involved in work. After practical experiences, kindness and understanding towards the patient became more important and the skill diminished somewhat in significance. The implication is that relationships with patients showed the importance of psychological care. This was the most important aspect of their work. The least important was routine work, and this continued to decrease in importance with experience. Routine tasks were also indicated, together with "dirty work,"
as being the least enjoyable. The most enjoyable task was the social contact with the patient.

<table>
<thead>
<tr>
<th>Most Enjoyable Tasks</th>
<th>% Who Considered It Enjoyable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Time 1)</td>
</tr>
<tr>
<td>Social contacts with patients</td>
<td>64</td>
</tr>
<tr>
<td>Nursing patients who reciprocate</td>
<td>33</td>
</tr>
<tr>
<td>Ability to acquire knowledge</td>
<td>10</td>
</tr>
</tbody>
</table>

This implies that before practical experiences, students thought they would enjoy patients who reciprocated, and thereby derive satisfactions in their role. On the second instance, this declined as being an enjoyable aspect of their work, implying that they gained greater insight into the psychological conditions of patients and why they were unable to respond.

When asked to mention the characteristics of ideal nurses, the following were the changes that were of any significance:

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>% Who Mentioned It As Important</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Time 1)</td>
</tr>
<tr>
<td>Ability to get along with people</td>
<td>77</td>
</tr>
<tr>
<td>Enjoying one's work</td>
<td>49</td>
</tr>
<tr>
<td>Ability to follow orders</td>
<td>38</td>
</tr>
<tr>
<td>Neat appearance</td>
<td>36</td>
</tr>
<tr>
<td>Technical skill</td>
<td>36</td>
</tr>
<tr>
<td>Recognition of own limitations</td>
<td>31</td>
</tr>
</tbody>
</table>

This suggests that ideal nurses have an ability to commit themselves to institutional requirements and professional role-images. They follow orders and appear neat. They enjoy their work. They work well within the hospital context by recognizing their limitations and by being able to get along
with people. Technical skill, which carries with it the stigma of impersonality and callousness, is not as important and becomes less important after experience.

**Rewards**

Students were asked what they thought most people liked about nursing as a future profession. Before their practical experiences, security and being able to help others were both considered important. After their experiences, however, security grew in importance. This indicates that their feelings of being able to help others were no longer considered as significant after they had experienced the practical situation. In addition, when asked why nursing was a good profession for women, students answered that it was such because of the security it offered, and also because it was practical in later life. Personal satisfaction became more important after experiences. When they were asked for their chief rewards, however, over 90 per cent in both instances felt that personal satisfaction was their chief reward.

**Strains**

After ward experiences students show that they believe that nurses are paid far too little. This was not as noticeable before they had practical experiences. This indicates that, to some extent, students discovered that playing the role of a nurse was more difficult than they had thought.
Students were asked whether they thought they were prepared for practical hospital experiences. These were the answers:

<table>
<thead>
<tr>
<th>Degree of Preparedness</th>
<th>% Who Mentioned It (Time 1)</th>
<th>(Time 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well prepared</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>Fairly well prepared</td>
<td>38</td>
<td>66</td>
</tr>
<tr>
<td>Not too well prepared</td>
<td>49</td>
<td>15</td>
</tr>
<tr>
<td>Not at all well prepared</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

These figures indicate a generally increasing satisfaction with university training. They also show the strength of their initial discontent in being isolated from their prospective work as nurses and "having only theory." Later, however, they show their preferences for university training in nursing, rather than hospital training. Thus does their initial discontent become diminished with time.

When the issue of unfavourable public images was raised, students thought that the public was ignorant of:

<table>
<thead>
<tr>
<th>Nursing Characteristics</th>
<th>% Who Mentioned It (Time 1)</th>
<th>(Time 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of glamour</td>
<td>33</td>
<td>28</td>
</tr>
<tr>
<td>Training and education</td>
<td>26</td>
<td>33</td>
</tr>
<tr>
<td>Psychological care given</td>
<td>23</td>
<td>13</td>
</tr>
<tr>
<td>More than just a dirty job</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>Diffuse nature of work</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>Part played in hospital life</td>
<td>13</td>
<td>28</td>
</tr>
<tr>
<td>Emotional strain</td>
<td>13</td>
<td>13</td>
</tr>
</tbody>
</table>

Increasing awareness of the hospital is indicated here.
Relation to Others

Students were asked what roles they considered indispensable to the functioning of the hospital. They answered in the following manner:

<table>
<thead>
<tr>
<th>Role</th>
<th>% Who Considered It Absolutely Indispensable (Time 1)</th>
<th>% Who Considered It Absolutely Indispensable (Time 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Nurses</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>Dietitians</td>
<td>51</td>
<td>31</td>
</tr>
<tr>
<td>Instructresses</td>
<td>33</td>
<td>31</td>
</tr>
<tr>
<td>Student nurses</td>
<td>23</td>
<td>36</td>
</tr>
<tr>
<td>Visitors</td>
<td>13</td>
<td>36</td>
</tr>
</tbody>
</table>

Therefore, in the students' eyes, student nurses and visitors became more important to the functioning of the hospital. Dietitians and instructresses became less important. Thus, before hospital experiences, students were not aware of the amount of service they would be asked to give. This is a form of strain for them. "We're supposed to learn and not give service." The increasing importance of visitors suggests that students begin to realize the significance of psychological care given to the patient, and accept the role of the visitor in giving this. Dietitians, in their opinion, decrease in importance, because of their inability to participate in the emergency of the sub-culture.

They were asked what they thought a doctor expected from a nurse. After practical experiences they placed more importance on occupational qualities, and less on individual
qualities. They were also asked what they thought that other nurses would expect from them. Mechanical skills and efficiency, professional attitudes and awareness of the hospital as an institution became more important.

Several questions were asked about the kinds of patients that students would like to nurse. When asked about the sex of their patients, students commented that they would like to nurse

<table>
<thead>
<tr>
<th></th>
<th>%6 Who Preferred Them</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Time 1)</td>
</tr>
<tr>
<td>Children</td>
<td>90</td>
</tr>
<tr>
<td>Men</td>
<td>28</td>
</tr>
<tr>
<td>Women</td>
<td>18</td>
</tr>
</tbody>
</table>

Their preference for men and women seemed to rise. This could be the result of their having, at the time that the question was posed, only experienced the nursing of adult patients. It could also suggest a commitment to nursing norms which expect nurses to show no discrimination among patients. Also, the order of preferences, children, men and women, indicates that an absence of critical abilities in a patient are important. They like to nurse cheerful patients, and this desire becomes intensified after hospital experiences. Grateful patients are also important. They dislike patients who swear, who demand more attention than they need, who cannot express themselves, who act superior, or who do not care what happens to them. They show an initial dislike for economically
privileged patients. This diminished markedly after experience. These results indicate that students like patients who reciprocate and that their giving must be complemented by receiving. In addition their decreasing dislike of economically privileged patients suggests that they prefer patients who conform most closely to their own middle-class way of life.

When asked about where they would like to nurse and where they would not like to nurse, they answer in the following manner:

<table>
<thead>
<tr>
<th>Ward</th>
<th>% Who Prefer to Nurse There (Time 1)</th>
<th>% Who Prefer to Nurse There (Time 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-private</td>
<td>46</td>
<td>54</td>
</tr>
<tr>
<td>Staff</td>
<td>38</td>
<td>44</td>
</tr>
<tr>
<td>Private</td>
<td>18</td>
<td>5</td>
</tr>
</tbody>
</table>

These answers indicate a conflict. They prefer to nurse the middle-class patient that is inferred by the semi-private ward, yet nursing values of charity and helping those who need it, indicate that they should nurse staff patients who come from the lower socio-economic level. The private ward patient, who is above them socio-economically, and also does not play such a prominent part in nursing norms, is not preferred.

They were asked what specialty they preferred. The answers indicated that before hospital experiences they preferred the emergency unit. This dropped significantly, but was still preferred, after students had encountered the practical situation. Preferences for other units were not
significant. The suggestion here is that the drama and the urgency of the medical sub-culture may have played an important part in initial motivation. When asked where they would dislike to nurse, the mental hospital maintained its unpleasant connotations. A change occurred with regard to the contagious unit. Only five students indicated a dislike for this before practical experiences, but seventeen showed a dislike after the hospital experience. This suggests that the monotony of the infectious diseases technique is fully realized after the practical contact with it.

Students were asked what illness they would like to nurse, and after their experience in the real situation, they were asked what illnesses they liked nursing. They answered as follows:

<table>
<thead>
<tr>
<th>Illness</th>
<th>% Who Would Like to Nurse It</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Time 1)</td>
</tr>
<tr>
<td>Surgical</td>
<td>28</td>
</tr>
<tr>
<td>Children's illnesses</td>
<td>26</td>
</tr>
<tr>
<td>Where patient recovers and does not suffer extremely</td>
<td>18</td>
</tr>
<tr>
<td>Mental</td>
<td>15</td>
</tr>
</tbody>
</table>

This supports the previous suggestions that students prefer contacts with patients who recover and reciprocate. Recovery of a patient is a source of satisfaction to the nurse. Furthermore the transference of a patient to a person, and hence to one who can reciprocate, is also an indication of nursing satisfaction. Surgical patients on the whole, after they have first become worse through an operation, begin to
improve. Very few referred to medical patients in this question.

Students were asked with whom they thought they would like to work. After practical contacts, they were again asked with whom they liked to work. They especially looked forward to their work with other nurses, and found that they still liked it above other relationships. Many looked forward to their work with doctors, but discovered that they did not like it as much as they had expected. This indicates that they had not anticipated their position of subordination to doctors, and that often they were ignored or treated impersonally. Their dislike of head nurses increased, and the suggestion is that this may have increased for the same reason, namely, their subordination to authority and punishment in case of deviation.

Students at both times were overwhelmingly person-oriented instead of illness oriented. After practical contacts, however, they elaborated their answers in some cases to show that an ability to combine the two would be preferable. They were also more human relations oriented than efficiency-oriented, but after working in the hospital, they showed a greater desire to find a balance between the two. These answers indicate that their idealistic view of nursing values, where the humane approach is emphasized, is replaced by a greater consideration for institutional requirements, such as efficiency, skill, knowledge and attention to illness.
Suggested Typology

During the course of this study, I began to notice emerging similarities and dissimilarities among the students studied. It seemed that certain groups, or types of nurses were in the process of emerging in the role-taking process. These groups appeared on the basis of a general orientation to nursing and in behaviour. The insufficiency of my data forces me merely to suggest the existence of a typology and to leave the discovery of its exact nature to future research. I have called my three elementary types "the practitioner," "the theoretician" and "the individualist"; and I shall resort to merely a description of each.

The Practitioner

These students see nursing as an end in itself; they are very interested in what they can do for nursing, as opposed to the "theoreticians" who see nursing as a means and whose main interest is in what nursing can do for them. They are eager to adjust to the institutional way of life, and place great importance on the part they play in the function of the hospital. They also conform more readily to the institutionalizing processes of depersonalization and discipline.

They feel their greatest satisfaction is in giving bedside care, and in "being able to help the patient." They
refuse to discriminate in showing personal preferences or dislikes and often declare that they like all their patients; only on probing do they admit that some patients are more pleasant than others. They accept their roles as institutional scapegoats and do not bear grudges against superiors. In short, they do not seem to experience the "reality shock" as much as do the other types.

Qualities of motherliness and femininity are prominent in this type of nurse. They conform to the nursing values of service and profess dedication to their work. They have the sympathy and understanding, which is often attributed to women and which is required in nursing. One of this type commented on a nurse of the "theoretician" type:

She's very masculine . . . I'm surprised she even went in for nursing . . . she would seem to be more in place as a taxi driver . . . can't you just see her in a cap with a union badge.

They may recognize the drudgery and the monotony of many of their tasks, but they perform them without complaints. Thus they take on many of the qualities of martyrdom. In many ways this type tends to internalize nursing values and norms to a greater extent than do the other types. They rely on the ideology of an oppressed group and gain prestige by conforming to the culturally desirable quality of altruism.

This typology could be correlated with the original orientation-typology suggested for the students before their
entry into nursing. The hypothesis suggested by the data I have collected is that the practitioner correlates with those students who expressed their wish for nursing, because they believed they were "born a nurse," or were taking on the role in "mother's image."

The Theoretician

To the theoretician, nursing is a means to something else. They are more interested in what nursing can do for them, than in what they can contribute as nurses. They could be seen as falling into two sub-types: 1) the individual who sees the practice of nursing as a means to a private end, and 2) the individual who sees nursing as a way into the professional world and therefore is interested in reforming the occupation and in elevating its status.

These individuals fitted well into the university culture. Consequently they are not eager to adapt themselves to the hospital, but rather indicate a wish for the hospital to adapt to them. They accept residence life and increasing institutional commitments only because they are defined as necessary.

Students of this variety display a motivation to learn, to "get ahead" and to become professional. They correspond more to the concept of the modern emancipated woman, who plays a professional role in the occupational
sub-system, who shows initiative and charisma, and who feels uncomfortable in a subordinate role.

They show little interest in bedside care and do not show the same evidence of dedication as the "practitioners." They feel that they have adequately met their obligations when they have done their day's work and have done it competently. However, where the "practitioner's" interest ends with the day's work, the "theoretician" carries hers further. They tend to be critical of all facets of nursing, from lectures to hospital administration. They define many aspects of nursing as "menial" and complain about the status-lowering function of these aspects. They seek recognition and show future authoritarian traits. This suggests that whereas the "practitioners" are liable to play the role of bedside nurses, "theoreticians" are liable to become administrators or supervisors. On the whole these students seem to emerge from groups who gave their reasons for entering nursing as "nursing as a means," or "a way out -- and into nursing." They do not conform so much to the traditional values of nursing, such as the required sympathy, understanding and dedication, but show a tendency to be more concerned with professional values and attitudes.
The Individualist

The "individualist" is the deviant and the rebel of the nursing role. She does not conform to nursing or to institutional expectations. Often it is first discernible in initial self-images, in agreements with adverse public images, or as the result of excessive demands of the subjection of the individual personality to the occupational group. As with many rebels who oppose authority, they earn the admiration of their fellows. They openly defy institutional subjection and discipline, and retain their initial individuality or develop a new type of individuality.

Their behaviour does not conform to occupational norms or to institutional requirements. They are cynical and show little eagerness to learn or to perform their tasks. They are flippant with superiors and defy the hospital hierarchical structure by taking their problems to the highest authority without following the prescribed channel. They do not feel responsible for fostering favourite public images, and admit their shortcomings in the nursing role to outsiders. They may even accept unfavourable public images and so often they agree that nurses are "scrubwomen" or that "anyone can be a nurse." They admit that the learning of the nursing role is not difficult.
They want to do something, they don't want to get married and they just don't want to work, because that lowers their social status. Just like a person without any skill. A lot of them don't want to be secretaries. They don't feel they have the brains or can't afford to go to college. So they go into nursing. That's respected and not too hard, although they like to make you think it's hard. You know, "Well, I didn't go to college, but I went through nursing and that's hard enough." It really isn't, you know.

Thus they violate the common norm of all occupational groups where each socialized member attempts to maintain the prestige and status of the group.

Division into the three types of "practitioner," "theoretician" and "individualist" does not eradicate the possibility that other types also may exist. This typology is merely based on the three distinct types of role-orientation that I noticed to be emerging in the group studied for this thesis.
CHAPTER VIII

PLAYING THE ROLE -- BEING A NURSE

Playing the role of a nurse can be understood by asking the question: what does it mean to be a nurse? In other words, it is important to ask what a nurse does, what images are held of nurses, what is expected from her, how she is repaid for these expectations, what conflicts she has and how she is related to others. One answer lies in analysing the role by the use of specific and related variables. I suggested in Chapter II that this can be done by the use of five variables: the images of the role, the character of the obligations, the rewards, the strains and the relation of the role to other roles. The meaning of the role hinges on the nature of these variables.

Therefore when the functions, the expectations, or the rewards of the role change, the meaning of "being a nurse" should also change. Historically, the role of a nurse has had a variety of different meanings. To illustrate this point, some consideration will be given, on the basis of my reading and inferences, to the historical development of nursing before examining the playing of the role at the present time. The material on which this chapter is based has been collected through observation, interviewing, reading and the resulting interpretations.
Nursing through History

Those who nursed in classical Greece were much different from those who nursed in the eighteenth century, and those who nurse today. In Greek times, the ill took up residence in temples and returned to health under religious instruction. Nursing was a role devoted to spiritual well-being, little thought being given to physical cure. The next distinctive stage was when nursing became associated with Christian monasteries and the Christian virtues of charity and mercy. For the first time in history nursing became a separate and recognized role, and moreover a role played by women. Then, it was the task of the wealthy and the aristocratic, who became nurses in penance for sins; and hence nursing was defined as an unpleasant duty meant to test one's Christian beliefs. Another change took place when the ill left the protection of the military and religious orders with which nursing was connected in medieval times and came into the care of tax-supported hospitals, staffed by paid personnel. Nurses at that time were entirely untrained and many were inmates of penal and welfare institutions. Then came the wet nurse, the medical discovery of the eighteenth century, and following her, the woman of Florence Nightingale's era. "Every woman is a nurse" wrote Florence Nightingale, and it was she who fashioned the

1 Florence Nightingale, Notes on Nursing, New York, Appleton, 1860, p. 3.
Images of the Role

Through the years, the public and self images of nurses have differed quite markedly. At first, a nurse was a religious figure, nursing patients in a Greek temple. The idea was that religious concepts could be transmitted, and at the same time a cure could be effected. Next, a nurse was a self-sacrificing nun, or a devoted monk of the Middle Ages, considering it Christian duty to live a lowly life and help the sick. By this a reward in heaven could be attained. Nursing tasks were also, at one time, sought by those who had to do penance for their sins. The drudgery of such work was considered adequate punishment for inmates from prisons and poorhouses. At the next stage, a nurse was the lowest paid of all servants, having no training, or liking, for her work. From this, she passed to the stage where she became the self-sacrificing "lady with the lamp." Now she is considered a professional person, and although some of her tasks are socially defined as unpleasant, she is rewarded by the high prestige given to those who devote their time to "service." Her self-image has at each stage been governed by the public image. Therefore it is different today from what it was when nurses were criminals or paupers.
Character of the Obligations

The obligations of a nurse have also differed. They have been to give religious teachings, to serve a religious deity, to seek forgiveness by doing work distasteful to others, or to earn livelihood in an occupational capacity. The tasks of a nurse have been to say the appropriate prayers when disease was a struggle between good and evil, to restrain a screaming patient while an eighteenth century surgeon amputated a leg, or to administer the latest wonder-drug. With each task and with each type of "nurse," standards, both institutional and public, have been imposed. Institutional standards must have differed markedly between the era of the Protestant Reformation and the twentieth century. For example, the former period saw a hospital in which one bed was occupied by a feverish child, a woman dying from tuberculosis and an epileptic; the latter sees such changes as private wards, foster beds and sterile, dazzlingly white operating theatres. There is a difference also between the "nurse" who considered sickness as an indication of evil, and the one who sees it as a normal function, the action of bacilli on the body.

Rewards

To balance obligations, there have always been rewards. The modern nurse is paid, but at one time the chief reward was the forgiveness of sins, or the knowledge that one
had conformed to the Christian ideal of mercy and that the ultimate reward would be bestowed in heaven. Twentieth century nurses are rewarded by a monetary income, by a relatively high status among women's occupations, and by security. Until the time of Florence Nightingale, nursing status was a matter of strain, rather than a reward. Nurses were paupers, sinners, criminals or servants of the lowest order. During monastic nursing, however, status was higher, but it is to be noted that this status accrued as a result of nurses being, primarily, monks or nuns. As examples of good Christian living and self-sacrifice, their prestige was high.

Strains

Role-playing, at any time, cannot be discussed effectively without mention of strains. The values associated with the playing of one role could be incompatible with the values associated with the playing of another. It seems that nursing, involving the care of the human body, has always been connected with sexuality. What strains this produced in nurses during monasticism, during the semi-religious military period when the function was fulfilled by the wealthy and the aristocratic, or prior to the advent of Florence Nightingale, can only be speculated. Certainly, student nurses experience conflicts when they are forced to overcome those inhibitions about the body which they have adopted as members of our society. Other strains, of course, occur and are often more pressing. They
are, however, too numerous to be mentioned here.

Relation to Others

The fifth variable -- relationship to other roles -- is also too varied to be followed to its limits. Perhaps it should suffice to speculate on the relationship of the "nurse" to the patient. He has been defined, in turn, as an evil individual, in league with the devil and consequently in need of spiritual guidance; as an instrument upon which one could work in order to have one's sins forgiven; and as an unfortunate to be cured.

Thus, the playing of the nursing role has changed through history. This change can be clearly described by the use of the five-variable system, for the meaning of the role depends on the meaning and nature of the chosen variables. The same analytical framework will be used to look at the nurse, as she plays her role today. As nurses of different cultures perform different roles, this investigation into the role shall be restricted to nursing in Anglo-American culture, and to nurses encountered during the course of this study. Role-playing infers, on the whole, that a role has been "taken," and should, therefore, concern itself with graduate nurses. On the other hand, in nursing, students are taught by an in-service training method. Therefore, they learn and "take on" their role, by seeing it played, and by playing it themselves. The material
used in this chapter, therefore, shall come from three sources: 1) from quantitative and qualitative information collected from the class of student nurses studied; 2) from participation with and observation of graduate nurses made during field work; and 3) from speculations and impressions derived from reading and from my own experiences.

1. Images of the Role

The images held of a single role can be numerous. The nature of each image depends on the group or individual by whom it is held. So as not to go too far into the realm of speculation, this thesis shall focus on only two images of the nursing role -- that held by the public, with all its diversity, and that held by the occupational group and by the nurse herself. I suggest that the public sees nurses, to some extent, in terms of how the nursing group sees itself and wishes others to see it. Similarly the nursing group forms conceptions partly on the basis of the public image, whether it be to adopt public views, or to correct them.

Public Images

Public images of the nursing role are numerous and often conflicting. They could be described as stereotypes, objectively communicated by mass media. Once possessed by the public, they function to form the attitudes held towards nurses,
and consequently play a major role in motivating some individuals to become nurses, or not to become nurses, whatever the case may be. It is important to note, however, that all images are not culturally defined, but are based to some extent on interaction with nurses. These, in their turn, could be transmitted and become public images. Thus all images, at their beginning stage, are constructed on the basis of interaction with the role of the nurse.

Public images, it has been shown, are dependent on such factors as age, sex and socio-economic status. For example, lower status individuals have a more favourable opinion of nurses than do individuals in a higher socio-economic bracket. Similarly, they can be expected to vary between patients and farmers, between doctors and lawyers, between high school students and university students.

In recent times I have observed a greater concentration on the medical sub-culture. One index of this is the nature of the mass media which has made its appearance in recent times. Paper-back literature on doctors and nurses is flooding the stands and the needs of the public are catered to by the provision of separate stands for "medical fiction." The past few years have seen many stories on successful nurses, devoted

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to duty, misunderstood by crabby superiors; they always manage, however, "to get their man." Titles such as *Nurses are People* and *Doctors are Different* attempt to clarify this subculture for the public. Movies and television follow the same pattern. Whatever the explanation for this concentration may be, objective data points to increasing interest in medical roles and values.

Despite this type of mass media, which may reach only a certain type of individual, several types of public images predominate:

The Ministering Army of Florence Nightingale

You know, the girl in white, the ministering angel, that kind of thing. At least it was with me anyway.

... . . . . .

I think people very highly regard nurses. Any time you say to them "Well, I'm in nursing," they're thrilled. They think it's the most wonderful thing a girl can do. I guess they've all had a little experience with a nurse and most nurses are very nice. Don't you think they are a nice group to talk to? And they think that nurses do a lot of good, and they do.

The above quotations, from the subjects interviewed, speak for themselves in showing the nursing perspective on a particular public image. It is an image which has its genesis in the Victorian era and the aspirations of Florence Nightingale to establish a secular, professional nursing role for women.
It has two phases: the concept of Victorian womanhood as gentle, withdrawn and obedient; and the drive by women for emancipation and professional recognition. These two are somewhat contradictory. One shows woman as being passive and content to remain in a subordinate position, while the other shows her as aggressively agitating for equality with men. One part of the image endows the nurse with all the desirable qualities of the Victorian woman -- patience, virtue and charity. She is in a subservient position and is the one to perform the lowlier tasks of helping the sick. She is strong, but also kind and understanding. She professes ideals of service and altruism. Florence Nightingale claims that every Victorian woman would make a nurse. This connection of women, and all their Victorian qualities, with the sick has persisted and may account, in part, for the definition of nursing as a woman's occupation. Furthermore, her subordinate position in the society of the day made her ideally suited to the hospital situation where the physician was in a position of authority. There is another side to the picture of the nineteenth century. Nursing began to be taught as a vocation. This was followed by demands for emancipation and professional status for women. Increasingly greater emphasis was placed on factors such as efficiency, independence and intelligence.

Therefore, when nurses are referred to as "ladies with the lamp" or "ministering angels," the image is twofold. It
sees women as ranging from the "efficient and brusque" to "kind and sympathetic." In one instance they are emancipated women with desires to be the equals of men, and in another they are Victorian women with their well-defined characteristics. Both parts of the image are involved in "ladies with the lamp" and the followers of Florence Nightingale. Although they seem contradictory aspects within the same image, both are considered as qualities of a good nurse.

Nurses, Waitresses and Housewives -- Scrubwomen?

I wish I could have a job where I could get as much out of nursing without doing all those menial things -- cleaning this and cleaning that and doing the other.

......

Men would think the reward for nursing was a sore back. They would do a lot of complaining. They wouldn't find anything much in it.

This image of nursing is also prevalent. As an example of how this image is transmitted, the following shows how such attitudes could become public knowledge. A daily newspaper carried an advertisement for a clinic shoe, which was recommended as "A new service . . . a new comfort . . . for Nurses, Waitresses and Housewives." This implies that those three roles were similar, in that each required the same equipment to carry out their tasks. This is a survival from the Victorian era where the work of women was associated with
menial tasks of a lower order. Such a public image as this, undoubtedly, leads to a low occupational status and a disadvantage in any desire for professional status.

Such an image compares to the previous image only in as far as the tasks are concerned. The only difference is that, although both depict traditional Victorian women, this latter image gives them a low status. Women of the Victorian era enjoyed a high status as "women," although their work was of a lowly order. This latter image sees nurses as carrying out the tasks of Victorian women, but afforded the status given to such tasks in present day society. They lack the "sacred" context, which was, and is, given to the followers of Florence Nightingale.

Hard Workers, Non-Drinkers and Puritans

I think the ideas have come from, you know, nurses are all this or all that. They expect all nurses to be . . . because in the old days they were. I don't want them to be Puritans, mind you, but I don't like them to go out drinking and beering, and all that, I don't think that is part of nursing.

. . . . . . . .

They think that nurses work hard, they've probably seen them. Nurses aren't allowed to sit down by the patient's bedside when on duty. You do an awful lot of walking.

These statements by student nurses show the existence of a Puritan philosophy. The definition often given to the
term "Puritanism" tends to misinterpret the meaning of the philosophy. They are seen as being non-hedonistic, plain, and in ways, dogmatic, pedantic and narrow-minded. To have Puritan ideals is not considered as entirely desirable. In reality, however, although the Puritans valued simplicity, the dignity of hard work and thrift, they surpassed other philosophies in their humanism and logic. They believed that man was basically a rational and responsible creature. Man was the master, woman merely his helper; they had no belief in the equality of men. Heavy drinking, dancing, sloth and "wasting time" were considered the ultimate in sin. Their history in the New World is marked with tales of hardship and lack of luxuries. The individual could indulge in luxury and leisure only if this indulgence could be justified in terms of the dominant values of the philosophy. 3

This public image sees nurses as conforming to the Puritan religious philosophy. Certainly Puritan ideals are dominant in North American culture, and its values are strongly supported in the nursing profession. Florence Nightingale, herself, despite her wish to reform and elevate the lot of women, declares that nurses should pay little heed to getting ahead status-wise and to gaining equality with men. "... Oh, leave these jargons, and go your way straight to God's work,

in simplicity and singleness of heart."4

Women with "Loose Morals"?

I get so fed up with people saying "Oh, nurses know everything!" or "Oh, you can tell a nurse a dirty joke!" It just makes me so mad. And the attitudes of the boys in the same way: "Oh, you're going to be a nurse, I can tell you this!" Well I don't think that's right at all. "You shouldn't get embarrassed -- you're a nurse." Every time anyone says that, I flare up. My own father even has said that.

When nursing left the realm of the monastery and nunnery, where it was carried out by individuals who played roles characterized by a disinterest in sexuality, it became the occupation of young, unmarried women. Social norms define attitudes towards the body and towards sexuality. These women in the normal process of socialization acquire the social norms. Hence they learn that sexuality and parts of the body and its functions remain unknown and undiscussed. One of the first requirements imposed by the nursing role is to unlearn these social norms. A new set of norms, which encourage knowledge of the body and of its functions, is taught and adopted. Conflicts undoubtedly arise. This could be seen when the subjects of this study had difficulties early in their training.

4 Nightingale, Notes on Nursing, p. 136.
in bathing and tending to male patients.

The public, however, is not aware that social norms are unlearned, or if not replaced by nursing norms, at least dissociated and differentiated from them. The tendency is to associate knowledge of the body with sexuality. This interpretation is made in terms of social norms which imply that knowledge of the body is synonymous with sexual promiscuity. Hence a public image, which tends to regard nurses as women with "loose morals," arises.

**Occupational Self-Image**

Some of the above quotations have given an indication of nurses' attitudes towards the various public images. These reactions, together with a desire to conform to cultural values, such as altruism and humanitarianism, determine nursing self-images. Values such as altruism, service and brotherly love, on the one hand, and independence, initiative and professionalism on the other, play important parts in these images. Public images are defined as either "good" or "bad," and an attempt is made to correct them. Thus the view of nurses as "ministering angels" is good, while the image of nurses as "women with loose morals" is bad. The image held out to nurses by the occupational group would promote the first and try to influence a correction of the second.
Occupational images, therefore, include cultural and institutional expectations. The values of society and the medical sub-culture are a large part of the image. It is a set of beliefs, ideals and myths. Appropriate behaviour, inside and outside of the sub-culture, is defined by ethics, and is supported by myths of achievements and success. It is an ideal view of the values of the group. As such it does, to a certain extent, ignore reality, although it is based on the reality of what is expected and what nurses are able to do. Nurses are committed to these values and their behaviour is regulated by them. Thus nurses are expected not to frequent beer-parlours, nor to conduct themselves in an unprofessional manner.

Occupational images manifest themselves in defined standards and codes of ethics. Adoption of these ethics makes an "ideal nurse." A look at the International Code of Nursing Ethics shows the obligations of every nurse:

1. The fundamental responsibility of the nurse is threefold: to conserve life, to alleviate suffering and to promote health.

2. The nurse must maintain at all times the highest standards of nursing care and of professional conduct.

3. The nurse must not only be well prepared to practise but must maintain her knowledge and skill at a consistently high level.

4. The religious beliefs of a patient must be respected.

5. Nurses hold in confidence all personal information entrusted to them.
6. A nurse recognizes not only the responsibilities but the limitations of her or his professional functions; recommends or gives medical treatment without medical orders only in emergencies and reports such action to a physician at the earliest possible moment.

7. The nurse is under an obligation to carry out the physician's orders intelligently and loyally and to refuse to participate in unethical procedures.

8. The nurse sustains confidence in the physician and other members of the health team; incompetence and unethical conduct of associates should be exposed but only to the proper authority.

9. A nurse is entitled to just remuneration and accepts only such compensation as the contract, actual or implied, provides.

10. Nurses do not permit their names to be used in connection with the advertisement of products or with any other forms of self advertisement.

11. The nurse co-operates with and maintains harmonious relationships with members of other professions and with her nursing colleagues.

12. The nurse in private life adheres to standards of personal ethics which reflect credit upon the profession.

13. In personal conduct nurses should not knowingly disregard the accepted patterns of behaviour of the community in which they live and work.

14. A nurse should participate and share responsibility with other citizens and other health professions in promoting efforts to meet the health needs of the public -- local, state, national and international.
Conformity to these standards makes an "ideal nurse" and all nurses are expected to aspire to this. It is an occupational expectation, which in time becomes a self-expectation. Thus a nurse cannot go into a beer parlour without a sense of discomfort and a hope that she is not detected.

Ethics serve many functions. Manifestly, they define the appropriate behaviour and attitude. They are part of the "expressive" knowledge that a nurse is expected to master. Latently, however, they integrate the members of the occupational group, giving them a sense of "we," as opposed to outsiders, who do not have the same system of ethics. The consistency of the nursing sub-culture is maintained by having the appropriate standards transmitted to all members. They serve to define nurses as professional selves in that they emphasize such professional qualities as confidence, trustworthiness and competence. This enables nursing to be grouped with the professional occupational group, giving it higher status. Above all, nursing ethics function to correct public images and to foster the public image that the nursing group desires. The public can then see nurses as trustworthy, professional selves with a strict set of ethics, which prevents them from being "women with loose morals" or "scrubwomen."

The occupational image and the public image combine to form the self-image of nurses. On the whole, adverse public images are considered by nurses to be the results of incomplete
knowledge of the nursing role, or a lack of experience with the work and responsibilities of nurses. In brief, they are considered unjust. Nurses who are overly influenced by adverse public images are not conforming to occupational expectations. Hence nurses who liken their role to that of scrubwomen or waitresses are considered deviants. They are members of the group whose attitudes are liable to distort the picture that nurses desire to present to outsiders.

2. **Character of Obligations**

The obligations of a nurse refer to what she must do and how she must do it. They are concerned with tasks that have to be performed and standards that govern these performances.

**The Tasks**

Nurses perform a variety of tasks. They range from measuring and administering the right medication to making sure that the diet kitchen does not put gravy on Mr. Smith's potatoes. It involves turning a cheerful face and a pleasant "good morning" to all the patients in the ward and listening to Mr. Brown's marital problems. Among this multitude of different obligations, there are two distinct aspects to her work: that dealing with impersonal tasks, and that dealing with personal tasks. These involve the two sides of a nurse's obligations, the technical side and the personal side.
Physically the nurse performs certain skills. She handles the instruments in an operating theatre, she prepares for the surgeon and she cleans up after him. On the wards she washes patients, gives them enemas, hypodermics, medications and food. She does skin preps and makes beds. She carries bed pans in and out. She marks fluid intake and output. She notes the regularity and the nature of bowel movements. She deciphers doctors' orders and makes nursing notes. The colour of a patient's skin, his sleeplessness and restlessness, his pain and his loss of appetite -- none of these escape her observant glance. Chocolates and confectionery are taken from a diabetic patient, and all diets are checked. She turns the foster bed and does a wound irrigation. The flow of an intravenous, or the respiration of a dying patient, are constantly checked. She answers the light and closes the window. A sudden haemorrhage or asphyxiation, and she immediately summons the intern and the oxygen tent. She keeps the clean apparatus clean, and the sterile apparatus sterile. She re-makes a soiled bed. She gives gastric gavages and lavages, wet and dry dressings. Patients are admitted and discharged. Temperature, pulse and respiration rates are taken periodically and recorded. She keeps the service room supplied and in order, and places parsley and gravy on patients' plates in the kitchen. She collects specimens and counts drugs. Charting, treatments, medications and ward tidiness are all her
responsibility. She runs messages or supervises the ward. All these tasks she performs in the impersonal aspect of her work.

A nurse's impersonal tasks could be seen in the light of Parsons' "pattern variables." Her behaviour in these instances is affectively-neutral, in that her relationship to her patient during the performance of these tasks is unemotional and formal. It is universalistic, in that the techniques are administered to the patient because of his role as patient, independent of any other roles he may play. Her role is also characterized by a specificity of function. The area of these impersonal tasks is well-defined. She cannot perform any functions normally allotted to the doctor, nor does she do the work of other personnel. She deals with the patient, only in so far as his illness is concerned, and she, as a nurse, can help him.

These tasks are usually of the routine variety, dealing with basic techniques, household duties and routine care of the body. When special treatment is required, the impersonal tasks take on a more personal flavour.

The Personal Tasks

There is also the human relations aspect of the nurse's work. She listens to the patient's troubles, whatever their nature. She consoles him before he is wheeled to the
operating theatre. She gives him encouragement before he receives his anaesthetic. She holds the hand of a mother in labour. She stops to talk to the immigrant, isolated because of language difficulties. She remembers that Mrs. Brown should be moved to another ward so as to be away from Mrs. Jones. The explanations and reassurances fall to her lot. She has a smile for visitors, a pleasant cooperation for doctors and a sympathetic ear for the woes of other nurses. Student nurses and ward aides expect help from her and get it. She listens to patients on matters of their illness, finances, broken love affairs or hobbies. She takes time to go to the candy counter to buy a chocolate bar for a patient. She arranges the flowers in just the way that patients wish. She knows and greets visitors by name. In general, she shows that there is a personal side to her work.

In this aspect of her work, the nurse as a "professional self" falls into the background, and the nurse as a "person" takes over. She does not concentrate so much on the illness, as on the patient himself. Her obligations are affective, particularistic and diffuse. She considers the patient and thinks of him in terms of his particular characteristics and defines him in terms of her own attitudes towards him, and not in terms of his being a patient. The boundaries to the tasks she can perform in this area are not defined, and she can be called on to perform a large variety of tasks.
The Nursing Definition of Work

We were talking about nursing, you know, about what to do for our patients, or something. And she saw us standing there and she came running down: "Nurses, nurses, what are you doing?" And then she said, "Look here, I've got a few things for you to do." Well she sent me counting bed pans, and she sent someone else doing piddly little things . . . I don't know what she expected me to find. Miss Brown told us so many times, "Now whatever you do, always look busy, whatever you do."

I would like to do away with a lot of the people that run around too much without doing anything . . . I like to see all of them really doing the work . . . I don't know, they rush so much and everything's just a big . . . baloney.

Nursing is a role characterized by action. The prevailing attitude is that constant motion signifies work. As the above quotations indicate, unceasing activity seems to be valued more for the effort involved, than for any ends that it may serve. At such times it functions only as a means. A side-product of this is that such effort loses the psychological reward that is experienced when an activity is followed to its conclusion.

Nurses feel that they should constantly be in motion. This is a middle-class, Puritan definition of work. They must be doing something with their hands, whether it is dressing a wound, or tidying the medicine cabinet. Thus when without work, they "make work." In this way they escape the
scrutinizing eye of their superior, who evaluates them in terms of their activity, apparent or real. They rush busily down the hall, go into the service room, but have nothing to do there. They turn the pages of a patient's chart, with a worried frown on their faces, but they are not looking for any material. They tidy the medicine cabinet for the second time. Under no conditions do they "just sit," when there is no work to do.

The other side of this is when the nurse has too much to do. She rushes around with the knowledge of a dozen tasks yet to be fulfilled. She hunts for linen on another ward, because her own ward does not have the rubber draw sheet that she requires to remake a bed. At the same time she reminds herself that she must shut the window in the end room, that Mrs. Jones requires a bedpan, that the light in one room was on, that the head nurse had asked her to go on a message to the central supply room, that a dressing has to be changed on another patient, that there is some charting that she must finish and a clinic she should attend and that her coffee time has passed. This in many instances is the nature of "work" for nurses.

The Standards

Not only is the nurse obliged to do these tasks, she is obliged to do them in a certain manner. A minimum level of competence is required in every task; if a nurse works
below this level, social control operates to force her to return to the required standards. So if a nurse is untidy in her work, the head nurse may point this out to her and imply that she should correct her work habits.

The standards required of a nurse are objectively listed on a Nursing Student Evaluation Report. Each student, on leaving a ward, is evaluated on this report by the head nurse, who subjectively estimates her ability to perform tasks according to the required standards. Any inabilities and mistakes are pointed out, and this implies that the student is now under an obligation to correct and improve.

For Impersonal Tasks

The impersonal tasks are measured and evaluated under the following headings: performance of nursing duties; recording; responsibility for materials; equipment and environment; application of the knowledge of nursing principles; dependability; and personal appearance. Under each heading the evaluator is given five possible choices, one of which has to be indicated. Thus, under performance of nursing duties, the head nurse can choose: 1) discharges assigned duties adequately in a reasonable time, displays consideration for the patient, 2) ineffectual in the performance of assigned duties, 3) a skilled performer, accomplishing her work quickly and with finish, displays consideration for the patient, 4) discharges assigned duties well, shows insufficient concern for the
patient, or, is careless in carrying out assigned duties, but is considerate of the patient, 5) accomplishes quickly and thoroughly assigned duties displaying consideration for the patient. Before asked to evaluate on this scale, the head nurse is reminded of the required standard: "A nurse when assigned responsibilities for ward routine should be capable of carrying these out neatly, accurately and with despatch, conscious always that these activities are for the patient's welfare." In the other items to be evaluated, a nurse is expected to record accurately, completely, neatly and concisely; she is to avoid waste by developing a consciousness for the cost of material and how much is needed for adequate nursing care; she must have thorough knowledge of medical and nursing principles behind her procedures; she must be conscientious in performing the duties assigned to her; she must appear well groomed, have good posture and be dressed cleanly and neatly.

For Personal Tasks

The tasks that I have termed "personal" are also evaluated. To quote from the evaluation sheet:
Teaching Ability: A nurse should be able to teach patients, relatives and her co-workers through personal example, by instruction and demonstration within the limits of her education and experience . . . Attitude Towards her Work: A sustained and growing interest in all aspects of nursing care is essential in the development of a nurse . . . Response to Supervision: A friendly, respectful relationship should exist between the nurse and her superiors. This largely determines the nurse's ability to co-operate, to accept constructive criticism, and to benefit from the instruction given . . . Executive Ability: Executive ability measures the skill in leadership of the nurse in directing the work of others, and assuming commensurate responsibility . . . Relationship to the Patient: This refers to the nurses' skill in establishing rapport with the patient so he will develop confidence in the nurse and her ability to meet his needs . . . Inter-Personal Relations: This factor measures the success with which the nurse establishes herself among those with whom she comes in contact . . . Poise and Self-Confidence: It is essential that a good nurse be emotionally stable and able to adjust to all situations in such a way that her responses tend to remove or reduce tension.

The standards of a nurse's work are clearly defined by the nursing group and by the medical sub-culture. They function to maintain the structure of the sub-culture and the purpose of the hospital. Besides the primary goal of tending to the welfare of patients, nurses have the secondary goal of tending to this welfare in the manner prescribed. They strive for both goals.

Boundaries of her Obligations

The functions of all roles could be seen as limited by boundaries. These come into being through interaction with
other roles and are either well-defined or ill-defined, depending on the type of function and the roles with which it is in interaction. Within the "impersonal" area, the role of the nurse is clearly defined, and she is aware of the tasks that she must fulfill. Her tasks are specific. For example she cannot insert intravenous tubes, cannot diagnose or operate. Each of these tasks is designated formally by the sub-culture as being the responsibility of another role. The limits of the student's work are clearly indicated. One "probie" stated:

We had it drilled into us, and drilled into us that we're not allowed to give medications, and yet we've had people come up to us and ask us to take this pill down to Mrs. So and So. It may be an aspirin or a 222, but it's the principle: you're not allowed to give medications.

In the "personal" aspects of her work, the boundaries are not well defined. Her role is functionally diffuse. She could be asked to do a variety of tasks that she had not expected. There is an informal indication of duties, which often cuts across the formal boundaries. This is exemplified by a continuation of the above quotation:

And some of the grads have become quite annoyed when we have refused to do that, and then again, maybe you're giving a treatment to a patient and the nurse comes along with his medication. The patient can't have it at that moment and so the nurse puts it down and asks you to see that the patient gets his medicine. Well, theoretically when you pick up that medication and give it to him, you're giving the patient a medication. It sort of puts you on a spot there. I felt awfully guilty even when they can't reach it and you've got to hand it to them. But what are you supposed to do? You can't go bustling down to the nursing station and say: "Would you mind coming back and giving so and so his medicine." When you're on the ward, you've got to do it.
Here two values, or standards of behaviour, have come into conflict. Firstly, the nurse must limit herself to the standards of the "impersonal" area and not perform tasks beyond her boundaries of competence. Secondly, she must meet the standards of her "personal" and informal duties by being cooperative. In this case the individual chose the latter of the two, because the threat of punishment was more immediate if she did this. Had she followed the rules she would have been subjected to the annoyance of her co-workers. Also, by choosing the latter, the chances were that her deviance from the formal expectations might not be discovered.

3. **Rewards**

The rewards of the nursing role are of two kinds: satisfactions from playing the role for its own sake, and satisfactions that can be achieved through the medium of playing the role. I have suggested four possible rewards: 1) personal satisfaction; 2) security; 3) remuneration; and 4) prestige. Of these, personal satisfaction is the only reward where nursing is seen as an end in itself. The other three rewards accrue from the nursing role as a means to an end.

1. **Personal Satisfaction**

This reward comes from seeing the purpose of nursing fulfilled. It comes with the feeling of having accomplished
one's tasks in the required manner and according to the prescribed standards. A nurse feels repaid for her duties when she finds that patients, who have been ill, are able to respond, or when her patients get better and go home. She feels satisfaction in being of service and in being able to work with, and for, people.

A reward of this nature is the reward that is considered appropriate in professional roles. Professional selves are not expected to be interested in monetary income, in financial or other forms of security, or in the prestige that a professional role enjoys. They are expected to get their rewards from being of service. These expectations, socially attributed to professional roles, are internalized to such a degree in the professional self, that they are considered as inherent. Thus the individual in the role feels that only her work of helping others could reward her.

It gives you a sort of nice feeling inside . . . People are always very glad for everything you do for others.

I didn't quite anticipate the feeling you get when a patient smiles at you. It really does something to you. They say: "Gee that feels good."

These rewards come from conforming to the expectations of the nursing role, and acting according to occupational norms.

That does not mean, however, that other rewards are not also received. Obviously without the support of the other three satisfactions, remuneration, security and prestige,
there would be far fewer nurses. These other rewards, however, are not considered important to professional roles, and are therefore ignored.

2. **Security**

Because of the continuous occurrence of disease and accident, the medical sub-culture will persist. Therefore at all times there will be a demand for nurses. Nurses feel, therefore, that they will always be needed, and would never be in a position of having to compete for work. As nursing is a woman's profession, it has a large turnover, leaving vacancies to be filled. Thus nurses feel secure in being able to find employment "at any time."

They also feel that nursing offers security in that it "prepares a girl for marriage." She is able to face emergencies and to look after the needs of a family. They feel that they are better equipped for these demands than members of other occupational groups.

3. **Remuneration**

As far as monetary rewards go, nurses imply that they are underpaid. Like all professional groups, however, they display a superficial lack of interest in their monetary income. It would be safe to assume, however, that if the income were overly small, fewer nurses could be recruited. Income, being
a means of livelihood, is undoubtedly the expected reward from any occupational role.

4. **Prestige**

One reward of the nursing role is its favourable public image and the social status that goes with it. Nurses are incumbents in a role which is often defined as being "good work for women," and hence an ideal feminine role. They also enjoy the prestige of working in a role, whose ethics imply altruism and service. Nurses are respected for their values, which bear similarity to those upheld by middle-class Puritan culture. They are considered as devoted, humble, self-sacrificing individuals with high moral standards.

4. **Relation to Others**

The nursing role could be considered in relation to other roles within three contexts. Each of these contexts includes groups of other roles. Nursing can be seen in the context of society and its relationship to other roles therein can be speculated. It can be seen in the context of the occupational world, and its status to other occupational roles can be discussed. It can also be given the status of a role in the women's world. Finally it can be seen in the context of the medical sub-culture.
Status refers to the position of a role in relation to other roles. It is determined by the interaction of a role with others. In that way status is important as a consideration when the relationship of nursing to other roles is assessed. Status is usually a two-dimensional thing, depending, on the one hand, on how a role is perceived by other roles, and on the other hand, on how it is perceived by the incumbents of the role itself.

The status of a nurse in the social system at large and in the occupational system is ascribed on the basis of the meaning of the role of "nurse." That is all nurses occupy the same status. Within the medical sub-culture, however, the status of a nurse depends on her individual performance. It is therefore an achieved status. In this way, each nurse has many statuses. Yet all three statuses are interdependent, in that the status of a nurse in the social system depends upon her status in the occupational system. Similarly her status in the occupational system depends upon her status in the medical sub-culture and in the social system. All are also undoubtedly influenced by her status as "woman."

Relation to Others in Social System

The nursing role in the social system is ill-defined. This can be seen by the numerous public images. On the one hand she is endowed with the qualities of womanly virtue. On the other hand, however, she is classed with waitresses and
scrubwomen. The public image of the nurse as a woman "with loose morals" should also be considered. Hence she is considered a professional person, a servant or performer of menial tasks, and a community leader. In the social system at large, therefore, the relationship of the nurse to other roles is somewhat uncertain, in that it can vary from one faction of the population to the next. Obviously much would depend on the role with which the nurse was interacting. It would depend on the age, sex and socio-economic status of the other.

Relations to Others in the Occupational Sub-System

Whereas in the social system, the insecure position of the nurse is due to her status as a woman, in the occupational sub-system, her position is also not well defined. The insecurity here hinges on her occupational status, that is, whether it is a professional status or not.

Nursing has the attributes of several categories of occupational roles. Firstly it uses science, and it is a profession in that it possesses a body of specialized technical knowledge, which has been accumulated as the result of a lengthy period of learning. Procedures and tasks are carried out according to the latest scientific techniques. Secondly, it is also an art, in that performance depends on individual talents. Books for nurses often stress this aspect of the role
in order to formulate a systematic self-image. Florence Nightingale's statement that "Nursing is an art -- it is one of the fine arts," is often quoted. Thirdly, it is a "service" occupation, and as such can be classified with the role of "servants," or, the other "service" occupational group, "professions." Many of its tasks are similar to those of the former, yet many of its values are similar to those of the latter. Nurses clean, tidy and wash, but at the same time they are trustworthy, altruistic and highly skilled. Interaction with other occupational roles, therefore, can depend on any of the four definitions of the nursing role.

**Relation to Others in the Women's World**

As women, nurses are subject to dual expectations. One view towards women is that they should "stay in the home," the other is that they should take their places as the equals of men. Here nurses are grouped with the latter, the professional women. Her role bears similarity to that of professional men and is treated with equality. She performs similar professional duties and is afforded similar privileges and statuses. Yet at the same time she is encouraged to retain the qualities of Victorian womanhood. Charity, sympathy, kindliness and empathy are desirable qualities. She is a feminine figure, associated with both the sex role and the maternal role of woman. She is subordinate to men and dependent on them. So the nurse integrates the qualities of
the woman who "stays at home" with the qualities of the woman who leads a professional life.

**Relations to Others in the Medical Sub-Culture**

The medical sub-culture is composed of hierarchies. Each nurse is faced with a medical hierarchy, a nursing education hierarchy, a nursing service hierarchy, a hierarchy of patients of different socio-economic levels, as well as other hierarchies with which she does not come so closely into contact. This would include the dietitians, the administration, the social welfare, the laundry and maintenance workers and the kitchen help. To each level of each hierarchy her relationship is different. The pattern is further complicated, as all hierarchies are not similarly organized.

To the hierarchy that ranges from the head of a medical department to the newest intern, the nurse is in a subordinate position. She is called to assist, to handle instruments, and to keep the patient under observation. She is not allowed to make any decisions as to treatment or medication, and at all times her actions are governed by the orders of the doctor.

Each individual doctor, however, is evaluated in terms of the respect he shows the nurse. If he greets her every morning and explains his medical diagnosis and the patient's condition to her, he is considered likeable and
pleasant. If, however, the only communication between doctor and nurse is through the patient's chart, the doctor is defined as "snooty" or unpleasant. In the latter case the nurse is liable to punish the doctor concerned by the nature of the assistance she gives him. Therefore she is able to control the situation in this manner, and to win for herself the respect of the doctor, who depends on her for reports on the patient's progress.

The nursing education hierarchy consists of a group of instructresses. These transmit the instrumental and expressive knowledge of the medical sub-culture to students, but lose significance as authority figures once the student graduates. Hence the student learns from her in the classroom. On the ward, however, she either welcomes her appearance or dreads it. This depends on the personality of each instructress. Whereas in the classroom they are evaluated mainly on their teaching ability, on the ward they are evaluated on their friendly and helpful manner. Hence the advice of an ill-tempered, unpleasant instructress is seldom sought. Her appearance does not give support to the student, but only makes her more nervous. She defines the function of the instructresses, not as one of guidance and assistance, but one of evaluation.

The nursing service hierarchy ranges from the "probie" to the head nurse and the supervisor. While a
"probie" a student feels subordinate to all of the hierarchy, but once she becomes a graduate, she is subjected only to the authority of the head nurse, the charge nurse and the supervisor. In a teaching hospital, such as the one studied in this thesis, a graduate nurse carries some authority in that she can give orders to students, and does not do "routine jobs." She is, however, under the jurisdiction of the head and assistant head nurses.

Because of a rigid system of authority and influence, there appears a phenomenon which could best be called "taking it out on those below you." An authority figure is, in most cases, defined as unpleasant, and those under the authority often feel persecuted. They feel that they had to endure hardships to become the kind of nurse that they are, and this to them then becomes the only way by which a nurse can be moulded. They, in their turn, then impose the same system of authority on those that follow them.

The relationships with patients are wide and varied. Nurses feel most comfortable with patients who respond, that is, patients who talk to them, who are thankful for services and who get better. Socio-economic levels, sex, age and the type of illness would also define the kind of relationship between patient and nurse. Nurses tend to be over-kind to patients of a lower socio-economic status than they, and uncomfortable in the presence of patients with whose social
status they are not familiar. They often indicate that they prefer men to women as the latter tend to be too "demanding" and too familiar with some of the instrumental tasks performed by the nurse. Most nurses, however, indicate a preference for children. These patients are mostly easily handled in the "personal" aspects of her work. They find it easy to talk to children, because of their own superior experience. Children, unlike adults, are not critical of nursing performances and give a nurse the respect given to a superior, both in age and knowledge. This makes her work easier.

With other female professional roles within the medical sub-culture the nurse has two types of relationship. It is either one of competition or one of cooperation, and in most cases both. Hence with a dietitian and a social worker the interaction is one of professional collaboration. The former, however, tend to regard the role of the nurse as an inferior one, in that the nurse has not a university education and is asked to perform menial tasks. The reaction of the nurse is to define her role as the one of greatest "importance," in that she, alone, is closely connected with the central purpose of the hospital, the cure of illness. The other roles are considered auxiliary and dispensable. She fulfills the immediate needs of the patient, and this is the claim that she lays to status.
With nurses' aides, maintenance workers, and kitchen helpers the nurse is pleasant, if not somewhat condescending. Often she ignores them, when she is a graduate, as the role she plays does not bring her into contact with these workers. It is the student who has the most to do with them. There is a common bond between them, both feeling themselves to be "under-dogs." This leads both groups to each other's protection should occasion warrant it.
CHAPTER IX

STRAINS AND CONFLICTS

In human interaction strains are inevitable. Each individual is a complex organization of roles, norms and personality traits. Each organization is unique. Indeed, such is the heterogeneity of society that contacts between individuals often prove incompatible. This discrepancy results in strain.

The underlying cause of conflict is, not so much the variety and diffuseness of norms adopted by the roles, as the phenomenon of "vested interests." 1 This is a term used by Parsons to imply the emotional attachment towards the existing state of beliefs and practices. Each individual's thoughts and behaviour are fashioned by the particular norms which he has internalized in the playing of his roles. These norms are defined by him as being "the best" and the most appropriate for him. When he comes into contact with different norms, or is asked to accept different norms, strains arise. If, however, he does not consider his own norms as "good," no strains may occur when the contact takes place. He may be eager to reject his former norms in exchange for the new ones.

1 Parsons, Social System, p. 491.
As far as the nurse's role is concerned, strains may occur as the result of external pressures or internal discord. Thus, strains can be externally imposed when the nursing role, with all its norms, interacts with other roles, or when outside forces impose restrictions. Conflicts also occur within the self as a result of conflicting internalized norms.

This chapter shall dwell on: 1) the nature and the extent of the strains that occur in connection with the nursing role, and how they are manifested; 2) the institutional ways by which they are overcome; and 3) the functions, both positive and negative, that they serve.

1. The Nature of Strains in Nursing

A nurse is often in a position where she must conform to diverse expectations. The strains, that are incurred, arise from:

The Unsatisfactory Status of Nursing

The role of the nurse is ill-defined. In the social system they are identified, on the one hand, with people devoted to helping others, with carrying out specialized work, and with being "ministering angels". On the other hand, however, they are considered as being people with "loose morals," who also perform the lowly tasks of carrying out bedpans and "cleaning up messes." In the occupational sub-system also, their
professional status is debateable. This is the result of the menial tasks they perform. Their occupational status is further complicated by the fact that nursing is largely a women's profession and hence carries with it the stigma of female subservience, a survival of pre-emancipated, Victorian womanhood. One nursing student, feeling this discrimination, remarked:

I think nurses are less respected than any other profession. Even less than teachers.

Unfavourable Public Images

Adverse public images are a source of strain. Nurses' knowledge of the human body is often identified with promiscuous experiences and they are, therefore, defined as unmoral. Nurses, on the other hand, become indignant at such attitudes and feel insulted when they are told uncouth stories on the basis of their being nurses, and hence, "in a position to understand." There is a conflict in being accused of socially-disapproved behaviour on the basis of one's occupational knowledge. Many students admit they think this unfair, especially when they consider themselves relatively naive.

Some sections of the public define nurses in the same category as scrubwomen, performing "dirty work". Nurses feel unjustly accused. They claim that they are given a lengthy and scientific training, that they are in possession of some of the latest medical techniques and that they are indispensable to both doctors and patients. They rationalize their menial work in terms of their altruistic beliefs — "someone has to do it". They imply
that such tasks fall to the lot of nurses as a result of bad organization and the scarcity of personnel. At the same time, they claim, such duties are of prime importance to the function of the hospital.

Another source of conflict is the public image which defines nursing as being easy and a role that "anyone could do". This obviously detracts from the status of the profession in classing it with unskilled jobs. Nurses, under this strain, point out the long hours of study, the examinations and the physical hardships. The public, they feel, are not aware of the nature and extent of nursing knowledge and obligations.

Bid for Professional Status:

Nursing, as an occupation, could be classified with several categories of occupational roles. Firstly, it uses science. It possesses a body of specialized technical knowledge, which has been accumulated and is taught during a lengthy period of training. Procedures are carried out according to scientific techniques. Secondly, it is an art, in that performance in the role is dependent to a large extent on individual talents. Books on nursing often stress this aspect of the role. Florence Nightingale writes: "Nursing is an art — it is one of the fine arts." Thus, in its first and second categories, nursing occupies a relatively high status. Thirdly, however, it is a "service" occupation, with its two:
diverging images. It can be classified either with "servants" or with "professions". Many nursing tasks are similar to the former, while most of its norms are similar to the latter. Thus nursing is a role where incumbents wash, clean, and run errands. At the same time, however, they profess attitudes of altruism, trustworthiness and a disregard for monetary reward.

Professionally, however, nursing is in an insecure position. It possesses specialized knowledge, a period of training, a system of ethics, a professional association and a monopoly over its recruits and members. Yet its full acceptance as a profession depends on the medical definition of their role. As long as certain segments of the public refuse to give professional status to nursing, and persist in defining it as "dirty work", "drudgery" and "menial tasks", professional standing can not be acquired. Not until the public accepts nurses with doctors, lawyers and clergymen will the status of nursing be professionally secure. Nurses express their strained position in the following terms:

I wish I could have a job where I could get as much out of nursing without doing all those menial things—cleaning this, and cleaning that, and doing the other.

The nursing group attempts to attain professional status by urging its members to act in a "professional manner". Nurses are discouraged, and often forbidden to behave in ways that are attributed to the lower classes and to unskilled workers. They are not allowed to whistle or hum.
on the wards. They cannot chew gum or place their hands on their hips. They are told not to slouch. They are forbidden to use perfumes and nail polish or wear long hair, in other words, they are encouraged to divorce themselves entirely from sensuous expressions of femininity. This function is further boosted by the uniform, which is, at once, disguising and equalizing. At the same time, however, the maternal expressions of femininity are greatly encouraged.

Nursing as a Marginal Role

The role of the nurse in relation to the hierarchies of the hospital is also not clearly defined. There is a conflict here which results in a constant bid for power and prestige. The ambiguity and strain of the nursing role can be exemplified by the following:

It's so limited. You know. You can only do so much. For instance, one thing when you finish, like when I finish I will have five years of training and study and yet you still can't say something was so, it only appears so. You can't say it because you don't know that sort of thing. And you have to say seems, even though you're pretty damn sure it is. It seems so silly.

Nurses feel they are qualified to perform certain tasks, and often they feel they are better able to perform them than other personnel. They are, however, in a position of subordination to the doctor. The doctor may only visit a patient for a few minutes each day, yet the nurse is in constant attendance. Therefore she feels more qualified to evaluate the patient's
condition and to give him full care. Yet she is forbidden to do anything without the doctor's orders. Her role is marginal to that of the doctor. She has less technical knowledge and ability, a smaller area of competence, lower status, a smaller income, and less prestige. She knows the nature of the patient's condition, and she is expected to recognize important symptoms, but she cannot convey this information to the patient. That is the doctor's prerogative. Although to some nurses, usually of the "practitioner" type this is fully acceptable, the "theoreticians" with initiative feel the strain. They imply that they are doing less than they know and feel capable of doing.

This conflict over status seems to be felt on both sides. The concept of marginality implies that the well-established status group attempts to keep out the intruders, in this case, the nursing group, while the marginal-status group seeks to acquire the higher status. Doctors, when lecturing to nurses, do so in such a manner that the material is too difficult for nursing students to comprehend and suitable only for medical students. Nurses retaliate by complaining of the inability of doctors to see patients "as individuals", thus attacking their humanistic values, which are considered very important in professional roles. Doctors talk to nurses in a disrespectful manner, often implying that they are there merely as their.

helpers; to carry out the unimportant, menial tasks of medicine. Nurses, on the other hand, cannot rationalize the reality of their low status in relation to doctors. They release their tension in hostility towards doctors by grumbling about their ignorance of sterile technique or their illegible writing.

Nurses are also Women

Undoubtedly, much of the strain caused by an insecure and ambiguous status is due to the fact that nursing is an occupation peopled primarily by women. There are two concurrent, yet conflicting, views on women. There is the traditional notion of the inferiority of women, and the modern North American notion, in which women are not placed in a role of subservience. The hospital tends to adopt the former view by expecting nurses to show subordination to doctors. Yet the hospital also gives them professional status, thus making them the colleagues of other professionals, such as doctors. In addition, nurses are products of the present day cultural definition, where women are given a high status. Therefore they strive not to be subservient to doctors. Yet hospital rules require the nurse to stand when a doctor enters the room, whereas the same individual, as a woman, would remain seated. This is a well-defined sanction meant to imply respect, while outside of the medical sub-culture the very same respect would be shown to the woman. This strain of conflicting norms is most marked when a nurse and doctor are in the same elevator and one has to precede the other out of the open doors. Is the self-image...
of the nurse: to be that of a "woman!", or that of a "nurse!".

The Strains in Change of Milieu:

Change usually means the giving up of one set of "vested interests!" for another. If there is no process of unlearning, there is still a process of integration of old values with new. The subjects of this study experienced a change when they left the university campus for the hospital. This was the cause of many conflicts.

The attitudes fostered at the university differ drastically from those instilled at the hospital. In the university setting students are encouraged to show initiative, charisma and individuality. The hospital, on the other hand, to maintain its existing pattern of organization, tends to discourage these attitudes. They expect students to follow orders, to overcome charismatic tendencies, and to do their work without question or argument. They are equalized, not only by their uniform, but also by their behaviour which has been pre-defined. Yet at the same time students are expected to be able to take the initiative and the responsibility in an emergency. Another instance of strain.

University versus Hospital

They come from an environment where they are defined as students. As such they are under no obligation to the university to pass examinations or to become good students.
Their only obligations are to outsiders, such as parents and friends. When they enter the hospital, however, they are still defined as students, but are expected to render services. They are also under an additional obligation to the school to give proper care to patients and to learn the material presented to them.

The head nurse and the seniors and everyone is getting after you, while out at the university everyone is just so nice to you: "That's fine, Miss Smith, that's very nice." You get down here and bang.

They feel that their life is restricted, and that they are now forced into feeling responsibilities, not only towards themselves, but also towards their superiors. This ambiguous status, which wavers between that of a student and that of a worker, leads to feelings of strain. They release tension by complaining about losing their independence, about the lack of imagination in the staff and about the monotony of uniformity. Instructresses and hospital-program nurses retaliate by identifying the university students with snobs. University students complain that when head nurses hear that they are in the degree-program, they expect extra capabilities from them. The instructresses state that they are disappointed in the university class, or claim that "The university class....they can't even do simple mathematics."

At the university the students are submitted to a training sequence made up almost entirely of theoretical knowledge. They feel the strain of being defined as student nurses, yet being far removed from all aspects of nursing and
hence not having the satisfactions gained when dealing with patients. They claim they are student nurses, but have never been near a patient, and show a marked eagerness to enter the hospital phase of their training. Once in the hospital, however, they soon find that their training has become almost completely of an apprenticeship type, and they begin to complain of not learning enough material. So from an environment where they are submitted to an oppressive load of theory, they come to one where they are entirely separated from theoretical learning and subjected to the monotony of routine activity. They complain that the lectures and exams are "too easy" and that the teaching is on an elementary level. They feel they are "being treated like children in elementary school." The hospital program students resent this demoralizing attitude. Their resentment is further heightened by the extra privileges given to the university students, such as affiliations to the mental hospital and public health agencies.

University students feel that their "vested interests" are abused when they discover that, what was taught to them at the university, is not observed in the real nursing situation. They were taught at the university that magazines should not be passed from patient to patient, yet they find that this is practised constantly. They were taught to give attention to the personal needs of the patient and to give him psychological care, yet they see graduate nurses ignoring the patient for the sake of speed and accuracy. Towards the people that taught them they were expected to show respect, and they were expected
to approach them with their queries. At the hospital, they feel the expectations are different:

There is a difference between the university girls and the others. They wouldn't dream of speaking to their instructors the way we do.

They complain that they seldom see the instructresses, and if they do, they are crabby and expect too much from them as university girls, or treat them as if they were 'stupid.'

She scares me. I wish she didn't bawl us out like that. We don't seem to be able to do anything to please her. She says that she is disappointed in the whole university class.

On the whole the initial attitudes and values appear to withstand the strain. Most university girls feel that they did well in taking the university course and would advise others intending to become nurses to take the same course. They claim that not only are they older, but they understand people a little more. They feel that they have more insight into the psychological problems of the patient and that the hospital program tends to cram too much knowledge into too short a time of concentrated study. This is a drastic change from their initial strain at the university of "too much theory and not enough practice."

The Pressure of Institutional Life:

Institutional life takes into account such phenomena as hospital hierarchies, hospital organization and routine, residence life, and strictly enforced regulations. It must be remembered that the students who enter this kind of life had
previously been university students, living at home or in university residences, and in general, existing according to their own desires.

Upon coming to the hospital they are restricted to hours, to hospital meals, to times when they work and when they study, and to an isolated existence where most of their contacts are with members of the nursing group. They feel that their independence and privacy are impinged upon. They feel a distinct lack of outside interests, and complain that they have nothing to discuss with outsiders. They begin to feel more and more like outsiders in non-nursing groups. Having accustomed themselves to the lax rules that exist at their homes and in the university, they consider the "militaristic" nature of institutional rules as "petty." Conflicts occur when they lose their "late leave!" because of a ten-minute lateness, or when their superiors take drastic measures when they, as students, absent-mindedly precede them through doors. Feelings of hostility develop towards residence matrons when students miss telephone calls from boy-friends because the matron did not ring long enough, or failed to enquire for them in the lounge. They complain about the "stupidities!" of residence rules. This occurs usually when they cannot rationalize the regulations. They cannot understand why they should be in their rooms at ten-thirty in the evening, when they could stay out of the residence until eleven. They object to restrictions which
do not allow them to have magazine stands, gramophones, or plants in their rooms. Only when rules make sense, or are compatible with the overall values and standards of the profession do they comply without feelings of strain. One student nurse bewails her loss of independence and defines her reactions as:

Independence. Definitely independence. And, I don't know, I think I'm losing...

my initiative. I never really exert myself to do anything. You get to the point where you can't be bothered to do anything. Maybe it's because you're tired and you just haven't the ompht to get up and do something. But, I don't know, you get sort of cut off from everything else, too. I find myself out with people and I just don't know what to talk about. Because all I can think of now is nursing... you start living it and that's all you know. And it bothers me too.

The Problems of being "The Lowest of the Low!"

The hospital is a bureaucratic structure consisting of sets of well-defined hierarchies. Each student when she takes on the nursing role begins as a "probie" and status-wise is placed at the bottom of the nursing and the medical hierarchy. Coming from the university milieu, and kinship systems where they are encouraged to become independent in both action and thought, "probies" feel the strain of being the "lowest of the low," and subjected to authority. This results in feelings of personal devaluation or in aggressive...
attitudes which turn into hostile actions when they move up the hierarchy. In other words, nurses in positions of authority have forgotten what it was like to be a "probie," or feel that all students should experience that phase with its subordination in order to be a successful nurse. Feelings of insubordination, accompanied by strain, are experienced when doctors: "usually look right through you and don't even see you," or ignore your status as a woman and precede you through doors. I suspect that doctors tend to define student nurses as children, and not as women, and hence feel justified in ignoring them and not extending to them the courtesies usually given to women. "Probies" feel that other nurses consider bed-making and other routine tasks as below their level of competence and therefore refuse to do them. When they sit down to rest in the nursing station graduate nurses remark that they "didn't know that 'probies' could sit down." Even students, who have reached a higher level of competence sometimes refuse during off-duty hours to allow them to use equalizing forms of address, such as: christian names, by reminding them: "Miss Jones to you." They are forced to greet doctors, who are also family friends, with a stiff "Good morning," even though the evening before they had conversed on equal terms. These are all instances of strain.

The Strain of Conflicting Demands:

Students are placed under conditions of conflict when traditional norms, which they have been taught, are.
supplanted by new norms in the real situation. There is often a difference between what they know and what actually is practised. A student is told that she should never diagnose the patient or divulge to him the signs and symptoms of his illness. She must recognize them, but cannot do anything about them. She must report them to the doctor, who then gives the pertinent information to the patient. This is the source of feelings of frustration. As one student put it:

They can tell when they have a temperature and they would lose faith in you as a nurse if you told them that they did not have one... but we were told never to give temperatures.

They are forbidden, as "probies," to give medications. They confide that they feel silly when they say they are unable to give medications, when "all you have to do is take a pill down to the patient." They are taught to carry out strict infectious diseases techniques with cases of staphylococcus aureus boils. Yet in reality they observe these patients wandering around the wards without restrictions. They claim that in the lecture-room such things as "good nursing care," "patient teaching" and "reassuring the patient" are frequently stressed. When they reach the ward situation, however, these terms become meaningless. The demands made upon them are in terms of action in the physical sense and they have little time for giving psychological care.

Great stress is caused when one instructress or head nurse teaches one version of a procedure, yet when the student changes floors, another head nurse demands another version of
the same procedure. Students also claim that they see their instructresses too infrequently and, during this absence of contact, they work under their own responsibility. When the instructress returns, however, they are once more treated as students and the work, that they performed previously as members of the staff, comes under observation and evaluation.

Higher in Authority, Lower in Competence

Nursing norms expect that student nurses show the appropriate respect to those in positions of authority, such as doctors, head nurses and graduates. They are told that, in cases of indecision, they should consult the nurse in charge of the ward or the instructress. These people are defined as having the knowledge and the required attitudes of the profession. Such expectations are often the cause of strain when student nurses discover that the individuals in positions of authority are not desirable models as they seem to be ignorant of much of the knowledge that they, as students, have already acquired.

Students respect doctors for their knowledge, but are indignant because they show ignorance of such nursing procedures and techniques as the "sterile field." Doctors sit on the side of a bed in the isolation section, or throw a chart on the bed and later retrieve it. They also claim that doctors give little attention to the psychological care of the patient, which they
have been told is an important function of the medical sub-
culture.

He couldn't have prepared the kid. He probably went in and said: "I want some of your blood"... of course, the kid just bawled... all he wanted was two ccs. The kid probably thought he was going to take a pint. You see, no preparation whatsoever.

Although they are expected to take their problems to the head nurse, in reality students often approach other students or graduates when in trouble. The head nurse may be incompetent in their eyes, or they may have developed an image which identifies her with a tyrant ready to devaluate them because they cannot perform their tasks without help. One junior spoke of her head nurse in the following terms:

She's really stunned. I have to tell her what to do, even though she is in charge. We had a new patient the other day and I had to ask her if she had phoned the doctor. "Oh no, I'll do it now... Hello, Dr. Green... Miss Watson, what do we want him for?... Oh, yes...!!"

Conflict also occurs when students, who have been on a floor where there were twenty patients and nineteen nurses, discuss their work with students, who have been on a floor where there were twenty patients and four nurses. Together they complain about the inability of the administration to organize the duties of the staff more efficiently.

Students note with disillusionment that the values of the nursing profession are often abused by those in positions.
of authority. They complain that head nurses and graduates are too efficient, and often quite mechanical in their relationship to the patient. They repeat anecdotes of where nurses in administrative positions forbade staff patients to fill their fountain pens in hospital ink. Graduates, they feel, are often two-faced. They will be pleasant to a patient, but then grumble to each other about her and make such statements as: "I wish to heck she'd die." In many cases, students find it difficult to render the right amount of respect to these graduates after they have observed such violation of nursing norms.

**Occupational Demands Exceed Physical Abilities.**

When a student: "takes on" the professional role, she begins to internalize the values of the role until they become a part of the self. Often, however, these expectations demand more from the nurse than she is physically able to give. Conflicts arise between the nurse as a human being and the nurse as a professional self. As the former, she is oriented to following the dictates of her organic needs and is limited by her intellectual and physical capabilities. As the latter, she is controlled by the expectations of a professional role, where she is oriented to the welfare of others at the expense of self-interest.

**A Nurse's Work is Never Done.**

A nurse is faced with the problem of organizing.
two things: her time and her tasks. She is allotted a specific amount of time to complete the tasks that fall to her lot. Having the values of our society concerning activity, she is inclined to finish a performance once she begins it. This calls for speed. She balances this against a shortage of time, her own abilities and the nursing norm of accuracy. When she is not able to follow activities to their logical conclusions, or is forced to spend more time on a task than the particular performance requires, or when she has not had the opportunity to learn the required technique, strains develop.

Not having enough time for things....like you're rushed, you don't have time to finish what you're doing....or just get finished and be called away to do something else....you never have time to look up on a chart what you've been doing ....you're very busy.

They begin to avoid certain rooms on the ward, because they know that their appearance signals the development of many needs. Suddenly windows have to be opened, pillows have to be adjusted, candy has to be bought from the candy stand, a magazine has to be picked up, a thirst has to be quenched, or a bed pan has to be fetched. The climax is reached when one patient requires an open window, while the man in the opposite bed, wants it shut. While the nurse is braiding Mrs. Jones' hair, Mrs. Brown asks for help in turning over, Mrs. Smith signals that she needs her help, no nurse is answering the light in the room opposite, and the head nurse is waiting to see her. So while she busily braids the hair and absently chatters with Mrs. Jones, she is also organizing her next move.
Above all, she is tired and would like to sit in the nursing station and perhaps acquaint herself with the patient's charts.

All nurses are faced with the inability to ever have their work entirely completed. They are always aware of more tasks that could have been done. The units or the cupboards need tidying, the ward manual or the patients' charts should be read, or the thermometer water should be changed. The work of nursing is defined by a state of constant activity. This engenders an anxiety in nurses as they seem never to have their duties completed.

These feelings of anxiety and the need for constant movement are reinforced by head nurses, who cannot tolerate students standing or sitting without physically doing anything. They are sent to perform such tasks as counting bed pans. This causes frustration as they are unable to see the need for such performance and see themselves being forced to work, not for the end it could serve, but merely for the sake of making work an end in itself.

Tasks beyond Their Competence

She walked on the ward when ward rounds were going on. The doctor stopped her and gave her a specimen bottle and told her to take care of it. She continued down the hall without the first idea of what to do with it.

Such situations occur when doctors are not aware of
the specific details of nursing education and cannot estimate a student's exact degree of knowledge by her uniform. Students remark that they have difficulties in telling others that they do not know how to perform simple tasks or "have not learnt that yet." It is humiliating and status-lowering, and another instance of strain.

The Strain of Integrating Conflicting Norms

It should be remembered that before a student takes on the role of a nurse she is an incumbent of several other roles. She is a daughter, a "teen-ager," a middle-class high school or university student. Her attempt to take on the nursing role is, to a certain extent, controlled by the experience she has had in performing these other roles. She has to integrate her previous convictions with the convictions held out to her by her occupational role. Thus attempts to conform are complicated by the persistence of learned patterns of behaviour and thought. Conflicts arise when she is torn between simultaneously incompatible expectations and the desire to retain previous patterns and yet adopt the new.

As "teenagers" and members of a family in North America, students have learned to expect individual attention and condolence. Their anxieties and frustrations have been considered matters of importance deserving attention. As nurses, however, they are socialized into a sub-culture where
their individuality and their problems are de-emphasized, and often ignored. They experience stress when the former expectations have to be unlearned to make way for the nursing role.

Most nurses belong to a socio-economic group, which, for the sake of a better description, could be called middle class. They have the values and expectations of that class. Their patients, on the other hand, come from three possible socio-economic strata: upper, middle, and lower. Although nursing norms forbid discrimination, most nurses indicate that they prefer the nursing of middle-class patients. They would feel uncomfortable with those on the status position above them, and somewhat condescending to those in the positions below them. Culturally, they are somewhat incompatible with both. Nursing ideals, however, encourage them to help the weak and show charity to the poor. Often, therefore, they indicate that they prefer to nurse staff patients. By such an indication they imply their conformity to occupational ideals. On the other hand, however, they complain of the squalor, the dirt, the swearing and the smell.

The stink down there hits you as soon as you go near it. The patients come in filthy and stinking... all from Skid Row.

As nurses, they know they are expected to disregard status and rewards. Yet previously acquired values, as members of the middle class, make them wish for higher salaries, or for a release from routine and "dirty" tasks. They have to
integrate their images of their professional selves. The image that they are specialists, experts, highly in demand, and that their standard of living should imply this, with the image that they are dedicated to service to others and self-interest is unimportant. Such contradictions lead to strain.

Cultural Ignorance and Professional Knowledge

Cultural norms of the appropriate behaviour for young women expect them to observe the correct inhibitions with regard to knowledge of the body and sexuality. They are expected to show ignorance of such topics. Nursing norms, on the other hand, expect them to be well-versed in all aspects of the human body and to be able to perform nursing procedures on this body. Students at the beginning often have much difficulty in tending to male patients. They show a marked awareness of the privacy which is required by patients and place emphasis on the correct draping and concealing techniques. These difficulties are eased by having orderlies tend to the "private" needs of male patients or by having a male patient "finish his own bath." Another strain occurs when these students go to the operating theatre. All pretences at modesty and respect for privacy are dropped and norms regarding the human body are violated as a normal pattern of behaviour.

To think of all the trouble we go to to drape the patient, and here there is no thought for such a thing.
Conflicting Attitudes towards Patients.

A well-known contradiction of all professional roles is the dilemma of efficiency versus humanitarian views. If the nurse is efficient, accurate, impersonal and functionally specific, she is successful as far as the technical aspects of her work require her to treat the patient as an individual and to show him sympathy and interest that are beneficial to his psychological welfare. If she tends toward the former, she is defined as "callous" and she violates the nursing norm of "personal care." If she tends toward the latter, she is liable to identify with the patient to such an extent that her own emotional stability is threatened when the patient becomes worse or dies. This is backed by her obvious preference for patients that improve, and therefore, in most cases, for surgical patients.

Barriers to Psychological Care

Psychological care is emphasized. Several other aspects of her existence make this difficult to perform. Firstly, psychological care means differentiated care. Nursing training tends to equalize students and to introduce a "like-mindedness." This makes it more difficult for them to attain insight into the wide range of problems that could beset a patient. Secondly, nursing is an activity-oriented role, as I have pointed out before. Work for a nurse is constant activity. Psychological understanding, however, can only be
attained through mental activity. In most instances, the kind of physical and mental activity required, cannot be carried out successfully if attempted simultaneously. Therefore, even while performing a task that requires little intellectual concentration, such as washing medicine glasses, a nurse cannot direct her thoughts sufficiently towards the psychological problems of a patient. Thirdly, nurses are faced with the choice between institutional requirements, such as charting and paper work, and the giving of psychological care.

Hurting, yet Curing.

Often the process of curing a patient involves causing him more pain. Nurses define themselves as people who cure, who soothe, and who help. They have a definite dislike for nursing techniques that force them to inflict pain and therefore contradict their image of helper. They have to rationalize their actions and to build a defense against wails of pain and statements such as "you're cruel, nurse."

Undoubtedly, this is an area of great internal strain. The self has to integrate the performance of painful techniques with the nursing norm of alleviating suffering.

Another such strain is the fear of error. Techniques are exacting and nurses are aware of the fact that often any mistake on their part could injure or even kill a patient. This accounts for the fact that when they are unsure of their
abilities; they show greater desires to tend to patients who are cured and do not need the administration of complicated procedures. It also explains their fear of the operating room, for here the need for accuracy and speed are emphasized.

They are expected to treat patients as people, and not to perceive them in terms of their illness. This increases the strain of having to perform painful techniques. Inner conflicts are therefore prevalent in the operating room where students see incisions, or worse still, when students are asked to dispose of amputated limbs. They adjust to this by developing attitudes where they defined patients as "cases." In other words, they become universalistic.

Thus strains occur in their orientation towards patients. They begin by being particularistic, and then become universalistic. At the same time, as students, they focus their interests on the specific area of their tasks. They find, however, that they become involved in diffuse functions. They are then faced with the conflicting problem of integrating their particularistic attitudes and specific areas of function in the beginning and their universalistic attitudes and diffuse areas of function when they begin to play the role.

Children or Adults?

Nurses have difficulty in developing a systematic self-image. In the lecture-rooms and in the presence of instructresses they are treated like children. They are expected.
to obey and respect, and in return, they are assisted and taught. They are led, every move being observed and evaluated. Mistakes are corrected, but tolerated. When giving nursing service, however, students carry out functions, and are responsible for their outcome. Mistakes are severely reprimanded and students see them being considered the results of negligence, rather than the result of ignorance.

What does Death Mean?

Nurses often rationalize the "importance" of their work on the basis that it deals with life and death. In the physical sense, they develop techniques and procedures whereby they can cope with these phases. They can stop hemorrhages, call for oxygen, or help save the life of a patient on the operating table. They have not, however, developed a definition for these important phases. In a culture where "living" is defined as the most important human function, the end of "living" has no clear connotation. Nurses often feel the stress of being faced with death and being unable to interpret its meaning. Their bewilderment is exemplified by the following:

He was yellow - his mouth and eyes were open...I couldn't believe he was dead.... I'd never seen anyone dead before...I felt strange as if it wasn't me there looking at the corpse...it was queer... I guess you always remember them how they were when they were alive...not that I felt sorry or anything...I just felt queer.

There is no prescribed form of behaviour in the presence
of death. Culturally they are expected to show reverence, yet the medical sub-culture expects activity and an ability to accept death without losing emotional stability. Nurses have difficulties in integrating the two expectations. They wonder what they should say when a patient asks them if they are going to die. "What do you say? 'I know' or 'I'm sorry.'" They feel the frustrations of fostering hope in a patient when they know that he will die. They question the norm of the medical sub-culture that patients be kept alive as long as possible. What if the patient wishes to die, they ask.

2. Institutional Means of Releasing Tension

Strains lead to some form of adaptation for the release of tension. Often this is dysfunctional to the persisting state of the sub-culture. Institutional ways of reacting to anxiety are by change, by humour, by generating social distance from the object of strain, by complaining, and by other means.

Aggressive talk is a major outlet for relieving conflicts. By this method tensions are released without the violation of nursing norms. Nurses feel justified in complaining to members of their own group. They receive the sympathy and support of their peers and gain fresh energy to meet the same problem again the following day. They complain of insulting doctors, enraged head nurses, incompetent graduates; they criticize techniques, evaluate the personalities of their.
co-workers: and suggest more efficient methods of performance. They see themselves as a persecuted minority and as martyrs. They complain that super-human deeds are expected from them and that they are greatly wronged by the adverse behaviour of the others involved. The strain felt by any one member is communicated, with varying intensity, through to the other members of the group.

They resort to humour and under conditions of strain, they joke. Humour is based on incongruity, and is used when nurses have difficulty in defining situations. They joke when they do not know what kind of relationship they should establish with a patient, when they do not know how to converse with him. When in the operating room and under strain, they liken a patient's leg to a leg of mutton, or compare the surgeons to men from Mars. This method of releasing tension, is resorted to more often in cases of internally generated strains, while aggressive talk is used more in cases of externally imposed strains. When the conflict occurs within the self they tend to conceal the strain from the other members of the group, being unsure as to whether the others experience the same strain. If the others do not experience it, the individual with the strain cannot be sure of support. When the conflict is caused by external factors the institutional form of release is aggressive complaining.

Another way of coping with strain is by withdrawal. Social distance develops between a nurse and an irrational
instructress or a complaining patient. The nurse avoids them and thereby avoids strain. Another form of this is the tendency to define patients as "cases" and thereby avoid interaction on a personal level, and the strains that could possibly arise.

When norms do not make sense or cannot be rationalized, outright defiance of the norms often occurs. Thus, although certain electrical appliances are not permitted in residence rooms and students are not permitted to prepare meals in the residence kitchens, these rules are often broken.

Strains are sometimes not coped with adequately, and anxiety is not reduced to manageable levels. This leads to open aggression where students "tell them off." Thus, when institutional modes of tension-reduction are not functional, students turn the results of strain directly at its cause. Often this can lead to change at the source, thereby preventing future strains in the same area.

3. Functions of Strain

Strain is usually defined as dysfunctional. It leads to such patterns of conduct as aggression, apathy, absences and illnesses. When, however, these strains exceed the limits of tolerance, the stability of the existing institutional pattern could be threatened.

It is a fallacy, however, to define strain as entirely dysfunctional. It could also be considered as functional.
Before the positive functions become apparent, however, the negative patterns of conflict have to appear. Strains lead to change, and change could be seen as being a necessary aspect of all existing social phenomena. In this way conflict illuminates the conditions which cause strain, and change is one way of correcting it, and of achieving harmony.

External strains lead to the unifying of the nursing group. Unity is achieved by the student group when common problems are discussed and group support is given. The group defines itself as a unit against all external factors, which are defined as "they." This internal harmony functions in maintaining the barriers which prevail between different groups in the nursing hierarchy and thereby the hospital organization becomes self-perpetuating.

Strain functions in maintaining the existing state of affairs. For example, although it is a cause of strain, nurses are oriented to constant activity. If they have nothing to do, this strain is aroused with the feeling of guilt in not conforming to the nursing norm of "work." Students react by wishing that they had something to do, and make a task of finding something to do. Again this strain functions in maintaining the existing state of the medical sub-culture, and in reinforcing the existing norms.

Even open aggression has positive functions. Tension is released. Over and above this, however, the aggression can prove to be an instance of communication between the different
levels of the hierarchy, during which each becomes aware of the problems of the other. I venture to suggest that many of the strains of a nurse's role are caused, or at least, heightened, by the fact that nurses are ignorant of the over-all picture. They are not fully aware of the problems of the whole hospital, of administration, of doctors, or of supervisors. The latter groups, in their turn, are somewhat unaware of the problems of students. By communication resulting from open aggression, both sides have the opportunity to become familiar with the strains and conflicts of the other. Change may, or may not, occur; but harmony could be achieved by insight and empathy.
CHAPTER X

CONCLUSIONS: AND IMPLICATIONS:

My conclusions and implications are based on material collected by interview, questionnaire, observation, reading, and interpretation.

Findings:

My study on "becoming and being a nurse" led me to the following conclusions:

Regarding Field Work Experiences

By keeping a flexible approach to the study, I found that I was able to collect material that would not have otherwise been forthcoming. I found, for instance, that unguided interviews during participant observation were very fruitful. This would not have been possible had my approach been a rigid one.

Field work made me aware of new areas for investigation, and a flexible approach allowed me to examine them. For example, what had begun for me as a piece of research on the role of the nurse, became enlarged to include the context within which the role functions.
Interaction with Subjects

Participant observation permitted me to adopt a double perspective. I assumed the positions of outsider and of insider, and by this means I was able to collect material from both viewpoints.

I found it impossible to retain a "pure" experimental situation. The attitudes and behaviour of my subjects influenced me and similarly my own attitudes and behaviour had effects on the subjects. They became increasingly aware of the nature and purpose of my study, and of the type of material that I was collecting. To be defined as a "friend," and thus to be more acceptable to the group, I had to answer questions that helped to mar the "purity" of the situation.

I became aware that my interaction with the subjects was based to a large extent on trust. I developed a system of ethics.

There were indications that interviews were not beneficial only to me, but seemed to serve a cathartic function for the subjects.

Role-taking

Participant observation involves the taking of a role. In my case, it involved the taking of several roles. The kind of information that I acquired in any situation depended on
how the particular subjects defined my role. As the roles in the hospital were numerous, I found myself playing several different roles in interaction with this multiplicity of roles.

With increasing socialization into my role, or roles, I was shown increasingly greater acceptance by my subjects. This was valuable in enabling me to become an "insider" and to be in a position to have access to more data.

Limitations of the Study

It was impossible to keep the situation as "pure" as a situation in the physical sciences. My advice to others attempting similar research, would be to keep the situation as "pure" as their particular role-playing would permit, but not to sacrifice entirely, the other aspects of field work for the sake of a situation that is a little "purer."

I found that I was not able to adequately unlearn and modify old norms. This made it uncomfortable for me in certain participant observation situations. I reacted by leaving the situation. In this type of field work, where unbiased observation is of prime importance, it seems more desirable to withdraw from an uncomfortable situation, rather than to make observations from an obviously biased point of view.

Invariably during interview I lapsed into the role of a sympathetic listener. I did this, not so much consciously,
but more in conformity to social norms which demanded sympathy in such situations. I feel, however, that although I was thus able to collect some valuable data, other types of information would not have been forthcoming. I would like to suggest that possibly this was one of the weaknesses of my method, and should have been avoided as much as possible.

During the process of my role-taking, I found that I was less able to reconstruct the situation as it was at the beginning. Field workers should be prepared, therefore, from the beginning, for losing their role as outsiders, and their ability to see the situation from a different perspective.

**Regarding the Wish for Nursing**

Students showed two types of orientation towards nursing: an ascribed orientation, where they believed that nursing was chosen by them because of their inherent suitability for the role; and an acquired orientation, where they admitted to choosing nursing for rational reasons.

Students admitting to the ascribed type of orientation were of two sub-types: 1) those who felt that they had always wanted to be nurses, would consider no other occupational role; and 2) those who said that they became nurses because their mothers were nurses. The latter sub-type were influenced directly by their mothers to become nurses, or indirectly, in that they had internalized the appropriate norms and finally found
that the nursing role was the most suitable.

Students admitting to the acquired type of orientation were of four sub-types: 1) those who felt that by being nurses, they would have the means to something else; 2) those who said that they went into nursing as the result of an emotionally disturbing incident to do with hospitals and nursing; 3) those who, after considering several other occupational roles, said that they discovered that nursing was the most suitable, as it seemed to have the same norms that the student had internalized; and 4) those who went into nursing as an alternative for another role, which they could not acquire.

The strength of the students' wish to become nurses was indicated by the alternative occupational roles they would choose, should they be forced to do so. They were roles in: 1) "women's" occupations, indicating that the feminine qualities involved in the nursing role could be considered attractive; 2) the medical sub-culture, indicating that the medical role was an attractive one; 3) occupations dealing with people, indicating that the desire to be altruistic strengthened the student's wish to be a nurse. Their desires to become nurses were also strengthened by the approval of family and friends. I discovered that, of the students interviewed, 85% indicated that their parents were pleased with their choice, while 15% had at first tried to redirect their interests.

When asked for their "ideal" occupational role, 40% of the students mentioned medicine, 40% mentioned nursing, and
20% had ideals ranging from designing to airline piloting. Attraction towards the medical sub-culture is, therefore, quite strong. Although the attraction towards nursing was equally strong, the inference is that many nurses would have preferred to be doctors.

Regarding Role-Anticipation

Images of the Role

Before beginning to play the role of a nurse, students anticipated that ideally nurses should have, in the following order of importance: an ability to get along with people, an ability to enjoy their work, a pleasing personality, a neat appearance, an ability to follow orders and a command of technical skill. Least important for a nurse, students anticipated, would be scientific curiosity and a high level of intelligence. This implies that students' anticipation of their work was not one of a scientific nature. Rather, they seem to place greater emphasis on a human-relations orientation. They also imply that they expected to be patient-oriented rather than illness-oriented. They thought that this was what the patient expected from them.

Students showed that they anticipated that doctors would see them mainly as subordinate helpers. Seldom did they indicate that doctors would see them as professional people.
Other nurses, students anticipated, would expect them to be cooperative and to carry their own responsibilities.

The hospital, they thought, would expect them to be loyal and obedient and to uphold institutional standards.

The non-medical culture of parents and friends would expect them to give personal nursing care, to be skilful and efficient, to be friendly and to be professional. The implication here is that students think that parents and friends want a nurse to retain her old qualities and at the same time to acquire the new professional ones.

The public, students thought, wanted nurses to be human and yet to give good, efficient care. They thought the public sees nurses as leaders, willing to serve, skilful, reliable, morally beyond reproach, and as people with a "good education." This indicates that, despite their awareness of adverse public images, students believed, on the whole, that the public sees nurses in a favourable light.

Character of Obligations

Students thought that the first obligations of a nurse would be to give psychological care to her patient. Her second obligation would be in nursing skills. Her least important tasks would be routine jobs. Generally, students showed a strong patient-centered interest.
They expected to enjoy work with patients who responded to the nurse. This would prove personally satisfying. Least of all, they expected to enjoy doing "dirty work," indicating a dislike for status-lowering tasks.

As far as value to the hospital was concerned, students estimated institutional roles in order of importance as follows: 1) doctors, 2) nurses, 3) dietitians, 4) instructresses, and 5) student nurses. The least valuable were visitors and nurses' aides. Although they were aware that they would be subordinate to the doctor, students thought that they, as nurses and as women, could give the patient a more personal, humane type of care. The doctor could only contribute greater medical skills.

Rewards:

Students considered personal satisfaction and altruism as the greatest reward, and the greatest attraction, of nursing. Other nurses, however, they felt were attracted by security and glamour. Thus, they tended to project "self-interest" on other nurses, but "other-interest" on themselves.

Status-wise, students saw themselves, once they became nurses, grouped with the medical team, with women's professions, with traditional professions, and with roles that deal with people. Thus, students expected to have the status-rewards of a professional role and a "service" occupation.
In order of importance, students thought that nursing would lead to the following: 1) public health nurse, 2) simply nurse, 3) mother. Thus the majority of the students visualized nursing as a means to an end.

Strains

Students felt that the public was ignorant of certain aspects of nursing, such as: the lack of glamour, the hard work, the extensive education involved, the psychological care given to patients and the full extent of a nurse's duties. Students indicated by these views their awareness of a somewhat unflattering public image. They also showed that they felt this image to be unjustified.

Relation to Others

Students indicated that they expected to like their work with other nurses and with doctors. All students showed that they admired doctors as professionals. Least of all, however, they would like their work with interns, head nurses and orderlies.

As far as patients were concerned, they mentioned that they would like to nurse illnesses where the patient recovered and was not suffering extremely. They gave examples such as: surgical cases, children's diseases and obstetrics. They showed preferences for patients who were cheerful, grateful and obedient. They indicated a preference for a semi-private
ward, and hence for patients from their own socio-economic group. In brief, they showed preferences for patients who would respond to them, thereby providing them with a nursing reward, and for patients who would not adopt status-lowering attitudes towards them.

Students admitted that they would like to nurse in the emergency unit, in the operating room and in pediatrics. This shows a tendency to prefer the more dramatic, in the case of the emergency unit and the operating room, and the more gratifying, in the case of pediatrics, where they would be permitted to develop and use their maternal qualities.

As for getting emotionally involved with patients, students were sure that they would be able to deal with this. Thus, although students indicated a patient-centered orientation and stressed a personal type of care above efficiency, they felt sure that they would not become personally involved, or over-identify with patients.

Regarding the Processes of Socialization

Internalizing New Norms

Students' initial interest in the patient as a "person" (particularism) changes to an interest in the patient, merely as a "patient" (universalism). This is one result of the internalizing of new norms and socialization into the nursing
role. Student interest in this is maintained and strengthened by a combination of routine, specialty training, rituals and official recognitions of the students' ability to cope with further responsibility. Illness, life and death, matters of abnormality in our culture, become for the student, matters of routine. Students tend to identify nursing with a process of "growing up," of increasing knowledge and of increasing responsibility. Norms are internalized with the help of processes of discipline, imitation and identification. Often the internalizing of nursing norms involves the unlearning or modification of old norms, as in the case of norms concerning illness, norms about causing pain and norms governing death and attitudes towards the body.

Increasing Group: Solidarity

The increasing isolation and inability to have common experiences with outsiders, together with increasingly greater contacts with peers, led to a growing solidarity among nursing students. Close identification with other members of the nursing group is also an aid in internalizing the new norms.

Each nursing group develops an "ethnocentricity," with its own sanctions, norms, systems of morality and myths. The group takes on the appearance of a secret cult, with its characteristic language, rites de passage, its close watch over its body of knowledge and its segregation from outsiders.
Thus, with increasing group solidarity there is a decreasing ability to identify with the non-medical group.

Increasing Awareness of the Institution

After entering the hospital, students show a greater awareness of hospital costs, of the need for more personnel, of the importance of knowing the rules and of the existence of other hospital roles beside their own. They come into contact with a hierarchy, and become aware of their position at the bottom of this hierarchy. Hospital norms of obedience, cooperation, and depersonalization are felt. They begin to feel equality with other nurses and a sense of loss of identity.

Regarding the Phases of Socialization

Socialization of nurses into their occupational role can be divided into four phases:

1. theoretical training, where instrumental and expressive norms are taught didactically in the university setting.

2. first practical experiences, the students' first contact with the "real" situation.

3. the "reality shock" that occurs because of the contradictions between phase one and phase two. It is the result of discrepancy between role-anticipation and "reality" or the result of the new type of role-playing being different from the old. It can occur, therefore, through the overcoming
of old norms, the discovery of imperfections in institutional life, the contradictions to previous learning, feelings of inadequacy, the replacement of glamour and drama with routine and the growing feeling of the loss of identity.

4. acceptance and routine, that is characterized by periods of cynicism. The student queries whether she really wants to become a nurse. During this phase, also, professional characteristics begin to appear.

Regarding Specific Changes:

At the beginning students tend to take a personal, emotional interest in the patient (affectively-oriented); they see patients as "people" (particularistic) and because of their inexperience, they confine their work to the specific area of their tasks (functionally specific). After practical experiences, however, the students gradually become more unattached emotionally from the patient (affectively-neutral), and tend to see patients more as "cases" (universalistic). At the same time they deviate from Parsons' image of a "professional role," in that instead of becoming functionally more specific, they tend to define more tasks in the area of their duties and hence become functionally more diffuse. In other words, although at first students were overwhelmingly person-oriented, after hospital experiences, however, they showed a desire to combine person-orientation with illness-orientation. They were also more human relations oriented than efficiency-oriented, but after working in the hospital, they showed a greater desire
to combine the two. They are, therefore, conforming to the institutional norms of attention to illness and its efficient and speedy treatment.

At first students thought that people were attracted to nursing because of its glamour and drama. After practical experiences, however, they thought that people were attracted to it mostly because of the opportunity to help others. This indicates that students have, possibly, experienced disillusionment with regard to the glamorous aspects of the role. Factors of attraction also considered important after practical experiences were a favourable public image and curiosity about illness and medicine.

The commitment to institutional norms becomes apparent after students have experienced hospital life. They become increasingly aware of the pressure to fit into the institutional context; they begin to feel the importance of carrying out the orders of superiors at all events; they admit also that they do not like their work with doctors as much as they had anticipated. Doctors, they think, place more emphasis on their occupational qualities, such as cooperation, good knowledge of techniques and so on, than on their individual qualities. This indicates the effect of the status hierarchy and the consequent feeling of personal devaluation. To support this indication, they show an increased dislike for head nurses.
Students show, to a greater degree after hospital experiences, that they consider nurses are paid far too little. This indicates that they thought that they worked harder, or longer, or had to put up with more than they had expected and hence were worth more in terms of monetary rewards.

Students show an increasing awareness of the need for giving psychological care. When considering the qualifications of an ideal nurse, students think that technical skill is not as important as they had thought previously. A personal, human-relations approach to the patient is more important. In addition, the value of visitors rises in their estimation. They also mention that they are able to contribute more of the psychological type of care than the doctor. By this they imply that, although the doctor has a higher status and more prestige, they are able to make a greater contribution to the needs of the patient in terms of a friendly, human-relations, personal approach. It should also be noted that psychological care, which involves to some extent, reciprocity on the part of the patient, is more gratifying to the nurse.

Personal satisfaction, over and above security, remuneration and prestige, remains the greatest reward of nursing. Students imply also that they think that social contacts with patients are the most enjoyable of their tasks. This implies that satisfactions come from contact with patients who respond. This is supported by their preferences to nurse patients who get better, who respond in other ways, and who
have similar socio-economic characteristics to their own. They like surgical nursing. Their interest in emergency has dropped. One explanation for this could be that their contacts with responsive patients in emergency would be few. Also the drama of this unit has lessened, and the students may begin to identify emergency with heavy demands made upon an incomplete knowledge of skills and doubtful competence.

After being in the hospital the student nurses' evaluation of herself changed. They think their role is more important than they had expected. This implies that they were not aware of the full significance of the service they would be giving. They had possibly seen themselves as "students," and not as "workers."

There is an indication of the emergence of a typology of nurses. This, however, needs to be more fully explored in future research.

Regarding Playing the Role of Nurse

By observing, interviewing and reading, I came to the following conclusions about the role-playing of a nurse:

The public images of a nurse include seeing her as a "ministering angel," as an emancipated follower of Florence Nightingale; as a waitress; and a scrubwoman; as a person who works hard, and has high morals; and as a woman with "loose morals."
Nursing self-images, supported by a system of ethics, place emphasis on norms of altruism, service and kindliness.

The tasks of a nurse are both impersonal, or technical, and personal or human relations oriented. They are governed by a system of standards imposed by the occupational group. Her tasks are defined by boundaries. The boundaries of her impersonal tasks are well-defined, while the boundaries of her personal tasks are more ill-defined. It is interesting to note that work, as defined by nurses, seems to involve constant movement.

The rewards of nursing appear to be of two kinds:
1) where nursing is an end in itself and hence the reward comes from personal satisfaction; 2) where nursing is a means to an end, and the rewards come from such ends as security, income, or prestige. The rewards, if they balance strains and obligations, keep the individual playing the nursing role.

Regarding the Strains and Conflicts of Nursing

Unsatisfactory Status

Adverse public images, as held by certain segments of the public, are sources of strain. Nurses dislike being thought of as "scrubwomen" or women with "loose morals." Nor do they like to be seen as doing work that "anyone can do."

Nursing as a profession, is in an insecure position: 1) as certain segments of the population refuse to give it
professional status; 2) as nurses feel the marginality and limitations of their role as compared to that of the doctor; 3) as nurses imply that they are often doing less than they know how to do; 4) as there are contradictory views towards women in our society.

Change of Milieu and Institutionally Imposed Strains

The change from the university to the hospital involves 1) a change in attitudes towards initiative and individuality, 2) a contradiction of what is taught at the university with what is practised at the hospital; 3) complaints arising from being defined as "students," yet being expected to give service; 4) a change from an environment of "too much theory," to an environment of "too much practice."

The institutional environment is the cause of many strains. Students complain about residence rules, and fail to see the rationalization for some of them. They complain about being defined as adults one instance, children the next. Feelings of personal devaluation are shown by students as the result of being at the bottom of the nursing hierarchy and of doing routine tasks. Students find that they do not have sufficient time to be able to give "good nursing care," and that there is the constant frustration of being unable to complete their work. They find that different versions of the one nursing technique are taught on different wards. Conflicts also occur when students are expected to perform beyond their
level of competence. They find that individuals in positions of higher authority are often ignorant of some of the basic knowledge that even they, as students, have acquired. They find that sub-cultural isolation, residence life, and constant interaction with nurses, gives them feelings of inadequacy and of not belonging when in the company of non-nursing groups.

Conflicting Norms:

There are strains when middle-class nurses are asked to nurse upper and lower class patients. A secondary strain develops from this when students have internalized a norm which expects them to help the needy, whatever their background should be.

Students have some difficulty in unlearning social norms which concern the body, and adopting nursing norms which require them to do painful procedures and also to prevent and cure pain; social norms regarding death, which students find difficult to define and cope with according to nursing expectations. To adjust to these, they begin to define patients as "cases." By this very adjustment to "cases," however, they are conflicting with their initial anticipations that they would not become like other nurses, hard and efficient.

There are strains between conflicting nursing norms. They have to attain a balance between efficiency and personal care, two somewhat incompatible expectations. At the same time the equalizing process of socialization, and the nursing
definition of work as physical activity, make personal and psychological care difficult. Yet nursing norms emphasize this type of care.

Institutional Ways of Reacting to Strain

Tensions arising from strains in the nursing role are released by aggressive talk, by humour, by withdrawal, by outright defiance, by open aggression, by change and by other means.

Functions of Strain

Strains are not entirely dysfunctional. They also have positive functions. They can lead to change, to increasing group unity, to the maintenance of the existing system, and even to eventual harmony.

Recommendations

I would like to suggest a few different ways of looking at some of the nursing strains, which are defined as "problems." I realize that in many instances I am merely suggesting treatment of the symptom, as my knowledge of the cause is fragmentary.

I suspect that the basis of many of the problems of nursing lies in the hierarchical system of the hospital. It seems to involve the inability of the superiors, that is the
head nurses and the instructresses; to know what it was like to be a student, and the inability of the student to appreciate and evaluate the problems of their superiors. In many ways, therefore, it seems that open aggression, which brings student strains to the notice of superiors, has many positive functions. It enables both sides to reach an understanding of the other, and to base action on this understanding. Students could, perhaps, be encouraged to reveal more of their problems to the staff, and in return be made aware of the position of the staff.

Matters of standards in techniques seem to cause conflicts. There is a contradiction often between: 1) the learning at the hospital and that at the university; 2) the practices on different wards; 3) what nurses know and what they are expected to do; and 4) what nurses know and practise and what other hospital staff ignore. This seems to be mainly a matter of enforcing conformity in standards. What is taught could also be made a matter of practice. Head nurses could be made aware of the fact that techniques are taught differently on other wards, and the need for conformity in practice. Hospital personnel, such as doctors, interns and head nurses could be made more familiar with the capacities of a student, and be more familiar with what a particular student could be expected to do. Nursing techniques, such as the sterile technique, could be brought to the notice of those that nurses consider offenders, such as interns and dietitians.
Conflicts arise from the gradually growing sense of isolation from the outside and the problem of "losing touch." Students could be constructively encouraged by members of the educational staff to take interest in matters which do not pertain specifically to the medical sub-culture. An educational program to stimulate such interest could be the answer. Interaction with outsiders, and with patients, could thus be facilitated.

Many strains arise from this problem of isolation from the outside. Many are hinged to the question of residence life and whether its positive functions balance its negative functions. The question to ask is: does the "orderliness of life," that is achieved by this method, balance the sense of loss of freedom, of individuality and the feeling of isolation from the non-medical world? Lack of data on this problem makes any speculation on the worthwhileness of having students living at home somewhat precocious.

The "residence problem" could be seen from another angle. If it is deemed necessary for students to live in residence, could it not be made more "home-like?" Students complain of the "pettiness of the rules." In terms of student satisfaction, it seems that it would be advisable to reconsider residence rules that students define as "not making sense": personal articles could be allowed in residence rooms; students could be permitted to enjoy each other's company after hours; group solidarity would place boundaries on the amount of noise
made, so that others could sleep. I suspect that if students were given the responsibilities of adults, they are liable to behave as such.

Students complain of their inability to give psychological care. Such care seems possible only if students are allowed to ponder on psychological problems. Nursing norms, however, seem to demand constant action, which gives the student little time to think about the psychological needs of the patient. If less emphasis were put on constant movement, students may be able to devote more time to thinking of ways in which they can "reassure the patient." I realize, of course, that the shortage of nursing personnel, often makes this impossible. This is a very "real problem," and needs to be made a matter of future study. I believe, however, that the shortage stems largely from matters of nursing prestige, and from cultural fears of illness and how to cope with it.

Nurses often work under the constant anxiety of not being able to complete their work. This anxiety is possibly the result of two things: 1) the shortage of nurses, and 2) a standard which defines the amount of work each nurse should be able to accomplish in a set time. More nurses could help to alleviate much of this strain. Otherwise it seems that such anxiety can only be released in specific cases by head nurses who have insight into the individual student's problem. They can then estimate when her anxiety is making her inefficient. In such cases the anxiety can be quelled by withdrawing the fear
of reprimand, and by not expecting the standard of speed to be upheld.

The problem of achieving the right amount of efficiency with the right amount of humanitarian interest is felt by all students. I suggest that the only help that could be given in this direction is to impress on students that each individual will achieve, in time, her own balance between the two. The full extent of the problem could be explained to them, in that if one adopts an entirely humanitarian view, they are liable to become involved and hence vulnerable. Yet if they conform only to the norm of efficiency, they are not giving "full" nursing care.

There is the problem of the feelings of division between the university trained students and the hospital trained students. The norm in the past appears to have been to attempt to equalize the two groups. Perhaps this approach deviates slightly from the root of the problem and attempts only to treat the overt manifestations. It could perhaps be pointed out to the two groups that they are striving for different, but equally important, ends.

Suggestions for Future Research

It would be interesting to discover the reasons students now give for going into nursing, and just how these compare to, or contrast with, the reasons that were given at the
Some thought could be given to the fact that the nursing part of the medical sub-culture is made up entirely of women. How does this affect role-anticipation, role-taking and role-playing?

A study on the extent to which public images play a part in role-anticipation would be interesting.

Research on the manifestations of residence life could provide further information of a practical nature.

A further and fuller exploration of the "types of nurses" that emerge would be valuable. This could be correlated with the initial types of orientation for a possible connection which would have meaning in predicting the type of nurse from her initial type of orientation.

General

A more systematic investigation of occupational roles, with the goal of discovering related variables for an analysis of occupational roles, would prove valuable.

On the basis of empirical data collected on role-taking in several occupations, a more clarified approach to socialization could be developed. It seems to me, that as far as the concept of socialization is concerned, there is an influx of data and
a lack of adequate theory.

The consequence of a scheme for analysis of occupational roles and a theory of socialization, could be a comparative study of all types of occupational roles, both in their role-taking and role-playing aspects.

A valuable investigation would be one on the nature of a "professional self."

1. Prior to role-taking, is the future "professional role" considered as: a) inherently appropriate and a manifestation of the self; or b) something separate in a professional context into which the self must fit?

2. After the role has been acquired, is the "professional self": a) only a part of the self, easily differentiated from other parts of the self; or b) a complete context which involves the entire self?
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APPENDIX A

BIOGRAPHICAL DATA ON STUDENTS STUDIED

1. **Ages in April, 1956**

<table>
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<th>Age</th>
<th>Number of Students</th>
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2. **Home Addresses:**

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<td>British Columbian towns</td>
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</tr>
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<td>Other provinces</td>
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3. **Religious Affiliations:**

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5. Place of Birth

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<th>Location</th>
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6. Father's Occupation

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<tr>
<td>dentist</td>
<td>1</td>
</tr>
<tr>
<td>doctor</td>
<td>3</td>
</tr>
<tr>
<td>engineer</td>
<td>5</td>
</tr>
<tr>
<td>manual</td>
<td>3</td>
</tr>
<tr>
<td>pilot</td>
<td>1</td>
</tr>
<tr>
<td>proprietor</td>
<td>7</td>
</tr>
<tr>
<td>school principal</td>
<td>2</td>
</tr>
<tr>
<td>retired</td>
<td>2</td>
</tr>
</tbody>
</table>
7. **Mother's Occupation before Marriage**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>clerical</td>
<td>4</td>
</tr>
<tr>
<td>designer</td>
<td>1</td>
</tr>
<tr>
<td>nurse</td>
<td>9</td>
</tr>
<tr>
<td>reporter</td>
<td>1</td>
</tr>
<tr>
<td>sales: clerk</td>
<td>1</td>
</tr>
<tr>
<td>school teacher</td>
<td>7</td>
</tr>
<tr>
<td>secretary</td>
<td>3</td>
</tr>
<tr>
<td>stenographer</td>
<td>2</td>
</tr>
<tr>
<td>student</td>
<td>8</td>
</tr>
<tr>
<td>telephone operator</td>
<td>1</td>
</tr>
</tbody>
</table>

8. **Mother's Occupation after Marriage**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>business</td>
<td>2</td>
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<tr>
<td>housewife</td>
<td>33</td>
</tr>
<tr>
<td>nurse</td>
<td>2</td>
</tr>
<tr>
<td>school teacher</td>
<td>2</td>
</tr>
</tbody>
</table>

9. **Student's Education**

<table>
<thead>
<tr>
<th>Education</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>two years at university</td>
<td>36</td>
</tr>
<tr>
<td>three years at university</td>
<td>4</td>
</tr>
</tbody>
</table>
THE FLORENCE NIGHTINGALE PLEDGE
APPENDIX B

THE FLORENCE NIGHTINGALE PLEDGE

I solemnly pledge myself before God and in the presence of this assembly to pass my life in purity and to practise my profession faithfully.

I will abstain from whatever is deleterious and mischievous and will not take or administer any harmful drugs.

I will do all in my power to maintain and elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling.

With loyalty will I endeavor to aid the physician in his work and devote myself to the welfare of those committed to my care.
QUESTIONNAIRE
APPENDIX C

QUESTIONNAIRE

This is part of an ongoing study for an M.A. thesis in the Department of Economics and Political Science at the University of British Columbia.

ALL WE WANT ARE YOUR OPINIONS. THESE OPINIONS WILL REMAIN ENTIRELY CONFIDENTIAL.

We would appreciate your cooperation in keeping the nature and contents of this questionnaire as CONFIDENTIAL. Only thus could the validity of the results be ensured.

1. Please check the relevant category. I see nursing as preparation for:
   - air hostess
   - clinical supervisor
   - nurse
   - public health nurse
   - mother
   - instructress
   - administrative position
   - other? ....

2. What do you as a nurse contribute to the welfare of the patient that the doctor cannot?
3. I would like to nurse in a private ward, semi-private ward, staff ward, and in a mental hospital, contagious unit, out-patient department, emergency unit, TB hospital. Please check the relevant categories.

4. What do you think most girls like about nursing as a future profession?

5. Mention a few characteristics that a patient would expect from a nurse.

6. What profession or professions do you admire?

7. Which of the following actions do nurses think make for a successful nurse? Check the relevant one.
   - Obeying strictly the rules of the hospital
   - Devoting oneself to the welfare of the patient without overconcern for the rules
   - Carrying out the orders of superiors at all events

8. Which of the above do you think make for a successful nurse? Mention one.

9. Where would you like to nurse—medical, surgical, obstetrics, operating room etc.

10. Circle which of the following conditions patients would feel ashamed of:
   - High blood pressure, asthma, nervous breakdown, tuberculosis, cancer, pregnancy, venereal disease, stomach ulcer, heart disease, skin disease; mention any other, if not listed
11. Which of the above mentioned conditions would you consider a result of misfortune? Mention any other, if not listed above.

12. Mention a few characteristics that a doctor would expect from a nurse.

13. We all have preferences. In the patients who you would prefer to nurse, which of the following characteristics would you like to see?
   - better than average education
   - quiet patients who keep to themselves
   - patients who obey orders
   - patients from rural areas
   - grateful patients
   - patients who do not complain
   - obviously economically privileged patients
   - patients who like to talk a lot
   - business people
   - working people
   - other?

14. What does the doctor contribute to the welfare of the patient that you, as a nurse, cannot?

15. What kind of a profession would you say nursing was to get into? Please check the relevant category:
   - difficult
   - not very difficult
   - fairly easy
   - easy

16. How do you feel that you were prepared for experiences in a hospital? Please check the relevant category:
   - very well prepared
   - fairly well prepared
   - not too well prepared
   - not at all well prepared
17. Please check the relevant category:
I would like to nurse:
 older men
 younger men
 older women
 younger women
 older children
 younger children

18. I especially look forward to my work with
 other nurses:
 doctors:
 head nurses:
 nurses' aides:
 medical interns
 ward aides:
 orderlies:
 and among nurses, I especially look forward to my work with
 head nurses.
 assistant head nurses.
 graduate nurses.
 private duty nurses.
 senior students.
 intermediate students.
 junior students.
 probationary students.

19. Please check the relevant category:
 Nurses are paid:
 too much
 enough
 too little
 far too little

20. Please check the statement that you feel best represents your approach. Mr. F., a T.B. patient, is expected to spend an indefinite time in hospital.
 a) To make Mr. F as comfortable and contented during his hospital stay as possible by showing a personal interest in him and carrying out good nursing care.
 b) To remember that if T.B. cases are to be reduced, thoroughness and efficiency in nursing care are essential and that Mr. F is one patient among many.
 c) To keep in mind the high standards of the hospital and the efficiency expected of me as nurse so that the head nurse and doctors in charge will be satisfied with patient care.
21. Some patients are more difficult to nurse than others. Which of the following characteristics would you least like to see in your patients:
- patients who cannot express themselves in English
- obviously economically privileged patients
- business people
- working people
- patients from rural areas
- patients who swear
- patients who demand constant attention beyond what they actually need

other?

22. Circle which of the following conditions you would consider a result of negligence?
- high blood pressure, asthma, nervous breakdown, tuberculosis
- cancer, pregnancy, venereal disease, stomach ulcer, heart disease, skin disease
- Mention any other, if not listed

23. Please check the relevant category:
- I would least like to nurse in a private ward
- semi-private ward
- staff ward
- and in a
  - mental hospital
  - contagious unit
  - out-patient department
  - emergency unit
  - T.B. hospital

24. Mention a few characteristics that the hospital would expect from a nurse.

25. You are extremely busy. Mrs. A you feel is greatly in need of sympathy and a greater degree of personal attention than her fellow patients. Check what you would do.
   a) I would pay Mrs. A more attention, give her a few extra kind words, spend a little more time with her, even though I may have to rush with the others.
   b) I would not pay Mrs. A any more attention at the risk of depriving any of the others of my time and help.
   c) I would do neither. I would
26. Which of the following would you say nurses find to be the greatest attraction about the profession? Please check one.

- income
- security in that one always finds work as a nurse
- nursing is a good profession for a woman to take up
- being able to help others
- nursing is a profession that is held in high regard by the community
- go into it because mother or some other relative was a nurse, or father a doctor, etc.

27. Which one of the above would you say attracts you most about the profession? Please write your answer below.

28. Nurses are expected to see disease and illness as things of misfortune and things to be accepted. I think they really see them as things of bad luck, negligence, escape, and things to be gotten over as quickly as possible, accepted without fuss, benefitted from, learnt from. Perhaps none of these really fit. Instead, nurses think of disease and illness as...

29. I least like my work with

- other nurses
- doctors
- head nurses
- nurses' aides
- medical interns
- orderlies
- ward aides
- and among nurses, I least like my work with head nurses
- assistant head nurses
- graduate nurses
- private-duty nurses
- senior students
- intermediate students
- junior students
- probationary students
30. What is it about nursing that first attracts people to it?

31. Mention a few characteristics that the public would expect from a nurse.

32. What kind of illnesses would you like to be nursing?

33. Which of the following conditions would you consider the most repulsive? Please circle.
- high blood pressure
- asthma
- nervous breakdown
- tuberculosis
- cancer
- pregnancy
- venereal disease
- stomach ulcer
- heart disease
- skin disease
- mention any other, if not listed above.

34. Please group the following list of occupations into about four or five groups. The names of the occupations need not be written out, but their corresponding letters could be used.

A - actress
B - architect
C - bank president
D - business executive
E - college professor
F - doctor
G - engineer
H - journalist
I - lab technician
J - lawyer
K - librarian
L - model
M - nurse
N - poetess
O - psychologist
P - school teacher
Q - secretary
R - social worker
S - dietitian

35. What are your main reasons for these groups?
36. Your mother is one of your patients. She asks you to spend more time with her. Check the statement that comes closest to what you would do.

a) I would probably spend some extra time with her, even though I may have to rush with some of the others.

b) I would not pay her any more attention at the risk of not being able to devote myself entirely to my duties.

c) I would do neither, I would...

37. How do you feel about the indispensability of each of the following groups to the hospital? Please indicate on the scale, which reads from "Can do without" at the left extreme, to "absolutely indispensable" at the right extreme. Please circle the figure that comes closest to your idea.

<table>
<thead>
<tr>
<th></th>
<th>Can do without</th>
<th>Absolutely indispensable</th>
</tr>
</thead>
<tbody>
<tr>
<td>cleaning women</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>dietitians</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>doctors</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>instructresses</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>medical social workers</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>nurses</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>nurses' aides</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>orderlies</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>student nurses</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>visitors</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

38. Mention a few characteristics that the other nurses would expect from a nurse.

39. Why is nursing a good profession for a woman to take up?
40. There are certain loyalties and obligations concerned with a nurse's work. Where do you think a nurse's first obligations lie? Mark the following in order of importance, putting the figure 1 beside the most important, the figure 2 beside the second most important, the figure 3 beside the third most important, up to figure 8, the least important.
- Obligations towards members of your family
- Obedience to head nurse and nursing director
- Respect towards doctors
- Responsibilities to the public
- Compliance to hospital rules and routines
- Skill involved in the work
- Kindness and understanding shown to patient
- Cooperativeness to other nurses.

41. What aspect of your work would you consider:
   a) most important
   b) most enjoyable
   c) least important
   d) least enjoyable

42. Mention a few characteristics that your own family and friends would expect from a nurse.

43. Some people appeal to us more than others. Which of the following would you find least agreeable. Please check.
   - Quiet patients who keep to themselves
   - Patients who like to talk a lot
   - Patients who constantly complain
   - Patients who tell you what to do
   - Patients who do not obey orders
   - Others, if not mentioned above...
44. Please indicate on the scale how you would rate the importance of each of the following characteristics when thinking of an ideal nurse. Circle the figure which is closest to the way you feel. The scale ranges from 1, the least important, to 7, the most important.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Least Important</th>
<th>Most Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>high intelligence</td>
<td>1 2 3</td>
<td>4 5 6 7</td>
</tr>
<tr>
<td>neat appearance</td>
<td>1 2 3</td>
<td>4 5 6 7</td>
</tr>
<tr>
<td>ability to get along with people</td>
<td>1 2 3</td>
<td>4 5 6 7</td>
</tr>
<tr>
<td>ability to follow orders</td>
<td>1 2 3</td>
<td>4 5 6 7</td>
</tr>
<tr>
<td>dedication to work</td>
<td>1 2 3</td>
<td>4 5 6 7</td>
</tr>
<tr>
<td>technical skill</td>
<td>1 2 3</td>
<td>4 5 6 7</td>
</tr>
<tr>
<td>pleasing personality</td>
<td>1 2 3</td>
<td>4 5 6 7</td>
</tr>
<tr>
<td>good organization of time</td>
<td>1 2 3</td>
<td>4 5 6 7</td>
</tr>
<tr>
<td>scientific curiosity</td>
<td>1 2 3</td>
<td>4 5 6 7</td>
</tr>
<tr>
<td>ability to organize thoughts clearly</td>
<td>1 2 3</td>
<td>4 5 6 7</td>
</tr>
<tr>
<td>recognition of own limitations</td>
<td>1 2 3</td>
<td>4 5 6 7</td>
</tr>
<tr>
<td>enjoying one's work</td>
<td>1 2 3</td>
<td>4 5 6 7</td>
</tr>
</tbody>
</table>

45. Which of the above characteristics would you consider most important. Mention two.

46. On the scale below please indicate whether you feel you are able to deal with the following problems (on the right hand side) and how much you have thought about them (on the left hand side). Please circle the relevant figure, on both the left and right hand side of each statement.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not sure</th>
<th>Quite sure I can deal with it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have not thought at all about</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have thought quite a lot about</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Of getting too attached to any one patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Of feeling the right amount of concern for all patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Of patients becoming too attached to a nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The occurrence of a possible attachment to a patient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Have not thought at all</th>
<th>Have thought quite a lot about</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3</td>
<td>4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>1 2 3</td>
<td>4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>1 2 3</td>
<td>4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
</tr>
</tbody>
</table>
47. As a nurse, your chief rewards are... Please mark the following according to importance, using 1 to indicate the most important, 2 to indicate the second most important, up to 4 to indicate the least important.

- prestige
- income
- security
- personal satisfaction
- other... mention if there is

48. Of what aspect of nursing do you think the general public is generally ignorant?