BLOOD MONEY: STRESS, DRUG USE AND THE NURSING PROFESSION

by

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ABSTRACT

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The purpose of this study is to compare the prevalence of drug and alcohol use between two comparable samples of registered nurses in New York City hospitals at two points in time, 1979 and 1994. The comparison shows that while the levels of alcohol and drug use among registered nurses remains fairly consistent over the survey period, the specific kinds of drugs used have changed: self-medication with addictive drugs such as tranquilizers decreased, while the use of antibiotics and other drugs rose. Rates of alcohol and marijuana use declined, but cross-tabulation analyses indicate a correlation between younger, highly-stressed registered nurses and marijuana use.

The research also examined stress among registered nurses, identifying the major occupational stressor of nursing to be the high patient load set by hospital administrators and supervisors. The majority of registered

nurses utilize healthier, non-chemical means of coping with stress, and are most likely to attempt to resolve workplace problems that promote stress. Registered nursing promotes stress by creating role conflicts: first, between the nurse's role as caregiver and her personal and family roles, particularly with regard to the use of the nurse's time; and second, when nurses advance to administrative or educational roles, by removing the nurse from her caregiving role and challenging her motivation to place patient care over personal and institutional profit.

Two areas of change are recommended. The education of registered nurses should include information on nurses' higher risk for using marijuana when they become highly stressed, and for having families with alcohol problems. The professionalization of nursing requires autonomy of practice and an independent body of knowledge. Autonomous practice outside the hospital setting and the incorporation of non-traditional areas of medical specialization are suggested as means of overcoming these obstacles.

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DEDICATION

In memory

of my mom, Ann Mahon, the daughter of Irish immigrants who, although she passed away when I was only nineteen years old, had already nurtured in me the idea that with diligent work and persistent study, by the grace of God, any achievement was possible.

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CHAPTER 1 - THE HISTORICAL CONTEXT OF THE NURSING PROFESSION

For many years the nursing profession ignored the use of alcohol and illegal drugs among registered nurses. Only recently, due to the increase in the number of nurses facing administrative and legal actions because of their substance abuse, has the nursing profession begun to scrutinize itself, and other groups of health service providers began questioning the implications of nurses' substance abuse.

The genesis and continuation of substance abuse among nurses reflect individual, social, cultural, vocational, life cycle and demographic considerations. The primary purpose of this study is to compare the prevalence of drug and alcohol use between two comparable samples of registered nurses (R.N.s) at two points in time, 1979 and 1994. We are interested in the extent to which the levels of alcohol and drug use among R.N.s remained constant, decreased, or increased over the survey period. We are also interested in the specific kinds of drugs used. Another purpose is to identify the major occupational stressors of the nursing profession in 1994.

The study will examine the locus of R.N.s' primary stressors within hospital settings, including other individuals with or employed within health care (physicians, administrators, insurance representatives, governmental regulators, and others).

An examination of the nursing profession's historical

context is a necessary preliminary to the presentation and analysis of the data of the study. This overview of nursing's social milieu will provide some understanding of how stress and drug use relate to this sector of the health care system. We are especially interested in those contexts in the field of nursing--social and economic status, education and training, and work environment--that can contribute to stress and contribute to nurses' use of drugs or alcohol as means of coping.

* * *

The registered nurse's present role was quite different in a variety of ways before the 1970s. The decision to enter nursing often occurred quite early in the life cycle, long before high school age, motivated by a desire to serve patients and physicians, and to be needed as a caregiver (Fox et al. 1961, p. 2). Typically, the nurse was a high school graduate who went to a hospital school of nursing and earned a diploma that qualified her to take the state board of nursing examinations to become a registered nurse. Students in these diploma schools were socialized into a submissive role by, among other things, a curriculum that designated compliance as a part of "professional" behavior (Mauksch 1963, p. 90).

Much emphasis was placed on the specific diploma school the nurse attended. Some schools, such as Bellevue in New York, carried more prestige than others, the nursing cap

became a status symbol since each school had its own cap. The uniforms were white with white stockings and shoes, because whiteness was associated with cleanliness, purity and the angelical.

Nursing care was very task-oriented and often concentrated on bedside nursing care. There was a head nurse on each nursing unit who got her orders from the doctor, and she in turn told the staff nurses what to do. The staff nurse had little autonomy but at the same time was responsible for everything she did for the patient. If the doctor did not like the nurse for any reason, he could complain to the nursing office. Nurses were often fired or transferred because a doctor disagreed with them concerning patient care, or simply because the doctor did not like them.

The nurse's salary was low: $13,000 a year in 1974 for full time work in a New York City medical center (cf. Appendix 3, A Registered Nurse's Salary Scale for 1973). With hospitals open 24 hours a day, working hours changed on a regular basis. Many times, the daytime nurse stayed for the evening shift when the evening nurse called in sick. Such status and schedule conditions contributed to role strain for the nurse, especially those who were married. Role strain is the felt difficulty in fulfilling

personal/professional role obligations (Goode 1960, p. 483). Changes in nursing practice were slow due to the reluctance of physicians and administrators to accept the new role of the nurse.

In the 1990s, the role of the nurse expanded, becoming more professional and involving greater responsibility. Very few diploma schools now exist; most nurses obtain, at minimum, a two-year college degree from a community college. Many R.N.s have a baccalureate degree in nursing which require courses in behavioral and physical sciences, such as chemistry, physiology, genetics, and psychology, in addition to courses in nursing, computer science, and the practical training given in the hospital. This role transformation has made the nurse a better practitioner in the hospital setting. She is more informed and more of a professional.

Concomitant with professionalization comes greater responsibility, and thus more malpractice suits against the R.N. than ever before. In a series of interviews on their roles conducted in 1994 with registered nurses in connection with this study, several made note of their legal liability. Some representative comments:

> I feel the reasons many nurses leave nursing are the following: 1. Low pay; 2. Long hours; 3. Staffing shortages; (and) 4. What I call "being dumped on." According to the legalities if a doctor makes a mistake and the nurse does not tell him (after trying to tell him he is wrong--which is a joke)--she, the nurse, can be sued for malpractice....Why do nurses bear the

> brunt for all the errors made by other professionals? Certainly the doctor is not held liable for the nurse's mistake (Appendix 2, no. 7).
>
> A dysfunctional nurse cannot look to her peers, supervisors, or even to her organizations for help. She must find a lawyer (Appendix 2, no. 9).
>
> Nurses leave the profession for many reasons ....we seem to be progressively involved with more liability/responsibility (Appendix 2, no. 11).
>
> Lawsuits--too many hospitals do not back up the nursing staff in this area (Appendix 2, no. 11).

With regard to status, the nurse's greater professionalization has also changed her attire. The caps are gone and many hospitals have nurses wear "scrubs" (uniforms) of different colors. The hospital identification tag with the nurse's name and specialty is the sole indicator of her status.

More flexible working shifts were introduced as a way to retain experienced nurses in the hospital after they started raising families. Nurses may work two twelve-hour shifts on a weekend and one eight-hour day during the week and still be considered full time staff, with all attendant benefits. The salary has increased dramatically as well; nurses can earn from $30,000 to $75,000 or even more annually, depending on their expertise.

Nurses who have completed master's degrees can take state board examinations to become nurse practitioners (N.P.s), and thereby expand their role in the health care setting. The N.P. sees patients of her own as long as there

is an M.D. in charge of the practice. Since 1992, the N.P. in New York State is allowed to write prescriptions for her patients, excluding controlled drugs. These changes in the nurse's role have attracted more people to the profession, including males and members of diverse ethnic groups.

The computer age has changed the way nurses do patient care. Computers are used to record daily nursing care of individual patients and to tell the nurse what specific care is needed for a patient with a particular disease. The computer records drugs, actions, interactions and dosages, and helps to reduce errors that previously might have resulted from a doctor's poor handwriting on orders. Computers also shorten writing for the nurse and increase patient contact, for the information that was once given only by the doctor is directly available to her.

Another change in the hospital setting is the invention of numerous computerized instruments and equipment that the nurse is responsible for operating and monitoring: telemetry, the external pacemaker, passive range of motion tables, hyperalimentation, intravenous pumps, and an assortment of machines used in the operating room. The list of new machines coming into the hospital each day is endless, and the nurse is constantly attending in-service education to learn how to use them. This ever-changing technological equipment contributes to role strain for the nurse because while it may make her work more efficient, her

patient load is also increased. The older nurse, furthermore, is not only deprived of her former role of providing bedside nursing care, but is also under greater stress because she must learn to operate all the new equipment just as she is approaching retirement.

The epidemic of AIDS (Acquired Immune Deficiency Syndrome, an apparently fatal condition) has also changed the nurses' role. Since it is illegal to test patients entering the hospital for the HIV (Human Immunodeficiency Virus, the suggested cause of AIDS that can be transmitted via blood and other body fluids), the nurse is at risk of infection every day. Required measures of protection include making sure she doesn't stick herself with a needle after she gives an injection, disposing of needles properly, using rubber gloves with every patient and in general, constant awareness of the risk of contracting this deadly disease.

Changes in medicine also contribute to the role strain of the nurse. Only after the appearance of the germ theory in the nineteenth century did physicians come to demonstrate techniques superior to other healers. They attained professional status because they acquired the technology necessary for performing the central function of saving lives. In 1910, the American Medical Association (A.M.A.) standardized medical education in a manner that served to exclude others from practicing medicine. From 1910 to 1960,

medical schools had an elitist bias, recruiting students mainly from white male upper- and middle-class populations. The A.M.A. has been successful in suppressing internal dissent and resisting external regulations by political lobbying. This organization can certainly be considered an agent of social control, and the nursing profession a primary object of this control.

When the cry for health insurance was first heard, hospitals and doctors joined forces. Blue Cross was created and controlled by hospitals to cover hospitalization costs, and Blue Shield was created and controlled by physicians to pay doctors' bills (Farley 1990, p. 477). Until recently, most people enrolled in Blue Cross and Blue Shield or other similar health plans could go to a doctor of their choice. When surgery was indicated, a patient could also choose a surgeon without getting a second opinion. When a patient was hospitalized, the surgeon maintained complete control over discharging the patient, and could keep the patient in the hospital for as long as he considered necessary.

Today, due to the high fees charged by doctors, the increased use of expensive technology and the increased cost of hospital stays, the status and power of the M.D. are undergoing major changes, and the once tight-knit, closed system of the profession is being forced to open itself to other social forces. Medicine is losing its unique characteristics--work autonomy, elitist status, monopoly of

knowledge, authority over clients, and freedom from third-party interference. Trent identified this change as "deprofessionalization" (Toren 1975, p. 325).

Today's physician is often under control of managed care, which includes insurance companies, outside agents, and levels of government that monitor all the services of the hospital and the doctors on a day-to-day basis. The patient needing surgery may first have to go to a primary doctor who is listed in his medical plan, and if that doctor says he needs surgery, the patient must secure two mandatory opinions from surgeons approved by his insurance plan. His hospital stay is restricted to a standard length of time, since doctors now have minimal control over the length of stay.

Finally, insurance companies are abandoning hospitals that will not negotiate their costs. In Westwood, New Jersey, for example, Blue Cross, Blue Shield and the Prudential Insurance Company, in 1994, removed their coverage from Pascack Valley Hospital. All doctors using that facility scrambled to affiliate themselves with another nearby hospital so they wouldn't lose their practice; patients sought out new doctors and hospitals that would accept their coverage. Enormous fiscal strain on hospitals, caused by rigid limits on what the governmental programs Medicare (for people age 65 and over) and Medicaid (for the poor and medically indigent) will pay, has resulted in

tremendous cost shifting to the medically insured.

The nurse is directly affected by these developments, for she is the one who has continuous daily contact with the patients. She increasingly feels more like an employee than a professional because she lacks the prerogatives normally available to a professional. She is under pressure to get the patient out of the hospital on time regardless of the patient's physical and mental conditions. Since a patient often leaves sicker than he did years ago, the nurse must instruct his family how to care for him at home; and there is a concomitant need for more home care nurses. William Paterson College, a New Jersey state school with a four-year B.S.N. program, recently announced a new graduate degree program (M.S.) in nursing, to begin in January 1996, emphasizing home health nursing. According to Sandra De Young, Chairperson of the College's Nursing Department, there is a documented need for nurses with graduate school training who can be employed as advanced practice nurses in the community setting (The South Bergenite, April 5, 1995, p. 26). Home care nurses in turn encounter greater stress because their patients are not fully recovered, and they have the added burden of dealing with other family members.

As the role of the nurse has become more managerial and more technical, less "hands on", role strain has increased. The requirement that nurses document everything also creates stress, because this must be done on the same day. Many

times the nurse leaves an hour after her shift is over because of unfinished paper work. It is not difficult to understand the role strain of the nurse of the 1990s.

* * *

Since the beginning of the use of pharmaceuticals to treat disease, nurses have had easy access to drugs. In a nursing ethics journal as far back as 1900, a nurse wrote

> of encountering members of the profession who had lost their power of self control and had become victims to the abuse of some powerful drug or alcoholic stimulant with all its intended evils (Schaffer 1983, p. 720).

Very little was know of drug/alcohol use among nurses, and if it was discovered they were dismissed (Winick 1974, p. 158). Usually such nurses went to other nursing positions where they had access to drugs, such as nursing homes. Others joined private practice situations where supervision was minimal and substance abuse was not easily detected.

For several decades, little was published about substance abuse among nurses, and the nursing profession itself denied that a problem existed. The image of the nurse--a Florence Nightingale figure whose vocation in life was to help the sick and who worked long hours with little pay doing many menial tasks--is difficult to correlate with the deviant behavior of taking drugs or abusing alcohol.

Since nurses routinely administer drugs to patients and

witness their curative powers, it is understandable that they might look to drugs for their own relief from pain and stress (Naegle 1988, p. 47). Nurses are among those health care professionals who believe that they can "self medicate" safely (Curtin 1987, p. 7). Some early accounts suggest that nurses started using drugs illegally after using them legitimately for their own surgical procedures (Curtin 1987, p. 7). Many popular drugs, such as the tranquilizer Valium and the analgesic Demerol, were not known to be addicting when they first began to be prescribed.

In 1955, a study of drug-abusing patients in the U.S. Public Health Service Hospital in Lexington, Kentucky, revealed that 40% of the inpatients were nurses and physicians (Smith 1989, p. 161). In the 1960s and 1970s, there was still little information about drug use in the nursing literature. However, as more synthetic narcotic drugs such as Dalmane and Demerole, as well as pain killers, were classified in the "controlled drug" category, it became harder for the nurse to get sleeping and pain medications without a prescription, for such drugs were subject to strict accounting procedures.

In 1974, I was a surgical nurse in a large metropolitan hospital in New York City. Doctors there prescribed 5 mg. of Valium three times a day for patients awaiting surgery, and I administered this drug and others without knowledge of their addictive qualities. In personal interviews with

nurses who attended nursing schools in the 1950s, they relate that students at that time were not paid for their services and had to live in the nursing school dormitories, working on the hospital units sometimes for as long as twelve hours a day. Some took Seconal in order to sleep and "bennies" to stay awake (one even used Balladonna drops in her eyes to make them shine when she went out on a date), but we do not know how many were taking these drugs routinely.

In the nursing journals of the 1980s, a number of articles about drug abuse appeared. Naegle (1988, p. 43) reported that 3% of registered nurses took illicit drugs on a regular basis. The American Nurses Association (A.N.A.) estimates that 6 to 8% of registered nurses have a drug problem (Skinner 1990, p. 15), while a contemporaneous study (Schaffer 1988, p. 720) claims drug abuse in nursing has reached epidemic proportions, 50% higher than the general population. Trinkoff (1991) concurs with the 50% figure.

Stress is related to drug use by nurses. The pioneer of stress theory, Selye (1974, p. 34) defines stress as a nonspecific response of the body to any demand made upon it. Whether a stressor is pleasant or unpleasant depends merely on the intensity of the demand made upon the adaptive capacity of the body. He further claims that we must carefully analyze ourselves to try to find the particular stress level at which we feel most comfortable, especially

since the stress of frustration is much more likely than muscular work to contribute to diseases like high blood pressure and peptic ulcers.

According to most stress theorists, stress is in the eyes of the beholder and can be stated as follows:

> Emotional experiences, and to some extent physiological and performance measures, are in part a function of the perceptions, expectations, or cognitive appraisal which the individual makes of the stressing situation (Fritz 1957, p. 67).

According to McGrath (1977, p. 67), several other studies express a similar view: Harris, Mayer and Becker (1955), Lazarus (1957, Lazarus, Deese and Osler (1957) and Reid (1948).

Most young women who choose nursing as an occupation probably have a desire to be caregivers early in their lifetime. They tend to have an altruistic need to help people in distress (Maykovich 1980, p. 299). Nursing is perceived to be rewarding, providing a sense of job satisfaction and achievement. Nursing schools, whether college- or hospital-based, reinforce this philosophy. Nursing schools teach nursing students to provide independent patient care, to make their own nursing diagnoses/care plans, and to be decision makers regarding critical patient care issues. Over the course of their training, students receive clinical experience in hospital settings, taking care of children, the acutely ill, the

terminally ill, the physically and psychiatrically disabled and the elderly.

After nursing students graduate, pass the state board exams and are hired by hospitals as registered nurses, a shock of reality often takes place. They quickly discover that hospitals are authoritarian employers and that nurses are expected to follow doctors' orders (Connel 1987, p. 64). The relatively autonomous nursing practice that the student expected is transformed in the bureaucratic setting of the hospital. An additional possible contributor to drug use among nurses stems from this bureaucratic conflict, which leads to changes in self image and hostile feelings against a demeaning system (Murphy 1987, p. 34). One of the nurses I interviewed expressed such a view:

> Nursing Administration is not supportive and creates most of the problems by being abusive--harassment, sabotaging, not understanding. Most of them are trying to use managerial techniques that do not fit into the nursing environment.
> ....loyalty to traditional nursing values and ethics is considered obsolete by these Nursing Administrators who try to connect with the supposed winners. They take on the values of the executive model and react to the traditional values with disdain; and consequently the nurse who promotes excellence in her work must compromise her values, thus hurting herself and becoming unhappy and bitter in the process.
> ....The sad part is that nurses interested in personal gain only have ruined the Nursing Profession for nurses that were truly dedicated and truly interested in work outside themselves (Appendix 2, no. 13).

Smith (1989, p. 65) contends that nurses are at high

risk of substance abuse due to high stress levels, easy access to drugs and the legitimation of drug use by doctors for their patients.

The author of this thesis assumes that the stressors of the nursing profession are real, based on many sources and the author's own experiences as a practicing nurse and a nurse educator, as well as interviews with others in the profession. A second assumption, that drug and alcohol use among the members of the profession is attributable in some degree to work-related stressors, is more problematic, for there may be other causes--changes in societal attitudes, and new discoveries on the health risks of using these substances--that affect a nurse' decision to use these substances.

The next chapter will discuss the methodology utilized in the surveys conducted in 1979 and 1994. In chapter three, a comparative analysis of the demographic data is set forth. Chapter four summarizes the findings derived from the survey questions relating to substance abuse, and chapter five the data involving stress and coping mechanisms. The final chapter will discuss several cognate issues and present recommendations for the profession.

CHAPTER 2 - METHODOLOGY

In 1979 I prepared, distributed and collected a questionnaire of female registered nurses' use of alcohol and other drugs (Appendix 1). At that time, I was a faculty member in a nursing program at a community college in the New York metropolitan area. I had access to registered nurses at several local hospitals' nursing staffs and a total of 351 questionnaires were completed.

The questionnaire itself focused on alcohol and drug use, self medication and stress management. The data were entered into a computer file for statistical processing and analysis using the Statistical Package for Social Sciences (SPSS) program (Nie 1975). These 1979 data may be the only large scale findings on the prevalence of drug and alcohol use among American nurses in an urban area.

In 1994, I administered the same instrument to a sample of 150 registered nurses at the three hospitals that were originally surveyed in 1979, and 137 were completed. The instrument included the same open-ended questions on alcohol and drug use, demographic characteristics, and personal techniques for stress management developed for the 1979 questionnaire. Two additional questions on stress, one regarding the nurses' perceptions about their autonomy in the workplace, and a second, open ended question requesting them to identify the major stress factor in their nursing

career, were included in the 1994 questionnaire (Appendix 1). In addition, one validated, well-known and objective instrument--the Nursing Stress Check List (Benoliel et. al 1990, p. 226)--was incorporated, in order to provide objective comparative data on subjects' stress exposure and response.

The Nursing Stress Checklist measures the degree of relevance, descriptiveness, or concern among nurses of potentially stressful workplace and personal conditions, in statements ranging from "I have felt frustrated" and "I have been unable to meet my personal obligations" to "I could not stop thinking about my patient (s)" (cf. Appendix 1). In a format with a scale range of 0 (indicating not at all relevant, descriptive, or of concern) to 8 (highly relevant, descriptive, or of concern), the instrument arose as a response to Oberst's (1978) survey of oncology nurses. The Nursing Stress Check List Authors identified the need to promote morale and prevent burnout among nurses in clinical work as of the highest importance. Thus, aware of both the stressful nature of nursing in clinical settings, and that the nature of such stress needed to be explicated in its particulars if interventions to counteract the effects of the workplace stress factors were to be developed, the research team created the Checklist (Benoleil et al 1990, pp. 221-222).

The wide range of potential stress factors measured by

the Checklist grew out of the research team's use of Lazarus' transactional perspective on stress, which views occupational stress as a multidimensional phenomenon resulting from a transaction that arises out of interchanges between an individual and the environment; i.e., that the existence of stress is a function of both personal life events (such as illness or role transitions) and environmental (workplace-specific) factors (such as role conflicts or strains, workload problems, negative patient outcomes, and communication difficulties with physicians and administrators) (Benoliel et al 1990, p. 222). The items included in the Checklist were tested in both positively- and negatively-worded statements to insure consistent results. The items were subjected to the Holmes Schedule of Recent Events (an instrument measuring long-term exposure to the specific items) to insure their validity beyond the time-span of the survey; and analyzed by the SPSS program, in order to isolate and retain only those items that factor analysis showed to be linear combinations of the team's theoretical and empirical conjectures about clinical stress (Benoleil et al 1990, pp. 224-26).

This instrument identifies a set of items thought to be representative of the domains comprising nurse stress in clinical settings. From the statistical processing and factor analysis of the data compiled after distribution of the checklist, the set of 74 items was organized into five

domains; personal reactions to physical, cognitive and emotional stress; personal concerns, for the most part indicating role conflict; work concerns, or the environmental stressors peculiar to nurses; role confidence, the nurses' self-evaluations of their performance as nurses; and work completion concerns, or time strains (Benoliel et al 1990, p. 226). In order to minimize sampling errors, the items were sorted according to an exploratory factor analysis, so that 47 of 74 items were retained, having met the criteria of a minimum factor loading of .40 and conceptual relevance to the topic of stress in nursing.

The two samples in 1979 and 1994 are approximately similar in terms of ethnicity, age, gender, education and socioeconomic status. As far as I know it is the only study of its kind. The survey is limited to R.N.s employed in acute-care public or private hospitals in New York City, and nurses in other workplaces--nursing homes, home care and mental hospitals--are excluded. Therefore, the project cannot claim to be a comprehensive study of all the kinds of nurses working in New York City. Nevertheless, it does attempt to present a profile of the sample in terms of employment status, geographic area, and educational level. In both survey years, confidentiality was guaranteed and informed consent was obtained from all subjects.

Answers to the 1994 questionnaire were tabulated and a series of cross tabulations were conducted: items subjected

to cross tabulation include alcohol and marijuana use, demographics, self-medication, and the ways subjects coped with stress. In addition to cross tabulation, appropriate statistical techniques were used to determine the relative importance of various factors. The factors are interpreted in terms of the kinds of social/cultural values discussed previously.

The two surveys were subsequently tabulated, measures of central tendency computed, and statistical comparison of the two samples made with computations of the significance of any differences, using the Pearson measurement system. Interpretations of the data include considerations such as role strain, the differences in social context of drug use in 1979 and 1994, changes in the nurse's role in 1979 and 1994, and the relative salience of drug use as a social problem in the two years. The interpretation of the data was supported by an additional seventeen personal interviews conducted by the author with metropolitan area R.N.s from the same three hospitals used for 1979 and 1994; focusing on nurses' primary occupational stressors (Appendix 2). When the 1994 survey was drafted, it included a question not included in the 1979 survey that read, "What is the one major stressor in your nursing career?"

The statistical comparisons will enable us to determine the prevalence of alcohol and illegal drug use in 1979 and 1994 among nurses, and to place our findings in the contexts

of the changing role of the nurse and the shifts in public attitudes toward drug and alcohol use.

CHAPTER 3 - DEMOGRAPHIC AND OTHER DESCRIPTIONS OF NURSES OF THE 1970S AND THE 1990S

This chapter compares the survey data of the 1979 and 1994 questionnaires with regard to changes and constants in the demographics of the nursing population surveyed. As set forth in Table 3.1, which compares the age, ethnicity, and the highest level of education between the two survey groups, there are significant changes in each category. The 1994 survey subjects are more mature, more ethnically diverse, and more highly educated than those of 1979.

Before analyzing each of these categories individually, it is important to briefly discuss the issue of gender. The survey data in Table 3.1, and in all the tables presented in this study, exclude male respondents. This exclusion reflects the fact that males made up less than .5% of the original 1979 survey respondents, and thus did not provide a sufficient sampling required for a valid comparative analysis. (According to a 1979 report by the A.N.A. Statistics Department surveying R.N.s in 1977, males made up 2% of the total R.N. population (Kelly 1981, p. 191).

The small number of males among nurses surveyed in 1979 is not surprising, given the historically negative public policies and private attitudes towards male nurses. In 1901, male nurses were explicitly excluded from the Army Nursing Corps (Kalisch 1985, p. 628). During the Second World War, males acting as nurses were given a minority

TABLE 3.1

Selected Demographics of Nurses Studied in 1979 and 1994

(all numbers indicate percentages)

	1979 (N=351	1994 (N=132)
Education		
Diploma School	2	14
Associate Degree (A.A.S.)	70	20
Bachelor's Degree	26	36
Master's Degree (M.S./N.P.)	1	20
Ph.D.	.3	--
Other	--	9
Age		
19-25	38	5
26-31	22	19
32-36	13	16
37-50	21	42
51-64	6	17
65+	0	1
Ethnicity		
White* (includes Hispanic in 1979)	91	63
Black	7	16
Asian	2	11
Hispanic* (1994 only)	0	7
Not Available	0	3

status, not recognized as nurses and served as nurses only during emergencies; and the A.N.A.'s request that the Army and Navy give male nurses the opportunity to serve as nurses as soon as possible after enlistment or induction was denied by Surgeon General Albert Love in 1942.

These military policies reflect a value system dictating that in health care, women should be nurses and men should be physicians; any man seeking a woman's job was considered odd or suspected of being homosexual. These attitudes probably dissuaded many men wishing to be caretakers from entering the field. That such attitudes prevailed into the 1970s was evident from my personal experience as a nursing school educator in 1976, where my female students did not make my male students feel very comfortable. It was embarrassing to the female students to discuss sex organs in front of males, in either the classroom or the hospital setting.

This situation had changed by the 1990s. A report in 1995 found that more than 9% of nursing school graduates are male ("Men in Nursing: the Novelty is Gone", Report Jan./Feb. 1995, p. 22). While there are still experienced male orderlies within the large medical centers in New York City, male nurses as a group tend to avoid bedside nursing, preferring supervisory and administrative nursing positions, nurse practitioner roles and entrepreneurial nursing. The 1995 report indicates that nursing for males (retired

policemen and firemen, among others) is often their second career, selected not so much out of nursing's traditional humanitarian concerns as for the modern nurse's competitive salary, benefits, flexible schedules and career security (Ibid.). The fact that male nurses today are older, married, and relatively well educated is an indication of the marked change in the social acceptability of males in nursing.

The statistics provided under the "age" category in Table 3.1 show the working nurse in 1979 to be much younger than her counterpart in 1994. (According to the aforementioned A.N.A. Report of 1979, the highest percentage of R.N.s were ages 25 - 34, and the next highest group were ages 35 - 44 (Kelly 1981, p. 191). Two possible reasons for this transformation may stem from concomitant changes in the educating and employment of nurses. In 1979, the time required for education a nurse was shorter; as the education data show, the highest degree obtained by most nurses in 1979 was the two-year Associate in Applied Science (A.A.S.), versus the four-year Bachelor of Science in Nursing in 1994: nursing today encourages a longer period of education, which leads to a more mature employment pool. The second possible explanation for the increase in age among practicing nurses may be the result of the conditions of employment for hospital nurses. Whereas in 1979 the majority of hospital nurses were not "employees for life" because of relatively

low salaries, meager benefits, and the lack of job security, in 1994 these factors were improved markedly by the unionization of most hospital nursing staffs. While the earlier pattern among nurses was to leave the hospital setting either in order to raise families or because the physical demands of the job became too difficult for women beyond middle age, the modern nurse is likely to remain in the field throughout her career. The nurse has economic incentives for doing so (such as pensions and health insurance benefits) as well as her responsiveness to the current societal trend that all women, single or married, with children or childless, be employed until retirement age.

The data compiled under the demographic category of "ethnicity'" for Whites and Hispanics are not precisely accurate and should not be taken at face value. While the data apparently show many more White nurses in 1979 than 1994, the statistics are questionable because of the wording of the 1979 questionnaire (see Appendix 1). In 1979 the questionnaire asked the open-ended question of the respondent's "race", and not her "ethnicity'; and because the category "White, Non-Hispanic" was not utilized by individuals or even by the U.S. Census in 1970, it is conceivable that many Hispanic women answered to "White" in the 1979 survey. Since I remember that there were in fact Hispanic respondents to the earlier survey, the "0%" of

Table 3.1 is clearly incorrect. Therefore, the numbers in the ethnic categories "White" and "Hispanic" in 1979 are skewed, so comparison with the same data in 1994 is not possible. (According to the 1979 report of the A.N.A., Whites made up 92% of nurses in 1977, and Hispanics 1.4% (Kelly 1981, p. 191).

The rise in the numbers of Blacks and Asians in the table parallels overall demographic increases by these groups in New York City over the 1979-1994 period, but there were other circumstances that fostered increases in nursing in these groups. During the 1980s, hospitals responded to a nationwide nursing shortage by offering incentives to nurses from foreign countries, and in 1988 the U.S. Immigration and Naturalization Service supported the hospitals' effort by granting one year extensions to nurses with H-1 visas facing deportation at the end of their five year visa permits (Professional Regulation News, June 1988, p. 4).

The low number of Blacks in the 1979 survey group can be attributed to historical factors. The earliest record of a Black nursing graduate dates from 1879 yet it wasn't until 1964 that Black nurses were accepted for membership in state nursing organizations (Campenha-Bacote 1988, p. 15). Kalisch asserts that the integration of Black nurses into all health care settings was not achieved until the early 1970s (1980, p. 627). I recall seeing many more Blacks in

the examination room when I took the test to become a Licensed Practical Nurse (L.P.N.) in 1972 than there were in my 1974 testing room for potential R.N.s. The L.P.N. title was probably favored over that of the R.N. by Blacks who usually had to support children and other family members, because the training period for the former degree was much less (nine months) than that needed for the R.N. (two years). The date in Table 3.1 indicate that there are over twice as many Black R.N.s today as there were in 1979, attributable not only to foreign nurse incentive programs, from which many Caribbean Blacks probably came, but also to the greater integration achieved by Black citizens in this and other service industries over the past fifteen years.

The trend in the level of nurses' education is towards higher university degrees involving lengthier time frames, which the survey data report. The A.N.A.'s first position paper on nursing education, issued in 1965, was prescient in this regard; it stated that the minimum preparation for beginning professional nursing practice should be a baccalaureate degree (Ashley 1976, p. 65). The overly ambitious tone of this position paper is evident from the 1979 data showing that it was the A.A.S. degree that the majority of nurses felt was necessary to be a nurse. Clearly, however, the data show that most nurses at that time felt that a diploma school education was no longer adequate; the university degree was not only more thorough

in its courses' contents, but was also more valuable in that the student obtained college credits that could be utilized in acquiring higher degrees at a future time.

The apparent increase in the number of diploma school nurses in 1994 is attributable to the change in nursing from a short-lived occupation to a life-long career; diploma school graduates reluctant to obtain further formal education were able to retain their positions as bedside caregivers through unionization privileges such as seniority-based job security and regular pay increases.

The greatest increase in the education of nurses indicated by the 1994 survey occurs at the master's degree level, and this supports the overall course of nursing away from the status of a vocation or calling, to that of a profession and a career. One writer in the early 1970s reported a perceived dichotomy in motivation between nurses with Associate's degrees and those with higher degrees: nurses with an A.A.S. indicated a vocational motivation, while those with a B.S.N. or higher, indicated a professional motivation (Wren 1971, as reported in Maykovich 1980, p. 299). Of interest is a later report finding no differentiation with regard to position, function or salary between nurses with A.A.S. degrees and those with B.S.N. degrees (Hogstel 1977, p. 1598). In any case, the data show that the percentage of R.N.s with a B.S.N. or higher degree rose from 27% in 1979 to 55% in 1994, demonstrating the

apparent achievement of the professionalization of nursing. There are more women with master's degrees in nursing and more women entering nursing education who already have master's degrees in other disciplines than ever before (Dunajski 1995).

The demographic changes among nurses working within the urban hospital setting caused conflicts and increased stress and role strain. In the 1970s, the administration of the hospitals granted professional status, more money, and authority to those with B.S.N. degrees over their lesser-educated colleagues. The latter, in turn, resented these policies, for they felt they were better trained in the nurse's core function of providing bedside nursing care of patients. While the nurses with A.A.S. degrees lacked the privileges of the B.S.N. nurses, their education enabled them to make certain independent nursing care diagnoses for patients, which they might use to distinguish themselves from the oftentimes more experienced diploma-school graduate.

These stress-causing conflicts among nurses have, to some extent, been replaced in the 1990s by the requirement that all nurses must undergo continuous training, be it technical or within the classroom, in order to renew their nursing licenses. In 1993, for example, R.N.s wishing to renew their licenses were required to attend classes on child abuse; and in 1995, they must receive instruction on

infection control. The greater solidarity among nurses of all educational backgrounds has also been fostered by a common resentment of the hospitals' use of unlicensed assistant personnel (U.A.P.)

In summary, then, our comparative analyses of the demographic categories of age, ethnicity, and level of education show that the nursing profession employs a more mature and more ethnically-diverse work force with historically high levels of education and training. The changes in the education and training of nurses can be expected to bring about new sources of stress and greater demands on the nurse's time, with an increase in her role strain.

CHAPTER 4 - ALCOHOL AND DRUG USE AMONG NURSES OF THE 1970S AND THE 1990S

A primary purpose of this study is to address the problem of drug and alcohol use among nurses. Of the numerous social theories proposing to explain why individuals consume alcohol or drugs, such as the distress experienced in withdrawal following the use of an addictive substance, the desire to heighten everyday experience, or as the ultimate retreat for individuals who fail in both the legitimate and the criminal worlds, one stands out by its multifactorial nature in its capacity to account for the wide variety of factors that predispose individuals toward usage. The sociological theory of the genesis of drug dependence by Winick (1974) stipulates three factors that are correlated with regular drug or alcohol use; namely, access to these substances, some mechanism by which individuals can disengage themselves from negative proscriptions about their use, and the occurrence of strains upon or perceived deprivations of the expectations and associated behaviors of one's position in a social system (Winick 1974, p. 4).

These three elements are readily found in the nursing field: the nurse administers drugs prescribed by physicians to their patients; the nurse experiences first hand the effectiveness of pharmaceuticals in acute-care situations, and frequently denies the long-term negative side effects

and addictions that result to be caused by the substance abused; and, as mentioned at the close of the previous chapter, the conflict between the nurse's traditional role as bedside caregiver and her more recent roles as semi-autonomous diagnostician, administrator (particularly with regard to documenting patients' medical conditions and treatments) is one kind of role strain, in which the nurse often finds it difficult to meet the demands of each of them within the time constraints of a delimited work period.

Each factor deserves deeper investigation. One pertinent perspective from which to examine nurses' access to drugs and alcohol is that of the workplace, and the consequences of use therein. In interviews conducted with 195 hospital nurses currently or previously drug dependent within seven years prior to the interviews, an overwhelming 81% used meperidine (Demerol), an inexpensive and readily-used opiate for treating pain in postoperative patients (Winick 1974, pp. 156-57). The nurse, who actually administers the drugs in most work settings, often has a variety of opportunities for accessing prescribed drugs by falsely charting that drugs she requests were administered to patients, by reducing the patient dosages in order to take them herself, or even replacing drugs in liquid forms with distilled water or milk sugar. Another avenue for gaining greater access to drugs is by requesting care for the chronically ill or working in a nursing home, where more

frequent drug medication is required and patients are rarely in a position to know or recall the frequency and strength of the drugs they receive (Winick 1974, p. 158). The author of this dissertation, working in a nursing home in 1973, recalls a situation in which the director of nursing, upon discovering that more Dalmane (an addictive hypnotic, prescribed for insomnia) was being used than could be accounted for patient use, placed it on the home's list of controlled substances before this was mandated by governmental regulations.

The expansion of the list of controlled substances is one way that patient care providers have attempted to restrict nurses' access to drugs. Prior to and during the 1970s, hospitals regularly maintained pharmaceutical storage areas on every floor, and nurses could remove the prescribed dosages themselves from containers. Now almost all hospitals use centrally-located pharmacies, and distribute drugs in individually-sealed dose ampules, which prevent partial distribution of a drug's prescribed dosage, or in "unit-dosages" for each patient, whereby if a particular patient requires three tranquilizers per day, for example, the unit dose will be distributed on a daily basis in a package of three (Winick 1974, p. 157).

A second means by which the health care establishment has sought to limit nurses' access to prescription drugs is through requiring greater diligence in reporting nurses

discovered to have a substance dependency problem. In most states an employer is required to report drug-dependent nurses to a state licensing board. In the past, however, hospitals often preferred quiet dismissals of suspected nurses "for health reasons" rather than issue a report to the licensing board in order to avoid undesirable publicity (Winick 1974, p. 158). Before the 1980s, a nurse could have had her license suspended for drug abuse for periods ranging from six months to seven years; other kinds of disciplinary action were license revocation, refusing license renewals, required surrendering of the license, and criminal probation (Pierce 1976, p. 656; "R.N.s and Drug Abuse: License Revocation", 1980, p. 12).

Since the 1980s, hospitals have become more open in acknowledging, disclosing, and recommending treatment for nurses with drug problems, and State Boards of Licensing in Nursing have sharply increased the number of permanent license revocations, reflecting the viewpoint that these problems are serious professional practice violations, not mere personal problems: in this we see the current trend of placing the state's interest in protecting public health and safety over that of the individual nurse's need to earn a livelihood ("R.N.s and Drug Abuse" 1980). Several states, however, utilize diversion programs as an alternative to actions against a nurse's license: these involve directing impaired nurses into treatment programs and requiring the

nurses to sign a contractual agreement in which they agree not to practice nursing during the treatment period (Naegle 1988, pp. 46-47). In summary, then, over the 1979-1994 survey period, nurses' access to prescription drugs has been curtailed and the penalties for illicitly appropriating pharmaceuticals increased, in an effort to prevent self-medication among nurses. Nevertheless, as nurses' comments from a 1987 survey show, there is a wide spectrum of opinion as to whether or not any real control over nurses' access to prescription drugs has been achieved (Naegle 1988, pp. 50-51).

The second factor that can influence an individual's decision to use drugs or alcohol is the capacity of an individual to disengage herself from the negative proscriptions about their use. The mechanism of magical thinking is the belief of nurses that their close familiarity with administering certain substances in their work enables them to control their own use (Winick 1974, p. 161). Nurses sometimes view a dependent patient's self-destructive behavior as evidence of weak character, not disease. The irony is that a nurse's knowledge about and experience with drug dependency can increase her own risk, by giving her a false sense of security about her ability to use drugs safely (Naegle 1988, p. 49). In a few instances nurses honestly believe that certain drugs have a lesser addictive potential than others (e.g., meperidine is less

addictive than morphine), or that drugs are a non-detectable alternative to alcohol use. These findings suggest that greater efforts to warn nurses of their higher risk might prevent the onset of using substances that can lead to dependencies.

The strains involved in nursing and the relative deprivation of social status and financial compensation (in comparison to the physician) are factors which, at minimum, indicate a correlation with the use of potentially addictive or harmful substances. Fatigue, ailments, and problems with family members and colleagues were the reasons cited most frequently by nurses in an earlier survey for turning to drugs or alcohol (Winick 1974, pp. 160-61). The anecdotal stressors reported by nurses in a 1987 study that they believed could lead to alcohol and drug use include an unmanageable workload, more paperwork, not being viewed as professionals, and the complications brought about with advanced technology. Nevertheless, research on addiction does not support the claim of a causal link between addictive disease and employment-related stressors (Naegle 1988, pp. 51-52).

Trends in substance abuse outside the field of nursing are also relevant to our discussion. The latest National Household Survey on Drug Abuse available in print, from 1992, shows the use of marijuana and alcohol declining from 1979 to 1992 among all adult age groups. Current users of

marijuana, for example, dropped from 35.4% to 11% for those ages 18-25, and from 6% to 3.2% for those 26 years and over; while alcohol use for these age groups is down from 75.9% to 59.2%, and from 61.3% to 50.1%, respectively (U.S. Substance Abuse and Mental Health Service Administration, in Statistical Abstract of the U.S. 1994, p. 141).

Similar downward trends are found in those reporting to have ever used these substances, with the exception of those ages 26 and over, where a steady increase (from 19.6% in 1979 to 33% in 1992) in exposure to marijuana appears. This exception applies to tranquilizers as well; declines are found in all age groups of past and present users except for the oldest segment of the population, in which 5.3% reported having used tranquilizers in 1992, versus the 3.1% reported in 1979. (Ibid.) Overall, however, current use of these potentially addictive and hazardous substances has declined in the United States from 1979 to 1992. National data for 1992 represents the last full set of data for a year, therefore comparison on this same data cannot be made with 1993 or 1994 national data.

These considerations provide a context for our surveys (see Table 4.1). The reported figures on nurses who self-medicate drugs indicate an increase in each category except tranquilizers. We can speculate that these mixed results--a doubling of self-medication overall between 1979 and 1994, with a reduction in self-medication of tranquilizers--to the

higher levels of education among the nurses in the 1994 survey, as seen in Table 3.1 of the previous chapter. It is possible that knowledge of the addictive qualities of tranquilizers, which were not known to the medical community in the 1970s, has led nurses away from this category of prescribed drugs, as well as from alcohol and marijuana. However, in 1979 there was a larger sample of younger nurses than in 1994 (see Table 3.2), and since a study in 1987 found that younger nurses (ages 20-24) as a group were more likely to have tried marijuana, and that occasional drug use was highest among nurses under age 40, this may have affected the findings of our study (Naegle 1988, pp. 42, 46). Table 4.2, summarizing the demographics of those nurses that use marijuana, also shows a positive correlation between younger women and marijuana use.

Returning to Table 4.1, the slight rise in the levels of self-medication of antibiotics and other drugs may also be due to the more highly-educated nursing workforce. Nurses are now routinely aware of the testing for bacterial infections and the diagnoses of conditions for which medications are used, and therefore feel more confident in using them without a prescription. These data are not consistent with the previously-discussed efforts of medical administrators and State Licensing Boards to dissuade nurses from taking prescription drugs without obtaining a doctor's prescription.

TABLE 4.1

COMPARATIVE DRUG AND ALCOHOL DATA REPORTED BY NURSES

(in percentages; "N" indicates total number of responses)

	1979 (N=351)	1994 (N-132)
Nurses Who Self-Medicate Without A Doctor's Prescription		
Self-medicate	19	42**
Antibiotics	56	65
Tranquilizers	41	19*
Other drugs	40	52
Use Of Specific Substances		
Marijuana	18	4*
Alcohol	84	65**
Attitudes Regarding Marijuana		
Favor legalization	39	29
Favor adminstration to dying/ chronically ill if proven effective	91	82**
Alcohol Use		
Daily	12	6**
Weekly	36	33**
Monthly	52	27**
No response	0	34
Alcohol Use Within The Past Month		
1 - 2 drinks	83	43**
3 - 4 drinks	13	21**
5 drinks	4	13**
6+ drinks	0	24**
Nurses With Alcoholics In The Immediate Family	18	35**

Pearson Measure of Statistical Difference
** $p \leq .01$
* $p \leq .05$

TABLE 4.2

Nurses' Marijuana Use By Selected Demographics
(1994 only)
(all numbers indicate percentages)

	USE	NON-USE	TOTAL
		Ethnicity	
		N=133	
White	4	96	100
Hispanic	11	89	100
African-American	5	95	100
Asian/Pacific Islander			
		Age	
		N=133	
20-25	14	86	100
26-31	8	92	100
32-36	5	95	100
37-50	2	98	100
51-64	0	100	100
65+	0	100	100
		U.S. Citzenship	
		N=133	
U.S. Citzens	4	96	100
Non-U.S. Citzens	0	100	100
		Education	
		N=133	
Diploma School	5	95	100
A.A.S.	12	88	100
B.S.N.	2	98	100
M.S.N./N.P.	0	0	100
		Current Marital Status	
		N=132	
Single	3	97	100
Married	3	97	100
Separated	0	100	100
Divorced	13	87	100
Widowed	0	100	100
		Using Childcare	
		N=30	
Paid	7	93	100
Unpaid	7	93	100
		Employment Status	
		N=128	
Full-time	5	95	100
Part-time	0	100	100

With regard to the statistics on alcohol use, the large number of "no responses" correlates with the results of the 1987 survey, in which nearly half of those receiving surveys failed to respond, due to concerns about confidentiality, possible repercussions, or the discomfort of examining this area of their lives (Naegle 1988, p. 43). The statistics of our surveys also corroborate a statement from the 1987 survey that "most female respondents could be considered light to moderate drinkers" (Ibid.). The apparent rise in alcoholism among immediate family members of R.N.s may be an accurate representation of the situation, a reflection of the large numerical difference of the nurses sampled in the surveys (N=287 in 1979, vc. N=73 in 1994), or the result of a change in social attitudes over the survey period. It is possible that the percentage reported in 1979 is lower than that which actually existed, and that the increase in the reporting could be due to the greater openness of our society in 1994 to the concept of alcoholism as a disease, perhaps even genetically determined, rather than an indication of deviant, socially unacceptable behavior. The interpretations of these data remain speculative.

In summary, then, our data on alcohol and drug use indicate that the multifactorial model of developing drug dependency may need to take into account the possible effects that can occur when more information about

dependencies becomes known by a social group such as nurses. The reported declines in the use of tranquilizers, marijuana and alcohol, with a simultaneous increase in the self-medication of antibiotics and other drugs, suggest that the more highly-educated nurse of the 1990s is less prone to engage in magical thinking and other forms of disengagement from the negative proscriptions about using addictive or harmful substances. In fact, the results perhaps indicate a sophisticated calculation as to which of these substances are less harmful or potentially addictive. While the variables of reduced access to controlled substances, the potential loss of child custody by substance-abusing parents, and a general lack of social acceptability may have influenced these findings as well, the fact that nurses still find it necessary to use any substances in order to cope with their vocational choice points to the need to examine changes in the third factor in the model, that of role strain and deprivation, to which we now turn.

CHAPTER 5 - STRESS AND THE PROFESSION OF NURSING

It is possible that the primary stressor in the nursing profession is the conflict between the nurse's value of caregiving, a value reinforced within the contexts of her education and training, and the nurse's responsibility to be an efficient and subservient employee of medical hospitals. In her social role as a nurse, she encounters administrative and supervisory mandates to work as often and as long as the hospital deems necessary, usually to the detriment of her ability to both provide quality patient care and to be a supportive member of her own family. These role conflicts are potential factors for creating stress, and this chapter will focus on the specific elements that nurses identify as stressful, and the coping mechanisms nurses use, including drug and alcohol use.

The data suggest that nurses today identify the lack of time they have to devote to their families to be the primary role conflict. Within the workplace, the most distressful element is the nurse-to-patient ratio, the overall patient load nurses bear, and the resulting insufficient time for completing their daily work requirements. The data confirm a correlation found by Naegle (1987, p. 51) of greater drug use among highly stressed nurses, but indicate an overall trend away from drug use as a coping mechanism. A brief overview of theoretical considerations will precede our examination of the results of the survey and interview data,

TABLE 5.1

NURSES' PHYSICAL, COGNITIVE AND EMOTIONAL STRESS

(numbers in percentages)

	High (5-8)	Low (0-4)	Total
Have felt tired	64	36	100
Have felt tense	46	54	100
Have felt frustrated	44	56	100
Have felt angry	44	56	100
Have been low in energy	42	58	100
Have felt extremely good	41	59	100
Have worried a lot	41	59	100
Have felt discouraged	38	62	100
Have felt anxious	38	62	100
Have felt restless	33	67	100
Have felt lonely	30	70	100
Have felt helpless	27	73	100
Have had headaches	26	74	100
Have had difficulty concentrating	21	79	100
Have had difficulty sleeping	20	80	100
Have been extremely irritable	17	83	100

TABLE 5.1A

NURSES' PHYSICAL, COGNITIVE & EMOTIONAL STRESS
STRESS QUARTILES
(numbers in percentages)

Marijuana Use
N=138

	Q1(low)	Q2	Q3	Q4(high)
Group I	(37)	(31)	(32)	(33)
Non-users	27.8	23.3	24.1	24.8
Group II	0	0	(3)	(2)
Users			60	40

Alcohol Use
N=138

Group I	(14)	(17)	(15)	(13)
Non-users	23.7	28.8	25.4	22
Group II	(18)	(23)	(26)	(12)
Users	22.8	29.1	32.9	15.2

Frequency of Alcohol Use
N=73

Daily	(1)	(0)	(2)
	25	0	50
Weekly	(7)	(8)	(5)
	29.2	33.3	20.8
Monthly	(6)	(6)	(5)
	30	30	25

Alcohol Use In The Last Month
N=63

1-2 Drinks	(6)	(9)	(8)	(9)
	22.2	33.3	29.6	14.8
3-4 Drinks	(2)	(3)	(5)	(3)
	15.4	23.1	38.5	23.1
5 Drinks	(2)	(2)	(3)	(1)
	25	25.1	37.5	12.5
6 Drinks	(7)	(4)	(3)	(1)
	46.7	26.7	20	6.7

in order to clarify the potential social ramifications of stress upon the nursing population.

* * *

Selye's definition of stress introduced variables in stress creation; the "response" ("the nonspecific response of the body" and the propagating "stimulus/event" ("to any demand made upon (the body)"). A third variable, called the "environmental factors" by Benoliel et al 1990, p. 223) incorporates the apparent fact that context will influence whether the response of the body is stress-producing or not. Taking the workplace as an example, if a nurse in an emergency care setting thrives on her capacity to perform triage on several patients simultaneously, then her daily routine will not produce "distress", Selye's term for damaging or unpleasant stress. However, should she be under pressure from her supervisor to work on days when she had planned to be off from work, and is having difficulty processing the paperwork of several inadequately identified, expired patients, perhaps due to a lack of competence or experience on the part of one of her colleagues, then the constant flow of incoming patients requiring triage may keep her from resolving these other issues. Thus the same task, triage, can be "unstressful" at one time and highly "distressing" at another, due to the impinging environmental factors of a given situation.

One nurse interviewee expressed a variety of factors

that created workplace stress, causing her to leave nursing. Her case typifies how frustration, an emotional response, turns stress into distress (Selye 1974, p. 78).

> I had great creativity and business sense and had nowhere to go in nursing, since I lacked a degree....I was bored and stressed in my VNA job. It was not the patients, it was the administration who never implemented any ideas of the staff....I left the hospital a few years before that due to the stress--the typical frustration of not enough time to be with the patient. Also I grew very discontented and tense being in critical situations all the time. With DRGs (Diagnostic Related Group) we never seemed to have anyone well enough to teach (Appendix 2, no. 3).

Thus stress theorists concur on two general propositions. One, that stimuli or events do not per se create negative stress; the onset of distress is a function of the adaptive capacity of the individual responding to it, and of the attendant environmental factors (Selye 1974, p. 31). Two, since the adaptive capacity among individuals varies, that which produces a non-destructive stress response in one person can produce a negative one in another.

Disagreement arises over whether the production of the distress response is conditioned primarily by hereditary and biological factors (i.e., the individual's unique genetic profile and nurturing) or by environmental and social factors (i.e., the contextual demands of the social role(s) in which the response occurs). Among the proponents of the

TABLE 5.2

NON-NURSING PERSONAL CONCERNS

(numbers in percentages)

	High 5-8	Low 0-4	Total
I need to spend more time with my friends and family	69	31	100
Not enough personal time for self	60	40	100
My house (apartment, room) has been unusually in need of cleaning or picking up	44	56	100
I have trouble finding time to meet my social obligations	39	61	100
I have been behind in doing my shopping	37	63	100
I have been behind in doing my laundry	31	69	100
Unable to meet my normal or expected role obligations in my personal life	28	72	100
My appetite has changed	27	73	100
Fear for my personal safety	22	78	100

TABLE 5.2A

NON-NURSING PERSONAL CONCERNS (1994)
STRESS QUARTILES

(numbers in percentages)

	Q1(low)	Q2	Q3	Q4(high)
Marijuana Use N=138				
Group I Non-users	(41) 30.8	(33) 24.8	(27) 20.3	(32) 24.1
Group II Users	(1) 20	0	0	(4) 80
Alcohol Use N=138				
Group I Non-users	(15) 25.4	(13) 22.0	(19) 32.2	(12) 20.3
Group II Users	(15) 19.0	(19) 24.1	(40) 50.6	(5) 6.3
Frequency of Alcohol Use N=73				
Daily	(1) 25	0	(2) 50	(1) 25
Weekly	(6) 25	(6) 25	(10) 41.7	(2) 8.3
Monthly	(4) 20	(4) 20	(11) 55	(1) 5
ALCOHOL USE IN THE LAST MONTH N-63				
1-2 Drinks	(6) 22.2	(7) 25.9	(14) 51.9	0 14.8
3-4 Drinks	(3) 23.1	(2) 15.4	(5) 38.5	(3) 23.1
5 Drinks	(1) 1.6	(1) 12.5	(5) 62.5	(1) 12.5
6+ Drinks	(4) 26.7	(3) 20.0	(8) 53.3	0

former are Selye (1974), Brown and Birley (1968), Brown and Harris (1978), Hudgens (1974), and Paykel (1971), as cited in Thoits (1983, p. 39), who posit that the more severe a single undesirable event or events experienced, the more likely that coping abilities will be overwhelmed and disorder will result. An undesirable event that threatens the physical survival or emotional well-being of the individual is thus more likely to exceed the organism's adaptive capacity, creating a psychologically determined, emotional response.

Among those who argue that responses are socially determined are Holmes and Rahe (1967), Abramson (1978), and Perlin and Lieberman (1979), as cited in Thoits (1983, pp. 82-83), who propose that distress is a function of the intensity of difficulties following an event, of the degree of change or readjustment required by an event. When distress results in a loss of mastery or control over life, it leads to a denial of the values of a social role or to feelings of inadequacy in those roles still valued, and self-esteem and the value of the individual in the eyes of others diminishes. In this model it is the individual's capacity to sustain her worth as a social being, rather than her survival as a biological organism, that is overwhelmed (Thoits 1983, pp. 82-83).

Selye seemed to recognize the latter position in his identification of the individual's dissatisfaction with life

and disregard for his own accomplishments as a major source of distress in modern society (1974, pp. 78-79). Self-doubt and regret can be mitigated by a strong sense of self-confidence, of course, but these are also a function of recognition on the part of others, i.e., social recognition. One nurse planning to remain in nursing believed that people were leaving the profession for three reasons:

> 1. No recognition for the tremendous responsibilities and amount of knowledge required, and the amount of risk of law suits.
> 2. Nursing per se no longer fits into the scheme of things. It is still gender dominated and gender affected.
> 3. Young women today have other options (Appendix 2, no 17).

Another specifically cited the lack of recognition for nurses.

> I believe nurses are leaving the profession because women in general are beginning to realize that we deserve to be recognized and appreciated. No longer are nurses willing to be the scapegoat for other departments that are less than adequate in their jobs, and as before, the nurse would be the primary contact with the patient and the target of families' frustrations. Nurses are now expected to take over a lot of the functions of doctors without any sort of recognition. The nurse's role is the responsible one, direct responsibility, but the power for choices and decisions has never been hers. The recognition a woman can receive in almost any other job is superior, for a person is no longer in a position of inferiority and few positions require working weekends and holidays (Appendix 2, no. 4).

A third found that her role as a midwife placed her on the lowest rung of the medical service hierarchy:

TABLE 5.3

WORK RELATED STRESS FACTORS

(numbers in percentages)

	High (5-8)	Low (0-4)	Total
The system makes things difficult or impossible	29	71	100
I could not stop thinking about my patients	18	82	100
Disagreement with physician over goals for patient	15	85	100
Physician would not really listen to what I had to say	13	87	100
Inability to meet patient's need	13	87	100
Difficulty making myself understood to a physician	9	91	100
Felt uncomfortable raising issues with patients and their families	6	94	100
Unable to answer questions from a patient or his family	3	97	100

TABLE 5.3A

WORK RELATED STRESS FACTORS
STRESS QUARTILES
(numbers in percentages)

Marijuana Use
N=138

	Q1(low)	Q2	Q3	Q4(high)
Group I	(35)	(36)	(30)	(32)
Non-users	26.3	27.1	22.6	24.1
Group II	0	0	(1)	(4)
Users			20	80

Alcohol Use
N=138

Group I	(14)	(14)	(16)	(15)
Non-users	23.7	23.7	27.1	25.4
Group II	(21)	(16)	(21)	(21)
Users	26.6	20.3	26.6	26.6

Frequency of Alcohol Use
N=138

Daily	0	(1)	(1)	(2)
		25	25	50
Weekly	(9)	(5)	(5)	(5)
	37.5	20.8	20.8	20.8
Monthly	(6)	(3)	(7)	(4)
	30	15	35	20

Alcohol Use In The Last Month
N-63

1-2 Drinks	(6)	(7)	(10)	(4)
	22.2	25.9	37.0	14.8
3-4 Drinks	(5)	(2)	(3)	(3)
	38.5	15.1	23.1	23.1
5 Drinks	(2)	(2)	(2)	(2)
	25	25	25	25
6 Drinks	(4)	(5)	(3)	(3)
	26.7	33.3	20	20

> The administration trashes on the physicians, the physicians trash on the nurses, and the nurses trash on one another. This was magnified multifold among midwives (I am one)....We are skilled professionals who still want to nurture and serve and be recognized and be paid. The system is not working for many of us....I have left the system and will not be back....I am a damned good nurse and a great midwife....I do not fit into the system (Appendix 2, no 9).

This interviewee illustrates an individual who found her social role as caregiver demeaned, yet retained her belief in the value of that role and her self-worth.

Our digression into these theoretical concerns illustrates the point that the "stressors" of nursing we are about to discuss do not in themselves "cause" stress. Rather, they are indicators of factors that nurses identified as being the most challenging to their coping capacities and the most threatening to their estimations of the value of their caregiver role.

* * *

The first set of tables represents the data compiled using the Nursing Stress Checklist of Benoliel et al (1990). This questionnaire, incorporated into the 1994 survey, measures stress in clinical nursing. The instrument was developed by identifying five domains within clinical nursing thought to be contributors to stress among nurses. These domains encompass psychologically based forms of stress [psychological, physical and behavioral responses (Table 5.1), non-nursing personal concerns (Table 5.2),and

TABLE 5.4

NURSES' SELF-EVALUATIONS

(numbers in percentages)

	High 5-8	Low 0-4	Total
I am not extremely self-confident	62	38	100
I have been unable to talk about all my concerns and to get the support I needed for my work	56	44	100
I have not been achieving up to my abilities	45	55	100
I have not been open and frank about my feelings	28	72	100
I have not performed competently	25	75	100
I have not felt good about my performance as a nurse	22	78	100
I have not felt good about my performance as a human being	22	78	100

TABLE 5.4A

NURSES' SELF EVALUATIONS (1994)
STRESS QUARTILES
(numbers in percentages)

	Q1(low)	Q2	Q3	Q4(high)
Marijuana Use N=138				
Group I Non-users	(35) 26.3	(35) 26.3	(31) 24.1	(31) 23.3
Group II Users	(1) 20	(3) 60	(1) 20	0
Alcohol Use N=138				
Group I Non-users	(13) 22.0	(14) 23.7	(20) 33.9	(12) 20.3
Group II Users	(13) 16.5	(26) 32.9	(16) 20.3	(24) 30.4
Frequency of Alcohol Use N=73				
Daily	(1) 25	(2) 50	(1) 25	0
Weekly	(6) 25	(5) 20.8	(5) 20.8	(8) 33.3
Monthly	(2) 10	(9) 45	(5) 25	(4) 20
ALCOHOL USED IN LAST MONTH N=63				
1-2 Drinks	(2) 7.4	(7) 25.9	(10) 37.0	(8) 29.6
3-4 Drinks	(3) 23.1	(3) 23.1	(2) 15.4	(5) 38.5
5 Drinks	(1) 12.5	(2) 25	(3) 37.5	(2) 25
6 Drinks	(5) 33.3	(3) 20	0	(7) 46.7

job-related time constraints (Table 5.5)], and socially-determined factors [nursing stress factors (Table 5.3), and nurses' self-evaluation (Table 5.4)]. The degree to which each item under these five factor categories was a concern was indicated by the R.N. on a scale of 0 (representing not at all) to 8 (an acute concern). In Tables 5.1, 5.2, 5.3 and 5.5, percentages represent the sum of those responses in the range of 5 to 8 in the scale, which are high enough to indicate a potential stress contributor. In Table 5.4, responses from 0 to 4 were cumulated, for in the case of the nurses' self evaluation the lower scale numbers would indicate lower self worth, and thus the greater potential stress factor.

Table 5.1 indicates that fatigue and negative emotional conditions associated with stress (tension, frustration, and anger) rate highest in concern, while mental dysfunction (anxiety, restlessness, loneliness, helplessness, difficulty concentrating) were lower.

Note the emphasis the following nurse interviewee gave to fatigue in her list of reasons for leaving nursing:

> Nurses are leaving the profession because they are tired of being 'told what to do' by other nurses. Paperwork fatigue. Tired of self-giving....Tired of working swing shifts, weekends, and holidays (Appendix 2, no. 12).

Clearly, fatigue in its psychological and emotional manifestations if a primary risk factor for stress in

nursing.

The data compiled in Table 5.1, on non-nursing personal concerns, include familial, domestic, physical and social matters. Lack of time to devote to family, friends, and themselves ranked higher than any of the job-related time concerns of Table 5.5, an indication of the primacy that nurses give to their professional roles. Nurses are likely to sacrifice their familial and personal time for the sake of the time their job requires. As one R.N. put it, "Our job often becomes longer and time factor or hours do not increase. Often we must work overtime to finish up due to inadequate staffing (Appendix 2, no. 11)." The competing time demands can create distress when they force the nurse to choose between serving her professional role and her familial or personal roles.

As interviews already quoted (nos. 9 and 13) indicate, nurses find the "system to be a primary social stressor in the hospital environment. Although the percentages here are low compared with those of other categories, the findings concur with responses to an open-ended question in the 1994 survey, in which those surveyed were asked to identify the one major stressor in their nursing career (Table 5.6). Patient load and the bureaucracy and politics of the workplace--elements that the "system" determines--received the highest number of responses, followed by problems with physicians and

TABLE 5.5

JOB-RELATED TIME CONSTRAINTS

(numbers in percentages)

	High 5-8	Low 0-4	Total
Not enough time to do all the things I need to do	56	44	100
I have not completed all the work on the job I wanted to finish	53	47	100
I have not completed all the work on the job I felt was necessary	35	65	100
I have not completed all the work on the job I was expected to finish	31	69	100
Behind in my work	26	74	100

TABLE 5.5A
JOB-RELATED TIME CONSTRAINTS (1994)
STRESS QUARTILES

(numbers in percentages)

	Q1(low)	Q2	Q3	Q4(high)
Marijuana Use N=138				
Group I Non-users	(45) 33.8	(22) 16.5	(36) 27.1	(30) 22.6
Group II Users	(2) 40	(1) 20	(2) 40	0
Alcohol Use N=138				
Group I Non-users	(15) 25.4	(18) 30.5	(15) 25.4	(11) 18.6
Group II Users	(15) 19	(31) 39.2	(27) 34.2	(6) 7.6
Frequency of Alcohol Use N=73				
Daily	(2) 50	(2) 50	0	0
Weekly	(5) 20.8	(9) 37.5	(8) 33.3	(2) 8.3
Monthly	(5) 25.0	(9) 45	(6) 30	0
Alcohol Use In The Last Month N-63				
1-2 Drinks	(5) 18.5	(11) 40.7	(8) 29.6	(3) 11.1
3-4 Drinks	(4) 30.8	(5) 38.5	(4) 30.8	0
5 Drinks	0	(2)	(4)	(2)
6 Drinks	(2) 13.3	(7) 46.7	(6) 40.0	0

supervisors (Table 5.3).

The-self evaluations of Table 5.4 are not posed in the questionnaire as negative propositions, but as positive ones (hence the first item reads "I am extremely self-confident"). My interpolation of negations for each statement reflects my use of the lower portion of the scale (0 - 4) to determine the percentages, since the higher scale rankings (5 - 8) tell us more about the degree to which each item may function in coping with distress, and the absence of distress, rather than the presence of a contributing stress factor. These results indicate that most nurses feel competent in fulfilling their roles, but not excessively confident, and that the greatest potential stressor in the psychological state of nurses is their lack of a support network in which they can discuss workplace concerns.

In summary: the data show that fatigue, role conflicts caused by time constraints, and non-communication about workplace concerns rank highest as potential factors for generating stress. Compounding these factors is the fact that they rarely occur in isolation, as the percentages in Tables 5.2, 5.3, and 5.5 indicate, and thus is is common for nurses to be exposed to overlapping, multiple stressors. These findings suggest that medical care settings with R.N.s could reduce employees' stress by providing regular work breaks, greater employee involvement in setting workplace policies and resolving workplace problems, and in

continuing/expanding more flexible work shifts in order to provide R.N.s with work hours that do not conflict with their familial and personal needs.

Tables 5.1A, 5.2A, 5.3A, 5.4A, 5.5A and 5.7 present the results of a data analysis investigating correlations between reported stress levels and drug and alcohol use. The analysis sorted respondents use of marijuana and alcohol into stress quartiles, four ranges of stress from the Nursing Stress Checklist data. The tables compare marijuana and alcohol use between all quartiles with the lowest reported stress concerns to those with the highest. The data show a correlation between high stress levels and marijuana use. A finding concurring with an earlier study showing that respondents who reported feeling very stressed at work also reported significantly higher drug use (16% versus 8%) (Naegle 1988, p.51).

Contrarily, there is a fairly even distribution of alcohol use among all stress levels, suggesting that alcohol is not used primarily as a stress coping mechanism even though there is a mild indication that high stress causes daily alcohol use. This finding is corroborated by data in Table 5.8, in which alcohol as a stress coping mechanism among R.N.s has remained nearly constant since 1979. The use of marijuana is constant as well. The mechanisms indicating the greatest change are the decline in the use of tranquilizers and the rises in less destructive and

healthier coping mechanisms such as forgetting the problem causing the stress, praying, meditation, and doing aerobic exercise. It is possible that the decline in the use of tranquilizers is attributable to nurses' greater knowledge about tranquilizers' addictive potentials, perhaps due to nurses' higher levels of education, and the rise in these other coping mechanisms to the increased interest in health and wellness among citizens and policy makers over the past two decades. Most encouraging, however, is the high proportion of nurses who believe that facing up to a problem is the best way to deal with stress.

Three excerpts below from interviews with nurses describe how nurses who choose to remain in the field are coping. They illustrate in a concrete way how recognition, workplace relations, and self-esteem can compensate for a variety of negative environmental factors:

> I stay because I always worked in those areas where there was recognition, a little prestige and a little better money--ICU/CCU (Intensive/Critical Care Unit)" (Appendix 2, no. 17).

> Benefits--time accumulation. Unpaid doctor assistance on the floor. In a new field, detoxification and rehabilitation. Need to be employed and nursing pays more than other positions open to me. Friendships with fellow nurses (Appendix 2, no. 14).

> If your self-esteem is pretty well established nursing is, however, an area where the individual can provide services and make changes that are meaningful, especially on a one to one basis.

TABLE 5.6
NURSES' PRIMARY STRESSOR

(numbers in percentages)

(N-122)

	%
Patient load/Nurse-patient ratio	22.1
Politics/Bureaucracy	16.3
Problems with M.D.	12.3
Problems with supervisors/management	10.6
Trying to continue higher education	9.8
Conflicts with co-workers	7.4
Inappropriate treatment (forced overtime/12 hour shifts)	5.7
Making decisions	4
Personal problems	2.5
Unemployment/job security	2.5
Fear of contacting AIDS	1.6
Burnout	1.6
Death of a patient under my care	1.6
Potential lawsuits by patients	.8
Potential cardiac arrest	.8

TABLE 5.7
OVERALL STRESS LEVELS AND ALCOHOL/MARIJUANA USE
STRESS QUANTILES
(numbers in percentages)

Marijuana Use

N=138

	Q1(low)	Q2	Q3	Q4(high)
Group I	(32)	(32)	(32)	(32)
Non-users	25	25	25	25
Group II	0	(1)	(2)	(2)
Users		20	40	40

Alcohol Use
N=138

Group I	(12)	(10)	(12)	(9)
Non-users	27.9	23.3	27.9	20.9
Group II	(19)	(21)	(27)	(12)
Users	24.1	26.6	34.2	15.2

Frequency of Alcohol Use
N=73

Daily	(1)	(1)	(1)	(1)
	25	25	25	25
Weekly	(9)	(5)	(7)	(3)
	37.5	20.8	29.2	12.5
Monthly	(6)	(6)	(5)	(3)
	30	30	25	15

Alcohol Use In The Last Month
N=63

1-2 Drinks	(6)	(8)	(9)	(4)
	22.2	29.6	33.3	14.8
3-4 Drinks	(3)	(3)	(4)	(3)
	23.1	23.1	30.8	23.1
5 Drinks	(1)	(1)	(4)	(2)
	12.5	12.5	50	25
6 Drinks	(8)	(6)	(9)	(3)
	30.8	23.1	34.6	11.5

TABLE 5.8
WHAT NURSES DO TO DEAL WITH STRESS

(numbers in percentages)

	1979 (N=351)	1994 (N=132)
Use drugs	2	2
Use tranquilizers	6	2
Put off work	49	73**
Have a treat to eat	54	74**
Drink alcohol	21	23
Buy something new	52	83**
Forget the problem	17	44**
Pray	48	85**
Meditate	6	28**
Do aerobics	4	47**
Face up to the problem	87	96**

** $p \leq .01$

CHAPTER 6 - SUMMARY, DISCUSSION, RECOMMENDATIONS

Our survey data show a number of trends in the nursing profession. Registered nurses today, compared with those in 1979, are more mature, more ethnically diverse, and more highly educated than in the past. They are more likely to self-medicate with all prescription drugs except tranquilizers, have lower rates of alcohol and marijuana use, and do not favor legalization of marijuana by larger percentages than in 1979. However, the use of marijuana is more likely among younger and highly-stressed nurses. The majority of nurses utilize non-chemical means of coping with workplace stressors, and are likely to attempt to resolve problems that cause them stress. Higher patient loads, a policy that is set by hospital supervisors and administrators, is their primary stress factor in the workplace.

These findings suggest significant improvements in the nursing profession overall. More knowledgeable experienced nurses who show greater awareness of the risks of addictive substances and unresolved stress are more likely to provide better care for their patients at higher productivity levels by virtue of their healthier mental and physical condition. The conditions of R.N.s, viewed solely from the perspective of the changes they themselves have implemented, ought to be better than ever before in the

history of the profession.

If, however, this is not the case, then the reasons for the conditions of nurses must be found in factors external to the individual nurse, in the attitudes and policies of those in the medical care setting who are not nurses. An understanding of the actual social conditions of the nursing profession therefore demands an examination of the larger environmental context. How do patients, doctors, and hospital administrators view the profession of nursing? Do recent developments in economic restructuring of hospital and health care provide an indication of nurses' value to the medical system and society overall? Indeed, can nursing properly be called a "profession" at all?

We can address these questions by examining nursing's origins, its function in the hospital setting, and its treatment by hospital employers. The discussion will illustrate that nursing is at a crossroads in its history, and that the only way nursing can become a profession is by investigating just how the skilled caregiving that nurses provide can best be delivered to those requiring their service.

* * *

In the eighteenth century, care in the United States and England was provided by wives and mothers in the home. Nurses of one kind or another functioned in hospitals under unattractive conditions; and much has been written about

drunken, thieving women who tended hospital patients at that time (Kelly 1981, p. 21). In this period, women from wealthy families did not work outside the home; the lower class working women worked as domestic servants in households (until the coming of factories.) Caring for the sick was considered work for the "uncommon women", female prisoners and prostitutes with little interest in providing care.

In 1860, Florence Nightingale started a training school for nurses at St. Thomas Hospital in England (Kelly 1981, p. 31). This was the beginning of training schools for nurses. Yet throughout the nineteenth century, women desiring to be nurses found themselves in competition with the lower paid work house inmates, and the concept of nursing in hospitals was unacknowledged, so that hospitals could continue to give lower labor costs priority over their function to provide patient care.

In 1873 the conditions at Bellevue Hospital in New York City became public. The nine hundred patients in Bellevue were kept in beds with three to five occupants strapped together. They were tended by ex-convict nurses and night watchmen who stole patients' food and left them in filth. Several society women, appalled at this state of affairs, sent a young doctor to England to confer with Nightingale. Shortly thereafter, the Bellevue Training School was formed in New York City.

By 1909, only thirty-six years later, there were 1105 hospital based diploma schools of nursing (Kelly 1981, p. 42). This rapid growth was not the result of altruism or public pressure on the part of hospitals, but of lower costs. Diploma school students provided free labor for the hospitals. Nursing students were unpaid and worked from sixty to one hundred hours a week on the hospital floors. Many applicants nevertheless applied because the occupational alternatives for untrained women were even less appealing, being limited to either domestic service, factory work, retail clerking or prostitution. (Similar conditions for females are said to exist in Moscow today). Diploma-school students lived on hospital grounds and were employed almost exclusively in providing bedside nursing care. They were taught the minimal care skills and medical knowledge necessary for patient care by doctors in the classroom.

Only in the 1960s did the development of the two-year associate nursing program appear, arising from the idea that nurses needed more training in the sciences in order to be effective. This development, along with the introduction of some baccalaureate programs in nursing and a visible women's movement, made it seem that nurses were taking the first step toward professionalization. Since the 1920s, nurses who finished diploma school training had been paid very low wages for their services by the hospitals. A more educated nurse might be of greater value to the hospital, and thus it

would be in the hospital's interest to raise salaries for such a nurse.

In 1972, New York State redefined the position of the Registered Nurse in order to give her an expanded role:

> The Practice of Professional Nursing as a Registered Nurse is defined as diagnosing and treating human responses to actual or potential health problems through such services as case-findings, health teaching, health counseling, and provision of care supportive to or restorative to life and well-being, and exercising medical regimens prescribed by a licensed or otherwise legally authorized physician or dentist. A nursing regimen shall be consistent with and shall not vary any existing medical regimens (New York State Education Law, Title VIII, Article 139, Section 6902, as cited in Bullough 1979, p. 150).

Did this statute make the R.N. a professional nurse? The answer lies in defining what constitutes a professional.

A profession entails several specific requirements:

1. provides services vital to human and social welfare;
2. has its own special body of knowledge;
3. involves essentially intellectual operations, accompanied by considerable individual responsibility;
4. educates its practitioners in institutions of higher learning;
5. establishes and controls its own policies and activities, with its practitioners being relatively independent in performing their functions;
6. attracts individuals whose primary motivation is

service rather than personal gain, and who conceive of their occupation as a life's work;

7. has a code of ethics; and
8. has an association that fosters and ensures quality of practice (Kelly 1981, p. 157).

Nursing as practiced does not satisfy criteria two and five; nurses do not have their own body of knowledge and do not practice autonomously. Thus, despite the rise in the educational level of the nurse, nursing remains an occupation for those individuals who enjoy caring for the sick and infirm, and professionalization accrues only to those nurses who as educators become professors within universities. Yet these are professionals in education, not nursing.

Of course there are a variety of situations where the higher level of education has its advantages for the nurse. A R.N. working in home care may perceive of herself as more of a professional than the hospital nurse because her work requires proficiency in a broad range of skills, social assessments, documentation, and skilled teaching of patients. Such a vision of professionalization is less likely with the hospital nurse, whose patient load, and especially the number of acutely ill patients, does not allow her time to provide all of these skills to each patient (Glazer 1988). Other avenues for advancement, aside from the aforementioned nursing educator on the university

level, are nursing administration and the status of nurse practitioner. These offer the promises of less frustration through greater autonomy, greater opportunity for advancement, and higher status and prestige than the R.N. The negative effect of such choices is that the nurse loses her primary motivation of providing care for the sick, substituting the economic motivation of the medical service industry: she exchanges the role conflict of the R.N. between her caregiving role and her personal/family role for the role conflict of the medical service provider (between providing medical service and increasing the profit of the medical service industry). As one author put it,

> Many nurses are discouraged because they cannot give the comprehensive care that they believe in, but are forced into functional and bureaucratic work patterns that do not give primary attention to the patients' total care (Kramer 1974, as cited in Kelly 1981, p. 196).

The attitude of the physician toward the nurse also contributes to her lack of professional status. In the nineteenth century doctors considered nurses as servants (Kelly 1981, p. 33). Such attitudes persist today, whenever a physician tends

> to consign the other allied health personnel to a non-professional limbo, regarding these persons as working for (him) rather than working for the patient. He considers these

> persons as his servants rather than as associates or colleagues. He may scarcely consider them at all....
> Physicians think of themselves as soloists, disclaiming their need for others. When the doctor does think of the nurse, he tends to view her primarily as his helper, following his orders and carrying out whatever he chooses to delegate (Bates 1970; repr. in Folta and Deck 1979, p. 196).

Thus, neither the efforts of the nurse nor her status in the eyes of her co-workers have led nursing closer to achieving professional status for its members. As a final illustration of how the nurse's environment reinforces the denigration of her caregiver role, we turn briefly to contemporary developments in restructuring the medical service industry, with regard to their effects upon and attitudes towards the R.N.

* * *

A recent issue of the American Nursing Association's The American Nurse, distributed to over two hundred thousand R.N.s nationwide, asked its readers to report on conditions within their hospitals ("Restructuring Shouldn't Victimize R.N.s:, Report Jan./Feb. 1995, p. 18). The results, shown in Table 6.1, illustrate widespread reductions in the staffing levels of R.N.s and an increased use of lesser-trained replacements known as Unlicensed Assistant Personnel (U.A.P.). The latter, sometimes also referred to as Certified Nurses Aides (C.N.A.s), lack nursing licenses and educational requirements but in some cases have passed a

state examination certifying them as nurses' aides.

A local example of an attempted restructuring plan provides some insight into the causes and motives of these workplace transformations. In 1994, Mt. Sinai Medical Center in New York City announced that all 1800 R.N. positions would be redesigned, and that every nurse being laid off would have to re-apply for a job. The motive seemed clear, given that the nurse's employment contract required that any lay-off follow a strict protocol that protects R.N.s who have seniority: Mt. Sinai was seeking to eliminate its highest-paid nurses and to abandon its contractual agreement with the nurses. Nadine Sanders, a R.N. in Mt. Sinai's education department, stated "The nurses felt it was a weeding out process to get rid of any nurse with more than ten years at this hospital because they were getting the highest salaries" ("Restructuring Shouldn't Victimize R.N.s", Report Jan./Feb. 1995, p. 18). Such restructuring has the character of something determined by accountants and consultants, without the input of those who deliver patient care, as the report's survey suggests.

Fortunately for them, the R.N.s at Mt. Sinai were represented for collective bargaining by the New York State Nursing Association (NYSNA), the oldest and largest collective bargaining representative for R.N.s in the nation. The NYSNA filed an Unfair Labor Practice charge with the National Labor Relations Board, claiming that the

TABLE 6.1

REGISTERED NURSES' REPORT ON HOSPITAL CONDITIONS

American Nursing Association (1995)

(numbers in percentages)

CONDITION	NATIONWIDE	NEW YORK
Registered Nurses in my facility have been cut back	68.4	71.7
Increased use of Unlicensed Assistant Personnel (U.A.P.) to provide direct patient care	44.7	33.3
Of those reporting reductions in R.N. staffing levels, how many found:		
Degraded patient care	78.6	63.8
Affected patient safety	64.0	53.4

NYSNA's four requirements for restructuring were not followed. These required that any restructuring

1. must have no adverse effect on patient care;
2. must include input from R.N.s who work at the bedside;
3. must not generate cost savings at the expense of registered nurses; and
4. must maintain the integrity of the nurses' employment contract, if they have one.

As noted, Mt. Sinai's operational shakeup failed to follow these four principles. The NYSNA also organized a boycott of a job fair that the hospital scheduled for their working nurses to apply for new jobs. The boycott was successful, and the management of the hospital was forced to forego its redesign plan. However, the hospital continues its fight with the nursing staff, in its current attempt to eliminate flexible time scheduling, another violation of the NYSNA contract. The NYSNA has taken action to prevent this move as well (Ibid.).

Unfortunately, R.N.s in hospitals where there is no collective bargaining are losing their jobs to U.A.P. or being redeployed to other areas, such as floor nurse, in which they are in charge of and responsible for the care provided by the U.A.P. (see Table 6.1). In a phone interview conducted in 1995 with Mr. Michael Stark of the ABC Training School in New York City, the seriousness of such a responsibility becomes plain (Stark 1995). New York

State approved the schools's $895., 120 hour certified nurses' aide course, whose students need not have a high school diploma, and were required to have only an "understanding" of English. The current student enrollment included students from over thirty-one different countries.

Upon completion of the program, C.N.A.s were legally permitted to do everything the R.N. did for the patient except for body invasive procedures such as injections. Among the permitted procedures are monitoring intravenous fluids and attendant equipment and tubing, calculating intravenous drips per minute and monitoring cc's from catheters. The delegation of such sensitive procedures to uneducated people with perhaps so little understanding of English that the patient might have difficulty communicating his needs seems to be bring nursing back full circle, so to speak, to the days when bedside nursing care was a refuge for an otherwise unemployable population group.

The results of such changes are more patient falls, ordered changes of dressings left undone, longer periods between checking on patients, inadequate changing of incontinent patients, medications given late, rushed assessments, and minimal patient teaching. Contrarily, the more nurses there are, the lower the mortality rates, the shorter the length of stays, the fewer the complications, and the lower the total patient costs ("Why NYSNA is Leading a Campaign to Promote the R.N.", Report Jan./Feb., 1995,

p. 14). Why, then, are hospitals taking such radical steps, given the decline in care provided and the ultimately higher costs.

The answer lies in the health care crisis of our day. Until recently, most third party payers in the U.S. were under the control of health providers; doctors and hospitals. Blue Cross, which covers hospitalization costs, was created and controlled by hospitals; Blue Shield, which pays doctors' bills, was created and controlled by doctors. Through political lobbying, these two groups insured that the "Blues" would be the third-party payers for the vast majority of the population receiving hospital care, and subsequently set their own prices. As prices for hospital care soared (from the acquisition of technological devices, the rise of "defensive" medicine by doctors to head off malpractice suits, and the cost of malpractice insurance), new payer groups arose out of either the desire to cash in on this industry or to control costs (Farley 1990, p. 477).

With new payment plans being offered by health maintenance organizations and corporate medical plans not controlled by either physicians or the hospitals, competition suddenly entered the medical services industry. From 1960 to 1985, there was an increase in the use of proprietary (for-profit) hospitals from only five percent of the total hospital beds in the U.S. to nearly ten per cent (National Center for Health Statistics 1988, p. 135, as

cited in Farley 1990, p. 478). New payer groups began to demand that their clients utilize Diagnostic Related Groups that determine the cost limits for specific procedures and the length of stay allowable, in order to retain their business. This drove the not-for-profit hospitals to drastically cut costs, often at the expense of the R.N.

Thus, it would seem that within the medical industry, the R.N. is considered an expendable luxury at best, and overpaid employee at worst. Despite her gains in education and training, the nurse has accrued no respect from the medical community in which she works; and the economic, political and social status of nurses prevents them from changing many of our laws and social institutions (Ashley 1979, p. 479). Her choice in the current hospital setting is to either accept an administrative position, and thus abandon her primary caregiving role, or accept greater patient loads, uncontrolled working hours, and lower pay, to the detriment of her personal/familial roles.

* * *

We, turn, finally, to some proposals for change, fully aware that they are based upon a limited study of R.N.s, employed exclusively in acute-care public and private New York City hospitals. Since employment conditions vary in other workplaces and regions, and among different nursing populations, these recommendations may not be applicable to nurses throughout the country. They are, therefore,

presented as topics for consideration, debate and modification by all groups interested in nurses and the field of nursing.

The results of our surveys suggest two modest additions to the R.N.s' current educational program. The first is that potential R.N.s be told of the strong correlation between stress levels and marijuana use, and warned of the hazards of using this coping mechanism not only to their health, but to their careers and even their families, for some states remove custody of the children from substance-dependent mothers. Secondly, the high percentage of alcoholism within families of R.N.s should be presented as part of the R.N.'s education. The potential nurse should be made aware of her risk of confusing her professional caregiver role with her spousal role, and of marrying someone she loves in order to "save" him from his alcohol dependency.

As the previous discussion indicates, nursing cannot be considered a profession without its members having an independent body of knowledge and practical autonomy in the workplace. Taking the latter problem first, there would appear to be no possible expansion of the nurse's autonomy within the current or future hospital workplace. However, as the case of the home care nurse illustrates, autonomous nursing is a feasible option. Whether through entrepreneurial home-care nurse contracting, or

collaboration with other medical providers in forming direct-payer medical groups, as long as the nurse is allowed to utilize her expertise independently, the obstacle of non-autonomous caregiving can be overcome. The most likely obstacle here will be the legal and political changes required to allow nurses to function independently of physicians and medical institutions.

The development of an "independent" body of knowledge peculiar to nursing requires more imagination, both on the nurse's part and society's conception of medical service. The present educational path of the nurse seeking higher degrees parallels that of the physician, thus precluding "independence" and insuring subservience, unless the nurse becomes an M.D. herself. However, there are many avenues of medical service, broadly conceived, that fall under the "caregiving" concept, yet are outside the purview of most physicians. Topics in preventative medicine such as nutrition, exercise, yoga and meditation; non-invasive physical healing methods such as physical therapy, chiropractic, applied kinesthesiology and reflexology; and alternative medical practices such as ayurveda, homeopathy, acupuncture and herbal medicine are possible educational areas which nurses could appropriate as specializations, just as physicians do.

A collective group of R.N.s with a variety of specialties might provide an even more cost-effective

"gatekeeper" service for group payers than the general practitioner physician, for their group would have a wider arsenal of relatively inexpensive and preventative therapies to apply before referring patients to high-priced specialist physicians. Thus they would be valued by medical payment groups as a cost-effective and beneficial element of a comprehensive medical plan. The nurse's traditional medical training would allow her to recognize serious chronic and acute conditions and thus make referrals to physicians when needed. At the same time, nursing would fulfill the requirement of having an independent body of knowledge, and thus truly become a profession in every sense of the word.

APPENDIX I

QUESTIONNAIRES FOR 1979 AND 1994

1979 SEX _____ AGE _____ RACE _____ EDUCATION _____

1. Do you smoke marijuana? _____
2. More than 3 times a week? _____
3. How old were you when you tried pot first? _____
4. Do you smoke to get mellow? _____
5. Stoned? _____
6. Both? _____
7. Do you smoke more pot now than you did earlier? _____
8. If yes, why? _____
9. Do you take other drugs too? _____
10. Separately? _____
11. At the same time? _____
12. Do you prefer pot to alcohol? _____
13. Why? _____
15. Do you use pot to deal with stress? _____
16. Do you notice any bad side effects? _____
17. If you don't smoke pot for a week or so, do you notice any change(s)?
18. Feel uncomfortable? _____
19. Miss a high? _____
20. Do you drive right after you smoke? _____
21. If no, why? _____
22. Do you feel less motivated toward a career or work when you are smoking pot regularly? _____
23. While at a party what percentage of people do not smoke pot? _____
24. What percentage smoke PCP? _____
25. Do most of your friends smoke pot? _____
26. Legalizing pot: A. In favor? _____
    B. Not in favor? _____
27. Do you feel marijuana should be given to chronically ill or dying patients if proven effective for certain conditions? _____
28. Can you describe any differences (physical or mental) you feel since you started to smoke pot? _____
29. Do you feel you can think as clearly as you did when you didn't smoke? _____
30. Do you feel you are dependent on marijuana? _____
31. Do you ever smoke alone? _____
32. Do you think smoking pot regularly makes people want to try stronger drugs like cocaine? _____
33. What do you use most often? Pot? ___ alcohol? ___ cocaine? ___
34. Do you think of yourself as a regular user? _____
35. Do you drink alcohol? _____
36. How often? _____
37. How much daily? _____
38. Alone? _____
39. Only at social functions? _____
40. Do you prefer wine? _____
41. Beer? _____
42. Other? _____
43. How much alcohol have you had in the last month? _____
44. Do you occasionally take other drugs when you are drinking? _____
45. do you drink alcohol to enjoy the feeling it gives you? _____
46. To reduce your level of stress? _____
47. To get bombed out? _____
48. How often? _____
49. Have you ever had a blackout? _____
50. Is there an alcoholic in your immediate family? _____
51. Other relatives? _____
52. Recovering alcoholics? _____
53. Active alcoholics? _____
54. Do you have a drinking problem? _____
55. Do you go to AA? _____
56. Does a family member go to AA? _____
57. Do you have mixed feelings about dealing with clients and their drug problems? _____
58. In you own life, how do you deal with stress? _____ a. Take drugs? _____
    b. Tranquilizers? ___ c. Other? ___
59. Or are you good to yourself by
    A. Putting off some work? ___
    B. Having a real treat to eat? ___
    C. Drink alcohol? ___
    D. Buy something new? ___
    E. Try to forget it till is goes away? _____ F. Pray? ___
    G. Meditation? ___H. Aerobics? ___
    I. Face up to it and problem solve whenever you can? ___
60. If you have tried several of the above at different times, which was most effective? _____
61. Do you feel you can selfmedicate without a M.D's prescription? Yes ___ No ___
    A. Antibiotics? ___
    B. Tranquilizers? ___
    c. Others? ___

Please add comments on the reverse side

1994

A SURVEY FOR REGISTERED NURSES

1. SEX
A. Male ____
B. Female ____

2. AGE
A. 16-19 ____
B. 20-25 ____
C. 26-31 ____
D. 32-36 ____
E. 37-50 ____
F. 51-64 ____
G. Over 65 ____

3. ETHNICITY
A. White, Non-Hispanic
B. Hispanic
C. African Amer./Black
D. Asian or Pacific Islander ____
E. Other ____

4. CITIZENSHIP STATUS
A. U.S. Citizen ____
B. Other Country ____
C. Green Card ____
D. Applying for Green Card ____
E. Temporary Visitor ____

5. ORIGINS
A. Write in country of origin of parents _____

6. EDUCATION
√ Highest degree achieved
A. Diploma School ____
B. Associate Degree ____
C. B.S.N. ____
D. M.S.N. ____
E. Nurse Practitioner ____
F. Other Degrees ____
G. Studying For ____

7. CURRENT MARITAL STATUS
A. Single ____
B. Married ____
C. Separated ____
D. Divorced ____
E. Separated ____
F. Widowed ____

G. Ages of Children living with you ____

H. Child care provided:
1. Paid: In home ____
Outside of home ____
2. Unpaid: In home ____
Outside of home ____

8. CURRENT EMPLOYMENT
A. Working full time ____
B. Working part time ____
C. Maternity leave ____
D. Family leave ____
E. Other ____

9. WORK SCHEDULE
A. Day Shift ____
B. Evening Shift ____
C. Night Shift ____

10. NURSING UNIT
A. Medical-Surgical ____
B. Intensive Care ____
C. Pediatric ____
D. Psychiatric ____
E. Operating Room ____
F. Other ____

I.D. No. _____

Stress Check List

Part I: Several circumstances are listed below that cause people some concern from time to time. Please consider the last two weeks and indicate the amount of concern you have experienced over each circumstance by circling the appropriate number.

	Amount of Concern								
	Not At All	Mild							Acute
1. Fear for my personal safety	0	1	2	3	4	5	6	7	8
2. Concern over my finances	0	1	2	3	4	5	6	7	8
3. I am overweight	0	1	2	3	4	5	6	7	8
4. Behind in my work	0	1	2	3	4	5	6	7	8
5. Difficulty making myself understood to a physician	0	1	2	3	4	5	6	7	8
6. Physician would not really listen to what I had to say	0	1	2	3	4	5	6	7	8
7. Difficulty understanding memos, meetings, policies	0	1	2	3	4	5	6	7	8
8. Dilemma over course of treatment for a patient	0	1	2	3	4	5	6	7	8
9. Not enough time to do all the things I need to do	0	1	2	3	4	5	6	7	8
10. Not enough personal time for self	0	1	2	3	4	5	6	7	8
11. Inability to meet a patient's need	0	1	2	3	4	5	6	7	8
12. Not doing as good a job as I think I can do	0	1	2	3	4	5	6	7	8
13. Unresolved disagreement with personal friend or family member	0	1	2	3	4	5	6	7	8
14. Unresolved difficulty with peers or supervisor	0	1	2	3	4	5	6	7	8
15. Unable to answer questions from a patient or their family	0	1	2	3	4	5	6	7	8
16. Felt uncomfortable raising issues with patient or their family	0	1	2	3	4	5	6	7	8
17. Disagreement with physician over goals for patient	0	1	2	3	4	5	6	7	8
18. Patient died	0	1	2	3	4	5	6	7	8
19. The "system" made it impossible or difficult	0	1	2	3	4	5	6	7	8

	Not At All			Mild					Acute
20. Unable to meet my normal or expected role obligations in my personal life	0	1	2	3	4	5	6	7	8
21. Difference in "life style" between self and patient and/or family for whom I am caring	0	1	2	3	4	5	6	7	8

Several circumstances listed below may have occurred during the last two weeks. Please indicate by circling a number whether you had such an experience and, if so, how satisfied it made you feel.

	Did Not Occur	Made Me Feel Extremely Unsatisfied							Extremely Satisfied
1. Did a particularly good job at something	0	1	2	3	4	5	6	7	8
2. Was caught up or ahead in my work	0	1	2	3	4	5	6	7	8
3. Encounter with physician	0	1	2	3	4	5	6	7	8
4. Encounter with supervisor	0	1	2	3	4	5	6	7	8
5. Encounters with family or friends	0	1	2	3	4	5	6	7	8
6. Had turning point in understanding or ability; "something clicked"	0	1	2	3	4	5	6	7	8
7. Had effective communication with someone who matters (I was heard, understood, got useful feedback)	0	1	2	3	4	5	6	7	8
8. Received support for my professional role	0	1	2	3	4	5	6	7	8
9. Patient died	0	1	2	3	4	5	6	7	8

For each of the statements listed below, please indicate how descriptive the statement has been of you during the preceeding two weeks by circling the appropriate number.

	Not at all Descriptive								Extremely Descriptive
1. I have had difficulty concentrating	0	1	2	3	4	5	6	7	8
2. I felt discouraged	0	1	2	3	4	5	6	7	8
3. I worried a lot	0	1	2	3	4	5	6	7	8
4. I could not stop thinking about one or more of my patients	0	1	2	3	4	5	6	7	8
5. I felt extremely self-confident	0	1	2	3	4	5	6	7	8

	Not at all Descriptive								Extremely Descriptive
6. I have been achieving up to my abilities	0	1	2	3	4	5	6	7	8
7. My appetite has changed	0	1	2	3	4	5	6	7	8
8. I have had difficulty sleeping	0	1	2	3	4	5	6	7	8
9. I have had headaches	0	1	2	3	4	5	6	7	8
10. I have awakened early	0	1	2	3	4	5	6	7	8
11. I have felt extremely good	0	1	2	3	4	5	6	7	8
12. I have felt restless	0	1	2	3	4	5	6	7	8
13. I have been low on energy	0	1	2	3	4	5	6	7	8
14. I have felt anxious	0	1	2	3	4	5	6	7	8
15. I have had a health problem	0	1	2	3	4	5	6	7	8
16. My stomach has been upset	0	1	2	3	4	5	6	7	8
17. I have been excessively irritable	0	1	2	3	4	5	6	7	8
18. I have felt frustrated	0	1	2	3	4	5	6	7	8
19. I have been angry	0	1	2	3	4	5	6	7	8
20. I have performed competently	0	1	2	3	4	5	6	7	8
21. I have felt helpless	0	1	2	3	4	5	6	7	8
22. I have felt good about my performance as a nurse	0	1	2	3	4	5	6	7	8
23. I have felt good about my performance as a human being	0	1	2	3	4	5	6	7	8
24. I have been open and frank about my feelings	0	1	2	3	4	5	6	7	8
25. I have avoided asking questions for fear of sounding stupid	0	1	2	3	4	5	6	7	8
26. I have felt lonely	0	1	2	3	4	5	6	7	8
27. I have felt tired	0	1	2	3	4	5	6	7	8
28. I have felt tense	0	1	2	3	4	5	6	7	8

Not at all Extremely

	Descriptive								Descriptive
29. My house (apartment, room) has been unusually in need of cleaning or picking up	0	1	2	3	4	5	6	7	8
30. I have always been preparing and eating my meals on time	0	1	2	3	4	5	6	7	8
31. I have trouble finding time to meet my social obligations	0	1	2	3	4	5	6	7	8
32. I need to spend more time with friends and family	0	1	2	3	4	5	6	7	8
33. I have had no trouble getting along with people	0	1	2	3	4	5	6	7	8
34. There have been no changes in my sexual activities	0	1	2	3	4	5	6	7	8
35. I have been behind in doing my laundry	0	1	2	3	4	5	6	7	8
36. I have been behind in doing my shopping	0	1	2	3	4	5	6	7	8

Even though you are a nurse, you also have many other roles: spouse, friend, lover, parent and others. Considering your activities for the last two weeks, how descriptive of you are the following statements. Please circle the best response.

	Not descriptive at all								Extremely descriptive
1. I did all the things I wanted to do in my	0	1	2	3	4	5	6	7	8
2. I met all the obligations I felt I should in my personal life	0	1	2	3	4	5	6	7	8
3. I met all the obligations others thought I should meet in my personal life	0	1	2	3	4	5	6	7	8
4. I have completed all the work on the job I wanted to finish	0	1	2	3	4	5	6	7	8
5. I completed all the work on the job I felt was necessary	0	1	2	3	4	5	6	7	8
6. I have completed all the work on the job I was expected to finish	0	1	2	3	4	5	6	7	8
7. I have been able to talk about all my concerns and get all the support I needed in my personal life	0	1	2	3	4	5	6	7	8
8. I have been able to talk about all my concerns and get the support I needed for my work	0	1	2	3	4	5	6	7	8

ANSWER EACH OF THE FOLLOWING QUESTIONS APPROPRIATELY IN BLANK PROVIDED.

1. Do you smoke marijuana? ____
2. More than 3 times a week ? ____
3. How old were you when you tried pot first? ____
4. Do you smoke to get mellow? ____
5. Stoned? ____
6. Both? ____
7. Do you smoke more pot now than you did earlier? ____
8. If yes, why? ____
9. Do you take other drugs too? ____
10. Separately? ____
11. At the same time? ____
12. Do you prefer pot to alcohol? ____
13. Why? ____
15. Do you use pot to deal with stress? ____
16. Do you notice any bad side effects? ____
17. If you don't smoke pot for a week or so, do you notice any change? ____
18. Feel uncomfortable? ____
19. Miss a high? ____
20. Do you drive right after you smoke? ____
21. If no, why? ____
22. Do you feel less motivated toward a career or work when you are smoking pot regularly?
23. While at a party what % of people do not smoke pot? ____
24. What % smoke PCP? ____
25. Do most of your friends smoke pot? ____
26. Legalizing pot: A. In favor? ____ B. Not in favor? ____
27. Do you feel marijuana should be given to chronically ill or dying patients if proven effective for certain conditions? ____
28. Can you describe any differences (physical or mental) you feel since you started to smoke pot? ____
29. Do you feel you can think as clearly as you did when you didn't smoke? ____
30. Do you feel you are dependent on marijuana? ____
31. Do you ever smoke alone? ____
32. Do you think smoking pot regularly makes people want to try stronger drugs like cocaine? ____
33. What do you use most often? Pot? ____ Alcohol? ____ Cocaine? ____
34. Do you think of yourself as a regular user? ____
35. Do you drink alcohol? ____
36. How often? ____
37. How much daily? ____
38. Alone? ____
39. Only at social functions? ____
40. Do you prefer wine? ____
41. Beer? ____
42. Other? ____
43. How much alcohol have you had in the last month? ____
44. Do you occasionally take other drugs when you are drinking? ____
45. Do you drink alcohol to enjoy the feeling it gives you? ____
46. To reduce your level of stress? ____
47. To get bombed out? ____
48. How often? ____
49. Have you ever had a blackout? ____
50. Is there an alcoholic in your immediate family? ____
51. Other relatives? ____
52. Recovering alcoholics? ____
53. Active alcoholics? ____
54. Do you have a drinking problem? ____
55. Do you go to A.A.? ____
56. Does a family member go to AA? ____
57. Do you have mixed feelings about dealing with patients and their alcohol or drug problems? ____
58. In your own life, how do you deal with stress? ____
    A. Take drugs? ____ B. Tranquilizers? ____
    C. Others to calm yourself down? ____
59. Or are you good to yourself by: A. Putting off some work? ____ B. Having a real treat to eat? ____ C. Drink alcoholic beverages? ____
    D. Buy something new? ____ E. Try to forget it, till it goes away? ____ F. Pray? ____
    G. Transcendental Meditation? ____
    H. Aerobics? ____ I. Face up to it and problem solve if it's within your capacity to do so? ____
60. If you have tried several of the above at different times, which are most effective? _____
61. Do you feel you can self-medicate due to your medical knowledge, without doctor's prescription? Yes ____ No ____ Such drugs as: A. Antibiotics? ____ B. Tranquilizers? ____ C. Others? ____
62. Do you have a sense of "moral distress?" e.g. in school you thought you would be independent in nursing care decision-making; on the job another health care provider or hospital policy prevents you from doing so. Yes____ No ____
63. Name the stressor in your nursing career that causes you most concern _____
    Elaborate _____

Please add any comments to survey on reverse side.

APPENDIX II

PERSONAL INTERVIEWS WITH REGISTERED NURSES

APPENDIX II - PERSONAL INTERVIEWS WITH REGISTERED NURSES
(Conducted in 1994)

In connection with this study, I conducted seventeen personal interviews with R.N.s in the New York City area. For each nurse interviewed, the following demographic data are provided: 1.) age; 2.) ethnicity; and 3.) years of nursing experience. The questions posed to each of them were "Why are nurses leaving nursing?" and "If you are not leaving, why are you staying?". Here are their responses:

No. 1 1.) 39. 2.) White. 3.) 15 yrs.

Lack of professionalism as a group; abdication of power; lack of unified support.

Our education and experience is so integrated and versatile that other professions encourage nurses to join their ranks, offering better salaries, more status, and less stress than nursing.

We sabotage our own.

No. 2 1.) 55 2.) White 3.) 20 yrs.

I left nursing when the hospital (diploma) school closed. I was an instructor at the school. I applied to be an instructor at a two-year school that was opening but was told that I was not "current" enough and did not have a Master's degree.

I was not willing to do patient care nursing in the hospital because I would be required to work rotation on all

three shifts.

I went to a university and got my Master's degree and sixth-year graduate certificate in counseling. I have worked as a counselor in the public schools and currently I am an administrator of a large school district. I am responsible for student personnel services. I have been honored for a distinguished career in education.

I still feel angry that nursing turned me away and rejected my gifts.

No. 3 1.) 37. 2.) Black 3.) 11 yrs.

Entrepreneurial spirit. I had great creativity and business sense and had nowhere to go in nursing since I lacked a degree. I have started a small clothing retail business and it is quite successful.

I entered this field ten months ago. I was bored and stressed in my VNA job. It was not the patients, it was the administration who never implemented any ideas of the staff.

I left the hospital a few years before that due to the stress; the typical frustration of not enough time to be with the patient. Also, I grew very discontented and tense being in critical situations all the time. With (the limitations of time imposed by DRGs (Diagnostic Related Groups) we never seemed to have any (patient) well enough to teach (about self-care).

No. 4 1.) 45. 2.) White 3.) 15 yrs.

I believe nurses are leaving the profession because women in general are beginning to realize that we deserve to be recognized and appreciated. No longer are nurses willing to be the scapegoat for other departments that are less than adequate in their jobs, and as before, the nurse would be the primary contact with the patient and the target of families' frustrations. Nurses are now expected to take over a lot of functions of doctors without any sort of recognition. The nurse's role is the responsible one, direct responsibility; but the power for choices and decision has never been hers. The recognition that a woman can receive in almost any other job is superior when a person is no longer in a position of inferiority and there are few positions that require working weekends and holidays in that sector.

No. 5 1.) 32 2.) Hispanic 3.) 10 yrs.

1. Burnout.

2. The responsibility; no back up.

3. Lawsuits; too many hospitals do not back up the nursing staff in this area.

4. Many other fields offer more opportunity to advance faster in a shorter time and the salary is much better.

5. The benefit package is not as appealing in this area versus industrial selling.

No. 6 1.) 32 2.) Black 3.) 12 yrs.

Need better shift hours; more use of flex(ible) plan(ning).

Will change if accepted to study for C.A.C. (Certified Alcohol Counselor).

No. 7 1.) 36 2.) Asian 3.) 12 yrs.

I feel that the reasons many nurses leave nursing are the following: one, low pay; two, long hours; three, staffing shortages; (and) four, what I call "being dumped on". According to the legalities, if a doctor makes a mistake and the nurse does not report him (after trying to tell him he is wrong; which is a joke), she, the nurse, can be sued for malpractice.

It seems that if things go well, doctors and the hospital administration get the glory. As soon as there is a problem, give the nurse the worry and the blame.

Why do nurses have to bear the brunt for all the errors made by other professionals? Certainly the doctor is not held liable for the nurse's mistake.

No. 8 1.) 52 2.) Black. 3.) 24 yrs.

1. Cannot find the kind of work that they enjoy.

2. In the hospital they cannot get the shift in the department that they wish. I know four nurses who wish to work in a hospital, but no hospital will hire them due to no hospital experience.

3. L.P.N.s are having a problem with programs to get their R.N. Most programs appear to be taking older people, and young people with their LPN have to wait or pay much more for this service. They are sick of waiting for their turn.

4. In most workplaces there is no place for growth. You are just a staff nurse and cannot move up the ladder.

5. A friend of mine was working for a private in-home agency as a L.P.N. She was making $9.50 per hour. Then she found out the agency was getting $23.00 per hour for her doing the work. They were making $13.50 per hour.

No. 9 1.) 42. 2.) White. 3.) 15 yrs.

I found myself spending so much energy trying to find the "game plan" on getting along with supervisors. The administration trashes on the physicians, the physicians trash on the nurses, and the nurses trash on one another. This was magnified multifold among midwives (I am one). They shoot their wounded soldiers. Women who come into power unfortunately continue with power and forget the needs of the people who look to them for direction. A dysfunctional nurse cannot look to her peers, supervisors, or even her organizations for help. She must find a lawyer. We are very skilled professionals who still want to nurture, to serve, be recognized and be paid. The system is not working for many of us. I have a husband who loves me and pays my bills. I have left the system and will not be back;

and by the way, I am a damned good nurse and a great midwife. I do not smoke, drink, or do drugs. I do not fit into the system.

No. 10 1.) 46. 2.) Black. 3.) 20 yrs.

I am taking my C.A.C. in October and will take my first step outside of the profession, but will use my nursing expertise to aid me as a counselor.

I have remained in the field this long because I love patient care and the science of medicine.

No. 11 1.) 43. 2.) Indiana 3.) 16 yrs.

Nurses leave the profession for many reasons; pay and hours are a part. Also, we seem to be progressively involved with more liability/responsibility. Along with this we receive relatively little recognition of our abilities or contributions. Our job often becomes longer and time factor or hours do not increase. Often we must work overtime to finish up due to inadequate staffing.

If your self-esteem is pretty well established nursing is, however, an area where the individual can provide services and make changes that are meaningful, especially on a one-to-one basis.

Jobs may be available in other areas besides hospitals and will suit individual needs.

No. 12 1.) 52 2.) White 3.) 26 yrs.

Nurses are leaving the profession because they are

tired of being "told what to do" by other nurses.

Paperwork fatigue; tired of self-giving, looking now for "something" for themselves; tired of working swing shifts, weekends and holidays.

Nursing makes it so hard on itself in its educational expectations that nurses give up and go into business administration, etc.

I am staying in nursing because I have found a way of being creative and innovative and am now gaining the reinforcements that I need to carry on.

No. 13 1.) 45 2.) White 3.) 20 yrs.

Nursing administration is not supportive and creates most of the problems by being abusive; harassment, sabotaging, not understanding. Most of them are trying to use managerial techniques that do not fit into the nursing environment.

Nurse(s) do not know (how) to compete in a sportsman (-like) way. Their techniques are VICIOUS and although they may accomplish what they want, it is usually for personal gain and not necessarily for the good of the organization. There is more anger than caring in these nursing administrators.

Nursing education (B.S.N., M.S., etc.) has created a dichotomy between degree nurses and other nurses who chose different paths of education (by) refusing to promote those with experience and expertise and choos(ing) to humiliate

and defame the working nurse rather than support her.

Nurses' loyalty to traditional nursing values and ethics are considered obsolete by these nursing administrators who try to connect with the supposed winners. They take on the values of the executive model and react to the traditional values with disdain, and consequently the nurse who promotes excellence in her work is belittled. In order to protect her job the nurse must compromise her values, thus hurting herself and becoming unhappy and bitter in the process.

The only other alternative is to quit your job. Now you have a problem with age, the job market, and the grieving process of loss of a job.

It is so complex. I could go on and on but it hurts too much and my thoughts run together, bombarded by what has happened to nursing. The sad part is that nurses interested in personal gain only have ruined the nursing profession for nurses that were truly dedicated and truly interested in work outside themselves.

I am still in nursing because I have tried other off-shoots of nursing, but because of the lack of respect by other professions for my expertise, I choose to work only part time.

No. 14 1.) 55. 2.) Black 3.) 25 yrs.

Wy are nurses leaving the profession?

Overwork, doing too much of M.D. duties; authority

pressure; high responsibility, low wages; weekend work and holidays; double shifts (musts), set by head nurse and her pressure; constant short staffing, linens, and essentials; lack of decision-making, only M.D. thinks well; constant monitoring; fear of contamination (AIDs, etc.); depressing; clients uneducated in the expectations of the nurse and hence dissatisfaction; M.D. spends 1 to 5 minutes with the client, the nurse gets client's disappointment.

Why are you staying?

Benefits, time accumulation; unpaid doctor assistance on the floor; in a new field, detoxification and rehabilitation; need to be employed, and nursing pays more than other positions open to me; friendships with fellow nurses.

No. 15 1.) 44. 2.) White. 3.) 15 yrs.

I plan to stay in nursing. In my 15 years experience in occupational nursing in the pre-employment screening or physical examination field, I have encountered approximately three R.N.s, one L.P.N., one x-ray technician, one respiratory technician who left medicine to go into the insurance/computer industry. Why? Financial; burnout; freedom with work schedule; better working hours.

No. 16 1.) 30 2.) White 3.) 8 yrs.

Nurses have been overburdened with other than nursing tasks and responsibilities and have not received recognition

for this.

Nurses in the political power struggle have always been the losers, especially in the hospital setting.

I am staying at present within the profession, but I have no guarantees that I will stay in the future.

No. 17 1.) 39 2.) White 3.) 13 yrs.

Reasons people are leaving nursing:

1. no recognition for the tremendous responsibilities and amount of knowledge required, and the amount of risk of law suits;

2. nursing per se no longer fits into the scheme of things; it is gender dominated (by females) and gender affected (by males); and

3. young women today have (other) options.

My reasons for staying:

I stay because I always worked in those areas where there was recognition, a little prestige and little better money: I.C.U., C.C.U. (Intensive/Critical Care Units), and teach students and professional staff.

APPENDIX III

A REGISTERED NURSE'S SALARY SCALE

DELAWARE VALLEY HOSPITAL, INC.

NURSING DEPARTMENT

EFFECTIVE OCTOBER 1, 1973

PAY SCHEDULE

New York State

REGISTERED PROFESSIONAL NURSES

FULL-TIME & REGULAR PART - TIME	HEAD NURSE	STAFF NURSE
7:00 A.M. - 3:00 P.M.	32.84 - 36.85 per 8 hour shift	30.22 - 34.02 per 8 hr. shift
3:00 P.M. -11:00 P.M.	33.90 - 37.85 per 8 hour shift	31.27 - 35.02 per 8 hr. shift
11:00 P.M. - 7 :00 A.M.	33.90 - 37.85 per 8 hour shift	31.27 - 35.02 per 8 hr. shift

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Increments to (Full-Time & Regular Part-Time Only)

	HEAD NURSE	STAFF NURSE
Completion of 6 mons. full time	33.90 (days) 34.90 (nites)	31.19 (days) 32.19 (nites)
Completion of 1 yr. full time	34.95 (days) 35.95 (nites)	32.12 (days)33.12 (nites)
Completion of 2 yrs. full time	35.92 (days) 36.92 (nites)	33.07 (days) 34.07 (nites)
Completion of 3 yrs. full time	36.85 (days) 37.85 (nites)	34.02 (days) 35.02 (nites)

Completion of 6 months Part-time	HEAD NURSE	STAFF NURSE
7:00 A.M. - 3:00 P.M.	33.90 per 8 hr. shift	31.19 per 8 hr. shift
3:00 P.M. - 11:00 P.M.	34.90 per 8 hr. shift	32.12 per 8 hr. shift
11:00 P.M.- 7 :00 A.M.	34.90 per 8 hr. shift	32.12 per 8 hr. shift

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Meals ---------- Available at nominal cost

Work Days ---------- Five days per week (full time only)

Hours of duty ---------- Eight hours per day (40 hrs.per week full-time)

Rest Breaks ---------- Fifteen minutes each half day

Payroll periods ---------- Every Two weeks (bi-weekly)

Annual increments for full-time and regular part-time employees are based on satisfactory performance of assigned duties. In case of sub-standard or unsatisfactory performance, the increase may be deferred or omitted.

REGULAR PART-TIME employees are those who work at least twenty four hours weekly to include every other weekend or, that work sixteen hours each week on weekends.

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