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Nursing functions in meeting patients' spiritual needs

NURSING FUNCTIONS IN MEETING PATIENTS' SPIRITUAL NEEDS

BY

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CHAPTER I

INTRODUCTION

In recent years, nursing has become increasingly concerned with such concepts as "total nursing care," "comprehensive nursing," and "adapting nursing care to the needs of the individual." This study is concerned with one aspect of total nursing care--the relationship and significance of the spiritual needs of patients to nursing.

There have been many attempts to define and delimit comprehensive nursing care; most of these include the spiritual aspects. Bratton states:

> Comprehensive nursing care may be defined as that process which, based upon the recognition that each individual has needs that are peculiar to him, attempts to meet the nursing needs of that individual. These may include physical, emotional, spiritual, economic, social, and rehabilitative needs.[1]

Another definition of comprehensive care states that the patient is recognized as an individual, and his care is adapted to his individual needs and demands. The patient receives supportive nursing care--mental, physical, spiritual, and emotional--providing for rest, security, good hygiene, and comfort.[2]

Abdellah further identifies meeting the spiritual needs of the patient as a nursing responsibility when she says, "One problem is to

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[1]Jennie K. Bratton, "A Definition of Comprehensive Nursing Care," Nursing Outlook, IX, No. 8 (August, 1961), 482.

[2]Mary E. Brackett and Joan R. Fogt, "Is Comprehensive Nursing Care a Realistic Goal?" Nursing Outlook, IX, No. 7 (July, 1961), 402.

facilitate progress toward the achievement of personal spiritual goals."[3] Moreover, she continues that it is especially important to recognize some patients' need for spiritual goals, particularly patients with serious illness, psychoneurosis, psychosis, and health problems that necessitate major readjustments in life patterns.[4]

Nursing has thus recognized the fact that the patient does have spiritual needs and has committed itself to the responsibility for recognizing these needs, with the realization that this responsibility for recognition must be accompanied by an obligation for action. It would seem that one of nursing's responsibilities in meeting the spiritual needs of patients is to determine what kinds of actions the nurse feels she might take in order to meet these needs.

Statement of the Problem

This study proposes to determine what nurses believe their functions should be in meeting the spiritual needs of their patients.

Importance of the Problem

Since nursing in its definition of comprehensive care has assumed that the patient does have spiritual needs, and since nursing has further assumed that the nurse has a responsibility for recognizing and aiding in the fulfillment of these needs, it would seem justifiable and necessary to determine what functions the nurse thinks she ought to perform in helping the patient to meet his spiritual needs.

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[3]Faye Abdellah, Almeda Martin, Irene Beland, and Ruth Matheney, Patient-Centered Approaches to Nursing (New York: The Macmillan Company, 1960), p. 17.

[4]Ibid., p. 198.

An implication involves planning personalized care and meeting the individual patient's needs. During illness, people tend to question the values and purposes of their existence. The attitude with which a patient views his purpose in life and the impact of illness in the accomplishment of life's goals will directly affect the patient's medical progress. More particularly, rehabilitation nursing deals with patients who have long-term illnesses, often of a permanent nature, necessitating major readjustment in life patterns. During this adjustment period, patients often experience some different feelings concerning the relationship of their spiritual beliefs to their life's meaning.

If the nurse recognizes that the patient's philosophy of his own individual worth and the relationship of this philosophy to his illness is an integral part of his spiritual being, then the nurse must consider this in planning her nursing care for this patient. If the nurse fails to recognize the patient as a spiritual being with spiritual needs, it would seem that her care would be devoid of an important segment in her plan for personalized comprehensive care.

Closely allied to personalization of care is the challenge of patient teaching. In this area, too, spiritual aspects assume importance because the patient's philosophy will affect his success or failure in his teaching and rehabilitative programs.

Still another implication involves nursing curricula in preparing nurses to function within the area of spiritual needs. Whether or not nurses are presently prepared to meet the spiritual needs of patients is a study in itself, but if the nurse is expected to meet some of the patient's spiritual needs as a part of comprehensive care, then those in

nursing education have a responsibility to prepare nurses for this function.

Scope and Delimitation

This study is based upon the ideas that nurses have of their functions in meeting the spiritual needs of patients.

Data were obtained from the expressed opinions of 277 respondents to a questionnaire and personal data sheet. The sample was drawn from one university school of nursing. Students from the Basic Professional Nursing, General Nursing, and six graduate programs were included in the sample. Faculty members from each of the programs also participated in the study.

Definition of Terms

Clarification and differentiation of the following terms seem necessary:

Spiritual in this study is meant to encompass both religious and philosophical connotations. It is that part of man which is concerned with the intellectual and higher endowments of the mind and includes moral feelings and the state of the soul. It considers man as a person, a self, capable of developing reason and values.

Philosophy is a complex and comprehensive term which implies concern with the nature of all things, including physical sciences. It involves a type of thinking which is directed toward concreteness and toward discovering the truth about all available experiences.

Religion differs from philosophy in that its major concern is the soul of man. It is characterized by order and organization and is con-

cerned with some type of systematized ritual in the observance of the professed faith and worship. It embodies the belief in and the worship of a God or gods.

Preview of Methodology

Information for this study was obtained by a questionnaire consisting of 64 items which listed a variety of possible functions by which the nurse might meet the spiritual needs of her patients. The format was constructed so that data could be tabulated by IBM machine. Respondents were contacted at a university school of nursing.

A personal data sheet accompanied each questionnaire. Responses to the questions were analyzed in relation to the information obtained from the data sheet. This information was concerned with number of years in nursing, program, hospitalization, religion, and age.

CHAPTER II

THEORETICAL FRAME OF REFERENCE OF THE STUDY

In this review of the literature, the discussion of the spiritual needs of patients proceeds from the historical significance of illness to man and his religion, through the relationships and meanings of man's sickness and suffering, to the ways in which patients might react to illness and thence express their spiritual needs to nurses. The last part of the chapter is devoted to a review of some of the present thinking about the nurse's responsibility for meeting the spiritual needs of patients and about ways in which the nurse can accomplish this.

> Have mercy upon me, O Lord:
> for I am weak: O Lord, heal me;
> for my bones are vexed.
> My soul is also vexed: but
> thou, O Lord, how long?[1]

The cry of David in his illness to his God is an ancient yet timely one, for man is a rational being and with his reason he seeks purpose and understanding of his being. One of the understandings which even primitive man sought was the relationship of his physical state to his spiritual or religious state. Man still seeks this understanding. Hoebel explains how the village priest assumed the religious functions of his tribe and at the same time assumed responsibility for healing his sick tribesmen through his supernatural powers.[2]

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[1] Ps. 6:2.

[2] E. Adamson Hoebel, Man in the Primitive World (New York: McGraw-Hill Book Co., 1958), p. 543.

Childe further identifies the union of religion and medicine. He says:

> Early medical theory was essentially magical, and medical practice inextricably bound up with spells and prestidigitation; . . . Doctors in Mesopotamia were also priests, and in Egypt sacerdotal and healing functions were closely allied.[3]

Elaboration of this ancient relationship is demonstrated by Standard:

> Medicine in the past was allied with magic and religion. The medicine man in savage countries who healed with incantations had no need to tell the patient the source of his knowledge or explain the powers of his ministration. The priest, the most literate and the most educated man of the community in olden days, knew very little about medicine; he healed with blessings and gave no explanations.[4]

Both the Old and New Testaments contain scripture concerned with the healing powers of God. It was not by accident that Christ in his ministry served not only the spiritual needs, but the physical needs, of man as well. The stories and parables of His healings are well known and serve to further strengthen the bond between man's spirit and body.

Our prime concern, however, cannot be either of primitive or Biblical man, but rather must be of modern man, for it is modern man's spiritual needs with which the nurse is concerned. Nevertheless there is a relationship. Dicks states:

> There is something primitive about sickness and death. In common with primitive man, we have the experience of enduring pain and of facing death and bereavement. Modern man is quite as much mystified by illness as were his forebears.[5]

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[3]V. Gordon Childe, Man Makes Himself (New York: New American Library of World Literature, Inc., 1951), p. 174.

[4]Samuel Standard and Helmuth Nathan, Should the Patient Know the Truth? (New York: Springer Publishing Co., 1955), p. 17.

[5]Russell Dicks, Who Is My Patient? (New York: The Macmillan Company, 1943), p. 14.

In his discussion of the relationship of religion and illness, Dicks continues:

> Religion had its rise in man's efforts to establish a satisfactory and satisfying relationship with the world in which he lives. In primitive religion man sought to overcome suffering and the forces which threatened to destroy him; modern man does the same.[6]

Of modern man's problems as a patient Westberg says:

> It is possible that a rather large segment of the population will lose confidence in religion and medicine and will easily revert to primitive conceptions. According to anthropologists modern man is not so modern; with a little encouragement he could bring back habits and customs based on magic and superstition.[7]

Many authors comment upon the stress and conflicts arising in patients' spiritual beliefs during illness. In one of the few studies in nursing of this problem, Aiken and Battiste interviewed sixty patients in a large state mental hospital in a study of spiritual beliefs of these patients about church service, prayer, and God. In this study they state:

> Religious beliefs may change during crisis--loss of loved ones or material possessions, illness, hospitalizations. Thus doubt and lack of faith often expressed by people encountering crises may reflect their inner conflict and helplessness. During a crucial period when man is hospitalized for a mental illness, his religious beliefs may be indicative of a need for a strong faith to cope with the problems of religious doubt, loneliness, anxiety and despondency.[8]

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[6]Russell Dicks, Pastoral Work and Personal Counseling (New York: The Macmillan Company, 1944), p. 124.

[7]Granger Westberg, Minister and Doctor Meet (New York: Harper and Brothers, 1961), p. 157.

[8]Eula Aiken and Dorothy Battiste, "The Beliefs of Patients Hospitalized for a Mental Illness About Church Service, Prayers, and God" (unpublished Master's field study, School of Nursing, Boston University, 1962), p. 5.

Although their study was concerned with patients having mental illnesses, it would seem that patients with physical illnesses might also have the same feelings. In this connection, Siirala states:

> The reality of illness is a stumbling block in our human existence. The prophets in the Old Testament saw how the crucial point in human existence comes in the confrontation of suffering and illness. Then human beings deal with the presence of a divine reality.[9]

Theologians must face the problem of religion and suffering. Westberg says, "There is, perhaps, no better time or place to test the validity of the faith handed down to us than in the hospital setting."[10]

Fundamental to the quest for understanding the relationship of religion and medicine seems to be the basic philosophical inquiry into the meaning of suffering and evil. The problem of suffering is essentially Job's problem. Man continually asks why he must suffer pain, anxiety, and grief. Dicks reports:

> In illness people who have not thought of religion seriously for years ask, 'Why has this happened to me? What is the use anyway?' Those are religious questions that have to do with the fundamental nature of things.[11]

Of the search for understanding Dicks continues:

> Our reasoning powers are the first to break under the pressure of prolonged suffering, but we have the power of observation which leads us to search for the cause of suffering even in the midst of it and for ways of gaining relief.[12]

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[9]Aarne Siirala, "The Meaning of Illness," Journal of Religion and Health, I (January, 1962), 154.

[10]Westberg, op. cit., p. 9.

[11]Dicks, Who Is My Patient, p. 4.

[12]Dicks, Pastoral Work and Personal Counseling, p. 126.

In general, theologians and philosophers tend to agree that through evil and suffering life is raised to a higher level, that without evil there would be no good, that evil and suffering lead to creative experience, that suffering is endured out of God's love, and that evil is inseparable from good because it challenges and arouses the best in us.[13, 14, 15, 16] Dicks summarizes the patients' problems in this way:

> God does not pick out mental pain and send it to us. He has planned a world in which pain seems inevitable for growing beings. He permits pain as He does ignorance and sin because unless these challenge us we do not grow. Unless we accept growth as the absolute good, unless we value joy, ease, and rest because they wake us up, mental pain is a blot on the universe. God plans an order which contains pain as stimulus, challenge, teacher, and guide. We co-operate in the process of our growth by accepting painful experience, and learning its lesson, or we refuse to face reality and so degenerate.[17]

The patients, however, are not alone in their search for understanding of the problem of suffering. The people working with the patients also must face this problem. Dicks states: "There is not a physician or a nurse who does not face this problem day after day. Why do the innocent suffer? And there is not a clergyman who has not struggled with it hour upon hour."[18]

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[13]Alfred North Whitehead, Religion in the Making (New York: Meridian Books, Inc., 1960), pp. 50-51, 93.

[14]Br. Fulkerson and Romaeus O'Brien, Religious Life in the Modern World (Notre Dame, Ind.: University of Notre Dame Press, 1961), p. 29.

[15]Dicks, Who Is My Patient, pp. 143-149.

[16]Richard Cabot and Russell Dicks, The Art of Ministering to the Sick (New York: The Macmillan Company, 1936), pp. 107-111.

[17]Ibid., p. 99.

[18]Dicks, Who Is My Patient, p. 143.

Dicks continues:

> The problem of evil becomes urgent when ministers see the accumulation of misery in hospitals and slums. They are forced to doubt whether there is more pleasure than pain in the world. They are carried on to question whether there is more good than evil in it, and so to wonder about God.[19]

The questions concerning suffering and evil become especially meaningful today with the prevalence of the effect of the existential philosophy. In this philosophy, feelings of despair and meaninglessness are current.[20] The implications of the preceding discussion are not that the nurse should become a pseudo theologian or philosopher, but that she recognize the existence of the former problems and their relationship to her effectiveness in giving patients nursing care.

If the spiritual needs of patients are important, and review of the literature has suggested that they are, then the nurse's problem becomes one of recognition and response. This does not mean that the nurse gives detailed explanations to the patient of the philosophical interpretations of the meaning of illness. Dicks supports this view:

> Philosophical discussion rarely if ever helps a patient who is in Job's situation. . . . Such arguments are dust and ashes to the sick man. Their value is for the healthy inquisitive student. Their proper place is in the college, in the theological school, and in the clinical year.[21]

If the nurse's problem is one of recognition and response, then it seems important to understand that the patient's behavior might be indicative of his spiritual needs. Patients often manifest certain spe-

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[19]Cabot and Dicks, op. cit., p. 102.

[20]Paul Tillich, The Courage to Be (New Haven, Conn.: Yale University Press, 1952), pp. 139-142.

[21]Cabot and Dicks, op. cit., p. 102.

cific recognizable reactions to illness. These reactions may be reflections of physical, psychological, or spiritual needs. All reactions will not mean the same to all patients. The same reaction may at one time denote a psychological need, at another time a spiritual need. The value for the nurse is not to be able to attach the right label to the reaction, but rather to recognize the meaning of the individual patient's reaction in its specific context of time and space. Of patients' problems and reactions to illness Westberg says:

> Their problems are obviously physical, psychological, and I think basically theological, for they are now required to look at the meaning of life in a new way. As they think in their hearts, will show up in their outer actions.[22]

Theologians suggest that some of the more common overt reactions which might suggest the patient's spiritual needs include two of the most common feelings with which the nurse must deal as bitterness and hostility. Westberg states, "Hostility may be directed against their doctor, or their relatives, but in actuality it is also against God."[23] He continues that bitterness is expressed in such ways as:

> 'There is no God, there could not be if this is true. I have been a fool to believe otherwise.' A patient suffering from bitterness must discover that you stand by him even though he may curse many things dear to you. If you oppose him directly or lead him into arguments he may transfer his bitterness to you; you thus add fuel to the fire of his hatred.[24]

Hence it would appear that bitterness can become a difficult problem with which the nurse must deal.

Cabot and Dicks suggest that a second common reaction to illness

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[22]Westberg, Minister and Doctor Meet, p. 76.

[23]Ibid.

[24]Cabot and Dicks, op. cit., pp. 76-77.

is guilt, which is often associated with bitterness. "Bitterness often hangs on a sense of guilt. Patients blame some other person or blame God for their suffering."[25] Dicks states:

> One frequently hears a patient, usually suffering severe pain, say, 'Why does God send this suffering to me. Why am I punished.' . . . Such a statement is often a symptom of a sense of guilt. . . . The above questions are not followed by question marks. They should not be, for they are not questions, but statements. Most people who make them know several reasons why they might be punished.[26]

As seen in the above statements, blame is also a common reaction which may be allied with either bitterness or guilt or which may stand alone. In time, the patient must progress beyond this point of blame if he is to assume a positive state of mind about his particular illness.

Pride as indicating a potential spiritual need may be difficult for the nurse to recognize. Cabot and Dicks state, "Helplessness and prolonged suffering in illness bring reflection and often humble strong pride. Many who have traded upon the mercy of God suffer from a stricken conscience even while they suffer physical pain."[27] That doubt is another reaction expressed by patients is suggested by Cabot and Dicks. "We have heard many patients say, 'I never doubted God until this experience.'"[28]

Illness is also reacted to as a crisis experience demanding immediate attention. This is one reason the sick person seems to be able to think only of himself. Westberg states, "Almost any kind of illness can be thought of as a crisis experience, which means we are forced to

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[25] Ibid., p. 78.

[26] Ibid., p. 227.

[27] Ibid., p. 78.

[28] Ibid., p. 228.

stop and deal with it, no matter how busy we are at the moment."[29]

Because illness demands immediate attention and suspension of daily activities, it also often affords the opportunity for serious reflective thinking. Westberg says:

> When people come into the hospital, we see what they are really like. Some of them do a good deal of serious thinking, too, about their illness and about life in general. Some become downright philosophical. Some keep asking why this happened to them. Others become cynical and blame God for the predicament they are in.[30]

Patients who appear overtly to be engaged in serious thinking may actually be manifesting some of their spiritual needs.

Silence is still another type of behavior which some patients may exhibit. Silence in itself is not bad, and the implication is not that every patient should tell all to the nurse. Caution must be taken, however, to note that the patient's silence is not one caused by the nurse's lack of interest in listening. In such an instance the following might occur, according to Westberg: "The patient, after putting out several tentative feelers to those around him, has decided that no one cares enough about him to listen to his deeper thoughts."[31]

A reaction which is common, particularly in disorders of a long-term or permanent nature, is the grief reaction. Westberg says:

> The way in which a person grieves over the loss of something important in his life has a startling effect upon health. Grief is involved in many of the situations of life in addition to those related to the death of a loved one. It is entirely possible that a large proportion of functional and spiritual illness is brought about by the loss of someone or something that means a

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[29]Granger Westberg, Nurse, Pastor and Patient (Rock Island, Ill.: Augustana Press, 1955), p. 14.

[30]Ibid., p. 13.

[31]Ibid., p. 46.

> great deal to a person. Because the doctor and the minister confront grieving patients and parishioners almost daily, they should be cognizant of grief's potential relationship to illness.[32]

Finally, in illness it may be said that people go backward in their spiritual growth when they are terrified, depressed, bitter, and lonely.[33]

While it is true that nursing's major concern cannot be the spiritual growth of the patient, neither can it afford to ignore these behavioral reactions which may be indicative of spiritual needs. The reason is obvious, for nursing has committed itself to the care of the whole man, and man in his wholeness is committed to spiritual matters. Westberg says:

> Every nurse is in a sense a minister. Therefore she will include in her nursing care the care of the whole man. She will be as sensitive to spiritual pain as to organic pain. She will not walk away from organic suffering because she knows that there are ways she can help relieve it and assist in turning suffering into a growth experience.[34]

Care of the spiritual needs of the patient is not new to nursing, for historically, when the nursing care of physical man was not as complex as it is today, one of nursing's major concerns was to give the patient psychological and spiritual support. Cabot endorses this statement when he says:

> The nurse was once a sister, ignorant of the techniques of modern nursing, but persistently concerned about religion. She grasped much of what now seems to us the minister's opportunity. She made bad blunders in asepsis or in medical care, but she was everlastingly concerned about the patient's soul and, therefore, she often

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[32]Westberg, Minister and Doctor Meet, p. 98.

[33]Cabot and Dicks, op. cit., p. 55.

[34]Westberg, Nurse, Pastor and Patient, p. 36.

> refreshed both his body and his mind in ways which the modern nurse is too busy and too exclusively medical to consider.[35]

Bettelheim views nursing the spiritual needs of the patient as follows:

> The true virtue, the true calling of the nurse, consists neither in following doctor's orders nor in administering prescribed treatments (though she ought to do both conscientiously), but in the two aspects contained in the very name of the profession: to nurse and to nurture . . . the nurse should nurture the body and soul of her patient. . . . During the last hundred years it was important to put nursing on a scientific basis and make it a profession. Perhaps, now, without relinquishing advances, it is time we began again to pay more attention to the uplifting of spirits, which is no less essential to nursing than the healing of the body.[36]

Many authors stress the unique position of the nurse in ministering to and seeing that the patient's spiritual needs are met. Westberg reminds us that the professional nurse has the privilege of being close to people during hours of extreme stress.[37] He goes on to say that because of her unique position, she is not only a very valuable assistant to the doctor but to the pastor as well.[38] Westberg continues:

> It is with the patient who is going through inner struggle that the chaplain finds a helpful teammate in the intelligent nurse. . . . The nurse can be a bright spot in the picture if she develops the intuitive sense for being at the patient's side at the right time. If in addition she is equipped to talk with the patient in the right way at the right moment, then nursing care takes on a dimension that contributes immensely to the healing process.[39]

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[35]Cabot and Dicks, op. cit., p. 8.

[36]Bruno Bettelheim, "To Nurse and to Nurture," Forum, I (Summer, 1962), 60.

[37]Westberg, Nurse, Pastor and Patient, p. 13.

[38]Ibid., p. 26.

[39]Westberg, Minister and Doctor Meet, p. 77.

Dicks is in agreement with Westberg on this subject. He says:

> By the nature of her work, the nurse is in the best position to observe these necessities and if she does not deal with them herself, she can call them to the attention of someone else. . . . Unfortunately most nurses are not trained in either recognizing or in meeting spiritual needs either of a simple or complicated nature.[40]

With the above statement, Dicks introduces another facet of the problem. Nurses often are either unable or unwilling to recognize and respond to the patient's spiritual needs. Sister Mary Berenice says:

> Too often nurses excuse themselves from effort by placing the full burden upon the priest, who is not always able to reach the patient, or if able to do so might yet have had the way smoothed and shortened by an understanding nurse.[41]

She also says that many nurses unconsciously may not be aware of and alert to the spiritual needs of their patients.[42] Cabot is more harsh with his criticism of nurses who are unaware of the patient's spiritual needs. He states:

> If the sick man can eat and sleep, if he moves all his muscles and performs all his excretions, if he talks sensibly and does not cry, curse, or complain, he will probably be taken for normal by his medical attendants. The huge total of what he keeps to himself, all that he cannot express, or fears may be ridiculed, what he dreads, what he depends on, what he takes for granted, what he loves and now misses, the hopes and affections that he lives by, the frustrations and successes that have shaped him--these and many more further or impede his convalescence.[43]

This is not a very pleasant picture of nursing if we consider the whole of man as a value in our nursing care.

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[40]Dicks, Who Is My Patient, p. 33.

[41]Sister Mary Berenice, The Nurse Handmaid of the Divine Physician (Philadelphia: J. B. Lippincott Co., 1945), p. v.

[42]Ibid., p. 3.

[43]Cabot and Dicks, op. cit., p. 10.

An essential point is to accept the patient as he is. Dicks says:

> Start with the patient where you find him. By this we mean, take in the facts of his physical illness, the present condition of his mind, his emotions, and his spirit. If he will not accept the fact of his illness, his handicap, his impending death, or if he does not know of them, then start there. This does not fail the patient or yourself. You study his present plight and steer your course accordingly. You are honest with him and face the miseries of his situation. You let him talk about them if he desires. Then he recognizes you as a friend with courage. . . . This is a mature outlook neither embittered or unreal. We see the worth of human life, yet we know how hideously it can demean itself around human existence and often balks all that is best in us.[44]

Listening, then, can be a very effective way of dealing with the spiritual needs of the patient. But before the patient will express needs to which the nurse can listen, rapport must be established. Gardella, using observation and the case method, studied communication of nursing assistants with patients and professional nurses in relation to meeting patient needs. She presents five cases in her study. She states, "The expression of needs depends a great deal on the relationship between the worker and the patient."[45] Westberg, in regard to listening, says:

> The words people speak in times of crisis are heavily freighted with meaning. How they say things, when and in what context, can say volumes about themselves. When a patient asks a serious question from out of the depths within him, it is hoped that the mature nurse will be able to help him find expression. He is not asking for 'yes' or 'no' answers. He knows that no other human can predict what is in store for him during the years ahead, and he is not asking that they should attempt to do so. All he is

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[44] Ibid., p. 179.

[45] Frances Gardella, "A Study to Demonstrate Communication of the Nursing Assistant with the Patient and the Nursing Team as a Measure of the Identification and Satisfaction of Patient Needs" (unpublished Master's field study, School of Nursing, Boston University, 1959), p. 3.

> asking is that someone go down into the valley with him for a few minutes and try to understand what he is going through.[46]

Dicks concurs when he says:

> The religious needs of the sick are for a constant renewing, not for an intellectual answer, not for an explanation of the creeds or an answer to the cry. An explanation or answer cannot be understood because of the stress that is blocking the thinking process.[47]

Dicks also feels that listening is one of the most important functions the nurse can perform. He states, "The ability to listen, the courage to face suffering, to hear of loneliness, of boredom, of fears, to take these unto oneself through listening, is like clothes for the naked, shelter for the lost."[48] Westberg is in agreement with Dicks in regard to the importance of listening. He says:

> Therapy does not begin when certain counseling techniques are employed. It has begun when human love is demonstrated by a willingness to listen and be concerned. New evidence of nature's spontaneous surge toward health, maturity, and integration comes as a result of a relationship built upon mutual respect for the sacredness and the importance of the individual.[49]

With this statement, Westberg has introduced an important dimension which must be considered in the care of patients with spiritual needs. Each patient must be given the right to seek help for his spiritual needs in whatever way he sees fit. The nurse should not be interested, per se, in the patient's religion. Cabot and Dicks state: "She [the nurse] should be interested in whether or not the patient's religion works for him."[50] Bertocci says, "There is no standard of truth, of

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[46]Westberg, Nurse, Pastor and Patient, p. 19.

[47]Dicks, Who Is My Patient, p. 20.

[48]Cabot and Dicks, op. cit., p. 190.

[49]Westberg, Minister and Doctor Meet, p. 29.

[50]Cabot and Dicks, op. cit., p. 227.

goodness, or of beauty for all men. All persons are different. Who then is justified in imposing on others the code that works for him?"[51] Realization that the patient has a freedom to his own philosophy concerning his spiritual needs is important in nursing. This thought is supported by Westberg's statement to the effect that the patient has the right to accept religious care or reject it. It is hoped that nurses will make such assistance regularly available to those patients who respond affirmatively to it.[52]

It appears, then, that it is important for the nurse to call the patient's clergyman when the patient desires this. The majority of authors stress the importance of nursing referring patients to theologians, and most nurses probably consider this as part of their function. A review of literature revealed, however, one possible conflict in this area. Sister Berenice says:

> A Catholic nurse is not permitted to summon the official representative of any other religion for the expressed purpose of having him minister to members of his community. If she did, she would be directly encouraging what she is convinced is false worship.[53]

More recent publications, however, seem to contradict to some extent this statement. In the Code of Medical Ethics for Catholic Hospitals, the following statement appears: "Requests by non-Catholic patients to call their ministers are to be honored."[54]

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[51]Peter Bertocci, "Education and the Vision of Excellence," Boston University Lecture, Boston, Mass., March 23, 1960, p. 4.

[52]Westberg, Nurse, Pastor and Patient, p. 46.

[53]Berenice, op. cit., p. 234.

[54]Code of Medical Ethics for Catholic Hospitals (St. Louis: The Catholic Hospital Association of the United States and Canada, 1954), p. 11.

Dicks says that some of his most important requests to see patients have come from observant nurses.[55] Westberg discusses at length the importance of the nurse's referring patients to the clergy and gives particular types of patients most often needing and most often benefiting from pastoral care.[56]

Physicians, too, recognize the importance of calling the patient's clergyman. Wohl says:

> Spiritual insecurity is a source of unhappiness and concern on the part of the patient. Patients with a deep religious motivation, regardless of their faith, should have access to their clergy. It is always a little surprising and heart warming for patients of one faith, to find a physician who professes another faith, or no faith, solicitous about arranging for them to be seen by a clergyman of their faith and of their choosing.[57]

Prayer, as a method in the fulfillment of spiritual needs, can be a very effective one for the nurse to use. Yet many nurses feel inadequate when a patient asks them to pray with him. Westberg supports the belief that prayer does not have to be elaborate in order to help the patient.

> The kind of prayer we are talking about is a brief prayer of one to five sentences which grows naturally out of a particular situation. It is spoken in a quiet conversational tone with content that brings a feeling of calm and assurance to the patient. The prayer should not excite or stir up the patient by arousing feelings of apprehension and fear. It should be spoken with a ring of honest awareness of the loneliness and confusion which often casts our souls down, yet with a type of confidence in God that is unshaken.[58]

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[55]Dicks, Pastoral Care and Personal Counseling, p. 212.

[56]Westberg, Nurse, Pastor and Patient, p. 62.

[57]Michael G. Wohl, Long-Term Illness (Philadelphia: W. B. Saunders Co., 1959), p. 65.

[58]Westberg, Nurse, Pastor and Patient, p. 51.

Dicks also devotes discussion to the use of prayer. Essentially he says that the nurse should first sincerely desire to help the patient when he asks her to pray with him and that the nurse should not be too concerned if her thoughts about prayer are not complete.[59] Throughout her book, Sister Berenice refers to the use of prayer and the occasions when it might be most beneficial.[60]

Closely allied to prayer is the use of the Bible and other religious literature in helping to meet the patient's spiritual needs. The use of the Bible may be particularly important to the Protestant patient. Dicks believes there are three major conditions under which it may be desirable for the nurse to read the Bible to the patient. The first occurs with the patient who is inclined to be religious and who is restless, apprehensive, or discouraged. Second are the patients who are trying to build morale, and third the patient who is seriously ill or dying and who requests that the nurse read the Bible to him.[61] Most books on the religious care of patients include a list of appropriate Bible passages.

Sister Berenice also discusses the use of the Bible and other religious literature for the use of the Catholic patient.[62] Most Protestant denominations also have literature available which may be requested by the patient. In such instances, the nurse should make efforts either to obtain the literature herself, or to contact the proper clergy so

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[59]Dicks, Who Is My Patient, pp. 114-115.

[60]Berenice, op. cit., passim.

[61]Dicks, Who Is My Patient, pp. 107-108.

[62]Berenice, op. cit., passim.

that the patient will get the literature. On occasion, a few patients might seek the answers to their spiritual needs in books. Westberg emphasizes this when he states, "These patients may want to read books that deal intelligently with the matter of changing attitudes under pressure."[63] In these matters it is best to consult with the clergy concerning the best books available.

Cabot proposes another method which is not usually thought of as a helpful one in meeting the spiritual needs of patients. He advocates the use of humor when he states:

> We can do something through music and through the other art to which most Americans are sensitive--the art of humor. It sometimes seems as if humor and good humor were the American's only window into the world of spiritual values. Laughter lifts us for the moment above the wounding surface of our road. It is the nearest that some of us come to the praise of God, and if we cannot help a man pray it is some comfort to help him laugh.[64]

Another area for the nurse's consideration of her patient's spiritual needs is that of ritual. Most authors agree that this is an important area with which the nurse should be concerned. Included with ritual must also be such matters as dietary laws. Dicks states:

> The ritual or practice is needed which will afford a renewing for the sufferer. For the Roman Catholic it is the Sacrament, for the Protestant the Jew it is the practice with which he is familiar. . . . For the person who is not a practicing Catholic, Protestant or Jew who has no understanding of the Sacrament or belief in prayer, then other methods must be found. It is my belief that often such help must come not from the clergyman but from the nurse and doctor if it is to come at all.[65]

Sister Berenice's book is most complete in terms of the specific func-

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[63]Westberg, Minister and Doctor Meet, p. 76.

[64]Cabot and Dicks, op. cit., p. 66.

[65]Dicks, Who Is My Patient, p. 21.

tions of the nurse in working with the clergy as they administer the Sacraments. The most common Sacraments with which the nurse must be concerned are Baptism, which the nurse herself might administer, and Holy Communion, Penance, and Extreme Unction.[66]

In general, review of nursing literature divulges a sparsity of material concerned with the spiritual needs of patients. Spiritual needs are usually mentioned as a part of comprehensive care, but little content is devoted to an elaboration of this need.

In an article by Ashbrook, some of the more specific problems which the nurse should be expected to meet in caring for the spiritual needs of her patients are discussed. These include skills in facing the emotional and spiritual problems of the sickroom, contacting the patient's minister or hospital chaplain, and the use of the religious resources of literature and Sacrament. He expects that the nurse should show understanding that religion has to do with man's basic concern--his concern with the meaning of life. Ashbrook also cautions, however, that the nurse in ministering to her patient's spiritual needs should never try to become more than a fellow lay person and that nursing should not expect too much from students in this area of nursing care.[67]

Nursing research, too, has done little in this area of the patient's spiritual needs. In addition to the previously mentioned study by Aiken and Battiste, three other studies are of particular significance to this study. Sister David Carson, in a study of policies of Catholic

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[66]Berenice, op. cit., passim.

[67]James Ashbrook, "Not by Bread Alone," The American Journal of Nursing, LV (February, 1955), 164.

hospitals concerning meeting the spiritual needs of non-Catholic patients, found that there was a variety of policies in effect, but that there is a need for more emphasis on the spiritual care of non-Catholic patients if total care is to be achieved.[68]

In a study concerned with students' reactions to conflicts in religion and psychiatry, Mansfield found that although student problems occurred early in their experiences, students were not able to respond to and discuss religious questions arising from the patients.[69]

Finally, in a study of the activities used by nursing students in caring for the religious needs of the critically ill Catholic patient, Sister Dennis Marie Sullivan found that students did feel that nurses have a responsibility to help meet religious needs. They also spoke of activities which the nurse might use to meet these needs, but in practice used these activities to a limited degree on the day observed.[70] These findings of Mansfield and Sullivan may be an indication that nurses, although aware that they have a responsibility in helping patients meet their spiritual needs, in actual practice find it difficult to help

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[68]Sister David Carson, "Study of a Selected Group of Catholic Hospitals to Determine Their Policies in Caring for the Spiritual Welfare of the non-Catholic Patient" (unpublished Master's thesis, Catholic University of America, 1955), cited in Nursing Research, IV (June, 1955), 44.

[69]Elaine Mansfield, "Investigation of the Reaction of Basic Students of Nursing to Conflicts Arising in Their Integration of Psychiatry and Religion" (unpublished Master's thesis, University of Nebraska, 1956), cited in Nursing Research, VI (October, 1957), 92.

[70]Sister Dennis Marie Sullivan, "Activities Used by a Selected Number of Nursing Students to Help Meet Religious Needs of Critically Ill Catholic Patients" (unpublished Master's thesis, Catholic University of America, 1957), cited in Nursing Research, VII (February, 1958), 40.

patients meet spiritual needs.

Review of literature has thus corroborated the notion that, regardless of sect, patients do have spiritual needs which often manifest themselves in times of illness. Nurses, regardless of their own religious beliefs, have a responsibility in nursing the whole man to try and meet their patients' spiritual needs.

Statement of Hypothesis

The main purpose of this study was to determine what nurses believe their functions should be in meeting the spiritual needs of their patients. This is based upon the hypothesis that nurses do expect to meet spiritual needs of their patients by engaging in specific activities rather than by participating with the patient in religious practices.

CHAPTER III

METHODOLOGY

Selection and Description of Sample

Students of nursing and faculty members from one collegiate school of nursing located in a metropolitan area in Massachusetts participated in the study. At the time of the study, the student enrollment in the school was 869, but a sample of 277 students was chosen as participants as representative of various levels of sophistication in nursing education. This sample included students from the Basic Professional Nursing Program, the General Nursing Program, and the six graduate nursing programs. The respondents were a heterogeneous group in regard to length of service in nursing, present educational status, whether or not they had been hospitalized, religion, and age. With the exception of the students enrolled in the Basic Professional Nursing Program, all subjects were registered nurses.

Students in their junior year of nursing were chosen from the Basic Professional Nursing Program after consultation with faculty members in that program. It was felt that as juniors they represented the neophyte group in the nursing profession but had enough academic and clinical preparation to be familiar with the field study problem. They were the only homogeneous group participating in the study in respect to age and academic preparation.

The sample from the General Nursing Program was also selected after consultation with a faculty member responsible for that program.

The students from this program who participated were chosen from those enrolled in two sections of one course. Thus they were as nearly alike as possible in their collegiate preparation. In all other respects, they were a heterogeneous group.

A conference with the Chairman of the Graduate Division was held to determine the best method for selecting graduate students. It was decided that since each graduate student was required to attend a course in Research Methods, this might be the best way to contact these students. A representative sample of the graduate students from each of the specialty programs in the school of nursing was included in the study. These graduate students represented all of the graduate programs: Medical-Surgical Nursing, Rehabilitation Nursing, Psychiatric Nursing, Public Health Nursing, Maternal and Child Health Nursing, and Administration in Nursing Service and Nursing Education.

Fifty-six faculty members from both the Graduate and Undergraduate Divisions participated in the study. They represented the highest level of sophistication in nursing education. Faculty members of the Undergraduate Division represented both the Basic Professional Nursing Program and the General Nursing Program. The sample of graduate division faculty members represented each of the previously mentioned programs.

The writer originally intended to include in the sample administration of the questionnaire to patients since it was felt that the views of patients concerning the nursing functions which might be used to help them meet their spiritual needs would be of much interest and significance. Four agencies were contacted. Unfortunately, difficulty was encountered in procuring agency permission for patient participation. In

the first agency which had given permission, it was decided that the patients, because of the nature of their disabilities, would not provide a valid sample. Two agencies refused permission on the basis that the subject of the study was "potential dynamite." After contacting the fourth agency, resistance was encountered, and the climate in the agency appeared to be so negative that even if permission were obtained, it was felt that the results again would not have been valid. It was then decided that the study would have to be limited to a study of the opinions of nurses.

The characteristics of the respondents are presented in Table 1.

Procurement of Data

The Dean of the School of Nursing was contacted to obtain her permission to ask faculty members and students for their cooperation in this study. Permission was granted. Conferences were then held with the Chairmen of the Basic Professional Nursing Program, the General Nursing Program, and the Graduate Programs to determine the best method of selecting a representative sample and administering the questionnaire. Permission was obtained from these program chairmen to contact individual faculty members, who agreed to allow the investigator to administer the questionnaire during a part of selected class sessions. In all, conferences were held with nine faculty members, at which time the purpose of the study, the description of the sample needed for procurement of data, and the administration of the questionnaire were explained.

The investigator met with students to administer the questionnaire in ten mutually agreed upon class sessions. Data were collected from seventy-six students enrolled in the General Nursing Program at two class

TABLE 1

CHARACTERISTICS OF THE 277 RESPONDENTS

Years in Nursing	N [a]	Educational Status	N	Hospitalization [b]	N	Religion	N	Age	N
None [c]	57	Faculty Member	56	Yes	200	Catholic	96	20-29	165
0 - 5	85	Basic Professional Student	57	No	77	Protestant	137	30-39	56
6 - 10	42	General Nursing Student	76			Jewish	31	40-49	43
11 - 15	29	Graduate Students				Other	13	50-59	12
16 - 20	27	Medical-Surgical	23					60-69	1
21 - 25	21	Psychiatric	16						
26 - 30	12	Rehabilitation	11						
31 - 35	3	Maternal and Child Health	19						
36 - 40	1	Administration in Nursing Service and of Educational Programs	8						
Total	277		277		277		277		277

[a] Number

[b] Whether or not respondents had ever been hospitalized.

[c] Basic Professional Students had no experience.

sessions, and from five groups of Master's students totaling eighty-eight students. The Basic Professional students were met in three groups totaling fifty-seven students. Two groups of Basic Professional students were met in the hospital where they were having their medical-surgical nursing classes. All other students were met at the University. The writer was introduced to the students as a graduate student seeking their cooperation in the preparation of her field study. The sample consisted of all those present who were willing to participate in the study. Prior to the administration of the questionnaire, a brief explanation of the purpose of the study was given. Respondents were asked first to read the instruction sheet attached to each questionnaire before replying to the statements. The importance of responding to the statements with reference to the ideal nurse and of answering all of the statements was stressed. The need for completing the personal data sheet attached to each questionnaire was also explained. Students' identities were not made known. Following the administration of the questionnaire, the writer discussed with each group any questions the students had concerning the field study.

Arrangements for administering the questionnaire to faculty members were made through the chairmen of the Graduate and Undergraduate Divisions of the faculty. The questionnaire was administered to the faculty in two groups--one to the Graduate Division faculty members at a Graduate Division faculty meeting, and to the Undergraduate Division faculty members at an Undergraduate Division faculty meeting. Explanations similar to those given to the students were given to the faculty concerning the questionnaire. Identity of the faculty members also re-

mained anonymous.

The time required for answering each questionnaire was ten to twenty minutes. Data were procured from all of the groups in a two-week period.

Tools Used to Collect Data

A questionnaire was developed for collection of the data. An instruction sheet was formulated to accompany the tool. The instruction sheet explained that respondents were being asked to reply to sixty-four statements concerning the functions of the nurse in meeting the religious needs of her patients. The instruction sheet indicated that there was no right or wrong answer to the questions, and that the respondents were asked to express their opinions by marking "agree" or "disagree" in the appropriate column. Respondents were also asked to answer all of the questions in the context of their concept of the ideal nurse. It was further indicated that identity of the respondents would remain anonymous.[1]

The questionnaire was developed primarily from two sources--through planned discussion with theologians and through review of literature concerning the spiritual needs of people.[2] The questionnaire was constructed so that the beliefs of nurses about their functions in meeting the spiritual needs of patients could be ascertained. The statements, therefore, were formulated in terms of functions which the nurse might or might not perform. Statements dealt with many hypothetical functions so that nurses could react to them with the realization that

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[1]Appendix A.

[2]Appendix B.

all of these hypothetical functions were not necessarily nursing responsibilities. An attempt to insure reliability and validity of the items was made by making the same statement in a slightly different or in an opposite manner. Many statements also dealt with similar functions, but were worded to determine whether or not slight variations would make a difference in response. Statements also were formulated in such a manner as to determine whether or not the religion of either the patient or the nurse made a difference in their response. Statements were concerned with the following major categories: philosophy, relationship of the nurse and the clergyman, prayer, religious literature, dietary laws, and the sacraments. Respondents were asked either to agree or disagree with the statements. Because of the nature of the subject, it was felt that a larger choice of response, particularly if one were neutral, would mask opinions. Respondents were, therefore, forced to make an agree or disagree decision.

An information sheet asking the respondents for their initial date of graduation from a school of nursing, their present educational program, whether or not they had ever been hospitalized, their religion, and age was attached to each questionnaire.[3] This information was sought to see whether or not these factors affected the opinions of the respondents.

The writer consulted personnel at the computing center for information concerning the advisability of IBM computing the data and for information about coding the questionnaire. Plans were made to have IBM compute the data. The questionnaires were coded for IBM tabulation ac-

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[3]Appendix C.

cording to information obtained on the personal data sheet.[4] The letters A B C D E appeared at the top of each questionnaire. Information from the personal data sheet was placed under the appropriate letter with the appropriate code. Hence, if the top of the questionnaire read $\begin{matrix} A & B & C & D & E \\ 3 & 3 & 2 & 1 & 2 \end{matrix}$, it was known that the respondent had between six and ten years of nursing experience, was enrolled in the General Nursing Program, had never been hospitalized, was of the Catholic faith, and was between thirty and thirty-nine years of age. Each statement on each questionnaire was also coded for agreement or disagreement--agree always being 1 and disagree 2. Finally, each questionnaire was numbered with mutually exclusive numbers. IBM cards were punched according to the coded questionnaire. Information was then tabulated and data were returned to the writer for analysis.

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[4]Appendix D.

CHAPTER IV

FINDINGS

Data were obtained from the responses of 277 students and faculty members of a collegiate school of nursing to a sixty-four item questionnaire. Respondents were asked to agree or disagree with the sixty-four statements which were concerned with the nurse's role and activities in meeting the spiritual needs of patients. Data were analyzed according to the number and per cent of agree and disagree responses to each statement and then to each section of the questionnaire, which was divided into nine areas.

The total number and percentage of agree and disagree responses to the sixty-four statements are presented in Table 2. Statements one through nine were concerned with the patients' religious beliefs and their importance and relationship to the care of patients. In response to the first statement, 264 of the 277 or 95 per cent of the respondents agreed, "the nurse realizes that during illness religion is important to the patient." There were 264 or again 95 per cent disagree responses to statement two, which was the antithesis of statement one. These responses seem to give support to the belief that nurses do think the spiritual needs of patients are important, which was the basis of the hypothesis. With the exception of statement four, responses to the first nine statements showed a ninety-five per cent or more agreement that both the nurse and the patient have a right to their own religious beliefs, and that their individual beliefs should not influence the manner

TABLE 2

NUMBER AND PERCENTAGE OF AGREE AND DISAGREE RESPONSES TO THE SIXTY-FOUR STATEMENT QUESTIONNAIRE

Statement Number	Frequency		Percentage		Statement Number	Frequency		Percentage	
	A	D	A	D		A	D	A	D
1	264	12	95	4	33	204	71	74	26
2	13	264	5	95	34	150	122	54	44
3	264	11	95	4	35	36	240	13	87
4	26	249	9	90	36	19	257	7	93
5	269	6	97	2	37	65	211	23	76
6	275	2	99	1	38	56	219	20	79
7	19	257	7	93	39	246	30	89	11
8	15	262	5	95	40	4	273	1	99
9	262	14	95	5	41	129	146	47	53
10	114	163	41	59	42	14	262	5	95
11	99	178	36	64	43	14	261	5	94
12	47	226	17	82	44	259	17	94	6
13	249	25	90	9	45	198	77	71	28
14	263	13	95	5	46	188	86	68	31
15	73	202	26	73	47	203	70	73	25
16	75	200	27	72	48	1	275	1	99
17	67	209	24	75	49	1	275	1	99
18	269	8	97	3	50	1	275	1	99
19	266	11	96	4	51	262	14	95	5
20	270	7	97	3	52	277	--	100	--
21	241	33	87	12	53	266	10	96	4
22	274	1	99	1	54	245	32	88	12
23	276	1	100	--	55	35	237	13	86
24	66	207	24	75	56	246	30	89	11
25	13	263	5	95	57	25	249	9	90
26	1	276	--	100	58	16	260	6	94
27	269	7	97	3	59	106	167	38	60
28	76	201	27	73	60	269	8	97	3
29	198	75	71	27	61	1	276	--	100
30	190	83	69	30	62	270	7	97	3
31	182	92	66	33	63	8	269	3	97
32	158	114	57	41	64	260	14	94	5

in which nurses meet the spiritual needs of their patients. It was of interest, however, that 26 of the 277 respondents or 9 per cent agreed with statement four, which read, "the nurse tries to change the patient's religious beliefs if she feels they hinder recovery." Although there were 249 disagree responses to this item, the writer found it surprising that even a few nurses felt they should try to change a patient's religious beliefs under any circumstances.

Statements seven and eight, "when the nurse disagrees with a patient about his religious beliefs she should tell him," and "the nurse should refuse to talk about religion if she does not agree with the patient," respectively, were intended to be opposites. Data indicate, however, that respondents apparently did not view them as such, since there were 297 or 93 per cent disagree responses to statement seven, and 262 or 95 per cent disagree responses to statement eight. It is impossible to project the real reason for this, but inadequate formulation of the statements could account for the inconsistency in response.

Items ten, eleven, twelve, and fifty-nine were concerned with the relationship of the nurse to the clergyman when he visits the patient. Although item fifty-nine does not follow numerically, its content makes it feasible to include it when discussing data relevant to this section of the questionnaire. Responses to these four statements show more divergence of opinion among the respondents than any other group of statements. To item ten, "the nurse automatically leaves the room if the clergyman is visiting the patient," there were 114 or 41 per cent agree and 163 or 59 per cent disagree responses. Analysis of responses to item eleven, "the nurse leaves the room only if the clergyman requests

her to leave," showed 99 or 36 per cent agree and 178 or 64 per cent disagree responses. The responses to item fifty-nine, "the nurse should let the pastor visit even if the patient is in the midst of care or treatment," revealed 106 or 38 per cent agree and 167 or 60 per cent disagree responses. Analysis of the responses to item twelve showed the least amount of divergence of opinion among respondents to this section of the questionnaire. There were 47 or 17 per cent agree and 226 or 82 per cent disagree responses. This item stated: "if the patient is seriously ill the nurse does not leave the room even if the clergyman requests her to leave." These data may indicate that the nurse does not feel she should leave the critically ill patient. The divergence in the response to this group of statements, however, may also indicate that nurses are not sure what they should do when the clergyman visits the patient.

Statements thirteen through twenty-three dealt with a variety of factors and philosophies which might influence a patient's spiritual beliefs during illness. There were ninety per cent or more agree responses to items thirteen, fourteen, eighteen, nineteen, twenty, twenty-one, twenty-two, and twenty-three indicating that nurses do believe they should understand the factors which influence the patient's spiritual beliefs during illness. Analysis of responses to the remaining statements in this area also supports this conclusion. To item fifteen, "the nurse understands that sickness is the will of God," there were 202 or 73 per cent disagree responses. Data related to item sixteen, "the nurse explains to the patient how the idea of God applies to health and illness," revealed that 200 or 72 per cent of the respondents did not

feel that this was a nursing responsibility or function. Analysis of responses to item seventeen, "the nurse knows that the patient wants an answer when he asks such questions as 'why does God punish me?'" showed that 67 or 24 per cent of the nurses felt they should answer at least some of the patient's philosophical questions. Analysis of the last statement in this group showed that all of the respondents felt the nurse should be concerned with the religious needs of the dying patient.

Statements twenty-four through thirty-four were concerned with nursing responsibilities for calling the clergyman for the patient. Analysis of responses to statements twenty-five, twenty-six, twenty-seven, and twenty-eight would seem to indicate that nurses feel they do have some responsibility for calling the clergy regardless of their own or the patient's faith. In response to item twenty-four, 207 or 75 per cent of the respondents did not feel that the nurse should call the clergyman when a patient was admitted. This may indicate that notifying the clergy is not a nursing responsibility in certain hospitals, or that the clergy are notified through other sources such as the admitting office personnel. Analysis of responses to statements in this area of the questionnaire showed considerable divergence of opinion concerning the circumstances under which the nurse should call the clergyman. All responses, however, indicated nurses were in agreement that they should call the clergy under certain circumstances. The two items which revealed the most divergence of opinion among the nurses were items thirty-two and thirty-four. There were 158 or 57 per cent agree responses and 114 or 41 per cent disagree responses to item thirty-two, "the nurse should refer patients whose illness has forced them to change

their way of living to the clergyman." There were 150 or 54 per cent agree and 122 or 44 per cent disagree responses to item thirty-four, "the nurse should refer patients with social problems such as the unwed mother to the clergyman."

Analysis of responses to statements thirty-five through forty, which were concerned with the use of religious literature in meeting the patient's spiritual needs, indicated that nurses are hesitant about using religious literature with patients. However, responses to statement thirty-nine, "the nurse regardless of faith should read religious literature to the patient if he asks her to," revealed that 246 or 89 per cent of the respondents agreed that the nurse should do this.

Items forty-one, forty-two, and forty-three pertained to the responsibilities of the nurse for using prayer as a means of helping to meet the patient's spiritual needs. There were 14 or 5 per cent agree and 262 or 95 per cent disagree responses to item forty-two, "only the nurse of the same faith as the patient should pray with him." To item forty-three, "the nurse should never pray with the patient," there was a similar degree of agreement, since only 14 or 5 per cent agreed and 261 or 94 per cent disagreed with this statement. Item forty-one showed the greatest divergence of opinion among respondents. One hundred and twenty-nine or 47 per cent felt that the nurse should suggest prayer to the patient, while 146 or 53 per cent did not agree that the nurse should suggest prayer to the patient.

Statements forty-four through fifty-three were related to the nurse's role in providing the means by which patients could receive Holy Communion. There were ninety-four per cent or more agree responses to

statements forty-four, fifty-one, fifty-two, and fifty-three. It appears nurses believe they should understand that Communion can be important to the patient, that nurses should prepare the patient for Communion, that the nurse should provide privacy for the patient to receive Communion, and that they should tell patients it is possible to receive Communion during hospitalization.

There were 275 or 99 per cent disagree responses to statement forty-eight, "only the Catholic nurse should make provision for the Catholic patient to receive Holy Communion," to statement forty-nine, "only the Protestant nurse makes provision for the Protestant patient to receive Holy Communion," and to statement fifty, "the Jewish nurse should not make provision for the Christian patient to receive Holy Communion." Although statements forty-eight, forty-nine, and fifty were intended to be the opposite of items forty-five, forty-six, and forty-seven, responses to these items indicate that respondents did not interpret the statements as opposites. Response to statement forty-eight, "the nurse regardless of faith makes provision for the Protestant patient to receive Holy Communion," showed 198 or 71 per cent agree and 77 or 28 per cent disagree responses. There were 188 or 68 per cent agree and 86 or 31 per cent disagree responses to statement forty-six, "the nurse regardless of faith routinely makes provision for the Catholic patient to receive Holy Communion." To item forty-seven, "the nurse regardless of faith makes provision for the Christian patient to receive Holy Communion only if asked by the patient," there were 203 or 73 per cent agree and 70 or 25 per cent disagree responses. There was a twenty per cent discrepancy in response to these six items, which could mean the statements were poorly

constructed.

In response to statement fifty-four, "the nurse routinely calls the priest to administer Extreme Unction to the dying Catholic patient," 245 or 88 per cent agreed and 32 or 12 per cent disagreed. The response to item fifty-five, "the nurse should call the priest to administer Extreme Unction only if requested by the patient's family," which was intended to be the opposite of item fifty-four, revealed consistency in total response, with 35 or 13 per cent agreeing and 237 or 86 per cent disagreeing to the latter statement.

Analysis of data from items fifty-six, fifty-seven, and fifty-eight showed that eighty-nine per cent more of the respondents felt that nurses should baptize the dying Catholic child or adult regardless of their own personal faith.

Data relative to statements sixty and sixty-one, which were concerned with dietary regulations, indicated that ninety-seven per cent of the respondents believed nurses should see that meals are in keeping with the dietary laws of the patient's religion regardless of the nurse's own faith. There was ninety per cent agreement to statements sixty-two and sixty-three, which means that the majority of the respondents felt that nurses regardless of their personal faiths should assist the Rabbi as directed.

The last item was concerned with provision for patients to attend hospital chapel service whenever possible, and ninety-four per cent of the respondents felt that this was a nursing responsibility.

The statements of the questionnaire were divided into nine sections according to the relationship of the content within the sections.

Data analyzed according to the categories of the respondents to each of the sections are presented in Tables 3 through 10. Data are presented by section of the questionnaire and categories of the respondents showing the percentage of agree and disagree responses to each item only when the specific category differed ten per cent or more from the total sample response. The only exception to this ten per cent differentiation is the category Hospitalization, where a differentiation of eight per cent or more is shown because of the general lack of divergence within this category. For ease in comparison, the percentage of agree and disagree responses of the total sample is included in each table; thus the "total" column is not the total of the responses in the table but is the total sample response. Many of the statements were left blank by some of the respondents, accounting for the fact that responses do not always total one hundred per cent. For a detailed item analysis of the numbers of agree and disagree responses to each item by category of the respondents, see Tables 11 to 15 in Appendix E.

The first nine statements of the questionnaire were concerned with the importance of religious beliefs to the patient during illness. Analysis of these statements is presented in Table 3. In general, there seemed to be no particular pattern of response to these items. The major categories Years in Nursing and Hospitalization showed no deviation from the total sample response. There were similar responses to item eight from the Educational Program category Rehabilitation and the Religious category "Other." It is unlikely, however, that this similarity can be attributed to having the same respondents in each category. There was also a similar response between the Rehabilitation group and

TABLE 3

PERCENTAGE OF AGREE AND DISAGREE RESPONSES TO STATEMENTS ONE THROUGH NINE CONCERNED WITH THE SIGNIFICANCE OF RELIGIOUS BELIEFS ACCORDING TO CATEGORIES OF RESPONDENTS WHICH SHOWED MORE THAN TEN PER CENT DIFFERENCE FROM THE TOTAL SAMPLE RESPONSE

Statement Number	Categories of the Respondents										Total Sample Response	
	Educational Program				Religion		Age Group					
	Rehab.[a]		Adm.		Other		30 - 39		50 - 59			
	A	D	A	D	A	D	A	D	A	D	A	D
1											95	4
2									25	75	5	95
3											95	4
4											9	90
5											97	2
6											99	1
7			25	75			18	82				
8	27	73			23	77					5	95
9	82	18							83	17	95	5

[a] The following key will be used throughout the remainder of the tables:

Rehab. -- Rehabilitation
Adm. -- Administration
Med.-Surg. -- Medical-Surgical
MCH -- Maternal and Child Health
Public H. -- Public Health
G.N. -- General Nursing
Psych. -- Psychiatry

the 50-59 age group. Again the reason for this similarity is not known, but it is known that the respondents in these two groups were definitely not the same, since the Rehabilitation category is a student group composed primarily of respondents younger than fifty to fifty-nine. In general, responses to these nine items indicated that nurses feel they do have a responsibility to understand the importance of religious beliefs to the ill patient. There was a high level of agree or disagree responses to all of these items regardless of category.

Table 4 shows the replies of the respondents to statements ten, eleven, twelve, and fifty-nine. These statements were concerned with the relationship of the nurse to the clergyman when he visits the patient. These data indicate that there was much more divergence of response to these items than to items one through nine. Variation from the total sample response to these four items is quite scattered among the categories. In considering item ten, with the exception of two categories, the differentiation in response from the total sample response was slightly more than a ten per cent reversal of the total sample response. The two categories which showed the most difference from the total response were the Religious category "Other" and the Age group 50-59. These respondents showed a high disagree response to the item as did the total sample response. The amount of conflict among respondents is evidenced by the small per cent of divergence between agree and disagree responses within the item, generally between forty-five and fifty-five per cent.

Items eleven and twelve did not show as much divergence as item ten. Two categories, Religion "Other" and the 21-25 group in the

TABLE 4

PERCENTAGE OF AGREE AND DISAGREE RESPONSES TO STATEMENTS 10, 11, 12, and 59 WHICH WERE CONCERNED WITH THE RELATIONSHIP OF THE NURSE TO THE CLERGYMAN WHEN HE VISITS THE PATIENTS ACCORDING TO CATEGORIES OF RESPONDENTS WHICH SHOWED MORE THAN TEN PER CENT DIFFERENCE FROM THE TOTAL SAMPLE RESPONSE

Statement Number	Categories of Respondents																					
	Years in Nursing										Educational Program											
	Student		6 - 10		11 - 15		21 - 25		26 - 30		Med.-Surg.		Psych.		Rehab.		MCH		Public H.		Adm.	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
10			52	48	69	31					52	48					53	47			63	38
11					21	79	57	43							64	36						
12									8	92					--	91			36	64		
59	28	72											19	81			58	42	55	45		

Statement Number	Religion				Age		Total Sample Response	
	Jewish		Other		50 - 59			
	A	D	A	D	A	D	A	D
10	52	48	15	85	25	75	41	59
11	26	74	54	46			36	64
12	32	65	23	77			17	82
59	19	81					38	60

category Years in Nursing, responded similarly to item eleven. The students in Public Health and Jewish nurses responded similarly to item twelve. In response to item fifty-nine, respondents in the Maternal and Child Health and in the Public Health programs responded similarly. Since these respondents were students in different educational programs, they were not the same respondents. The category which showed the most differentiation from the total sample response to these items was Religion. The Jewish nurses and nurses who designated their religion as "Other" consistently differed in their response to the total sample response to all four items. The relationship of these groups of respondents to their clergy might be a factor underlying their response. Although responses to these four items were scattered among the categories and the items, the responses indicate that nurses do feel conflict about what to do when the clergy visits the patient. Analysis also suggests that most nurses do not think they should leave the seriously ill patient even if asked to leave by the clergyman.

Responses to statements thirteen through twenty-three are presented in Table 5. These statements are concerned with some of the factors which might influence a patient's religious beliefs during illness. Responses to these items were widely scattered in relation to both category and item. The categories 26-30 Years in Nursing and Age 50-59 showed very similar responses to statement thirteen. It is quite likely that this similarity could be attributed to many of the same respondents being in both groups. Also in response to this item, the Faculty group totaled only a sixty per cent response, indicating that many faculty members left this item blank. The Faculty and students in the Administra-

TABLE 5

PERCENTAGE OF AGREE AND DISAGREE RESPONSES TO STATEMENTS THIRTEEN THROUGH TWENTY-THREE WHICH WERE CONCERNED WITH FACTORS WHICH MIGHT INFLUENCE A PATIENT'S RELIGIOUS BELIEFS DURING ILLNESS ACCORDING TO CATEGORIES OF RESPONDENTS WHICH SHOWED MORE THAN TEN PER CENT DIFFERENCE FROM THE TOTAL SAMPLE RESPONSE

Statement Number	Categories of Respondents																			
	Years in Nursing								Educational Program											
	Student		16 - 20		21 - 25		26 - 30		Faculty		G.N.		Med.-Surg.		Psych.		MCH		Adm.	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
13							67	25	44	16							79	21		
14																				
15			7	93					11	89			39	61					13	88
16																			50	50
17					14	86	--	92	7	91	36	64					47	53		
18																				
19																				
20																				
21	77	23					67	33											100	--
22																				
23																				

(concluded on next page)

TABLE 5 (concluded)

Statement Number	Categories of Respondents													
	Hospitalization				Religion						Age		Total Sample Response	
	Yes		No		Catholic		Jewish		Other		50 - 59			
	A	D	A	D	A	D	A	D	A	D	A	D	A	D
13			84	13							67	33	90	9
14													95	5
15					48	51			8	92	--	100	26	73
16			19	81	38	63	19	81					27	72
17													24	75
18													97	3
19													96	4
20													97	3
21											75	25	87	12
22													99	--
23													100	--

tion Program responded alike to statement fifteen. The greatest deviation from the total sample response occurred in the category Educational Program. Respondents who had never been hospitalized varied twice in comparison to the total sample response. Deviation in response according to Religion was evidenced in response to items fifteen and sixteen by Catholic, Jewish, and "Other" respondents. Although no particular pattern is discernible, these two items were concerned with "sickness as the will of God." In general, responses to statements thirteen through twenty-three indicated that the nurses felt they should be understanding and accepting of the varieties of factors which might influence a patient's religious beliefs during illness, but that they should not take an active role in discussing these factors with the patient.

Table 6 is, perhaps, the most interesting and significant of all the tables. Analysis of statements twenty-four through thirty-four is presented in this table. These statements were concerned with nursing responsibilities for calling the patient's clergyman. Hospitalization of respondents was the only major category which did not seem to affect response. This further supports growing indication that hospitalization is not a discriminatory factor in response differential. There were some differences in response to item twenty-four. The categories Student in Years in Nursing and Basic in Educational Program revealed the exact same response, probably because both groups were comprised of exactly the same respondents. This likeness in response between these two categories was carried through generally to items twenty-nine through thirty-four. The following categories of respondents showed similar response to item twenty-four: Years in Nursing 16-20 and 21-25,

TABLE 6

PERCENTAGE OF AGREE AND DISAGREE RESPONSES TO STATEMENTS TWENTY-FOUR THROUGH THIRTY-FOUR WHICH WERE CONCERNED WITH CALLING THE CLERGYMAN ACCORDING TO CATEGORIES OF RESPONDENTS WHICH DIFFERED MORE THAN TEN PER CENT FROM THE TOTAL SAMPLE RESPONSE

Statement Number	Categories of Respondents																	
	Years in Nursing												Religion					
	Student		11 - 15		16 - 20		21 - 25		26 - 30		31 - 35		Catholic		Jewish		Other	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
24	42	58			11	89	10	90							35	65	--	100
25																		
26																		
27																		
28			38	62									18	82			46	54
29	86	14			56	41			42	42	33	67			84	16		
30	89	11							17	58					84	13	31	69
31	82	18			48	48			25	58			79	21	77	23	23	77
32	89	11			59	37			33	58			69	29			8	92
33															87	13	46	54
34	72	28					29	71	8	75			65	33			23	77

(concluded on next page)

TABLE 6 (concluded)

Statement Number	Categories of Respondents																							
	Age						Educational Program																	
	40 - 49		50 - 59		60 - 69		Faculty		Basic		G.N.		Med.-Surg.		Psych.		Rehab.		MCH		Public H.		Adm.	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
24									42	58					13	88	45	55	11	89	9	91	13	88
25																								
26																								
27																								
28	16	84	50	50	100	--							9	91	38	63							38	63
29			33	67			45	50	86	14	83	16			56	44								
30	53	37	17	83			41	52	89	11					38	63	82	10					50	50
31			8	92			39	55	82	18					50	50							38	63
32			8	92			27	66	75	25					44	56							38	63
33	60	35	33	67			50	46	89	11							55	45					63	38
34	26	63	8	92			29	64	72	28	68	30	74	26			45	55	32	68	45	55	13	88

and the Educational Programs, Psychiatry, Maternal and Child Health, Public Health, and Administration. It is possible that one of the reasons for this might be that many of the same respondents fell in both categories. Only one group, the Rehabilitation students, responded like the Basic students.

This table, then, shows that there were no deviations from the total sample response to statements twenty-five, twenty-six, and twenty-seven. The total sample response to these items showed a high percentage of agree or disagree unity. There was, however, considerable divergence by category to items twenty-nine through thirty-four. Within the major category Years in Nursing, the Student, 16-20, and 26-30 groups showed the most divergence in response to items twenty-nine through thirty-two. Of these groups, the Students showed the least conflict, with better than eighty per cent agree responses to these items. Again, the Student group responded the same as the Basic group because both categories were comprised of the same respondents. The nurses who had 26-30 Years of Nursing experience showed more difference than the Student group both within itself and to the Student group by showing more disagreement to the item.

The groups within the Religion category also showed conflict to these six items. In general, the respondents who categorized themselves as "Other" responded in reverse to the total sample response and to the Catholic response. Since this is not the first time that the "Other" category has reversed itself in response, it is possible that two factors are operating within this category. The fact that some people did not select a religion might indicate that they would respond differently to questions of a spiritual nature. The second factor concerns the fact

that respondents might have been foreign students who themselves adhere to one of the Eastern religions and who also might not have understood the questions worded in a Western context. In the Religion category, the Jewish nurses and the Catholic nurses tended to respond to these items somewhat alike. This could be due to the Judaic foundation of the Christian religion.

Respondents in the Experience category 30-35 years, and in the Age category 50-59 years, gave the exact same response to item twenty-nine. Probably many of the same respondents were in both groups. Age categories 50-59 years and Religion "Other" responded the same to item thirty-two. Educational Program again showed the most divergence in response to the total sample response. The Faculty and Basic students consistently were opposed in their responses to the six items. The Student group was consistently more sure and positive in its response than the Faculty group, which showed much more conflict in response. Respondents in the Faculty and Rehabilitation categories showed the same response to item thirty-three. The reason for this is not known, but the same respondents could not have been in both groups because they both came under the major category of Educational Program. There were no other patterns of response to these items. In general, responses to statements twenty-four through thirty-four indicated that nurses feel they have a responsibility under certain circumstances to call the clergy. There was considerable conflict, however, concerning the specific circumstances under which the nurse should do this.

Statements thirty-five through forty were concerned with the use of religious literature in helping to meet the patient's spiritual needs.

Analysis of these data are presented in Table 7. Differences in response by category and item were fairly well scattered. Three categories showed one hundred per cent disagree responses to item thirty-five. These were: Public Health, 50-59 years of Age, and "Other." In response to item thirty-eight, again the Basic and Student responses are alike because the same respondents are in both groups. In response to this same item, the Faculty, Psychiatric, and Age groups 40-49 answered alike. It is quite possible that many of the same respondents were in the Faculty and 40-49 Age categories. This table also shows that there was more differentiation according to Educational Program than any other major category. There was also indication that nurses were resistant about initiating the use of religious literature but that they would comply if the patient suggested this.

Table 8 demonstrates the responses to statements forty-one through forty-three, which were concerned with the use of prayer in helping to meet the patient's spiritual needs. Differentiation according to category was widely scattered, although most differentiation occurred to item forty-one. The Medical-Surgical and Rehabilitation nurses responded alike to item forty-one, which may be an indication of similarity in educational preparation and interest. Faculty and Psychiatric nurses' groups responded alike to this item but in opposition to the Medical-Surgical and Rehabilitation groups. The Catholic and Protestant respondents also showed opposition. The Catholic response was like the Rehabilitation and Medical-Surgical response, while the Protestants responded like the Faculty and Psychiatric groups. This response could be the result of a predominance of one religion in the respective Educa-

TABLE 7

PERCENTAGE OF AGREE AND DISAGREE RESPONSES TO STATEMENTS THIRTY-FIVE THROUGH FORTY WHICH WERE CONCERNED WITH RELIGIOUS LITERATURE ACCORDING TO CATEGORIES OF RESPONDENTS WHICH SHOW MORE THAN TEN PER CENT DIFFERENCE FROM THE TOTAL SAMPLE RESPONSE

Statement Number	Categories of Respondents																			
	Years in Nursing								Educational Program											
	Student		16 - 20		21 - 25		26 - 30		Faculty		Basic		Psych.		Rehab.		Public H.		Adm.	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
35							8	92									--	100		
36																				
37													6	94			9	91	38	63
38	33	65			--	100	--	100	5	93	33	65	6	94	9	91				
39			74	22									69	31						

Statement Number	Hospitalization				Religion				Age				Total Sample Response	
	Yes		No		Jewish		Other		40 - 49		50 - 59			
	A	D	A	D	A	D	A	D	A	D	A	D	A	D
35							--	100			--	100	13	87
36													7	93
37	26	74	17	82	19	81							23	76
38									7	91	--	100	20	79
39													89	11
40													1	99

TABLE 8

PERCENTAGE OF AGREE AND DISAGREE RESPONSES TO STATEMENTS FORTY-ONE THROUGH FORTY-THREE WHICH WERE CONCERNED WITH PRAYER ACCORDING TO CATEGORIES OF RESPONDENTS WHICH SHOWED MORE THAN TEN PER CENT DIFFERENCE FROM THE TOTAL SAMPLE RESPONSE

Statement Number	Categories of Respondents																			
	Years in Nursing		Educational Program										Religion							
	26 - 30		Faculty		Med.-Surg.		Psych.		Rehab.		MCH		Catholic		Protestant		Jewish		Other	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
41			29	70	61	39	31	69	64	36			64	35	36	63			15	85
42	17	83									16	84					16	84		
43																				

Statement Number	Age		Total Sample Response	
	50 - 59			
	A	D	A	D
41	8	92	47	53
42			5	95
43			5	94

tional Program categories. Three categories responded similarly to item forty-two. These were: 26-30 Years in Nursing, Maternal and Child Health, and Jewish categories. It would not seem that many of the same respondents were in all of these groups, thus this could not account for this likeness in response. In general, analysis of these statements revealed that nurses were hesitant about using prayer, but that if the patient suggested it they would comply.

Statements forty-four through fifty-three were concerned with the responsibilities of the nurse in making provision for the patient to receive Holy Communion. These statements and responses are presented in Table 9. The heaviest concentration of differentiation in response is seen in items forty-five, forty-six, and forty-seven, which were concerned with the relationships of the faith of the nurse and the patient in providing for Holy Communion. Most of the conflict was seen in relationship to item forty-five, which specifically was concerned with helping the Protestant patient. Again the Basic and Student responses were alike because of the same respondents being in both groups. Conflict to the total sample response was seen in categories 26-30 Years in Nursing, Psychiatry, Administration, Age 50-59 years, and "Other." One possible explanation for this response might be an unawareness by respondents that some Protestant patients do receive Communion. In response to item forty-six, the categories 16-20 and 26-30 Years in Nursing, Rehabilitation, and Administration groups answered alike. To item forty-seven, 50-59 Age group and Administration categories agreed one hundred per cent. Four of the categories responded differently from the total sample response to all three of these items. These categories were: "Other"

TABLE 9

PERCENTAGE OF AGREE AND DISAGREE RESPONSES TO STATEMENTS FORTY-FOUR THROUGH FIFTY-THREE WHICH WERE CONCERNED WITH HOLY COMMUNION ACCORDING TO CATEGORIES OF RESPONDENTS WHICH SHOWED MORE THAN TEN PER CENT DIFFERENCE FROM THE TOTAL SAMPLE RESPONSE

Statement Number	Categories of Respondents																					
	Years in Nursing						Educational Program												Hospitalization			
	Student		16 - 20		26 - 30		Faculty		Basic		Psych.		Rehab.		Public H.		Adm.		Yes		No	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
44					75	25	80	18														
45	84	16			42	50			84	16	50	50	64	36			50	50				
46			56	41	50	42							45	45			50	50	66	34	74	25
47	61	39			92	8			61	39							100	--				
48																						
49																						
50																						
51															82	18						
52																						
53					75	17																

Statement Number	Religion		Age		Total Sample Response	
	Other		50 - 59			
	A	D	A	D	A	D
44					94	6
45	46	54	50	50	71	28
46	38	62	42	58	68	31
47	85	15	--	100	73	25
48					--	99
49					--	99
50					--	99
51					95	5
52					100	--
53			83	17	96	4

Religion, 26-30 Years in Nursing, Administration, and Age group 50-59. In general, the reason for this response to these three statements is not known, but is probably due to inadequate item formulation. General response to statements forty-four through fifty-three indicates that nurses do feel they have a responsibility for providing that the patient receive Holy Communion regardless of their own or the patient's faith. Responses again indicated that nurses were hesitant about initiating religious activities.

Table 10 presents analysis of items fifty-four through fifty-eight. These statements were concerned with the sacraments of Baptism and Extreme Unction. Differentiation in responses were clumped according to major category rather than by item. There was no particular pattern of response. The category 11-15 Years in Nursing differed in response to items fifty-six, fifty-seven, and fifty-eight as did the Administration group. The differences, however, were not similar. Maternal and Child Health nurses differed in response to items fifty-four, fifty-five, and fifty-seven, while the "Other" group responded differently to items fifty-four, fifty-five, and fifty-six. Although there were these differences in responses, there did not seem to be similarities in responses either within the categories or between items.

In summary, the greatest area of conflict was seen in those items concerned with the relationship of the nurse and the clergy. Nurses generally were willing to meet the patient's spiritual needs, but preferred that the patient initiate actions in this area of nursing care. Hospitalization of respondents was the category which showed the least effect on the response of the respondents, while Educational Programs

TABLE 10

PERCENTAGE OF AGREE AND DISAGREE RESPONSES TO STATEMENTS FIFTY-FOUR THROUGH FIFTY-EIGHT CONCERNED WITH EXTREME UNCTION AND BAPTISM ACCORDING TO CATEGORIES OF RESPONDENTS WHICH DIFFERED MORE THAN TEN PER CENT FROM THE TOTAL SAMPLE RESPONSE

Statement Number	Categories of Respondents																	
	Years in Nursing				Educational Program								Religion		Age		Total Sample Response	
	11 - 15		26 - 30		Faculty		MCH		Public H.		Adm.		Other		50 - 59			
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
54							63	37	100	--			54	46	75	25	88	12
55			33	58	21	73	32	68					46	54	33	67	13	86
56	76	24									50	50	77	23			89	11
57	14	76					11	89			38	63					9	90
58	21	79									25	75					6	94

seemed to be the best indicator of differentiation. Many relationships to similarities of responses could be seen both within the categories and the items, although no definite conclusions concerning these similarities could be drawn.

In support of the hypothesis that nurses expect to meet the spiritual needs of patients by engaging in specific activities rather than by participating with the patient in religious practices, the study showed that nurses do have definite expectations of their functions in meeting patients' spiritual needs. These definite expectations are revealed by the number of statements to which ninety per cent or more of the respondents either agreed or disagreed, most often to those statements which had definite implications for specific actions. Analysis of the data, however, does not support the latter part of the hypothesis as clearly. The study shows that nurses are hesitant about functions which would involve their participation, but it does not show that they would refuse to participate in religious practices with the patient if the patient requested this. The hypothesis, therefore, was completely supported only in part.

CHAPTER V

SUMMARY AND RECOMMENDATIONS

This study was concerned with the beliefs of nurses about nursing responsibilities and functions in meeting the spiritual needs of patients as a part of comprehensive nursing care. It tested the hypothesis that nurses do expect to meet the spiritual needs of their patients by engaging in specific activities rather than by participating with the patient in religious practices.

Data were obtained through a questionnaire which the writer developed to investigate nurses' opinions about their functions in meeting the spiritual needs of patients. The questionnaire consisted of sixty-four statements of hypothetical functions which the nurse might or might not perform in meeting the patient's spiritual needs. Respondents were asked to answer the statements within the context of their concept of the ideal nurse, and to either agree or disagree with the statements. Statements were concerned with six major categories: philosophy, relationship of the nurse and the clergyman, prayer, religious literature, dietary laws, and the Sacraments.

Respondents to the questionnaire came from one collegiate school of nursing. Each of the educational programs and the faculty were represented in the study sample as an attempt to represent various levels of sophistication in nursing education. Faculty members from the Graduate and Undergraduate divisions and students from the Basic Professional Nursing Program, the General Nursing Program, and six Graduate Programs

participated in the study. These six Graduate Programs included: Medical-Surgical Nursing, Rehabilitation Nursing, Psychiatric Nursing, Maternal and Child Health Nursing, Public Health Nursing, and Administration in Nursing Service and Education.

Analysis of the data consisted of an item analysis of the sixty-four statements according to agree or disagree responses. The total sample response to each of the sixty-four statements was first determined. Data were then analyzed according to the information supplied by the respondents in the personal data sheet attached to each questionnaire. Information on this sheet included years in nursing, present educational program, whether or not the respondent had ever been hospitalized, religion, and age. Respondents were grouped according to these categories. Response of each group was compared to the total sample response and analyzed when the group differed more than ten per cent from the total sample response.

Conclusions

The findings of the study supported the hypothesis only in part. Analysis showed that nurses did expect to meet the spiritual needs of patients by engaging in specific activities, thus supporting the first part of the hypothesis. Results concerning responsibilities for participation with the patient in religious practices were not as clear. Statements concerning this area showed conflict in response. There were instances, however, when nurses did feel that they should participate with the patient in religious practices. Agree responses, however, came only when the patient initiated such activities. The latter part of the

hypothesis then was not completely supported.

The study also showed that nurses do have definite opinions about what their functions should or should not be in meeting the spiritual needs of patients. This was shown by the large percentage of statements to which ninety per cent or more of the respondents agreed or disagreed.

Another finding indicated that nurses felt the most conflict in the relationship of the nurse to the clergyman. There was considerable divergence of opinion concerning what to do under various circumstances when the clergyman visits the patient, and under what circumstances the nurse should call the clergyman.

Still another finding showed that nurses feel they have a responsibility for meeting the patient's spiritual needs regardless of their own or the patient's religion.

Finally, the study showed that there was variation of expectations of nursing functions in meeting the spiritual needs of patients according to the information sheet completed by the respondents. Educational program and religion seemed to show the most divergence of opinion within responses to each item. Hospitalization was not a good indication of expectation and seemed to make little difference in the response.

Recommendations

The following recommendations are made as a result of this study:

1. That the tool be revised because of inadequate formulation of some of the items as indicated by data analysis.
2. That a similar study using the revised tool be conducted using

nurses who have not pursued their education further than a diploma school of nursing.

3. That a similar study using the revised tool be conducted using patients as respondents.
4. That a similar study using the revised tool be conducted using the general public as respondents.
5. That a similar study using the revised tool be conducted using only one of the variables--such as religion or educational program.
6. That such studies as the above analyze in detail the differences in response within each statement as well as between statements.
7. That a study of correlation be conducted using each of the variables to determine if such factors as educational program or religion determine response.
8. That nursing education further define the role of the nurse in meeting the patients' spiritual needs as a part of comprehensive nursing care.
9. That the theological and nursing professions join in a cooperative effort to further clarify the relationship of the nurse and the clergyman in meeting the spiritual needs of the patient.
10. That the theological and nursing professions join in a cooperative effort to further clarify the role of the nurse in meeting the patient's spiritual needs.

11. That a similar study be conducted using the revised tool, with clergymen as respondents.

APPENDIX A

On the following pages are sixty-four questions concerning the functions of the nurse in caring for the religious needs of her patients. You are being asked to answer these questions so that information may be obtained for a Boston University School of Nursing field study. There is no right or wrong answer to these questions. Please check your feelings in the appropriate column for each question. If you agree with the statement, check the column marked agree. If you disagree, then make the check in the column marked disagree. Please answer all of the questions.

As you answer the questions, think of what you would like the ideal nurse to do and answer accordingly. Your identity will not be made known in the study.

Your cooperation in this study is deeply appreciated.

Sincerely,

Phyllis E. Porter

APPENDIX B

QUESTIONNAIRE

A B C D E F G

	AGREE	DISAGREE
1. The nurse realizes that during illness religion is important to the patient.....	1 ____	2 _____
2. The nurse is aware that the patient's religious needs are not her concern.....	1 ____	2 _____
3. The nurse should accept the patient's feelings about religion.....	1 ____	2 _____
4. The nurse tries to change the patient's religious beliefs if she feels they hinder recovery.....	1 ____	2 _____
5. The nurse senses the patient's feelings behind what he says.....	1 ____	2 _____
6. The nurse does not have to agree with the patient's religious beliefs, but admits that he has a right to his beliefs.....	1 ____	2 _____
7. When the nurse disagrees with a patient about his religious beliefs she should tell him.....	1 ____	2 _____
8. The nurse should refuse to talk about religion if she does not agree with the patient.....	1 ____	2 _____
9. The nurse cares for the patient's spirit as well as his body.....	1 ____	2 _____
10. The nurse automatically leaves the room if the clergyman is visiting the patient.....	1 ____	2 _____
11. The nurse leaves the room only if the clergyman requests her to leave.....	1 ____	2 _____
12. If the patient is seriously ill the nurse does not leave the room even if the clergyman requests it.....	1 ____	2 _____
13. The nurse realizes that grief influences the patient's idea of God.....	1 ____	2 _____
14. The nurse realizes that a patient's belief in God may change during illness.....	1 ____	2 _____

	AGREE	DISAGREE
15. The nurse understands that sickness is the will of God.....	1 _____	2 _____
16. The nurse explains to the patient how the idea of God applies to health and illness.....	1 _____	2 _____
17. The nurse knows that the patients wants an answer when he asks such questions as "Why does God punish me?".....	1 _____	2 _____
18. The nurse knows that when the patient asks a question like "Why does God punish me" he wants the nurse to listen to him for a few minutes....	1 _____	2 _____
19. The nurse should be aware that some patients may believe that God punishes sinners with illness..	1 _____	2 _____
20. It is important for the nurse to be aware that some patients may believe that diseases like syphilis are punishments for sin.....	1 _____	2 _____
21. The nurse should realize that illness is not a punishment for sin.....	1 _____	2 _____
22. It is important for the nurse to accept the patient even though he blames God for his illness.	1 _____	2 _____
23. The nurse should be concerned with the religious needs of the dying patient.....	1 _____	2 _____
24. The nurse should call the patient's clergyman when the patient is admitted.....	1 _____	2 _____
25. The nurse never calls the clergyman because it is not her responsibility.....	1 _____	2 _____
26. The nurse calls the clergyman only if she is of the same faith as the patient.....	1 _____	2 _____
27. The Catholic nurse may call the minister of a Protestant patient or the Rabbi of the Jewish patient.....	1 _____	2 _____
28. The nurse calls the clergyman only when the patient asks her to.....	1 _____	2 _____
29. The nurse should refer patients who are lonely and have few visitors to the clergyman.....	1 _____	2 _____

	AGREE	DISAGREE
30. The nurse should refer patients who are fearful to the clergyman.....	1 _____	2 _____
31. The nurse should refer patients who are facing surgery to the clergyman.....	1 _____	2 _____
32. The nurse should refer patients whose illness has forced them to change their way of living to the clergyman.....	1 _____	2 _____
33. The nurse should have the clergyman visit patients whose own pastor is unable to visit them.	1 _____	2 _____
34. The nurse should refer patients with social problems such as the unwed mother to the clergyman.....	1 _____	2 _____
35. The nurse should suggest Bible verses for the patient to read.....	1 _____	2 _____
36. The nurse should quote Bible verses to the patient.....	1 _____	2 _____
37. The nurse should suggest books for the patient to read about self-understanding and the meaning of prayer and faith.....	1 _____	2 _____
38. The nurse of the same faith as the patient should read religious literature to the patient.	1 _____	2 _____
39. The nurse regardless of faith should read religious literature to the patient if he asks her to.....	1 _____	2 _____
40. The nurse should never read religious literature to the patient.....	1 _____	2 _____
41. The nurse should suggest prayer to the patient..	1 _____	2 _____
42. Only the nurse of the same faith as the patient should pray with him.....	1 _____	2 _____
43. The nurse should never pray with the patient....	1 _____	2 _____
44. The nurse should understand that Christian people appreciate the benefits of Holy Communion in times of illness.....	1 _____	2 _____
45. The nurse regardless of faith makes provision for the Protestant patient to receive Holy Communion.	1 _____	2 _____

	AGREE	DISAGREE
46. The nurse regardless of faith routinely makes provision for the Catholic patient to receive Holy Communion.....	1 _____	2 _____
47. The nurse regardless of faith makes provision for the Christian patient to receive Holy Communion only if asked to by the patient.....	1 _____	2 _____
48. Only the Catholic nurse should make provision for the Catholic patient to receive Holy Communion.....	1 _____	2 _____
49. Only the Protestant nurse makes provision for the Protestant patient to receive Holy Communion.....	1 _____	2 _____
50. The Jewish nurse should not make provision for the Christian patient to receive Holy Communion.	1 _____	2 _____
51. The nurse should prepare the patient and the room for Communion according to the ritual of the patient's church.....	1 _____	2 _____
52. The nurse should see that the patient has privacy while receiving Holy Communion.....	1 _____	2 _____
53. The nurse should tell the patient that it is possible to receive Holy Communion while in the hospital.....	1 _____	2 _____
54. The nurse routinely calls the priest to administer Extreme Unction to the dying Catholic patient.....	1 _____	2 _____
55. The nurse should call the priest to administer Extreme Unction only if requested by the patient's family.....	1 _____	2 _____
56. The nurse regardless of faith should baptize a dying Catholic child or adult who is not baptized.....	1 _____	2 _____
57. Only Christian nurses should baptize the patient.....	1 _____	2 _____
58. Only Catholic nurses should baptize the Catholic patient.....	1 _____	2 _____
59. The nurse should let the pastor visit even if the patient is in the midst of care or treatment.	1 _____	2 _____

	AGREE	DISAGREE
60. The nurse regardless of faith should see that meals are in keeping with the dietary laws of the patient's religion.....	1 _____	2 _____
61. Only the nurse who is of the same faith as the patient should be concerned with dietary laws...	1 _____	2 _____
62. The Christian nurse should assist the Rabbi as directed in preparation of the infant for circumcision.....	1 _____	2 _____
63. Only the Jewish nurse should assist the Rabbi as directed in preparation of the infant for circumcision.....	1 _____	2 _____
64. If possible the nurse should make provision for the patient to attend hospital chapel services..	1 _____	2 _____

APPENDIX C

The following information is needed for data analysis:

A. Year of initial graduation from School of Nursing _____

B. Program -- please check appropriate blank

1. Faculty member _____

2. Basic Program _____

3. General Nursing Program _____

4. Graduate Student

Medical-Surgical _____

Psychiatry _____

Rehabilitation _____

Maternal and Child Health _____

Public Health _____

Administration _____

C. Have you been hospitalized as a patient? Yes ____ No ____

D. Religion:* Catholic _____ Protestant ____ Jewish _____

E. Age:

20 - 29 _____

30 - 39 _____

40 - 49 _____

50 - 59 _____

60 - 69 _____

70+ _____

* Respondents who did not categorize themselves were categorized as "Other."

APPENDIX D

QUESTIONNAIRE CODE

A. Years of Service in Nursing

1. Basic Professional Student
2. 0 - 5
3. 6 - 10
4. 11 - 15
5. 16 - 20
6. 21 - 25
7. 26 - 30
8. 31 - 35
9. 36 - 40

B. Present Educational Program

1. Faculty member
2. Basic Professional Student
3. General Nursing
4. Medical-Surgical
5. Psychiatry
6. Rehabilitation
7. Maternal and Child Health
8. Public Health
9. Administration

C. Hospitalization

1. Yes
2. No

D. Religion

1. Catholic
2. Protestant
3. Jewish
4. Other

E. Age in Years

1. 20 - 29
2. 30 - 39
3. 40 - 49
4. 50 - 59
5. 60 - 69

APPENDIX E

TABLE 11

NUMBER OF AGREE AND DISAGREE RESPONSES TO THE SIXTY-FOUR STATEMENTS ACCORDING TO THE RESPONDENTS' YEARS IN NURSING

Statement Number	Years in Nursing																	
	Student		0 - 5		6 - 10		11 - 15		16 - 20		21 - 25		26 - 30		31 - 35		36 - 40	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
1	56	1	81	4	39	3	27	2	27	--	19	2	11	--	3	--	1	--
2	2	55	--	85	4	38	1	28	2	25	1	20	2	10	1	2	--	1
3	51	6	83	2	42	--	28	--	24	2	20	1	12	--	3	--	1	--
4	5	51	7	78	6	36	3	26	2	24	2	19	1	11	--	3	--	1
5	56	1	84	1	42	--	28	1	24	1	20	1	11	1	3	--	1	--
6	57	--	84	1	42	--	29	--	26	1	21	--	12	--	3	--	1	--
7	4	53	4	81	4	38	3	26	2	24	1	20	1	11	--	3	--	1
8	--	57	6	79	6	36	2	27	1	26	--	21	--	12	--	3	--	1
9	55	2	82	3	39	3	29	--	24	3	18	2	11	1	3	--	1	--
10	25	32	29	56	22	20	20	9	6	21	7	14	4	8	1	2	--	1
11	15	42	36	49	16	26	6	23	9	18	12	9	5	7	--	3	--	1
12	11	45	16	69	5	36	6	23	3	22	4	17	1	11	1	2	--	1
13	54	3	77	8	38	4	25	4	24	1	19	2	8	3	3	--	1	--
14	54	3	80	4	41	4	28	1	24	3	20	1	12	--	3	--	1	--
15	15	42	30	54	12	29	9	20	2	25	5	16	--	12	--	3	--	1
16	10	47	29	56	11	31	8	21	7	20	7	14	2	8	1	2	--	1
17	13	44	23	62	12	30	7	22	8	19	3	18	--	11	1	2	--	1
18	57	--	84	1	40	2	28	1	24	3	21	--	11	1	3	--	1	--
19	56	1	84	1	39	3	27	2	27	--	18	3	11	1	3	--	1	--
20	55	2	82	3	41	1	28	1	27	--	21	--	12	--	3	--	1	--
21	44	13	78	7	37	4	27	2	24	2	19	1	8	4	3	--	1	--
22	57	--	84	1	41	--	29	--	26	--	21	--	12	--	3	--	1	--
23	57	--	84	--	42	--	29	--	27	--	21	--	12	--	3	--	1	--
24	24	33	18	67	10	32	6	21	3	24	2	19	2	8	1	2	--	1
25	4	53	5	80	--	42	3	25	--	27	1	20	--	12	--	3	--	1

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TABLE 11 (continued)

Statement Number	Years in Nursing																	
	Student		0 - 5		6 - 10		11 - 15		16 - 20		21 - 25		26 - 30		31 - 35		36 - 40	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
26	--	57	--	85	--	42	1	29	--	27	--	21	--	12	--	3	--	1
27	56	1	82	3	39	2	28	1	27	--	21	--	12	--	3	--	1	--
28	12	45	23	62	11	31	11	18	8	19	6	15	3	9	1	2	1	--
29	49	8	64	20	29	13	22	7	15	11	13	8	5	5	1	2	--	1
30	51	6	63	22	26	16	21	8	13	13	13	8	2	7	1	2	--	1
31	47	10	61	24	27	15	19	10	13	13	11	10	3	7	1	2	--	1
32	43	14	54	30	23	19	17	12	10	15	9	12	1	9	1	2	--	1
33	51	6	66	19	34	8	19	10	16	10	13	8	4	7	1	2	--	1
34	41	16	54	31	23	19	15	13	9	16	6	15	1	9	1	2	--	1
35	12	45	10	75	7	35	5	24	2	24	--	21	--	12	--	3	--	1
36	7	50	6	79	3	39	2	27	1	25	--	21	--	12	--	3	--	1
37	10	47	25	60	11	31	9	20	5	21	3	18	1	11	1	2	--	1
38	19	37	18	67	9	33	7	22	3	23	--	21	--	12	--	3	--	1
39	51	6	76	9	39	3	26	3	20	6	19	2	11	1	3	--	1	--
40	--	57	2	83	2	40	--	29	--	27	--	21	--	12	--	3	1	--
41	31	26	41	43	20	22	15	14	10	16	9	12	2	10	1	2	--	1
42	6	51	4	81	3	38	--	29	1	26	--	21	--	12	--	3	--	1
43	5	51	5	80	3	38	--	29	--	27	--	21	1	11	--	3	--	1
44	56	1	81	4	39	3	28	1	24	2	18	3	9	3	3	--	1	--
45	48	9	62	23	29	13	21	8	17	9	15	6	5	6	1	2	--	1
46	44	13	60	25	29	12	19	10	15	11	14	7	6	5	1	2	--	1
47	35	22	69	16	28	13	21	6	19	7	16	5	11	1	3	--	1	--
48	--	57	1	84	--	42	--	29	--	27	--	21	--	11	--	3	--	1
49	--	57	1	84	--	42	--	29	--	27	--	21	--	11	--	3	--	1
50	--	57	1	84	--	42	--	29	--	27	--	21	--	11	--	3	--	1

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TABLE 11 (concluded)

Statement Number	Years in Nursing																	
	Student		0 - 5		6 - 10		11 - 15		16 - 20		21 - 25		26 - 30		31 - 35		36 - 40	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
51	54	3	79	6	38	4	28	1	27	--	21	--	11	--	3	--	1	--
52	57	--	85	--	42	--	29	--	27	--	21	--	12	--	3	--	1	--
53	56	1	84	1	41	1	26	3	25	2	21	--	9	2	3	--	1	--
54	56	1	71	14	37	5	26	3	22	5	19	2	11	1	2	1	1	1
55	3	54	13	71	7	35	2	26	5	21	1	19	4	7	--	3	--	1
56	54	3	78	6	33	9	22	7	25	2	19	2	11	1	3	--	1	--
57	1	56	7	77	6	36	6	22	3	24	1	20	1	11	--	3	--	--
58	1	56	3	82	3	39	6	23	1	26	1	20	--	11	1	2	--	1
59	16	41	33	50	18	24	15	14	8	19	10	11	5	6	1	2	--	--
60	55	2	82	3	41	1	29	--	26	1	21	--	11	1	3	--	1	--
61	--	57	--	85	--	42	--	29	1	26	--	21	--	12	--	3	--	1
62	55	2	84	1	39	3	29	--	27	--	21	--	11	1	3	--	1	--
63	2	55	2	83	3	39	--	29	1	26	--	21	--	12	--	3	--	1
64	56	1	83	2	38	4	26	3	23	2	20	1	10	1	3	--	1	--

TABLE 12

NUMBER OF AGREE AND DISAGREE RESPONSES TO THE SIXTY-FOUR STATEMENTS ACCORDING TO EDUCATIONAL PROGRAM OF RESPONDENTS

Statement Number	Educational Program																	
	Faculty		Basic		G. N.		Med.-Surg.		Psych.		Rehab.		MCH		Public H.		Adm.	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
1	50	5	56	1	73	3	23	--	16	--	10	1	18	1	11	--	7	1
2	8	48	2	55	1	75	1	22	--	16	1	10	--	19	--	11	--	8
3	53	2	51	6	73	2	23	--	16	--	11	--	19	--	11	--	7	1
4	2	53	5	51	11	65	--	23	2	14	--	11	3	16	2	9	1	7
5	52	2	56	1	76	--	22	1	16	--	11	--	18	1	11	--	7	1
6	55	1	57	--	75	1	23	--	16	--	11	--	19	--	11	--	8	--
7	4	51	4	53	3	73	3	20	1	15	1	10	1	18	--	11	2	6
8	2	54	--	57	4	72	3	20	1	15	3	8	1	18	--	11	1	7
9	50	6	55	2	74	1	23	--	14	2	9	2	19	--	11	--	7	1
10	18	38	25	32	29	47	12	11	6	10	4	7	10	9	5	6	5	3
11	18	38	15	42	34	42	8	15	5	11	7	4	5	14	4	7	3	5
12	7	47	11	45	13	63	3	20	4	12	--	10	3	16	4	7	2	6
13	44	9	54	3	71	5	21	2	15	1	11	--	15	4	11	--	7	1
14	52	4	54	3	72	3	22	1	16	--	11	--	18	1	11	--	7	1
15	6	50	15	42	24	51	9	14	3	13	4	6	7	12	4	7	1	7
16	10	44	10	47	28	48	8	15	4	12	2	9	5	14	4	7	4	4
17	4	51	13	44	27	49	5	18	1	15	3	8	9	10	3	8	2	6
18	52	4	57	--	75	1	23	--	15	1	10	1	18	1	11	--	8	--
19	49	7	56	1	76	--	23	--	16	--	10	1	18	1	11	--	7	1
20	54	2	55	2	76	--	22	1	16	--	11	--	17	2	11	--	8	--

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TABLE 12 (continued)

Statement Number	Educational Program																	
	Faculty		Basic		G. N.		Med.-Surg.		Psych.		Rehab.		MCH		Public H.		Adm.	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
21	48	6	44	13	70	6	20	3	15	1	9	1	18	1	9	2	8	--
22	55	--	57	--	76	--	23	--	16	--	10	--	18	1	11	--	8	--
23	56	--	57	--	76	--	23	--	16	--	11	--	18	1	11	--	8	--
24	8	45	24	33	16	59	7	16	2	14	5	6	2	17	1	10	1	7
25	1	55	4	53	4	71	--	23	1	15	--	11	2	17	1	10	--	8
26	--	56	--	57	--	76	1	22	--	16	--	11	--	19	--	11	--	8
27	56	--	56	1	75	1	21	1	15	1	11	--	17	2	10	1	8	--
28	19	37	12	45	19	57	2	21	6	10	4	7	7	12	4	7	3	5
29	25	28	49	8	63	12	18	5	9	7	7	4	14	5	7	4	6	2
30	23	29	51	6	60	16	17	6	6	10	9	2	13	6	7	4	4	4
31	22	31	47	10	57	19	16	7	8	8	8	3	14	5	7	4	3	5
32	15	37	43	14	51	24	15	8	7	9	7	4	10	9	7	4	3	5
33	28	26	51	6	63	13	16	7	12	4	6	5	14	5	9	2	5	3
34	16	36	41	16	52	23	17	6	7	9	5	6	6	13	5	6	1	7
35	1	54	12	45	13	63	4	19	1	15	2	9	2	17	--	11	1	7
36	--	55	7	50	6	70	3	20	1	15	1	10	--	19	--	11	1	7
37	7	48	10	47	25	51	9	14	1	15	4	7	5	14	1	10	3	5
38	3	52	19	37	20	56	6	17	1	15	1	10	2	17	2	9	2	6
39	45	10	51	6	73	3	23	--	11	5	10	1	15	4	11	--	7	1
40	--	56	--	57	1	75	1	22	--	16	1	10	1	18	--	11	--	8
41	16	39	31	26	40	35	14	9	5	11	7	4	7	12	6	5	3	5
42	1	55	6	51	2	74	1	22	1	15	--	10	3	16	--	11	--	8
43	2	54	5	51	3	73	1	22	--	16	--	10	1	18	1	10	1	7
44	45	10	56	1	73	3	23	--	15	1	11	--	18	1	11	--	7	1
45	34	20	48	9	59	17	16	7	8	8	7	4	14	5	8	3	4	4

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TABLE 12 (concluded)

Statement Number	Educational Program																	
	Faculty		Basic		G. N.		Med.-Surg.		Psych.		Rehab.		MCH		Public H.		Adm.	
	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
46	32	22	44	13	54	22	18	5	9	7	5	5	15	4	7	4	4	4
47	44	10	35	22	55	20	18	5	13	3	8	2	14	5	8	3	8	--
48	--	55	--	57	--	76	--	23	--	16	--	11	1	18	--	11	--	8
49	--	55	--	57	--	76	--	23	--	16	--	11	1	18	--	11	--	8
50	--	55	--	57	--	76	--	23	--	16	--	11	1	18	--	11	--	8
51	51	4	54	3	74	2	23	--	16	--	10	1	18	1	9	2	7	1
52	56	--	57	--	76	--	23	--	16	--	11	--	19	--	11	--	8	--
53	49	6	56	1	75	1	23	--	15	1	11	--	18	1	11	--	8	--
54	46	10	56	1	68	8	22	1	14	2	9	2	12	7	11	--	7	1
55	12	41	3	54	7	67	1	22	2	14	2	9	6	13	1	10	1	7
56	49	7	54	3	66	9	21	2	13	3	10	1	19	--	10	1	4	4
57	8	46	1	56	6	70	3	19	1	15	--	11	2	17	1	10	3	5
58	4	51	1	56	6	70	--	23	2	14	--	11	1	18	--	11	2	6
59	22	32	16	41	29	45	11	12	3	13	5	6	11	8	6	5	3	5
60	54	2	55	2	74	2	22	1	16	--	11	--	18	1	11	--	8	--
61	--	56	--	57	--	76	--	23	--	16	--	11	--	19	--	11	1	7
62	54	2	55	2	75	1	22	1	16	--	10	1	19	--	11	--	8	--
63	--	56	2	55	1	75	2	21	--	16	1	10	1	18	--	11	1	7
64	46	7	56	1	73	3	23	--	16	--	9	2	18	1	11	--	8	--

TABLE 13

NUMBER OF AGREE AND DISAGREE RESPONSES TO THE SIXTY-FOUR STATEMENTS ACCORDING TO HOSPITALIZATION OF RESPONDENTS

Statement Number	Hospitalized				Statement Number	Hospitalized			
	Yes		No			Yes		No	
	A	D	A	D		A	D	A	D
1	189	10	75	2	33	144	55	60	16
2	11	189	2	75	34	108	89	42	32
3	191	8	73	3	35	25	175	11	65
4	18	181	8	68	36	13	187	6	70
5	195	5	74	1	37	52	148	13	63
6	199	1	76	1	38	37	163	19	56
7	15	185	4	72	39	180	20	66	110
8	12	188	3	74	40	3	197	1	76
9	189	10	73	4	41	94	106	35	40
10	83	117	31	46	42	9	190	5	72
11	76	124	23	54	43	5	193	9	68
12	35	163	12	63	44	186	14	73	3
13	184	15	65	10	45	139	60	59	17
14	192	7	71	6	46	131	67	57	19
15	51	147	22	55	47	148	50	55	20
16	60	138	15	62	48	--	199	1	76
17	49	150	18	59	49	--	199	1	76
18	192	8	77	--	50	--	199	1	76
19	193	7	73	4	51	190	9	72	5
20	196	4	74	3	52	200	--	77	--
21	172	6	69	7	53	191	8	75	2
22	199	--	75	1	54	179	21	66	11
23	199	1	77	--	55	21	176	14	61
24	49	148	17	59	56	179	20	67	10
25	9	191	4	72	57	19	178	6	71
26	1	199	--	77	58	12	187	4	73
27	195	4	74	3	59	85	112	21	55
28	52	148	24	53	60	196	4	73	4
29	147	50	51	25	61	1	199	--	77
30	138	59	52	24	62	195	5	75	2
31	131	67	51	25	63	4	196	4	73
32	115	81	43	33	64	186	13	74	1

TABLE 14

NUMBER OF AGREE AND DISAGREE RESPONSES TO THE SIXTY-FOUR STATEMENTS ACCORDING TO RELIGION OF RESPONDENTS

Statement Number	Religion							
	Catholic		Protestant		Jewish		Other	
	A	D	A	D	A	D	A	D
1	94	2	126	10	31	--	13	--
2	3	93	7	130	2	29	1	12
3	93	2	130	6	28	3	13	--
4	10	86	12	123	2	29	2	11
5	94	1	131	5	31	--	13	--
6	96	--	135	2	31	--	13	--
7	4	92	11	125	2	29	2	11
8	5	91	7	130	--	31	3	10
9	91	5	128	8	31	--	12	1
10	47	49	49	88	16	15	2	11
11	38	58	46	91	8	23	7	6
12	9	87	25	109	10	20	23	77
13	86	9	122	13	30	1	11	2
14	89	7	132	4	30	1	12	1
15	46	49	21	115	5	26	1	12
16	36	60	30	105	6	25	3	10
17	21	75	34	102	8	32	4	9
18	94	2	132	5	31	--	12	1
19	94	2	131	6	29	2	12	1
20	96	--	133	4	29	2	12	1
21	87	8	117	19	24	7	13	--
22	95	1	135	--	31	--	13	--
23	96	--	137	--	31	--	12	1
24	25	69	30	105	11	20	--	13
25	2	93	9	128	2	29	---	13
26	1	95	--	137	--	31	--	13
27	92	3	135	2	30	1	12	1
28	17	79	46	91	7	24	6	7
29	75	20	89	45	26	5	8	5
30	73	23	87	47	26	4	4	9
31	76	20	79	55	24	7	3	10
32	66	28	72	62	19	12	1	12
33	80	16	91	44	27	4	6	7
34	62	32	69	65	16	15	3	10
35	10	86	21	115	5	26	--	13

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TABLE 14 (concluded)

Statement Number	Religion							
	Catholic		Protestant		Jewish		Other	
	A	D	A	D	A	D	A	D
36	3	93	13	123	3	28	--	13
37	27	69	29	107	6	25	3	10
38	19	76	25	111	9	22	3	10
39	85	11	121	15	28	3	12	1
40	1	95	3	134	--	31	--	13
41	61	35	49	86	17	14	2	11
42	5	91	4	132	5	26	--	13
43	4	92	6	129	3	28	1	12
44	93	3	124	12	30	1	12	1
45	75	21	92	43	25	6	6	7
46	73	23	90	44	20	11	5	8
47	62	32	108	27	22	9	11	2
48	1	95	--	136	--	31	--	13
49	1	95	--	136	--	31	--	13
50	1	95	--	136	--	31	--	13
51	92	4	130	7	29	1	11	2
52	96	--	137	--	31	--	13	--
53	94	2	130	6	30	1	12	1
54	88	8	120	17	30	1	7	6
55	11	84	14	119	4	27	6	7
56	85	10	122	15	29	2	10	3
57	9	85	14	122	1	30	1	12
58	8	88	7	129	--	31	1	12
59	46	50	48	85	6	25	6	7
60	95	1	132	5	30	1	12	1
61	1	95	--	137	--	31	--	13
62	94	2	134	3	30	1	12	1
63	4	92	2	135	2	29	--	13
64	94	1	124	11	30	1	12	1

TABLE 15

NUMBER OF AGREE AND DISAGREE RESPONSES TO THE SIXTY-FOUR STATEMENTS ACCORDING TO AGE OF RESPONDENTS

Statement Number	Age Group									
	20 - 29		30 - 39		40 - 49		50 - 59		60 - 69	
	A	D	A	D	A	D	A	D	A	D
1	159	6	53	3	39	3	12	--	1	--
2	4	161	3	53	3	40	3	9	--	1
3	157	8	54	1	40	2	--	12	--	1
4	13	151	8	48	4	38	1	11	--	1
5	163	2	53	2	40	2	12	--	1	--
6	164	1	56	--	42	1	12	--	1	--
7	8	157	10	46	--	42	1	11	--	1
8	7	158	6	50	2	41	--	12	--	1
9	160	5	51	5	40	2	10	2	1	--
10	66	99	28	28	17	26	3	9	--	1
11	61	104	19	37	15	28	4	8	--	1
12	29	135	10	45	7	34	1	11	--	1
13	153	12	48	7	39	2	8	4	1	--
14	157	7	53	3	41	2	11	1	1	--
15	52	111	11	45	10	33	--	12	--	1
16	43	122	15	41	14	27	3	9	--	1
17	42	123	14	42	8	34	3	9	--	1
18	163	2	53	3	41	2	11	1	1	--
19	160	5	54	2	39	4	12	--	1	--
20	159	6	56	--	42	1	12	--	1	--
21	142	22	51	5	38	3	9	3	1	--
22	164	1	55	--	42	--	12	--	1	--
23	164	1	56	--	43	--	12	--	1	--
24	47	118	12	43	5	35	2	10	--	1
25	10	155	2	54	1	41	--	12	--	1
26	--	165	1	55	--	43	--	12	--	1
27	159	6	54	1	43	--	12	--	1	--
28	42	123	20	36	7	36	6	6	1	--
29	127	37	41	15	26	14	4	8	--	1
30	125	40	40	16	23	16	2	10	--	1

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TABLE 15 (concluded)

Statement Number	Age Group									
	20 - 29		30 - 39		40 - 49		50 - 59		60 - 69	
	A	D	A	D	A	D	A	D	A	D
31	120	45	37	19	24	16	1	11	--	1
32	108	56	29	27	20	19	1	11	--	1
33	134	31	40	16	26	15	4	8	--	1
34	105	60	33	23	11	27	1	11	--	1
35	25	140	10	46	1	41	--	12	--	1
36	14	151	4	52	1	41	--	12	--	1
37	40	125	16	40	8	34	1	11	--	1
38	41	123	12	44	3	39	--	12	--	1
39	150	15	48	8	36	6	11	1	1	--
40	2	163	2	54	--	43	--	12	--	1
41	78	86	31	25	19	23	1	11	--	1
42	13	152	--	55	1	42	--	12	--	1
43	11	153	2	53	1	42	--	12	--	1
44	159	6	53	3	36	3	10	2	1	--
45	126	39	39	17	27	14	6	6	--	1
46	119	46	36	19	28	13	5	7	--	1
47	121	44	38	16	72	23	12	--	1	--
48	1	164	--	56	--	42	--	12	--	1
49	1	164	--	56	--	42	--	12	--	1
50	1	164	--	56	--	42	--	12	--	1
51	154	11	53	3	42	--	12	--	1	--
52	165	--	56	--	43	--	12	--	1	--
53	163	2	52	4	40	2	10	2	1	--
54	147	18	51	5	37	6	9	3	1	--
55	20	144	6	50	5	34	4	8	--	1
56	150	14	47	9	36	6	11	1	1	--
57	11	153	10	45	3	40	1	11	--	--
58	5	160	7	49	3	39	1	11	--	1
59	59	104	22	34	21	21	4	8	--	--
60	159	6	56	--	42	1	11	1	1	--
61	--	165	--	56	1	42	--	12	--	1
62	161	4	54	2	43	--	11	1	1	--
63	6	159	1	55	1	42	--	12	--	1
64	160	5	51	4	37	4	11	1	1	--

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