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The attitudes of eleven public health staff-nurses toward the patient with long-term illness and his care.

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Boston University
THE ATTITUDES OF ELEVEN PUBLIC HEALTH STAFF-NURSES TOWARD THE PATIENT WITH LONG-TERM ILLNESS AND HIS CARE

BY

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CHAPTER I

INTRODUCTION

At one time misconceptions of long-term illness were so widespread that attitudes even of those who gave care constituted a major block to progress. However, chronic disease is no longer thought to be entirely hopeless, nor is it thought to be completely associated only with the aged. At present we are in the process of change from pessimism and neglect to confidence in the value of treatment and rehabilitation. But in spite of these changes there still remain areas of professional and public indifference. Reasons for such attitudes are numerous. Often institutional facilities for care are poor and shoddy and located in unattractive areas; these conditions may repel the public. Work associated with long-term illness is often taxing and may be felt to be discouraging. Moreover, many professional workers still think of patients with long-term illness as uninteresting. 1

Just as these negative attitudes have had an effect on the prevention of chronic disease and the promotion of treatment centers, so can

the negative attitude of a nursing staff toward patients with long-term illness curtail the progress of patients. If such cause and effect are to be prevented, attitudes toward long-term illness must be clarified so that negative attitudes may be changed to more positive ones. Since the attitudes of the people who work directly with patients have the most effect, the public health nurse was chosen for study as one who often works with chronic illness. The problem of this study therefore is to discover the attitudes of public health staff-nurses towards the patient with long-term illness and his care.

Statement of The Problem

The problem for this study is to explore the attitudes of the public health staff-nurse toward patients with long-term illness and their care. Particular attention will be given to the way attitudes promote independence in the patient.

Justification of The Problem

The impact of chronic illness on our society is one reason why further study of the effect of attitudes upon patients is needed in public health nursing. Incidence of chronic illness is increasing today because of the fall in birth rate, the reduction in immigration and the decrease in infectious diseases.² Not to be ignored is the cost of three billion

dollars to the nation for the care of the chronically ill. \(^3\) Just how much the cost can be reduced depends on how adequately the needs of the chronically ill are met. However, the greatest toll is on the life of man who must live with his chronic disease.

The nature of chronic disease is such that its onset is insidious and many times undetected until the disease is far advanced. The slow nature of its destruction to life and even the slow recovery to health make tremendous emotional and economic demands on family members who are directly or indirectly involved. Even though the continuous disease process and slow recovery may necessitate constant medical care, continuous services are not always available to families. Nor does the slowness of the disease process necessarily rule out the remissions and exacerbations which require immediate medical attention. A chronically ill patient often suffers personal losses in his earning capacity, in his social status in family and community, and in his physical function. These losses in turn create difficult adjustments for the rest of the family, a situation which may end in a complete disorganization of family life.

To restore morale and to maintain intellectual and emotional health for the chronically ill a wide range of services are needed, one of which is public health nursing service. Because of the public health staff-nurse's direct relation to the patient and family, she can by her attitude alleviate the stress of difficult adjustments while giving

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nursing care.

The importance of the problem under study lies not only in the impact of chronic illness in our society and the consequent need for proper nursing care, but also in the importance of maintaining quality in nursing care. The attitude of the nurse toward herself, the patient, and the patient's family influences the quality of nursing. While there are many influences on the development of the public health staff-nurse's professional attitudes, we are most interested in the attitude which is presumably created from the stress found in the care of long-term illness.

The following is an example of how one negative attitude, apathy and indifference, can affect the quality of nursing care. Apathy and indifference of a nurse may be communicated unintentionally to the patient by the way she accomplishes tasks normally associated with nursing care. The patient may react in turn by interpreting the nurse's attitude as a special affront to his individual worth, rather than understanding it as a stress reaction pattern of the nurse. The patient cannot be expected to understand how the nurse's own personal problems affect her care of him. Thus by a communication of her negative attitude, the nurse has already influenced negatively the patient's chief motivating factor, his sense of his own individual worth, so important for the realization of his own potential towards maximum function. The more completely the nurse expresses indifference and apathy the more difficult it will be for the patient to achieve the goal of independence.

So the nurse's negative attitude and the extent to which she holds and expresses these attitudes not only limits the patient's participation in the realization of his own potential, but also increasingly hinders his desire for self-growth.

The indifference and apathy of the nurse may have other unwholesome effects; that is, her attitude may reinforce a wish of a member of the family to dominate someone who is dependent; it may make the family members dependent on the nurse for keeping them "comfortable" by having the nurse do those tasks that family or patient may assume. In this situation, if the patient is aware of what is happening to him he will be confronted with a reinforcement of negative attitudes making it increasingly difficult for him to reach any degree of independence.

When a situation has reached this point, a nurse may be unable to understand why the patient is not progressing and the net result would show that nursing efforts have helped the patient very little. The family would then be dependent on the nurse for service in order to function as a "comfortable" family unit with professional approval. Both nurses and family members would then meet any change with doubled resistance and nursing care directed toward helping the patient to reach for independence would in turn be interpreted as "poor" nursing care.

Scope and Limitation

This study centers on the attitudes of eleven public health staff-nurses toward the patient with long-term illness and his care. No attempt was made in this study to explore the attitudes of patients and
families toward long-term illness. The nurses interviewed were employed by two separate nonofficial public health agencies. Each of the agencies provided a bedside care program for patients with long-term illness, employed a similar number of staff members, and were located in different communities. The conclusions of this study will be considered valid only for the eleven nurses in this study.

Preview of Methodology

Situational analysis through an interview technique was the method used for collection of data for this study. The "situation" refers to a focus on special events experienced by the nurse in her care of patients with long-term illness. The interview guide contained questions of variable forms: of choosing words, of liking or disliking a task, of imagining her own role from looking at pictures of a nurse giving care, and of solving problems. Nurses were questioned in four areas: (1) their feelings toward specific long-term illness, (2) their past experiences related to long-term illness, (3) their responses to nursing procedures in long-term patient care and (4) their ways of approaching problems of patients with long-term illness. The interviews were tape recorded to reduce the possibility of bias on the part of the interviewer and to provide for more accurate and complete data analysis.

Overview

The remaining four chapters contain a more detailed account of this study. Chapter II includes the theoretical framework and a review of literature to indicate what other studies have shown in
examination of this problem. Chapter III explains the development of methodology, and describes the sample. Chapter IV includes a synthesis and an analysis of the data. Chapter V contains a summary of the study and recommendations for further research.
CHAPTER II
THEORETICAL FRAMEWORK

Relevant literature has been reviewed to understand more clearly how public health staff-nurse attitudes affect promotion of independence in patients with long-term illness. Two main ideas will be discussed: promotion of independence in nursing and the effect of nurse attitudes on promotion of independence. Then these two main ideas will be related to the study design and to public health nursing.

Promotion of Independence As Viewed for This Study

The promotion of independence may be understood by looking first at the meaning of independence and then the meaning of dependence. Independence is characterized by a person's state of optimum health, by his usefulness to the limit of his capacity, by his ability to continue experiences which help him to remain useful and to maintain both his own physical and mental health. Various rehabilitation nursing publications have shown, in addition, the importance to the patient of initiating his own actions, as in setting his own goal with the nurse helping to clarify the realistic nature of this goal. According to Terry, the handicapped person must do for himself; he
must be the one to make the effort. This is reinforced by Morrisey who says, "It is not enough for the . . . nurse to accept the patient's handicap in a realistic way. Until the patient is ready to accept his limitations and build on his assets, very little progress can be made in rehabilitation." She points out that "facing reality and accepting the inevitable are meaningless phrases to the troubled person unless he has within him that quality, essentially spiritual, that helps to unite all of the factors of his being." The significance to nursing is that the desire for independence rests within the individual, in his spirit, mind and body.

To understand the phrase, "promotion of independence," it is necessary to look at the meaning of both emotional and physical dependence and its implications for rehabilitation nursing. In patients with long-term illness, Terry notes that the stress and/or disability which a long-term illness creates may usually be accompanied by emotional dependency and that there is no clear line of separation. Peplau describes how a patient may behave when illness strikes him

3Ibid.
this way:

[He] may become more dependent than has been [his] pattern in adult life . . . [He] may over compensate for feelings of dependency by acting as if [his] independence of other was greater than that shown in previous pattern of behavior . . . [He] may deny the illness, acting as if the event was not being experienced.

Muller's idea that a need to be mothered is often times re-activated when a patient is struck with illness adds another perspective to this problem of dependence. She says:

undue dependencies are sometimes characterized by irresponsibility, passivity, effective poverty, conventionalized values, over-regard for public opinion and reliance on prestige figures. Such evidences of failure in the development of self-reliance are marks of a dependent person who is unable to cope with ordinary everyday problems without support from the stereotype of external authorities.

The conditions which foster dependence and which foster independence are often times influenced by a nurse who sets the tone in her relationship to the patient. Emotional dependency is fostered by an autocratic setting in which an authoritarian figure discourages a patient from using his own initiative. To change such a setting to a democratic one, the nurse must be able to accept the patient unconditionally. When a nurse can laugh at her own human shortcomings, she can permit the patient to gain some insight into himself and to feel some acceptance of himself as a person. She can also permit enough freedom so that a

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7 Ibid.
patient can perceive and exercise his own responsibilities. Through this kind of awareness a setting for promoting independence can be established.  

One of the major problems in caring for patients with physical disabilities centers around his acceptance of help to meet physical dependency needs. In Barker's report, a study of the injured done by Dembo shows what this help meant to both the disabled and the professional worker. She pointed out that a patient may not accept unessential but useful help because he clings to an old pattern of finding security. Until the time of his illness the patient has been able to perform the functions of daily living. When disability strikes him suddenly, he still attempts to function independently. People who can help him to adapt to new ways of living with a disability now become symbolic of taking away his former association of independence such as: gaining social status, promoting self-esteem, and protecting himself against the dishonor of being "babied." Thus a patient may not accept help. When the professional worker does not understand this process, she may reinforce in the patient inability to accept help.

Another problem of accepting help was that a patient may reject help because he fears that he is socially inferior. The helpful relationship between a nurse and a disabled person is asymmetrical.

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8Ibid., p. 79.

It is one in which a patient is dependent for help on a nurse, but a nurse is not reciprocally dependent on the patient. The nature of this asymmetry helps the patient to better accept himself as a person. A patient may reject help from the nurse when he perceives her as being in a better position than himself, when she pities him, when she calls attention to his disability or sets him apart from others. Where such rejections block roads to treatment, the nurse must question what the patient is in fact rejecting and in turn examine herself, as she is the one in close relationship to him. Nurses have a responsibility to know themselves and to use this knowledge to further the treatment process with the individual patient. "This business of sharing with the patient is not always easy." Before a patient can accept help he faces a conflicting "desire to achieve maximal independence while being treated like anyone else and yet requiring help that others do not need." For a patient to accept help he needs to reorganize his whole attitude toward help so that he sees himself as a person who is having difficulties in a particular situation rather than as a totally disabled person. A patient is more able to accept help when a noninjured person caring for him is not overly conscious of the disability.

10 Ibid.
12 Barker, loc. cit., p. 79.
13 Ibid.
For this study, promotion of independence means meeting emotional needs of dependency and a further psychological need of accepting help, both of which accompany physical dependency. Two statements by the National League for Nursing on the rehabilitative aspects of nursing can be appropriately seen as a generalization of what nurses can do in promoting independence: "to recognize the rehabilitation potential as dependent upon the individual . . ." and "to emotionally accept the individual with a disability."  

Effect of Nurse Attitudes on Promotion Of Independence

To understand the effect of nurses' attitudes on the promotion of independence, it is necessary to look at the meaning of attitudes. The significance of the term "attitudes" will be further applied to its effect on relationships in nursing care and to the study design.

Brown and Fowler in their conceptual study of nurse-patient relationship defined attitude as a "tendency to act with regard to persons, places, or objects." Perhaps this is the clearest definition and supports the one given by Jahoda, Deutsch and Cook. An attitude does not include motives. An attitude changes with the experiences that an individual has and differs from individual to individual.

14 Jensen, op. cit., p. 72.


individual. It is not directly observable but rather discoverable by inference. It not only is a tendency to act but also has dimensions which make it measurable. 17

The major dimensions of an attitude are summarized in the following way by Jahoda, Deutsch and Cook: "how the object is perceived and thought about; the subject's feelings toward it; the action implications of cognizing it and feeling toward it in a certain way..." 18 The degree to which these dimensions play an active part in one's life makes up still various other dimensions. 19

The significance of attitudes for this study is even greater in considering Simmons and Wolff's concept of habituated attitudes. They point out that attitudes are formed from the constitutional make-up of the individual and his previous life experiences, both of which result in a set of predispositions to respond in a specific way at a given time to certain situations. After a period of time, a person develops a set of attitudes to situations that repeat themselves. This set of attitudes are appropriately called "habituated attitudes." 20

Attitudes may be conveniently regarded as personal variables intervening between stimulus situations on the one hand and emergent responses on the other. It is assumed that their

19 Ibid.
formation is conditioned both by the constitutional make-up of the individual and his previous life experience, resulting in a set of predispositions to respond in a specific way at a given time to certain situations. Presumably over a period of time individuals come to possess a fund of attitudes, or particular organizations of attitudes, that recur in repetitive situations and that provide characteristic behavioral responses. Until we have a better formulation, we suggest that these habituated attitudes constitute the linkage between the situational stimuli evoking stressful states and the reaction patterns that may prove inept for the organism.  

In this study it is assumed that the care of long-term illness is a potentially stressful situation for the public health staff-nurse because it may reopen for her some previous traumatic life experiences which she may not have resolved satisfactorily. As a result a nurse may find that she has a set of negative attitudes which might effect the quality of her nursing care. She may find that these are habituated ones. To change attitudes under these circumstances is a difficult problem because of the crystallized nature of habit.

Although Gilbert does not say that bedside care is stressful to the public health staff-nurse, she shows how a program of bedside care, presumably of patients with long-term illness, can create negative attitudes in the public health staff-nurse. She says that the public health staff-nurse receives a great deal of satisfaction from her technological skills, particularly those that are directly related to bedside care. When bedside care becomes symbolic of low professional status, the public health nurses who wish to iron out their internal conflicts, to dominate, to mother and to be secure in familiar

\(^{21}\) Ibid.
technological skills. 22

The importance of attitude in nursing care is in its positive effects on promotion of independence. According to the report of the Commission on Chronic Illness, the effect of attitudes upon patients is as important as any one of the technological skills and is an integral part of care directed toward the promotion of independence.

Rehabilitation

is an innate element of care: . . . it is a continuing process which should begin early in the course of an illness or disability. It includes not only formal and well-defined services such as surgery, physical therapy, vocational training, but also such tenuous aids as the attitudes of those around the patient, and encouragement and help toward even the smallest gains in self-care. 23

The importance of the effect of attitudes on establishing and maintaining relationships can be illustrated by data from Rogers, who has made extensive studies on client-centered approach. He feels that the counselor's attitude toward the worth and significance of the individual is the foundation to his therapy. 24 Peplau who has explored interpersonal relations in nursing, indicates the importance of the effect of the nurse's attitudes on patients by showing that the patient learns more about himself from the nurse's attitudes than he does from actual information given to him. He does this by relating


23 Commission on Chronic Illness, op. cit., p. 138.

to working out his problem with a nurse. 25

In contrast to the desirable effects which positive attitudes may have, results of two recent studies demonstrated that negative attitudes effect the quality of nursing care for patients with long-term illness. The quality of nursing care was found to be in such jeopardy that both authors proposed programs of inservice education as a method for creating change. One of these studies was done at Cornell University with student nurses as participants. Their characteristic responses toward the care of long-term illness as "uninteresting, boring, routine, or the same day after day" were representative of their negative attitudes toward chronic disease nursing. 26 When these students completed newly developed curriculum for the care of chronically ill patients, a change in attitudes in more effective nursing care was noted. 27 Part of the import of this study seems to be the influence attitudes have on nursing care of patients who are chronically ill.

In the other study which was done at a Veteran's Administration Hospital in Kecoughtan, Virginia, negative attitudes were identified as a problem in care of patients with long-term illness. 28 Fox and Spain found that:

25 Peplau, op. cit., p. 185.


27 Cornell University-New York Hospital School of Nursing, Toward Better Nursing Care of Patients with Long-Term Illness, (New York: National League for Nursing, 1956).

Caring for the chronically ill has been unpopular with nurses. Many think that working with such patients is depressing, distasteful, and uninteresting—both in personalities and disease conditions encountered. Younger nursing personnel, especially, may even think that nursing efforts spent on these patients is a waste of their time and skill. Certainly, this attitude creates a problem.29

The Relation of Theory to Study Design

The importance of adequate nursing care which underlies this study makes it necessary to establish some criteria to show attitudes which promote independence. It has been assumed that the promotion of independence is an important goal of good nursing care. It has also been implied that the nurse's attitude toward individuals is an influential factor in promoting independence in patients. In keeping with these assumptions, Muller's concept of mature sympathy30 was chosen as the most effective attitude for promoting independence in care of patients with long-term illness. As a result a reasonable choice for this criteria was Muller's concept of mature sympathy:

Sympathy is the act of entering into and sharing feelings interests and acts of another person or persons. It is an expression which lays the foundation for establishing and promoting mutual accord . . . . It is the expression of a secure person who has the ability to give appropriate support to those in need of it. Such sympathy shares by participating in the good fortunes or easing the difficulties of another . . . .

Mature sympathy evaluates others with trust and esteem. . . . It rests in the ability to estimate the needs of others with unbiased understanding and regard . . . .

Constructive sympathy . . . imparts truth.31

29 Ibid.
30 Muller, op. cit., pp. 158-159.
31 Ibid.
This criteria was a basis for developing a part of the methodological tool; it was also a means for classifying data.

Brown and Fowler's description of actions with underlying negative motives was chosen as actions which contained a negative attitude. A nurse may be curious about the patient. Although curiosity is essential for learning, this alone may make the nurse so scientific that she may forget she is working with another human being and consider him as an inanimate scientific interest. She may test a patient's own strength of personality by exerting pressure upon the patient to act the way in which she believed he should act. She can attempt to minimize or justify the existence of her own conflict by feeling that the patient is worse off than she is. She may promote personal gain by using her skills indiscriminately, i.e., not for the best welfare of the patient. She may act out her own conflicts by not giving into logical demands of the patient. She may care for the patient merely because the doctor, head nurse, or instructor says that she should. This description was a basis for classifying the data of attitudes which were not helpful to both good nurse-patient relationships and promotion of independence.

Reasons for Focus on Attitudes of Public Health Staff-Nurses

With the increasing numbers of disabled and chronically ill patients in homes and with the limited numbers and uneven distribution of local public health nurses who practice bedside nursing, it is

inevitable that each nurse may feel overwhelmed and burdened with this responsibility. Because of insufficient or incomplete data about the distribution of and need for public health nursing services, only a partial picture can be given of the extent to which these services are available for the care of the sick at home. According to the study done by the Commission on Chronic Illness, there is no data to show how many official health agencies provide home nursing care to the chronically ill, though professional opinions indicate that this service is small. 33 This same study shows that local non-official agencies generally provided home care of the sick on a much more extensive basis than did the health departments. 34 In 1952 there were 1,005 such agencies. 35 No data on home nursing care are available in combination public health nursing services. This is a form of service which is jointly administered by governmental and voluntary agencies, in which field services are given by a single staff of public health staff-nurses. The overall distribution of public health nursing services for bedside care in 1951 was shown to be limited as to the comprehensiveness of service or segments of the population covered.

In 1951 a survey of nursing organizations by the Commission on Chronic Illness and the National League for Nursing revealed that of 106 cities in the United States with population of 100,000


33 Commission on Chronic Illness, op. cit., pp. 7-8.

34 Ibid. p. 39.

35 Ibid.
and over, 74 have a separate visiting nurse association
and 17 have a combination agency. 36

When comprehensive public health nursing service which includes the care of the sick at home is provided, it is roughly estimated that there should be a ratio of one nurse to 2,000-2,500 population. 37

Although at one time it was thought that a ratio of nurses to population gave a reasonable measure for meeting community needs, the measurement is now felt to be inadequate, though there is no other method of measurement to take its place. 38

The following descriptions of well defined services as recommended by the Commission on Chronic Illness show that the public health staff-nurse is consistently in direct contact with the family and community services. As a result she is necessarily exposed to the greatest amount of stress from patient and family situations. She provides:

1. **Personal care services.** This includes general nursing care—bathing and feeding; training in proper body posture; keeping the patient comfortable and clean; helping teach the patient to get dressed, to get in and out of bed, and to perform other essential activities for himself.

2. **Nursing procedures which have been ordered to implement medical care.** In some cases there will be need for highly technical treatments over a long period of time; or for treatments which require considerable judgment to administer; and for improvisation of furniture or equipment. Temperature, pulse, and respiration must be recorded as necessary... Treatments such as surgical dressings, hypodermic injections, respirator care, irrigations of various sorts,

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36 Ibid.


38 Freeman, *op. cit.* p. 53.
artificial feeding, or catherization are frequently necessary. With the help of a physical therapist, the nurse may be called upon to provide massage and therapeutic or re-educational exercises for paralyzed muscles or for reservation of function. Throughout such treatments the patient's condition must be observed carefully, and evidence of progress or distress reported to appropriate medical personnel.

3. Instruction and guidance in relation to the disease and for general health promotion and maintenance. Both patient and family need to understand the disease and its usual course--and how to avoid preventable complications and recurrence of disease. They may need instruction in care of treatments such as insulin injection or colostomy dressings. Instruction relative to general hygiene, nutrition, preventive measures, and general health maintenance is needed on a family-wide basis, and may or may not be related to the immediate disease situation. Prevention of fatigue for the family member giving care is an example of such instruction.

4. Emotional support and guidance. The nurse can help the patient and his family understand, accept, and adjust to illness and to temporary or permanent physical limitations. Expert counseling as part of general nursing care is necessary to minimize or to cope with fears and hostilities that commonly develop in response to the illness situation. An opportunity to express fears and worries about the disease or family problems to a professional worker who knows when to reassure and when to listen, and when and how to offer specific help may release, and so reduce, the force of these difficult emotions and their causes. Realistic discussion of rehabilitation possibilities and of the community resources available often do much to relieve legitimate anxiety.

5. Guidance in the use of community services. In the prediagnostic period, those with potential chronic illness need to be directed to facilities for screening and diagnosis, and encouraged to make full use of available facilities. When illness has been recognized supplementary and related services may be needed--physical therapy, occupational therapy, diversional activities, religious counseling, rehabilitation, or educational activities. There is need for interpretation of the services, charges, and policies of hospitals, nursing or convalescent homes, homemaker services, or of the services of nutritionists, social workers, or other specialists who can bring special skills to the family is to use them wisely. 39

39 Commission on Chronic Illness, op. cit., pp. 36-37.
The public health staff-nurse is in a strategic position to effect change, but she faces many problems due to too few trained personnel and stress that she may confront in the home situation. If a nurse finds that she has negative attitudes which she would want to change, she would still have another problem.

Statement of Purpose of The Study

The purpose of this study is to explore the attitudes of public health staff-nurses toward the care of patients with long-term illness. It is directed specially to attitudes of mature sympathy as it affects promotion of independence in persons for whom the nurse is caring. It may be useful for helping nurses meet the needs of their patients and thus improve the quality of nursing care. Because the intent of this study is to define more accurately certain attitudes held by nurses, no formal hypothesis has been formulated. Instead the study is designed to understand more clearly the nature and implications of the following: (1) the feelings of the nurse about long-term illness, (2) the effect upon the nurse of early experiences with persons or patients with long-term illness, (3) the nurses' likes and dislikes that are associated with specific nursing tasks, (4) the effect of other processes underlying nursing practice, (5) the way the nurses approach the problems of patients.

It is hoped that the data will indicate what does or does not bring satisfaction to the nurse as she cares for patients with long-term illness, the key problems in nursing attitudes of patients.
with long-term illness and their care, and an identification of problems for further study in this area.
CHAPTER III

METHODOLOGY

The Interview Guide

The interview was the most appropriate tool for collecting data because the "measurement of the characteristics of an attitude is always indirect . . . getting attitudes boiled down to the simple matter of asking people questions about an issue in order to elicit a response which is interpreted as the respondent's opinion or attitude toward the given issue."¹

In addition to the above general reason there are other more specific reasons for using this method. The interview helps to bring out the emotional and value-laden implications of the nurses' responses and to determine the significance of her various attitudes. It also permits full and detailed expression. This technique achieves the intent of the study because responses are spontaneous rather than forced, highly specific and concrete rather than general, and self-revealing and personal rather than superficial. Also this method is

¹Jahoda, Deutsch and Cook, op. cit., p. 113.
useful as a source of hypotheses which can be tested.\(^2\)

The interview guide was developed by the use of situational analysis, a concept useful for data analysis and one which required that questions be phrased in relation to specified areas that refer to nurses' experiences in caring for patients with long-term illness.\(^3\)

These areas were: (1) nurses' feelings toward thirteen specific long-term illnesses in her contacts with these illnesses in the last two years, (2) nurses' early experiences with persons or patients with long-term illness, (3) nurses' way of accomplishing eight nursing tasks commonly associated with long-term illness within her present caseload, (4) nurses' ways of solving problems which demand a mature approach, also from her experiences within her present caseload. The specific focus which the definition of the situation afforded in the interview design also helped to formulate the questions. The development of these is as follows: (Please refer to the Appendix for the entire interview guide.)

The first area was: What have been the nurses' feelings toward thirteen selected diagnostic categories in her contacts with these illnesses in the last two years? A nonverbal form was used to elicit the nurses' feelings and the intensity of these feelings toward the selected diagnostic categories. Each nurse was asked to indicate the

\(^2\)Ibid., pp. 175-176.

\(^3\)Simmons and Wolff, op. cit., pp. 101-103.
feelings she had experienced during the past two years toward long-term illnesses.

The written form included three lists of words: long-term illness categories, adjectives that might describe feelings about these long-term illnesses, and adjectives which might show the intensity of feelings toward these long-term illnesses. The thirteen long-term illnesses were identified from the Baltimore and Connecticut studies on the care of long-term illnesses found in public health nursing case-loads. The diagnostic list of long-term illnesses used in this study included: cerebral arteriosclerosis, hemiplegia, coronary heart disease, hypertensive heart disease, Buerger's disease, Raynaud's disease, fractured hip, quadriplegia, paraplegia, multiple sclerosis, Parkinson's disease, diabetes, neoplasm, and any other illness which the nurse wished to add.

Two lists of adjectives were selected by the writer from the readings related to the problem for study, especially those describing attitudes towards long-term illnesses. Adjectives for describing feelings were: formidable, depressing, painful, fearful, slow, difficult and any other which the nurse wished to add. Adjectives for describing the intensity of feelings were: hopeful, very hopeful, hopeless, very hopeless, tolerable, and intolerable.

The form was systematic in design to permit the nurse to select adjectives descriptive of the illnesses and to indicate by checks the time span of her contact with the specific long-term illness. The time span

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4 Commission on Chronic Illness, op. cit., p. 586.
question helped to make the data more valid by allowing elimination of replies from nurses who had had no contact with the illness and/or had contact with the illness more than two years previously.

The second area of the interview was concerned with the nurse's early experience with persons or patients with long-term illness. Three questions were asked as follows: The first of these was: What was the nurse's first experience with patients with long-term illness: i.e., before entering a program of nursing, during her educational program and in public health nursing? The purpose of asking about earlier experiences was to allow for a comparison of her current attitudes with remote experiences. It might be assumed that if the data were consistent, this would also be an evidence of validity. However, this procedure is not to be considered a conclusive test of validity.

The third area in the interview guide was: What were the nurses' ways of accomplishing nursing tasks commonly associated with the care of patients with long-term illness? There were two parts to this question. One was on whether she liked or disliked specific tasks and the reason for her response. The second part was concerned with her response to five pictures in which a public health staff-nurse was performing tasks for a patient with long-term illness.

The like-dislike question was designed to discover habituated attitudes of the nurse. According to Jahoda, Deutsch and Cook this form of question is particularly appropriate for well-structured attitudes. Because of the daily need for the performance of nursing tasks, public health staff-nurses were assumed to have a fairly well developed set of attitudes towards these. Eight tasks were selected from a study which served as a basis for deciding which tasks were most commonly performed by public health staff-nurses. The final selection included bath, hypodermic injection, health instructions, massage and exercise, dressing, enemas, crutch-walking and catheter irrigation. In the interview, nurses were asked if they liked or disliked each one of the tasks and then asked to give reasons for their like or dislike.

In the response to pictures the respondents were presented with pictures one at a time. With each picture, except the last, they were also told that the patient in each picture had just made a remark. The respondent was then asked what the nurse would reply. This particular form was developed to discover attitudes around a task. Jahoda, Deutsch and Cook have indicated that responding to pictures is a simple projective technique from which thoughts of a private nature may be inferred.

The pictures which were selected depicted tasks involved in the

6Tbid.
7Commission on Chronic Illness, op. cit., p. 586.
8Jahoda, Deutsch and Cook, op. cit., p. 226.
care of patients with long-term illness. Realism was furthered by choosing pictures in which the nurse was in her official uniform. The remarks which accompanied the pictures were created by the author's recall of her own public health nursing experiences and by imagining how the patients might feel in a similar situation. The pictures with their accompanying remarks are described in Table 1.
TABLE 1.--A description of five selected pictures with their remarks presumably made by the patient for securing projected responses from eleven public health staff—nurses

<table>
<thead>
<tr>
<th>Description of the pictures</th>
<th>Interviewer's spoken remarks presumably made by the patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>A nurse if giving a bed bath to an elderly lady. (The face of the nurse was omitted as her facial expression appeared posed for the photograph.)</td>
<td>&quot;Oh, it feels so good to be washed.&quot;</td>
</tr>
<tr>
<td>A nurse is ready to give a hypodermic injection to an elderly lady seated near a kitchen table. An elderly gentleman is standing behind her.</td>
<td>&quot;I think it's going to hurt.&quot;</td>
</tr>
<tr>
<td>A nurse is assisting an elderly lady out of bed. This patient is helping herself with a self-help device attached to the foot of the bed.</td>
<td>&quot;It's so easy when you help me.&quot;</td>
</tr>
<tr>
<td>A nurse is assisting an elderly lady who is seated and exercising her afflicted arm with a pulley device attached to a door in her home.</td>
<td>&quot;This is as far as my arm will go.&quot;</td>
</tr>
<tr>
<td>A nurse is assisting a young boy from behind while he is crutch-walking.</td>
<td>No remark by the patient was applied, but a question was put to the nurse: &quot;What do you think the nurse might be saying to the patient?&quot;</td>
</tr>
</tbody>
</table>
The fourth area in the interview guide was: What were the nurse's ways of solving problems that demanded a mature approach of sharing, evaluating with trust, estimating needs of others, giving appropriate support and of imparting truth or working with reality of the patient situation? The five problems that were presented were constructed so that each embodied one of these aspects of a mature approach to a problem situation. The relationships between the problems presented and the aspects of mature approach upon which they were constructed are as follows:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Aspect of Mature Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How does a nurse participate while teaching a patient to do for himself as in the activities of daily living?</td>
<td>Sharing</td>
</tr>
<tr>
<td>2. How does a nurse draw conclusions about what she expects trust from the patient in between her visits?</td>
<td>Evaluating with trust</td>
</tr>
<tr>
<td>3. How does the nurse support a patient who is going to the doctor, or to a clinic or hospital for hospitalization?</td>
<td>Supporting appropriately</td>
</tr>
<tr>
<td>4. How does the nurse estimate patient needs when talking to co-worker, to doctor, to hospital?</td>
<td>Estimating needs of others</td>
</tr>
</tbody>
</table>

\*Muller, op. cit., pp. 155-156.
5. How does the nurse help the patient recognize or accept the reality of events related to his illness?

This question is a form of projective technique also in which the object, the problem solving, is reacted to by the nurse. In solving the problem the nurse defines her own approach of promoting independence. The mature approach as understood here is the concept of "mature sympathy" which Muller describes as the most appropriate helping relation in nursing care.⁹

Each respondent was also asked why she had entered nursing and her reasons for remaining in nursing. These questions were expected to yield some data on her whole attitude toward nursing. It was assumed that this data could be related to her approach to problem solving.

The interview schedule was pretested with 3 graduate nurses of Boston University School of Nursing. A final testing of the interview guide was performed with one graduate student in the rehabilitation program, but who also had public health nursing experience in a non-official agency. This testing was done primarily to gauge the time it took to interview and to increase the emotional sensitivity of the questions.

⁹Muller, op. cit., pp. 155-156.
Selection of Sample

The personal knowledge of the writer and the studies of public health nursing services in Baltimore and Connecticut showed that the local non-official agencies in the Greater Boston area would have a bedside care program for the chronically ill. Interviews with the directors of two local non-official public health agencies, made a sample available for this study. The directors of each agency calculated from previous years records that about 75% of the staff-nurse's time was devoted to bedside care.

The two local non-official public health nurse agencies from which the sample was drawn were located in urban areas. One had a population of 100,000 and the other a population of 67,000. One agency had eleven staff-nurses and the other had ten staff-nurses. Each had a director and a secretary on the staff. Both carried graduate students who were doing their field work at the time. One had no supervisor although their budget allowed for one, while the other did have a supervisor.

The original intention of the writer was to draw the sample from one agency. Two factors entered into the decision to utilize two agencies from which to draw the sample, namely one, the cost of time to the agency if the entire sample was drawn from one and two, the elimination of possible bias of the policies and organization of one agency upon the entire sample.

In one agency the director selected staff members to participate in the study on the basis of availability during a summer season.
In the other agency, the director asked the writer to meet the group of staff-nurses and to ask for volunteers. Six nurses were drawn from each of the agencies. Data of one nurse had to be omitted because of the poor tape recording.

Description of Sample

The characteristics of the sample which will be described are age, marital status, years of public health nursing experience, educational experience, both formal and informal, and the time spent in care of patients who need bedside care.

Age range was from twenty-two years to sixty-two years; median age was thirty-one and mean age, thirty-four. Out of the entire sample three were married. Years of experience in public health nursing ranged from three months to thirty-six years; the median, five years; and the mean, nine and a half years. Formal education varied from a three-year hospital diploma school to a five-year baccalaureate degree program. Four staff-nurses met the qualification for public health staff-nurse positions as indicated by the "Functions Standards and Qualifications." ¹⁰ Seven had formal courses in public health nursing but these courses were insufficient for a certificate or for a degree in nursing; three were graduates of collegiate schools; and the remaining were graduates of diploma schools. Three nurses had attended workshops in rehabilitation, and all staff members had participated in

in-service educational programs. For this group of nurses 72% of their work time was devoted to bedside care. In general this sample is satisfactory in its variation.

Procurement of Data

Data were procured by a tape recorded interview except in the first area on nurse feelings about long-term illness which was written. Each nurse was interviewed by appointment. Preparatory to the interview each participant was asked--

1. If she objected to having her interview tape-recorded
2. If she had any questions about the recording
3. If participant would test the microphone by reading some article, while interviewer adjusted the sound to her voice and explained the signal lights on the machine.

Then the interviewer assured the participant of the confidentiality of data by explaining that names would be withheld, by explaining that another agency was involved and that neither would be identified. The interviewer permitted discussion during the interview where a question brought more reaction than was anticipated.

The first interview took two hours, but the remaining eleven interviews took one and a half hours each. Eighteen and a half hours of interviewing were spaced in one month. This was followed by forty seven and a half hours of removing data from the tape by paid secretarial help.
CHAPTER IV

PRESENTATION OF DATA

The findings will be presented under the following headings:

Description of feelings toward long-term illness
Early experiences with long-term illness
Nurses' way of accomplishing nursing tasks
Nurses' way of helping patients solve problems

Within each of these areas these data are summarized as they relate to the theoretical framework of the study, that is, promoting independence. At the end of each section of the data some nursing problems are identified.

Description of Feelings toward Long-Term Illness

The public health staff-nurse described their feelings toward long-term illnesses by selecting adjectives from two lists. These lists dealt with feelings of unpleasantness and feelings of hopefulness or hopelessness. Through their choices of adjectives the nurses stated the type of unpleasantness which various chronic illnesses had for them. Table 2 presents a summary of their responses.
TABLE 2--The responses of eleven public health staff-nurses' description of unpleasant feelings toward long-term illnesses

<table>
<thead>
<tr>
<th>Adjectives of unpleasantness</th>
<th>Long-term illnesses</th>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow</td>
<td>Cerebral palsy</td>
<td>Hemiplegia</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Depressing</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Difficult</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Fearful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Painful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formidable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Responses</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Data collected in 1959 in two non-official nursing agencies.

One third of the respondents used the adjective "slow" to express their feelings toward the chronic nature of long-term illness. About one-sixth were "depressed" by long-term illness and found long-term illness "difficult" and "fearful." Another one-sixth felt long-term illness to be "painful" or "formidable." Two even supplied the adjectives "apprehensive" and "apathetic" to describe their feeling toward long-term illness.

Table 3 summarizes the responses of the nurses regarding feelings of hopefulness or hopelessness toward long-term illness.
TABLE 3.--The responses of eleven public health staff-nurses' description of hopeless-hopeful feelings toward long-term illnesses

<table>
<thead>
<tr>
<th>Adjectives of hopefulness-hopelessness</th>
<th>Long-term illnesses</th>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cerebral vascular accident</td>
<td>Hemiplegia</td>
</tr>
<tr>
<td>Very hopeful</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Hopeful</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Tolerable</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Hopeless</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Very hopeless</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Intolerable</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total responses</td>
<td>11</td>
<td>9</td>
</tr>
</tbody>
</table>

Data collected in 1959 in two local non-official agencies.

A little over half of the responses were "hopeful" or "very hopeful." The rest of the responses were "hopeless," "very hopeless," "tolerable," and "intolerable." It does not seem that specific disease conditions made any difference in the respondents' choice of adjectives; for example, a condition considered hopeful by some was considered hopeless by others. A little over half the responses indicated that in spite of the unpleasant nature of long-term illness the public health nurses had a hopeful outlook.
Early Experiences with Long-Term Illness

The nurses recalled their first experiences with long-term illness from three different periods: before nurse education, in nurse education, and in public health nursing.

Before Nurse Education

Almost one-half of the sample objectively described an experience with long-term illness. Such a description indicated that the nurse was not particularly involved. The following remarks illustrate this:

My uncle had Hodgkin's disease a few years before he died. It didn't make too much of an impression on me. I was only sixteen. He was a doctor, and it's funny, because I was there the first time that he really got sick: when he started to vomit, to get sick to his stomach and feel terrible... It was just that he would go to the hospital, come home again... go to the hospital and come home again. I used to visit him every once in a while.

In my immediate family my grandmother was diabetic and a cardiac... and also had a kidney involvement... She was bedridden, and it was a matter of in and out of a hospital.

Two-fifths of the sample subjectively described their experience. One claimed that an experience with long-term illness "was part of my everyday living." The nurse's feeling is one of fairly complete acceptance:

I had a grandparent who lived with us who had a hypertension, cerebral arteriosclerosis and a fractured hip. I probably wasn't aware of all the psychological effects on the family at the time. It seemed like a normal home situation to me because I had always had it at home, ever since I was growing up... since I was about nine years old until I was twenty. It was part of my everyday living.
Another expressed awe over the impact of long-term illness upon the life of an individual, "I had never seen anyone who had lost contact with reality:"

In nursing home, first impression was a little old lady. She had several cerebral accidents. She didn't know anything that was going on, and the impression was how thin she was. She just seemed so bony, there was nothing to her. I had never seen anyone who had lost contact with reality. She must have been late 90's when she died. She never spoke, she never moved, just positioning... just living.

One-fourth of the sample had no early experience with long-term illness.

In Nurse Education

As compared to the period before, during their nurse educational program, four-fifths of the respondents appeared to be more emotionally involved. The following data illustrates this involvement: the nurses keenly felt patients' demands and also expressed how much the patient needed the nurse or how the patient's needs were abused by experimentation:

She was a fractured hip, and she too was an alcoholic. She was in her seventy's. She was a very, very demanding, very difficult patient. But I really enjoy patients like that, to tell you the truth, because I think they need so much.

A patient who was comatose; I think she was also diabetic. As time went on, her disposition and all did change. As she became more demanding she expected much more of her family, nurse and medical staff. She did die eventually. I thought there was a lot of experimenting going on.

Nurses felt "very depressed:"

There were a lot of 'CVAs' [Cerebral Vascular Accident]. Just being new at it you just felt that you wanted to do all you
could for them; you'd sympathize greatly with them; you just
couldn't understand why they didn't improve . . . After working
with them for awhile, you get the feeling that you aren't
satisfied with them at all and become very depressed . . .
well, not very depressed, but you just don't seem to be
going anything out of it, and they don't seem to be getting
anything out of it either.

Nurses felt that giving nursing care was "constant" and "special,"
a never ending routine:

The patient that comes to my mind, a Parkinson's
disease on one of the wards in the hospital . . . she was an
elderly woman, in her seventy's . . . she was just in the
bed. It was a city hospital . . . and it took care of
chronic cases. People would come in there and stay for
years . . . wouldn't be sent anywhere else, they just stayed
there and that's what she was like . . . When you're a
student nurse you're sort of laughing at it, because you don't
understand all the things that go into it, and she was kind
of comical although she didn't mean to be . . . but she could
only lie there. She couldn't do a thing. They didn't get
her out of bed. She couldn't do anything for herself . . . you had
to . . . bring her water to drink, and . . . she wet the bed, and . . .
she had to be changed . . . just regular convalescent, constant,
chronic care, that was all.

One nurse was quite impressed with the acute stages of illness
through her experience of a patient dying:

It was a cancer case. All I can remember is that he
came in like we'll say Monday and died Wednesday and . . .
I was . . . I don't know what to say . . . because this was the
first time I had seen death or knew it and what it actually
meant . . . It remained with me a long time because it
was so quick.

Another wondered whether she could tolerate the care if she
were so ill and whether she would have any or much energy left from
being ill:

This man had cancer, metastasized. I remember I used to
take a long time . . . so much to do . . . it took me a long
time to do him. I think he had cancer of the bowel . . . the
works: catheter tubes, intravenous. He didn't talk too
much. His wife used to come in and we helped her along . . .
he finally passed away. I wonder if I could ever do it . . .
we're doing all these things to these people. Injections, rolling and pushing and 'Better get on your side.' And they would do it. I wonder if I were in the same situation, 'Could I stand it!' And I try to think of that.

In this category, one nurse showed little emotional involvement. She said, "I just never thought anymore about it. . . it never impressed me that much to think of because I was used to this . . . ." One nurse said she had not had contact with a chronically ill patient during her education.

In Public Health Nursing

In this category all the nurses were emotionally involved, but they were involved in very specific ways. Two-thirds of the sample remarked about the impact of death in their experiences with patients who had long-term illness. A fairly typical feeling was one of resignation to death. Remarks about death were frequently phrased as "eventually died" "went downhill and died," or "she finally died." The following illustrates the impact of death upon the nurses and also the tediousness of terminal care:

There's a woman that comes to my mind, a woman with cancer. She had to have daily care, she was in bed. The family was very good to her; I got quite . . . not involved, but very friendly with the family. I used to go in to give her daily care, and I think I carried her about five or six months . . . if that long . . . until she finally did die . . . But it was just a question of going in to bathe her and to give her enemas when she needed them.

One-third of the sample seemed not as effected by death, but instead indicated other feelings. One felt a patient was happy now that she was in a chronic disease hospital:
I had a young girl; she had quite a rare disease like Parkinson's only lots worse. She had been in bed seven years. That was the first one that really impressed me the most; she was so young, twenty seven years . . . It got so that her family couldn't take care of her so she was admitted to a chronic disease hospital where she is now . . . very happy.

Another felt that giving daily care in a family setting gave her a feeling of accomplishment.

She is a complete bed patient . . . She requires a lot of care, skin care, because she only lies on her back, other than in turning; she doesn't move at all on her own. She speaks very very little. There's all the equipment there necessary to work with . . . she's just a satisfying case, I mean, you have everything to use . . . then when you're through you have done something.

One other was proud of her patient because she had participated in activating the patient's potential toward independence.

I had my one pride and joy, my first . . . elderly woman. She had a 'CVA' [Cerebral Vascular Accident]. She came home with a partial paralysis. She needed passive exercise; she cried easily, very emotionally unstable . . . this crying business. She had a catheter, of course her bowels gave her trouble. I think she was very depressed. I think she felt that she had it; this was it. She had a lot of potential. Now she's walking with a cane. She's proud.

In general, the development of the public health staff-nurses' feeling towards long-term illness, in the three different periods, showed a remarkable change from one of eagerness to one of resignation. In the nurses' learning period, a conflict between doing all a nurse could do and finding that the care was monotonous and routine was evident. Replies concerning their work in public health nursing indicated that most of the nurses no longer experienced a conflict. Two-thirds of the sample commented on death, indicating an impression of resignation. However, data were insufficient to show exactly how
this impression might be interpreted in relating to feelings about death.

One response, that of recognizing a patient's potential, indicated an attitude favorable for promoting independence. Here the nurse promoted the use of a patient's own potential for accepting her disability. "The patient proudly used a cane." The nurse also recognized the patient's accompanying depression as a part of the patient which she must accept. Furthermore, this feeling response, "I had my one pride and joy," showed her personal satisfaction in promoting independence.

The nursing problem seems to rest in how the nurse can get satisfaction from her work in an area where there is so much pain, death and great demands. A review of her earlier experiences repeatedly confirms the current feelings of unpleasantness toward long-term illness. Apparently a few of the nurses in this study had partially solved this contradiction by giving a great deal of themselves to the felt needs. By and large, however, the nurses had not solved this problem to a point where they gained satisfaction.

Nurses' Way of Accomplishing Tasks

In this area two different methodological approaches for study were used. In the first approach nurses were asked whether they liked or disliked eight selected nursing tasks. In the second approach nurses were asked to respond to five pictures one at a time. Each picture showed a public health staff-nurse performing some task with a patient. Data from these two approaches are presented.
separately: first, as like-dislike responses and second, as projected remarks in response to pictures.

Like-Dislike

**Bath.** About one-third of the sample derived satisfaction from giving baths when patients were seen as helpless and dirty so that the nurse was instrumental in making them comfortable and so received gratitude from patients. Following are some illustrations:

Well, patients who are helpless and can't do for themselves, and they have no one else to do for them, I don't mind doing at all. I only feel as though I'm helping them, and they're grateful and...I don't mind doing it.

I will say that when I go in for an initial visit that the dirtier they are, the better I like it. To clean them up...well, sometimes...of course I have a district where...It's not the slums; it isn't, well, you know it's the other side of the tracks, so to speak. So you're a little more apt to find people who need care, and a bath...

It seemed that the greater the difference between the original state which tells the nurse that a patient needs a bath and the nurses' desired state for the patient, the greater the satisfaction for the nurse. The degree of satisfaction is well-illustrated in the remark "the dirtier they are, the better I like it."

Over one-half the sample simply liked to make patients comfortable:

I think the satisfaction of giving a bed bath is not the actual problem in giving the bed bath, but the patient is more comfortable, and...feels a little better afterwards.

However, comfort for one nurse was equated with the nurse's idea of being clean:
Well, yes, I mean...if somebody is terribly, terribly uncomfortable, I...I feel clean myself, when I wash them, you know? I feel as if...naturally, they're so much more comfortable, when you're washed up and cleaned...made comfortable, clean clothes, clean sheets...it's just proper hygiene.

Three nurses liked to give a bath for reasons directly connected with themselves. One respondent enjoyed conversing with a patient while giving the bath:

I don't know if it's the actual bath, but I enjoy talking with the patient you know...it's a good time to talk, and joke, and just converse, you know...I don't know if it's the bath so much as it's easy to talk to them then.

Another enjoyed using her technological skill:

I enjoy, naturally, calls where there's a little something with it. If you have a little treatment to do...

A third reason came from a felt need of one nurse to like all aspects of nursing:

I think of course, on the whole nursing is something that you have to like to do anyway...If you don't like to do it, I don't see any...I don't see how you can do it. Because you really...it's work that you really have to love, both for the patient and for yourself too...

Certain conditions directly related to the patient caused about two-thirds of the sample to dislike giving baths. Nurses disliked this task when the patient was up and about:

Well, let's say normally speaking, anybody gets a day when they...probably they're more tired than on another day...and the bath...and you have to go in, and you're tired yourself, and you give a bath to somebody who is up and about ordinarily, and about the house, and they may...oh, their diagnosis may be general debility, or...nothing too serious...well, those days...you don't appreciate...

One nurse did not like to give a bath to an embarrassed male:
'Course, sometimes if you have a heavy young male patient, I suppose you don't, but...you know. In the hospital there's no worry, but...there's one...I think it's a forty-five year old man that we see, that is difficult, sometimes, but he's just embarrassed. He is; and you feel embarrassed for him. That's the only time I don't like it.

Two nurses distinctly disliked giving a bath when a capable member of the family seemed able to perform the task:

Well, the only time that I feel that a bath is not necessary is when people have someone very capable in their own home who could do it for them...you know, they just call the visiting nurse to do it because it's just something they don't want to do. And then, although I feel that it should be done...if the patient is up and walking around, and they're perfectly capable almost of washing their own face and hands, then there really isn't any reason why they couldn't have a bath in the evening...I feel that the person who should have the bath would be somebody that has no one else to care for them, somebody that's bedridden, somebody who really needs it...It's just that I don't feel that a nurse should be doing things that somebody else could be doing: the patient himself, that is...a member of the family.

Certain conditions directly related to the nurse caused about one-fifth of the sample to dislike giving baths. One condition was when the nurse was tired. Another was when she had four to five baths to give in one day:

...if you have four or five which we don't have very often, we don't have that many, we generally spread them around, but after you've done about the fourth one, if it's just a straight bath, you kind of feel this isn't nursing. I feel that way.

The task of giving bed baths brought the satisfaction of meeting immediate needs for both nurse and patient. However, meeting the immediate needs generally sacrificed the long range goal of promoting independence. No nurse indicated a recognition of the patient's
potential for doing either all or part of her bath. When a nurse disliked being "used" by a family member or a patient, she overlooked or was unable to appeal to the potential of either of these parties to assume responsibility.

Apparently meeting the immediate needs in giving a bath brings a high degree of satisfaction to the nurse and perhaps she is unwilling to relinquish this feeling of reward for a delayed satisfaction that might come from promoting independence. The generally unrewarding nature of care of long-term illness may intensify the degree of satisfaction for the nurse in giving baths.

**Injections.**—Over one-half the nurses liked to give injections for two reasons. Four nurses made it clear that they liked to give injections because it helped the patient and that any pain they caused was a necessary part of the treatment:

> Well, I think again, it's the results that you get, you know, that by giving them, that...I...wonder if anybody likes to get them. And...I think somehow you feel that you are hurting a person by giving them. I think so many times we do things...the nurse does, that cause some discomfort to the patient, but we don't give any hypodermic injections without a reason, this...the same as with cases of asthma, and things like that...you know the patient is going to get benefit and relief, so if you don't enjoy giving them you just know that they are going to get the benefit of it in the end.

Two nurses enjoyed their own skill in being able to give injections which caused only minimal pain to the patient. They took pride in this:

> When I can do a good job, why then I like it...Maybe I'm sadistic. Well, the only thing that I can say without the risk of being overly...
of myself. I've been told that I give good ones.

The other half of the sample disliked giving injections. For four nurses, conditions which tended to increase pain made the giving of injections an unpleasant task, i.e., with infants and with patients who had "tough" skin, or with a patient who made an issue of receiving injections. They expressed the unpleasantness this way:

But oh, to a baby; I hate to give needles to babies... when they squirm and you have to pull it out and stick it in again and you really feel as though you were being very cruel to them, poor little things.

Well, when their skin is tough, you know, and it's hard to...it hurts them. Then I don't like it.

Well, it all depends on the patient. If they don't like them and they make such an issue of it then, I don't like to give them.

One nurse disliked giving injections because she felt insecure in one particular instance. This nurse gave a drug from which a patient could have had an anaphylactic reaction, and the nurse did not have any means at her disposal to protect the patient from such a reaction. She said:

Well, we have an asthmatic that we give injections to... anyway we were giving her vaccine. And it was against the agency's policy, that we give vaccine, or anything like that, but this was an exception, and we did do it. I felt very insecure about doing it. I had no way...of doing...about the child, if she had any reaction to it at all. We ordered a sort of nonspecific...if too big a reaction occurs...well, how can you define too big a reaction when you don't know about it? And, we had no adrenalin or anything like that. So really, I felt as though I was assuming too much responsibility...giving the shot.

In general the public health staff-nurse were aware of the pain which they caused with the hypodermic needle. From half of the
responses, the nurses indicated that this pain must be tolerated to help the patient gain treatment from medication. When a nurse can share with the patient, the tolerance of a necessary pain, she already displays an attitude for promoting independence.

Data relative to the satisfaction derived from the giving of injection is not outstanding. This may be because the nurse is instrumental in causing a certain amount of discomfort to the patient in order to be helpful.

Giving Instruction.--In giving health instructions as part of the nursing care of patients with long-term illness, about one-half of the respondents appeared to receive satisfaction when they felt accepted by the patient. One respondent gave the following example:

Like a diabetic . . . you give them some ideas and things and they're not carried out and really it's a challenge to see if what you've told them a few days ago has been carried out. I think it's a challenge and I do enjoy it... I don't know.

A cooperative and willing patient was another example:

I think it's nice; I like to do it, if the person is cooperative and willing to...absorb all the teaching that they can, that is, if they're willing to carry on in between and of course, if you get a member of the family that is willing to do it, and cooperative, and anxious to give the care in between...it's quite satisfying.

A patient's acceptance of the nurse and her instruction was another illustration:

Instructions . . . it depends on the patient. I have to have the patient accepting me first before I can give instructions with...any...meaning to it...and how well she accepts the suggestions too. Many times...I feel it's the way that you propose them.
One-fifth of the respondents gained satisfaction when both nurse and patient shared in the work. In one instance, a nurse saw this as facilitating her own work as well as meeting patient needs:

Well, after I fix them up and I'm going to take care of them over a long period of time, I like to instruct the patients and the ones who are going to take care of them on how to keep them comfortable in between my visits...and it makes it easier for me too...setup a bedroom or whatever room they're going to live in and...keep them comfortable and discuss their needs.

Another nurse liked giving instruction when it increased the patient's self-sufficiency:

There are so many things that aren't told to these people when they leave the hospital, as far as instructions and care, just simple little things that they can understand, and of course, it makes a difference...so much difference to the patient, if you just...try to help them along. I like to feel complete about my visit...Like a 'CVA'[cerebral vascular accident]...I feel you should instruct the patients on how to care for these people, between your visits and eventually get the patient so they know their conditions better than anyone else, so that perhaps maybe later on, their only medical need, would be their own immediate doctor. I think you should consider...from head to toe...regardless of what their diagnosis including of course their mental...their hobbies...and their outlook. It may take a longer time per visit, but it'll make it a lot easier for the patient if you, I mean, if you should consider him as a whole, not as a part.

Over half the respondents disliked giving instructions in situations which created, in them, a feeling of uselessness, such as, when a patient was not receptive of and did not intend to carry through the instructions given. An example of this kind of situation is reported as follows:

If you get someone, as you very often do, and you know that you're boring them...and you just don't care, and it seems like almost a waste of time to do things, like sometimes something will sink in, you'll be surprised that they'll do it, but often times you have the feeling that they just
wished that you would go along and not bother them.

The basis for a nurses' dislike for giving health instruction appeared to be due to a feeling of frustration, i.e., impatience when a patient did not learn quickly:

Well...I don't know...if they don't catch on after I've explained to them a number of times, I mean, I try not to be impatient, I don't think I am, but, if they don't seem to catch on, you know after, I think I've explained it enough times, I find myself getting impatient with them.

One nurse felt rejected and then guilty when a patient was unreceptive to her instruction:

Perhaps if I went into a home and found that patients...unreceptive or perhaps they didn't care, but it's not for us to feel that way...We should try, no matter how long it takes...to see with these people because there might be a reason why they act unreceptive about your instructions and...even though we feel a little bit discouraged, after all, I mean they are people that need us.

In general, what nurses liked or disliked in the immediate situation played a more determinant role when giving instructions than in a long range goal of promoting independence. Two responses in which the nurses emphasized patient's need for self-sufficiency showed the greatest possibility for promoting independence. When a nurse accepted the patient only on the basis of his cooperativeness, she showed that she had not accepted patients unconditionally. About one-half the respondents tended to emphasize the patient's acceptance or non-acceptance of her as a nurse. When a nurse can accept a patient on the basis of his own needs and not for the patient's degree of cooperativeness or acceptance of her as a nurse, then a nurse can
be said to have an attitude necessary to promote independence. Only about one-fifth of the sample accepted patients on the basis of their needs.

Certainly a problem is created when an uncooperative patient calls forth feelings of frustration or anxiety within the nurse because she feels the patient is non-accepting of her. These feelings of the nurse can get in the way of dealing with the actual needs of the patient. Under these circumstances a nurse is unable to promote independence.

**Massage And Exercise.**--Five nurses, or almost one-half of the sample, indicated that they received satisfaction when they gave massage and exercise to patients. Three liked this task because they could see improvement in patients:

I just enjoy seeing someone getting better, and of course, there's no..this physio-therapy is really a very important thing..even in CVA [cerebral vascular accident]. I have a lot of faith in exercise and physio-therapy, even though the progress is slow; it is for sure!

One liked this task because she knew that the patient received comfort and relief from pain:

It makes a patient feel..get better..patient gets comfort from it. The same as in the arthritic condition or rheumatic condition or strained condition where we apply heat or liniment which I suppose is the..combination of the heat and massage that gives relief, and by massaging of course, you feel that you are giving them relief.

Another nurse felt that the patient was disinterested in himself because he didn't promote his own exercises:

It's a man who..had a shock, and will not do the exercises for himself..and to my way of thinking..to go in twice a week and do the exercises for him
doesn't help him in the least when he doesn't do them every day himself, or twice a day himself, and so...more or less it seems like a waste of my time, to go in and do it. Whenever you go in, he says to you, 'Well, I know I should have done it, but I didn't.' In other words, he has no interest in doing it himself, and so I just feel that it might be a waste of my time to be going in to do it...

Two nurses gave nurse-centered reasons for their dislike of giving massage and exercise when they were tired:

Only if I have a backache... I know there have been days when I...walking in the district...snow knee-high and thinking of going to the other side of town to do P. T. I wasn't too happy going, but I got there. I mean, I think with all those things it's how you feel that day..

One disliked this task when she felt insecure because of her inadequate knowledge about massage and exercise:

I gave it [massage and exercise] to a paraplegic, and he also had a physical therapist who came in every day. She showed me exactly what she wanted done. But for the first couple of weeks, I didn't enjoy doing it, after that it just became routine and I'd ask her, you know, if she was getting what she wanted. But massage...didn't feel that I knew that much about.

Two indicated their dislike because they were unable to see patient progress:

No, because I think it's...with massage and exercise, you can never see any difference in the patient. You might, maybe, over a...a number of years, but as far as I'm concerned, you go in and you do the same thing over and over again...and never see any difference in the patient.

One of these went so far as to express a lack of confidence in this treatment due to the slow patient progress:

No, I guess that's the one thing...I don't mind but I don't care for it. Well again, I don't seem to feel that I am getting anywhere; I don't have very much
faith in it myself. I expect that's why; well, you know?...

In general, there was a greater degree of dissatisfaction expressed about performing massage and exercise than about giving baths. This may be due to the fact that the nurses could not see what had been accomplished by the massage and exercise as they could by giving a bath. The results of long-range goals especially associated with an exercise program seem to make it difficult for the nurse to have a positive attitude for promoting independence.

Promoting independence implies recognizing the patients' need for exercise and massage and pointing out progress to the patient so that he can see this for himself. Almost one-half the sample indicated personal satisfaction in giving massage and exercise from knowing ultimately what this meant to the patient rather than from identifying progress for the patient. Here tendencies for promoting independence were present. However, the nurse missed the opportunity to gain satisfaction from identifying progress for and with the patient.

More than half the sample derived no satisfaction when a patient did not improve immediately or could not be seen by the nurse as improving. The nurse in this situation was unable to see patient needs. In this way she indicated that her basic attitude was not one of promoting independence. Furthermore, when a nurse stated a lack of confidence in the treatment because of the little immediate satisfaction she gained, she showed a lack of concern for patient needs and an attitude which could not possibly promote independence.

Problems occur when a patient is so dependent on the nurse for
exercise that he is unable to do them when the nurse is not present. The problem increases when a nurse interprets this behavior as the patient's disinterest in himself without considering possible depression due to the disability. A nurse also has a problem when she is not adequately prepared to perform massage and exercise and does not receive the consultative help she recognizes she needs.

**Application of Dressings.**--Over one-half of the sample liked to apply dressings. One nurse received satisfaction because she could make the patient more comfortable. She said:

> Yesterday I saw a patient. She had been in the hospital and she had a radical mastectomy...she came home on Sunday. 'Course there was nobody to give her any care on Sunday, and the call was supposed to have been put in early yesterday morning, and it hadn't been, and I didn't get it until late in the afternoon; the family had neglected to do it. Well, she was just soaked, her night clothes, her bed linen and her dressing right through the binding...was just soaked...with this...sort of a bloody serum; and she was very uncomfortable. Well, just to get her cleaned up, and washed up, and get a nice fresh dressing on her, change her night clothes and bed linen and all that, just to have her tell you that she felt so much better...that...makes you like to do those things.

Two nurses liked to talk to the patient while attending to the change of dressing; "Usually the patient is not quite as sick; he's more talkative, and I just enjoy it more than anything." One nurse liked this skill because she liked the technique for itself:

> Having had experience in the operating room, you know, surgical nurse, I take a great deal of interest in post-operative patients, I don't know, it makes me feel like I'm back in the hospital again, maybe...breaks the...maybe I shouldn't say this, but sort of the monotony of a chronic...you know? ... When you're the only nurse going in there, it isn't like in a hospital, you don't have anybody that's going to take your
place on the three to eleven shift. I think you take
more responsibility . . . you really feel . . . this had
got to heal . . . it's like a challenge, almost. You
just make sure every thing is done just right, until
you come back the next day . . . but that's the way I feel.

Another nurse also liked applying dressings because she liked to see
patients neat and clean:

Well, I enjoy seeing things clean and neat; and I
think there's nothing worse than going in to see a
patient with dressing or even a wound open and not
clean. It just gives you a nice feeling to go in and
clean something up; a nice clean dressing on it.
You feel you made him more comfortable and they
also look better.

Another liked the opportunity which a change of dressing provided for
a check on the possibility of any complication:

Mostly because it makes the patient more comfortable
and you can check and see if there are any complications
at the time. We had a case recently where the woman
seemed to be coming along very well her drainage and all.
Well, it was a pus pocket. It had backed up and maybe if
you had not been going in something more seriou's would
have happened . . . But the doctor opened it up right away
and she's fine now.

About one-third of the sample disliked certain conditions of
patients which resulted in "messy" dressings as in the case of a
patient with an amputation:

I'm not always keen on amputation dressings, but I mean
they have to be done so I do them . . . Oh, such a mess, you
know? If the patients are restless and then you come in to
them . . . I can think of one patient I had . . . and oh boy . . . try to
keep that dressing on . . . I've had to do more improvising and . . .
instruct his wife, and instruct the patient, so that it would
stay in place.

Another condition which a nurse disliked was a dressing for a patient
with a colostomy:
Oh, depending on the dressing, I think. I can't say I'm crazy about colostomies... I think they're kind of messy and you can get them all cleaned up just about ready to put the final piece of tape on, and they're gone again.

About one-third of the sample gave a "don't mind" response which conveyed a lack of feeling and/or a confusion of feeling:

I don't dislike it... and I'm not thrilled, I mean, well, I enjoy seeing how the incision is coming along. If you mean that I enjoy it, it's not one of those things I could get crazy about, I don't dislike it; I'd just as soon do a dressing as anything else. I never thought of it... well, that's something that you do; I don't think I have feelings one way or the other. I don't mind it.

I could say not particularly. I don't know if I have any. I can't think of why I don't like them. No, I wouldn't say I disliked it, I just you know, I'm not crazy about it either way. As I say, I do them, but I don't care for them particularly. I don't know why though, I couldn't give you a reason.

Another third of the sample did not respond.

Generally, the nurses' responses indicated concern with cleanliness and preventing the messiness of a dressing. They felt that a patient who had dressings changed seemed more talkative and less of a chronic patient. On one occasion a nurse considered her own like for this technique, thus minimizing the patient as an individual. None of these descriptions indicate a tendency for promoting independence.

According to these data, the nurses did not verbalize their recognition of the meaning to the patient of the loss of body parts or functions and its accompanying feelings of disfigurement and inferiority. This recognition is really of grave importance if independence is to be promoted. This lack of recognition was further highlighted by the "don't mind" responses from one-third of the sample, and by the "no response" from another third of the sample. The magnitude of this
to nursing lies in the total absence of the nurses' recognition of the
factor of "loss."

Administering Enemas.--Over one-half of the sample did not like
the unpleasantness of the enema procedure and considered this task only
as a necessity. The following expression of a nurse is an illustration
of how several felt: "I don't think anybody gets a thrill out of giving
an enema...just something you do because the patient needs it."

Nurses recalled some disagreeable factors associated in the
giving of enemas. One difficult situation which a nurse described was
with a patient who was fecally impacted. She said, "When I have to do
it and...like with some of them, they're so impacted, and you have so
much trouble, I don't enjoy them." Another situation was reported this
way:

Only reason I can think of is when you get into complications
and you give two, three and four [enemas] and you don't get
results. You may have results and you may have it probably
all over the bed and everything else. That's about it.

Patients who appeared resentful or embarrassed also made it
difficult for the nurse:

I think that in many cases they're [enemas] more embarrassing
to the patient...the...well, I think some of the patients resent the
idea that somebody is doing something to them...or...what...
I don't know.

One nurse found the procedure disagreeable when a patient requested this
treatment for reasons not apparent to the nurse:

Sometimes, well most often would be...aged...they seem to
worry about their bowels for no reason at all. And they just
have to have an enema, or the day's not complete. And, in
this case, I don't care about giving them. It's just a waste of
time; I don't feel that they really need them.
Negative family attitudes intensified the dislike for this task. The following illustration showed the family attitudes but it also showed a concept which the nurse held about patients with long-term illness; that chronic people are bowel conscious:

I'll have to be very truthful; I can't say that I love it, no. I think that they're a very important treatment, and most of these conditions I do feel that they're necessary ... I mean, these people, these chronic people, they become very bowel conscious; they don't have much else to think about except their condition, and of course, the nurse coming in, it has to be a job for the nurse; most of the relatives find this a very unpleasant task. ... we have members of families who refuse to give patients laxatives only because they don't want to have to take care of this end of it. so they sort of leave that for the nurse, and I don't think people, lay people really...they don't consider it as important as it should be; I mean, it's really their problem, I mean, we should go in and try to rehabilitate their bowels, as well as their bodies and minds, I mean it's just as important, but they sort of want to ... put it in the back of their mind...you know.

About a third of the sample liked the procedure on the basis that it helped the patient:

I suppose it's the same thing again, that...a person has to have an enema, they're so anxious...that is, a person, that really wants it, and is so anxious to get it, that they get relief from it, and get results from it, and in turn, that is satisfying to you. I think it all goes into our work; all these things you have to like to do, if you didn't like to do them, you wouldn't do them, you wouldn't take up this line of work.

One expressed satisfaction for a successful treatment which brought results. "With enemas, when I get results, I enjoy doing them...then I don't mind doing it ... if I get results."

A little less than half the sample did not respond.

The word "like" in this question provoked five protests from nurses because they felt that the use of this word was not appropriate. Perhaps a little different protest was that "you have to like to do all
these things." An opposite sentiment was "no one actually does (like)."

These data, relative to the administration of enemas, did not demonstrate that these nurses had an attitude for promoting independence. The nurses did not indicate that loss of bowel function is a physical disability. One-half of the sample who responded, were concerned with the unpleasantness of the task and with the apparently unreasonable demands of the patients. Data indicated that there was a lack of recognition of the loss of bowel function and its emotional components. These data also did not indicate whether or not the respondents knew how to deal adequately with the loss of bowel function.

**Crutch-walking.** --About one-third of the sample liked to teach crutch-walking and gave several reasons. Two nurses felt that patients were getting well, i.e. walking again:

It's sort of feeling that somebody is getting better . . . Just knowing that they're getting up from bed encourages the entire situation . . . and it does a lot for the patient to think that they're going to walk again . . . no matter how poorly . . . their crutch-walking is.

One nurse found that she could use her knowledge and felt happy over patient improvement:

Yes, especially since there was a rehabilitation course I took . . . we were taught proper crutch-walking. If the patients get to the stage where they're crutch-walking, I feel they're improving, and I'm just happy for them. If I can get the patient out of bed and start them crutch-walking, well, that's good!"

Another saw this task as a "challenge" to her:

I think in something like crutch-walking again it's a challenge to get the patient to do it right, and to do it so they're not going to hurt themselves, because there are quite a few patients that have shoulder trouble, trouble from using crutches incorrectly.
Almost one-half the sample did not like to teach crutch-walking.

Two were afraid that patients would fall and hurt themselves:

I think that you have to be real careful, so they'll do it right, and nothing happens to them while they're using the crutches...because they're very apt to, if they're inexperienced at crutch-walking until they get adjusted and get used to it. There's the danger and possibility of their falling, so you have to be real careful...sometimes you're fearful, or fear that you're doing it right when you're helping them, giving them the help that they really need, that they really should be having.

Two more nurses felt insecure in their ability to teach crutch-walking:

The only reason is that I myself, I think I'm a little bit insecure and what we have has come from training here in physical therapy and crutch-walking, but it hasn't been over an extended period of time yet. We feel that we've the more technical things of giving injections during the dressing, bed baths. Crutch-walking has been part of the hospital training, but that's one of the things which I don't think any hospital gives you enough of. I know we didn't get it and I think the girls here, all from different hospitals, get too much of it, anyway so I feel a little bit insecure...and teaching anybody about it.

And one felt useless when she could not see that patients made progress:

I don't know...if we get into a little physical therapy, I don't seem to have the feeling that I'm accomplishing too much with them.

Three nurses considered crutch-walking as a sign that patients were gaining more functional ability. This illustrates an attitude toward promoting independence. However, none verbalized the meaning of the loss of walking function to a patient. Two nurses assumed that patients would walk again. Among three other nurses, each was concerned about her individual problem associated with the task, i.e., fear of falling, inadequate knowledge and inability to see the progress of the patient. These data indicate that unrealistic
assumptions about walking again, and the problems associated with
the task itself tended to obscure, for the nurse, the importance of
considering the meaning of loss of function to the patient who needs to
walk on crutches.

These data indicate, however, areas in which these public health
nurses might need help: (1) increasing knowledge of crutch-walking,
(2) learning to measure patient progress, (3) understanding fears of
falling both in herself and in the patient and (4) relating this understand-
ing to patient progress. If the nurses had a better understanding of
the factors that promoted "dislike" responses, then they might be
more free to like what they are doing and to convey a more positive
attitude to the patient.

**Catheter Irrigation.** Almost one-half of the sample liked to do
catheter irrigation because of certain effects of this treatment on the
patient. Four nurses felt patients were kept "in condition." A typical
expression for this group is as follows:

Well, I have a patient now that has a catheter; she's had it
for six years, she's...well...and an elderly woman, ninety-
eight years old...and she had a fractured hip...and
she's had it [a Foley catheter] in for six years, and we
irrigate it every day. And we really have never had any
trouble with her...and...I think that we keep it in condition
by irrigating it and we insert it, that is, we change it once
a week, and we've really never had any difficulty with it, and
I think...when you go along without any interruptions, or
trouble or any difficulties, that...you just like to do it to
keep them in condition. (Trouble?) Well, like when they
become blocked...and sometimes a person may become
irritated, probably, from it...but we...with this individual,
this patient that I was speaking of, we've never had any
trouble, and...so that really, you like to do it to keep it in
condition.

One nurse saw this treatment in relation to the patient's temporary loss
of bladder function:

If they're on a catheter temporarily . . . you probably irrigated their bladders . . . and you can see an improvement. It's a therapy that's actually a healing therapy. Although I will say, that most of these chronic patients that do go on a catheter . . . it's sort of a . . . well, it's kind of . . . depressing . . . I think, myself . . . because, when a person who's controlled his bladder . . . I think it's a very discouraging thing for a patient . . . I'd like to . . . I'd rather spend extra time to encourage the voiding and . . . pushing fluids . . . I would like them to hold on to . . . those functions as long as they can, you know? I just hate to think, 'Oh, put 'em on a catheter.' attitude, that seems so . . . well, as if you're giving up hope, . . . and I think patients are very depressed when they're on catheters, I think that if they have terrible bed sores, of course, you can explain to them that it's a temporary thing, until it heals. I mean you have a reason for it them. But . . . just because they're old, and incontinent, and things of that sort . . .

Over one-half of the nurses expressed dislike for this task. One nurse did not like this technique but she saw it as a "necessity" which she "did not care about." However, this was accompanied with feelings of guilt . . . "If you took all the things you didn't like, then you wouldn't be doing nursing:"

Well, that's another necessity . . . I don't care about it. Of course, if you took away all these things, then you would . . . if you didn't . . . if you took away all the things you didn't like then you wouldn't be doing nursing . . . I don't know what you'd be doing. I suppose it's just a necessary thing that you do with out thinking, I don't think . . . really . . . about it one way or another.

Another was fearful that she might be the cause of an infection:

Dislike it? I can't tell, the only time I think I might dislike it is if the return showed that the patient had an infection or something, and I . . . wondered if it were because of my technique.

Two nurses, about one-fifth of the sample, neither liked nor disliked, but "didn't mind" the task. Answers in this category were
vague and conveyed a feeling of not having thought through this question:

I don't know, I hadn't thought about it. Oh, I guess
if the patient...it's the same thing, something you do...
I think that makes a big difference, how much benefit the
patient is going to get. If the patient is going to be comfortable
then you do it. I have no...dislike for...

Another stated that "this line of questioning was "hard." "This strikes
me odd, the question in that one:"

In general, nurses considered the physical comfort of the patient
when she liked or disliked this task. One felt guilty about saying that
she did not like to do catheter irrigations. About one-fifth of the
sample gave vague responses. For these the basic attitude for pro-
moting independence was not evident.

However, one nurse's approach promoted independence when
she saw this treatment in relation to the patient's temporary loss of
bladder function. Out of the recognition of the patient's loss, the
nurse was able to see the need for explanation of procedure and a need
to relate to the patient how this treatment would help him.

Data indicate that nurses apparently need a better understanding
of the meaning of loss of bladder function to a person. This understand-
ing would promote a more effective program for patients' independence.
Nurses need help in dealing with guilt about their own negative feelings
toward a task so that they are not blocked from seeing the patient as a
person. The nurse needs help in thinking through such question as
what the catheter irrigation of the bladder means to herself as well as to
the patient.
Response to Pictures

Bath. —Almost three-fourths of the sample liked to give baths because this task met the patient's and the nurse's own immediate needs. One way in which the nurses were satisfied was to bring satisfaction to the patient:

Projected Remarks
I'm glad it's making you feel more comfortable. Is the water warm enough; and are you warm enough?

Reasons for Remarks
Well, first of all she wanted the patient to know that she was concerned that the patient was enjoying her bath, and also that she was interested in keeping her comfortable by the temperature of the water and of her own temperature.

Another was to project the nurse's own pleasure of what a bath felt like to herself:

Well, agree with her . . . everybody enjoys them.

... it feels good when I take a bath. I was thinking of the hot weather mostly. And it does refresh you, usually.

Another way was to comfort her patient by a bath:

Well, she'll probably tell her how happy she was that the patient liked being washed, and she liked to keep her comfortable and washed.

I know that patients still like to have a . . . get washed, and even if you don't have a . . . sometimes when I do the dressings or something like . . . but they all seem to . . . be comforted by it . . . and they . . . clean and comfortable, and if you're ill it's really a blessing.

To feel that the nurse had "accomplished" was another way of expressing her enjoyment of meeting needs:
### Projected Remarks

Well, I'm glad we are making you more comfortable.

### Reasons for Remarks

Well, you are very pleased that the patient does appreciate your care... that's one thing... you think well, I am accomplishing something.

Another approach was to meet the nurse's concept of cleanliness as it related to a "good" bath:

Well, especially in the summer time, I suppose you would say, it must feel good to... be cooled off, to be washed... and fresh sheets put on the bed, and make yourself feel a little more comfortable... or if the patient is particularly messy... you know, you're sure that it must make them feel better to be cleaned up.

Giving them a bath should help to relax them, it should help to make them sleep better... and if they sleep after they have the bath, it's a good sign that it was a good bath.

One exceptional response with regard to promoting independence was a felt need to evaluate the family's ability to assume responsibility for giving the bath. However, this response was not a projection but a rationalization:

I think that she should have told the patient that even though it felt good, it was good for her to be washed, in helping her circulation and general condition. Perhaps she did, I don't know. I mean, she should have encouraged her to do it herself... some herself, or some member of the family, depending on the extent of the woman's disability. I don't know how sick she was here, telling her she'd feel just as good if she sponged herself a bit if she was able to, or there may have been another member of the family she
Projected Remarks

Reasons for Remarks
could have used this type of encouragement, too.

One did not respond because she was unable to.

In general the nurses gained the greatest satisfaction in giving a bath from meeting immediate needs of both herself and the patient. They imposed their feelings of pleasure, comfort, accomplishment and cleanliness on the task. These findings continue to support the high degree of satisfaction that a nurse receives in giving a bed bath. Nurses did not appeal, except for one in the sample, to the individual's ability to provide his own comfort from a bath. Apparently this high degree of satisfaction for the nurse obscures the long-range goal of promoting independence in patients.

A problem for the nurse is to learn to distinguish these immediate needs and to replace them with the satisfaction of seeing the patient assume responsibility for his or her own bath, however small this participation may be. In this way the nurse may be able to incorporate the long-range goal of promoting independence.

Hypodermic Injection. -- The nurses' response to this picture showed how they handled the problem of causing pain. Two-fifths of the sample denied pain to the patient upon giving injection. One denied it by the rationalization of not wanting the patient to become "anxious:"

Well, you will feel pin-prick. If you don't think about it, it won't be too bad.

It does definitely hurt some, but you don't want them to get anxious.

Another denied it also by either telling the patient not to think about it
or by saying "I'm sure it isn't going to hurt."—a kind of magic.

**Projected remarks**

Don't think of it and you won't feel it at all. Well, would you like that I wait a few minutes before I give it or would you rather be in a different position? And she'll say, 'No, you'd better give it and get it over with.'

Oh, I'm sure it isn't going to hurt. (giggle)

**Reasons for remarks**

That you're more afraid of the needle itself, of the idea of getting the needle, that the actual injection, and that if it hurts a little bit, most of the time it's usually the medicine going in, that gives that burning sensation, but that the needle itself won't hurt you at all, especially in that the hypodermic needle is so small, sometimes, you know, I show it to them and tell them that it's such a tiny little thing, that it couldn't possibly hurt them.

A little more than half the sample admitted causing pain upon giving injections and felt that patients could tolerate the pain for a therapeutic value. They felt quite strongly about telling the patient that they were to cause pain:

**Well, yes, it probably will hurt a little, but... I'll try to be as careful... you know, and do it as painlessly as I can.**

I don't think that anybody is so perfect that they can say I'm not going to hurt you... I mean you should not lie... Naturally if I had a needle myself, it would hurt me; in fact I'd run a mile before I'd take one... but I mean... I think that if you say, 'Yes, it will a little.' then it won't hurt quite so much, but if you say, 'No it won't.' they're going to think that little hurt is a big hurt.
Projected Remarks

If I say that it will, that will prevent it.

That's what they all say.

Reasons for Remarks

Well, you shouldn't deny that...that it's going to hurt. I think you should tell the truth about it...Well, just let her know it's nothing that's going to last. It'll be short..hurt..prick..I think that's the common word.

I wouldn't fool them. I don't think any nurse should try. I think they are far more willing to accept the sting they get from a needle once in a while.

In both denying or admitting the pain each nurse made an effort to minimize the pain by her choice of words, i.e., "It would hurt for just a minute:"

Well, it'll hurt for just a minute, it might hurt for just a minute, but I'll try and be as careful as I can so it won't hurt any more than it has to...and the results that you get from it will overcome any little hurt that you might get.

Well, I suppose...she knew she had to give it; I suppose she tried to make it as pleasant a talk as she could. She knew it had to be given...so, she wanted to make it as, well, with as little pain as she could.

Another example of minimizing the pain was that it would be a "little prick:"

Just for a minute, then it'll be all over.

Naturally you aren't going to say it isn't going to hurt one bit when you know there will be a little prick, and it hurts to a...I don't know...what kind the injection is, SC or IM, or whatever it is, but you really shouldn't tell a patient that it isn't going to hurt, when there's a certain degree of sensation.

Other words of imagery as "needle is such a tiny little thing," "short hurt prick," "little pain" were given to make the pain minimal:
Injections seemed to hurt the nurses as much as it did the patient. Two could not project a response, but made comments about pain and how to prevent it.

Apparently pain is very distressing to the nurse when she is responsible for it as shown by both her denial and her effort to be honest with the patient about the pain and also by her unconscious selection of words which minimized the pain to herself.

Over one-half the sample displayed an ability to share the patient's feeling of pain by honestly admitting that she would hurt the patient when she gave the injection. An ability to share a patient's feeling is part of an attitude basic for promoting independence. In this theoretical framework, denial of pain is not an attitude which would promote independence. An understanding of what the pain of injection means to both nurse and patient may help to clarify the true picture of the patient's fears more realistically and effectively.

Helping a Patient out of Bed. -- Responses to this picture showed how the nurses dealt with the patient's dependent feelings which accompany a physical disability. A little over half of the sample recognized the dependent feelings this patient had. Following the recognition, the nurses handled these dependent feelings in two ways; one-fourth reacted to these feelings personally, and another one-fourth helped the patient to see how much she had already accomplished for herself. One nurse's personal reaction was simply to see that the patient was "willing."
Project Remarks

We want to help you; we're glad to help you; and we want to help you get on your feet... want to help you... want you to help yourself to do as much as you can.

Another way to tell the patient that she, the nurse, would not be here all the time, implying that the patient could not depend on her:

I won't be here all the time to help you. It's... it may not be so easy to do it for yourself, but it would be better for your own good.

In helping the patient to understand how much she had accomplished the nurse pointed out how the patient was actually helping herself out of bed:

Look how well you're helping yourself.

Well, I'm really not helping you, you're really doing this yourself.

Another way was to make statements that indicated expected success of a patient's activity and to be present when he practiced as in the following illustration:

Sam, come on, let's get up now, hold tight... Naturally you're not going to let the patient feel insecure because if she is just getting up and learning to walk; and she's unsteady; why that would be an awful thing!
<table>
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<tr>
<th>Projected Remarks</th>
<th>Reasons for Remarks</th>
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<tbody>
<tr>
<td>So, you try to reassure the patient, and let them know that you're happy you can be there to hold on to them, and teach them how to get up properly and get on their feet.</td>
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To promote independence in helping the patient out of bed, it is necessary to appeal to the individual to make his own effort, thus emphasizing the patient's strength and minimizing his dependent feelings without denying them altogether. When a nurse identified, for the patient, his positive actions, praised them, or assumed that self action was expected of the patient, a nurse was appealing to the patient to make his own effort. She was promoting independence.

One-fourth of the sample fitted into this category.

When a nurse reacted personally to these dependent feelings, she magnified the dependent feelings of the patient. Such reactions tended to reinforce negative responses in the patient, increased helplessness or overcompensation. Promotion of independence is minimized. About one-fifth of the sample reacted this way.

One nurse saw the patient as willing and in this way recognized the patient's potential for growth. A basic attitude of promoting independence was demonstrated. At this point, however, this nurse needed her special skills and knowledge to help identify for the patient what he could do realistically.

A problem in nursing occurs when a nurse creates possible distortion of the patient's degree of ability with her feelings about the patient's dependency, i.e., she may not recognize the patient's dependent feelings.
upon her by saying, "I won't be here all the time to help you." This remark may create feelings of greater helplessness in the patient and encourage poorer performance. Another problem occurs when a nurse is not able to evaluate physical dependence realistically through the use of both her knowledge and specialists such as the physical therapist and the orthopedist. A greater problem is one of not recognizing dependent feelings in patients or in oneself. This may have been indicated when almost half of the sample did not respond to this picture.

Helping The Patient Exercise His Arm with A Pulley.---The responses to this picture indicated how the nurses accepted the patient's perception of his disability. The findings showed two general ways of accepting the patient's limitation. While a little more than half the sample encouraged the patient to do more than he felt he could do, one accepted the patient's limitations and encouraged different goals for the future.

A nurse would try to help the patient by using the word, *try*;
"keep trying," "try a little bit more." Examples of verbal encouragement for patients to do more than they think they can were:

<table>
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<tr>
<td>Just try a little bit.</td>
<td>She needed some encouragement as far as she went the day before... try a little bit more.</td>
</tr>
<tr>
<td>Well, let's do just a little bit more, let's see if you can't go a little farther, just a little bit farther today, probably tomorrow we can go a little bit</td>
<td>She wants to encourage the patient, she wants her to do as much as she can. In fact, you really have to put a little pressure on them sometimes, as much pressure as you know</td>
</tr>
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</table>
Projected Remarks
farther then today...
so we keep on trying and see
how much more you can do today, and then if you do a little
more today, then probably you can do a little more
tomorrow, just keep on trying.

Let's try a little more.

Reasons for Remarks
is good for the patient...a little pressure to do a little
bit more each time. It'll be quite a bit after awhile...they
might be a little bit fearful of doing too much, or they
might be fearful of getting hurt and they just don't want to do
anymore.

Another way the nurse helped was to suggest actual physical assistance
as well as verbal assistance:

Let me help her a little bit this time.

I think that the patient can see that it is going a lot higher
when you do it, but she is going to put a little more effort into
it herself.

In one instance, physical pain for the patient limited how much one
nurse did for a patient. In this example, the nurse asked the patient
to participate. She did not take the opportunity to listen to what the
patient said initially. "This is as far as my arm will go up!"

Well, right now, but let me help you just a little even though it hurts a little, the
minute it really hurts a little, I'll stop doing it. Every day it will improve a little bit
more.

One nurse expressed how difficult it was to accept the limited range
of movement of the arm, i.e., to maintain range in preference to in-
creasing range:
Projected Remarks

But if you continue with the exercises, by the end of the month perhaps we will have increased it a half inch or an inch and it's something we have to keep working with.

Reasons for Remarks

To encourage people to do as much as they can. It's hard for me to realize that limited range is the end, since I have never been afflicted with anything.

One nurse out of the total sample accepted what the patient was saying by her response, "good for the day." She also encouraged a different goal for the future by saying, "It'll go up a little tomorrow:"

That's very good. Very good. Very good for the day. It'll go up a little more tomorrow.

Actually this particular patient who has this attitude probably has some kind of mental block about her condition. She probably...I mean she's tired, no doubt, I mean she feels that's as high as her hand will go, and no doubt it will go further, because then you discourage them, you know? You should say, 'Well, that's very good.' and then you know, they'll say it's gone further, they can, if they can see their own improvement that's half the battle, you know? If only you can see it, well, it's up to them.

To promote independence the nurse must help the patient see what he is doing as a person. A nurse can help the patient feel like a person when she listens effectively, and in this way, appeals to his potential for change. One example showed how a nurse gave recognition to what the patient was saying by her response, "very good for the day." She explained how important it was for the patient not to feel discouraged by the way she the nurse, responded. Both her action and reason displayed an attitude for promoting independence.

About four-fifths of the sample showed attitudes which did not appear to be conducive to promoting independence. Nurse-centered
responses were more evident than patient-nurse-centered responses. Three were unclear as to how to respond.

These data indicated that nurses apparently need help in how to approach patients in a manner that encourages movement of limited joints by conveying an understanding of the fears and anxieties that naturally accompany efforts to increase range of motion. Nurses also need to know the limitation of normal range and to reassure patients by explanation. In addition, nurses need to learn that understanding and considering how patients may feel is the key to helping patients move toward self-help.

Helping A Child with Crutch-walking. The responses to this picture showed how nurses encouraged a child to crutch-walk. A little less than one-half of the sample indicated that they gave instruction in crutch-walking to give reassurance to the patient:

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<tr>
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<tr>
<td>Now steady . . . put the crutch forward</td>
<td>She's certainly going to give that fellow a chance; and he wants to get him going; so, naturally she'd reassure him that he's going to be able to use the crutches properly, and how to use the crutches properly, so he can get going.</td>
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<tr>
<td>Let's get your crutches under here in the right position; let's get your feet on the floor; put your right foot forward and see what we can do.</td>
<td>Because she wants him to make progress.</td>
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Different concepts of children were displayed in the nurses' perception of what the crutches meant to a boy child, as in being "disgusted" with
Projected Remarks

You're doing fine, John, just take it slow, and you certainly have improved a lot on your crutch-walking since the last time I was here; you're doing very well.

or that he "loves crutches and thinks it's fun;"

Well, you're doing very, very good; now be careful. Go very slow...haste makes waste...

Reasons for Remarks

Well, I think the child probably needs some encouragement, and he's probably disgusted with the crutches, and doesn't like them; and probably she feels that he needs encouragement.

Probably just like any one learning something he needs encouragement, and support, I mean, it shouldn't be anything that he's going to get marked for, I mean it should be... of course, with him you can make sort of a game out of it... little boys love crutches, they think it's kind of fun, you know?

Less than half of the nurses displayed an attitude for promoting independence. They asked the child to participate but they did not suggest they understood the significance of what the crutches might have really meant to this child. They tried to understand the feelings of dependence by the way they thought the child perceived the crutches. Evidence seems to show that these nurses did not deal with the real issue namely, that these crutches were a substitute for a normal function, walking.

It would seem that when nurses have limited experience in teaching crutch-walking, they also have less practical knowledge. Two nurses indicated a lack of experience in this area. Lack of experience in teaching crutch-walking may have accounted for the fact that half the respondents did not answer this question.
Ways of Approaching Problems

In this section nurses were asked how they solved certain problems in patient care which were relevant to promoting independence. These problems were as follows: self-help, anticipation of a hospital clinic or a doctor visit, acceptance of illness or an event of an illness, encouragement of activities between home visits from the nurse, transferring information of patients to nurses, doctors, and a representative of an institution.

Self-Help

The public health staff-nurses were asked how they entered into and shared feelings, interests and acts of patients to establish mutual accord when they taught self-help. Four nurses, or better than one-third of the sample "shared" by focusing on patient-centered needs. Three nurses, or less than one-third of the sample, "shared" by focusing on nurse-centered needs. Four nurses did not respond to this question.

In sharing tasks four nurses asked and waited for patient's readiness to initiate his own action. The nurse balanced what the patient could assume as his responsibility by gradually introducing new tasks. Introducing tasks in this manner meant doing for the patients what he could not do for himself until he was ready. A nurse's interest was displayed in how consistently she worked at this balance of activities. An illustration is shown in the nurse's task of helping a patient bathe himself:
Well, I just go at it gradually. This patient that I was talking about, my first patient, was a good example, because she really can do an awful lot for herself now. First of all, when I was giving her a bath, I guess I started out by handing her a face cloth and let her wash her hands and face. That was about all she could do at first, and then gradually she did a little more, and a little more, until now, she can give herself a complete bath. Just gradually, and I had her working at rubbing the creams on, and...you know, little things at a time.

Did she say anything to you when you gave her the wash cloth or did you say anything?

Well, I think she was kind of surprised. 'Do you think I can do it?'

What did you say?

'Sure.'

Another illustration which carries a different feeling tone is one in which a nurse helps through exercising a patient who had a hip injury. The feeling tone is one of "playing it by ear" or tending to do unconsciously:

Well, this P.T. case...I did the exercises...and I did them passively on both legs, when I first went in, and then...I let her do them herself, on the one, the right leg, which...was not affected, and I still did the left leg passively. And now, I've gotten to the point where I let her do them both actively first, and then I do the left leg, and then while that leg is resting, then she does the right leg, and then I let her try the left leg again...She has had a hip injury, and hip nailing...

I went in the next week, I said, 'Now, we'll try something new; let me see you try the left leg, first, then you can see the difference when I do them. Then you do them again.' And that's all there was to it. I think some of these things you tend to do unconsciously.

One other illustration of nurses sharing on the basis of felt patient need was one in which a nurse entered creatively into a patient's interest. This patient had impaired speech and impaired movements of his limbs from a cerebral vascular accident. This nurse helped his speech by encouraging him to read aloud news items which he liked.
She helped him with his limited movements by encouraging him to dance, an activity which he previously enjoyed. This nurse displays the use of many of her abilities:

Well, I have one man that I visit. He was a 'CVA.' I would say about three years ago he was bedridden with his condition. He is a very capable person, in fact, he has done remarkably well... I'll go to him once a week now; I give him a bath only because he lives alone, and I'm afraid he would forget himself... and of course, I make sure... like his clothes are changed, and his bed linen changed... Well, I'll walk in and I'll say... 'Hello, Louie,' and he'll immediately have to tell me what he's been doing all week, and... oh dear, I have to sit down and listen, and oh, he just wants someone to talk to and someone to say, 'Oh, that's wonderful attitude.' And he tells me that he's been exercising. He was really paralyzed in one arm. He can really swing that arm, and of course, I immediately make him shake hands. I'll hold my hand this way, and I'll say, 'All right, come on, Louie, up here.' He tries so hard to get it up there. I give him a little help; he doesn't know it, and then I tell him how wonderful he's doing, what a great job he's done with himself.' And, I spend about fifteen minutes elating him to the nth degree, and then he'll say, 'Do you really think so?' He really questions... and then oh, he feels so good, he really does. Of course, I make him... put on the music, used to be quite a dancer when he was young... and quite a singer. His speech was terribly impaired by the shock, and I used to make him read the newspaper to himself aloud, because he had no one to talk to, there was nobody there. He felt so embarrassed, and so... conspicuous... mumbling, and making mistakes in getting his words out, and people would become so impatient with him that he wouldn't try. He would do anything the nurse would tell him, so he was telling me, he read so many columns, and he read it. 'Don't you think I'm getting better?' And I'll say, 'Yes.' Of course, the fact that he's Italian makes it difficult for me to understand him so that I have to strain my ears to make sure I know every thing he's saying... and he did that and really and truly it did help him; it really did; he tried that much harder. And I make him put on the radio, and dance a little... 'Come on now, we'll do a little fox trot.' And he does. And I'd say, 'If you're going to sit and listen to the music, you might as well get up and...
do a few steps...see if you can get that leg exercised and get it improved, and so forth and he does. I perhaps go at it in a much different way than I should, but I like to keep it on a higher, spirited level as I can. I hate to think that I'm making a real, serious project out of this. If you make it a little gay for them, they kind of get a kick out of it as well. They don't consider it work.

Three nurses shared the patient tasks by focusing on their own needs. In this approach, the mutual relationship was lost even though the nurse felt a need to accomplish her own goals as she wanted with a patient. Her need to "accomplish" determined the way in which she perceived the patient's need. The differing factor was that the patient did not have an opportunity to participate in assessing her needs and the patient was not asked about what she wanted to do about them. The following is an illustration:

I have a very nice Russian lady. She's diabetic and she's had it for four or five years now... In her case even though she doesn't have enough sight to give it herself, she has her equipment ready, all boiled, does her own urine test, and is ready for us every morning. We accomplished that much with her... If you're too bossy with her, she doesn't like it at all. You have to use a little bit of psychology. I feel as though we've accomplished something lately because I convinced her that she should have her teeth removed. You have to sort of treat this woman as a little child. I didn't tell her she should go in, I just told her about the clinic. She's in out patient for her diabetes and for her eye and she's in the nerve clinic. They're quite familiar with her and I told her at the clinic in there that quite a few of the other patients out in the district have gone in there and were satisfied with the work that done and how they don't charge too much... One day she had a very bad toothache... This was a Saturday, and I then said to her, 'Why don't you go into the hospital Monday and just have them look at it and if they think they should have it removed, they'll ask and tell you if you want it removed.' And sure enough when I went down to visit her on Monday morning, there was a note on her door, saying that she had gone into the hospital to have her tooth out and her daughter had given
her insulin. Once she had started she really got along and she didn't need too much encouragement after that. But she's very happy now... She was glad I had told her about the clinic; that was all. Well, I just was glad that she had it and I kept telling her how nice she would look when she gets her new set of teeth. That's important to bring up because she is just a little bit vain, not too much...

Another nurse felt a need to have a patient do something for her. When she perceived patient needs this way she saw the patient as doing every little thing to help her:

Oh, they [chronic patients] are very willing to be taught... be taught to feed themselves...if they've had a hemiplegia, they are delighted to be taught, and they'll put their nightgown on for you or their pajama top and do every little thing they can trying to help me with the blankets when they can.

One nurse felt that she needed to have the patient trust her before she could begin a task.

Promotion of independence by sharing is based on how much a nurse is able to enter into the patient's feelings, interests and acts. Evidence indicates that the ways in which the nurse shared the tasks of self-help determined whether she did or did not promote independence. When the nurse provided an opportunity for a patient to evaluate his own ability and then decided what to do about it, she established not only a mutual accord with the patient, but also permitted the patient to experience his own strength. When the nurse dealt with the problem of meeting patient needs more than meeting her own needs she established mutual accord between herself and the patient. These data showed that when a nurse valued her needs more than the patient's needs, the nurse saw the patient, i.e., with the diabetic patient, as a "child" or a "vain" person. In another example,
the nurse saw the hemiplegic patient as one who liked to help her, not himself.

In general, when the nurses in this sample met their own needs, their technological skill was not affected but their perception of patient needs was influenced. The data do not show the problem of the patient who refuses to do what he can. It would seem from the findings that a patient-nurse task which has a higher value for the nurse than for the patient can mean a loss in therapeutic value.

Anticipation of A Hospital Clinic Or A Doctor Visit

The public health staff-nurses were asked how they supported the patient in three types of situation: when a patient anticipated a hospital clinic or doctor visit, when a patient received good news regarding his health, and when a patient received bad news regarding his health. Nurses were asked how they participated in easing the difficulties of the patient. Nearly all the nurses said they could not recall any experience with a patient receiving good or bad news about his health. Therefore no data will be reported about these situations.

Essentially, responses to these questions showed how the nurses in the sample handled the patient's anxiety. The data showed three approaches: one of dealing with the problem in a directive way and, another of dealing with the problem in a non-directive way and, the last by not dealing with the problem. One-third of the sample dealt with the problem in a directive way. One of the sample dealt with the problem in a non-directive way. Another one-third of the sample did not deal with the problem. A little less than a third of the sample did not respond.
When a nurse was directive in her approach, she told the patient what she felt must be considered or believed to be true according to her own observation. An example of this is a nurse who felt that self-respect for himself and his family was an important basis for insisting to a patient that he must return for a chest x-ray:

Well, I think perhaps the family that I speak of, the doctor didn't know that he had been in the tuberculosis hospital. I think that...because he felt that he was starting in life, and starting a family, and that if he had an x-ray, they might find some trouble...I told him I didn't think it was fair to himself, or to his wife, or to his family, that he was just starting a family and really just starting out in life, and that...today there is so much that can be done about it, that it really wasn't fair to himself, or to his family...

...Well, he...not too much response. And I don't think...he still wasn't convinced that he should go...

...I thought he wasn't fair to his family, and...that is, fair to his wife and children, and that, if he didn't...have regard for himself, why he should have of them; which I think is reason enough; if he didn't care for himself, he should care for his wife and family.

Another repeatedly encouraged the patient to make regular clinic visits, for foot care in spite of the patient's feeling that she the patient cared for her feet adequately:

Well, one instance; we have this little Russian lady again. She'll go to any clinic in the hospital except the foot clinic. I don't know why; I can't figure it out. She gets a paper telling her to go to such and such a date and she'll tear it up; she won't go. I don't know whether it's that she doesn't feel as though she needs it. She does take pretty good care of her feet, but I mean she's still like a wall; she won't go into that...

That is one that I haven't been able to handle. She won't go to the foot clinic...I've tried for a long time telling her they just want to examine her feet, maybe cut her toenails, but no..she doesn't want her toenails cut or anything.

Another gave examples of allaying fears of people whom she knew who had been in and out of the hospital:
I think when you're in this public health field where you do so much geriatrics, you run into that problem with older people an awful lot. For some reason they have a fear of and it's just it's the same with all of them. It's no one particular case, with a lot of the older people in the eightys and ninetys today you run into it they have a fear of going; they have an idea that once you go to a hospital you go to die, and nothing else. And you fight that with a lot of them. Many times you can use instances where the family of somebody has been in and out of the hospital, and give examples. That's about all you can do. Some respond well, others don't even hear you talk.

In dealing with a problem in a non-directive way, one nurse considered the patient's fears by dealing with each problem raised by the patient:

Well, the patient's ankles, you see, were swelling, had become edematous, and I asked him how he was feeling and he said, 'Good.' And he noticed that I had been looking at his legs; he was lying on the bed and we were waiting for the return of the irrigation, he said, 'My feet are a little swollen.' And I said, 'Yes, do you use salt in your diet?' And he said, 'No, I'm on a low-salt diet.' And I said, 'Do you drink a lot of liquids?' 'Oh, yes, I drink a lot of water. You know, the other nurse used to come in and give me a shot, but I got all over that I don't require that anymore.' And I said, 'Do you have a regular check with your doctor?' And he said, 'Oh, yes, I'll see him sometime.' I tried to get him to be more definite, and I said, 'Well, what does sometime mean?' And he said, 'Oh, when I get five dollars; it's a lot five dollars; just to go see a doctor; and all he says is, you're looking good, or everything's okay, and he doesn't actually do anything for you.' But I think perhaps he's apprehensive that he might have to have his mercuhydrin shots again.

In this illustration, both nurse and patient dealt together with the problem as it occurred to the patient. The nurse took the initiative by making openings for the patient to tell his problem. She asked questions to help the patient clarify for himself not only what was the problem, but also to find the possible solution for himself.

One-third of the sample used methods which did not directly involve the nurse with patient problems. They accomplished this in various ways. The following illustration shows how one nurse enlisted
the aid of a social worker in helping a patient to get to a doctor.

This illustration also shows that the nurse had many feelings of failure in reaching her own concept of the patient's goal—to examine the patient's breast for tumor:

I did one very underhanded thing, if you want to hear about that. It was a patient who was diabetic, who had a lump on her breast, and she had showed to me, and she had showed it to one of the doctors in the clinic, and the doctor had told her that if it grew... I can't remember how he put it, but anyhow, if it started to grow, that she should do something about it. That was the way he left it anyhow, so I wasn't very satisfied with that. Although I didn't do anything about it for a few months, I thought maybe well she kept going back to the diabetic clinic, that they would eventually...someone there would discover it, and someone there would try to do something about it. So when no one did, and I kept thinking about it and thinking about it, and every time I tried to approach her about it, she wouldn't let me look at it, and she wouldn't let me feel it, and...she was very...she was a funny kind of women to deal with, although I knew her. I carried her for along, long time, I knew her quite well, she seemed like the type of person that, once you crossed her, you could never go back to her again, if you know what I mean. Once you did something she didn't like, she would never accept you again, she wasn't a very forgiving person. So when nothing was done about his lump on her breast, I called the social worker, at the diabetic clinic, and I asked her that the next time that this doctor had stopped her in the hall and asked if they had looked at the patient's breast, if it had grown any larger. In other words I just used it in that way, so when the patient came to the clinic, the social worker told her about it in front of the doctor at the clinic, and then he looked at it, then they hospitalized her and removed the breast, finally.

One nurse used the patient's experience of intense pain to motivate him to seek help:

Yes...I had this patient who had a great fear of hospitals and the pain became so severe. She had an abscess in the intestine...not a colostomy...and it pain became so intense, while they had been trying to get her in for three days, that she just couldn't stand it any longer and she finally went in expecting that she would be dead within the week and now she is discharged and perfectly fine, but still has a fear of hospitals.

Another respondent employed activities to distract the patient from thinking about his arthritic condition. In distracting a patient from...
thinking about her arthritic condition the nurse showed not only how she
approached the patient, but also how pained she was over the patient’s
prognosis. This was evidenced by her protest over having to deal with
this problem:

Well, I have one patient...she was an arthritic and she had a chronic
...gall bladder...we were going in there for physio-therapy on her
arthritis, which was almost...impossible, I mean...she was so...
crippled with it...and she feared...it was a funny thing, she feared
hospitalization, because she felt that she would never recover,
which she never did, but...They need more to be withdrawn
from themselves than they need encouragement about their condi-
tion. They need a hobby, they need something else to think about.
I mean, you should really distract their thoughts. You know, read-
ing a book or seeing a happy program on TV...you can't tell these
people that have had arthritis for years that they're going to get
better. And you can't tell them...you can't encourage them
about a condition that they've already gone over that point, you
know? Especially if you're new in it, because their immediate
reaction is 'Well how would you know? You've never had it; I've
had it for thirty years.' And all this...so you can do more good
by distracting their thoughts than you can by trying to discuss their
condition with them.

A little over one-half the sample did not participate in the problem
of easing the patient's difficulty. In directive methods the nurses used
their own experiences and conviction to have the patient take action,
i.e., go to the clinic. One nurse used her own conviction that self
respect was "right" to convince a patient that he should go to a chest
clinic for x-ray. Another nurse used her own observations of patients
who had been hospitalized to allay fears of dying when hospitalized.
In using her own experiences rather than the patient's, the nurse un-
wittingly did away with the opportunity to permit the patient to partici-
pate in making a decision about himself. About one-third of the nurse
sample did not involve themselves and used other methods of dealing
with the problem. Lack of involvement does not promote independence.
One nurse showed an attitude for promoting independence by dealing with the patient's problem in a non-directive way. She eased the patient's difficulty, edematous feet, by participating in the following ways. She silently observed his problem. When the patient stated the problem, she accepted it. By using searching questions for possible causes, both the nurse and the patient looked for solutions. The nurse listened to what the patient felt was his difficulty. At the same time she would question the patient, asking for clarification, until the patient arrived at a reasonable solution.

These findings indicate that allowing the patient to cooperate with the nurse in dealing with a problem constitutes one aspect of giving support to the patient. Another is to be able to use the patient's experience as a basis for his own decision making.

Acceptance of Illness or An Event of An Illness

To discover how a nurse dealt with the real situation of a patient, she was asked, how she told a patient about his illness, or some event of his illness, especially when the patient did not accept it.

In dealing with this problem, these nurses approached the problem directly or indirectly. One of those who responded dealt with the problem directly. For example, a patient had a recurrent inflammation of a chronic osteomyelitis, a condition which the patient wanted to deny. For three consecutive days, the nurse pointed out to the patient the redness, swelling, increased heat and pain in spite of her denial. On the third day the patient asked the nurse's opinion at which time the nurse reinforced what the patient now felt to be a problem which needed
medical care:

I haven't had too much of that, except the same case of the osteo where apparently the osteo had travelled from the thigh down, in the knee joint; and they did an incision and drainage on it, and sent her back home, and it was healed up well on the outside and then one day I noticed the knee was swollen and when I got right down to the bandage over the incision, and took that off, she had a large red, swollen area. Now for two days she wouldn't accept the fact; she kept telling me that it was just a cold she had; and would not accept the fact that something else had started up again. And it took two or three days actually, before I could call a doctor. I explained the entire situation to her, these various symptoms of infection, and she could feel the heat, she could see the redness, but she has, well, it would be natural for a person like that, a fear of having to be admitted again to a hospital so therefore she will look for any other way out, so it would be... well, she could feel the redness... she would agree, but she would still think it was a cold, and we would wait one more day. But finally there, she had enough pain, and she finally broke down about the third day. The... day she had pain, she asked me again my opinion. I told her that she was letting herself in for more trouble, she just turned around and agreed with me.

One-half the sample dealt with this problem indirectly. They took care of it in ways which ultimately did not deal with the real patient situation. One nurse wished to talk about everything else but the illness:

Well, she's [arthritic patient] been in a wheel-chair for eight years, and what is most discouraging to her is that she had a physio-therapist, but whose services were very expensive, so that was discontinued. Then we go in there and all we really do is rub on... she had some kind of ointment, like Bengue;... she likes that... but it's only once a week, so when you're not there, the husband, he's an elderly man of eighty-five, rubs her shoulders, or her knees. But then, of course she's an avid reader, so she was reading all about this... miracle drugs for arthritics. She got the doctor to give her some type of a pill. But, she's allergic to it so that really took the sails right out of her, because she kept thinking that after she got the pill into her she'd be out of the wheel chair and walking, and greatly improved. And I think that's really too bad that she was allergic to it, because I don't think personally she'd ever have got up again, no, but she probably would have had more relief from pain.
Oh yes, we talk about everything... and anybody... and she's a great Republican, and we were always doing puzzles, and, in the 'Name the Town'... and recognize the pictures of the famous men and all... but it's fun while it lasts... sometimes she'd get stuck on somethings or other or I'd call her if I found out the name of a famous place or a person and that helps... she writes me notes all the time, to...

Another preferred to talk about cheerful subjects. In this particular situation the nurse's stress is clear when she says that this was "a strenous case" and when she describes how she felt each time she left this patient:

She [the patient] had symptoms of weakness and fainting, and she couldn't walk, it had gone to her bone, and her spine, and that, she wouldn't recognize; she... thought she had something else; some type of bone ailment. I forget the diagnosis... she didn't recognize, in fact... oh, my goodness gracious, she would... look to you, she'd say, 'what's the symptoms of this disease?' 'And now, 'Don't you think I'm putting on weight?' Or, 'Oh, I could walk.' Or see, 'I've done much better.' and that type of thing. And all the time you knew in your heart, that she didn't, and she couldn't. It was really a very strenous case... I never really got so involved with a patient before as I did in this particular case, and... of course, your heart goes out to these people, and sometimes you give more than you should. When you feel it, yourself, then you know that you're giving too much... But it was almost like one of your own; it was just like living there, after going in every day, so that I used to hope... that we could talk about cheerful things. If not for her, for myself... I used to feel... in fact when I used to leave, she used to say to me... After you leave, I really feel light.' I used to feel like saying, 'Well, after I leave, I really feel dead.' I mean, honestly, you practically give... your life, sometimes, I don't mean physical, but spiritual life to these people. She had more desire and will to live than anyone I've ever met in my life, and she grabbed on to everything, everything.

Two nurses hoped that the patient would not bring up the subject of illness. When the nurse was confronted with the real situation by the patient, she gave an indefinite answer or no answer as in the following illustration:

He [patient] was about fifty; he's very active man, and a well-to-do man; he owned a business here in... and it was some kind of a freak accident; I don't remember exactly what it was now, but
anyhow, he was paralyzed from the waist down, and he had the
physical therapist coming in every day, and a nurse come in
three times a week to assist him with his bath, and...he...never
seemed to realize...he always expected to be able to get up and
didn't notice it at all. You'd say, 'How do you feel?' and he'd
say, 'Oh, I feel wonderful. Don't you think I look good?'

In a way I hoped he wouldn't bring it up for discussion he had
his own private doctors and nurses, and...as a matter of fact,
I thought it was more their responsibility. I never offered him
any encouragement, you know...Like saying that he was looking
better or anything. I just sort of let it pass, or answered him with
some remark that gave no definite...

In one instance, the nurse assured the patient that she would be
"all right" and hoped that the patient would simply accept what she said:

Colostomy patients are very difficult to accept their own illness...very difficult and very depressed...and they are not too willing to
be taught at first...until you try to explain to them they are only
one of a great many others surrounding them that have the same
thing...and sometimes after a period of time they'll accept it, but
I don't think entirely. Some are wonderful about it,...they accept
it right away...others find it difficult. We try to go into detail and
explain that they will be perfectly all right; But I think that they
think that death will be meeting them within the next two or three
months. They look on that side of life. They think it's hopeless
...and it's very, very hard...to make them realize that they have
a very good future if they take care of themselves.

In another situation a nurse tried to encourage a patient by a
statement which had no basis for reality:

Well, I've known patients who would not accept their illness,
which would be the man with cerebral vascular accident. He
can't accept the fact that he's well handicapped to a certain
extent...Oh, I talk about it, because he will bring it up. Yes, he'll
bring it up, and...I always try to point out to him, that he's not
a burden to the family; that he can do the things that he doesn't
think he's capable of doing. Oh, yes, we discuss it, because
most of the time he brings it up, although we discuss lots of other
things...too.

Promotion of independence is assumed to mean imparting the
truth, i.e., that the nurse impart the actuality of the real situation of
illness or an event of illness in spite of patient's illness by pointing
out directly to the patient the recurrent inflammation of a chronic osteomyelitis. Although in the remaining six responses the nurses dealt with the illness itself, the nurses' feelings were that they hoped a patient would pick on a "cheerful subject" for conversation or that the patient "wouldn't bring up" the subject of his illness. One-fifth of the sample denied the presence of the patient's illness i.e., to a patient with colostomy a nurse said that he would be "perfectly all right," or to a patient with cerebral vascular accident the nurse said he was "not a burden to his family." The patients' logical demand may have been that they would like to learn to live with their illnesses. Stress for the patient occurs when nurses deny this demand by channeling the patients' activity and conversation away from what the patients may really want. Nurses do not promote independence with this approach.

Nurses have some unpleasant problems regarding long-term illness situation. In the terminal illness situation, a patient asked a nurse to tell her that she was better even though she was not. The patient wanted to live so much that the nurse felt torn between giving what the patient asked for, an unrealistic support about events of illness, or telling the patient what the nurse knew was true, that the disease process was fatal. Apparently the nurse supported what was true by her silence. It is questionable whether or not silence eases the patient's difficulty.

In a situation where a patient was permanently disabled, a nurse hoped that the patient would not ask her if he would walk again since she would be responsible for confronting him with his real situation.
In a situation were a patient's prognosis was uncertain the nurses sometimes made statements to encourage patients, that had no basis of reality. This is illustrated by the nurse who said she told a patient who had had a cerebral vascular accident that "he is not a burden to his family." These situations are as stressful to the nurse as they are to the patient. There were three unformulated responses and one nurse did not respond. The fact that some of the nurses could not formulate a response might indicate that this was the first time they had ever been asked to think about such problems.

Encouragement of Activities Between Visits from The Nurse

To discover how the nurse evaluated patients with trust, she was asked during the interview what she expected from patients when she had taught them certain tasks to be done when she was not present. About half of the sample showed that their trust in patients developed from tangible evidence. One of the respondents developed her trust without evidence. Four nurses, or one-third of the sample, did not respond.

Nurses developed trust through direct contact with patients and they based their trust on evidence about patient behavior observed during visits. In one case, a nurse saw that a diabetic patient could learn how to give insulin:

Well, consider an insulin patient...teaching him...the same as going on the first visit, and doing everything on the first visit, that is, the preparation, the equipment, the hypo and the needle, and all that, and then the insulin, and then giving the doses of insulin. And then the next day, probably have him boil up the hypo and the needle, and probably the next day get him to fill up the needle, get the dose ready, and work up that way, so that after three of four days, that he
was able to give them to himself. We wouldn't leave them, until he was able to give it himself, until we felt that he was able to give it himself. That is, that he prepared the right dose, and give it to himself properly, and we wouldn't leave him until we felt that he was giving it as we would give it, or as it should be given.

In another example, a nurse could see the patient's initiative and desire to achieve her goals:

Well, right now I have an eighty-six year old woman for whom we were called in about two months ago. She had broken her hip four years ago and was up and about with a walker. She had to start walking so she would like to have physical therapy. Well, I went to her the first day, very keen, good eyesight, she was just a little bit hard of hearing, not too much and I showed her the exercises the doctor had prescribed and was going in to her three times a week. I told her to do these exercises morning and night herself which she has told me and her son who lives upstairs in the apartment says she does them faithfully. it's just she has so much faith in these exercises since we started going that she does these twice a day and she walks a whole lot better now, and she's not walking without the walker but she's gradually and I know she does these exercises in between visits.

In another case, the nurse observed some events in the patient's family situation and drew conclusions from it. Evidence was much more conspicuous because the information from the family contradicted the nurse's observation of the patient:

Well, in her case mostly it's exercise keeping her limbs in motion and her family realize the importance of it, but I think they're lax. And so I've told her that they're too busy and they are, they're very busy a big family, and they check, too, but she is very forgetful, because of this CVA and so her daughter says she rarely does exercise on her own although she tells me she exercises every day. So I don't know whether the daughter just doesn't see her, or whether she forgets to do it...

Her mother has five children and it's very difficult for her to keep the house, and take care of the mother, but she's done a wonderful job. But I know that she isn't in the room all the time; she couldn't be. And when she is in there, she never sees her mother exercise, evidently, this is sort of taken for granted, but I do know whether she
did or did not, and I know that patient is forgetful, because every
time I tell her something, it's as if I told her for the first time.

In the following illustration the evidence is drawn not from a contradic-
tion but from the information of a family member. The nurse has not
considered her observation of the patient in the light of family
information:

Well, we did have a CVA a couple of years ago. He was an
old Irish man. We always called him 'Pop'. I was very fond
of him. In fact I babyed him to begin with, then I realized I
was just making it hard on the family, because he would
expect more from them too. And so when I had a physio-
therapist come in with me to see him, she decided just what
his limitations were. And he did his exercises for awhile,
and then he thought, no this is too much bother...but it was
sort of as if I was treating him as a child, and...if he didn't
do it for me, I'd be angry with him. In order to please me,
he would do it. So he did get a little movement again; it
wasn't as painful as before because he used it more...

I did...and then speaking to the family, I found out that he
wasn't. He just let it go at night. So then I told him that I
had heard he wasn't carrying through with his instruction.
And that I was going to check on him, and...he...started
doing them again when he found out that I was interested
enough to ask about it the following day...I think you
expect a lot more of sick people because you're well
yourself,...and you don't realize that...when you're not
well, maybe you won't do them either.

Mostly by her fortitude and from what she had told me...she
had come along and doing all her own housework with
this walker. As she stated she gets up at 6:30 every
morning and bakes bread and washes and irons and starches
dresses and does all her own dusting and cleaning, etc.
She is just a remarkable woman, she really is...mostly by
the initial visit...how she tried very hard.

After the first day I met her I knew that she would do them
and do them very well and to the best of her ability; she
has an awful lot of spunk...

I feel that in this particular case that he really wants to
get better, and that means so much...He asks me, 'How
can I do this? What can I do about this? Can I do this?
Can I exercise more?'...I don't want him to expect to
be well overnight. He's the one that tells me, you see;
he's the one that grabs onto suggestions, and holds on to them, and I feel that if he is trusted, he will try, and if he's not of course, it will show up; maybe something else is what he needs. I think most of these chronic patients, if you're encouraged, they'll be encouraged; your attitude is so important, you've got to be cheerful, and have a bright outlook on everything; it's hard sometimes, because underneath you probably don't feel that way.

Evidence came from sources other than the patient. In one instance a nurse put together some clues from the environment and drew some conclusion:

Well, when I went in first, she told me she couldn't eat. She'd just had a diagnosis of a CVA [cerebral vascular accident]. I said well, try some eggs and some soup, and she did. It got so that she was eating eggs three times a day. So, each time when I went in I'd ask how she was eating. I first suggested, to give her a little variety, and also to help the fact that we won't have to give her two or three enemas a week if he'd try to regulate her bowels, by diet. And then the baby soups, and vegetables and meat, would be something that she wouldn't have to chew too much, and would go down fairly easy, and might also help to alleviate the problem.

Yes, this is a patient that has. . . we were called in for. . . and order of high soap suds enema. . . The patient has been mentally ill. . . She was very apprehensive, and she doesn't speak, and up to the time she had the fall, she would ramble, at somebody going by the window. And it's taken two of us to go in and give her an enema, along with her husband. . . . The husband appears to me to be overwhelmed by the situation. He's gone along with it for two years. . . . She hasn't eaten too much and we've got her now eating baby food, eggs and things like that.

Mainly because the empty jars, are right there. Also the minister told me that he saw the jars while he was there, so I knew that. . . well, the jars were right there where he opened them.

Promotion of independence requires that the nurse have an unbiased understanding of the patient. The quality of evaluating with trust is demonstrated by the nurses' consideration of all the information about the patient, and not just her observation, nor just a family's report. The responses from one-fifth of the sample indicated they
had some awareness of this.

Transferring Information of Patients

To discover if the nurses estimated patient needs with unbiased understanding, nurses were asked in the interview how they transferred information of patients to a co-worker, a doctor or a representative of an institution.

To a Co-worker.—Three-fourths of the sample indicated that they estimated the need of a patient on the basis of personal and individual reasons as follows—

"I think you feel more confident when you first go into a home situation, if you've had some background as to the type of home, the reception you're going to get, the facilities to work with, and...how cooperative the family is.

to offer "everything that I could know"

I felt that is she was going to take care of her patient that she should know as much about her as I could know...what was best for the nurse to know, and what the nurse should know, and...what would be helpful to her, and in fact, everything that I could know.

to state "things in general":

When I transfer my cases, I just tell them generally, what you do for them, where the equipment is who helps you, and who doesn't help you, or...how hard the patient is to take care of...sometimes what interests they have. What they like to talk about. Just things in general, I can't think of anything specific that I tell them.

to note "what to expect that wasn't happening at the moment:""
happen while you were not there.

to show "what I have to do":

Well, of course, I've taken care of them so long, and seen them so often, that I know...what I have to do when I take care of them so often, so...I tell the nurses.

to note "little quirks" that families have:

If a different nurse was going...it's something that's done continuously the changing of patients and nurses, etc., and we tell a little bit...well, we tell by the setup of the home if there are any little quirks that certain families have...I mean some families would rather have you washing in the kitchen or something like that. Of course, that's not pertaining to patient care, but I mean not only patient care but other things, too, are important because you can set yourself off on the wrong foot if you wash in the wrong place or something like that.

to preserve "time" in what the nurse taught the patient:

Oh yes, I have told the nurse...and usually it's about what they can do for themselves...and usually about the patient's mental attitude...and how you can treat the patient, and have him respond well to them. It was just things that happened to come up...and I had spent lot of time, probably, in getting somebody to do something, to be fine for awhile that they'd stop doing it, and I'd have to start all over again.

to make it "easier" for the patient and the nurse:

We often explain what we do in the service and how they are doing now and any of the specialities we do that would maybe make it easier if we try to explain, maybe lifting from the shoulders, going back to the bed to lift them instead of from the side and things like that; and they are all very good about that and really take time to go into detail. Any little things that will make it easier for the patient and the nurse

To A Doctor.--Almost one-third of the sample gave selected information from which she expected certain medical action from the doctor. Therefore, one nurse described an event so that an order would be changed:
Well, I just told him what was needed. I mean, I didn't tell him, I just told him what was happening to the patient and let him make up his own mind. Well, I had one patient who had a vaginal discharge and that's what I told him, and I described the discharge, and he ordered a douche.

Another would report certain conditions of a patient to have him placed in a nursing home:

Oh, any case where the condition changes, we report to him, the particular condition. Occasionally, if you felt that the patient was a candidate for a nursing home problem care long enough home care, you would talk to him about it; that would be about the only. I don't think the financial end of this business enters too much with the doctor, and we very seldom have to discuss that with him. I think it would be more a question of nursing home or hospital admission, or change in condition.

Sometimes a nurse would call the doctor to facilitate having an order written for the patient at home:

And often the patients seem to feel that if I call the doctor, they'll get faster and better results that's why I well, I'd do it anyway, but I do it and then I generally do it in the home, but not within earshot of the patient, so if there's any information, prescriptions or such, they can be given right there, and I know it's taken care of.

Almost one-half of the sample indicated that the doctor was a professional person with whom one shared both the progress and the problems of patients. This was said to be especially true in a situation where the doctor did not see the patient as often as the nurse.

About one-fifth of the sample not only gave information, but also withheld information to other nurses in the agency. One gave information "a little bit" and felt that her opinions about the "personality" of the patient held too much of a bias:

I just told her a little bit about it, and of course, on your record is what you do, so just run over that. Sometimes I try to tell them a little bit about the patient's personality, but not too much; my opinions might not be some one else's as far as
personality...goes...

One withheld information because of the meaning of confidentiality to herself:

I think you should tell them what is important as far as their physical being... I am a firm believer that you should never betray a patient's confidence... and I think that... if a patient tell you something in confidence, it should never be repeated, or put down on paper, as their family problems, and their... emotional needs, and things that they would never tell anybody ever again, and would probably never even repeat it to you. It might have been something that was buried inside for years, and... probably just getting it out of their system just that once opened the door to a more relieved mind, and I do think that nurses shouldn't betray patient's confidence... I think that... that's one fault we do have, you know? We should use a lot of discrepancy about what we repeat, to... to our fellow workers... I mean if a patient is depressed... that is something you should know, or if a patient is reluctant to care, or unreceptive... of course, the physical things, you can see it with your eyes, but... anything that would make the patient's recovery that much quicker... as far as your conversations with the patient, those are things that I feel aren't necessary to repeat... I feel that if they have mentioned something to you, they have told you because they have been able to establish enough confidence in you, a relationship, and they think that you care for them; and there's nothing more disillusioning, or any greater... harmful than to... repeat somebody's confidence; I know I would feel that way. If I were a patient, I wouldn't want to feel that what I told this person is going to be repeated to... half of the staff, or half of the hospital wherever I work, or wherever I'm a patient... I think that's something that... it might be their only means of relief, no matter how bad it is... you know? I think it should be just completely forgotten once you leave the patient's bedside. Unless it's something that... like they're going to commit suicide, or something that might be vital to their well-being.

Many times the doctor will leave it up to you to call him. He will make a visit, we'll say, the first week of the month and then he won't go again until the following month unless you want him; and if you are a little bit worried over anything you call him and explain in detail what it is. Sometimes he has to visit the patient and sometimes you get the orders or instructions over the telephone.

When nurses felt inadequate after estimating patient needs they would appeal to the doctors:
things that seemed to be important at the time. Things that were bothering me and wanted an answer to. Just recently I had a patient who's an arthritic, and she's very very depressed, and she won't do a thing. When I gave her a bath, have her wash her face, her hands, and then when I finish up and put her to bed, I have her clean her nails, or something like that. And, she was very very rebellious about the whole thing; she didn't like me at all. She thought I was pushing her too far, and had no consideration for her. And then she didn't want me to come any more, So I called the doctor, and explained what the situation was... very very depressed... she had two other doctors and they were all quite discouraged, and they felt there was nothing more they could do unless she was willing to help herself.

About one-fifth of the sample showed that their own feeling about the doctor determined how much information they would give to the doctor. If a nurse felt that a doctor was interested then she would tell him all:

... it depends on the doctor I call. Sometimes I call a doctor, and he's very much interested in everything about the patient, so I let him in on everything that I know, about the patient, about the home situation, as well as the physical situation. But now sometimes I call the doctor, and they're just anxious to get off the telephone, and so I tell them just exactly what I want to do, like cut down the dressing, or... no, yes, cut down the dressing and then he'll say, 'Sure, sure, go ahead.' So more or less it depends on the doctor; if he shows an interest in how the patient's doing generally, besides being specific then I go ahead and explain what I understand about the situation.

... I think on the whole, doctors are very ethical-minded, when it comes to a patient's confidences, more so than a nurse. I mean I don't think they would repeat things for the sake of repeating them. I think they are much more medical minded. They might tell another doctor, but they don't think anything of it. They'll say. 'Oh, this patient was a... did this or did that, that might be very important in their care for the patient, but... maybe it's because they're men, and nurses are women, and they don't have a lot to do with... the repeated I mean... and nobody's perfect, and... but... I don't feel... I feel that some things are very important for the doctor to know. Now, he... would be the person that... I would prefer to give my report to; I think he's the only one who could help the situation I mean, after all... another nurse is in the same boat you are. I mean, as long as the doctor, the patient, and the nurse... they should be a team, but you don't have to... tell the whole
world, you know?

To a Representative of an Institution:—One-fifth of the sample showed they considered social facts were of importance to the physical condition of the patient, as in the following illustration:

... perhaps the hospital would be able to help the child a lot more if they knew from whence it came, I mean from what type of home environment, what type of parents they were; so that, if the child should need home care, exercises or things, they'll know they get it, or whether this child should be hospitalized or institutionalized. I think that... the child should really be considered in that type of a situation, and I do think that... concrete facts... about... a patient, whether they live in a poorly-furnished, or... well-heated; or... whether they're well-educated... things like that, those things are very important.

For another nurse, social facts were of importance because she gained a new perspective about the patient and his family:

I think I enjoy that part of the work... talking with someone else who is familiar with the case and... even more so, than with the doctors, who sometimes take one point of view; the social worker also understands... the whole situation. In other words, they go into the... home situation, not that it's physical... only. So usually, I have long conversations with social workers about everything that affects the patient... Well, generally, I think it would be a discussion of the family, and of the patient, and telling her what I know, and, then finding out what she knows; I think... the two of you the social worker and the nurse might have different ideas about one situation, and usually when I talk to them it's more or less of an exchange of information. And I tell her, what the family does for the patient, and what the patient does for himself, and... she tells me what she finds out on her visits to the home. I can't think... can't put it in any better words.

Another fifth of the sample reported observable abnormal conditions:

I can think of one patient who was very mal-nourished and there had been some talk in the clinic, to him, about going to Clinic. He was very thin and he had a lot of chest pain. When I went up there to the Board of Health to get a sputum specimen, that's when I first met him, he was all packed and ready to go...and he was miserable. He was gray-colored, and very thin, and he ate on about two dollars a week; that's about all he had to eat with. And he had a lot
pain; he really looked terrible...and...so I called the Board of Health to see if they knew anything about his going to Clinic and they had no idea bout it, so...because I knew he'd been seeing the clinic at the hospital I called there and told them...what I thought; just the same thing I've told you, nothing I could put my finger on, just this pain, and I knew he'd been seen there, and the doctor there had told him about Clinic so they looked at his reports, and he did have x-rays for a chest condition.

Less than half of the sample could not recall any experience where they communicated to a representative of an institution about patients needs.

The responses indicate that all of the nurses were not using their communication skills for the best welfare of the patient because they indicated a biased understanding of patient needs. An unbiased understanding is essential for the promotion of independence. On giving information to other nurses within the agency, all of the sample estimated the needs of the patient on the basis of personal reasons. With a co-worker, the nurse assumed that they understood patient goals. In withholding information the nurses again operated on a personal bias.

In relaying information to doctors, one-half of the sample showed basic tendencies for promoting independence by sharing the patient problems with the doctors. However, the reason which the nurses gave showed various degrees of unbiased understanding of patient needs. Personal feelings about the doctor's interest and ethics tended to influence how much a nurse communicated about patient needs. One of the respondents indicated sharing information on the basis of the patient's welfare.

One-half of the sample communicated with a representative of an institution chiefly for patient needs. These needs were based on
obvious abnormal conditions or on pertinent social facts about the patient as observed by the nurse. The nurses indicated much more understanding of patient needs and less personal bias in this area than in their reporting of how they communicated with co-workers and doctors, however responses were fewer than to a co-worker or to a doctor.

It would seem that a nursing problem occurs when patient needs are not the focus of communication. There appeared to be a tendency for the nurses to meet certain of their own and other nurse's needs instead of the patient's needs. Whether this effect is the result of working closely together is not clear. Nurses tend to consciously formulate statement of patient needs when relating to someone other than a co-worker i.e., a representative of an institution. A problem occurs when a nurse does not see a doctor as another professional person with whom she can share the problems of the patient. According to these data, perceiving the doctor as an interested person, a certain kind of professional and as a man seems to have made some difference in what the nurses communicated about the patients.
CHAPTER V

SUMMARY CONCLUSIONS AND RECOMMENDATIONS

Summary

Eleven public health staff-nurses from two non-official public health nursing agencies were interviewed about their feelings toward specific long-term illness, their past experiences related to long-term illness, their responses to nursing procedures in long-term patient care and their ways of approaching problem of patients with long-term illness. The interviews were tape recorded. The problem of the study was to explore the attitudes of public health staff-nurses toward the care of patients with long-term illness, with special attention to the attitude of mature sympathy and the promotion of independence.

It is assumed in the study that independence is promoted by an attitude of mature sympathy:

Sympathy is the act of entering into and sharing feelings, interests and acts of another person or persons. It is an expression which lays the foundation for establishing and promoting mutual accord. Sympathy is the expression of a secure person who has the ability to give appropriate support to those in need of it. Such sympathy shares by participating in the good fortunes or easing the difficulties of another.

Mature sympathy evaluates others with trust and esteem. It rests in the ability to estimate the needs of others with unbiased understanding and regard.

Constructive sympathy imparts truth.

1Muller, op. cit., pp. 158-159.
Conclusions

Description of Feelings toward Long-Term Illness

All nurses described their feelings toward long-term illness as unpleasant, with special emphasis on the slowness of the disease process. In spite of the unanimous feeling of nurses that the nature of long-term illness was unpleasant, over one-half of the sample expressed a hopeful outlook.

The Effect of Early Experiences with Long-Term Illness upon The Nurses' Attitudes

Early experiences of nurses with long-term illness showed a remarkable change in attitudes from one of eagerness to help, of being overwhelmed from the demands of nursing care, to one of resignation to the tediousness of care. Particularly in the early experience of public health nursing, two-thirds of the sample made comments on death—"went downhill and died" or "They eventually died." Although data are insufficient for an interpretation, the number of responses and their implications seem to indicate a need for further examination of the effect of death upon the attitudes of nurses toward long-term illness.

Attitudinal Factors Related to Nursing Tasks Which Did Or Did Not Bring Satisfaction to Nurses

Table 4 and table 5 are presented to show how nursing tasks, which did or did not bring satisfaction to the nurses, effected their attitudes.
<table>
<thead>
<tr>
<th>Attitudinal factors</th>
<th>Nursing tasks</th>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling unaccepted by patients</td>
<td>Health instructions</td>
<td>7</td>
</tr>
<tr>
<td>Feeling unsuccessful</td>
<td>Exercises</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Enemas</td>
<td>2</td>
</tr>
<tr>
<td>Being &quot;used&quot;</td>
<td>Bath</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Enemas</td>
<td>2</td>
</tr>
<tr>
<td>Feeling guilty</td>
<td>Enemas</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Catheter irrigation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Bath</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Health instruction</td>
<td>1</td>
</tr>
<tr>
<td>Feeling disgust for crutches</td>
<td>Crutch-walking</td>
<td>1</td>
</tr>
<tr>
<td>Intolerance of messiness</td>
<td>Bath</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Dressings</td>
<td>4</td>
</tr>
<tr>
<td>Causing pain</td>
<td>Injections</td>
<td>5</td>
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<tr>
<td></td>
<td>Exercise</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Crutch-walking</td>
<td>2</td>
</tr>
<tr>
<td>Having patient dependent on nurse</td>
<td>Bath</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Helping out of bed</td>
<td>1</td>
</tr>
<tr>
<td>Accepting partial functional loss</td>
<td>Exercise</td>
<td>1</td>
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<tr>
<td>Feeling tired</td>
<td>Bath</td>
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<td>Feeling insecure</td>
<td>Crutch-walking</td>
<td>2</td>
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<tr>
<td></td>
<td>Injection</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Exercise</td>
<td>1</td>
</tr>
<tr>
<td>Not seeing patients improve</td>
<td>Exercise</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Crutch-walking</td>
<td>1</td>
</tr>
</tbody>
</table>

It is apparent that additional feelings of unpleasantness are created from the demands made around nursing tasks which are commonly given in care of long-term illness. These feelings of unpleasantness indicate areas for further examination to relieve nurses from the stress of unpleasantness.
Table 5 gives a summary of the attitudinal factors related to nursing tasks which brought satisfaction to the nurses.

**TABLE 5. — Attitudinal factors related to nursing tasks which brought satisfaction to eleven public health staff-nurses**

<table>
<thead>
<tr>
<th>Attitudinal factors</th>
<th>Nursing tasks</th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving gratitude from patients</td>
<td>Bath</td>
<td>4</td>
</tr>
<tr>
<td>Giving comfort and relief</td>
<td>Bath</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Massage and exercise</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Dressings</td>
<td>1</td>
</tr>
<tr>
<td>Providing cleanliness</td>
<td>Bath</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Dressings</td>
<td></td>
</tr>
<tr>
<td>Feeling successful</td>
<td>Bath</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Enemas</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Injections</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Crutch-walking</td>
<td>1</td>
</tr>
<tr>
<td>Enjoying conversation</td>
<td>Bath</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Dressings</td>
<td>2</td>
</tr>
<tr>
<td>Seeing patients improve</td>
<td>Crutch-walking</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Massage and exercise</td>
<td>3</td>
</tr>
<tr>
<td>Maintaining optimal conditions for patients</td>
<td>Catheter irrigation</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Enemas</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Dressings</td>
<td>1</td>
</tr>
<tr>
<td>Sharing self-sufficiency</td>
<td>Health instruction</td>
<td>3</td>
</tr>
<tr>
<td>Sharing loss of body function</td>
<td>Catheter irrigation</td>
<td>1</td>
</tr>
<tr>
<td>Feeling that crutches are fun</td>
<td>Crutch-walking</td>
<td>1</td>
</tr>
<tr>
<td>Feeling accepted by patients</td>
<td>Health instructions</td>
<td>1</td>
</tr>
</tbody>
</table>

These findings indicate that certain nursing tasks are associated with feelings of pleasantness and bring satisfaction to the nurse. Although the feelings of satisfaction could, in a few instances, be attributed to having promoted independence in patients, this was not the basis of satisfaction for the majority of the nurses.
The Relation of Nursing Tasks and The Ways of Approaching Problems to Attitudes Which Promote Independence

In regard to sharing, data showed that two nurses shared with patients in the nursing task of the bath, two shared in giving health instructions, seven in giving hypodermic injections, one in exercising, and one in helping with speech impairment. Data further showed that three nurses made a point of the need for inducing the patient gradually to take more responsibility for himself.

In regard to supporting or participation in easing difficulties, data showed that to one nurse, participation meant accepting a patient's problem, listening to his felt difficulty, clarifying his problem with questions, and looking for solutions to this problem together.

In regard to imparting truth, data showed that seven nurses dealt with the real situation in giving hypodermic injections, one in catheter irrigation, and one in exercise of the arm. Data further showed that one nurse said she thought she must consistently present the real situation until the patient acted constructively for himself.

In evaluating with trust, data were unproductive in the area of nursing tasks. However, in the approach to problems, data showed that five nurses trusted patients from observed facts about patients and one said that her trust grew with the consideration of many facts in relation to her observations.

In estimating needs of patients with unbiased understanding, data were again unproductive in the area of nursing tasks. It was apparent from data relative to an approach to problems that an unbiased understanding meant focusing on the needs of the patient. Data from six
nurses further showed that when they related to a representative of an institution, they had the least bias. Six nurses manifested less bias when relating to doctors about a patient problem. One nurse manifested unbiased understanding in relating to another nurse about a patient. In general, it is important to note that the data showed very little evidence that the nurses in the sample had either attitudes or skills which would encourage independence in patients. It is recognized that this conclusion might be due, at least in part, to inadequacy in the methodology.

Nursing Problems Found in This Study

From these data, certain problems are evident. Nurses seem to need help in changing their negative attitude toward promoting independence in long-term illness. The problems appear to fall in the following three broad areas:

I Problems associated with dealing with dependency.

Inability to convert dependent family relations to independent ones.

Inability to convert a dependent patient to an independent one.

Inability to interpret patient's dependence needs.

Inability to deal with emotional dependency which comes with loss of body functions.

Difficulty on the part of these nurses in giving up the satisfactions of doing things for patients in the interests of encouraging patients to do for themselves.

II Lack of understanding of the meaning of loss of body parts, of body function and of life.

III Lack of ability to apply skills basic to promoting independence in patients.

Listening to patients.

Identifying progress to the patient.
Realistically encouraging patients.

Using the patient's frame of reference when instructing.

Understanding the fears of patients.

Understanding personal feelings of guilt.

Accepting a patient unconditionally.

Understanding personal bias.

From the general picture of attitudes disclosed by this study, the nurses apparently found the care of patients with long-term illness a stressful task. Much re-learning would be required if the respondents were to become able to give better care and to enjoy their work more. Careful guidance could perhaps be useful in such re-learning.

Recommendations

This study only assumes that the attitude of promoting independence is most helpful in the nursing care of patients with long-term illness. It does not show the effects of a positive or negative nurse attitude upon the patients. Therefore, further study is recommended to show both the attitudes of the nurse and the effects of these attitudes upon the patient with long-term illness and his care.

The variation in the qualification of the public health staff-nurse in this study raises a question as to whether the education of the nurse is a critical factor in developing an attitude of promoting independence toward patients with long-term illness. Therefore, a comparative attitudinal study of qualified public health staff-nurses and unqualified public health staff-nurses is recommended. For further research on either one of these problems, a refinement of the methodological tool
is also recommended.
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APPENDIX

The Interview Guide

For Description of Sample:

1. Would you tell me about your formal educational background in nursing? Any additional classes, institutes, workshops?
2. What is your marital status?
3. What is your age?
4. What is your nursing experience since finishing school? How long in nursing? How long in public health nursing? Any other specialty? How long in other specialty?

For Past Experience with Long-Term Illness:

1. What was first experience with long-term illness before entering nursing? Tell me more about it? With whom? What illness? What was the outcome?
2. What was your first professional experience with long-term illness? Tell me more about this. With whom? What was the illness? What was the outcome?
3. What was the first public health nursing experience with long-term illness? Tell me about this. With whom? What was the illness? What was the outcome?
For Response to Technological Care:

1. With reference to long-term illness do you like giving____? 
Recall to present caseload and to her experience with this specific item. What were some of the reasons?

2. With reference to long-term illness do you dislike giving____? 
Recall to present caseload and to her experience with this specific item. What were some reasons?

3. The items to be filled in blank spaces for both questions 1 and 2 (pencil check as you ask.)
   a. Bed bath
   b. Instruction in care of patients
   c. Dressings
   d. Crutchwalking
   e. Hyperdermic injection
   f. Massage and exercise
   g. Enemas
   h. Catheter irrigation

For Ways of Solving Problems in Approach to Patient

(Help recall to the present caseload and to patients with long-term illness.)

1. For those who can do for himself, how do you get the patient to do for himself? (i.e. his daily hygiene) How did you work this out? Say? Do? What did the patient say? Do? What was the final agreement?

2. Have you a patient for whom you were encouraging to do more for himself while you were not there? Tell me about this. How do you expect the patient to carry his part out? How did you arrive at this conclusion?
3. Have you had a situation where the patient expressed anxiety over going to the doctor, to the clinic, or to the hospital for hospitalization? Tell me what you said. Tell me what you did. What did the patient say? Do? What were your reasons for saying and or doing, or for both?

b. Have you had a patient return from the clinic or the doctor visit assured that this progress was good? Tell me about this. What was your reaction? Did you express this in any way? To whom? How?

c. Have you had a patient return from the clinic or doctor visit feeling that the visit was a setback to his progress? Tell me about this. How did you react to this? Say? Do? To whom? How?

4. Has there been a situation where you knew the patient did not recognize some event of his illness which were happening to him or even not accept this own illness? Tell me about this. Did you try to help him with the real situation? (Clues for interviewer: Not bothered with it? Hoped that the patient would not bring it up for discussion? Talk about something else?) In what way did you do this. What were the reasons? What has been your past experience with this kind of situation?

5. a. Sometime in the course of your work with those who have long-term illness have you had to transfer information about your patient to your co-worker so that your co-worker could carry on your work while you were gone?

b. Sometime in the course of your work with those who have
long-term illness, have you had to transfer information about your patient to the doctor? Tell me about this.
What patient needs did you discuss with the doctor? How did you select what you wanted to discuss?

c. Sometime in the course of your work with those who have had long-term illness have you had to transfer information about your patient to the clinic or hospital? Tell me about this. What did you consider were patient needs in this case? How did you determine this?
For Responses to Pictures of Technological Care:

Pictures with Corresponding Remarks

Picture A
"Oh! It feels so good to be washed"

Picture B
"I think it's going to hurt."

Picture C
"It's so easy when you help me."

Picture D
"This is as far as my arm will go"

Picture E
Patient remark was not supplied. Instead a question was put to the nurse, "What do you think the nurse might be saying?"
1. The pictures which follow are identified by capital letters:

2. In the interview guide each picture was presented separately. After the picture was presented, the interviewer said, "Here is a picture. The patient in this picture says, "__________." Then following this, nurses were asked "How do you think the nurse answered?" Why do you think she answered this way?"
For Description of Feelings toward Long-Term Illness

INSTRUCTIONS

1. Place a √ in blank spaces in column 1 to indicate any relationship you have had with persons diagnosed as having these conditions within two years.

2. Place a O in blank spaces in column 2 to indicate no contact with these conditions.

3. Select an adjective that best describes your feeling about each illness:
   a. By filling in the blanks in column 3 from the list of adjective in column 3.1.
   b. By filling in the blanks in column 4 from the list of adjectives in column 4.1.

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>NURSE - ILLNESS</th>
<th>FEELINGS - ILLNESS</th>
<th>ADJECTIVES</th>
<th>ADJECTIVES</th>
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<td>col. 2</td>
<td>col. 3</td>
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<td></td>
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<td>depressing</td>
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<td>PARKINSON'S DISEASE</td>
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*If you wish to add any other illness, please add.