1990

Professionalism and Job Satisfaction of Registered Nurses in the Commonwealth of Virginia

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Professionalism and Job Satisfaction of Registered Nurses in the Commonwealth of Virginia

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[redacted] Committee Member	✓ Pass	Fail
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April 16, 1990
Date

Professionalism and Job Satisfaction of Registered Nurses in the Commonwealth of Virginia

A Dissertation submitted to Virginia Commonwealth University
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy in Urban Services

by

Elisabeth B. Hutton

April 16, 1990

Virginia Commonwealth University
Richmond, Virginia

DEDICATION

This dissertation study is dedicated to all

Registered Nurses practicing in the Commonwealth of Virginia

ACKNOWLEDGEMENTS

The author would like to express her sincere appreciation to the following people for their kind, considerate and supportive assistance throughout the preparation of this dissertation.

I would like to acknowledge the members of the dissertation committee who provided their expert guidance and support of the content and the process of the study.

Alice Pieper, Ph.D., Associate Professor, Director of Dissertation

James McMillan, Ed.D., Associate Professor, School of Education

Jean Lokerson, Ed.D., Associate Professor, School of Education

Jeannette Kissinger, Ph.D., Professor, School of Nursing

Leigh Grosenick, Ph.D., Professor, School of Public Administration

I would like to thank Dr. JoAnne Henry, Interim Dean of VCU/MCV School of Nursing, and Dr. Lorna M. Barrell, Chair of the Department of Community Health and Psychiatric Nursing, whose support and understanding assisted me in the achievement of this dissertation.

Norma Szakal, Esquire and Brenda Edwards, Division of Legislative Services, General Assembly who were staff member of HJR. 165 Subcommittee on the Shortage of Nurses in the Commonwealth of Virginia, assisted me in the implementation of the statewide survey of factors to attract and retain nurses in the work setting. This study formed the basis for the dissertation.

Larry Garten, Computer Center, General Assembly assisted me in drawing the random sample, printing the mailing labels and the postcards for the initial mailing of the dissertation study. Perry Ozcan assisted me with computer programs and follow-up mailing.

Many people were involved in the process of the initial mailing and follow-up mailing. With little notice Garland Rasmussen, Cristle McCaughan, Fay Butler, Laurie Hylton, Jean Crawford and Laurie Crawford folded questionnaires, stuff and stamped envelopes.

A special thanks to Lydia Ho, doctoral student at VCU School of Health Administration, who assisted me in imputing the data into the university computer system. Both she and Peri Ozcan assisted me in the interpretation of statistical commands to obtain analysis of the data. Debi Wood was instrumental in the many copies that were needed and in the production of the final copy of the dissertation. Dr. Neil Henry, Dr. Janet Younger and Dr. Jim McMillan were very helpful as I analyzed the data.

Most of all I appreciate the understanding of and support of my family. My husband, Charles E. Hutton was always there with patience, understanding and thoughtfulness which helped achieve my goals. My daughter, Joan Winder and her husband, George Winder, were always there to help me relax. My mother, Eleanor C. Beijer, and brother, A. Jan Beijer and his family were always there ready for the next report.

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IN THE COMMONWEALTH OF VIRGINIA
Elisabeth B. Hutton, Ph.D.
Virginia Commonwealth University, 1990.
Major Director: Alice Pieper, Ph.D.

The purpose of this study was to investigate current views of professionalism and job satisfaction of registered nurses practicing a variety of health care settings in the State of Virginia. Five research questions were investigated in this analytical-descriptive study. A two percent stratified random sample of 427 registered nurses, female and actively employed, represented all nurses from five regions in the state of Virginia. The demongraphic findings indicated that the majority of nurses were diploma graduates, staff nurses, employed in hospital settings, and working full-time.

A descriptive analysis of Stone and Knopke's Health Care Professional Attitude Inventory items modified by Lawler indicated that registered nurses have professional status according to Dumont's model of professionalism. Nurses indentified consumer control, indifference to credentials, compassion, and impatience with the rate of change as important elements of professionalism. However, there was no significant relationship between nurses' professionalism and highest levels of education in nursing, current job positions, and major job settings.

Job satisfaction findings using Atwood and Hinshaw's Work Satisfaction Scale indicated that nurses were generally satisfied in their work setting although they were concerned about pay compensation, opportunities to advance, and control of nursing practice. A significant relationship was found between nurses' work setting and job satisfaction. Hospital nurses exhibited greater job satisfaction than nurses in other health care settings. A small relationship was revealed using job satisfaction as a predictor of professionalism.

Professionalism and Job Satisfaction of Registered Nurses in the Commonwealth of Virginia

INTRODUCTION

STATEMENT OF PROBLEM

Nurses are the largest group of health care providers in the professional health care system, numbering approximately 1.5 million or half of the work force (Division of Nursing, 1986). Although the supply of registered nurses continues to grow, the nation is experiencing a major shortage of nurses. This persistent shortfall has received considerable attention in relation to economic and quality care perspectives. The economic aspect of shortage is that the demand at a specific market price for nurses exceeds the supply available. In terms of quality care this nursing shortage means an insufficient number of nurses to care for patients at a professionally determined level of competence (Prescott, 1987; USDHHS Secretary's Commission on Nursing, 1988). Professionalism and job satisfaction issues are important to practicing nurses as they strive to be recognized as valued professionals in the health care system.

Nurses are taught to view themselves as professionals, to provide holistic care, and to be coordinators of client care. Frequently they are called upon to make astute judgments in the care of clients whose acuity level has been affected by illness and/or medication. Lynaugh and Fagin (1988) stated that "nurses are on the front line of care and the administration of health care in its vast variety of settings throughout the world" (p. 187). Yet nurses who describe themselves as professionals are viewed as semiprofessionals by physicians and health

care administrators (Etzioni, 1969; McCloskey, 1981). They are usually viewed as secondary members of the health care team while physicians are viewed as the primary persons responsible for health care services (Katz, 1969; Yeaworth, 1972). Rather than protest, nurses remain passive. They are given to intragroup conflict and are ambivalent or generally less than assertive (Lynaugh & Fagin, 1988). This stance accommodates the policies of physicians and health care administrators, and ultimately, contributes to the growing disillusionment of nurses (LeRoy, 1986).

Reports from outside the profession indicate that nurses cannot govern themselves and cannot organize (Lynaugh & Fagin, 1988). This is evident in discussions about levels in nursing education. Current disharmony can be traced to the early 1920s with the beginning of the movement for college education of nurses. Concomitant with this movement was the 1923 Goldmark Report advocating two levels of educational preparation of nurses: collegiate education and hospital-based education (LeRoy, 1986; Parsons, 1986). Thus a division emerged and persists among practicing nurses. One group advocates collegiate education while the other group favors hospital-based education.

Subsequently, work environments for nurses in hospital settings have become increasingly more complex. Growth in technology and more sophisticated medical treatments require a high level of education as well as appropriate experience for effective patient care. Multiple physicians are now often involved in the treatment of hospitalized patients, further complicating quality patient care (Aiken, 1981;

LeRoy, 1986). Nurses work longer hours and are responsible for more tasks in hospital settings.

Conversely, today's hospitals create ongoing difficulties for nurses by influencing salary and benefit decisions, keeping the staff lean with agency nurses, and cutting support staff members (Prescott, 1987). Many nurses reach their peak earning power in five years (Billingsley, 1989). National hospital figures reveal unfilled nursing positions averaging from 11 percent to as high as 45 percent for registered nurses (Buerhaus, 1987).

Nurses seeking improved professional status and working conditions do not generally leave the profession. They seek alternative positions in other hospitals, nursing agencies, or health care settings (Aiken, 1981; LeRoy, 1986). If nurses have professional ambitions, they tend to individually pursue nursing careers outside the hospital setting (Andrews, 1986).

Nurses are reluctant to utilize collective action to enhance their professional status with hospital administrators. Detmer (1986) stated that "because nursing has never made it clear to management, medical staff, and the consumer what nursing is...hospital administrators have logically interchanged women in white...without regard for clinical expertise as a cost-effective strategy" (p.21). Mounting responsibilities contrasted with minimal professional status and respect have had a continued impact on nurses' professional attitudes. This study will address some of the factors of nurses' professionalism and job satisfaction.

RATIONALE FOR STUDY OF PROBLEM

This study will contribute to the current knowledge and understanding of professionalism of nurses in a variety of settings. Previous empirical findings in the nursing literature reflect the still accepted guild model of professionalism based on the apprenticeship premise (Greenwood, 1957; Scott, 1965; Hall, 1968). This model persists as the basis of most studies on professionalism of nurses (Lynaugh & Fagin, 1988). However, Dumont (1970) indicated professionalism is the result of academic experiences in health care. To date there appears to be no studies of practicing nurses using this model. This study will utilize Dumont's (1970) model of professionalism.

This study will contribute to our understanding in the following manner. There is an apparent paucity of research data on the relationship of levels of education, job position, current work setting and registered nurses' view of professionalism.

Most of job satisfaction research is related to nurses' roles, responsibilities and rewards in a particular setting, primarily hospitals. This study will gather job satisfaction data from nurses working in a variety of health care settings.

The relationship between professionalism and job satisfaction is of special interest. It appears that no study has examined the relationship between professionalism and job satisfaction of nurses. The investigator believes there may be a relationship. This study will investigate this possibility.

STATEMENT OF PURPOSE

The overall purpose of this study is to investigate current views of professionalism and job satisfaction among nurses practicing in a variety of work settings. The study will investigate

(1) how registered nurses' view themselves as professionals;

(2) what relationship, if any, exists between education, job position, current work setting and registered nurse's professionalism;

(3) how registered nurses' view job satisfaction;

(4) what relationship, if any, exists between current work setting and registered nurses' job satisfaction; and

(5) what relationship, if any, exists between registered nurses' view of job satisfaction and professionalism.

LITERATURE AND RESEARCH BACKGROUND

Attempts to define professionalism and job satisfaction have resulted in a multitude of conceptual frameworks. Sociologists are the prime source of the conceptual views of professionalism and job satisfaction. Two major concepts of professionalism affecting nursing have emerged from the literature: the ideological model of professionalism based on the guild premise and the academic professionalism model.

PROFESSIONALISM

The accepted definition of professionalism is based on the guild model of the law-medicine-church-traditionalist view. This concept is based on the perception that an esoteric professional community exists which possesses knowledge and service not accessible to the public. A

professional's practice is guided by the profession's ethics, knowledge, and standards of training (Friedson, 1973; Greenwood, 1957). The professional community sets higher standards than the law. Therefore, its practitioners enjoy more prestige and power, and a monopoly of services (Goode, 1965).

Certain professional characteristics are selected to identify established professionals from non-professionals. Greenwood (1957), Scott (1965) and Etzioni (1961) have identified the following as suggested professional characteristics: (1) a systematic body of knowledge, (2) an exertion of authority, (3) a code of ethics, (4) a professional culture, and (5) formal and informal community sanctions. However, problems have emerged when measuring the criteria for professional status (Goode, 1960).

According to the guild model, professionalism is also defined as a behavioral process along a multidimensional continuum that reflects the orientation and the socialization of the group itself (Hall, 1968, p.92). Hall's (1968) classic study of professionalism and bureaucratization classified occupational groups and developed an instrument to measure five attitudinal attributes delineated by Scott (1965): use of the professional organization, belief in service to the public, the belief in self-regulation, sense of calling to the field, and autonomy. Thus, attorneys (who may be part of a larger organization) are viewed as professionals having strong views of autonomy, self-regulation, and belief in public service. Yet nurses, who emerge as strongly professional as to belief in public service and

sense of calling to the field, are not considered autonomous professionals (Hall, 1968).

The academic professional model presents a view that today's professional organizations are learned societies whose members' allegiance is primarily to the field and orientation is toward social change. According to Dumont (1970), young professionals and students in professional schools (lawyers, architects, educators) possessed a social conscience derived from educational experience that is different from the orientation around the accumulation of wealth and prestige. Professionals are joining with other professionals to form networks of informational exchange and informal collaborational activities that reflect shared ideology. Their work takes place in a bureaucratic context where science defines employment standards. These newer professionals create a different relationship with society and thus, cannot be evaluated by the guild premise (Goode, 1960).

Wilensky (1964) in a transition model proposed that professionalism in the true sense may not be possible when control is split among professionals, laymen, and administrators and when careers may not lead to management positions. Though Wilensky considered nursing a marginal profession, he advocated that nursing may be one profession that needs to combine the elements of both the professional and bureaucratic model.

Dumont (1970) perceived a redefinition of professional life to meet the demands of constantly changing environments in modern society. Included in Dumont's professional model were six factors contributing to the new face of professionalism. Among the six factors, the ultimate

and most salient purpose of a professional is superordinate purpose—the well-being of people. Diers (1986) reflected this by saying that the essence of nursing practice is caring, but that society has yet to understand that professional nursing concept. However, Lynaugh and Fagin (1988) believed that nurses are still too preoccupied with the pervasive guild paradigm of professionalism which divides nurses against each other.

Lynaugh and Fagin (1988) suggested the empirical testing using the guild premise of professionalism has undermined the understanding of professionalism of nurses. Most studies reported higher levels of professionalism from faculty and students in schools of nursing where professionalism is fostered. Schriner and Harris (1984) and Wakefield-Fisher (1987) found the higher the educational preparation of the faculty, the higher their attitudes on professionalism. Corwin and Taves (1962) found baccalaureate degree nursing students have higher views of professionalism than diploma nursing students. Studies of nurses in clinical practice generally reported lower views of professionalism than nursing faculty and students (McCloskey & McCain, 1987; Monnig, 1978; Simmons, 1982). It appears that only one study by Monnig (1978) looked at the relationships of highest level of education in nursing, field of nursing, health care setting, and view of professionalism of practicing nurses.

JOB SATISFACTION

Difficulties emerge in defining job satisfaction for there is no well-accepted theoretical framework. Vroom's (1964) multiplicative model posited that a person's positive attitudes toward the job are

equivalent to job satisfaction. The model proposed that job satisfaction is the result of situational factors (supervision, wages, job content, the work group) and personality factors (attitudes and abilities). Although Vroom's model identified specific components of job satisfaction, it proposed that a person's job satisfaction is dependent on the work situation, and neglected the perceptions of satisfaction with other workers in similar situations.

Another popular model used in nursing studies is the theory developed by Herzberg, Mausner and Snyderman (1968) which identified two factors influencing job satisfaction: hygiene and motivational factors. Satisfaction and dissatisfaction were seen as two separate phenomena (Herzberg et al., 1969). Although a popular theoretical framework for nursing studies of job satisfaction, Herzberg's theory is controversial and widely debated (Stamps & Piedmonte, 1986).

Problems remain in defining parameters of job satisfaction in nursing despite a plethora of studies. Smith, Kendall and Hulin (1969), who have conducted extensive studies in a variety of work settings, defined job satisfaction as the feelings or affective responses a person has about the facets of the work situation. They suggested that multiple measures such as pay, supervision, co-workers and the job itself contributes to overall job satisfaction (Smith, Kendall & Hulin, 1968). Stamps and Piedmonte's (1986) more recent and extensive review included a self-referent approach to six components of nurses' work setting--pay, professional status, interaction, task requirements, autonomy, and organizational policies.

The research focus on job satisfaction of nurses is on hospital-based nurses. These studies seem to be prompted by general reports of dissatisfaction and the persistently, high turnover rate. McCloskey and McCain (1987), Taunton and Otteman (1986), Prescott (1986), and Weisman, Alexander, and Chase (1981) suggested that bureaucratic-professional role conflicts affect hospital nurses' job satisfaction, with autonomy and professional control being the prevailing issues. The general lack of opportunity to use knowledge and skills gained from educational preparation appeared to be another major concern of nurses in the hospital environment (Stamps & Piedmonte, 1986).

JOB SATISFACTION AND PROFESSIONALISM

Review of the literature suggests that many factors have contributed to nursing's present situation in the health care system. Recurring themes of professionalism and job satisfaction appear to be interrelated. Studies tended to focus on each concept as it related to nurses in a particular setting. Although some studies on job satisfaction of nurses included components of professional autonomy, they have not considered other components of professionalism. Both professionalism and job satisfaction are important as nurses struggle to be recognized as valued professionals in the delivery of health care. From the review of literature two major assumptions emerge that form the basis of this research study.

ASSUMPTIONS

The assumptions underlying this research study are:

1. Views of nurses from a variety of educational backgrounds, work settings, and job positions will provide insight into some current problems in the field of nursing.
2. The factors affecting job satisfaction and view of professional status contribute to the underlying causes in the shortage of nurses today.

RESEARCH QUESTIONS

The specific research questions of this study are:

1. How do registered nurses view professional status?
2. What is the relationship between registered nurses' highest levels of education in nursing, current job positions, major work settings, and their professionalism?
3. How do registered nurses' view job satisfaction?
4. What is the relationship between work setting and job satisfaction of registered nurses?
5. Does view of job satisfaction of registered nurses relate to their professionalism?

METHODOLOGY

This study is an analytical-descriptive survey. The purpose is to describe the existing phenomena of nurses' views of their professional status and their job satisfaction in a variety of health care settings.

The subjects for this study are drawn from a population of 46,452 registered nurses in Virginia who are from the 1988 Virginia Board of Nursing Registry. The Registry contains the nurse's name, address, license number, and renewal date. Five designated regions developed by ZIP Code, with their known population of nurses, are Richmond, 12,906; Charlotte, 7,239; Norfolk, 9,898; Northern Virginia, 10,599; and Roanoke, 5,810. A two percent stratified random sample will be computer drawn from each region resulting in a total sample of 929 registered nurses.

A survey packet will be mailed to each sample participant. The packet contained three instruments presented in a combined format for collection of data. A general questionnaire of 10 items will elicit data about the nurse's background and professional experience. Stone and Knopke's (1978) Health Care Professional Attitude Inventory which contains a 38-items in a five-point Likert response scale as refined and modified for nursing is also included (Lawler, 1988). This measure was developed using Dumont's (1970) construct of professionalism in six scales addressing the professional's responsiveness to consumer control, indifference to credentialing, sense of superordinate purpose, attitude of critical thinking, impatience with need for change, and compassion.

Reliability and validity norms were established with medical and nursing students using alpha coefficients and a varimax rotation. Atwood and Hinshaw's (1984) Work Satisfaction Scale, which builds on Maslow's and Herzberg's theories about work satisfaction, completed the packet. The instrument's five scales addressed the components of pay or reward, professional status, interaction/cohesion, administration, and

task requirements. The instrument contained 32-items using a five-point Likert response scale modified from Slavitt, Stamps, Piedmonte and Hasse's (1978) Occupational Satisfaction of Hospital Nurses Instrument. Reliability and validity norms were established by a five-year testing program of nursing staff members in 15 urban and rural hospitals.

PROCEDURE

A stratified, random sample of two percent of all registered nurses in Virginia will be computer drawn from the Virginia Board of Registry. Subsequently, a survey packet will be mailed to each prospective participant containing an overview letter, a postcard, and the three instruments. The overview letter contains information including rationale for the research study, methods to assure confidentiality, and guidelines for completion of survey instruments. Participants will be asked to respond to three instruments in a combined format: a questionnaire about their background and experience, Stone's Health Care Professional Attitude Inventory, and Atwood and Hinshaw's Work Satisfaction Scale. They will be asked to return the postcard to the researcher upon completing the survey packet. A time limit of two weeks from the date of mailing will be given for return of the instruments. A follow up letter will be sent if no response was received within three weeks after the initial mailing. A 42-day cut-off date from the initial mailing will be established before data was tabulated.

Data from the returned questionnaires will be placed on file in the university computer system. Only responses from female participants who were employed full-time in nursing will be included in the data

analysis. Descriptive and inferential statistical procedures will be used to analyze and report group data.

Analysis of data related to each research question is as follows.

Research question (1):

How do registered nurses view professional status? Scores will be obtained for each of the 38-items of the modified Stone and Knopke's Health Care Professional Attitude Inventory. Measures of central tendency will be used to describe the data. Internal consistency of the total and subscale scores will be assessed by Cronbach Alpha. Results of this test reliability will be compared to previous findings.

Research question (2):

What is the relationship between registered nurses' highest levels of education in nursing, current job positions, major work settings, and their professionalism? Group mean scores will be obtained for each of the 38-items of Stone and Knopke's Health Care Professional Inventory. Data analysis of the independent variables will used cohort mean scores. One-way analysis of variance and multivariate analysis will be conducted to determine the relationship between each independent variable (highest levels of education, current job positions, and major work settings) and the dependent variable (nurses' overall view of professionalism) by the total mean score from the Health Care Professional Attitude Inventory.

Research question (3):

How do registered nurses' view job satisfaction? Group mean scores were obtained for each of the 32-items of Atwood and Hinshaw's Work Satisfaction Scale. Measures of central tendency will be used to

describe data. Group mean scores from the five regions of the state will be obtained for each of the five subscales and the total instrument. Internal consistency of the total and subscale scores will be assessed by Cronbach Alpha. Reliability of this test was compared to previous findings.

Research question (4):

What is the difference between work setting and view of job satisfaction of registered nurses? Group mean scores will be obtained for each of the 32-items of Atwood and Hinshaw's Work Satisfaction Scale. Data analysis will be of the independent variable (current work setting) using cohort mean scores. One way analysis of variance and multivariate analysis will be conducted to determine the relationship between nurses' work setting and job satisfaction by the total mean score from the Work Satisfaction Scale. Wilk's Lambda and Scheffe's tests will be used to determine comparisons and which groups were different from each other.

Research question (5):

Does view of job satisfaction of registered nurses relate to their professionalism? Using Pearson product-moment correlation (r), the association between nurses' overall job satisfaction and professionalism mean scores will be explored. Bivariate regression will be conducted to see if there was a predictive relationship between the two variables, job satisfaction and professionalism.

DEFINITION OF TERMS

The following definitions are applicable to this study.

Professionalism is defined by Dumont (1970) as a multidimensional, behavioral construct composed of six components which are

(1) consumer control (the professional's response and support of citizen participation in various programs)

(2) indifference to credentials (the professional's concern with measures of effectiveness rather than preoccupation with credentials)

(3) superordinate purpose (the egalitarian mutual support system among professionals toward the well-being of people)

(4) attitudes of criticism (the premise that professionals are always searching and questioning, wanting to know alternatives)

(5) impatience with the rate of change (the belief that time is of the essence and social change is a matter of survival) and

(6) compassion (the professional's dedication towards the needs of public).

Job Satisfaction is defined by Slavitt et al. (1978) as a multidimensional view related to worker satisfaction within the health care setting. Atwood and Hinshaw (1984) identified five of Slavitt's seven concepts related to job satisfaction of nurses which are

(1) pay or reward (the financial remuneration and fringe benefits received from work performance completed)

(2) professional status (the general feelings toward the skills, usefulness, and status of the job)

(3) interaction/cohesion (the opportunities and requirements for both formal and informal social contacts during working hours)

(4) administration (the effect of administration on job procedures, personnel policy, and amount of staff participation in these policies) and

(5) task requirements (those elements that must be done as a regular part of the job).

Registered nurse is a practicing nurse who meets the current requirements for licensure by the Commonwealth of Virginia for professional nurse, registered nurse or registered professional nurse (54-367.1 of the Code).

Current work setting is a health care setting where a nurse is employed. These settings include private and public hospitals, ambulatory care settings, physician offices, health departments and home health agencies.

Highest level of education is the ultimate degree earned by the individual nurse respondent to the survey. These degrees are awarded by institutions of higher education and range from associate degree (two years), diploma (three years), baccalaureate degree (four years) to master's and doctoral degrees (post baccalaureate).

SUMMARY

Nurses are the largest group of health care providers in the health care system. Economic and nursing work conditions are identified as contributing to the current shortage of nurses in the work setting. Major factors of job dissatisfaction currently reported in hospital

settings are lack of professional respect, lack of control over working conditions, changing demand of nurses as a result of complex technology, and inadequate wages and benefits.

Nurses view themselves as professionals, yet they enjoy few of the rewards of other health care professionals. They have been reluctant to organize to enhance their position and professional status. Job satisfaction and professional self-perceptions of nurses have ultimately been affected.

This study attempts to further the knowledge of the relationship between professionalism and job satisfaction of nurses in a variety of health care settings. It looks at the relationship between nurses' professionalism and their highest level of education in nursing, current job positions, and major work settings. It will explore the relationship between current work setting and nurses' job satisfaction. Lastly it will investigate the possibility of a relationship between job satisfaction and professionalism.

CHAPTER TWO: REVIEW OF THE LITERATURE

INTRODUCTION

Humanistic and religious institutions that once dominated health care are being challenged by bureaucratic institutional changes and professional issues. Powerful coalitions are being formed in the health care system. Health care administrators and government representatives are joining together across agency and departmental lines to form new networks of information and initiate collaborative activities in the delivery of health care. The work force is comprised of two types of health care professionals, physicians and nurses. Each of these professionals have a strong need for personal independence, prefer maximum freedom and autonomy in their work, and are inclined to dislike regimentation (Bush, 1988). Despite nurses' increased educational training and specialized practice, their major concerns surround the issues of professional status and control of the work environment.

Preoccupation with the concept of professionalism and factors that affect job satisfaction of nurses produced a varied and vast literature. This review of professionalism is a discussion of the concepts of professionalism and job satisfaction of nurses. The review of professionalism also includes the theoretical models of professionalism and the factors that affect professionalism of nurses. The review of job satisfaction includes major theoretical approaches and factors that affect nurses in the work setting.

PROFESSIONALISM

Many occupations are engaged in the struggle to become recognized as professions. Theoretical approaches are often used to describe and differentiate professionals from nonprofessionals. Influenced by scientific and technological advances the labor forces as a whole is becoming professionalized. The ideological model of professionalism, based on the guild premise, emphasizes autonomous expertise and the service ideal as the measure of a true professional. The academic model views professionalism as emerging from an educational setting and focussing on social change. Currently a power struggle between professional and organizational ideals is attributed to a movement by the challenge from the academic model. However, data suggests the guild paradigm is the pervasive model (Lynaugh & Fagin, 1988).

The earliest recorded use of the word profession in 1541 described a learned vocation indicating any calling or occupation by which a person habitually earns his living (Cogan, 1953). Carr-Saunders and Wilson (1964) stated that "to Bacon the term profession indicated certain vocations with peculiar characteristics..."(p. 1). The guild model has viewed professionalism as a means to attain prestige, power, and control (Goode, 1965).

Ideological Model

The ideological model of professionalism is based on the true professions of law, medicine and theology whose origins are from the guilds. All true professions are thought to exhibit certain similarities: avoidance of commercialism, criteria for practice, group consciousness, and integration of their members (Carr-Saunders & Wilson,

1964). Professions which have specialized knowledge, authority, and self-regulation obtain certain sanctions from the public and their members are called professionals.

Mastery of Knowledge

Professional status is attained through the professional's mastery of knowledge along with high, rigorous and enforced standards of training. This mastery of knowledge is demonstrated through altruistic service (Flexner, 1915; Wilensky, 1961). Although Flexner (1915) first attempted to describe the professions, it was not until the 1950s that sociologists began a major effort to develop professional criteria. Greenwood (1957) developed criteria to distinguish professionals from non-professionals whose occupations could be grouped according to professional attainment. Professions were distinguished by five characteristics: (1) the presence of systematic theory, (2) authority recognized by clientele, (3) formal and informal community sanctions, (4) a code of ethics, and (5) professional culture sustained by the professional organization (Greenwood, 1957). The established professions, law, medicine, and theology, were described as possessing the five criteria and thus enjoyed professional status. However, many diverse occupation including architecture, engineering, and city planning, strive to be recognized as professionals and hold in rudimentary form some, if not all, of above elements. When debates on professionalism ensued, the criteria were changed or altered (Wilensky, 1961).

Although it became difficult to substantiate how systematic the theoretical knowledge of a profession must be, the ideological model,

based on the guild premise, prevailed. The older, more established professions of medicine and law, having staked out jurisdictions, established professional norms to maintain a monopoly over services. Newer professions struggled to meet the criteria, often attempting everything at once (Wilensky, 1961). Problems arose in measuring the criteria. For example, it became difficult to substantiate a claim of what constituted legitimate autonomy and authority (Goode, 1961). As a result, other theoretical approaches emerged as alternatives when more occupational groups sought professional status.

Behavioral Process

Professionalism is also described as a behavioral process by Scott (1965). Scott suggested this is a process by which occupations could assume the attributes of a profession. He proposed a sequential series of five steps towards the attainment of professional status. These steps were as follows. First, the occupational group establishes a professional organization. Second, the group's name is exchanged for a title to assert a monopoly in the public domain. Third, the group develops and promulgates a code of ethics. Fourth, the group prolongs political agitation to gain power from public support, and last they obtain a specialized title for members who meet the specialized criteria (Volmer & Mills, 1966). For example, hospital administrators in their pursuit of professional status have changed their name to health care administrators to obtain a monopoly in the health care system. Whether new professional groups progressed sequentially or attempted all the steps simultaneously, they still were not recognized as achieving comparable status.

Bureaucracy and Professionalism

Most theorists agree that conflicts between bureaucratization and professionalism occurred among professionals employed in institutions. Recent emerging professionals from academic settings appeared to be in greater conflict with these elements of bureaucratic rules, the division of labor, and the system's hierarchial authority (Hall, 1975). For example, hospitals enjoyed certain prerogatives and their control was enhanced because they were the primary source of employment for many professionals. Hospital administrators and physicians maintained the male system of capitalistic values, promoting ideas of dependence, discarding tasks of lesser importance to subordinates, and increasing stratification among employees in institutional settings (LeRoy, 1986).

Scott (1965) proposed a model of three professional groups based on the organizational work setting. According to Scott, all professional groups were different based on the nature of their work, and they could be classified as autonomous, heteronomous or departmental professional organizations (Scott, 1965).

Autonomous professional organizations were exemplified by those activities subject to the practitioner's control rather than to external or administrative jurisdiction (Scott, 1965). Since physicians developed the patient's care plan and prescribed orders that are carried out by others, they were seen as autonomous in the health care system. They represented the established professional group who controlled the content of their work, the conditions, and the division of labor that provided the health services to the public (Friedson, 1973).

Heteronomous professional organizations, conversely, were seen as partially subordinate to an externally imposed administrative force with little control over standards of their work (Scott, 1965). They were viewed as predominantly female professions such as nursing, teaching and social work, whose members worked in settings subject to bureaucratic or legislative norms. The norms often served as specific guidelines for practice, thus lessening the professional's autonomy (Hall, 1975).

Departmental professional organizations were viewed as part of a larger organization which may or may not determine how work was structured. These professionals were accountants or researchers who were part of a larger institution and generally had lesser professional status than the established professions (Scott, 1965).

Richard Hall's (1968) classic study of bureaucratization and professionalism empirically supported Scott's classifications of professional organizations of the lineage professionals. It became a model for subsequent studies of professionalism based on the guild premise. Hall developed a professional inventory scale from Scott's five behavioral attributes of professionalism: (1) the use of a professional organization as a major reference, (2) a belief in service to the public, (3) a belief in self-regulation, (4) a sense of calling to the field, and (5) a feeling of autonomy (Hall, 1968). Eleven occupations were represented by 328 participants, a small sample, and classified into three organizations using Scott's criteria. Physicians and lawyers scored higher on the five attributes of professionalism supporting the autonomous nature of their work. Teachers, nurses, and social workers scored lower on all the attributes, except for a belief

in service to the public, and were viewed as subject to both administrative and medical staff policy practices (Hall, 1968). The research findings substantiated Scott's classification.

Hall's Professional Inventory Scale, modified by Snizek (1972) became the instrument to measure professional attributes. Overall reliability of the instrument ranged from .78 to .80. Many research studies during the late 1970s and 80s of nurses, teachers, and social workers used Hall's instrument in attempts to disprove his findings. However the studies did not reflect higher views of professionalism except among nursing faculty.

As a whole it was also thought that if heteronomous professional organizations, teachers, nurses, and social workers increased their degrees of professionalism, their members' employment in bureaucratic organizations would lead to collective frustration and conflict (Corwin, 1965). In his research study of 124 staff nurses and 71 nursing students from baccalaureate and diploma programs, Corwin attributed baccalaureate degree nurse graduates conflict with the bureaucracy to their strong professional orientation and lack of loyalty to a particular hospital. Diploma graduates were more compliant since their initial loyalty to a particular hospital was developed as a student (Corwin & Taves, 1961).

Research among teachers and social workers presented similar findings. Teachers who were more professionally oriented were in greater conflict and less satisfied with their school systems. A study of professional satisfaction among 540 middle school teachers suggested that positive aspects were collegial relations and student interactions,

while negative aspects were working conditions and professional prestige (Chissom, Buttery, Prince, & Henson, 1986). Woodruff's (1984) study of 137 teachers suggested that in the more bureaucratic schools, teachers had lower scores of professionalism. A national survey of 682 social workers also indicated that organizational bureaucratic factors had a greater influence on performance than did professionalism (Rieser, 1986).

Friedson (1973) posited, however, that in the domain of the health care system "the structural relations among occupations...are not established by the management of work organizations but by occupational principle—exercise of authority over work by the occupations themselves, often with the support of the state which approves exclusive licensing and jurisdiction" (p. 26). The more established lineage professionals were able to maintain their autonomy, prestige, and control in the bureaucratic organizational setting. However, some authors disagreed with Friedson's premise of occupational principle.

Wilensky (1961) asserted that as more professionals worked in complex organizations the power was more likely to be split among various professionals, nonprofessionals and laypersons. Professionals had neither exclusive nor final responsibility for their work. Although Wilensky viewed nursing as a marginal profession, he believed that nursing must incorporate both elements of professional and bureaucratic models: a professional orientation mixed with career orientation rooted in the hierarchial work place (Wilensky, 1961). Goode (1960) also contended that it is no longer possible for lineage professions to maintain their professional monopoly, protected by the guild premise.

Science defines employment standards, and since the new professionals' origin was from an academic model, they functioned under different criteria in a bureaucratic setting (Goode, 1965).

Academic Model

The academic model of professionalism presents a view that today's professional organizations are learned societies whose member's allegiance is primarily to the field, and orientation is toward social change. Young professionals and students in professional schools possess a sophisticated and critical perspective of their roles in society that differs from the orientation around the accumulation of wealth and prestige. Professionals are joining other professionals across agencies to form networks of informational exchange and informal collaborational activities that reflect shared ideology. Their work often takes place in bureaucratic settings where science defines employment standards (Dumont, 1970).

Houle (1980) expands the professionalism concept to a lifelong socialization process in developing characteristics of professional behavior. Instead of meeting certain criteria, Houle proposes that the professional group should be concerned with continued refinement of standards. For example, young professionals will maintain the central mission of the profession if it is introduced in the education process and refined in service (Houle, 1980). Professionals never fully achieve the characteristics but as the profession raises its performance professional recognition comes from society. McCloskey and McCain (1987) found that in a study of 350 nurses, master's degree nurses are more satisfied and have higher scores on professionalism at the end of

six months' employment than did the other respondents. However, when initial expectations are not met, nurses become less attached to the job, the organization, and the profession (McCloskey & McCain, 1987).

Dumont (1970) contends that professionals must internalize a combination of bureaucratic, service, and professional concepts. Modern society has created new expectations of the professional who must be responsive to consumer control, be indifferent to credentials, possess a sense of superordinate purpose, hold an attitude of criticism, be impatient with the need to change, and be driven by compassion (Dumont, 1970). According to Dumont, the new face of professionalism is turned toward social change. The nature of professional life is changing as more professionals are emerging from universities with a sophisticated and critical perspective of their roles in society (Dumont, 1970). These professionals are attempting to develop mutual and supportive relationships in research, training, and service programs, placing a higher value on the well-being of people.

Professionalism in Nursing

Nursing practice primarily occurs in bureaucratic health care organizations where the majority of nurses are employed by other professionals and nonprofessionals. Professional efforts are fraught with conflicts peculiar to nursing, often influenced by organizational directives and societal forces. Though others have often made basic decisions about delivery of health care and nursing practice, throughout the years nursing has maintained its idealogy of the care of people, a concept devalued by other professionals. However, nurses have been

preoccupied by professional status, which divided them among themselves and their achieving power and authority (Lynaugh & Fagin, 1988).

Nurses are seen as an oppressed group because of the images and symbols linked to female stereotypes and female status ascriptions (Corley & Mauksch, 1988). Throughout history, nursing was a function performed by women who provided care. American society has not highly valued this care-taking aspect of the nursing profession. The enduring character of modern nursing reflected the social reforms of the nineteenth century and the emphasis of good character fostered by Victorian women (LeRoy, 1986).

Proponents of autonomy as the critical component of professionalism generally viewed nurses as wage professionals and who were not career oriented. Two theorists who greatly influenced this professional view of nurses were Abraham Flexner and Amatai Etzioni. Flexner, a prominent educator known for his evaluation of medical schools, presented a paper in 1915 titled, "Is Social Work a Profession?" In the paper Flexner viewed nursing, like pharmacy, as "an arm added to the medical profession, a special and distinctly higher form of handicraft", (Flexner, 1915, p. 12). Although Flexner applauded nursing's effort to achieve professional status, he proposed that the nurse's role was instrumental or collaborative at most and not autonomous since "it is the physician who observes, reflects and decides" (Flexner, 1915, p. 12). Flexner, the expert, was never questioned. The physician's authority was strengthened as nurses were seen in a dependent, subordinate role (Parsons, 1986).

Prior to Flexner's report, nurses were secure in their identity

as professionals. Nursing's confidence waned and was replaced by self-doubt, resulting in a major effort to professionalize (Parsons, 1986). Parsons' synthesis of the American Journal of Nursing articles published after Flexner's report indicated nursing became very preoccupied with ways to meet Flexner's criteria and the subsequent cultural norms of professionalism (Parsons, 1986). Since Flexner's definition of professionalism became widely accepted, nursing's attention focused on two themes: (1) the need for nursing to develop a unique body of scientific knowledge and (2) the necessity of assuring autonomy in practice.

A collection of essays edited by Etzioni (1969) also greatly influenced nursing's professional status by implying that occupations composed of women could not claim professional status. Etzioni (1969) designated nurses, teachers, and social workers as semi-professionals whose role in the organizational environment did not support their professional status (Etzioni, 1969). Katz (1969) supported the premise by observing that the traditional hospital arrangement made nurses subservient to physicians although autonomous in their patient care. The present hospital system does not promote collegial relationships between nurses and physicians. Katz (1969) indicated that in order for nurses to achieve professional status in this setting, organizational arrangements would need to change.

Since the 1950s many theoretical models have created a cultural norm for the professional nurse. Nurses have been viewed as not controlling the terms and conditions of their work, which strengthens

the prevailing view that nursing is a subordinate, supportive profession of medicine.

The historical interplay by health care administrators and physicians perpetuated this view due to fear of competition from nurses and the loss of the nursing student work force in the work setting (Parson, 1986). Efforts to improve the professional status of nurses in hospital settings by early nurse superintendents were stymied by the political alliances they had to forge with physicians and administrators (Reverby, 1987). Hospital administrators, who advocated the system of apprentice training, determined wages and controlled the work environment, seeking the least expensive and most compliant worker. Physicians controlled nursing practice through their care plans for patient care. Both hospital administrators and physicians influenced the educational content of hospital nursing programs, later called diploma programs (Lancaster, 1986).

When nursing organizations focused on state registration laws and educational reforms in schools of nursing, they became isolated from the majority of working nurses whose concerns were not the same. Nursing leaders were concerned about the exploitation of students pursuing admission standards for education and sought registration laws. Working nurses were more concerned with wages and working conditions. Reverby (1987) reported "both ideology and social position splintered nursing as an occupational group undergoing the pressures of a professionalization effort" (p. 122). Physicians and hospital administrators fearing competition from nurses with more education or loss of the student labor force fought their efforts (Reverby, 1987). The public, not really

convinced of the necessity for specialized nursing education, did not rally to nursing's demands for professional status and autonomy.

Despite the lack of a united front to improve nursing's situation, a new hope was to separate nursing education from the nursing service in hospitals. The first national study on nursing culminated in the Goldmark Report of 1923. Among the report's conclusions was support for university-based schools of nursing resulting in two levels of education and training for nurses: the expert nurse educated in university settings and the subsidiary nurse who provided routine patient care (LeRoy, 1986; Reverby, 1987).

Although nursing improved its position by gaining a foothold in university settings, the report stratified the nursing profession. Symptoms of disharmony among nurses can be traced to this event (LeRoy, 1986). Nurses who favor hospital-based education advocated the need for nurses to be expert in the physical and emotional care of hospitalized patients, while the proponents of collegiate education argued that nurses must deliver services to the entire population (Parsons, 1986). Both groups described nurses as professionals, but the real issue of the debate was what constituted the essence of nursing.

Physicians and hospital administrators continued to thwart attempts by nurses to upgrade educational standards and improve practice conditions. A recent example and the latest attempt was the American Medical Association's proposal to solve the nursing shortage by the creation of the registered care technician to provide bedside care (Billingsley, 1988; Carlsen, 1988).

Despite more women entering the medical profession, physicians continued to exert considerable influence over nursing. Medicine continued its efforts to stratify nurses as physicians have been faced with increased competition and possible decline of income. Since 1950, the physician-to population ratio rose from 140 to 175 per 100,000, and it was estimated that by the end of the 1980s the ratio would be 240 per 100,000. The physician population continues to grow with a surplus predicted to occur by the year 2000 (Ginzberg, 1981).

Styles (1982), a prominent nursing leader, claimed it was time for new relations between nursing and society. Styles proposed four goals that the profession of nursing should undertake to obtain power and recognition in the health care system. First, nursing should play a central role in the formulation of standards of nursing services in the work setting through official representation by nurses on policy-making boards. Second, nursing should designate the baccalaureate degree as the standard for professional practice. Third, the American Nurses' Association's definition of nursing practice should be the guideline for state nursing practice acts. And last, nursing should implement state criteria for specialty practice in nursing (Styles, 1982).

Styles (1982) called these standards the parameters of the new model of professional nursing that provided the framework to act and to carry out the society's expectations of nursing, monitored by nurses. The ability to develop professional spirit depended on development of an assertive posture and of a movement of unity among nurses. Therefore, she proposed only that nursing would be able to garner public support and gain power to control the nursing field (Styles, 1982). Edmunds'

(1986) national study of 610 registered nurses suggested that professional participation by nurses in policy making and development of a unified approach would increase nurses' professional autonomy and control in the work setting.

Diers (1986) proposed that professional authority of nurses would emerge as "...the new system of hospital reimbursement transfers the power of decision making—economic decision making—into the hands of nursing" (p. 29). Nursing's low placement in the hospital hierarchial system has stymied it's authority. The power of policy-making was transferred back to nursing via the 1983 system of reimbursement. Hospitals was interested in defining the cost of patient care. Nursing was in a position to separate nursing cost from other direct and indirect costs to describe the measures of health care (Diers, 1986). Nursing already had professional status, it just needed to take advantage of its position as a large unified force in the economic market.

Education

Central to professionalism of nursing is educational preparation. Academic communities train the majority of professional nurses. Nursing faculty play a significant role in the development of the future graduate's professional goals. Educational preparation for the practice of registered nursing is obtained from three nursing programs: associate, diploma, and baccalaureate.

Styles and Holzemer (1986) raised a concern that if the goal of nursing is educational preparation of the professional nurse then "educational mapping must become the core for a national plan to reach

our chosen destiny" (p. 64). Baccalaureate nurses are being prepared at the rate of 24,370 per year, roughly one half the output of the combined associate degree and diploma schools (Styles & Holzemer, 1986; USDHHS, 1988). The existing and projected nurse supply has comes from four entry levels of nursing (LPN, Diploma, ADN, BSN or higher). The majority of nurse graduates who took the National Licensure Examination for Registered Nurses were from associate degree programs generally considered technical training for practice (Division of Nursing, 1986).

Nursing was not able to achieve its 1980-1985 national plan of retitling and licensing the baccalaureate degree as the entry level for professional practice. This plan was based on the 1965 American Nurses' Association position paper formalizing the national position that two types of nurses were recognized: (1) technical nurses prepared in community colleges and (2) baccalaureate nurses prepared at the university level (ANA, 1965).

Nursing schools declining enrollments since the mid 1980s may reflected expanded options for women to achieve professional reward in other occupations. Enrollments in basic nursing programs fell sharply from 250,553 in 1983 to 198,339 in 1986 (Tregarthen, 1987). Prospective students were enrolling in other educational programs, business, medicine, and dentistry, which were admitting more women. A 1986 nationwide survey of college freshmen by UCLA's Higher Education Research Institute reported that nearly five times as many women were planning to enter business careers as were planning to enter nursing (Tregarthen, 1987). A major shift occurred among freshmen women at four year educational institutions. For every ten aspiring to be physicians,

only eight aspired to be nurses (Green, 1987). Business, medicine and dentistry were attracting women who perceived these professions facilitated opportunities to enjoy professional status.

Since education was believed to foster professionalism, nursing studies using Hall's Professional Inventory Scale focused on nursing faculty professional beliefs. Schriner and Harris's (1984) study of 370 nursing faculty reported that the higher the educational preparation of faculty, the higher the attitudes on professionalism. Likewise, Miller's (1984) study of 600 nurse educators reported doctoral nurse faculty have higher views of professionalism. Wakefield-Fisher's study of 215 nursing faculty teaching in doctoral nursing programs also reported higher views of professionalism, further substantiating the results of the two previous studies (Wakefield-Fisher, 1987).

Studies of nursing students and practicing nurse graduates were conducted to support the above findings. Generally, nursing students held higher views of professionalism, while nurses in the work force reported lower views of professionalism. The dissonance in nurses' professional self-image was contributed to nurses' inability to improve their working conditions. Decline in satisfaction, commitment, and professionalism among nurses occurred during the first six months of work, whether new graduates or experienced nurses. This suggested that job expectations were not met (McCloskey & McCain, 1987). In a comparison sample of 52 graduate nurses, 23 nurse managers, and 103 junior and senior nursing students from associate degree and diploma nursing schools, Corwin, Taves and Haase (1981) reported that students hold higher professional views than nurse managers and staff nurses,

again suggesting that beginning job expectations were not met. Christain's (1985) comparison sample of 500 nurses in New York State reported that baccalaureate graduates had a greater professional orientation than did associate and diploma graduates, but all respondents viewed hospitals as inhibiting professional practice.

Nurse leaders overtime have worked toward having nursing education occur in collegiate setting (Styles, 1982). Joel (1988) suggested that before state regulatory boards could move with titling and licensure changes, the work place must distinguish among nurses according to their educational credentials. Professional status for nurses in the work setting depended on the organization's willingness to change its structure to reward professional behaviors. Recent trends has been that more nurses are pursuing baccalaureate and master's degrees from schools of nursing that are affiliated with colleges and universities (USDHHS Secretary's Commission on Nursing, 1988).

Work Setting

The lack of control over the terms and the conditions under which nurses work was reflected in their feelings of powerlessness and lack of professional autonomy. Aydelotte (1982) reported that "autonomy resides within the technical and scientific knowledge of the professionals and the exclusiveness of their services" (p. 129). Yet nurses continue to view themselves as employees rather than as salaried professionals who direct work, make clinical decisions, and manage the content, the critical path, time, and selection of services for patients (Aydelotte (1982).

Nurses, as employees in the organizational structure, experience conflict and demonstrate a lower degree of professionalism. Nurses have lost control in their struggle with hospitals when they have left the initiative in decision-making to hospital administrators, either by acquiescence or by losing legitimacy within the organization by opting out of hospital employment (LeRoy, 1986). The concessions that hospitals extracted from nurses created the dominance of organizational rules that affect the professional's ability to be autonomous and to have authority over work conditions. Organizational standards determined the reward system and demand unconditional loyalty from the professional (Scott, 1982).

McCloskey and McCain (1987) longitudinal study of 320 registered nurses found 17 percent of the registered nurses, whether young or experienced, left in their first year of work and by the end of 18 months, 24 percent had left. Their findings, on the other hand, contradicted most of the literature on professionalism, which suggests that there was no conflict between professional and bureaucratic values. Rather, declining favorableness of the job and the organization reflected on the nurse's image of nursing. Koerner, Cohen and Armstrong's (1986) longitudinal study of a collaborative practice model of physicians and nurses on a 27-bed medical unit supported the above premise. Under the collaborative practice system, nurses were able to implement their goals of nursing practice. After one year, physicians were able to distinguish more clearly the technical and professional roles of nurses, and over 90 percent of the physicians and 100 percent of the nurses wanted the collaborative practice continued.

Nurses, however, were not socialized to expect professional control of their practice and yielded to political and economic pressures. Many nurses revised their view of independent practice and the need for autonomy as a trade-off for quasi-independence within the corporate structure. Furthermore, older nurses who worked in the organizational structure adopted the perspectives of the organization. Calhoon's (1985) sample of 89 staff nurses, although a small sample, reported that older nurses had higher scores of compliance than did younger nurses who perceived more conflict and less control in the work setting.

Nurses often were ambivalent about protesting real or perceived threats and generally preferred accommodation (Lynaugh & Fagin, 1988). Christain's study reported that nurses viewed themselves as lacking self-regulation and were concerned about their lack of control and accommodation of administrative policies (Christain, 1986). Although nurses resorted to strikes against hospitals for better working conditions in various sections of the country, their activities were not universal.

Some authors believed that nursing's power in its numbers (Joel, 1985). However, the American Nurses' Organization's (ANA) attempted to organize nurses were met with mixed success since there are many specialty nursing organizations. Approximately 189,000 nurses were members of the ANA ("what's next", 1988). Monnig's (1978) study of 300 registered nurses from a variety of settings reported that only nurses with master's degrees believed that it was important to hold membership in professional organizations. Bailey's (1987) more recent study

reported that only 32 out of 162 baccalaureate nurses indicated they were members of the ANA, although they viewed the professional organization as valuable.

Corporate management, who often are nonnursing professionals, require the commitment, loyalty, and control of employees in order to reach organizational goals. This demand created a conflict over professional ideals among nurses, especially if they were hired, promoted and fired at the will of management (Raelin, 1984). Lewis and Batey (1982) conducted interviews with 12 directors of nursing service at selected, small hospitals to obtain the meaning of the concepts of accountability and autonomy of nurses. Findings indicated that in order to strengthen nursing's position within the organization, it was important for directors to cultivate values of self-regulation and autonomy among nurses in hospitals (Lewis & Batey, 1982). Perry's (1984) more recent study of a random sample of 106 registered nurses reported a positive correlation between autonomy and highest educational degree held by nurses. Newer graduates scored higher on autonomy and self-regulation (Perry, 1984).

To summarize, nurses viewed themselves in an occupational and organizational position in which the freedom, power, and support to perform their functions have not been accorded to them. Nurses have been socialized in the educational system to be professionals, and yet they remain restrained within their own hierarchy. Nurses have been subject to the policies and procedures of the institutions in which they work. As women, nurses were not socialized to utilize power to improve their position. When nurse leaders sought to improve nursing's position

through college education for nursing, the work force became stratified. Moreover, professional status has been accorded to the lineage professions and society's image of nursing has greatly hampered the profession's progress towards self-governance.

JOB SATISFACTION

Perhaps the most immediate outcomes of conflicting expectations between management and new nurses who enter the work setting are job satisfaction and nursing turnover. Since the 1930s, nursing shortages have occurred in cyclic fashion. The recent shortage in the 1980s was a major concern of hospitals, where two thirds of nurses were employed. Previous hospital strategies to remedy shortages relied heavily on recruitment of nurses from a large pool of new graduates (Prescott, 1987). However, the declining enrollments in schools of nursing supported the fear that nurse vacancies will become more widespread and the effect more severe.

Through the years, job satisfaction of nurses has been the most widely studied concept in nursing. Many studies have attempted to pinpoint the causes of job dissatisfaction and nursing turnover. The credibility of the studies varied in their ability to anticipate the contributing elements that appeared to contribute to overall job satisfaction. Stamps and Piedmonte (1986) posited that "most of the difficulties related to job satisfaction studies are contributed to the lack of a well-accepted theoretical framework that could define parameters of applied efforts" (p. 2).

Some authors distinguished between career and job satisfaction. They often cited career satisfaction as a more long-term and more enduring phenomenon, whereas job satisfaction is short-term, requiring minimal commitment of the person to organizational activities (Raelin, 1984; Smith, 1982). Like job satisfaction, however, career orientation brought similar concerns about pay, advancement opportunities, relationship with employer, security, success, and commitment to the organization (Raelin, 1984).

Other descriptors of job satisfaction were positive attitudes of employees arising from opportunities in the work environment that facilitate good working relations with employers, success on the job, and other positive experiences in the work situation (Mottaz, 1987). Smith, Kendall, and Hulin (1969), who have done extensive research on job satisfaction, defined it "as the feelings a worker has about his job" (p. 6). Many nursing studies used job satisfaction index to measure affective responses to the facets of the worker's situation. However, the index lacked a well-defined theoretical framework.

Concern about employees' level of job satisfaction was traditionally assigned to the academic domain. The major motivation for studying work satisfaction was to create a link between productivity and satisfaction (Tosi, Rizzo, & Carroll, 1986). Although varied and contrasting results have been reported, low job satisfaction has been directly linked to absenteeism, accident rates, and tardiness, while increasing job satisfaction has been linked to increased productivity (Stamps & Piedmonte, 1986).

Economic theories were often used to study the supply of nurses and in order to understand national labor markets and shifts in aggregate supply and/or demand. In the health care industry, where labor costs are a major part of the budget, turnover rate among nurses has often been cited as the cause of nursing shortages. Predictors of the labor force participation at local hospitals were used to understand nursing shortages at the national level (Prescott, 1987). Turnover data, however, suggested that many nurses did not leave nursing; rather they took a similar jobs at another hospitals setting (Aiken, 1982; Weisman, Alexander & Chase, 1981). Thus, the aggregate data used to explain nurse shortages may not be accurate since this only shown the revolving door at that aggregate level (Prescott, 1987).

The inability to document the relationships of such factors and job satisfaction from one unit of analysis to another is important. This is why hospitals tend to believe that nursing shortages has been caused by sociodemographic factors beyond their control (Prescott, 1987). It fostered the recruitment solution to the problem of hospital shortages. Such response failed to acknowledge other important factors that contributed to retention of nurses in the work setting such as sufficient nursing staff, support from nursing management and hospital administration, scheduling factors, and salary and benefits (Buerhaus, 1987; Prescott & Bowen, 1987).

Organizational theorists, over the past 60 years, formulated several theories to address employee productivity, human relationships, and most recently, the task attributes of the job as well as the interpersonal and organizational context in which it is performed (Moos,

1986). Beginning theory on organizational behavior and job satisfaction traced its roots to the concept of scientific management. Frederick Taylor, the most prominent theorist, assumed that individual performance can be motivated if rewards are tied directly to the worker's carefully planned tasks. His studies led to concerns of worker fatigue, boredom, and job design (Tosi et al., 1986). Mayo, who in the 1930s experimented with working conditions of a chosen group of factory employees (the Hawthorne studies), concluded that the group interaction and leadership practice affected worker satisfaction and performance. This led to the humanistic movement and theories of motivation. The following theoretical approaches have been more closely associated with nursing: the multiplicative model of need fulfillment theory by Vroom (1964) based on Maslow's hierarchy of needs, the two-factor theory by Herzberg (1959), and the social-ecological framework by Moos (1986).

Multiplicative Need Fulfillment Theory

The multiplicative model has been a variation of the need fulfillment theory developed by Vroom (1964). The need fulfillment theory, based on Maslow's theory of hierarchy of needs, posited that the greater the need, the more satisfied the person will be when it is fulfilled (Stamps & Piedmonte, 1986). It used a multi-dimensional model that measures the degree to which the job fulfills work-related and personal needs. The components of Vroom's theory are supervision, the work group, job content, wages, promotional opportunities, and hours of work (Vroom, 1964).

Most conducive to job satisfaction appeared to be a work environment that provided high pay, promotional opportunities,

considerate and participatory supervision, opportunities to interact with peers, and a high degree of control over work methods and work pace (Vroom, 1964). Importantly, Vroom's theory emphasized that work satisfaction cannot be taken as totally separate from personal factors of satisfaction. Vroom suggested that the more satisfied a worker is, the more he or she is inclined to remain in the position (Vroom, 1964). Although his study and review of other studies of job satisfaction and job performance yielded modest correlations in worker satisfaction (.05 to .86), Vroom suggested that continued review of individual worker satisfaction may result in better job satisfaction theories. Vroom concluded that there is no simple relationship between job satisfaction and job performance, and suggested that the variables may be two distinct outcome variables (Vroom, 1964).

Two Factor Theory of Job Satisfaction

Most research studies generally reported that the physiological or lower-order needs of workers were satisfied in the work setting while they continually seek to satisfy their higher-order needs (Maslow, 1970). A growing concern of workers appeared to be related to power, prestige, and autonomy in the organizational hierarchy (Bush, 1988; Prescott, 1986).

Herzberg's theoretical framework of job satisfaction was partially based on Maslow's hierarchy of needs but differentiates between lower-order and higher-order needs. Herzberg, Mausner and Snyderman (1958) conceptualized people as having two separate needs in the work setting, one that affects satisfaction and the other that affects dissatisfaction.

The factors that affected satisfaction were motivational factors or higher-order needs, the elements of achievement, recognition, advancement, growth, and responsibility. When present, these factors produced high levels of work satisfaction since they satisfied the person's need for self-actualization. However, their absence did not necessarily produce work dissatisfaction. The other separate set of factors were hygiene factors or lower-order needs, company policy and administration, supervision, interpersonal relationships, working conditions, pay, status, and job security. When these factors deteriorated to a level below what is considered acceptable, job dissatisfaction ensued (Herzberg, et al. 1959). These two factors were not polar opposites on a continuum but instead operated as two separate and sometimes unrelated phenomena. A person could be both satisfied and dissatisfied with the work setting at the same time.

Although a popular theory and widely researched, Herzberg's theory represents the complexity of measuring levels of work satisfaction; one factor may be a satisfier for one person and not for another. It has been controversial since it used the incident recall method. The notion, moreover, that satisfaction and dissatisfaction are two distinct and separate dimensions has been widely debated (Stamps & Piedmonte, 1986). Researchers have found that the relationship between motivational and hygiene factors and work satisfaction was neither consistent nor always occurring in the predicted direction (House & Wigdor, 1967). For example, White and McQuire's (1973) study of 34 nurse supervisors reported that an additional factor, competence-

commitment-contentment of allied personnel co-workers, emerged and could not be classified as either a motivator or a hygiene factor.

Some authors even suggest that the wrong questions were being raised. The work paradigm was built on theories that fail to recognize the hierarchial power system in which most people work. Work satisfaction was related to workers' level of frustration in the work environment and affected their level of performance (Korman, 1971; Nord, 1974). Many research studies using the humanistic approach assumed that the majority of workers continued seek to satisfy their higher-order needs. Yet self-actualization, the most important need identified by Maslow, was often not achievable in the work setting for many workers. For example, Slocum, Susman and Sheridan's (1972) comparison study of 39 professional and 41 paraprofessional employees reported that professionals perceive they have higher prestige, more job autonomy and report higher levels of job satisfaction than do paraprofessionals. This might have been related to the psychological factors associated with perceived expectations of superiors and subordinates (Slocum, Susman & Sheridan (1972).

Social-Ecological Model

Most recently job satisfaction was viewed as related to an individual/organizational system commitment. The intrinsic and extrinsic benefits that workers received in a reciprocal relationship between management and employees (Moos, 1986). This model depicted a broad, complex view of the worker's environmental system as composed of organizational and work-related factors as well as personal factors. Moos (1986) contended that "the personal and environmental systems

affect each other, as do work and non-work factors in both systems" (p. 11). The individual perspective of the situation and the interplay with the environment resulted in individual adaptation and satisfaction in the work setting (Moos, 1986). A national study by Bokemeier and Lacey (1986) of 7,812 male and female respondents reported that job rewards, job values, working conditions, individual attributes and occupational prestige were important indicators of job satisfaction.

Moos (1987) proposed that an optimal match between the person and the environment contributed to morale and reduces dysfunctional aspects in the work setting. For example, a correspondence between personal and work environments could be complimentary. Moskowitz and Scanlan's (1986) cross-sectional survey design of 170 allied health program directors indicated that a complementary relationship existed between organizational and professional commitment. Even with relatively low levels of commitment to the organization, program directors exhibiting strong professional affiliation could find gratification in fulfilling institutional roles (Moskowitz & Scanlan, 1986). However, this study did not represent the majority of workers in the work force. Mottaz's (1987) descriptive survey of 1,385 full-time workers from five homogeneous occupational groups suggested that work rewards were better indicators of job satisfaction and have a greater effect on organizational commitment. Individual characteristics had very little impact (Mottaz 1987).

From the review of the literature of job satisfaction, it appeared that many views have been proposed and with diverse results. Slavitt, et al. (1978) reported that even though job satisfaction

studies focused on many variables, including the relationship of psychological variables and organizational factors, many were unable to pinpoint needs that would predict satisfaction in all jobs.

Job Satisfaction in Nurses

Within the health care field, nurses have been the group most often studied, and the theoretical framework most often used was Herzberg's two-factor theory (Slavitt et al., 1978). Positions in nursing have traditionally met the safety and security needs of nurses. Recent research showed that nurses repeatedly emphasize recognition, achievement, responsibility and growth as being the most important long-term job satisfiers (Berns, 1982). Decreases in nursing school enrollment, increase of nursing unions, strikes at the staff level, and the movement of nurses to other positions and other fields suggested continuing discontent over the years (Kleinknecht & Hefferin, 1982; Raelin, 1984). More women have been entering the work force and over 60 percent are employed in the work force. Most opted for other fields, perceiving that nursing offers low wages and few rewards ("are we becoming", 1989). Still, more registered nurses have been employed in hospital settings where presently 68 percent hold staff nurse positions (USDHHS Secretary's Commission on Nursing, 1988). This finding was verified in a Commonwealth of Virginia study in 1986 (Commonwealth of Virginia Department of Health Regulatory Boards, 1986).

Nursing opportunities for professional growth, prestige, power, and autonomy were frequently cited as major areas of long-term job satisfaction (Berns, 1982, Prescott, 1981). Most nurses agreed that there was a short-term need to correct the wage compression, which was

one major factor in the current nursing shortage. Although beginning salaries for nurses were comparable to salaries in other professional careers, many nurses reached their peak earning power within five years (Billingsley, 1989). Prescott (1987) reported that "today the differential between a beginning and an experienced nurse remains very slim, with staff nurses in practice five years or less averaging approximately $22,000 per year, and nurses with 6 to 10 years' experience averaging $25,000 and gaining little thereafter" (p. 206). To combat vacancy rates, many hospitals have invested in advertisements of bonuses, but as wage rates increased, employers tried to use less labor and explored types of equipment that could reduce labor costs (Murphy, 1988).

A growing segment of the nurse supply is the agency nurse. Temporary nurse agencies both big and small reported a growing demand for agency nurse services. Although no specific figures have been reported on the number of nurses employed by these agencies, the evidence showed that the field was expanding rapidly. Even hospitals which were not experiencing a severe shortage of nurses often relied on temporary nurses when the patient census was up. This stemmed in part from hospitals trying to contain labor costs and to keep their full-time staff as lean as possible. For nurses, high pay and flexibility in scheduling appeared to be the major attractions of temporary work (Selby, 1988).

There was an intense effort by hospitals to increase the productivity of nursing services while keeping labor costs down. Many hospitals were renewing efforts to retain nursing staff to direct

patient care and were moving toward a registered nursing staff (Kinshaw, Smeltzer, & Atwood, 1981). The national labor pool of nurses increased despite declining enrollments in schools of nursing (USDHHS, 1988). More nurses were working, reflecting an overall trend of women in the work force. The nurse labor force increased from 72.7 percent in 1977 to 78.7 percent in 1984 (Division of Nursing, 1986).

The growing movement of career development in nursing is the clinical ladder system. This was described by Zimmer as a strategy to help solve recruitment and retention problems in nursing (Davis, 1987). This was a vehicle used by hospitals to encourage nurses to stay in clinical nursing by promotion opportunities to reward and retain registered nurses (Prescott, 1987). A clinical ladder program could have multiple objectives. One was to improve the quality of care by rewarding personal growth. Another objective was to improve nurses' job satisfaction and reduce turnover (Decker, 1985). Clinical ladder models have been developed as a strategy for professional recognition (Kneedler, Collins, & Lavery, 1987). However, some authors believed that it was a further ploy to stratify professionals in the work force (Dumont, 1970).

Kleinknecht and Hefferin (1982) reported that nurses perceived little administrative support for their pursuit of personal and professional growth in the work setting, and that they felt powerless. Programs for self-direction and professional growth among nurses were identified as one way to retain nurses. Participation in individualized career development was one factor that could lead to satisfaction and

retention of nurses within the organization (Kleinknecht & Hefferin, 1982).

Nurse researchers suggested that the feeling of powerlessness was a major cause of job dissatisfaction among nurses employed in hospitals (Bush, 1988; Hinshaw, et al. 1981). Berns (1982) and Smith (1982) called for strategies to remedy this situation by changing the image of nursing from a job to a career that promoted self-actualization, a professional ideal. The nurse professional of 1980s has become more assertive by asking questions about patient care and requesting more control of the work setting. Research on nursing turnover indicated that the problems were not the motivators or characteristics of nurses but rather the nature of hospital nursing jobs and incentive structures (Weisman, 1982).

The classic longitudinal study of nurses' job satisfaction by Weisman, Alexander and Chase (1982) was a two-stage panel study of 1200 hospital full-time staff nurses at two large university-affiliated hospitals. Nurses were employed in 105 units representing all major clinical areas. The researchers found that perceptions of autonomy and task delegation were consistent predictors of job satisfaction followed by incentive structures promoting nurses to higher levels of clinical responsibility (Weisman, Alexander & Chase, 1981). Another study of 4,987 nurses in five hospitals by Simpson (1985) reported that the five motivating factors identified by Herzberg (achievement, recognition, work itself, responsibility, and advancement) were not met. Dissatisfaction with the various aspects of work and the work environment were reported by the majority of nurses.

When clinical nurses were rewarded for nursing skill and performance in patient management, they tended to remain in the patient-care delivery role, and the environment was conducive to attracting patients and physicians to an institution (Hinshaw, et al. 1987). Taunton and Otteman (1986) survey of 581 staff nurses described seven major components of staff nurses' role. Professional activities consisted of participating in continuing education and reading research reports and professional literature. Job activities were related to coordinating care among various disciplines, counseling patients, and acting as advocates for patients. Autonomy and authority issues were related to nurses' freedom to initiate referrals for patients to other health care providers, to develop relationships with physicians, and to communicate nurses' decision about patient care (Taunton & Otteman, 1986).

Lack of opportunities to exercise autonomy and authority were often cited as major concerns by nurses. Prescott (1986) collected data in 1981 and 1982 from staff nurses, nursing administrators, physicians and hospital administrators to gain a perspective on the factors that affected nurse turnover in hospitals. Fifteen hospitals participated in the sample which included four private teaching hospitals, eight church or community-owned hospitals, and three municipal hospitals. Both quantitative and qualitative data was collected and step-wise multiple regression was performed. High vacancy rates were predicted by the combined efforts of inadequate working conditions, minimal opportunities for decision making and fragmented patient care. Prescott suggested

that a relationship existed between nurse vacancy rates and independence of nursing practice (Prescott, 1986).

Another major study conducted by Hinshaw, Smeltzer and Atwood (1987) used a five-stage theoretical model of organizational and individual factors that would influence job satisfaction. Organizational factors were group cohesion and control over practice and autonomy. Individual factors were age, education, and kinship responsibilities. Sixty-eight percent or 1,094 nurse participants were from urban hospitals and 32 percent or 503 nurse participants were from smaller rural hospitals. Control over practice factors influenced organizational job satisfaction in addition to job stress and group cohesion. Group cohesion, they found, was more important for baccalaureate than for diploma prepared nurses. Conversely, organization satisfaction and the ability to control practice was more important for the diploma prepared nurse. Professional status and control of practice were named by nurses as the most important factors of job satisfaction (Hinshaw, et. al 1987).

To summarize, professional status and autonomy appeared to be long-standing issues of job satisfaction. Studies conducted by Slavitt et al. (1978) and Stamps and Piedmonte (1986) reported that levels of job satisfaction for staff nurses was predicted by degree of autonomy. Since autonomy was also considered a professional attribute, strategies to retain nurses in the marketplace were best addressed by an in-depth view of professional issues and the sources of job satisfaction.

SUMMARY

Sociologists' theoretical concepts of professionalism greatly influenced the professional development of occupations in the work setting. The conceptual definitions proposed by Greenwood (1957) and Scott (1965) and the empirical research by Hall (1968) described an environment and set forth the norms for subsequent research on professionalism. Flexner (1915) and Etzioni's (1969) conceptual descriptors of nursing as a marginal profession have greatly influenced views of nursing's professional status.

Despite newer theoretical approaches, the lineage professions of medicine, law, and theology remain the societal paradigm of professionalism. There appears to be no general consensus on the definition of professionalism. Definitions have varied depending on purpose and point of view. Nursing has never been considered to be a true profession. Diers (1986) made an astute observation when she reported that the world has an outdated view of nursing. Nursing is still professionally young but has the potential to become a powerful economic force (Diers, 1986).

Occupational sociologists have raised many issues, but their theoretical frameworks about job satisfaction as applied to nursing has been inadequate. The most controversial theoretical framework used in nursing studies has been Herzberg's two-factor theory focusing on hygiene and motivation. However, most issues affecting job satisfaction of nurses appeared to be multidimensional. These included issues such as professional growth and status, autonomy, control of practice,

working conditions, wage compression, and support from nursing management and hospital administration.

A confusing dichotomy has emerged between nursing education and practice. Nursing education has socialized nursing graduates to have greater expectations of autonomy and professionalism while nursing practice denied these expectations. Although many factors have been identified as affecting job satisfaction in the work setting, autonomy and professionalism control appear as major recurring themes in nursing. Thus, participation in the control of the work environment and it's tasks surface as vital to the future of professionalism of nurses.

The current study has been designed to further clarify the essence of nursing as a profession.

CHAPTER THREE: METHODOLOGY

DESIGN AND POPULATION

The design for this study was an analytical-descriptive survey. The purpose was to describe the existing phenomena of nurses' view of their professional status and their job satisfaction in a variety of health care settings. Descriptive survey research is limited to characterizing something as it is, the status quo, although it can suggest tentative casual relationships. Analytical research attempts to derive relationships, summarize findings and drawn conclusions from the data. The purpose is to describe and analyze an existing phenomenon by quantitative means with no manipulation or treatment of subjects (McMillan & Schumaher, 1984).

The population of this study was 46,452 registered nurses in Virginia who were from the 1988 Virginia Board of Nursing Registry. The Registry only contains the nurse's name, address, license number, and renewal date. Five designated regions developed by ZIP Code with their known population of nurses were Region I, 12,906; Region II, 10,599; Region III, 9,898; Region IV, 7,239; and Region V, 5,810. The purpose of dividing the population into five regions was to obtain a closer approximation of registered nurses' views across the state of Virginia (see Appendix D for regions by ZIP Code).

Sample Distribution

A two percent stratified random sample was computer drawn from each designated population region. A total sample of 929 registered nurses represented by region are Region I, 258; Region II 212; Region III, 198; Region IV, 145; and Region, 116. A stratified random sample

selected in this manner is to closely approximate the population characteristics in the state of Virginia (Agresti & Finlay, 1986). The sample size of 929 was chosen to minimize error since the investigator expects to find slight differences among the independent variables (highest levels of education, current job positions and major work settings) and nurses' views of professionalism. The research aim is to obtain a meaningful interpretation of the data.

PROCEDURE

A mailed survey packet was sent to each sample participant. The packet contained an overview letter, three instruments for collection of data, and a postcard to acknowledge completion of instruments and request for a summary of the results. The overview letter contained information including rationale for the research study, methods to assure confidentiality, and guidelines for completion of survey instruments (see Appendix C for letter to participants). A research identification code on the first page of the instrument package was used for mailing purpose and for data analysis. Participants were asked to respond to three instruments presented in a combined format: (1) a questionnaire about their background and experience, (2) Stone and Knopke's Health Care Professional Attitude Inventory, and (3) Atwood and Hinshaw's Work Satisfaction Scale (see Appendix B for instruments). A postcard was included requesting that participants return it to the researcher when they have completed the instrument package. It had an identification code on the back (see Appendix C for postcard content). The same identification code was on the first page and subsequent pages of the instrument package.

A time frame of two weeks from the initial date of mailing the survey packet was established for the return of instruments by sample participants. If no response was received two weeks after the initial mailing, a follow up letter was sent. The investigator established a 42-day cut-off date before the data is tabulated.

INSTRUMENTATION

Three instruments were used for the collection of data. Nurses' Background and Experience Questionnaire (1989) was a questionnaire created by the researcher composed of 10-items used to elicit data about nurses' background and professional experiences. Three of the items addressed the independent variables: highest level of education, current job position, and major work setting. Other items included the participant's employment status, the shift normally worked, the number of years employed, length of current position, years employed in nursing, gender and year born, and ethnic background. Participants were asked to circle the appropriate response to each item of the questionnaire (see Appendix B for questionnaire).

Stone and Knopke's (1978) Health Care Professional Attitude Inventory, the second instrument, modified by Lawler (1988), is used to measure participants' attitudes toward professionalism. Permission to use the Inventory was granted by both researchers (see Appendix A for permission letters). The modified instrument contains 38-items using a five-point response Likert scale to correspond with Dumont's (1970) paradigm of professionalism. The Inventory neither supports nor negates the six constructs of Dumont's paradigm of professionalism (consumer control, indifference to credentials, superordinate purpose, attitude of

criticism, impatient with the rate of change, and compassion). The items represent the participant's attitude and approach to the nature, duties, and responsibilities of her/his profession (Stone, 1978). The participant's responses are thought to reflect a professional attitude. Seven scores are obtainable: a composite score reflecting the individual's total professional attitude and six category scores reflecting the individual's response to Dumont's foundational principles (Stone, 1987).

Alpha coefficients on the Inventory were obtained by Stone (1978) from a sample of 153 freshman nursing students and a sample of 201 first year medical students. Alpha coefficients were conducted for each of the subscales of the instrument as well as item-to-item scale correlations and for each of the six categories ranged from .17 (superordinate purpose) to .70 (consumer control). However, overall coefficients were .70 for nursing students and .79 for medical students, indicating the items were internally consistent for the whole Inventory (Stone, 1978). Stone (1978) attributes the low alpha coefficients for the two subscales, superordinate purpose (.17 to .28) and indifference to credentials (.23 to .29) to the small number of items (6) representing each construct.

Lawler (1988) modified Stone's and Knopke's Inventory with the assistance of eight nursing experts who taught/or administered programs for baccalaureate students. A two round analysis of the Inventory was conducted. In the first round, panel revisions were related to item construction, the ranking scale, and the scoring. Questionable items were modified or deleted, and construction of new items was implemented

to measure the domain, resulting in the current 38-items to measure professionalism. The response scale was changed to a 5-point response Likert scale (strongly agree to strongly disagree) to be more explicit and to allow computer scanning for large samples. The scoring plan was simplified to absolute scores (Lawler, 1988).

In the second round the panel judged each item as to its relevance to the operationally defined constructs of professionalism. Consistency of instrument performance is obtained by the degree of agreement of interrater scores to the same objects or responses (Waltz et.al, 1984). A coefficient of agreement was set at .75 (1.0 is considered a perfect agreement), the acceptance of an item. Interrater coefficients of agreement ranged from .75 to 1.0, showing agreement on items tapping concepts (Lawler, 1988).

Lawler (1988) obtained further reliability and validity data on the modified Inventory. A sample was composed of 77 senior nursing students (41 participants were from two baccalaureate programs and 36 participants were from one associate degree program). Construct validity was determined by contrasting the two groups, anticipating that baccalaureate students would score higher on professionalism. Significant differences were obtained between the group means on five of the six subscales ($p<.05$), and on the total instrument. The subscale attitude of criticism was the only one not found to discriminate (Lawler, 1988).

Further validity testing was attempted by Lawler in the application of the convergence principle is based on the premise that different measures of the same construct should correlate highly with

each other (Waltz and Bausell (1981). Lawler (1988) used the modified Stone and Knopke's Inventory and the modified Corwin's Professional subscale Role 1 that purports to measure professionalism. Weak positive correlations of the constructs were found between the two measures. Lawler (1988) attributed it to the impreciseness of the Corwin's scale, since strong positive correlations were found between Stone and Knopke's total Inventory and its scales (Lawler, 1988).

Internal consistency of the modified Stone and Knopke's Inventory was assessed by Lawler (1988) using Cronbach Alpha. According to Waltz et al. (1984), alpha coefficient is preferred because internal consistency of an instrument is achieved to the extent that all of its items are measuring the same characteristic. The alpha for the total Inventory was .73; however, lower reliability coefficients for the subscales were found. When a group of participants are homogeneous in the attribute being measured, the alpha is generally lower (Waltz et al., 1984). Alpha ranged from .30 (compassion) to .60 (consumer control) for five of the subscales except for .07 superordinate purpose. The subscale superordinate purpose again proved troublesome, reflecting the lowest item intercorrelation. The lower reliability coefficients on the subscales, likewise, were attributed by Lawler (1988) to the small number of items (6-7) that comprise each subscale.

Despite the lower reliability coefficients on the subscales, the findings indicated that the modified Stone and Knopke's Inventory could prove to be useful as a measure of professional orientation in nursing. The overall reliability appeared to be sound for the entire instrument. Since the major purpose of this study was to determine the overall views

of professionalism of nurses, the superordinate subscale was not analyzed.

The modified Stone and Knopke's (1978) Health Care professional Attitude Inventory was used to measure professionalism of nurses in this study.

Atwood and Hinshaw's (1984) Work Satisfaction Scale, the third instrument, is a modification of Slavitt and Associates (1978) Occupational Satisfaction of Hospital Nurses Instrument. The Scale contains 32-items using a five-point Likert response scale (strongly agree to strongly disagree). Five subscales address the aspects of pay or reward, professional status, interaction/cohesion, administration, and task requirements. Permission to use the Scale was granted by the researchers (see Appendix A for permission letter).

The original instrument by Slavitt et al. (1978) contains two parts: Part A, a 15-item forced ranking of six components, and Part B, 48-items of attitudes that represents six subscales. The instrument is based on Maslow's and Herzberg's theories about work satisfaction. Half of the items within each subscale are phrased positively and half negatively. Each subscale yields a separate score and a total score for the entire scale.

Testing of the original instrument was conducted using two samples of nurses employed in two urban hospitals. In the first hospital, 83 percent of 336 nurses participated in study during the summer of 1972. In the second hospital, 62 percent of 450 nurses participated in the study during the summer of 1974. A modification of the Instrument was also developed and tested during the summer of 1974,

geared toward health care professionals in an ambulatory setting that included physicians, nurses and support staff personnel. All three groups ranked the component of autonomy as most important. Although nurses valued autonomy the most, they were only moderately satisfied with it in their current position (Slavitt et al., 1978).

Validity and reliability of the instrument was obtained by Slavitt et al. (1978) using factor analysis based on the responses from the second hospital with a 62 percent return rate. A Varimax rotation produced 19 factors that accounted for 59 percent of the variance among items. Regrouping of the items occurred in each subscale, which provided for maximum interpretability and reduced the 78-item instrument to 48-items that more closely approximated the concepts of Maslow's hierarchy of needs (Slavitt et. al., 1978). According to Waltz et al. (1984) factor analysis is considered an empirical data reduction tool that simultaneously assists in determining the different constructs underlying the items.

Internal reliability of the instrument was obtained using Cronbach Alpha. Slavitt and Associates (1978) found that for the 72-items overall reliability was .929; for the 48-items chosen by factorial analysis, .912. Subscale reliability for the 48-items instrument ranged from .696 (autonomy) to .846 (pay). High reliability of the subscales suggests that each item within the subscales measures that particular aspect of job satisfaction.

Further research occurred after the original testing. Atwood and Hinshaw (1984) dropped the Part A after a five-year testing program: 15-item ranking section and modified the Part B: attitudinal section to

32-items representing five subscales (pay or reward, professional status, interaction/cohesion, administration, and task requirements) using a five-point response scale (strongly agree to strongly disagree).

Hinshaw et al. (1986) used the modified instrument to study anticipated turnover among nursing staff. The instrument was administered to 1,597 staff nurses (63 percent registered nurses, 37 percent licensed practical nurses and nurses aides) in 15 urban and rural hospitals. Cronbach Alpha for the subscales ranged from .67 (pay or reward) to .69 (professional status). The total scale alpha was .87 (Hinshaw et.al., 1986). High reliability was obtained again for each subscale and overall instrument. Construct validity was obtain through the use of factor analysis and predictive modeling.

Atwood and Hinshaw's (1984) Work Satisfaction Scale was used to measure job satisfaction of nurses in this study. Two modifications were made of the instrument in consultation with Atwood. The word hospital was changed to health care agency or agency and a brief introduction was added to clarify the terms. Verbal consent for the changes was provided by Atwood (J. A. Atwood. personal communication. February 27, 1989).

DATA ANALYSIS

Data from the survey packet of female nurse participants who were employed was used in the data analysis to obtain a more homogeneous representation. The Division of Nursing (1986) reported that approximately 97 percent of nurses are females. Data was placed on file in the university computer system. Descriptive and inferential

statistical procedures were utilized. For research presentation purposes, the analysis of data was related to each research question.

PROFESSIONALISM

Research question (1) How do registered nurses' view professional status? Scores were obtained for each of the 38-items of the modified Stone and Knopke's Health Care Professional Attitude Inventory. Measures of central tendency were used to describe the data. Group mean scores from the five regions of the state were obtained for the five subscales (superordinate purpose was not analyze) and the total Inventory. Distribution of scores may indicate the amount of spread or scatter among the scores obtained on professionalism (Waltz et al., 1984). Descriptive analysis of the items was also conducted since previous measures of central tendency were obtained with nursing students.

Cronbach Alpha was used to determine the internal reliability of the instrument. Alpha is the preferred measure since it assumes equivalence of all items (McMillan & Schumacher, 1984). Alpha measures the extent to which performance on any one item of an instrument is a good indicator of performance on any other item in the same instrument (Waltz et al., 1984). The extent to which the instrument is internally reliable is a good indicator that the subscales are measuring the same characteristic (Waltz & Bausell, 1981).

Internal reliability of the total instrument mean scores and five of the subscale scores were analyzed. The alpha value for this instrument was obtained in the following manner: (1) the number of items in the test, (2) the sum of the individual item variances, and (3)

the variance of the distribution of instrument scores (Waltz et al., 1984). Reliability of this test was compared to previous findings. If the internal reliability on the subscale scores are low and a item correlation and a correlation matrix between the overall scale and the subscales should be conducted (Waltz, et. al 1984).

Research question (2) What is the relationship between registered nurses' highest levels of education in nursing, current job positions, major work settings, and their professionalism? Group mean scores were obtained for each of the 32-items of Stone and Knopke's Inventory. Data analysis of the independent variables used cohort mean scores. Measures of central tendency were used to describe the data.

Multivariate analysis (MANOVA) and analysis of variance (ANOVA) were conducted to determine the relationship between the independent variables (highest levels of education, current job positions, and major work settings) and the dependent variable (nurses' overall view of professionalism) by the total mean score from Stone and Knopke's Inventory. MANOVA was used first to determine the effect of the independent variables on professionalism as it can be useful when there are many variables. Then analysis of variance was conducted. A 1 X 4 ANOVA was conducted to determine the affect of highest educational level on professionalism. A 1 X 7 ANOVA was conducted to determine the affect of current job position on professionalism. A 1 X 5 ANOVA was conducted to determine the affect of major work setting on professionalism. ANOVA is also a useful general procedure to test whether any number of group means differs from one another (Waltz & Bausell, 1981). When using

ANOVA, it is more precise to include the levels of categories for each independent variable (McMillan & Schumacher, 1984).

JOB SATISFACTION

Research question (3) How do registered nurses' view job satisfaction? Measures of central tendency were used to describe the data. Scores were obtained for each of the 32-items of Atwood and Hinshaw's Work Satisfaction Scale. Group mean scores were obtained for the total instrument and each of the five subscales. Reliability of the total and subscale scores was assessed by Cronbach Alpha. Reliability of this test was compared to previous findings. Descriptive analysis of the items was also conducted since previous studies did not include mean scores.

Research question (4) What is the relationship between work setting and job satisfaction of registered nurses?" Group mean scores were obtained for each of the 32-items of Atwood and Hinshaw's Work Satisfaction Scale. Data analysis of the independent variable (current work setting) used cohort mean scores. Measures of central tendency and frequency distribution were used to describe the data. MANOVA and a 1 X 5 ANOVA were conducted to determine the relationship between the independent variable (work setting) and the dependent variables (nurses' overall view of job satisfaction) by the total mean score from Atwood and Hinshaw's Work Satisfaction Scale. Wilk's Lambda, a test of the ratio of the between group sum of squares, was used to determine the degree of association between two or more groups. Scheffe's multiple comparison procedure also permits statements about all contrasts and does not require equal size samples (Agresti & Finlay, 1986).

JOB SATISFACTION AND PROFESSIONALISM

Research question (5) "Does view of job satisfaction of registered nurses relate to their professionalism?" Using Pearson product-moment correlation (r), the association between the two variables, nurses' overall job satisfaction and professional mean scores were explored. According to McMillan and Schumacher (1984), correlation coefficient is used to indicate the degree to which two sets of scores are related, or covary, and the nature of the relationship between the two variables. The interpretation of correlation is usually in terms of the percent of variance shared by the two variables.

Bivariate regression is conducted when the investigator has reason to believe that one of the two variables will be a function of or a change due to the influence of the other variable. If the two variables are linearly related, the means of the contingent distributions will fall in a straight predictive line (Waltz & Bausell, 1981). The investigator was interested in exploring whether the mean scores of job satisfaction show a relationship to mean scores of professionalism.

LIMITATIONS

The limitations identified in this study were as follows. This study was limited to female registered nurses who are employed in a health care work setting in the state of Virginia. The research findings only described an existing phenomenon by quantitatively characterizing nurses present situation relating to views of professionalism and job satisfaction. There was no manipulation or treatments of subjects, and the investigator only reported things as

they existed. The study was limited to the research questions as stated in Chapter One.

CHAPTER FOUR: FINDINGS

INTRODUCTION

The principle objective of this chapter is to report the findings of the data gathered to investigate the research questions identified in the Introduction of this analytical-descriptive study of registered nurses' professionalism and job satisfaction. Five research questions identified were:

(1) How do registered nurses view professional status?

(2) What is the relationship between registered nurses' highest levels of education in nursing, current job positions, major work settings, and their professionalism?

(3) How do registered nurses' view job satisfaction?

(4) What is the relationship between work setting and job satisfaction of registered nurses?

(5) Does view of job satisfaction of registered nurses relate to their professionalism?

A description of the population and sample is presented along with statistical analysis and a discussion of findings for each research question.

RESULTS OF THE STUDY

POPULATION

The population for this study was 46,452 registered nurses in Virginia who were from the 1988 Virginia Board of Nursing Registry. Five regions or subgroups were identified by ZIP Code: Region I, 12,906; Region II, 10,599; Region III, 9,898; Region IV 7,239; and Region V, 5,810 (see Appendix D). The purpose of using the five regions

was to obtain a closer approximation of the demographic characteristics and registered nurses' professionalism and job satisfaction across the State of Virginia.

SAMPLE

A two percent stratified random sample was drawn from each of the five population regions resulting in a total sampling frame of 929 registered nurses residing in the State of Virginia. In the sample each region was represented as follows: Region I, 258; Region II, 212; Region III, 198; Region IV, 145; and Region V, 116 (see Appendix D).

A total of 530, or 57 percent, of the questionnaires were returned in two mailings. The first mailing from the sampling frame resulted in a return of 407 questionnaires (45%) followed by a second mailing three weeks later with a return of 123 questionnaires (12%) from the sample. Of the total questionnaires returned, only responses from female participants presently employed in nursing were included in the final sample for data analysis. ELiminated from the sample were seven males nurses and 96 females nurses who were unemployed or retired, resulting in a total sample of 427 (46%) employed registered nurses.

Table 1 reports the number and percentage of registered nurses by region in the sample and shows that Region I had the greatest percentage (26.5 %) of participants while Region V had the lowest (10%). Representation by percentage from the other three regions were similar (Region II, 22%; Region III, 22%; and Region IV, 19%), falling between the two extremes.

Table 1

Sample Representation by Region of Registered Nurses

Group	N	Returned n	Returned %	Final Sample n	Final Sample %
Total Sample	929	530	57	427	46
Region I	258	145	27.3	113	26.5
Region II	212	109	20.1	94	22
Region III	198	121	23	95	22
Region IV	145	100	19	82	19
Region V	116	65	10.4	43	10

Since the percentage of representation in the final sample by region was not equal, a 1 X 5 ANOVA was conducted by region to determine if there was a difference between the mean scores (see **Table 2**).

Table 2

Means and Standard Deviation for Sample by Region on Professionalism and Job Satisfaction

	Professionalism		Job Satisfaction	
Group	M	SD	M	SD
Total Scale	132.82	11.15	93.54	18.46
Region I	132.82	11.15	93.96	17.64
Region 2	130.12	11.67	95.67	18.75
Region 3	132.00	12.95	91.98	17.10
Region 4	131.26	12.54	92.95	20.04
Region 5	128.52	13.75	93.40	20.06

As shown in **Table 2** that follows, no significant differences were obtained by region on professionalism ($F = 1.275$, $p > .05$) and job satisfaction ($F = .502$, $p > .05$). Therefore, location (region) was not a

significant factor and the total sample was used to analyze the research questions.

CHARACTERISTICS OF THE SAMPLE

The sample consisted of 427 registered nurses who were female and actively practicing nursing in a variety of health care settings in the State of Virginia. As shown in **Table 3** that follows, half of the nurses (49.5%) were 40 or older with a mean age of 41.3 years and a median age of 39.6 years (range from 23 years to 74 years). Employment status showed that most of the nurses (64.2%) worked full-time and more than half (60.7%) worked the day shift. The majority (87.1%) have been working for six years or more with a mean of 15 years (range from 1.3 years to 52.5 years). Most of the nurses (62.8%) indicated they had been in their present position for at least six years with a mean of 5.8 years (range from one month to 43.2 years). In addition, 93 percent identified themselves as Caucasian and six percent as Black.

TABLE 3

Sample by Demographic Characteristics

Variable	n	%	Mean	Median
age in years			41.3	39.6
23-29 years	38	8.9		
30-39 years	174	40.4		
40-49 years	118	27.6		
50-59 years	69	16.5		
60-74 years	23	5.4		
missing	5	1.2		
shift normally worked				
days	259	60.7		
evenings	44	10.3		
nights	43	10.1		
rotating shifts	75	17.3		
missing	5	1.2		
employment status				
full-time	74	64.2		
part-time	118	27.6		
full-time and part-time	11	2.6		
more than one part-time	20	4.7		
missing	4	.9		
years in nursing practice			15	13
less than two years	4	.9		
2 to 5 years	37	8.7		
6 to 10 years	99	23.2		
11 to 15 years	100	23.4		
16 to 20 years	66	15.5		
21 to 25 years	45	10.5		
26 to 53 years	62	14.5		
missing	14	3.3		
years in present position			5.8	3.5
less than one year	73	17.1		
1 to 5 years	74	17.3		
6 to 10 years	112	26.2		
11 to 15 years	80	18.7		
16 to 20 years	48	10.8		
21 to 43 years	28	7.1		
missing	12	2.8		

DESCRIPTION OF SAMPLE BY INDEPENDENT VARIABLES

Table 4 displays the education, job position, and current work setting of the sample of registered nurses.

TABLE 4

Description of Sample by Education, Job Position, and Work Setting

Variable	n	%
Highest levels of Education		
Nursing Diploma	178	41.7
Associate degree	71	16.6
Baccalaureate degree	133	31.1
Master's degree	44	10.3
Doctorate	1	.2
Job Position		
Staff Nurse	273	63.9
Unit Coordinator	28	6.6
Supervisor	45	10.5
Administrator	24	5.6
Nurse Practitioner	6	1.4
Nurse Educator	21	4.9
Nurse Anesthetist	1	.2
other	23	5.4
missing	5	1.2
Work Setting		
Hospitals	244	58.5
Ambulatory/Physician/HMO	52	12.6
Home Health/Health Department	37	8.9
Nursing Home/Convalescent Center	15	3.6
Schools of Nursing	10	2.6
Other	58	13.6
missing	1	.2

The largest representation of nurses in the sample were diploma nurses (41.7 %). Following in rank order were baccalaureate nurses (31.1%), associate degree nurses (16.6%), and master's prepared nurses (10.3%). Most nurses (63.9%) were employed as staff nurses with the remainder representing management positions, clinical specialty areas, or

education. A majority (58.5%) of the sample were employed in hospital settings with the remainder working in a variety of health care settings, ambulatory care or physicians' offices (12.6%), home health care agencies and health departments (8.9%). Generally, the sample was composed of registered nurses who primarily were diploma graduates and staff nurses, employed in hospital settings, and worked full-time.

DATA ANALYSIS OF THE RESEARCH QUESTIONS

Data analysis focused on the research questions related to professionalism and job satisfaction. The SPSSX statistical package was employed for this analysis (SPSS, 1988).

PROFESSIONALISM

Stone and Knopke's (1978) Health Care Professional Attitude Inventory modified for nursing by Lawler (1988) was used to measure registered nurses' attitude toward professionalism. Cronbach Alpha was used to determine the reliability of the instrument and its subscales. The Superordinate Purpose subscale was not included in the overall alpha analysis, because of previous findings of low reliability, resulting in a 32-item scale.

The total alpha was .67, for the Inventory which is indicative of a marginal range of reliability. The standardized coefficients for the subscales were low, ranging from .12 (Critical Thinking) to .50 (Consumer Control). A correlation matrix showed that many items had weak correlations (.5 or below), and several items were strongly correlated with other items not in the subscales. Two items in particular indicated a minus coefficient. These two items were contained in the subscale Critical Thinking. Their content pertained

to aspects of critical thinking of students which appeared not be appropriate for this sample of practicing nurses. Both statements addressed student performance in the practice setting: incorporating the philosophy of their educational program into their practice and demonstrating their performance to faculty.

The two items were omitted which reduced the Inventory to 30-items. The total alpha increased to .69 for the Inventory and .23 for the subscale, Critical Thinking, as seen in **Table 5.** Since the overall reliability was strengthened, the 30-items Inventory was used for subsequent data analysis.

Table 5

Internal Reliability oF Professionalism Inventory

Scale/Subscales	No. of Items	First Cronbach Alpha	No. of Items	Second Cronbach Alpha
Total Scale	32	.67	30	.69
Consumer Control	6	.50	6	.50
Indifference to Credentials	6	.44	6	.44
Critical Thinking	6	.12	4	.23
Impatience With Change	7	.33	7	.33
Compassion	7	.29	7	.29

Note. Number = 362.

Since the correlation matrix exhibited weak correlations among the items, a Pearson product-moment correlation (r) was conducted to determine the relationship between the overall Inventory and its subscales. The relationships (expressed as correlation coefficients) ranged from .07 to .73. All were in a positive direction and showed a

moderate correlation between each subscale and the total Inventory. Critical Thinking, Impatience With Change, and Compassion subscales exhibited the strongest relationship with each other and the Inventory as a whole but exhibited weak correlations with each other. Consumer Control and Indifference To Credentials subscales exhibited weak correlations with each other and the Inventory (see **Table 6**).

Table 6

Correlation Coefficients Between Subscales on Professionalism Inventory

	Scale	Consumer	Credent	Critical	Impat	Compas
Scale	---					
Consumer Control	.70	---				
Indifference To Credentials	.53	.12	---			
Critical Thinking	.65	.36	.22	---		
Impatience With Change	.68	.54	.07	.35	---	
Compassion	.73	.46	.27	.32	.48	---

Subsequent data analysis of the two research questions on professionalism of nurses was conducted using the total mean scores of the Inventory since there were weak correlations between the Inventory and its subscales.

Research Question (1): How do registered nurses' view their professional status?

Measures of central tendency were used to describe the data. Scores ranged from 61 to 171 on the modified Stone and Knopke's Health Care Professional Attitude Inventory (total possible score = 190). The mean was 131.319, the median was 131, and the mode was 128 with a standard deviation of 12.23 for the sample of registered nurses in Virginia.

Since previous studies were conducted with medical and nursing students using the Inventory and no studies were available with registered nurses to obtain mean scores, a more descriptive assessment of responses by nurses in the sample (see Appendix E). The purpose was to describe how nurses viewed their professional status.

Sixty-six percent of the nurses sampled indicated that consumers have not been adequately involved in the development of the health care delivery system and 82 percent believe that consumer involvement is essential. Although 44 percent of the nurses sampled disagreed that the use of centralized decision-making is the best strategy for nurses, 40 percent were undecided. Seventy-two percent of the nurses sampled disagreed that credentialing assures competency of nurses. Forty-three percent of the nurses sampled agreed that nurses were actively promoting change (See **Table 7**).

Table 7

Distribution of Response by Percentages on Selected Professional Items by Nurses

Items	Strongly Agree %	Agree %	Undecided %	Disagree %	Strongly Disagree %
Consumer Control					
At this point in time, the consumers have been adequately involved in the development of the health care delivery system.	2	8.5	23	46	20
Consumer involvement is essential to provide new alternatives in developing health care delivery systems.	34	48	15	3	1
Indifference to Credentials					
Certification of competence upon receipt of the professional degree is necessary to assure that the behavioral sciences, basic sciences, and health care services were a part of professional education.	13	7	17.5	29	43
Health care providers who work with professionals from other disciplines discover a common purpose in providing adequate health care for all citizens.	.5	9	21	45.5	24

Note. Percentages may not total 100 because of rounding.

Note. Responses range from 416 to 426.

Table 7

Distribution of Responses by Percentages on Selected Professional Items by Nurses

Items	Strongly Agree %	Agree %	Undecided %	Disagree %	Strongly Disagree %
Attitudes of Criticism					
Health Care Professionals have developed adequate self-evaluation of procedures and techniques in the delivery of health care.	10	21	24	33	12.5
Priorities for the user of human and material resources in the health care professions are best achieved through centralized decision-making.	4	12	40	25.5	18.5
Compassion					
The health care professional such as a nurse should be concerned solely with clinical practice and not with social change.	2	5.5	7	35	51
Health Care professionals generally fail to show adequate interest in the health needs of consumers.	5	20	21	32	21
Impatience with Change					
Education programs for health care professionals have not been adequately responsive to the identified needs of local communities.	5	24	26	28	17
Health Care Professionals have been actively promoting change in the health care delivery systems for the improvement of health care for all citizens.	13	33	35	17	2

Note. Percentages may not total 100 because of rounding.

Therefore, it could be determined from the sample of descriptive responses in Table 7 that nurses in the sample have professional status using Dumont's model of professionalism since they indicated

(1) consumer involvement is important to nurses,

(2) performance is more important than credentials,

(3) nurses are compassionate, and

(4) nurses are involve in social change

Research Question(2): What is the relationship between registered nurses' highest levels of education in nursing, current job positions, major work settings, and their professionalism?

Group mean scores were used to obtain a distribution of highest levels of education in nursing, current job positions, and major work settings with professionalism using Stone and Knopke's Inventory. Group mean scores ranged from 130.38 to 131.57 for highest levels of education and professionalism. Group mean scores ranged from 128.87 to 133.89 for current job positions and professionalism. Group mean scores ranged from 128.87 to 133.89 for major work settings and professionalism. Since there was very little variability of the distribution of groups mean scores in the sample of nurses on professionalism, multivariate analysis tests were conducted to determine if there was a difference between groups.

Multivariate analysis tests for highest levels of education in nursing, current job positions, and major work settings with professionalism were not significant, $p > .05$. None of the one-way analysis of variance tests (1 X 4 ANOVA of educational levels, 1 X 7 ANOVA of current job positions, and 1 X 5 ANOVA of major work settings) reached significance, $p > .05$. Therefore, no significant differences were found between nurses' professionalism and the three independent variables.

JOB SATISFACTION

Job satisfaction of nurses was measured using Atwood and Hinshaw's (1984) Work Satisfaction Scale which is based on Maslow's Hierarchy of Need and Herzberg's Two Factor Index of job satisfaction. Reliability of the total scale and subscales was assessed by Cronbach Alpha (see TABLE 8). The alpha for the Scale was .90 which is indicative of a high range for reliability. The standardized coefficients for the subscales ranged from .77 (professional status) to .85 (pay or reward). The majority of items in each subscale demonstrated moderate to good (.39 to .72) reliability. This suggests that each item within the Scale and subscale components measures that particular aspect of job satisfaction.

Table 8

Internal Reliability of Work Satisfaction Scale

Scale/Subscale	No. of Items	Cronbach Alpha
Total Scale	32	.90
Pay or Reward	7	.85
Professional Status	7	.77
Interaction/Cohesion	7	.83
Administration	6	.82
Task Requirements	5	.79

Note. Number = 384.

A Pearson product-moment correlation (r) indicated a strong correlation between the Work Satisfaction Scale and its subscales (see TABLE 9). The relationships ranged from .18 to .83. All were in a positive direction and showed moderate to strong correlation between each subscale and the total scale. There were moderate correlations between the subscales. The Administration subscale had the strongest

relationship with each subscale while the Task Requirements subscale had the weakest relationship with the other subscales. The items in the Work Satisfaction Scale appear to represent the concept of job satisfaction.

Table 9

Correlation Coefficients Between Subscales on Work Satisfaction Scale

	Scale	Pay	Profess	Interact	Admin	Task
Scale	---					
Pay or Reward	.66	---				
Professional Status	.68	.25	---			
Interaction	.75	.26	.49	---		
Administration	.83	.47	.50	.52	---	
Task Requirements	.61	.29	.18	.35	.41	---

Since the reliability of the Scale and subscales were strong and the subscales appeared to be related to the concept of job satisfaction, the Scale and subscale mean scores were used to answer the two research questions on job satisfaction of registered nurses in Virginia.

Research Question (3): How do registered nurses' view job satisfaction?

Measures of central tendency were obtained to analyze the data. Scores ranged from 34 to a maximum of 143 on Atwood and Hinshaw's Work Satisfaction Scale (total possible score = 160). The mean was 93.539, the median was 94, and the mode was 95 with a standard deviation of 18.85 for the sample on job satisfaction.

Since no comparison data of mean scores from previous studies using the Work Satisfaction Scale were available, a more descriptive assessment of responses is presented by nurses in the sample (see **Table 10**).

Table 10

Distribution of Responses by Percentage on Selected Items by Nurses

Items	Strongly Agree %	Agree %	Undecided %	Disagree %	Strongly Disagree %
Pay					
An upgrading of pay schedules for nursing personnel is needed at this health care agency.	4	7	18	28	43
Considering what is expected of nursing service personnel at this agency, the pay we get is reasonable.	11	17	24	24	24
My present salary is satisfactory.	8	23	21	24	24
Professional Status					
It makes me proud to talk to other people about what I do on my job.	44	30	18	4	5
There is no doubt whatever in my mind that what I do on my job is really important.	69	20	7	3	5
Interaction/Cohesion					
There is a lot of "rank consciousness" on my unit; nursing personnel seldom mingle with others of lower rank.	43	35	11	8	3

Note. Percentages may not total 100 because of rounding.

Note. Responses range from 416 to 426.

Table 10

Distribution of Responses by Percentage on Selected Items by Nurses

Items	Strongly Agree %	Agree %	Undecided %	Disagree %	Strongly Disagree %
The nursing personnel at my health care agency do not hesitate to pitch in and help one another out when things get in a rush.	29	32	23	11	4
Effect of Administration					
There are plenty of opportunities for advancement of nursing staff at this health care agency.	3	13	24	28	33
I have enough opportunities to make administrative decisions in planning procedures and policies at my health care agency.	18	22	22	21	17
Task Requirements					
I could deliver much better care if I had more time with each patient.	5	12	20	27	36
The amount of time I spend on administrative work at my health care agency is reasonable, and I am sure that patients do not suffer because of it.	11	20	24	26	19

Note. Percentages may not total 100 because of rounding.

Note. Responses ranged from 417 to 426.

As Table 10 shows nurses were concerned about pay for comparable work, viewed themselves as having professional status, and wanted more opportunities to participate in policy making activities and advancement within their work setting.

Forty-eight of the nurses sampled felt strongly that their salaries were not reasonable and 71 percent felt that salaries needed to be improved in their particular work setting. Eighty-nine percent agreed that their job was important and 74 percent were proud of their job. Sixty-one percent of nurses sampled agreed that there were not many opportunities for advancement nor involvement in policies and procedures that affect patient care. Nurses responded evenly by percentage to statement on opportunities to participate in policy-making activities.

On elements of interaction/cohesion and task requirements nurses did differ. Seventy-eight percent of the nurses sample agreed there was a lot of "rank consciousness" on their units. However, 61 percent agreed that nurses did pitch in when other nurses needed assistance. Sixty-three of the nurses agreed that if they had more time they could deliver better patient care, but differed on the amount of time spent on administrative work. Therefore, it appears that generally nurses were satisfied except for pay compensation, participation in policy-making activities, and opportunities to advance in their work setting.

Research Question (4): What is the relationship between the work setting and job satisfaction of registered nurses?

Atwood and Hinshaw's (1984) Work Satisfaction Scale was used to obtain a distribution of group mean scores by work setting. Multivariate analysis and one-way analysis of variance tests were conducted to see if there was a relationship between nurses' work setting and job satisfaction.

The work setting for the multivariate analysis tests was divided into five groups: Group 1, nurses from hospitals; Group 2, nurses from ambulatory/outpatient, physician offices and HMO's; Group 3, nurses from home health care agencies and health departments; Group 4, nurses from nursing homes and convalescent centers; and Group 5, nurse educators from schools of nursing. The multivariate analysis tests were significant indicating that five work settings mean scores were not the same for job satisfaction. Wilks' Lambda, a test of the ratio of the between group sum of squares to the total sum of squares, was statistically significant ($F = 3.695$, $p < .05$). Wilks' Lambda was used to show that a difference exists between work setting and job satisfaction since two or more groups were involved. **Table 11** which follows shows the group mean scores, standard deviation, and F ratio.

Table 11

Means, Standard Deviation and F Ratio of Job Satisfaction by Work Setting

Setting	n	Mean	sd	F
Group 1	244	97.22	16.08	(4,353) = 3.697, p=.000)
Group 2	37	92.68	21.39	
Group 3	52	83.12	21.49	
Group 4	10	84.80	18.11	
Group 5	15	89.07	24.39	
Entire Sample	358	94.15	18.67	

$p < .05$

Since Wilks' Lambda was significant, a 1 X 5 ANOVA was used to determine which groups were different resulting in a difference between groups ($F = 7.9554$, $p < .05$). Scheffe's test further indicated that Group 1 (nurses from hospital settings) was different than the other groups, especially Group 3 (nurses from home health and health department settings). The results indicated that hospital nurses have greater job satisfaction than nurses from other work settings.

Given the significance of the interaction between work setting and job satisfaction, univariate tests were then conducted to identify which groups and subcomponents were responsible for the observed multivariate effects. As **Table 12** shows, a 1 X 5 ANOVA F test indicated significant differences between the five groups on mean scores of Administration, Task Requirements, and Interaction/Cohesion subcomponents of job satisfaction.

Table 12

Means and Standard Deviation of Job Satisfaction Subscales by Setting

Subscale/Settings	n	Mean	sd	F
Task Requirements				(4,353) = 9.09*, p =.0000)
Group 1	244	17.38	4.44	
Group 2	37	16.00	5.04	
Group 3	52	13.59	5.24	
Group 4	10	12.30	6.83	
Group 5	15	16.67	5.14	
Entire Sample	358	16.52	4.94	
Interaction/ Cohesion				(4,353) = 6.23*, p =.0001)
Group 1	244	19.90	4.14	
Group 2	37	18.29	5.59	
Group 3	52	16.13	5.34	
Group 4	10	19.30	3.98	
Group 5	15	16.86	5.42	
Entire Sample	358	18.68	4.69	
Administration				(4,353) = 7.51*, p =.0000)
Group 1	244	20.78	5.14	
Group 2	37	18.73	5.53	
Group 3	52	16.87	5.94	
Group 4	10	16.00	5.01	
Group 5	15	18.80	7.65	
Entire Sample	358	19.78	5.62	

*p <.05, two-tailed.

Scheffe's test for multiple comparisons was conducted on the data from the five work settings and the Work Satisfaction subscales. The results indicated that Group 1 (hospital nurses) was significantly different than nurses in other settings and job satisfaction. Group 1 (nurses from hospitals) was significantly different from Group 3 (nurses who worked in home health care agencies and health departments) on task requirements and interaction/cohesion. Group 1 (nurses from hospitals) was significantly different from Group 3 (nurses who worked in home health care agencies and health departments) and Group 2 (nurses who

worked in ambulatory care/physician offices and HMO's) on the effects of administration. Therefore, hospital nurses indicated greater job satisfaction on task requirements, interaction/cohesion, and effects of administration than nurses in other health care settings.

PROFESSIONALISM AND JOB SATISFACTION

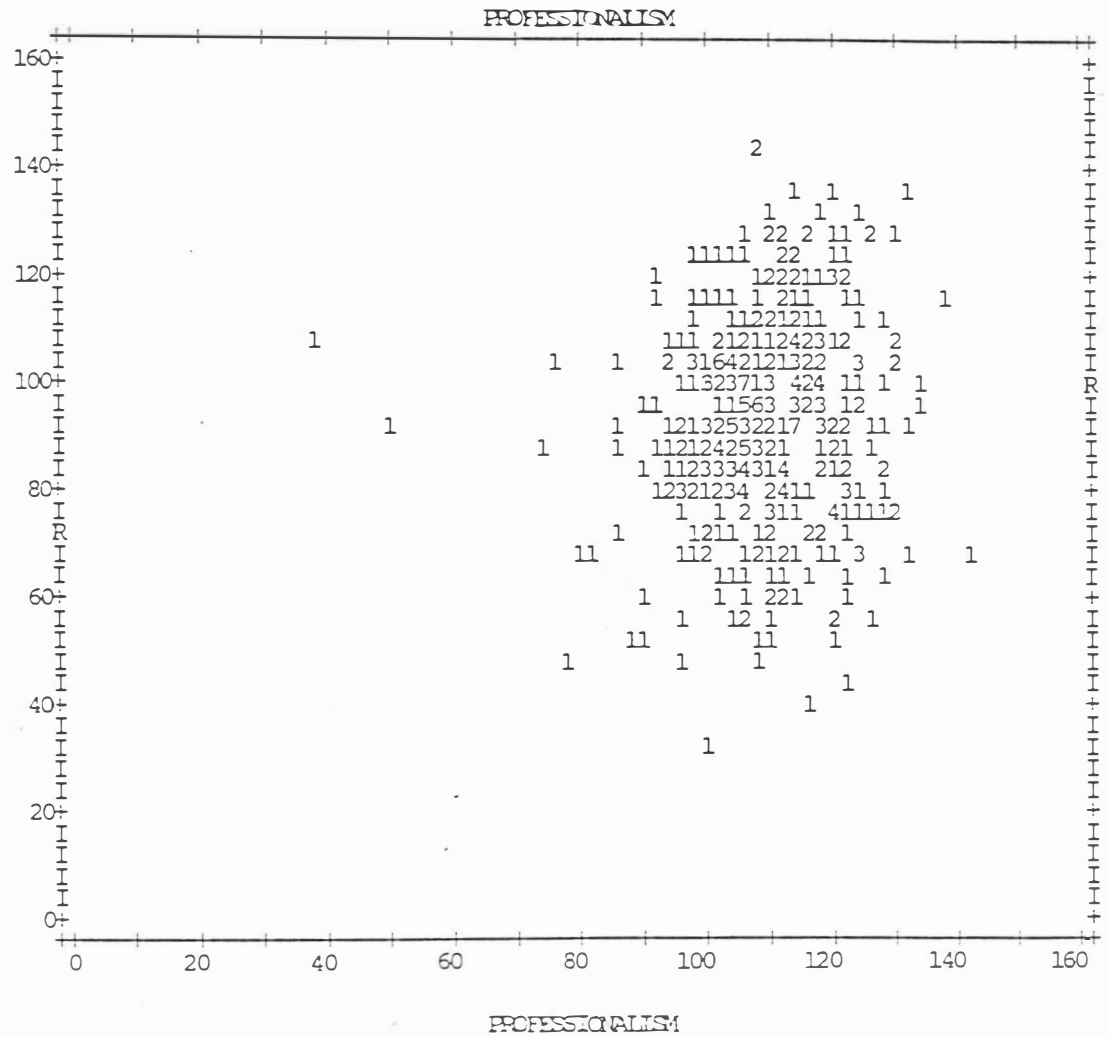
A major interest of the researcher was the possibility of a relationship between nurses' job satisfaction and professionalism.

Research Question (5): Does view of job satisfaction of registered nurses relate to their professionalism?

A Pearson product-moment correlation (r) was conducted using job satisfaction as a predictor variable of professionalism. The correlation showed a weak positive relationship, $r = .098$ ($n = 426$), $p<.05$, between the two variables. A bivariate regression analysis was then conducted to determine if there was a predictive relationship between job satisfaction and professionalism. The independent variable, job satisfaction, showed a multiple R of .11 ($F = 5.32$, significant $F = .022$, beta = .11). Only 1.2 percent of the shared variance was explained by job satisfaction with professionalism. **Figure 1** displays a scatterplot of job satisfaction and professionalism. Therefore, there appears to be some relationship between nurses' job satisfaction and professionalism.

FIGURE 1

SCATTERPLOT OF JOB SATISFACTION AND PROFESSIONALISM



426 CASES PLOTTED. REGRESSION STATISTICS OF WORK ON PROFESS:
CORRELATION .11132 R SQUARED .01239 S.E. OF EST 19.36864 2-TAILED SIG. .0216
INTERCEPT(S.E.) 71.28458(9.10472) SLOPE(S.E.) .19165(.06309)

SUMMARY OF FINDINGS

The summary findings are presented as they relate to the study's five research questions. A stratified random sample of 427 registered nurses was obtained from the five Regions of the State of Virginia. Although Region 1 had the greatest representation in the sample, a one-way analysis of variance indicated that region was not significant to professionalism or job satisfaction. Since the findings indicated that the groups were statistically similar, the findings were reported by total sample. The sample was composed of registered nurses who primarily were diploma graduates and staff nurses, employed in hospital settings, and worked full-time.

Five research questions on professionalism and job satisfaction were investigated. Purposes were to explore possible factors that might effect the two concepts and to determine if there was a relationship between any such factors.

PROFESSIONALISM

Research Question (1): How do registered nurses view professionalism?

Cronbach Alpha indicated a marginal range of reliability for the Stone and Knopke's Health Care Professional Inventory and its subscales. An item analysis also indicated that many items exhibited weak correlations. A Pearson product-moment correlation (r) also indicated weak relationship between the Inventory and its subscales. The mean, mode and median on professionalism were within four points of each other of the sample of registered nurses.

A descriptive analysis of nurses' responses indicated that nurses have professional status according to Dumont's model of professionalism

since nurses indicated that consumer involvement is essential, performance is more important than credentials, compassion is critical, and professionals need to be involved in social change. Moreover, nurses agreed that health care providers need to be more responsive to the needs of patients and communities.

Research Question (2): What is the relationship between registered nurses' highest levels of education in nursing, current job positions, major work settings, and their professionalism?

Multivariate analysis and one-way analysis of variance tests did not indicate a significant difference between professionalism and highest levels of education, current work settings, and major job positions.

JOB SATISFACTION

Research Question (3): How do registered nurses' view job satisfaction?

Cronbach alpha indicated an acceptable range of reliability for the Work Satisfaction Scale and its subscales. The mean, mode, median were within three points of each other for the sample of registered nurses. Thus, nurses were satisfied in their work setting.

A descriptive analysis revealed that nurses identified salary compensation, opportunities for advancement, and control of nursing practice as important elements of job satisfaction.

Research Question (4): What is the relationship between the work setting and job satisfaction of registered nurses?

Multivariate analysis tests indicated a significant differences between work settings and job satisfaction of registered nurses. One-way analysis of variance tests was significant for the effects of work

setting, administration, interaction/cohesion, and task requirements. An examination of the direction of this significance, using the Scheffe test, indicated that hospital nurses were more satisfied than nurses in other work settings.

PROFESSIONALISM AND JOB SATISFACTION

Research Question (5): Does view of job satisfaction of registered nurses relate to their professionalism?

The relationship between professionalism and job satisfaction was explored and only a weak positive correlation was found between the two variables. A bivariate regression analysis indicated a very small percentage of shared variance was explained by job satisfaction as a predictor of professionalism.

CHAPTER FIVE: CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

INTRODUCTION

The purpose of this chapter is to briefly identify conclusions, discuss implications, and suggest recommendations for future research. Five research questions were examined in this analytical-descriptive study on professionalism and job satisfaction of registered nurses in the State of Virginia.

CONCLUSIONS

The sample consisted of responses from 427 registered nurses who were female and employed in a variety of health care settings in the state of Virginia. Location (region) was found not to have an impact on nurses' view on professionalism and job satisfaction. Generally, the sample was composed of registered nurses who primarily were diploma graduates, staff nurses, employed in hospital settings, and worked full-time. The conclusions are presented from the findings of the study's five research questions.

1. **How do registered nurses' view their professional status?**
   The overall results from the internal reliability between the Stone and Knopke's Health Care Professional Inventory and its subscales indicate that the Inventory needs to be examined as to its ability to measure the concept of professionalism. Dumont's (1970) model of professionalism verifies that nurses view themselves as professionals.
2. **What is the relationship between registered nurses' highest levels of education in nursing, current job positions, major work settings, and their professionalism?**

Multivariate analysis and one-way analysis of variance tests yielded no significance relationship between highest levels of education in nursing, current job positions, major work settings and professionalism. Therefore, these variables that were previous thought to have a relationship with professionalism appear to have no relationship when using Dumont's model of professionalism. There may be other variables, such as years in current position and years in nursing which may have a relationship to professionalism.

3. **How do registered nurses' view job satisfaction?**

The overall results from the internal reliability and correlations of the Atwood and Hinshaw's Work Satisfaction Scale indicated that it is a valuable instrument to measure job satisfaction of nurses. The findings indicate that nurses were generally satisfied but continue to verify recurring themes of pay, opportunities to advance, and control over nursing practice.

4. **What is the relationship between the work setting and job satisfaction of registered nurses?**

Multivariate analysis and one-way analysis of variance tests yielded significance and indicated that nurses from hospital settings were more satisfied than nurses in other work settings. The results were unexpected which may reflect the composition of the sample or recent trends by hospitals to retain nurses.

5. **Does view of job satisfaction of registered nurses relate to their view of professionalism?**

   Only a weak positive correlation in a positive direction between job satisfaction and professionalism was found. The findings support a positive relationship between job satisfaction and professionalism. This may represent a sample of nurses who were more satisfied, and thus who may be more professionalized.

IMPLICATIONS

Implications for the study are drawn from the sample characteristics, findings, conclusions, and comparable studies on professionalism and job satisfaction.

SAMPLE CHARACTERISTICS

The sample characteristics that have been identified as having a relationship with professionalism and job satisfaction were highest levels of education in nursing, current job positions, and major work settings. Employment status, years in current position and years in nursing may also be contributing factors.

Educational preparation of nurses in the sample reflected previous findings that the largest proportion (58.3%) of nurses graduates were from diploma and associate degree nursing programs. Previous studies indicated that most of the nurse graduates are from diploma and associate degree schools of nursing (Styles & Holzemer, 1986; USDHHS, 1988). A 1986 survey of nurses in Virginia indicated that a little more than 50 percent of registered nurses reported that their preparation for licensure was through the diploma programs (Commonwealth

of Virginia Department of Health Regulatory Boards, 1987). The recent trend of declining enrollments in nursing programs and the need for more baccalaureate degree nurses supports the need for continuing monitoring of the educational level of nurses at the state and national level (Styles & Holzemer, 1987; Tregarthen, 1987). Future predictions indicate that there will be a greater demand for registered nurses who hold baccalaureate and master's degrees in nursing (Styles & Holzemer, 1986). Since the goal of nursing is educational preparation of the professional nurse and the baccalaureate level is the designated the entry level for professional practice, it will be important to continue investigating the relationships between nurses' educational background and their view of professionalism.

The recent shortage of nurses is a major concern of hospitals who employ approximately two-thirds of nurses in the work force. Recent State of Virginia and national findings reported that approximately 68 percent of registered nurses were employed in hospitals (Commonwealth of Virginia Department of Health Regulatory Boards, 1987; USDHHS Secretary's Commission on Nursing, 1988) while the sample only represented 58 percent from this work setting. Although the difference may be related to nurses who were interested in participating in the study, the findings clearly support national findings that hospitals will continue to be the major employer of nurses. As changes are occurring in hospitals, it will be important to monitor the employment patterns of nurses and their job satisfaction.

Approximately 64 percent of the study sample were staff nurses, a finding similar to national figures which found that staff nurses

comprised 67 percent in 1984 and 68 percent in 1988 (USDHHS, 1988). The present study reflects continuing national reports that the majority of registered nurses hold staff nurse positions. Since staff nurses provide patient care, it will be important to investigate the group's development of professional spirit and control of nursing practice.

Other sample characteristics included in the study that may have an impact on future studies are years in nursing, years in present position, shift normally worked, and employment status. The national labor pool of nurses has increased and more nurses are working despite declining enrollments in schools of nursing (USDHSS, 1988). Fifty percent of the nurses in the sample were over forty years of age with a mean of 41.3 years and a median of 39.6 years. Ninety percent of the nurses in the sample have been in nursing for six years or more and 65 percent have been in their present position for more that six years. Moreover, 65 percent of the nurses in the sample were employed full-time. National figures indicate that the nurse labor force has increased from 72.7 percent in 1977 to 78.7 percent in 1986 (USDHHS, 1988). Therefore, it appears that based on the study sampled and national trends more nurses are remaining in the work force. It will be important to investigate the reasons for their continued employment in nursing.

PROFESSIONALISM

The most striking finding in this study was that nurses did not differ in their view of professionalism. This was true for all nurses regardless of their educational background, job position or current work setting. The overall reliability of the Inventory unfortunately was

marginal. Since the descriptive analysis of nurses' responses to the items supported Dumont's model of professionalism, the Inventory needs to be refined.

An item analysis and factor analysis should be investigated to determine whether there are any non-contributing or other flawed items. Non-contributing items should be revised or eliminated, and new items that focus on Dumont's intent and description of concepts with an interrater panel of nurse experts. In particular, the items should be closely examined as to their relevancy for practicing nurses. Then further studies comparing nurses from hospitals and other health care settings on the reliability and validity of the instrument will be valuable.

Since previous studies using the Inventory have only reported data for nursing students, it would be important to replicate the two research questions on professionalism and investigate other variables that may be related to professionalism.

Research Question (1): How do nurses view their professional status?

Previous studies of nurses using the guild premise of professionalism have generally supported that nurses do not have professional status (Hall, 1969, Monnig, 1978). Since the mean scores from previous studies were with medical and nursing students, comparisons could not be made. However, a descriptive analysis of nurses' responses in the sample reflected Dumont's academic model of professionalism and the concepts of consumer control, indifference to credentials, compassion, and impatience with the rate of change.

Dumont (1970) reported that a overriding principle of professionalism was consumer control. Patient involvement or consumer control was important to nurses in the sample. In the nursing literature, Lynaugh and Fagin (1988) supported the idea of consumer control by reporting that nurses are concerned first about the well-being of people. Therefore, previous studies using the guild premise may not be appropriate for today's nurses since they may hold a different view of professionalism (Diers, 1986). Further research using Dumont's concept of professionalism is needed to statistically support nurses' professional status.

Research Question (2): Is there a relationship between nurses' highest level of education in nursing, major job positions, current work settings, and their professionalism?

If there really are no differences between nurses' educational background, current job positions, and major work settings and their professionalism, it would be important to improve the Inventory reliability and include more studies with registered nurses.

Previous studies found that practicing nurses report less professionalism than students. McCloskey and McCain (1987) study found nurses' professionalism declined during the first six months of work. Christain's (1985) comparison study indicated that baccalaureate graduates have a greater professional orientation than associate degree and diploma graduates but they all viewed hospitals as inhibiting professional practice. Recent trends indicate that more nurses are obtaining baccalaureate and master's degrees in nursing from schools of nursing affiliated with colleges and universities (USDHHS Secretary's

Commission on Nursing, 1988). Therefore, further research should investigate professionalism concepts that are important to today's professional nurses, such as consumer control, compassion, indifference to credentials, and social change.

JOB SATISFACTION

The internal reliability of Atwood and Hinshaw's Work Satisfaction Scale and its subscales indicated a high range of magnitude that reflects previous findings (Atwood and Hinshaw, 1984). Further research should use the instrument replicating the two research questions and add other variables that may relate to job satisfaction of nurses.

Research Question (3): How do registered nurses' view job satisfaction?

Nurses appeared to be overall satisfied from the statistical analysis of measures of central tendency. Since mean scores from previous studies were not available, comparisons could not be made. However, a descriptive analysis of items resulted in the identification of three important elements: pay or reward, opportunities to advance, and involvement in policy-making decisions. These concerns appear to be related to the continuing themes of nurses' job satisfaction.

Nurses were concerned about pay compensation and had mixed feelings about whether their present salary was reasonable. Twelve years ago, in 1978, Slavitt, et. al reported similar themes regarding pay compensation of nurses. The United States Department of Health and Human Services Secretary's Commission on Nursing (1988) reported that the compressed salary range of nurses is a chronic problem in retaining

nurses and affects the supply of potential nurses. It has become a major concern of nurses and appears to be an important factor affecting their job satisfaction.

Opportunities to advance were identified to be the second most important element by nurses in the study. Today's nurses are called upon to use leadership skills, managerial expertise, and increasingly, advanced education to meet the demands of an increasingly technical, complex and more cost-effective approaches to patient care. McCloskey and McCain (1987) attribute the lack of advancement to the disillusionment of nurses that occurs when expectations are not met, so that nurses become less attached to the job, the organization and the profession.

Control of nursing practice or involvement in policy-making decisions is the third most important element that was a concern expressed by nurses in this study. This finding is consistent with several previous studies. Hinshaw, et. al (1987) found that nurses were concerned about the control of their practice. Alexander and Chase (1982) reported that nurses' view of task delegation affected their view of control of practice and was a predictor of job satisfaction. Prescott (1987) also found that high vacancy rates were predicted by minimal opportunities for nurses in decision-making and control of their practice.

Therefore, it is important that further research focus on pay, opportunities to advance, and control of practice in relation to nurses' job satisfaction in the work setting.

Research Question (4): What is the relationship between nurses' work setting and their job satisfaction?

A striking finding in this study was that hospital nurses were statistically more satisfied than nurses from other work settings. Hospital nurses were more satisfied on elements of task requirements, the effects of administration, and interaction/cohesion of staff than nurses from other health care settings. These elements are identified by Herzberg, et.al (1959) as lower-order needs that are important for job satisfaction.

Although pay, a lower-order need, was identified as important by nurses in the descriptive analysis, it was not statistical important when comparing work setting and nurses' job satisfaction. It may be the result of recent reports that starting salaries for nurses are increasing in many areas of the country (Billingsley, 1989). In addition, hospital nursing services are also developing nurse practice models such as career ladders and self-governance models to increase nurse's pay compensation and job satisfaction (Davis, 1987). Hospitals in the State of Virginia may be making changes regarding elements of pay and control of practice that are improving nurses' job satisfaction in their settings. As changes are occurring in hospital settings, it will be important to investigate whether hospitals are having an impact on the lower-order needs of pay, task requirements, and interaction/ cohesion of nurses' job satisfaction. It will be also important to investigate whether the innovative nursing practice models, such as the movement towards self-governance models in nursing departments in hospitals, are having an impact on higher-order needs of nurses to advance and to control their nursing practice.

JOB SATISFACTION AND PROFESSIONALISM

Professionalism and job satisfaction of registered nurses are two important concepts that need to be studied further as indicated by the conclusions and implications in this study.

Research Question (5): What is the relationship between nurses' job satisfaction and their professionalism?

Since both professionalism and job satisfaction contain multiple factors, it is difficult to determine the reasons for the weak positive relationship and a small shared variance between the two concepts. Still, the findings indicated there was a small relationship between job satisfaction and professionalism.

A previous study also suggested that there was some relationship between the two concepts. McCloskey and McCain (1987) suggested that nurses' job satisfaction and professionalism play an important role in their performance, turnover, and absenteeism in the work setting.

Job satisfaction is affected by professional factors regarding opportunities to advance and control of nursing practice. When nurses are rewarded for nursing skill and performance in patient management, they tend to stay in the patient-care delivery role (Hinshaw, et al. 1987). Since nurses will continue to be major providers of patient care and will have a major impact on future patient care outcomes, comparison studies of nurses from different settings will become more important as technology increases and chronic diseases become more prevalent.

Moreover, further refinement of the professionalism instrument is essential in order to reflect the concepts of today's professional nurse. Professionalism will become more important in determining the essence of nursing and its effect on patient outcomes.

RECOMMENDATIONS

The following recommendations are suggested for further research on professionalism and job satisfaction of registered nurses. Since location (region) of the State of Virginia was not found to be significant, future studies should employ random sampling of registered nurses using other criteria. A means to verify the data revealed in this study would be a follow-up telephone survey of 10 percent (stratified random sample) of nonparticipants. The confidence in representation of the sample would be increased if the participants and nonparticipants are similar with respect to the important characteristics of education, employment status and work setting.

Comparison studies employing random sampling should investigate differences between registered nurses working in urban and rural settings. Replication of the five research questions could be also conducted to obtain comparison statistical data regarding nurses' professionalism and job satisfaction. The research design might be expanded to include other variables such as employment status, years in current position and years in nursing.

Specific Recommendations

The specific recommendations are presented to stimulate further investigation of professionalism and job satisfaction of registered nurses.

1. **Recommendations on Professionalism.** The Stone and Knopke's Health Care Professional Inventory modified by Lawler needs further refinement. Suggested modification could include focusing on "self" rather than "other" in the profession and items that closely represent registered nurses' view of professionalism. Further research should compare nurses from hospitals and other health care settings to obtain reliability and validity of the instrument. Comparison studies using Dumont's academic model of professionalism are needed to determine professional status of nurses. Other variables such as age, years in present position, and employment status of nurses should also be explored as to their relationship with professionalism. It would be helpful to compare the view of professionalism of other health care professionals with registered nurses in order to determine the important professional issues.

   The subcomponents (superordinate purpose, indifference to credentials, and consumer control) of professionalism should be major areas of future research. Superordinate purpose ought to be more carefully examined to determine if a more collaborative relationship evolves among physicians and nurses. Indifference to credentials may become a more

important component as more nurses become certified. Moreover, consumer control will be important catalyst in health care delivery as health care costs continue to escalate.

2. **Recommendations on Job Satisfaction.** More nursing studies should be conducted using Atwood and HInshaw's Work Satisfaction Scale. Comparison studies using statistical analysis are needed to determine job satisfaction of registered nurses in multiple work settings. Other variables, such as educational background, job position, and years in nursing could be investigated.

   Specific attention should focus on control of nursing practice, opportunities to advance, and pay or reward. It will be important to determine if the motivational factors (accountability, professional status and autonomy) are fostered by schools of nursing and supported by departments of nursing in the work setting. Further, multiple analysis could be conducted comparing nurse practice models (self-governance and career ladders) that are currently being developed to retain nurses in the work setting.

3. **Recommendations on Job Satisfaction and Professionalism.** The relationship, job satisfaction and professionalism, should continue to be explored. The refinement of Stone and Knopke's instrument may lead to new insights in this relationship or a new professional instrument may need to be developed.

Additional Recommendations

Continued nursing research must focus on providing more data about professionalism and job satisfaction of nurses. It is predicted that the demand for nurses will continue to increase and thus it is important to find ways to retain nurses in the work setting. Recent available evidence also suggests that there will not be a commensurate expansion of the nurse supply. Strategies will become more important to increase retention of nurses in the work setting. More studies will be needed to develop ways to improve professionalism and job satisfaction of nurses.

Furthermore, studies should be conducted on methods to improve work environments and organizational climates. Specific studies might include rigorous evaluation of the usefulness of case management, the concept of shared governance, and compensatory measures based on educational attainment, performance, and leadership experiences to increase nurses' job satisfaction and professionalism in the work setting.

SUMMARY

The overall purpose of this study was to investigate current views of professionalism and job satisfaction of registered nurses practicing in a variety of health care settings in the State of Virginia. Five research questions were investigated in this analytical-descriptive study. A stratified random sample of 427 registered nurses, female and actively employed, represented all nurses from five regions in Commonwealth of Virginia. The majority of the nurses in the sample

were diploma graduates, staff nurses, employed in hospital settings, and working full-time.

A descriptive analysis of Stone and Knopke's Health Care Professional Attitude Inventory items modified by Lawler indicated that nurses viewed themselves as professionals according to Dumont's model of professionalism. Nurses identified consumer control, indifference to credentials, compassion, and impatience with the rate of change as important elements of professionalism. However, there was no relationship between nurses' professionalism and highest levels of education in nursing, current job position, and major work setting.

Job satisfaction findings using Atwood and Hinshaw's Work Satisfaction Scale indicated that nurses were generally satisfied in their work setting although they were concerned about pay compensation, opportunities to advance, and control of nursing practice. Findings indicated that there was a relationship between nurses' work setting and job satisfaction. Hospital nurses exhibited greater satisfaction than those nurses in other health care settings.

No significant differences were found by region on nurses' view of professionalism and job satisfaction. A small relationship was revealed using nurses' job satisfaction as a predictor of professionalism.

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APPENDIX A

Instrument Permission Letters

UNIVERSITY OF
WISCONSIN-MADISON
MEDICAL SCHOOL

February 16, 1989

Elisabeth B. Hutton, MS, RN, C.
Ph.D. Candidate in Urban Services
Virginia Commonwealth University
Asst. Professor, Community Health Nursing
VCU/MCV School of Nursing
Box 567, MCV Station
Richmond, VA 23298

Dear Ms. Hutton:

I am happy to grant you permission to use the Health care Professional Attitude Inventory that I developed at the University of Wisconsin-Madison. Enclosed is a paper describing the reliability and validity data I obtained on the original instrument. I do not have similar data for the instrument as modified by Dr. Lawler. Perhaps you can obtain it from her. Good luck with your study.

Sincerely,

[redacted]

Howard L. Stone, Ph.D.
Professor and Director
Educational Research and Development

HLS:aer
Enclosure

EAST CAROLINA UNIVERSITY
GREENVILLE, NORTH CAROLINA 27858-4353

SCHOOL OF NURSING

Telephone (919) 757-6061

February 23, 1989

Elisabeth B. Hutton, MS, RN, C
Virginia Commonwealth University
School of Nursing
Box 567 MCV Station
Richmond, Virginia 23298

Dear Ms. Hutton:

I'm delighted that you contacted Howard Stone and that he was helpful and supportive of your proposed research. Aside from being well known for his expertise in program evaluation, Dr. Stone is a charming person.

Certainly, I would also be willing to facilitate your study in any way possible. You have my permission to use my modification of Stone's Inventory, as presented in Strickland & Waltz, to measure professionalism in Virginia nurses. I would appreciate knowing about the outcome of your investigation since job satisfaction is another concept of interest to me.

Good luck! Dissertations are really an exercise in perseverance.

Sincerely,

[redacted]

Therese G. Lawler, RN, EdD
Acting Assistant Dean

TGL/sc

THE UNIVERSITY OF ARIZONA
TUCSON, ARIZONA 85721

COLLEGE OF NURSING

February 14, 1989

Elizabeth Hutton
Assistant Professor
Virginia Commonwealth University
School of Nursing
Box 567 MCV Station
Richmond, VA 23298

Dear Elizabeth:

Thank you for your recent phone call in which you requested information about instruments as used in the Anticipated Turnover Among Nursing Staff study (#R01 NU000908). We are pleased to be able to share this information with you.

Enclosed is the Nursing Job Satisfation Scale and the Work Satisfaction Scale along with the validity and reliability estimates obtained on our sample. You have permission for use, and we trust this information will be helpful to you.

If we can be of any other assistance to you, please let us know. We may be reached at [redacted]. Also, we would request that you share any information regarding the process of using the instrument and the results or outcomes of its use. We wish you much success in your research.

Sincerely,

[redacted]
Jan R. Atwood, Ph.D., F.A.A.N.
Professor
College of Nursing
Behavioral Sciences Coordinator
Cancer Prevention and Control
Arizona Cancer Center

JRA/las

cc: A.S. Hinshaw, Ph.D., F.A.A.N.
Co-P.I.

APPENDIX B

Instruments

CODE_____

PROFESSIONALISM AND JOB SATISFACTION OF REGISTERED NURSES

The intent of the questionnaire is to obtain data about the view of job satisfaction and view of professionalism of registered nurses in the state of Virginia. The questionnaire contains three sections: background and experience, work satisfaction, and professionalism.

Your thoughtful and honest responses will contribute to a better understanding of the view of nurses in various health care settings in the state of Virginia. Your responses will be confiential; no individual or institution will be indetified.

Thank you for your willingness to participate.

1.0 BACKGROUND AND EXPERIENCE

DIRECTIONS: The information you supply on the questionnaire will be completely confidential. Please circle the number of the answer that best reflects your background and experience.

1.1 Indicate the highest educational degree you have received (Circle One).

1. A.D. in Nursing
2. Diploma in Nursing
3. B.S. in Nursing
4. B.S. in another discipline
5. M.S. in Nursing
6. M.S. in another discipline
7. Ph. D. in Nursing
8. Ph. D. in another discipline
9. Ed. D.
10. D.S. in Nursing

1.2. Are you currently employed in nursing?

1. yes
2. no

1.3. Identify your current nursing position (Circle One).

1. Staff Nurse
2. Unit Coordinator
3. Supervisor
4. Nurse Administrator
5. Nurse Practitioner
6. Nurse Educator
7. Nurse Anesthetist

1.4. Identify your employment status (Circle One).

1. Full-time position
2. Part-time postion
3. Working full-time plus some part-time
4. More than one part-time position

1.6. Indicate the number of years employed in nursing. (Please include the total number of year(s) and month(s), e.g. 2 years and 5 months). _____Year(s) _____Month(s)

1.7. How long have you been in your current position? (Please indicate the total number of year(s) and month(s), (e.g. 1 year and 0 month). _____Year(s) _____Month(s)

1.8. Your major work setting is:

1. Private Community Hospital
2. Ambulatory/Outpatient Center
3. Teaching Hospital
4. Home Health Care Agency
5. Health Department
6. Physician's/Dentist's Office
7. School of Nursing
8. Nursing Home
9. Convalescent Center
10. Health Maintenance Organization
11. Federal Hospital
12. Other _____

1.9. Indicate your gender and year you were born.

1. Female
2. Male
3. 19__

1.10. Describe your ethnic background

1. Caucasian
2. Hispanic
3. Native American
4. Black
5. Asian
6. Other _____

(PLEASE CONTINUE TO NEXT PAGE)

CODE _____

3.0 THE HEALTH CARE PROFESSIONAL ATTITUDE INVENTORY

This Inventory contains a series of statements about today's health care professions and health care delivery systems. These statements are not intended to elicit a right or wrong answer; rather to collect your perceptions of the accuracy and/or validity of each statement.

Please read each statement. Then, utilizing the response scale below, indicate the degree to which you agree or disagree with each statement in respect to the health care professions and/or delivery systems.

Health care professionals, for the purpose of this inventory, include all registered nurses who function as a member of the health care team. Health care delivery systems are those mechanisms and strategies designed to facilitate the delivery of health care to the consumer.

RESPONSE SCALE

Strongly Agree 1 2 3 4 5 Strongly Disagree

Statements		Response Scale
3.1.	Current health care delivery systems adequately meet the needs of society.	1 2 3 4 5
3.2.	The potential for a financially secure position is a major reason for pursuing a career in the health care professions.	1 2 3 4 5
3.3.	There has been inadequate interaction between health care professionals and their client public in the development of health care delivery systems.	1 2 3 4 5
3.4.	Students in the health care disciplines should be expected to emulate or model the role to their instructors.	1 2 3 4 5
3.5.	Students in the health disciplines should incorporate the philosophy of their educational program into their practice.	1 2 3 4 5
3.6.	Policies based solely on scientific methodology are most appropriate for the resolution of society's health care problems.	1 2 3 4 5
3.7.	The introduction of nurse practitioners, physician's assistants and paramedical personnel has been of significant importance in improving the delivery of health care.	1 2 3 4 5
3.8.	Health care professionals such as nurses generally are impersonal and scientifically oriented.	1 2 3 4 5

RESPONSE SCALE
Strongly Agree 1 2 3 4 5 Strongly Disagree

Statements		Response Scale
3.9.	Health care professionals generally fail to show adequate interest in the health needs of consumers.	1 2 3 4 5
3.10.	Criticism of health care practices and procedures by persons outside the profession is usually acknowledged and acted upon by health care professionals.	1 2 3 4 5
3.11.	At this point in time, the consumers of health care have been adequately involved in the development of health care delivery systems.	1 2 3 4 5
3.12.	Certification of competence upon receipt of the professional degree is necessary to assure that behavioral sciences, basic sciences, and health care services were part of professional education.	1 2 3 4 5
3.13.	Education programs for health care professionals spend more time preparing students for careers in research and/or teaching than for careers as practitioners.	1 2 3 4 5
3.14.	Education programs for health care professionals have not been adequately responsive to the identified needs of local communities.	1 2 3 4 5
3.15.	Health care teams tend to become so busy coordinating care that they lose sight of patient needs.	1 2 3 4 5
3.16.	Priorities for the user of human and material resources in the health care professions are best achieved through centralized decision-making.	1 2 3 4 5
3.17.	Health care professionals have actively encouraged consumer participation in current delivery systems.	1 2 3 4 5
3.18.	Inefficient use of existing personnel poses a major problem for delivering adequate health care.	1 2 3 4 5

CODE _____

RESPONSE SCALE
Strongly Agree 1 2 3 4 5 Strongly Disagree

Statements		Response Scale
3.19.	The desire for a position of status should be accorded little importance as a reason for pursuing a career in the health care professions.	1 2 3 4 5
3.20.	In order to alleviate health manpower shortages in certain geographic areas, health care professionals should be encouraged to deliver health legislation.	1 2 3 4 5
3.21.	Special economic interests have too often had a negative influence on public health legislation.	1 2 3 4 5
3.22.	Education programs for health care professionals are currently designed to prepare professionals who will be able to appropriately respond to the needs of local communities.	1 2 3 4 5
3.23.	Health care professional education programs offering certification, e.g., physician assistants, nurse practitioners, etc., are alternatives that will result in more effective health care.	1 2 3 4 5
3.24.	Training greater numbers of health care professionals to deliver primary care is one alternative that will be beneficial in meeting the long-term health needs of society.	1 2 3 4 5
3.25.	Health care professionals have been actively promoting change in the health care delivery systems for the improvement of health care for all citizens.	1 2 3 4 5
3.26.	Health care is currently available to people at differing income levels on a selective basis.	1 2 3 4 5
3.27.	Health care professionals have developed adequate self-evaluation of procedures and techniques in the delivery of health care.	1 2 3 4 5
3.28.	Consumer involvement is essential to provide new alternatives in developing health care delivery systems.	1 2 3 4 5
3.29.	Health care providers who work with professionals from other disciplines discover a common purpose in providing adequate health care for all citizens.	1 2 3 4 5

RESPONSE SCALE
Strongly Agree 1 2 3 4 5 Strongly Disagree

Statements		Response Scale
3.30.	Societal class and social distinctions should be of no importance in a health care setting.	1 2 3 4 5
3.31.	Educational institutions have assumed a central role, not only in the education of professionals, but in determining the nature and quality of health care and services provided to the community.	1 2 3 4 5
3.32.	The health care professional such as a nurse should be concerned solely with clinical practice and not with social change in his community.	1 2 3 4 5
3.33.	Nursing educators are considered alternate rather than ultimate sources of information for their students.	1 2 3 4 5
3.34.	Consumer-oriented agencies should play a minimal role in establishing standards or criteria to assess the quality of care provided to health care consumers.	1 2 3 4 5
3.35.	The greatest need for improvement in health care education concerns knowledge and skills about delivery of health care rather then in expanding knowledge about disease.	1 2 3 4 5
3.36.	The existing forms of health care delivery systems allow professional personnel to efficiently deliver health care services to meet the needs of individual consumers.	1 2 3 4 5
3.37.	The inability to change the attitudes of people is a greater obstacle to effecting change in the delivery of health care services than a lack of adequate finances.	1 2 3 4 5
3.38.	When cost accounting and systems research techniques are applied to health care, it can be concluded that the health care needs of some citizens have not been adequately served.	1 2 3 4 5

(PLEASE CONTINUE TO NEXT PAGE)

CODE_____

2.0 WORK SATISFACTION SCALE

The Work Satisfaction Scale contains a series of statements about elements that contributes to worker satisfaction of registered nurses within the health care system. These statements are not intended to elicit a right or wrong answer; rather to collect your perceptions of the accuracy and/or validity of each statement.

Please read each statement. Then, utilizing the response scale below, indicate the degree to which you agree or disagree with each statement in respect to registered nurses working in the health care system. The terms health care agency or agency relate to the setting where you are working.

RESPONSE SCALE
Strongly Agree 1 2 3 4 5 Strongly Disagree

Statements		Response Scale
2.1.	When I am at work in this health care agency, the time generally goes by quickly.	1 2 3 4 5
2.2.	I am often bored because my job is routine.	1 2 3 4 5
2.3.	There is a great gap between the administration of this agency and the daily problems of the nursing service.	1 2 3 4 5
2.4.	Considering what is expected of nursing service personnel at this health care agency, the pay we get is reasonable.	1 2 3 4 5
2.5.	It makes me proud to talk to other people about what I do on my job.	1 2 3 4 5
2.6.	There is no doubt whatever in my mind that what I do on my job is really important.	1 2 3 4 5
2.7.	I have enough opportunities to make administrative decisions in planning procedures and policies at my health care agency.	1 2 3 4 5
2.8.	An upgrading of pay schedules for nursing personnel is needed at this health care agency.	1 2 3 4 5
2.9.	New employees are not quickly made to "feel at home" at my health care agency.	1 2 3 4 5
2.10.	There is ample opportunity for nursing staff to participate in the administrative decision-making process.	1 2 3 4 5

RESPONSE SCALE
Strongly Agree 1 2 3 4 5 Strongly Disagree

Statements		Response Scale
2.11.	There are plenty of opportunities for advancement of nursing staff at this health care agency.	1 2 3 4 5
2.12.	The present rate of increase in pay for nursing service personnel at this health care agency is not satisfactory.	1 2 3 4 5
2.13.	I could deliver much better care if I had more time with each patient.	1 2 3 4 5
2.14.	What I do on my job doesn't add up to anything really significant.	1 2 3 4 5
2.15.	Nursing personnel at this agency do a lot of bickering and backbiting.	1 2 3 4 5
2.16.	Considering the high cost of health care, every effort should be make to hold nursing personnel salaries about where they are, or at least not to increase them substantially.	1 2 3 4 5
2.17.	Excluding my self, it is my impression that a lot of nursing service personnel at this health care agency are dissatisfied with their pay.	1 2 3 4 5
2.18.	I have plenty of time and opportunity to discuss patient care problems with other nursing service personnel.	1 2 3 4 5
2.19.	There is a good deal of teamwork and cooperation between the various nursing staff at my agency's setting.	1 2 3 4 5
2.20.	There is no doubt that the agency administrative staff cares a good deal about its employees, nursing personnel included.	1 2 3 4 5
2.21.	The nursing personnel at my health care agency do not hesitate to pitch in and help one another out when things get in a rush.	1 2 3 4 5
2.22.	The nursing administrators generally consult with the staff on daily problems and procedures.	1 2 3 4 5

CODE _____

RESPONSE SCALE
Strongly Agree 1 2 3 4 5 Strongly Disagree

Statements		Response Scale
2.23.	The nursing personnel at my health care agency do not often act like "one big happy family".	1 2 3 4 5
2.24.	There is a lot of "rank consciousness" on my unit; nursing personnel seldom mingle with others of lower rank.	1 2 3 4 5
2.25.	The amount of time I must spend on administration ("paper") work at my health care agency is reasonable, and I am sure that patients do not suffer because of it.	1 2 3 4 5
2.26.	I do not spend as much time as I would like to taking care of patients directly.	1 2 3 4 5
2.27.	The nursing personnel at my health care agency are not as friendly and outgoing as I would like.	1 2 3 4 5
2.28.	Even if I could make more money in another health care agency, I am more satisfied here because of the work conditions.	1 2 3 4 5
2.29.	My present salary is satisfactory.	1 2 3 4 5
2.30.	I think I could do a better job if I did not have so much to do all the time.	1 2 3 4 5
2.31.	If I had the decision to make all over again, I would still choose my line of work.	1 2 3 4 5
2.32.	From what I hear from and about nursing service personnel at other health care agencies, we at this agency are being fairly paid.	1 2 3 4 5

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE. PLEASE RETURN IT IN THE ENCLOSED SELF-ADDRESSED ENVELOPE.

APPENDIX C

Participant Permission Letters

June 9, 1989

Dear Registered Nurse Colleague:

Many changes are occurring in the health care system. As a doctoral candidate in the School of Education, Virginia Commonwealth University, I am conducting a study to explore the relationship between view of job satisfaction and professionalism of Registered Nurses in the Commonwealth of Virginia. The findings could have implications for influencing institutional and legislative policy decisions in the delivery of health care.

You have been randomly selected as part of a state sample to participate in this study. It is important that current views of nurses from a variety of settings are included in the study. Your support and assistance is needed to achieve its goals. The accompanying survey packet contains three instruments: (1) nurses' background and experience, (2) health care professional attitude inventory, and (3) work satisfaction scale. Completion of the survey packet should take only 20 to 30 minutes.

When you have completed the survey packet please return it in the self-addressed stamped envelope. Please also return the postcard separately when completing and mailing the packet. If you are interested in receiving a summary of the study results, please check that response on the post card.

Questionnaires and postcard have been coded. Confidentiality will be maintained. Code numbers will be used for mailing purposes. Only group data will be identified in any report of this study. Your completed questionnaire implies informed consent.

I hope you will take time to respond to the questionnaire and return it to me in the enclosed envelope by June 26, 1989. Your participation in the study is appreciated and is critical to the representativeness of the sample. If you have any questions about this study, please write or contact me at ([redacted]. I will be happy to respond.

Sincerely,

Elisabeth B. Hutton, M.S., R.N.,C.
Ph.D. Candidate, Ph.D. Program in Urban Services
School of Education, and Assistant Professor,
Department of Community Health & Psychiatric Nursing
School of Nursing
Box 567, MCV Station
Richmond, Virginia 23298-0567

June 28, 1989

Dear Registered Nurse Colleague:

Two weeks ago I sent you a questionnaire on Job Satisfaction and Professionalism.

If you have returned the completed questionnaire, thanks a million and please disregard the rest of this letter.

If you have not returned the questionnaire, please send it to me by Monday, July 10, 1989. With the many changes occurring in the health care system your participation is important. A representative sample is critical to provide a current picture of registered nurses' professional status and job satisfaction in the Commonwealth of Virginia.

I am enclosing another questionnaire and return envelope. If you have any questions, please call me at [redacted] I will be happy to respond. Thank you.

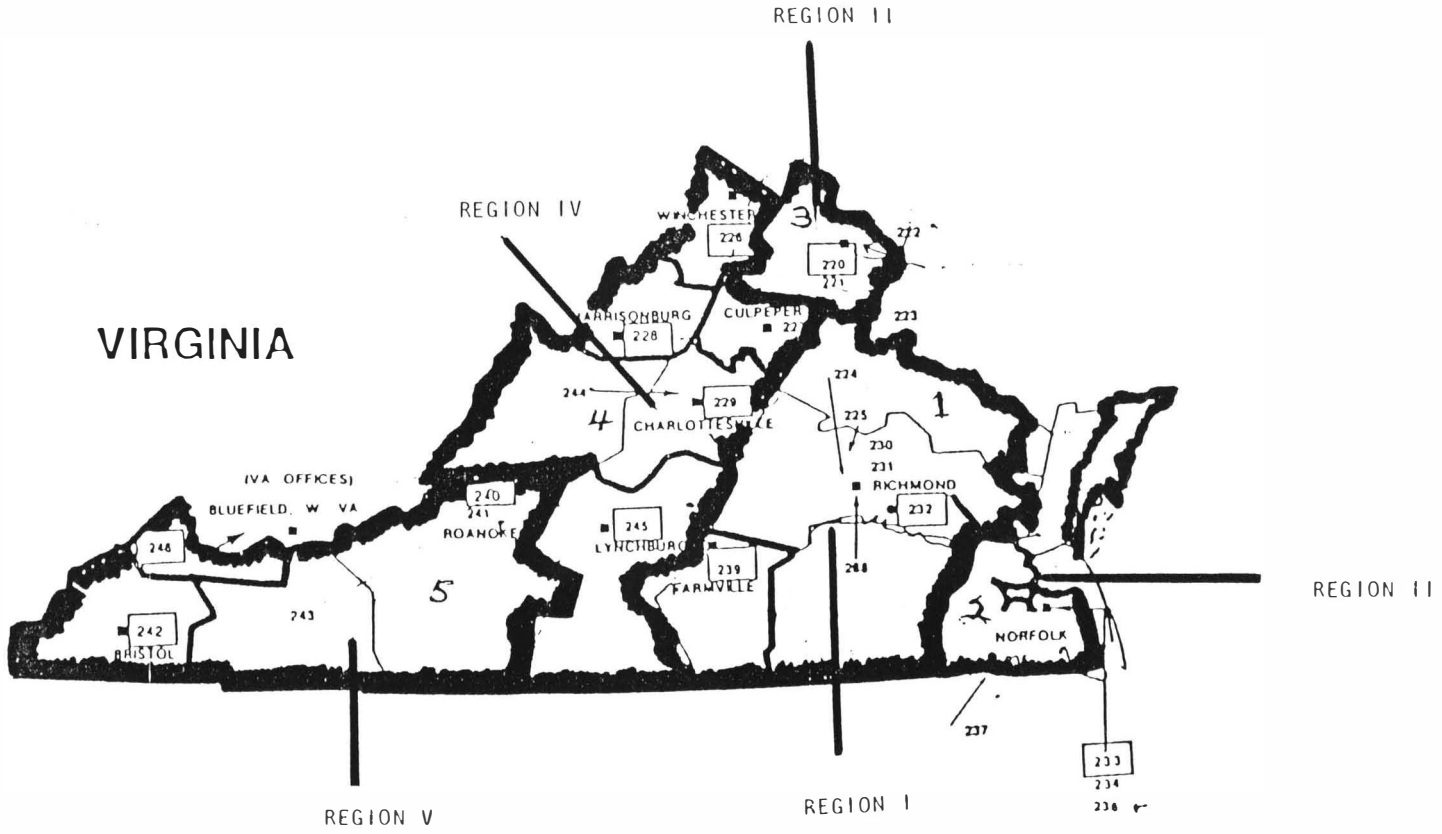
Sincerely,

[redacted]

Elisabeth B. Hutton, M.S., R.N., C.
Ph.D. Candidate, Ph.D. Program in Urban Services
School of Education, and Assistant Professor,
Community Health Nursing
Department of Community & Psychiatric Nursing
MCV/VCU School of Nursing
Box 567, MCV Station
Richmond, Virginia 23298-0567

APPENDIX D

Nurse Population Regions by ZIP Code


VIRGINIA
REGION II
REGION IV
REGION II
REGION V
REGION I
WINCHESTER
226
HARRISONBURG
228
CULPEPER
227
CHARLOTTESVILLE
229
RICHMOND
232
NORFOLK
(VA OFFICES)
BLUEFIELD, W VA
ROANOKE
240
241
LYNCHBURG
245
FARMVILLE
239
BRISTOL
242
246
243
270
271
272
223
224
225
230
231
244
238
237
233
234
1
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APPENDIX E

Percentage Responses of Registered Nurses to Health Care Professional Attitude Inventory

PERCENTAGE RESPONSES TO EACH ITEM BY REGISTERED NURSES

3.0 THE HEALTH CARE PROFESSIONAL ATTITUDE INVENTORY

This inventory contains a series of statements about today's health care professions and health care delivery systems. These statements are not intended to elicit a right or wrong answer; rather to collect your perceptions of the accuracy and/ or validity of each statement.

Please read each statement. Then, utilizing the response scale below, indicate the degree to which you agree or disagree with each statement in respect to the health care professions and/or delivery systems.

Health care professionals, for the purpose of this inventory, include all registered nurses who function as a member of the health care team. Health care delivery systems are those mechanisms and strategies designed to facilitate the delivery of health care to the consumer.

RESPONSE SCALE
Strongly Agree 1 2 3 4 5 Strongly Disagree

Statements		Response Scale				
3.1.	Current health care delivery systems adequately meet the needs of society.	1 1.2%	2 14%	3 33%	4 34%	5 19%
3.2.	The potential for a financially secure position is a major reason for pursuing a career in the health care professions.	1 7%	2 9%	3 24%	4 25%	5 25%
3.3.	There has been inadequate interaction between health care professionals and their client public in the development of health care delivery systems.	1 13%	2 37%	3 33%	4 14%	5 3%
3.4.	Students in the health care disciplines should be expected to emulate or model the role to their instructors.	1 10%	2 24%	3 35%	4 22%	5 9%
3.5.	Students in the health disciplines should incorporate the philosophy of their educational program into their practice.	1 21%	2 39%	3 32%	4 7%	5 2%
3.6.	Policies based solely on scientific methodology are most appropriate for the resolution of society's health care problems.	1 1%	2 2%	3 26%	4 43%	5 28%

RESPONSE SCALE
Strongly Agree 1 2 3 4 5 Strongly Disagree

Statements		Response Scale				
3.7.	The introduction of nurse practitioners, physician's assistants and paramedical personnel has been of significant importance in improving the delivery of health care.	1 23%	2 35%	3 26%	4 11%	5 .5%
3.8.	Health care professionals such as nurses generally are impersonal and scientifically oriented.	1 1%	2 5%	3 6%	4 27%	5 62%
3.9.	Health care professionals generally fail to show adequate interest in the health needs of consumers.	1 5%	2 20%	3 21%	4 32%	5 21%
3.10.	Criticism of health care practices and procedures by persons outside the profession is usually acknowledged and acted upon by health care professionals.	1 2%	2 15%	3 40%	4 33%	5 10%
3.11.	At this point in time, the consumers of health care have been adequately involved in the development of health care delivery systems.	1 2%	2 8%	3 23%	4 46%	5 20%
3.12.	Certification of competence upon receipt of the professional degree is necessary to assure that behavioral sciences, basic sciences, and health care services were part of professional education.	1 13%	2 7%	3 17%	4 29%	5 43%
3.13.	Education programs for health care professionals spend more time preparing students for careers in research and/or teaching than for careers as practitioners.	1 17%	2 28%	3 26%	4 24%	5 5%
3.14.	Education programs for health care professionals have not been adequately responsive to the identified needs of local communities.	1 5%	2 24%	3 26%	4 28%	5 17%

RESPONSE SCALE
Strongly Agree 1 2 3 4 5 Strongly Disagree

Statements		Response Scale				
3.15.	Health care teams tend to become so busy coordinating care that they lose sight of patient needs.	1 21%	2 32%	3 21%	4 20%	5 5%
3.16.	Priorities for the user of human and material resources in the health care professions are best achieved through centralized decision-making.	1 4%	2 12%	3 24%	4 33%	5 12%
3.17.	Health care professionals have actively encouraged consumer participation in current delivery systems.	1 4%	2 20%	3 32%	4 33%	5 10%
3.18.	Inefficient use of existing personnel poses a major problem for delivering adequate health care.	1 37%	2 37%	3 14%	4 7%	5 4%
3.19.	The desire for a position of status should be accorded little importance as a reason for pursuing a career in the health care professions.	1 31%	2 23%	3 20%	4 19%	5 7%
3.20.	In order to alleviate health manpower shortages in certain geographic areas, health care professionals should be encouraged to deliver health legislation.	1 26%	2 33%	3 34%	4 5%	5 2%
3.21.	Special economic interests have too often had a negative influence on public health legislation.	1 34%	2 40%	3 24%	4 3%	5 1%
3.22.	Education programs for health care professionals are currently designed to prepare professionals who will be able to appropriately respond to the needs of local communities.	1 4%	2 24%	3 39%	4 26%	5 7%
3.23.	Health care professional education programs offering certification, e.g., physician assistants, nurse practitioners, etc., are alternatives that will result in more effective health care.	1 17%	2 39%	3 28%	4 9%	5 6%

RESPONSE SCALE
Strongly Agree 1 2 3 4 5 Strongly Disagree

Statements		Response Scale				
3.24.	Training greater numbers of health care professionals to deliver primary care is one alternative that will be beneficial in meeting the long-term health needs of society.	1	2	3	4	5
		31%	44%	17%	6%	2%
3.25.	Health care professionals have been actively promoting change in the health care delivery systems for the improvement of health care for all citizens.	1	2	3	4	5
		13%	33%	35%	17%	2%
3.26.	Health care is currently available to people at differing income levels on a selective basis.	1	2	3	4	5
		12%	33%	24%	21%	10%
3.27.	Health care professionals have developed adequate self-evaluation of procedures and techniques in the delivery of health care.	1	2	3	4	5
		10%	21%	24%	33%	12%
3.28.	Consumer involvement is essential to provide new alternatives in developing health care delivery systems.	1	2	3	4	5
		34%	48%	15%	3%	1%
3.29.	Health care providers who work with professionals from other disciplines discover a common purpose in providing adequate health care for all citizens.	1	2	3	4	5
		1%	9%	21%	45%	24%
3.30.	Societal class and social distinctions should be of no importance in a health care setting.	1	2	3	4	5
		65%	20%	8%	4%	3%
3.31.	Educational institutions have assumed a central role, not only in the education of professionals, but in determining the nature and quality of health care and services provided to the community.	1	2	3	4	5
		15%	37%	29%	15%	3%

RESPONSE SCALE
Strongly Agree 1 2 3 4 5 Strongly Disagree

Statements		Response Scale				
3.32.	The health care professional such as a nurse should be concerned solely with clinical practice and not with social change in his community.	1 2%	2 6%	3 7%	4 35%	5 51%
3.33.	Nursing educators are considered alternate rather than ultimate sources of information for their students.	1 13%	2 31%	3 32%	4 18%	5 5%
3.34.	Consumer-oriented agencies should play a minimal role in establishing standards or criteria to assess the quality of care provided to health care consumers.	1 7%	2 14%	3 33%	4 32%	5 14%
3.35.	The greatest need for improvement in health care education concerns knowledge and skills about delivery of health care rather then in expanding knowledge about disease.	1 10%	2 25%	3 29%	4 26%	5 10%
3.36.	The existing forms of health care delivery systems allow professional personnel to efficiently deliver health care services to meet the needs of individual consumers.	1 2%	2 13%	3 28%	4 40%	5 18%
3.37.	The inability to change the attitudes of people is a greater obstacle to effecting change in the delivery of health care services than a lack of adequate finances.	1 18%	2 36%	3 25%	4 15%	5 5%
3.38.	When cost accounting and systems research techniques are applied to health care, it can be concluded that the health care needs of some citizens have not been adequately served.	1 39%	2 40%	3 18%	4 3%	5 1%

VITA