UNIVERSITY OF ALBERTA

THE POLITICAL PARTICIPATION OF ALBERTA REGISTERED NURSES

BY

MARGARET HADLEY

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

FACULTY OF NURSING

Edmonton, Alberta

FALL, 1994

ISBN 0-315-94978-3

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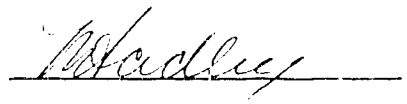

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **THE POLITICAL PARTICIPATION OF ALBERTA REGISTERED NURSES** submitted by **MARGARET HADLEY** in partial fulfillment of the requirements for the degree of **MASTER IN NURSING.**

Janet C. Ross Kerr

Marilynn J. Wood

Linda Trimble

August 4, 1994

For Louise Broad,

1913–1994

A loving and much loved mother.

ABSTRACT

In times of rapid change and fundamental restructuring of the health care system it is important that the professional contribution of nurses be recognized by politicians and the public. Political participation, which involves exerting power and influence in order to effect the direction of governmental decisions and the allocation of funds, is one route to achieving this goal. The purpose of this study was to examine the levels of political activity and involvement among Alberta registered nurses and perceptions of the appropriateness of a politically active role for nurses. A descriptive correlational design was used. Questionnaires were mailed to a stratified random sample of 600 AARN members, 200 hundred each from administration, education and clinical practice areas. A 66% return rate was achieved. Demographic data and responses to three scales collected. The Campbell, Converse, Miller, and Stokes Scale measured political involvement, another scale measure political activity in different areas, and a third scale measured perceptions of the appropriateness of the political role for nurses. Respondents were also encouraged to comment on the need for political involvement among nurses. Statistical analysis revealed very high levels of political activity and involvement and positive perceptions of the political role for nurses. There were significant differences between the three practice areas, however when differences in age, education, and years of experience in nursing were held constant these differences disappeared. Respondents commented on

the need for political action, the role of nursing organizations in lobby activities, and the barriers to participation.

ACKNOWLEDGMENTS

The completion of this thesis marks a very significant step in my life which would not have been possible without the contributions of many individuals and groups. The following deserve special mention and thanks.

My parents who taught me to love books and learning;

My sisters, Elizabeth and Mary, and my brothers, Robert and George, and their families, who gave me the strength and support available only from a close and loving family;

My son, Robert, who makes everything worthwhile;

My thesis chair, Dr. Janet C. Ross Kerr, for her continuous personal and professional support and encouragement throughout the completion of this degree, and to my committee members, Dr. Marnie Wood and Dr. Linda Trimble, it was a pleasure to work with people one both respects and enjoys;

My friends and colleagues, Sheila Smith and Shirley Fisk, for their support, encouragement, and humour;

The administration of the Royal Alexandra Hospital School of Nursing, specifically Maureen McQueen and Gloria Bauer, who translated encouragement for graduate education into action;

The library staff of the Royal Alexandra Hospital School of Nursing, especially Karen Crobar, Jocelyn Blackie, and Donna Gordon, and the staff of the Alberta Legislature library, the House of Commons library, the Canadian Nurses' Association library, for their willingness, tenacity, and intelligence which assisted me greatly;

Susan Shaw and Dr. Terry Taerum for their assistance with data entry and analysis;

The Alberta Association of Registered Nurses for the clerical support provided by Margaret Malo, Janet O'Donnell, and Pam Hemeon during data collection;

Jarmila Sazavsky and Vanessa Ianson for their expert assistance with word processing and photocopying;

The Women's Auxiliary of the Royal Alexandra Hospital and the Alberta Foundation for Nursing Research for their generous financial support for this project;

Finally and heartily, the registered nurses of Alberta, especially those who took the time to participate in this research, your concern for and commitment to nursing was most evident.

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INTRODUCTION AND STATEMENT OF THE PROBLEM

Background of the Problem

Registered Nurses are the largest single professional and occupational group in Canada's health care system and by virtue of their strength in numbers are potentially the most powerful and influential group in the health professions, yet on the surface such would not appear to be the case. Nevertheless it is true that nursing leaders have demonstrated considerable interest as well as skill in the political arena of the past decade and a half. Many would argue that Florence Nightingale's success as a consummate politician led to her subsequent legacy and that examples of the success of nursing leaders in gaining support, both internal and external, for issues of concern can be found throughout this century. Yet recent provincial governmental initiatives to decrease public funding and restructure the health care system have demonstrated little recognition or support for the clearly articulated alternatives put forward by nursing organizations. These initiatives have resulted in outcomes believed by nurses to be contrary to the goals of the nursing profession. The provision of quality health care for the sick is one ideal which nurses believe to have been sacrificed as governments pursue the objectives of fiscal restraint and deficit elimination at the expense of a health system based on universality, accessibility, comprehensive coverage, portability, and public administration.

Far from the simple governmental administration of activities directed at prevention of illness, health promotion and maintenance and illness care for the population, the Canadian health care system

is a complex, multilevel bureaucracy subject to influences from many different, and often competing, directions. Factors which serve to drive the health care system and determine the direction of activities include the public, sectarian interest groups, clinical and scientific advances, economic forces, and most significantly, political interests. A diagrammatic representation of the forces acting upon the health care system is presented in Figure 1.

The public has consistently demonstrated pride in and concern for the maintenance of medicare, which ensures universal coverage and equal access to a portable, publicly funded and administered system. Public expectation also modifies the delivery of health care. As examples, the previous intervention-based, medicalized model of obstetrical care has been replaced with a family-centered normalized approach largely due to changing consumer expectations and demands. In the past ten to fifteen years, the care of "handicapped" adults has moved from institutional settings to individual or group homes largely due to the demands of this group for self-determination. We can only imagine the strains produced by an educated and aging baby boom generation as it reaches old age, where intense use of and expense for the health care system occurs.

Different sectarian interest groups have attempted with varying degrees of success to influence the health care system. The recent success of the midwifery lobby in Alberta and Ontario has created a potential alternative for obstetrical care in these provinces. This was a lobby which successfully held physicians from preventing encroachment into their previously exclusive territory. Physicians have also been unsuccessful in preventing chiropractors from practicing within provincial payment systems, but have kept naturopaths and homeopaths entirely out of the fee-for-service

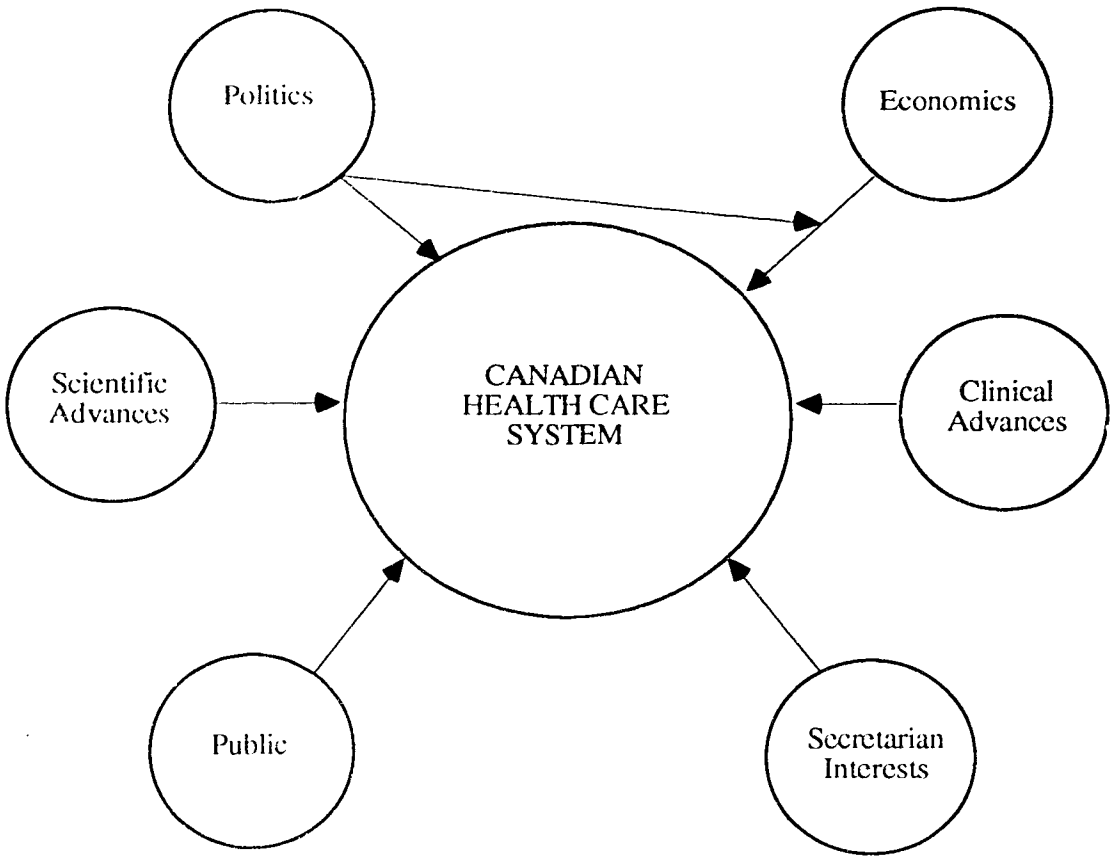

Figure 1.1

Forces acting on the Canadian health care system

reimbursement system. Due to provincial funding cutbacks, nursing, particularly at the executive, middle management, and inservice education levels has been unable to prevent the erosion of its role in most institutions in Canada. Despite the protests of consumer groups, hospital associations, and provincial governments, the pharmaceutical industry representing "big business" interests was successfu' in lobbying the federal government to pass legislation extending the protected period for drug patents from seven to twenty years in the form of The Patent Act Amendment Act, 1992 (Bill C91). This legislation has had a profound effect on the price of drugs, and consequently, costs to provincial health care plans and patients within Canada as drug costs represent a substantial source of health care expenditures.

Scientific and clinical knowledge are important drivers of the health care system. Advances such as endoscopy have replaced open laparotomy with laparoscopic techniques, and reduced hospitalization for what used to be commonplace major surgical procedures such as a cholecystectomy from as long as ten days to 24 hours. Knowledge of the HIV and AIDS and the impact of this one disease on public health, hospital utilization, palliative care, the blood donor system, and preventative care are examples of a changing scientific and health care environment. Conversely, one need only think of the tremendous system-wide effects of a vaccine producing immunity to the HIV to understand this fully.

Clinical advances have produced profound changes in the delivery of in hospital care. Studies of health outcomes have been and will continue to be important in advancing the state of clinical knowledge. As costs have exponentially increased, the need to examine the validity of previously accepted practices has become an

imperative. It is now accepted that post-partum women may safely return home twelve hours after giving birth, post-operative patients can be safely discharged home in four days following coronary artery bypass grafting, or two days after a lumbar discectomy. Other clinical studies have demonstrated that surgical outcomes are not adversely affected by shortened pre and post operative hospitalizations. This has resulted in the development of pre-admission clinics and early discharge programs, as well as an expanded role for home care.

Economic factors have appeared to drive the health care system in Canada and elsewhere. Health care in Canada is a multi-billion dollar industry consuming nine point nine per cent of the Gross Domestic Product (Health Canada, 1994). Prior to June, 1993 $4 billion, or 30.4% of the Alberta provincial budget was used to provide health care to Albertans. The "boom" years in Alberta had resulted in almost unrestricted growth in the type and quantity of health care services, an unprecedented rate of construction of rural and urban hospitals, growth in the number of physicians far exceeding general population increases, and the allocation of large sums of money to medical research through the Alberta Heritage Foundation for Medical Research. However, the resource-based provincial economy faltered in the early 1980's and revenues fell sharply when the price of oil decreased. Furthermore, the global economic down-turn occurring in the late 1980's led to increasing federal and provincial government deficits, a growing debt and sharp restrictions in the available financial resources for health care.

While economic factors are potent, they are shaped and directed by political forces. It is these political forces which are the most significant influences in health care today. Government policies and priorities are not absolutes. They are established on the basis of

political priorities, not necessarily on the basis of whether they are right, just, or in the public interest. When revenue shortfalls occurred, the government chose to respond with massive global budget cuts, rather than to launch an examination of current costs and programs and develop a comprehensive plan for the preservation of necessary services and elimination of waste. The choice of one action over the other was political in nature.

Health care in Canada is a provincial responsibility, but the federal government participates by way of funding contributions and in the provision of national standards legislation. The Hospital Insurance and Diagnostic Services Act of 1957 established a cost-sharing arrangement between both levels of government. In response to the need for control over ever-increasing costs, the federal government enacted the Federal Provincial Fiscal Arrangements and Established Programs Financing Act, (EPF) in 1977. This legislation altered the method of federal unding of health care from block 50/50 participation to an arrangement whereby the federal government gained more control over the total amount of its contribution, at the same time permitting some degree of provincial flexibility in the financial support of various programs and services. The Canada Health Act of 1984 described and limited the conditions under which federal funds identified in the EPF would be transferred to the provinces for health care. It specified penalties to the provinces for allowing physician extra-billing above the fee schedule approved by the province in the provincial payment plan. The transfer of federal monies to the provinces was fairly predictable following the EPF, until 1991 when the federal government passed the Government Expenditures Restraint Act in an attempt to control its own growing deficit. The passage of this law suddenly froze

transfers to the provinces for two years and tied future increases to the growth of the GDP. A draft of a new Act to Amend the Spending Control Act (Bill C-130), which would have further restricted federal contributions to the provinces received first reading on May 13, 1993, but did not progress further due to the dissolution of parliament and defeat of the Government in the October, 1993 federal election.

In the period 1971–1985, the Alberta government was able to provide extremely high levels of health care services, while at the same time imposing a very low level of taxation on the population. However, mandates run out, ideologies change, and political parties look for surefire routes to election. The provincial election of 1993 was won on promises of a balanced budget by 1996/97 and a stern program of deficit elimination. The Treasurer in his pre-election budget announced cuts of $127 million to provincial health funding. Total provincial budget cuts were announced as $1.5 billion, and total cuts to health care by 1996/97 were projected to be 18%, or approximately $800 million if fiscal targets were met. A series of round table discussions on health were initiated by the government in the summer of 1993 and chaired by Dianne Mirosh, a nurse and Member of the Legislative Assembly.

Fulton (1993) describes Canada's health care system as existing in:

> ...an environment in which logic and mandate may be no match for a charismatic politician...Those who wish to have influence must often understand the political and behavioral elements of decision making better than they know how to handle data, conduct research or scientifically evaluate the options (p. 4).

Politics is the process and the principles that contribute to decisions about the allocation of public resources. Participation in the political process involves exerting power and influence in order to affect the direction of these decisions that have impact on most aspects of life. It is a central and fundamental concept for life in a democracy. There are limited resources available for the health system. The needs of Canadian consumers for affordable and high-quality health care can be met in part by nurses, if nurses secure an expanded role in the system. Nurses as a group must position themselves advantageously in order to receive their rightful "share" of the fiscal pie, which is both cut and served by politicians. As political factors are the most significant influence on health care policy in Canada today, and as nurses are the largest group of health care providers, the following questions are asked: How active are nurses in the political system? What is the type and degree of activity? What do nurses have to gain by increased activity within the political realm?

At least until recently, nurses have been uncomfortable with the business of politics. It has been perceived as a competitive "man's game" with back room dealings and a large measure of unpleasantness associated with the entire pursuit. Many nurses have felt that politics was best left up to others (Mason & Talbott, 1985) though several nursing leaders have advocated politicization. Epstein (1982) urged nurses to develop the skills and understanding needed to function within the areas of power and influence either in the workplace or larger society. Nurses, she argued, should communicate dissatisfaction, organize opposition, and offer alternatives when working in organizations where quality care is not valued. Kalisch & Kalisch (1982) stated that nurses should recognize the need to work

together through interest groups to specify appropriate political responses to problems within the American health care system and to redirect resources to bring about improvements. Ross Kerr (1991) argued for nurses shedding any notion of powerlessness, as it is antithetical to the nurse's responsibility as patient advocate. She further states that nursing organizations have long understood the value of political lobbying, and are now increasing the political awareness of the individual members. Ross Kerr believes that nurses must work within the political system to achieve professional goals. Larsen & Baumgart (1992) also assert that nurses need to take an active, central role in public policy formation in the area of health care.

Politics of the Nursing Labour Movement

In Alberta strikes by registered nurses can be seen as resulting from the politics of anger and frustration. A thorough examination of labour disputes involving Alberta nurses from 1977-1982 was conducted by Hibberd (1987). Hospitals in Alberta were represented by the Alberta Hospital Association (now the Alberta Healthcare Association), a non-profit organization funded by the government and mandated to negotiate contractual agreements with hospital employees. Until 1977 the Alberta Association of Registered Nurses functioned as both the professional body and the collective bargaining agent for the majority of nurses practising in hospitals. Hibberd states that "mainstream nurses resented the control of what may be regarded as the elite decision-makers on the AARN Provincial Council" (Hibberd, 1987, p. 285) and in May of that year

the bargaining function was separated from the AARN and the United Nurses of Alberta formed. Six weeks later the first Alberta nurses' strike occurred. Nurses' demands at this time included wage increases of 37% to reestablish the differential between themselves and nursing aides and to achieve wage parity with registered nurses in British Columbia and Saskatchewan, benefits for nurses working part-time, changes to the contract governing the scheduling of shift work and week-ends, and establishment of institutional committees on nursing. The strike lasted for six days, involved 2,500 nurses in seven major urban hospitals, and was finally ended by an Order in Council of the Lieutenant Governor following the declaration of a state of emergency. An arbitrated settlement was imposed whereby nurses were awarded a nine percent across-the-board settlement and a one year contract. All other demands were rejected.

Salary and benefits remained problematic, and in 1980 Alberta nurses were again on strike and demanding a 33.3% wage increase, improvements to work schedules, a professional responsibility committee, portable benefits, and employer-paid premiums for health-care, dental, and disability insurance. The strike involved 6,400 nurses in eighty-one hospitals. The United Nurses of Alberta had managed this strike well— the media were used to publicize the frustrations nurses felt with salaries and working conditions and a letter writing campaign to MLA's was undertaken. The ten day strike began in April following an overwhelming vote in favour of work action. Again the strike was ended by an Order-in-Council and a negotiated settlement was achieved. Registered nurses were awarded a 39.8% increase in salary effective over two years, professional

responsibility committees in each hospital, work scheduling improvements for both full and part-time nurses and a dental plan.

In 1982 a twenty-three day strike of 6,000 nurses at sixty hospitals ended in bitterness and anger as nurses were legislated back to work by passage of the Health Services Continuation Act (Bill 11). This legislation was passed rapidly through the legislature after receiving three readings in one day. The Act laid out extremely severe penalties for non-compliance including decertification of the union, and was widely criticized by both parties as well as the public. An arbitrator awarded a 29% salary increase over two years, and substantial improvements to scheduling, safety, and professional responsibility clauses following sixteen days of public hearings.

In the period from 1983-1988, salaries of registered nurses rose by seven percent while inflation increased by sixteen percent. Patient acuity had increased, public spending had been reduced, and yet the provincial government proceeded to approve funds for unprecedented construction of new hospitals in both rural and urban settings. Changes in labour laws made it illegal for hospital workers to strike and compulsory arbitration was mandated for disputes. In this climate the UNA began a nineteen day illegal strike involving 11,000 nurses in ninety-eight hospitals. Hibberd (1988) states the following:

> ...the union made it abundantly clear that this work stoppage was a political protest...The straw that broke the proverbial camel's back was the attempt by the AHA to have the union's "strike vote" declared illegal under the revised labour statute. Perceived interference in union

> affairs galvanized nurses into civil disobedience. What surprised most observers was the scope of the strike which, for the first time, included three provincially owned hospitals and the extent of public support for the illegal activity. The timing of the strike, just before the opening of the XV Winter Olympic Games in Calgary, threatened to bring international attention to the dispute. This position was a formidable bargaining advantage for the nurses' union (pp. 21-22).

Clearly the leaders of UNA had gained considerable experience and sophistication in dealing with governments, the public, and the media.

In Canada there were 32 strikes by nurses between 1966 and 1982 (Hibberd, 1987, p.33). In the five-year period 1985 to 1989 there were, "ten strikes, one lockout, six threatened strikes, and one threatened mass resignation" (Hibberd, 1992, p. 583). These strikes occurred in six different provinces and the North. Two of the strikes, those in Alberta and Quebec, were illegal. It is obvious that nurses' unions are more visible to the Canadian public than they were even a decade and a half ago, and nursing leaders are assuming bolder positions on many issues. However, provincial nursing groups including both professional bodies and unions have been hampered in the area of policy analysis and formation due to limited resources. Given judicious and creative use of available resources, nursing groups must seek membership on boards or commissions charged with policy formation in order to achieve broadly based input in the public debate. As well, they must continue to formulate and publicize independent reports on health policy issues framed within the context of a nursing perspective.

Politics and Nursing Organizations

"Nurses, through their associations, their clinical importance, and their large numbers should dominate"...in health decision making (Fulton, 1993, p. 6). This is clearly not yet the case. If nurses wish to contribute their unique knowledge and perspective to public policy decisions involving health and social services, then their leaders must bring forward issues of concern to politicians and the public in order to ensure recognition of their professional contribution in discussions and decisions in these areas. This recognition is dependent upon increasing the political awareness of individual nurses, mobilization of nurses as a political force, and increasing the overall public profile of nurses. Accomplishment of these tasks is the responsibility of both national and provincial nursing organizations. The position of Principal Nursing Officer, is held at the federal level by Josephine Flaherty. This, and similar positions, represent a potentially valuable route to achieving the goal of providing nursing input into health policy formation. Unfortunately, Dr. Flaherty's role is primarily a consultative one to external agencies rather than an internal advisory one to government on nursing and health issues. At the provincial level, both British Columbia and Alberta have appointed nurses to similar positions. In Alberta, Sharon Snell, a former president of the AARN, occupied such a position created as part of the Premier's Nursing Initiatives arising from the longest, and most bitter, provincial nurses' strike in 1988. Ms Snell chaired a committee that produced an action plan for nursing, "to anticipate future nursing care needs of Albertans, and resolve nursing issues related to personnel planning, education and worklife" (Alberta Provincial Nursing Action Plan, p. 2). The plan was designed to

address the many frustrating, and unresolved issues of nurses in hospitals (and long-term care settings) who had recently returned to work. Through departmental reorganization in Alberta following the 1993 provincial election, Sharon Snell was somewhat distanced from the Minister and Deputy Minister of Health.

The Canadian Nurses' Association (CNA) employed a health policy consultant beginning in 1990. This individual is charged with identifying, analyzing, and interpreting the trends and issues which have implications for the nursing profession and the health of Canadians. The CNA has attempted to influence federal health policy by proposing or responding to federal legislation related to health care, lobbying politicians and bureaucrats, and working in collaboration with other interest groups. As an example, the CNA is a major partner in HEAL (The Health Action Lobby), a coalition of seven national health and consumer groups working to preserve the Canadian health care system (N. Brochu, personal communication, December 6, 1993). The CNA has also presented health related submissions to various House of Commons Standing Committees in the past. Two notable examples are the Statement on Select Issues in Health Care Delivery (CNA, 1990) and the Statement on the Health Care System and Its Funding (CNA, 1988).

The CNA compiled and distributed to its 104,000 members a federal election guidebook (CNA, 1993) through an issue of Canadian Nurse, received monthly by every CNA member. The handbook urged nurses to become involved in the election "to ensure that nursing's voice is heard...we will be telling politicians that medicare is a core value of Canadian society and that better utilization of nurses is the solution" (Oulton, 1993). Nurses were encouraged to become involved in the election by questioning candidates, writing

letters, attending meetings, and working with the media to ensure that a nursing perspective was heard.

The National Federation of Nurses' Unions developed strong positions on several pieces of current and proposed legislation in preparation for the October, 1993 federal election. The NFNU stated Bill C-91 (revisions to the drug patent act), Bill C-69, (established programs financing), Bill C-113, (changes to unemployment insurance act) and the Canada-United States Free Trade Agreement were "unprecedented attacks on Canada's Medicare and Unemployment system" (Connors, 1993, p. 4). These positions were adopted by several of its provincial member organizations.

The Registered Nurses Association of Ontario developed an extensive federal election kit (RNAO, 1993), containing the CNA booklet and information on targeting key individuals in the campaign, how to participate in lobbying, sample letters, press releases, letters to the editor, and notes on user fees. The RNAO position was clearly allied with that of CNA. The Registered Nurses Association of Nova Scotia organized a series of town hall meetings throughout the province to encourage discussion of health care issues between members, candidates, and consumers (E. Shuttleworth, personal communication, September 3, 1993). The Northwest Territories Registered Nurses' Association did not prepare a special package of information for the membership for the 1993 federal election. However the Executive Committee identified and communicated strategies to members at the territorial and local level (K. Hilliard, personal communication, September 28, 1993). The Saskatchewan Registered Nurses' Association, the Manitoba Association of Registered Nurses and the Association of Nurses of Prince Edward Island did not develop election packages, but rather

encouraged members to use the CNA handbook (J. Deatrich, personal communication, August 20, 1993; P. Gauthier, personal communication, September 7, 1993; M. Hodgson, personal communication, May 5, 1994). The Registered Nurses Association of British Columbia prepared and distributed a package of materials for the Association's chapter presidents, workplace facilitators, and workplace representatives prior to the 1991 provincial election. The package contained RNABC positions on such issues as multi-service community health centres, midwifery, improved home care, illness prevention and health promotion, poverty, substance abuse, early retirement for nurses, funding for "specialized" nursing education, federal funding of health care, and user fees within the health care system. Individual nurses were urged to meet with candidates and to discuss these issues at rallies, all-candidates meetings, in campaign offices, and to arrange for candidates to address groups of RNABC members at special meetings (RNABC, 1991). However, RNABC did not distribute information to members specifically geared to the October, 1993 federal election (J. Cox, personal communication, August 20, 1993).

Both the British Columbia Nurses' Union and the Manitoba Nurses' Union prepared and distributed federal election guides for their memberships in September, 1993. These guides contained Progressive Conservative, Liberal, New Democratic, and Reform party positions on the problematic legislation identified by the NFNU. Members were encouraged to become active and to make politicians accountable for their past decisions and current positions (BCNU, 1993; MNU, 1993). One of the major unions representing nurses in Quebec has been concerned with constitutional issues rather than federal electoral concerns. La Fédération des Infirmières et

Infirmiers du Québec has prepared and distributed several documents espousing a pro-sovereigntist position in the Canadian constitutional debate (FIIQ, 1993, 1991; Mercier, 1993). The sovereignty issue was debated at the second biennial convention of the FIIQ in 1991, where delegates adopted a motion in favour of the separation of Québec from Canada (S. Bissonnette, personal communication, November 11, 1993). In Ontario, the ONA had a draft proposal for a federal election package (ONA, 1993) which contained concerns regarding federal funding for health care and social issues such as violence against women, provisions for adequate day care for children, pay equity, and poverty among the elderly. Work on the final election package was proceeding in August, 1993 (J. Cornelius, personal communication, August 24, 1993). The Prince Edward Island Nurses' Union did not develop specific election guidelines (E. MacFadyen, personal communication, September 27, 1993).

In New Brunswick, both the union and the professional association were very active prior to the 1993 federal election. The Association of New Brunswick Nurses prepared a federal election lobby kit containing riding assignments for the different chapters; a list of candidates; "fact sheets" on nurses' roles in health care, user fees, federal transfer payments, and primary health care; the five principles of the Canada Health Act; a sample press release; and suggestions for activities such as letter writing. The New Brunswick Nurses' Union published a special edition of its newsletter detailing the concerns previously identified by the NFNU (NBNU, 1993). The union also prepared an election kit containing materials to assist in determining candidates' positions on issues, a list of news media outlets in the province, a sample letter to candidates, and the union's stance on significant issues. Of particular interest were election

materials prepared by the Nurses' Association of New Brunswick, which were included in the union package. This was the only example noted of a provincial nurses' professional organization and nurses' union working in concert to mobilize the collective membership of both organizations toward political action. Nurses' unions and professional organizations from other provinces and territories did not respond to a request for membership information prepared for the federal election and have therefore not been included in this discussion.

Neither the UNA nor the AARN attempted to engage their respective memberships in the provincial election of June, 1993. In November 1992, there was an attempt by some nurses to influence the direction of the Alberta Progressive Conservative leadership race, a contest that would in fact determine the next Premier of the province. Nancy Betkowski, an Edmonton Member of the Legislative Assembly and Minister of Health, was both an extremely popular and credible politician, and the choice for leader of many Albertans working in the health care sector. As any member of the Progressive Conservative party was allowed to vote for the leader, many nurses bought party memberships and served as campaign workers for Ms. Betkowski's campaign. The North Central District of the Alberta Association of Registered Nurses organized forums for two of the candidates for the leadership, Ms. Betkowski and Rick Orman, the Minister of Energy from Calgary. The race was eventually won by Ralph Klein, the choice of many rural Conservatives. Successful or not, this kind of political activity on the part of nurses had not occurred previously in this province and is perhaps an indication that at least some of 24,000 Registered Nurses in Alberta are increasing in their political awareness. However, a full page

advertisement on the back cover of the November issue of the provincial newsletter paid for by the Nancy Betkowski campaign, did prompt criticism for the "blatant support of a candidate" (Lawrence, 1992; Gwatkin, 1992). The AARN responded by indicating that advertising policy would be reviewed and tightened. The AARN did not make any attempt to provide information for members in the subsequent provincial or federal elections later that year.

When provincial cut-backs began in earnest, the AARN was committed, in money, time, and effort, to lobbying for increased direct access to nursing services by members of the public. This initiative, announced in March of 1993, was designed to give Albertans the option of contacting a registered nurse directly when they required health care. The AARN argued that direct access was part of a solution to escalating costs and health care restructuring in Alberta. The AARN recommended that directly accessed nursing services should be funded by the government (AARN, 1993). Without debating the merits of direct access as a solution for increasing quality of care and decreasing costs, it can be argued that the majority of Alberta registered nurses, most especially those without university preparation, did not see this initiative as an appropriate response to the repeated layoffs occurring within hospitals. The association had failed to assure that the membership understood the direct access and potential benefits for nurses.

The United Nurses of Alberta was very active prior to the October federal election, urging the membership to contact candidates and attend all-candidate forums to determine the various positions on health care issues and social programs. Members were urged to "talk to friends, colleagues and relatives to raise the issues and to gain support for your candidate...join your candidate's

campaign and volunteer your time...write letters to the editor promoting your candidate and your issues" (United Nurses of Alberta, August, 1993). The UNA also organized a mail campaign to both Jean Chretien, then leader of the Official Opposition, and Prime Minister Kim Campbell urging preservation of the Canada Health Act. A Federal Election Guide (UNA, September, 1993) was mailed to the 14,000 members of UNA encouraging nurses to become politically active, "It is up to all of us to work in this election to ensure we elect a government that will take action to preserve and enhance our health care system" (Smith, 1993).

Responding to the provincial hospital grant reductions and concomitant job losses among the membership, the AARN, UNA, and the Staff Nurses' Association of Alberta (SNAA) held the first-ever joint press conference to inform Albertans of concerns regarding the effects of cutbacks on quality and access to health care. Each organization president provided a statement to the media and then questions were entertained (Appendix A). Heather Smith of UNA disputed the government's assertion that health care spending was out of control and in crisis. Linda Sloan of SNAA raised concerns about the safety of patients in Alberta institutions due to reductions in staffing. Mary Pat Skene of the AARN called for a systematic plan to address the needed restructuring of Alberta's health care system. She also asserted that before reductions occurred within institutions, community services must be in place to ensure care for patients in need who could no longer be accommodated in hospital. These three Alberta organizations also collaborated on a proposal submitted to Health Minister Shirley McClellan on August 25, 1993 calling for a work force adjustment in nursing resulting from government re-direction of funding to facilitate the transition of the bulk of nursing

care delivery to the home and community from the hospital setting (Appendix B). The AARN, UNA, and SNAA also launched a publicity campaign in August, 1993. Large, half-page advertisements appeared in all urban and rural newspapers in the province on August 15, 22, and 29. The campaign was timed to coincide with the government-sponsored round table discussions on health care reform. Featuring the slogan, "Nurses aren't part of the problem. We're part of the solution," the ads emphasized the effects of cutbacks on the elderly, the chronically ill, and children suffering from cancer (K. Weigers, personal communication, August 19, 1993). Despite these initiatives, funding cutbacks continued, nursing positions were terminated, and there existed at least the perception that the level of care in Alberta hospitals had badly deteriorated.

On November 12, 1993, in response to member concerns that the AARN leadership should be more vocal in its criticism of government actions, Lillian Douglass, by then AARN president, sent a letter to the 24,000 members describing the organization's responses to government action (Appendix C). Registered nurses were urged to contact Premier Klein and express concerns regarding the impact of funding cuts and to encourage friends and family members to also participate in this manner. A copy of a letter sent by Dr. Douglass to the editors of the major provincial daily newspapers was also included in the member mail-out as well (Appendix D). Finally, the December issue of the AARN Newsletter was mailed with a special wrapper exhorting nurses to write in with their personal stories of the effects of cutbacks on patient care as witnessed in their own practice. An example of such a story was included on the wrapper. It described an elderly patient who was inadequately monitored in hospital, sent home too soon, developed a wound infection and

required weeks of antibiotic therapy. The following question was asked, "The goal of Registered Nurses is to provide safe, competent, ethical nursing care to the public—Are you meeting this goal?" A stamped and addressed envelope was provided for members to send in their stories. Oberle and Grant (1994) analyzed the situations reported to the AARN. The sixty-five narratives detailed concerns with inadequate physical and emotional care due to reduced staffing in a number of different settings. The stories were presented to both politicians and the media.

There is further evidence that nurses' perceptions of the relevance of political knowledge and action is increasing. In November, 1992, a national conference of nurse administrators was held in Ottawa. The Positioning for Leadership Conference, jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association, featured Jeffrey Simpson as keynote speaker. As national affairs columnist for The Globe and Mail, it was Mr. Simpson's task to indicate current and future political trends in Canada which may have significant implications for health care. He clearly identified federal and provincial deficits as having a tremendous effect on nursing and health care in Canada. The selection of this speaker and topic for an address suggests increasing relevance of political issues in nursing management and administration.

Nurses and Electoral Politics

In electoral politics, registered nurses have sought and been elected to public office in Alberta and in other areas of Canada. At the local level, Sheila McKay, a member of city council in Edmonton,

was first elected in 1989. Irene Walker has served as a Town Councillor in Canmore, Alberta since October, 1992. Within the realm of provincial politics, Sheila Embury was first elected Member of the Legislative Assembly for Calgary Northwest in 1979. She was re-elected in 1982, but did not seek return to office in the election of 1986. During her term in the legislature Ms. Embury served as Party Whip for the Progressive Conservatives. Dianne Mirosh, the current sitting Member for Calgary Glenmore was first elected in 1986. Prior to the June, 1993 provincial election she served as Minister of Community Development with responsibility for Culture and Multiculturalism, Seniors, and Women's Issues. Ms. Mirosh has experienced considerable difficulty in her role as a public representative. Prior to the June, 1993 provincial election, she issued a written apology and a retraction for remarks made indicating that non-English speaking immigrants were a tax burden. These statements precipitated a 5,000 name petition calling for her resignation and a letter to the Premier from the Edmonton Multicultural Society asking that she not be re-appointed Minister of Community Development. Ms. Mirosh has also been criticized by Alberta women's groups for rejecting suggestions that equal pay legislation was required in the province. She has also mused openly about abolishing the Alberta Human Rights Commission and has linked homosexuality and criminality in remarks to the press. Despite these controversies, Ms. Mirosh was re-elected and appointed Minister Without Portfolio with responsibility for the Health Planning Secretariat and the Alberta Alcohol and Drug Abuse Commission.

Other nurses have also held elected office in Alberta. Yvonne Fritz was elected to the legislature in 1993 as the Progressive Conservative member for Calgary Cross, and at the same time Muriel

Ross Abdurahman was also elected Liberal Member representing Clover Bar-Fort Saskatchewan. Ms. Abdurahman is a Registered Fever Nurse educated in Glasgow, Scotland. At the federal level, Bobbie Sparrow, elected as the Progressive Conservative Member from Calgary Southwest in 1984, served a short term as Minister of Energy in the Progressive Conservative government of Prime Minister Kim Campbell from June to October, 1993.

In other jurisdictions nurses have also played a role in electoral politics. There are three current sitting Members of Parliament who have nursing backgrounds: Margaret Bridgman is the Reform Member for Surrey North, Christine Stewart is the Liberal Member for Northumberland, and Rose-Marie Ur-Lambton is the Liberal Member for Middlesex. Ms. Ur-Lambton trained as a nursing assistant. Dorothy Wyatt and Shannie Duff have both served as Mayor of St. John's, Newfoundland. Ms Wyatt has served as councillor and mayor in various terms from 1970 to the present. Ms. Duff served as councillor, deputy mayor and mayor from 1977-1993. A public health nurse prior to seeking elected office, Marion Dewar served the City of Ottawa as alderman, senior controller, deputy mayor and mayor between 1972-1985. She was also president of the national New Democratic Party from 1985-1987 and a NDP Member of Parliament for Hamilton-Mountain from 1987-1988. Ann Breault, the Liberal Member for St. Stephen-Milltown in the government of New Brunswick, was first elected to the Legislature in 1987 and has served as a member of the Special Committee on Social Policy Development. She is the current Minister of Human Resources Development and Minister of State for Literacy.

If there exists a need for nurses to take political action to ensure the best positioning for the profession in the allocation of

resources for health care, then further research is required in order to determine the current state of nurses' political awareness and activity.

The purpose of this study is to determine the following: does political activity, political involvement, and perceptions of the appropriateness of the political role for nurses vary significantly between three groups of Alberta registered nurses involved in clinical, administration, and education practice areas? What is the influence of age, education, and years of experience in nursing on any variances between groups?

Research Questions

This study will address the following specific research questions:

1. What level of political involvement and political activity is characteristic of Alberta registered nurses?
2. What do registered nurses from three different areas of practice perceive as the appropriateness of nurses' role in politics?

Definition of Terms

Registered Nurse

A graduate of a recognized School of Nursing who is registered with the Alberta Association of Registered Nurses.

Political Involvement

A concept defined as interest and involvement in the political process as described by Milbrath and Goel (1977) and Campbell, Converse, Miller, and Stokes (1964).

Political Activity

A concept defined as active political behaviors as described by Hofmann (1989).

Nurse's Role in Politics

A concept perceived as appropriate or not, described by the National League for Nursing and adapted by Moore and Oakley (1983)

Level of Education

is defined as the highest level of education attained.

CHAPTER 2
LITERATURE REVIEW

Introduction

The political participation of citizens living in a democratic system is not an undifferentiated, unitary phenomenon, such as voting. Rather it is the sum of behaviors occurring after the decision has been made to act or not to act politically. As with any complex human activity, there are a number of antecedent factors occurring in combination that result in political participation. In order to explain how and why people become involved in politics Milbrath and Goel (1965) developed a theoretical construct in which political participation is seen as having many different aspects, or "modes", and levels of intensity.

Modes of Political Participation

The different modes: voting, party and campaign activism, community activism, particularized contacting, protesting, communicating, and complete activism, are not exclusively electoral in nature, an important element of the multidimensional aspect of the model. "Political acts are distinguished not only in terms of how difficult they are, but also in that they represent different styles by which citizens attempt to relate to government and politics" (p. 12). Milbrath and Goel use an interesting analogy to describe these acts. The modern political arena is likened to the arenas of combat in ancient Rome where a small group of Gladiators "battle" for political

victory before large crowds of "Spectators" who eventually determine the political outcome by voting for their favorite. A group of "Apathetics" pay no attention to the contest, nor are they interested in the outcome. The Voter participates passively and no particular intensity of commitment is required for this activity. Many people vote because of feelings of duty or a sense of citizen responsibility, rather than the belief that their individual vote makes a significant difference.

Party and Campaign Activists invest time and money in the support of a political party or candidate. They attend rallies, hold memberships in political parties, and actively attempt to persuade others to vote in a particular manner or for a certain candidate. The Community Activist differs from Campaign Activist in a lower level of interest in partisan politics. Community Activists focus their energies on dealing with the social problems of a community, such as prostitution, hunger or poverty. Both community and campaign activists share a general activist pattern and a high level of psychological involvement in community matters. The Particularized Contactors are a group of participants who limit involvement to issues of narrow and personal concern and demonstrate little interest in general political matters. Contactors participate by writing or telephoning their views to political officials in order to alter a specific situation, rather than to indicate a need for social change. Such activity, Milbrath and Goel indicate is only minimally political in nature.

Protestors are part of a small proportion of individuals who, under certain circumstances, are willing to adopt a protest posture

toward the official political system. Members of this group will join protest marches and street demonstrations, engage in acts of civil disobedience, and in the extreme, riot. Protesting is not a common type of political participation, and the majority of citizens do not participate in protest activities nor do they consider this a valid form of political participation: "It is clear that the great majority ...feel little responsibility to engage in protest activities. Even more striking are the sizable percentages who believe it is wrong to protest and demonstrate" (p. 14). Despite this, protests may have considerable public support. The Winnipeg General Strike of 1919 (Bercuson, 1974 & McCormack, 1977), the Edmonton Hunger March of 1932 ("Crowd sees melee," 1932), and the On to Ottawa Trek and Regina Riot of 1935 (Liversedge, 1973) are examples of large and effective Canadian protests. More recently in Alberta there have been large public protests in response to government funding cutbacks to health and education. On April 7, 1994 16,000 people protested the planned closure of Edmonton's Grey Nuns' General Hospital. Seven days later, 10,000 demonstrators in Calgary protested proposed amendments to the School Act.

Communicators are the final group. These participants make great efforts to be informed of current events and political issues by engaging in political discussions, writing letters to newspaper editors, and readily sending messages of support or criticism to political leaders. Communicators are generally much more likely to find fault with the actions of government and politicians than are party and campaign activists. Due to the high degree of verbal skills and amount of time required for this type of participation, there are a lot

more people who wish to be "Communicators" than actually participate in this manner.

Complete Activists are members of the group of people who participate by most means available to them. They may have membership in a political party, work for a candidate during an election campaign, maintain a community activist posture, and readily communicate with elected officials. Thus, the different types of participation may overlap in some instances. Party and Campaign Activists may become Communicators, Community Activists may become Protestors. Movement in the reverse direction may also occur. An exception to this is Particularized Contactors, who, as stated previously, participate by pursuing personal concerns. Figure 2.1 is a diagrammatic representation of the various modes of participation, modified after Milbrath and Goel.

Antecedents to Participation

What motivates people to participate in the ways described by Milbrath and Goel? Just as there are different types of political participation, so are there many variables influencing participation in one manner or another, or not at all. Political participation and intensity of participation are closely associated with the amount of exposure the individual has to various kinds of political stimuli or information. These stimuli may take the form of mass media messages, campaign literature, political meetings, and personal discussions. Milbrath and Goel assert that informal discussions are a particularly effective source of stimuli for individuals with limited

political involvement. A reciprocal causation related to political stimuli is suggested where exposure to political stimuli produces more active participation, which in turn increases the desire for exposure to more political stimuli. Receptivity to political stimuli occurs for a variety of reasons. Individuals with strong partisan interests are more receptive to political stimuli, especially, but not exclusively, from their favoured candidate or party. Deliberate exposure to political stimuli tends to increase with age and education. The family is an important early source of stimuli for the development of political participation patterns. Children growing up in a home where there is lots of political discussion and therefore a high intake level for political stimuli are more likely to maintain a high level of exposure to stimuli about politics when adults (p. 38).

Those people who are well informed about political matters tend to expose themselves to many other types of information and are thus generally well-informed. Finally, individuals who feel they are too "busy" to be interested in politics deliberately do not attend to the presence of political stimuli. Some of the personal factors influencing political participation are: psychological involvement, sense of obligation, political efficacy, personal identification, age and gender. Psychological involvement refers to the degree to which an individual is interested and concerned with political issues and public affairs. The nature of psychological involvement required for participation in the various modes is one of the major distinguishing features between them.

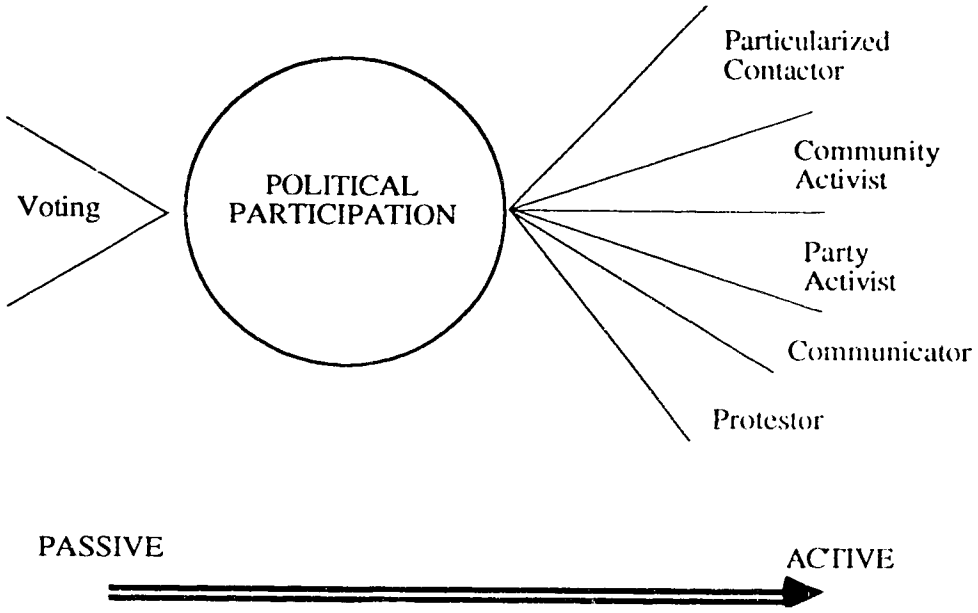

Figure 2.1

Political participation

As an example, campaign, party or community activism requires a greater degree of psychological involvement, or belief in a purpose than does voting which requires little psychological involvement as it is an act of duty or responsibility. The sense of duty and a feeling of political efficacy are closely linked. The duty to vote, felt by many individuals, is likely learned as part of the socialization processes of the family and with the acquisition of new roles for young adults. This sense of obligation to participate is not common to all types of participation and does not apply to campaign or party politics and only occasionally to community activism and the other areas of political participation. Political efficacy, or the feeling that one is capable of exerting political influence, is important in creating actual involvement. Politically efficacious individuals feel like "actors" rather than the "acted upon." They believe that their voice matters in the formation of public policy, and that politicians should listen to their views. Beliefs of this nature increase political participation. When it is believed that politicians and governments are uninterested in issues of personal concern, or that politicians are absorbed with maintaining power, or that special interest groups have a privileged position, feelings of alienation, cynicism, and distrust result. Such alienation frequently leads to the belief that political leaders do not tell the truth to the electorate, either before or after election. A very significant relationship between political distrust and efficacy is hypothesized by Milbrath and Goel:

> ...when political distrust is combined with feelings of efficacy, the result is likely to be protest against the system; when, on the other hand, distrust is combined

with feelings of inefficacy, the consequence is likely to be withdrawal from politics. (p. 69).

Both age and gender are thought to significantly influence political participation. "Age seems to make the greatest difference among the least educated persons; the best educated are likely to vote at all ages" (p. 114). Among less educated groups, increasing age results in increased political participation, until middle age when participation appears to gradually decline. The question of a gender gap in voting and political participation has persisted for many years. In the mid-1960's, Milbrath and Goel stated the following: "men are more likely to participate in politics than women...although the gap is becoming gradually narrower (pp. 116-117). The authors indicated that social and economic changes were gradually altering these gender differences in both participation and perception between men and women.

Strong personal identification with a political party greatly increases participation as voting and electoral activities are largely partisan in nature, while community activism and particularized contacting are non-partisan. Finally, sociability, extroversion, ego strength, self-confidence, and strong feelings of group identification are further personal factors which influence political participation. Members of established ethnic groups, for example, who are proud of their distinctiveness are more likely to participate politically than others. This strong sense of community translates into participation in other ways. The longer an individual has resided in an area, the more likely it is that they will participate actively in politics. For

similar reasons, homeowners are also much more likely to participate than non-homeowners.

Like all other types of individual behavior, political participation is subject to the forces of different social variables including social position, socio-economic status, and a strong sense of community. Social position describes the relative position of an individual with reference to the centre or periphery of society. "Centre of society" relates to the position of those individuals best able to obtain and comprehend different types of communication and the messages contained therein, and to influence the direction of decisions. Obviously, individuals occupying such positions have far more ability to actively participate in politics. Education and socioeconomic status move one toward the centre, while illiteracy and isolation forces one toward the periphery. Membership in most groups moves one closer to the centre of society as the increased amount of social interaction in these groups increases the exposure to communication.

Closely related to the concept of social position is that of socioeconomic status which involves three factors: education, income, and occupation. As members of higher socio-economic groups are exposed to more political stimuli and possess the resources that are required for active participation, they are much more likely to participate actively in politics than those of low socioeconomic status. They are also more likely to feel a sense of responsibility to participate in the political activity of the community, but voting and particularized contacting are less strongly related to socio-economic status than the other more active types of political participation.

There are aspects of the political environment which might increase or decrease the likelihood of participation, including modernization, "rules of the game," the party system and lobby group activities. Modernization, or the move away from traditional social patterns and economies, is associated with increased political participation because of both the expanding numbers of individuals within the middle class and their increasing expectations for participation. The "rules of the game," are the official and unofficial laws and conditions under which individuals are allowed to participate and govern such issues as residency, citizenship, suffrage, enumeration, and candidacy. These 'rules' influence all aspects of participation, but are particularly noticeable in the area of voting. Thus they also serve to limit participation.

The party system characteristic of western democracies is another environmental variable influencing participation. Where party competition is intense and there is a perception that each individual vote can alter the outcome, there is generally a greater voter turnout. There is more publicity and discussion surrounding intensely competitive elections and, therefore, the amount of political stimuli increases. The importance of an election is also a significant factor influencing voter turnout and, therefore, the response to national elections is almost always greater than to regional or local elections. People also vote more readily when they perceive the contested office or the political race to be an important one and when a clear difference between alternative courses of action is perceived.

Finally, sectarian interests or lobby groups often attempt to influence the formation of public policy by government. These non-

electoral aspects of political participation are a result of the combination of the individual's or group's need to make a position known and the perception of willingness on the part of a governmental body to listen. Many groups have established formal institutions that not only regulate membership interests but also serve to represent membership demands and concerns to government through lobby groups. There are several examples of such groups, the various provincial medical associations and the Canadian Medical Association have long enjoyed having the ears of various levels of government. In Alberta, many would argue the lobby groups representing resource industries such as oil, timber, and pulp have a louder voice with government than does that of the environmental or labour lobby.

In summary, political participation is far more than simple voting behavior. It is a complex phenomenon of related activities spanning many modes of action. Voting is one such type of behavior, though it is essentially passive, and thus "Spectator" in nature. Party and Campaign and Community Activism are similar types of "Gladiator" activities, differing largely in partisan political interest and community involvement. Particularized contacting of officials occurs usually out of a need to remedy a situation of narrow, personal concern. Protesting is an activity engaged in by small numbers of citizens to correct societal wrongs and disobey what is perceived to be unjust laws. A final group, Communicators, participate by making great effort to be informed of political and current events. They act as "watch dogs" of the system and readily criticize politicians and public policy. Communicator activities require

a high level of education and good verbal skills. A final group, "Apathetics," have chosen not to be interested or involved. The different variables influencing both the type and amount of political participation are political stimuli or information, and personal, social, and environmental variables, such as political efficacy, socioeconomic status, and the party system.

Women and Politics

Four factors have been suggested for the differential rates by gender differential for political participation: differences in socialization patterns between girls and boys; restrictive female roles; structural demographic factors; and lack of appealing issues for women (Kay, Lambert, Brown, Curtis, 1988). The cultural socialization explanation focuses on the societal norms for acceptable behavior for children. Female children are generally encouraged to be agreeable and somewhat passive, while male children are encouraged to be outgoing and competitive, traits usually associated with success in the political realm. The restrictive roles of homemaker and mother are both physically and psychologically isolating, resulting in women being removed from most political stimuli. Working mothers today are still politically isolated, in that the burden of multiple roles leaves little time for political activity. Demographic differences between groups are reflected in the influence of socio-economic variables on women. As political participation is positively linked to socio-economic status, the discrepancy between wages and occupational opportunities may have negative effects on

participation levels. The lack of issue appeal to women (Black and McGlen, 1979) has been asserted as causing discrepancies. When political parties are able to table policies that address the concerns of women such as "day care services, pay equity, and the election of more women" (Kay et al.), then women may turn out in substantial numbers to participate. This factor hypothesizes that women do not participate in politics as frequently as men because the current political agenda does not have relevance for them.

The Milbrath and Goel framework implies that any citizen can participate at any and all levels, while Brodie (1985, 1988) and Brodie & Chandler (1991) argue that at the mass level, women participate as frequently as men, but at the upper levels there are social and political practices which limit potential political leaders to a select few. In the latter realm women are rarely included. Women comprise more than one half of the population, yet they are under–represented at all levels of political life and are only rarely part of the political elite. The political party and social organizations have "gatekeepers," who control the recruitment and training of future political leaders and are not neutral to gender, discouraging the participation of women. As participation at this level is vital to the development of the political skills necessary for a successful run for office, this discrimination effectively limits political careers. Gatekeepers also control the sponsorship, money, and support necessary for a campaign. One might conjecture that when women do become candidates for political office they are less often elected, either because they have been nominated by major parties in ridings where the chances of winning are low, or have run for minor parties

with little electoral support, or do not have the broad base of support and political experience necessary to get elected.

Randall (1987) suggests that the models traditionally used to evaluate political participation fail to measure the considerable contributions made by women in non-conventional politics. Even when looking at conventional political participation, Randall states:

> Overall, the evidence suggests that women's political participation, conventionally defined, is everywhere less than men's. Even so, a number of caveats are in order. The first is that political activism tends in any case to be a minority attribute. Second, these sex differences are not constant but vary noticeably over time and across cultures. (p. 57)

Milbrath & Goel and Black & McGlen noted a gradual narrowing in the discrepancy between the participation of men and women. Randall suggests that existing differences are not intrinsic and given time may eventually disappear; however, she states that important aspects of female political behavior are going unnoticed because they do not fit in to the conventional, and currently more masculine, patterns of participation. This points to "ad hoc" politics, "protest" politics, industrial militancy, the indirect exercise of power in traditional societies, and women's associations, as being unconventional political participation.

Ad hoc political activity, that is temporary coalitions formed to focus on issues of local concern, correlates somewhat with the term Community Activist used by Milbrath and Goel. Randall cites a long historical tradition of this type of political activity on the part of

women, such as the food riots in eighteenth and nineteenth century Great Britain and France; the demonstrations against the Poor Laws in 1837; the British suffragette protests in the early twentieth century; and more recently the participation of individuals in community-based groups formed to deal with various local and national issues such as crime, prostitution, gun control, early childhood education, the taxation of child-support payments, hunger, etc. Further to this, Randall discusses the considerable contribution women have played in many countries: the revolutionary movements in early twentieth century Russia, and more recently in South and Central America, Africa, and Asia. The peace movements and some environmental groups are political protest organizations that have as members large numbers of women. The Women's Peace Camp at Greenham Common in England and the formation of the Green Party in West Germany are examples of this type of non–conventional political activity. Women's organizations have played a vital role in campaigns for social reform. The Women's Christian Temperance Union in the United States was originally formed to prohibit alcohol, but later became involved in such social issues as child labour, prison reform, and women's suffrage.

Industrial militancy refers to action taken to support the demands of workers, and as such corresponds to the activities of Milbrath and Goel's 'Protestors'. Women have demonstrated the ability to organize and take collective strike action against labour laws perceived as unjust in many settings. Hibberd (1987), discussing the importance of the Alberta nurses' strikes on future political behavior, makes the following point:

> Once the decision is made and services are withdrawn, solidarity is built up on picket lines and feelings of liberation and power otherwise rarely experienced by nurses contribute to militancy and rising expectations, nurses expect to see real progress in bargaining. The experience of walking a picket line may have a radicalizing effect on nurses, especially if the strike is successful in securing important bargaining objectives. (p. 590)

Thus at least for a time a very large group of nurses were united in a common political goal under strong, decisive leadership.

Though indications are that though women seem to participate less than men in some of the more conventional political activities, there are many examples of the important contributions of women to many different societies utilizing less conventional means of political participation. Even though women may be more comfortable with these less conventional approaches to politics, it is important not to neglect the traditional pathways to power. Trimble (1992), discussing women's political issues in the province of Alberta, advocates that women "not overlook mainstream strategies. If women's groups continue to express antipathy towards conventional politics, they may guarantee their own marginalization." (p. 240)

Unfortunately, there is little research available on the political participation of nurses anywhere in the world, and none on the participation of nurses in the unique Canadian political and health care contexts. Following is a review of the results of investigations

which have looked at nurses' involvement in politics. The discussion focuses on the sample, tools, and salient conclusions and recommendations.

Nursing and Politics

Creason (1978), the first nurse researcher to study political participation, did so by examining public records and comparing the voter registration and voting behavior of four different faculty groups at a Michigan university. Nursing faculty (n=75) were compared to random samples of the medical, education, and music faculty. The samples of nurses and physicians were exclusively women and men respectively, while the education and music faculty samples were composed entirely of women. Creason selected these groups to control for the male–female components of prestige and power differential between the nursing and medical professions.

Voting consistency was defined as voting at least once each year following voter registration. Of the four groups, nursing had the highest percentage of registered voters, but a less consistent voting pattern in several regional and national elections during the research period. Medical faculty members had the most consistent voting patterns. It is important to note that the nursing group was significantly younger than the other three groups.

Archer and Goehner (1981) and Archer (1983) reported on the political participation of nurse administrators (n=522) in various practice settings throughout the United States. The instrument utilized was designed specifically for this study and contained a 19

item array of political activities developed from the work of Milbrath & Goel and Verba & Nie (1972). More than half this group reported being active in professional organizations. This group of nurse administrators had high frequencies of voting behavior (93%) and contacting of political officials (83%). Fifty-five percent of the group reported actively attempting to persuade others to vote for specific issues or candidates. As politically active individuals must be well-informed, the respondents were asked to rate the value of different information sources for the individual or group wishing to become politically active: nursing organizations (87%), the media (89%) and community organizations (89%) were all closely rated as helpful. When asked if nurses were as politically active as they should be, 94% responded negatively. The reasons cited for low levels of participation were inadequate educational preparation (40%), family and job commitments (35%), and the socialization of women and nurses (28%). Respondents indicated that as members of a largely female profession, nurses are quiet, passive, and self-sacrificing and for these reasons, handicapped in the political arena.

Archer (1984) was commissioned by the College of Nursing of Australia to examine the participation of that country's nurses—the only non-American study in the literature. The sample (n=276) was drawn from administration, education, and clinical practice and approximated the actual distribution of working nurses within the country. Archer found that 30% of respondents had campaigned for an individual seeking political office. The main political issues affecting health care in Australia were identified as health care funding, staff shortages, nursing salaries, a lack of autonomy for

nursing practice, and a lack of unity within the nursing profession. Respondents also indicated that unemployment and the status of women were important societal concerns affecting health. Several recommendations were made to the College of Nursing based on the information obtained in this study. Nurses were urged to be better prepared to take political action by educating themselves and others, specifically the media, about issues affecting health care and nursing. Professional nursing groups were encouraged to develop political action wings and to sponsor ongoing programs to examine the political issues affecting nursing and health care. Australian nurses were encouraged to be active at the community level in order to identify local health concerns. With this information, it was recommended that individual nurses and their professional organizations work closely with elected officials to influence health policy.

Frenkel and Pickett (1983) conducted an informal survey of seventy-five nurse practitioners in New England which revealed little or no involvement in any political issues related to nursing or health care by this group. Non-participation was justified on the basis of inadequate educational preparation, lack of time, or the pressures of family commitments. The few respondents who did indicate active political participation did so to maintain and promote the nurse practitioner role for reasons of job security, perceiving the role to be potentially under threat. This group of nurse practitioners voted in high numbers; state and national elections (89%) and local elections (83%).

Sweeting (1984) also studied the political participation of nurse practitioners. Generally well-educated, this specialized group of nurses usually practice independently and may be expected to display different political attributes than other groups of nurses. Sweeting obtained a convenience sample of North Carolina nurse practitioners (n=209) and utilized Archer's framework for determining political participation while also examining the knowledge of state and federal legislative activities and levels of perceived political effectiveness. As expected, this was a well educated group; 51% had baccalaureate or master's degrees. Sweeting found this group to be regularly involved in different types of political activities. Age was positively associated with political participation. These nurses also scored in the middle to high range on a scale measuring perceived political effectiveness. Respondents displayed an adequate level of knowledge of various relevant legislative processes. Interestingly age, not level of education, was associated with high levels of political knowledge in this study. Sweeting discovered a positive relationship between perceived political effectiveness, political knowledge, and political participation.

Moore and Oakley (1983) adapted an instrument developed by the National League for Nursing for use in examining the relationship between political participation and the degree of support for selected reforms to the American health care system. The questionnaire was self-administered and contained 41 closed-ended questions based on the work of Milbrath and Goel. A randomly selected group of 153 Michigan nurses responded. There was almost complete agreement on the appropriateness of political involvement for nurses. More than

80% of these nurses agreed that political participation is very important and that nursing organizations must serve to assist the political participation of member nurses. Utilizing the Milbrath and Goel terminology, greater than 90% of nurses had participated in Spectator activities. Participation in various Gladiator activities ranged from 30-64% in this sample.

Maraldo (1984) was interested in the personal characteristics that may influence an individual's political participation. The socialization process of nursing students thirty to forty years ago frequently involved physically isolated living accommodations, strict dress and behavior codes, and educational settings separated from mainstream academic life. It was hypothesized that such experiences would result in a rigid and dogmatic belief system which would likely preclude conventional political participation. Nurse administrators (n=54) were compared to non-nurse administrators (n=46) using a political participation questionnaire based on the work of Verba & Nie (1972). The study was limited to women 35 years or older, as younger women were likely to have been influenced by the women's movement of the early 1970's. Maraldo found those in the nursing group to be significantly less dogmatic than those in the non-nursing group. The variables of age and income, not group membership, showed the greatest amount of variance between the two groups in both voting and political participation.

Hayes (1988) also focused her inquiry on the personal factors associated with political efficacy, specifically the relationship between locus of control, amount of political participation and

attitudes toward the appropriateness of a political role for nurses. Hayes defined locus of control as the degree to which an individual perceives that a particular event is due to personal behavior rather than outside forces. Locus of control would clearly be a factor in the development of political efficacy, the belief that one is capable of exerting political influence. Hayes used a self-administered questionnaire based on the National League for Nurses adaptation of Milbrath and Goel for this descriptive-correlational study of 95 registered nurses living in Massachusetts. In this region membership in a professional organization is not a requirement for registration. Forty per cent of this group reported belonging to a professional organization or nurses' union. Membership in a professional organization was positively correlated with both political activity and increasing levels of education. Hayes did not find a direct relationship between locus of control and political participation. However a significant relationship between internal locus of control and the political attitudes of those nurses who had taken political science courses as part of their undergraduate education was discovered. While 90% of this sample agreed that political involvement was appropriate, 78% indicated that political involvement was an important activity for nurses and that professional organizations must take a role in assisting member nurses to become politically involved. Family responsibilities (50%) and a lack of political knowledge (50%) were indicated as preventing greater political participation.

Hanley (1987) drew random samples of nurses (n=267), women teachers (n=66) and a convenience sample of women

engineers (n=55) in Michigan to determine if nurses participated in political activity at the same rates as other professional women. The nurses were all members of a county professional association. A self-administered questionnaire with a similar framework to that of Milbrath and Goel was utilized. When controlling for differences in academic preparation at the baccalaureate level, nurses were as active as the other professional groups. It was discovered, however, that nurses prepared at the diploma and associate degree level voted in significantly lower numbers than university prepared nurses, teachers, or engineers. As level of education so clearly made a difference in level of political participation, Hanley recommended including political education in all basic nursing programs and in the continuing education programs for graduate nurses. She also suggested that professional nursing organizations could enhance the political participation of their members by both monitoring health policy and informing the membership of current political issues.

Small (1989) was also interested in the role of education in developing political activism within the nursing profession. Utilizing a correlational design and a self-designed instrument based in part on the work of Milbrath and Goel, Small also examined the relationship of "Social Power Motivation," or the desire to influence events and have an impact on others. Once again, this selected construct seems closely related to that of political efficacy. A significant and positive relationship between income, social power motivation, participation in continuing education activities, involvement in both professional and non-professional organizations and political participation was found. As expected, those nurses who

had membership in a political party were also more politically active. Age and education were not related significantly to political participation. The author posited that both continuing education and organizational activities serve to expose the individual to change and new ideas through the expanded social interactions afforded by membership. Political affairs and issues would be part of the intellectual stimulation afforded in such settings. Small had strong words for educators:

> Nurse educators associated with professional continuing educational programs should assert more leadership in the planning and implementing of politically-oriented content and learning experiences. As planners of continuing education they may be overemphasizing clinical development and neglecting programmatic thrusts which address the contextual role of nursing. Both are needed. (p. 145-146)

Utilizing an instrument developed by Woodward & Roper (1956), Rothacker (1985) found a sample of Tennessee registered nurses to be more politically active (48%), compared to 31% of a non-specific professional group, and 10% of the general population. This sample of nurses (n=157) was randomly selected from the Tennessee Nurses Association in which membership is optional. Ninety-seven per cent of this group reported occasionally or frequently engaging in discussions of nursing issues. Thirty-seven per cent had contacted federal or state legislators regarding issues relevant to nursing at least once within the past year. Thirteen per cent had worked on an election campaign and 49% had attended meeting where political

speeches had been given. Rothacker further found amount of education to be significantly related to political activity. Nurse educators were much more likely to be politically active than other groups of nurses. Nurses engaged in medical–surgical practice or hospital–based general duty nurses were significantly less likely to be politically active. Age, socioeconomic status, geographic region, and active support for a nursing organization were not found to be significant variables. The latter is not surprising since the sample was drawn from the membership of a nursing organization, and nurses not valuing such organizations would have therefore been excluded from the study.

Daffin (1988) developed a causal model of political expectations and political participation based on role theory. The work of several nursing authors (Archer & Goehner, 1982; Kalisch & Kalisch, 1982; Mason & Talbot, 1985; Weiczorek, 1985) was condensed to discern the various behaviors and roles advocated by these authors for the ideal politically active nurse. Nine roles were eventually described, and agreement on the appropriateness of each was sought from nursing leaders throughout the United States. These roles were: voter, monitor, negotiator, networker, leader, spokesperson, campaigner, lobbyist, and player. A questionnaire was subsequently developed, pilot tested and found to have good reliability.

Daffin then examined both the expectations for political participation and the actual political participation of 194 nurses in three separate areas of practice, education, and administration in Alabama. There was consensus in ranking the five highest groups in order of importance: voter, monitor, negotiator, networker, and

leader. It was found that though this group had high expectations of participation, actual participation was largely limited to voting, and that nurses involved in clinical practice are significantly less politically active than those in education and administration. Daffin's recommendations included increased amounts of political content in nursing curricula and collaboration of administrative, education, and clinical nursing groups for the purpose of planning and implementing continuing education on health policy and political issues and strategies.

Hofmann (1989) was interested in the influence of membership in a state nurses' association on political participation and interest in current legislative issues affecting nurses. She examined the political participation of a group of nurses (n=595) in New York state, where membership in the state nurses' association is optional. Half the sample was composed of members of the state association and half non-members. A correlation was found between membership in the state association and political activity. Hofmann postulated that similar factors appear to influence both voluntary membership in professional associations and political participation. It was difficult to discern a relationship between membership in the state association and concern with legislative issues due to low reliability of the instrument. Education and years of work experience were positively associated with political participation. At the time of the research, the general population of New York state was 62% voter registered, while the study sample was well above this at over 90%.

As in the case of earlier researchers, Hofmann recommended the inclusion of political issues and awareness into nursing curricula.

She also identified an important role for professional nursing organizations in monitoring of current legislative issues, informing the membership, and lobbying on behalf of the nursing profession. Such organizations must also work to establish consensus on important issues and present a united front to legislators. Hofmann asserts that the power to influence the political agenda lies in informed and united nurses, but unfortunately does not offer specific suggestions for how nursing organizations may achieve this goal.

In summary, previous research has demonstrated that nurses are more politically active than members of the general population (Archer, 1984; Archer & Groehner (1981); Archer (1983); Creason, 1978; Hanley, 1987; Frankel & Pickett, 1983; Sweeting, 1984). This includes greater participation in community and partisan politics as well as higher rates of voting and voter registration. The major factors constraining nurses from even greater participation are identified as a lack of political knowledge, inadequate educational preparation, family and job commitments restricting time available for political activities, and the socialization of women and nurses into passive, non-confrontational roles (Archer & Groehner, 1981; Archer, 1983; Frenkel & Pickett, 1983; Hayes, 1988). Political participation was positively associated with membership in a professional organization (Hayes, 1988; Hofmann, 1989; Small, 1989); amount of education (Hanley, 1987; Hofmann, 1989; Rothacker, 1989); income (Maraldo, 1984; Small, 1989); age (Maraldo, 1984); participation in continuing education programs (Small, 1989); and years of experience in nursing (Hofmann, 1989). Conflicting results were obtained by Small (1989), who did not report an association between

political participation and either age or education, and Rothacker (1989) who did not discover an association between political participation and age, income, or participation in professional organizations. Daffin (1988) indicated that nurses employed in clinical practice were less inclined to political activity than are those in either administration or education.

Different theoretical constructs have been used by nursing researchers to study political participation. Milbrath & Goel's work has been the basis of research done by Moore & Oakley (1983), Hayes (1988) Small (1989) and Hofmann (1989). Archer (1983), Sweeting (1984), and Hanley (1987) used elements of both Milbrath & Goel and Verba & Nie (1972), while Maraldo (1984) used the Verba & Nie construct alone. Rothacker relied on the work of Woodward & Roper (1956). Daffin (1988) developed a unique nursing-oriented theoretical framework to explain political participation within the profession.

The political participation of nurses in Alberta requires study as political, health care, registration and union membership requirements may be rather unique in comparison to other groups about whom previous research has been conducted. A large sample drawn from different areas of practice would promote the generalizability of the study to other groups of Canadian nurses. For maximum usefulness, the study should be organized around a recognized framework and incorporate the use of reliable and valid instruments tested in previous research. A description of the methods used in this study follows in the next chapter.

CHAPTER 3
METHODS AND PROCEDURES

A descriptive, correlational survey design was selected for use in this research. The study was designed to determine the level of political involvement and political activity of Alberta registered nurses. The influence of age, experience in nursing, level of education, and area of employment within nursing on political involvement and political activity was also examined.

Sample

A stratified random sample of registered nurses was obtained from the membership lists of the Alberta Association of Registered Nurses. In Alberta, nurses renew their licenses on a yearly basis with this professional association. The area of practice within nursing: clinical, administration, education, research or "Other" is indicated on the renewal form. Respondents were randomly selected from the clinical, administration, and education categories. Anticipating only a moderate response rate to a mailed questionnaire, two hundred nurses from each of the three categories received a survey package for a total sample of six hundred individuals. Kirk (1982) stated that based on a power of .95 with a three group design, minimum sample size is 32 at the .05 significance level (p. 841).

Instruments

There were a total of 58 questions in the survey instrument used in this study (Appendix E): 13 demographic, five relating to union membership and activities, three relating to professional group activities, one relating to previous political education, and one relating to political party membership. The demographic portion of the questionnaire was adapted for this study from the Alberta Association of Registered Nurses annual membership renewal form. A 12–item Political Involvement Scale, 14–item Political Activity Scale, and a 7–item Nurses' Political Role Scale, and one additional question concerning ad hoc political activities made up the remainder of the questionnaire. Two items were open–ended, one related to professional group political activity, the other to the need for Alberta Registered Nurses to be politically active.

The Political Involvement Scale was selected as it had been used in previous studies of nurses and conforms closely to the Milbrath and Goel theoretical framework. It was designed to assess the degree of interest and personal involvement in political affairs. There are 3 sub–scales within the tool: Intensity of Partisan Interest, Interest in the Campaign, Concern over Election Outcome. Sense of Political Efficacy, and Sense of Citizen Duty are scales also developed in the same original research. Reliability of the first three components (Intensity of Partisan Interest, Interest in the Campaign, Concern over Election Outcome) is reported at 0.80. Sense of Citizen Duty has a reliability coefficient of 0.96. The Political Efficacy sub–scale has a reliability coefficient of 0.92. These reliability coefficients were reported from the original research conducted by Campbell, Converse, Miller, and Stokes (1964) on American presidential

elections. Permission was obtained from Dr. W. E. Miller to use the Political Involvement Scale (Appendix F). In her research, Hofmann (1989) adapted this work from a structured interview form to a written response form, "with minor alterations in the questions" (Hofmann, p. 49). Unfortunately, Hofmann does not report reliability coefficients for this adapted instrument.

The Political Activity Scale was developed by Hayes (1988) and Hofmann (1989) directly from the work of Milbrath and Goel, specifically for use on a nursing sample. A similar instrument had been utilized by Archer and Groehner (1982) and Moore and Oakley (1983). Hofmann reported a reliability coefficient of 0.8193, and Hayes 0.78, for the Political Activity Questionnaire in separate studies. Permission was obtained from Dr. J. Hofmann to use the Political Activity Scale (Appendix G). The Nurses' Political Role Scale was adapted by Moore and Oakley (1983) from one developed by the National League for Nursing. Hayes reported a Cronbach's alpha of 0.69 for this scale.

Procedure

A request to the Alberta Association of Registered Nurses was granted for access to the roster of its members. Two hundred registered nurses employed in either clinical nursing, nursing administration, and nursing education were randomly selected. A survey packet was mailed out to each of the six hundred nurses. The packet contained a cover letter explaining the purpose of the study and assurance of confidentiality of responses (Appendix H), the questionnaire on colour-coded paper, and a stamped, addressed

envelope. A postcard reminder was mailed after three weeks to promote return of completed questionnaires (Appendix I).

Protection of Human Rights

This study received ethical clearance from the Ethics Review Committee, Faculty of Nursing of the University of Alberta (Appendix J). There was no physical testing of human subjects in this study, and participation was voluntary. Individual consents were not obtained, implied consent was obtained by return of a completed questionnaire. No solicitation of responses took place and nothing was offered to participants in return for their participation. The respondents were informed of the purpose of the study by the cover letter. It was specified in the cover letter that only group findings would be used in presentations, discussions and publications. No distinguishing information would be revealed at any time from this study. Participants were assured that individual questionnaires would be destroyed on successful defense of this thesis, but that copies of the raw data would be retained on disk for the possibility of further work in this area. Before undertaking secondary analysis in further research, ethical clearance would be obtained from the University of Alberta.

Data Analysis

Data from the questionnaires was entered into SPSS 4.0 for the Macintosh and analyzed using the SPSS software. Descriptive

statistics including means, ranges, frequencies, and standard deviations for each of the three groups and for the total sample were obtained and summarized. Differences between the groups were identified through analysis using chi-square or analysis of variance depending on the level of the data. Analysis of variance was done on the mean scores by group for the Political Involvement Scale, the Political Activity Scale, and the Nurses' Role in Politics Scale, to determine differences between groups on aggregate scores. As significant differences were determined, Scheffé contrasts were carried out to locate the sources of these differences. Analysis of variance was also carried out on data by area of practice and level of education to determine if differences in participation were due to these two variables. Multiple regression analysis was carried out to determine if there were differences in participation due to age, education, and years of experience in nursing. Reliability was calculated for the different scales.

The questionnaire utilized in this study gave respondents the opportunity to comment on any political activity engaged in by a professional group in which the respondent held membership, personal participation in ad hoc political activities, and the need for political involvement of Registered Nurses in Alberta. Results of the analysis are presented in the following chapter.

CHAPTER 4
RESULTS AND INTERPRETATION

Introduction

This chapter contains results of data analysis for this study. Reliability of the Political Involvement Scale, the Political Activity Scale, and the Nurses' Role in Politics Scale is important to the integrity of this study and will be presented first. A discussion of the sample profile and response rate will follow. To compare and contrast characteristics of the three practice setting groups, frequency distributions, chi square tests, and analyses of variance were done. Frequencies expressed in tabular form of the nominal categories of response rate, employment setting, current enrollment in educational programs, and previous education, including political education. Chi square tests were completed on the categorical variables of active membership in the Alberta Association of Registered Nurses, membership in a professional specialty group, membership in a nurses' union, current or former union executive member, regular attendance of nurses' union meetings, and participation in a nurses' strike. The chi square values, degrees of freedom, and probability are reported in the appropriate frequency tables for each of these variables. A discussion of the results obtained from each of the three instruments follows, also with appropriate descriptive statistics, analyses of variance and Scheffé contrasts in tabular form. Additional written responses were contained in 137 of the 378 returned questionnaires. These responses were transcribed, and a distillation and analysis of the

major themes occurring in the written comments made by the subjects of the study is included in this chapter. A discussion of the results of data analysis in relation to the research questions posed in Chapter 1 will conclude this chapter.

Response Rate

The sample consisted of 387 registered nurses providing a response rate of 64.5% for the mailed questionnaire (Table 4.1). This response rate reflects the interest in politics of the nurses in this sample and is thought to be very good based on the much lower response rates found by other researchers in similar studies. Of the thirteen previously cited studies investigating the political participation of registered nurses, response rates for twelve range from 37.5—59%. Only Rothacker (1985) reports a better response rate at 78%.

For all questions a "missing value" was incorporated for coding purposes to enhance accuracy of the analyses. There were 120 "missing values" on the demographic portion of the questionnaire out of a possible 9288 responses (1.29%); on the Campbell, Converse, Miller, and Stokes Political Involvement Scale there were 21 "missing values" out of a possible 4644 responses (0.45%); on the Political Activity Scale there were 93 "missing values" of a possible 5805 responses (1.6%); and there were 4 "missing values" on the Nurses' Role in Politics out of a possible 2322 responses (0.17%).

Table 4.1

Questionnaire Response Rate By Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	TOTAL
DISTRIBUTED	200	200	200	600
COMPLETED & RETURNED	134	111	142	387
PERCENTAGE RETURNED	67.0%	55.5%	71%	64.5%

Reliability

In this study a reliability coefficient (Cronbach's alpha) of 0.72 was obtained for the Nurses' Perceptions of the Appropriateness of the Political Role Scale. A reliability coefficient of 0.77 was obtained for the Political Activity Scale. The Political Involvement Scale reliability coefficient was 0.79. These internal consistency coefficients were deemed to be very good.

Sample Profile

There were 377 women and 10 men in the sample who ranged in age from 22–66. The mean age for the entire sample was 44.1 years (Table 4.2). The clinical group was the youngest with a mean age of 41.8 years; administrative and education groups were similar in mean age at 45.6 years and 44.3 years respectively, differing significantly on this variable (Table 4.3). Seventy-six point nine percent of the sample were married; 11.9% were single, 8.1% were divorced, 1.8% were separated, and 1.3% were widowed.

The average number of years employed in nursing for the entire group was 19.7 (Table 4.4). Analysis of variance of years of experience by practice category revealed significant differences between groups (Table 4.5) at the 0.05 level with an F ratio of 25.39, df = 2, 381 and p = 0.00. Thirty individuals had been nursing for less than nine years, 154 for between ten and nineteen years, 147 for between twenty and twenty-nine years, 50 for between thirty and thirty-nine years, and three individuals had nursed for more than

Table 4.2

Mean Age by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	TOTAL GROUP
MEAN	45.60	41.78	44.34	44.06
ST. DEV.	7.43	9.88	7.09	8.22

Table 4.3

Analysis of Variance of Age by Practice Category

SOURCE	d f	SUM of SQ.	MEAN SQ.	F RATIO	PROB.
Between Groups	2	872.12	436.06	6.65	.0015
Within Groups	369	24185.69	65.54		
TOTAL	371	25057.81			

Scheffé Contrasts–Significant difference between Group 2 (clinical) and Groups 1 and 3 (administration and education)

Table 4.4

Mean Years of Experience in Nursing by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	22.17	15.65	20.55	19.71
ST. DEV.	6.96	8.41	6.73	7.78

Table 4.5

Analysis of Variance of Years of Experience in Nursing by Practice Category

SOURCE	d f	SUM of SQ.	MEAN SQ.	F RATIO	PROB.
Between Groups	2	2724.29	1362.14	25.39	.0000
Within Groups	381	20441.05	53.65		
TOTAL	383	23165.34			

Scheffé Contrasts–Significant differences between Group 2 (clinical) and Group 1 (administration) and Group 2 and Group 3 (education)

forty years. Clinical nurses had the least experience, administrators the most. As extensive experience in clinical nursing is a prerequisite for teaching and administration, this difference is expected.

Eighty-five percent of the sample had either full or part-time permanent employment in nursing while 11.9% were employed on a casual basis. Twenty-nine point two percent of respondents reported working less than thirty hours per week, 44.5% worked 30-40 hours per week and fully 26.3% reported an average of greater than 41 hours per week in nursing. A household income of less than $25,000 was reported by 0.8% of the sample, $25,001 to $35,000 by 4.3%, $35,001 to $45,000 by 7.4%, and $45001 to $55,000 by 18.6%. Sixty-eight point seven percent of respondents reported a yearly household income of more than $55,000. Clearly this group of nurses is among the more affluent members of the Alberta public.

As outlined in Chapter 3, questionnaires were mailed to three equal groups of nurses involved in clinical nursing, administration, and education. Membership in these categories was determined when individuals identified the nature of their work in nursing when completing the AARN membership renewal form in the fall of 1992. In this study, clinical nursing was indicated as the primary area of responsibility by 31.3% of the sample, 31% indicated education, and 25.6% indicated administration. "Other" was indicated by 10.3%, 0.5% of the population were primarily engaged in research. These changes from the previous year's assignation could have resulted from a job change, a change in primary activity within the same job, or a change in personal emphasis on the part of the subject. A decision was made

to adhere to the original self-selected categories, as the subjects had recently indicated those as descriptive of their practice.

Employment settings were reflective of the great variety of areas in which registered nurses practice in Alberta (Table 4.6) due to proportional sampling, 40.3 % of the sample was employed in general hospital settings, and general hospitals were the largest employer category for both administrators and clinicians. Currently 60.9% of Alberta registered nurses are employed in general hospitals (AARN, 1994). Nineteen point six per cent of the sample were employed by educational institutions such as universities, colleges, and schools of nursing. Among the general AARN membership 2.5% of individuals are employed by educational institutions.

This sample was a well-educated group, as both current enrollment in educational programs (Table 4.7) and past education (Table 4.8) demonstrated consistent progress toward the professional goal of baccalaureate preparation as the minimum level of education for entry to practice by the year 2000. As expected, educators had the highest numbers of completed degrees and degrees in progress, both in nursing and other disciplines. Administrators demonstrated lower levels of education preparation than educators but also require formal educational preparation both to obtain and fulfill their roles as leaders within healthcare institutions and the nursing community. The clinical practice group had considerably less past or in progress educational preparation.

A knowledge of the political system and awareness of the political issues affecting both the health care system and nursing are necessary for nurses to participate effectively in the political system.

Table 4.6

Employment Setting by Practice Category

EMPLOYER	ADMINISTRATION	CLINICAL	EDUCATION	TOTAL
GENERAL HOSPITAL	50	67	39	156
PSYCHIATRIC CENTRE	3	1	2	6
LTCC	5	6	0	11
OTHER HOSPITAL	15	9	8	32
HOME CARE	11	6	1	18
COMMUNITY HEALTH	16	6	4	26
INDUSTRY/ OCCUPATIONAL HEALTH	3	4	1	8
LODGE	1	0	0	1
EDUCATIONAL INSTITUTION	2	0	74	76
SELF-EMPLOYED	1	0	5	6
ASSOCIATION/ GOVERNMENT	4	1	2	7
OTHER	9	3	1	13

Table 4.7

Current Enrollment in Educational Programs by Practice Category

NURSING:	ADMINISTRATION	CLINICAL	EDUCATION	TOTAL
BACCALAUREATE	13	14	8	35
MASTER'S	5	2	11	18
DOCTORATE	0	0	1	1
OTHER:				
BACCALAUREATE	4	3	1	8
MASTER'S	6	0	12	18
DOCTORATE	0	0	5	5
CERTIFICATE	1	3	0	4

Table 4.8

Education since Graduation from Basic Program by Practice Category

NURSING:	ADMINISTRATION	CLINICAL	EDUCATION	TOTAL
POST-BASIC BACCALAUREATE	40	18	60	118
MASTER'S	14	0	21	35
DOCTORATE	0	0	1	1
OTHER COURSES	55	49	33	137
OTHER:				
BACCALAUREATE	7	1	11	19
MASTER'S	17	1	24	42
DOCTORATE	1	0	6	7

Few members of this sample had received any form of education in political science as part of their basic education programs (Table 4.9). The University of Alberta has required an elective political science course as part of the basic and post–basic degree program for many years while the Universities of Calgary and Lethbridge do not have similar requirements. In these centers, students have the option to take such courses, but clearly most have pursued other areas of interest.

Education within a professional practice discipline increases knowledge and skill levels and changes professional attitudes. Attitudes toward professional organization membership and involvement and the development collegial relationships within a profession are learned in large part during educational preparation. Fewer clinical nurses are university prepared and this may have produced the discrepancies in the professional group involvement of this segment of the sample. The Alberta Association of Registered Nurses is the professional organization and representative body for Alberta nurses at both the provincial and federal levels. The AARN serves as a licensing body, establishes standards of practice to ensure safe and ethical nursing care for Albertans, and deals with issues of professional conduct. The membership of the AARN is divided into five geographical districts which are further subdivided into local wards. Membership is a requirement of practice within the province and the opportunity also exists for any registered nurse in Alberta to become involved on a voluntary basis at the local level, either ward or district, or at the provincial level. There are both elected and

Table 4.9

Political Education in Basic Program by Practice Category

COURSE	ADMINISTRATION	CLINICAL	EDUCATION	TOTAL
YES	17	14	22	53
NO	116	97	120	333

volunteer positions available at all levels. There was a significant difference in active AARN involvement between sample groups (Table 4.10) at either the local or provincial level. The clinical group was less involved.

There were also significant differences between practice groups in membership in professional specialty groups (Table 4.11). These specialty groups at local, provincial, and national levels are focused on issues of practice expertise, within such diverse areas as critical care, pediatrics, gerontology, orthopedics, occupational health and others. While there exists an increasing movement toward professional certification in Canada, these specialty groups currently serve a largely educative function. Clinical nurses from this sample were less likely to belong to such organizations than nurses from the administration and education groups.

Interesting results were obtained for those items related to union activity. As expected there were differences between groups in union membership. Sixty-six point four percent of this sample belonged to a collective bargaining group, somewhat less than the approximately 72% of all Alberta nurses. Again this is probably due to proportional sampling, with some educators and all administrators not belonging to a collective bargaining group. Approximately 75% of Canadian nurses are unionized compared to 20% of those in the United States (Hibberd, 1992). Few nurses in administration (management) have the opportunity to belong to unions, while most nurses in clinical practice are members of these organizations. Nurses working in education are frequently represented by bargaining groups of some type such as United Nurses of Alberta, Staff Nurses' Association of

Table 4.10

Activity at Local/Provincial Level of AARN by Practice Category

ACTIVITY	ADMINISTRATION	CLINICAL	EDUCATION	TOTAL
YES	18	3	25	46
NO	115	108	116	339
$x^2=13.82$ df = 2 p< .05				

Table 4.11

Membership in a Professional Specialty Group by Practice Category

MEMBER	ADMINISTRATION	CLINICAL	EDUCATION	TOTAL
YES	63	25	63	151
NO	70	85	76	231
$x^2=18.36$		df = 2	p< .05	

Alberta, or the academic staff associations of various universities and colleges. When nurses in administrative roles were eliminated, and clinical practice and education groups were compared, there were no significant differences found in regular attendance at nurses' union meetings.

While the great majority of members did not regularly attend union meetings, a core group of 14% of clinicians and educators did so. There were no significant differences between practice groups in response to the question, "Have you been an officer or elected official in a nurses' union?" This is likely a function of the past activities of many nurses now involved in education and administration. When previously involved in bedside nursing, it is likely that a considerable number were active in nurses' unions advocating on behalf of nurses. However, it seemed that the question was not sufficiently sensitive to elicit this information.

Political Activity

Several events occurred in rapid succession which increased the level of interest in partisan politics in Alberta at the time of data collection. In October, 1992 a federal referendum on constitutional renewal was held throughout Canada. Renewal which implied special treatment for the province of Quebec was strongly rejected in Alberta. Then the tightly fought provincial Progressive Conservative leadership campaign to select the next premier occurred in late November, 1992. As noted above Nancy Betkowski, the Minister of Health, was unsuccessful in her bid to become the party leader. She was both popular and respected within the Alberta health care industry and the leadership choice of many nurses. On June 13, 1993, the federal Progressive Conservative leadership contest was won by Kim Campbell, who then became the first woman to be Prime Minister of Canada. At this point the unofficial campaign was on for the fall federal general election. Data for this study was collected on the eve of the June, 1993 provincial general election and many respondents received their mailed questionnaire package on election day, June 15, 1993. Interest in this election was high in Alberta and nurses turned out in very large numbers to vote, as is typical for nurses in all elections (Table 4.12). As these reports of voting rely on recall data and as such are subject to memory and the influence of social desirability, some caution should be exercised in accepting them as the actual voting behaviours of Alberta registered nurses (Gidengil, 1993).

Table 4.12

Voting Rates by Practice Category

ELECTION	CLINICAL	ADMINISTRATION	EDUCATION	TOTAL	GENERAL PUBLIC*
CIVIC	94.5	93.8	94.9	94.4	41.8
PROV.	96.4	96.2	98.6	97.1	57.6
FEDERAL	91.8	93.9	94.2	93.4	72.8 65.3 (AB)

*Voter turnout rates for past civic, provincial, and federal elections: mean voter turnout for Edmonton and Calgary civic elections, 1986-1992; mean voter turnout for Alberta provincial general elections, 1975-1993; mean voter turnout for federal general elections, 1974-1993; turnout of Alberta voters in October, 1993 for the federal general election. (City of Edmonton Returning Officer, 1994; City of Calgary Returning Officer, 1994; Alberta Legislative Assembly, Office of the Chief Returning Officer, 1993; Elections Canada, 1994)

Voting, though representing a limited form of political participation, is a behavior that sharply distinguishes registered nurses form the general population and form previously studied groups of nurses (Creason, 1978; Hanley, 1987; Daffin, 1988; Hayes, 1988; Hofmann, 1989). It is clear that Alberta nurses vote in very high numbers in all types of public elections. Tangential to this is the following: in other election which may not seem as important to them such as professional association elections, registered nurses vote for their local and provincial representatives in much lower numbers. The Alberta Association of Registered Nurses holds elections for officials yearly with presidential selection occurring every second year. Returned ballots averaged 28.32% from 1986 to 1994 when a president was being elected, and 24.7% in the intervening years (M. Wacko, personal communication, May 11, 1994).

For purposes of discussion, the Political Activity Scale was separated into components representative of the participation modes described in Chapter 2. Specific activities were then selected for further analysis. Those activities representative of Party and Campaign Activism are displayed in Table 4.13. High frequencies were found for many activities such as initiating political discussions, attending political meetings and rallies, and attempting to influence the votes of other individuals. There were significant differences between practice categories in membership in a political party (Table 4.14); however, "active" membership in a political party did not result in significant differences between groups.

Milbrath and Goel describe two types of political participants, Particularized Contactors and Communicators. These types, though

Table 4.13

Frequencies of Political Activities Characteristic of Party/Campaign Activists by Practice Category

ACTIVITY	ADMINISTRATION n= 132 (%)	CLINICAL n=110 (%)	EDUCATION n=140 (%)	TOTAL n=382 (%)
Initiates political discussions	113 (85.6)	81 (73.6)	128 (91.4)	322 (84.3)
Attends political meetings/rallies	74 (56.1)	38 (34.5)	68 (48.6)	180 (47.1)
Attempts to influence another's voting	62 (47.0)	45 (40.9)	64 (45.7)	171 (44.8)
Campaign button/sticker on the car	55 (41.7)	28 (25.5)	51 (36.4)	134 (35.1)
Contributes money to a campaign	55 (41.7)	28 (25.5)	51 (36.4)	134 (35.1)
Membership in a political party	48 (36.3)	25 (22.7)	45 (32.1)	118 (30.9)
Active membership in a political party	36 (27.3)	17 (15.5)	27 (19.3)	80 (20.9)
Contributes time to a political party	33 (25.0)	16 (14.5)	23 (16.4)	72 (18.8)
Attends political caucus/strategy meetings	18 (13.6)	9 (8.2)	12 (8.6)	39 (10.2)
Solicits funds for a political party	10 (7.6)	4 (3.6)	1 (0.7)	15 (3.9)
Has held public or party office	4 (3.0)	1 (0.9)	1 (0.7)	6 (1.6)
Candidate for public political office	3 (2.3)	1 (0.9)	0	4 (1.0)

Table 4.14

Membership in a Political Party by Practice Category

MEMBER	ADMINISTRATION	CLINICAL	EDUCATION	TOTAL
YES	48	25	45	118
NO	85	86	97	268
$x^2 = 5.38$		df = 2	$p < .05$	

qualitatively different, share a similar vigilance for current affairs and frequent contact with both public officials and elected politicians. Table 4.15 illustrates the very high frequency of these types of a activities within this sample of Alberta registered nurses. There were significant differences between practice categories in the degree to which these individuals contact officials (Table 4.16). Education and administration groups were similar; however, the clinical group engaged in this activity markedly less frequently.

When participation in ad hoc political activities is equated with Community Activism and participation in a nurses' strike with Protesting, a picture of Alberta nurses filling these roles emerges. Approximately twenty percent of the sample had engaged in a wide variety of ad hoc political activities (Table 4.17). Respondents listed such organizations/activities as "Take Back the Night" marches by women's groups, lobby and advocacy groups for equal rights for women, pro-choice activities, seat belt legislation, services for the frail elderly, adult literacy programs, specific environmental concerns such as the Old Man River dam and commercial development in wilderness areas, and the anti-nuclear movement. Other concerns in which these nurses had participated included the drive to eliminate child pornography and support for food banks. There were significant differences between groups in protesting activities, or participating in a nurses' strike (Table 4.18). Unfortunately this question was not worded sufficiently well to discriminate between those respondents who participated by being on strike and walking a picket line and those whose participation entailed working at a hospital involved in a strike, as many

Table 4.15

Frequency of Political Activities Characteristic of Particularized Contactors/Communicators by Practice Category

ACTIVITY	ADMINISTRATION n= 132 (%)	CLINICAL n=110 (%)	EDUCATION n=140 (%)	TOTAL n=382 (%)
Exposes self to political information via newspapers, T.V. radio	123 (93.2)	105 (95.5)	137 (97.9)	365 (95.5)
Contacts public officials or political leaders	91 (68.9)	50 (45.5)	90 (64.3)	231 (63.3)

Table 4.16

Contacting a Public Official/Politician by Practice Category

CONTACT OFFICIAL	ADMINISTRATION	CLINICAL	EDUCATION	TOTAL
YES	91	50	90	231
NO	41	60	51	152
$x^2 = 13.82$ df = 2 p< .05				

Table 4.17

Community Activism (Ad Hoc Activities) by Practice Category

	ADMINISTRATION n= 132 (%)	CLINICAL n= 110 (%)	EDUCATION n= 140 (%)	TOTAL n= 382 (%)
Ad Hoc Activities	28 (21.2)	19 (17.3)	27 (19.3)	74 (19.8)

Table 4.18

Protest Activities/Participation in a Nurses' Strike by Practice Category

ON STRIKE	ADMINISTRATION	CLINICAL	EDUCATION	TOTAL
YES	39	54	63	156
NO	94	57	79	230
x^2= 11.05 df = 2 p< .05				

administrators might have done. Nurses working at hospitals not governed by a UNA contract may have felt that they also participated in a strike by coping with a greatly increased workload and patient acuity levels.

Political Involvement

The Political Involvement Scale measures three aspects of the phenomenon of involvement: concern over election outcome, interest in the campaign, and intensity of partisan preference. A combined score out of a possible eleven indicating high involvement, is calculated, and three subscores for the different aspects are also obtained. The overall scores for this sample were very high, with the mean for the entire sample being 9.83 (Table 4.19). Analysis of variance indicated significant differences between practice categories with an F ratio of 4.43, df = 2, 378 and $p < .01$ (Table 4.20).

Calculation of the various subscales yielded similar results. Mean responses to Concern over Election Outcome were identical for both the administration and education groups (Table 4.21). The clinical group achieved a significantly lower mean score than either of the other groups (Table 4.22). The mean scores for Interest in the Campaign were high with an overall mean of 2.57 (Table 4.23). Again, analysis of variance yielded significant differences between the three practice categories with an F ratio of 4.32, df = 2, 382 and $p < .014$ (Table 4.24). The mean response to Intensity of Partisan Preference was high for all three (Table 4.25). However, there were no significant differences between groups (Table 4.26).

Table 4.19

Mean Response to Political Involvement by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	9.95	9.44	10.01	9.83
ST. DEV.	1.65	1.89	1.36	1.64

Table 4.20

Analysis of Variance of Mean Response to Political Involvement by Practice Category

SOURCE	d f	SUM of SQ.	MEAN SQ.	F RATIO	PROB.
Between Groups	2	23.51	11.75	4.43	.0126
Within Groups	378	1003.06	2.65		
TOTAL	380	1026.57			

Scheffé Contrasts–Significant differences between Group 2 (clinical) and Group 1 (administration) and Group 2 (clinical) and Group 3 (education)

Table 4.21

Mean Response to Concern over Election Outcome by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	4.55	4.30	4.55	4.48
ST. DEV.	.77	1.01	.77	.85

Table 4.22

Analysis of Variance of Mean Response to Concern over Election Outcome by Practice Category

SOURCE	d f	SUM of SQ.	MEAN SQ.	F RATIO	PROB.
Between Groups	2	5.02	2.51	3.50	.03
Within Groups	381	272.77	.72		
TOTAL	383	277.79			

Scheffé Contrasts– Significant differences between Group 2 (clinical) and Groups 1 and 3 (administration and education)

Table 4.23

Mean Response to Interest in the Campaign by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	2.57	2.46	2.67	2.57
ST. DEV.	.61	.61	.47	.57

Table 4.24

Analysis of Variance of Mean Response to Interest in the Campaign by Practice Category

SOURCE	d f	SUM of SQ.	MEAN SQ.	F RATIO	PROB.
Between Groups	2	2.74	1.37	4.32	.014
Within Groups	382	121.40	.32		
TOTAL	384	124.14			

Scheffé Contrasts– Significant differences between Group 2 (clinical) and Group 1 (administration) and Group 2 and Group 3 (education)

Table 4.25

Mean Response to Intensity of Partisan Preference by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	2.80	2.68	2.79	2.76
ST. DEV.	.50	.54	.42	.49

Table 4.26

Analysis of Variance of Mean Response to Intensity of Partisan Preference by Practice Category

SOURCE	d f	SUM of SQ	MEAN SQ.	F RATIO	PROB.
Between Groups	2	1.00	.50	2.10	.125
Within Groups	379	98.80	.24		
TOTAL	381	99.80			

Appropriateness of Nurses' Role in Politics

This scale was utilized to measure various aspects of the respondents' beliefs about the involvement of nurses in politics. The overall scale and the individual items received positive mean responses in all cases by the three practice groups, though there were differences in the degree of positive response and degree of dispersion about the mean between groups and for individual items. Generally the administration and education groups shared very similar mean responses and standard deviations on each item. The clinical group in all instances was less positive in mean response and the greatest amounts of deviation from the mean in individual responses occurred fro this group. The overall mean response to the Appropriateness Scale was 22.84, of a maximum possible of 30. The education and administration groups had similar mean scores in responding to this scale (Table 4.27). However, there was a significant difference between groups on the one way analysis of variance of this scale ($F= 15.31$, $df = 2, 380$, $p< .00$). Upon further analysis using Scheffé contrasts, the significant differences were between Group 2 (clinical) and both of the other two groups and these reached the 0.05 level of significance (Table 4.28).

Each item in this scale was analyzed as well. Individual items are discussed in descending order, from most to least positive response. The item, "Political participation is very important for nurses" received the most positive response (Table 4.29).

Table 4.27

Mean Response to Appropriateness of Nurses' Role in Politics by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	23.30	21.23	23.67	22.84
ST. DEV.	3.33	3.99	3.71	3.80

Table 4.28

Analysis of Variance of Mean Response to Appropriateness of Nurses' Role in Politics by Practice Category

SOURCE	d f	SUM of SQ.	MEAN SQ.	F RATIO	PROB.
Between Groups	2	411.11	205.56	15.31	.0000
Within Groups	380	5102.17	13.43		
TOTAL	382	5513.28			

Scheffé Contrasts- Significant differences between Group 2(clinical) and Groups 1 and 3 (administration and education)

Table 4.29

Mean Response to Item: "Political participation is very important for nurses" by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	4.30	3.86	4.37	4.20
ST. DEV.	.78	1.01	.85	.90

Table 4.30

Analysis of Variance of Mean Response to Item: "Political participation is very important for nurses" by Practice Category

SOURCE	d f	SUM of SQ.	MEAN SQ.	F RATIO	PROB.
Between Groups	2	18.36	9.18	12.05	.00
Within Groups	384	292.71	.76		
TOTAL	386	311.07			

Scheffé Contrasts– Significant differences between Group 2 (clinical) and Group 1 and 3 (administration and education)

Administration and education groups were similar and the clinical group was less positive. Here the standard deviation was greatest in the clinical group. Analysis of variance revealed significant differences between groups ($F= 12.05$, $df = 2, 384$, $p< .00$), and Scheffé contrasts indicated that the differences occurred between Group 2 (clinical) and each of Groups 1 and 3 (Table 4.30). The item, "Participation in politics is compatible with the nursing role" also received a positive overall response (Table 4.31), the standard deviation again being greater in the clinical group than in the others. One way analysis of variance indicated significant differences between groups ($F= 13.88$, $df = 2, 384$, $p< .00$). Further investigation using Scheffé contrasts indicated that the differences occurred between Group 2 (clinical) and each of Groups 1 and 3 (Table 4.32). The item, "Professional organizations have a role in making nurses politically effective" received a positive overall response (Table 4.33). Group scores indicated very similar responses between the administration and education groups and a less positive response to the statement by the clinical group. One was analysis of variance indicated significant differences between groups ($F= 11.78$, $df = 2, 383$, $p< .00$). Scheffé contrasts indicated the differences existing between Group 2 (clinical) and both Groups 1 and 3 (Table 4.34). The item, "Nurses should be encouraged to run for political office" resulted in an overall mean response of 4.06 (Table 4.35). Again the administration and education groups rated this item similarly and the clinical group was less positive. One way analysis of variance indicted significant differences between the groups ($F= 9.20$, $df = 2, 384$, $p< .0001$). The Scheffé contrasts again revealed significant

Table 4.31

Mean Response to Item: "Participation in politics is compatible with the nursing role" by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	4.19	3.77	4.33	4.12
ST. DEV.	.85	1.02	.76	.87

Table 4.32

Analysis of Variance of Mean Response to Item: "Participation in politics is compatible with the nursing role" by Practice Category

SOURCE	d f	SUM of SQ.	MEAN SQ.	F RATIO	PROB.
Between Groups	2	20.98	10.49	13.88	.00
Within Groups	384	290.31	.76		
TOTAL	386	311.29			

Scheffé Contrasts– Significant differences between Group 2 (clinical) and Group 1 (education) and Group 2 and Group 3 (education)

Table 4.33

Mean Response to Item: "Professional organizations have a role in making nurses politically effective" by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	4.22	3.72	4.25	4.09
ST. DEV.	.93	1.01	.92	.97

Table 4.34

Analysis of Variance of Mean Response to Item: "Professional organizations have a role in making nurses politically effective" by Practice Category

SOURCE	d f	SUM of SQ.	MEAN SQ.	F RATIO	PROB.
Between Groups	2	21.14	10.57	11.78	.00
Within Groups	383	343.86	.90		
TOTAL	385	365.00			

Scheffé Contrasts– Significant differences between Group 2 (clinical) and Groups 1 and 3 (administration and education)

Table 4.35

Mean Response to Item: "Nurses should be encouraged to run for political office" by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	4.16	3.75	4.20	4.06
ST. DEV.	.84	1.04	.84	.92

Table 4.36

Analysis of Variance of Mean Response to Item: "Nurses should be encouraged to run for political office" by Practice Category

SOURCE	d f	SUM of SQ.	MEAN SQ.	F RATIO	PROB.
Between Groups	2	14.95	7.47	9.20	.0001
Within Groups	384	311.80	.81		
TOTAL	386	326.75			

Scheffé Contrasts– Significant differences between Group 2 (clinical) and Groups 1 and 3 (administration and education)

differences between Group 2 and each of Groups 1 and 3 (Table 4.36). The mean responses to items, "Nurses lack political knowledge," (Table 4.37) and "Family responsibilities make political participation by nurses difficult" (Table 4.38) were both positive but less so than the previously discussed items in this scale. One way analyses of variance for both of these items did not reveal significant differences between administration, clinical, and education groups.

An item, "The professional goals of nursing can best be achieved through political action" was added to the Appropriateness of Nurses' Role in Politics Scale for this study. It achieved an overall positive mean response of 3.55 (Table 4.39). In this item as well, the clinical group was less positive and there was a greater standard deviation in the clinical group. One way analysis of variance indicated significant differences between groups ($F=4.86$, $df = 2, 382$, $p < .0082$) and Scheffé contrasts indicated the differences to be between Group 2 and Groups 1 and 3 (Table 4.40).

Two scales, a five-item Sense of Efficacy and four-item Sense of Citizen Duty resulted in low Cronbach's alpha coefficients of .35 and .15 respectively in this study. Both scales were in an Agree/Disagree format thus negating other levels of response which might have fallen between these polar opposites. Both scales were developed some four decades ago in the United States. The usefulness of these scales appears to have deteriorated with age, and they appear not to translate well into different geopolitical settings.

Table 4.37

Mean Response to Item: "Nurses lack political knowledge" by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	3.31	3.02	3.27	3.21
ST. DEV.	1.14	1.18	1.19	1.18

Table 4.38

Mean Response to Item: "Family responsibilities make political participation by nurses difficult" by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	3.12	3.14	3.24	3.17
ST. DEV.	1.09	1.16	1.11	1.11

Table 4.39

Mean Response to Item: "The professional goals of nursing can best be achieved through political action" by Practice Category

	ADMINISTRATION	CLINICAL	EDUCATION	ALL GROUPS
MEAN	3.47	3.36	3.76	3.55
ST. DEV.	1.04	1.12	1.03	1.07

Table 4.40

Analysis of Variance of Mean Response to Item: "The professional goals of nursing can best be achieved through political action" by Practice Category

SOURCE	d f	SUM of SQ.	MEAN SQ.	F RATIO	PROB.
Between Groups	2	10.91	5.45	4.86	.0082
Within Groups	382	428.54	1.12		
TOTAL	384	439.45			

Scheffé Contrasts– Significant differences between Group 3 (education) and Groups 1 and 2 (administration and clinical)

Responses to Open-ended Questions

Respondents were asked to provide additional written comments on the need for political involvement and political activity for Alberta Registered Nurses. Fifty-six individuals indicated that increased political action should be directed at revising the health care system to result in a greater contribution by registered nurses to the health of Albertans. Many more nurses from education and administration identified the need for this type of change than from clinical areas. One nursing administrator indicated that "nurses need to become politically active and mold a strong unified voice to promote the health of all Canadians regardless of socioeconomic status". Another stated, "We have the opportunity to become involved, to have significant influence in many aspects of health care such as community health and public education". An educator commented: "Many of the health care problems we see are at least in part driven by societal and community factors—nurses need to be more involved in health care policy development. The future of our profession and the quality of health care for future generations will depend upon nurses' ability to 'wisely' shape the system".

Many nurses indicated that urgent action was needed due to the current political and economic influences on the nursing profession and the health care industry in Alberta.

A nurse involved in clinical practice complained about the effects of cutbacks on other areas of health care:

> I work for Home Care and find that we are getting early hospital discharges, increased client need especially in the senior age group and patients unable to gain admission to LTC facilities due to fewer beds.

She also expressed concerns about the lack of adequate funding for home care programs:

> Our funding has not increased and our nursing visits have been decreased. This means double client work-load for less staff and increased demands from the handicapped, disabled, brain-injured, and early post-op discharges returning to their homes. The public is told that Home Care is the way of the future and that there will be less costs associated with hospitals. They are not told that we need increased funds for our increased work load.

Administrators also expressed the need for imperative action. One individual exhorted: "The time for political activity for nursing is now. Health care reform is inevitable and being actively involved is the only way to ensure a voice." Another stated:

> Nurses MUST be politically aware and politically involved if they expect to be heard and recognized as a profession with considerable knowledge about

> affairs outside patient care. As we are currently seeing, what happens in politics does affect our jobs, patient care, etc. I think we as nurses could have done a lot to form the type of health care the economy is now forcing us to consider. Nurses too often operate in a crisis management mode and do not take the time to really look at what could happen, and changes that could or should be made and lead people into new ways.

Respondents to this survey had strong feelings about the organizations which represent nursing in the province of Alberta. Thirty-six respondents made comments critical of the AARN's response to government actions, while there were 22 comments supportive of AARN actions. A nurse in clinical practice stated:

> The AARN has a strong potential for political action. However, they do not use it in ways that could benefit nurses, because I believe they <u>often</u> do not represent nurses' views. They are out of touch with what is really happening in nursing and how grass roots nurses at the bedside feel and think.

Another clinician stated:

> I am mystified by the <u>lack</u> of any noticeable (i.e. media, info-drives) lobbying by the AARN in these times of health care cuts and the general direction of health care. A higher profile for nurses is crucial!

Several respondents expressed similar sentiments to the following three from clinicians, "Unfortunately many nurses do not

see the AARN as being representative of a common voice for nurses in Alberta" and "I don't see the AARN as a very vocal or effective organization" and "Very few nurses are interested in 'Direct Access' or feel it has anything to do with them. We are losing our jobs and the professional organization is spending a lot of time and money on something which will benefit very few nurses." A clinician stated, "The majority of nurses are not concerned about health promotion. They are worried about having a job, keeping their homes, and feeding their families."

Other nurses felt that they were well represented by the AARN. An educator stated, "In politics today, every group seems to need a lobby wing and the AARN has done that well." A clinician indicated that "Students should be encouraged to participate in the AARN and learn early about the importance of this organization." An administrator stated that, "RN's need to be aware of the impact of political decisions that effect nursing such as funding. Our professional organization has addressed such issues." An administrator stated, "I feel the AARN has represented us extremely well in the political arena: great leadership has been shown by Mary Pat Skene."

Nine respondents were critical of the actions of nursing unions, there were ten remarks supportive of union activities. An administrator indicated, "I must say that union activity is a power mongering strategy to better the ends of nurses (through higher wages etc.). This activity does not result in improved quality of care." Another administrator stated, "I would leave nursing before I joined a nurses' union. The union stance on withdrawing services cannot be

justified." Another negative remark from an administrator was, "I would rather see the AARN do the political action lobbying for nurses than the trade union UNA. It gives an unacceptable public image. No matter how hard UNA tries to convey that they are interested in patient safety issues, it always comes down to pay packages first and patient issues second.

Administrators and educators were more informed about current AARN initiatives and activities such as Direct Access. These two groups were less negative about the AARN and appeared to be more conversant with the AARN's contribution to professional goals. Generally members of these groups saw the AARN as increasing the profile of nurses, though they frequently indicated that the voice of the AARN should be much louder.

A strong theme was the dissatisfaction felt by many nurses with the perceived adversarial stance between the AARN and nursing unions. Twelve nurses specifically commented that the current threats to nursing and health care were such that a united approach was urgently needed and that confrontations between organizations was detrimental to all. A clinician stated:

> Nurses need to present themselves as a cohesive group interested in the political nature of this province if we are to be the advocates of change/quality care. I don't believe we should endorse one party, but we should be a recognizable group at political forums, asking questions and bring data from nursing research to the attention of all parties.

An educator agreed:

> To make a political difference, unions and the AARN must be united in presenting views to politicians. I believe unions and the AARN have separate agendas and so nurses do not have a loud and united voice in Edmonton.

Another educator stated:

> Both the AARN and UNA need to make politicians aware of the number of nurses in the province and their roles in health care. Supporting each other is extremely important.

An administrator also expressed concerns about unity:

> Government decisions are highly influenced by voting power. Therefore, professional associations with large memberships should hold substantial sway with government provided they are perceived to be well informed, organized, credible, and supported by their members.

Nurses also stated that nursing organizations should inform their members about the issues, but that a non-partisan approach to political concerns was necessary.

Several reasons emerged for what was perceived as a lack of political activity relative to the nursing profession among registered nurses (Table 4.41). Many comments were directed at a perceived lack of education or preparation for the political role. Nurses commented on the need for nursing courses to encompass political

Table 4.41

Reasons for Lack of Political Activity by Practice Category

REASON	ADMINISTRATION	CLINICAL	EDUCATION	TOTAL
LACK OF PREPARATION	9	4	9	22
TIME CONSTRAINTS	6	4	5	15
SOCIALIZATION	6	3	3	12
APATHY	5	3	0	8

action. "We have very little education in this area and few role models. I have only in the last year become more aware of nurses like Ginette Rodger, who gave us some excellent information on political lobbying. We need more of this, both at the undergraduate and graduate levels." A clinician stated:

> Nurses need to understand the correlation between politics and nursing early in their careers. A course on nursing and politics should be developed for first year nurses. Students should be encouraged to participate in committees in the AARN and learn early about the importance of this organization.

An administrator indicated that nursing students should have the educational preparation "to identify concerns and to mobilize nursing as a group to influence government action and the formation of health policy". Educators agreed with these statements, "Nurses need more knowledge about the political process. This should start in the basic education programs so nurses recognize that being politically involved is how change is made and nursing's voice is heard", and "Nurses need to be educated about their potential. They need to speak up and protect our health care system. Too many nurses are unaware of what is happening to health care in Canada and Alberta."

Nurses are busy people. As most nurses are women, they are often having to care for children, manage a home, and work full time. When combined with the rigours of rotating shifts and furthering educational preparation, it is not surprising that several individuals expressed interest in, but lack of time for political participation. An

administrator described a common problem, "I am doing my best to become politically active in my own way. My children need my time and attention, and I am the sole wage earner in my family. There is only so much time and energy to go around." An educator agreed:

> I strongly support political involvement by nurses, but I have four teenagers and a spouse to care for in addition to working full time, my community volunteer work and my studies. I find it difficult to find much more time just now for involvement, but this is a goal when other obligations decrease.

A clinician echoed the above remarks and indicated the overwhelming nature of the many demands on nurses who are also students and mothers,

> Political activity or involvement is very difficult to achieve at this time. I work shift in a critical care area where the work environment stressors are always increasing—increased patient acuity, and fewer nurses and support services due to cutbacks. We are always being asked to "do more with less." There is also constant need to expand my knowledge base, clinically and professionally—a baccalaureate degree is no longer enough. The reality in our society is that the woman/wife/mother is the primary caregiver and custodian of the family. Political lobby efforts are long-term, time consuming efforts and just not realistic for me right now.

The remarks above lead to another thread in the written comments. Several nurses attributed the lack of political activity to the wider issues of the socialization of women in our society. Nurses do not speak up and demand recognition and a voice in the management of health care and the formation of health policy because they are women, and as such do not assume these assertive behaviors readily. A clinician stated, "Nurses always seem to be subservient. Unfortunately it's a man's world and until nurses show they are intelligent and a force to be reckoned with we will always be ignored." An administrator declared,

> "I believe that as nursing is a predominantly female profession it has great difficulty stirring members to action because they perceive political action to be incompatible with caring and compassion. Nurses avoid using the male-dominated political forum for effecting change believing that their critical contribution would be recognized. This has obviously not happened. If we want to be equal participants, we must speak up. If not, we will become victims of the health care system.

An educator agreed with these sentiments,

> Political action by nurses is related to larger feminist issues. Nursing, like the care and concern for children and the elderly, is considered to be women's work, which is devalued in this society. How many times have you heard, 'How come you're not a doctor?' Being a good nurse is not simple or

> mindless, it's too bad the public does not understand this.

Another commented,

> Political action by women is, I believe, strongly linked to feminism. Nurses/women must develop a sense of confidence in our views and our contributions. We must find the self-esteem to speak in our own voice. We need to support each other, which will sustain us as we step into the public field. We must then summon the courage to champion an agenda that has been largely ignored. There is much to do before all this is a reality for nurses.

While several respondents indicated the devaluing by society of women's work as a factor in lack of participation, a few respondents cited apathy or lack of interest as a the cause of reduced political participation by nurses. An administrator stated, "It is very difficult to get many nurses interested in their professional bodies, let alone the political stands these organizations may take."

A clinician complained,

> One has to look no further than noting the number of ballots returned in electing AARN representatives. Ballots are mailed out and can be returned in a postage paid envelope. All they must do is read about the people running, mark the ballot, and mail it. The number of ballots returned is usually less than 50%. Unfortunately, the same

> nurses who don't vote will feel free to complain about the AARN. They ignore the opportunity to actively participate in decision making at a provincial level.

Many nurses were cynical about politicians and the political process in general, "Personally I have little faith as far as politicians go. It seems the honest ones cannot survive without becoming greedy and dishonest." A clinician stated, "People vote for the party. You could run a horse or cow in some parts of this province and it would be elected. This government will run our health care into the ground while we watch it happen." An educator complained, "I am very angry at the politicians' irresponsibility toward people, especially the poor, in this province. These are the people most affected by government policies. How can a poorly nourished and housed person have good health? How can their children learn?

As a final point of interest, a nurse prominent in the field of politics was not gently treated by several of her colleagues. A representative remark was made by an administrator, "We need more nurses involved in our political process to influence the government's agenda. Hopefully we won't have another nurse–politician like Dianne Mirosh with her attitudes toward women and minorities." An educator said, "I believe there are many nurses who could represent me very well. Unfortunately, the one in the Alberta legislature right now is a source of great embarrassment for all nurses." An administrator stated, "There is an example of a nurse who has achieved political success, but she is a disaster in health care reform—the MLA from Calgary–Glenmore." Another educator stated,

"Nurses should be involved more at all levels, if only to illustrate that not all nurses are like Dianne Mirosh."

Discussion of Research Questions

This study was undertaken in part to gain an understanding of the political participation of Alberta registered nurses and of the factors which may influence participation. The high response rate found in this study and the number of additional written comments on the questionnaire would suggest that this topic is of great interest to nurses in this province. The results obtained from this study provide some basis for of the answers to the research questions posed in Chapter 1.

Question One

What level of political involvement and activity is characteristic of Alberta registered nurses?

This sample of registered nurses demonstrated high levels of political involvement as measured by the Campbell, Converse, Miller, and Stokes Political Involvement Scale. Mean score on this scale was 9.83 of a possible maximum score of 11. Standard deviation was 1.64. Administration and education groups had similar scores, the clinical group score was significantly different. Three aspects of political involvement are measured by this scale, "Concern over Election Outcome," "Interest is the Campaign," and "Intensity of Partisan Preference." When the item measuring concern over election outcome was examined in isolation, it yielded scores that were

identical for administration and education groups and significantly different for the clinical group. The item representing interest in the campaign produced significantly different scores for all three groups. Intensity of partisan preference produced positive responses in all three groups though there were no significant differences between groups. It appears based on the data from this study that the administration and education groups, containing older, more experienced, and better educated nurses than those in the clinical group, were interested in election results and the general course of the campaign. Younger, less experienced, and less well educated clinical nurses were less interested in both campaigns and elections. All three groups appeared to have favorite parties or candidates, and cared about who won the election.

On all items of the Political Involvement Scale, Alberta registered nurses scored higher than the sample of New York state nurses studied by Hofmann (1989). Hofmann reported total sample mean scores of 3.68 for "Concern over Election Outcome", 2.33 for "Interest in the Campaign", and 2.59 for "Intensity of Partisan Preference". The mean scores for the total sample in this study were 4.48, 2.57, and 2.76 respectively.

This sample of Alberta registered nurses was also politically active as measured by a scale based on the work of Milbrath and Goel. Extremely high frequencies of voting in all public elections were demonstrated. Those activities indicative of Party and Campaign Activism were also associated with high frequencies of participation. As an example, 84% of the sample had initiated political discussions, 47% has attended political meetings or rallies, 35% had contributed

money to a campaign, and 19% had contributed time to a political party. There were significant differences between groups in membership in a political party, though when asked about active membership, the significance disappeared. Activities indicative of Particularized Contacting or Communicating also had high frequencies of participation by members of this sample. Sixty-three percent had contacted public officials or political leaders, and 95.5% of the sample indicated they purposely sought out political information in the newspapers, and on the radio and television. There were significant differences between groups in contacting officials. Twenty percent of the sample had engaged in some type of ad hoc activities, linked in this study to Community Activism. Participation in a nurses' strike was linked to Protestor activities, and 156 respondents indicated participation in this type of activity. While there were significant differences between groups on this item, the phrase "participation in a nurses' strike" was likely not sufficiently clear to discriminate between individuals who had worked during the strike as nurses in administration and employees at non-UNA hospitals would have done, and those who had been on a picket line.

This sample of Alberta nurses also compared very favourably to samples of registered nurses in different areas of the United States (Moore and Oakley, 1983; Hayes, 1988; and Hofmann, 1989) on various measures of political activity. A comparison of the behaviours characteristic of Party/Campaign Activists indicates that in nearly all aspects Alberta nurses are more active than these groups (Table 4.42). Rothacker (1985) reported on a sample of the Tennessee Nurses' Association in which 12.7% of subjects had

Table 4.42

Comparison by Percentage of Political Activities Characteristic of Party/Campaign Activists among Registered Nurses in Alberta, Michigan, Massachusetts, and New York

ACTIVITY	ALBERTA n=382	MICHIGAN* n=153	MASS.** n=98	NEW YORK*** n=595
Initiates political discussions	84.3		39	63.10
Attends political meetings/rallies	47.1		8	28.5
Attempts to influence another's voting	44.8		16	35.15
Campaign button/sticker on the car	35.1	56.8	13	24.95
Contributes money to a campaign	35.1	48.6	18	34
Membership in a political party	30.9			
Active membership in a political party	20.9		6	12.55
Contributes time to a political party	18.8	33.8	7	14.45
Attends political caucus/strategy meetings	10.2		4	9.5
Solicits funds for a political party	3.9		1	3.05
Has held public or party office	1.6		1	2.2
Candidate for public political office	1.0		2	1.85

*Moore and Oakley (1983)

**Hayes (1988)

***Hofmann (1989)

contributed time to a political campaign, 22.9% had contributed money, and 49% had attended a political meeting or rally. Similar conclusions may be drawn regarding the behaviors associated with Communicators/Particularized Contactors. Hofmann reported 76.25 of the sample of New York state nurses deliberately exposing themselves to political stimuli, Hayes reported this behavior in 86% of the Massachusetts sample. Moore and Oakley described 65.3% of the Michigan sample having contacted public officials, Rothacker reported 37.6%, Hayes reported 10%, and in the sample of New York nurses studied by Hofmann, 56.8% of the sample had contacted a public official.

Question Two

What do registered nurses from three different practice settings perceive as the appropriateness of the nursing role in politics?

The various aspects of the appropriateness of nurses' roles in politics were measured by a scale developed by the National League for Nursing and adapted by later researchers. Overall scores were obtained, then individual item scores were calculated. The overall response for the scale was positive, a score of 22.84 of a possible 30 was obtained. The standard deviation was 3.80. The clinical group was significantly different than either the administration or education groups. The items, "Political participation is very important for nurses," "Participation in politics is compatible with the nursing role," "Professional organization have a role in making nurses politically effective," and "Nurses should be encouraged to run for political office" all received positive responses in descending order

from most to least positive. There were significant differences between groups on all of these items. In all cases the clinical groups differed significantly from the administration and education groups. Responses to the items, "Nurses lack political knowledge," and "Family responsibilities make political participation by nurses difficult" were much less positive and did not differ significantly between groups. Based on these results it may be inferred that this sample of nurses believes the political role to be appropriate for nurses. The administration and education groups were much more positive in their endorsation of the role than the clinical group. Again this may be attributed to group differences in age, experience and education.

The wording of individual items in the Moore and Oakley study differs slightly from that used in this study, however it is clear that Alberta nurses feel much more positively than the sample of Michigan nurses about the appropriateness of the political role for nurses (Table 4.43). Similar comparisons cannot be made with the data obtained by Hayes as she did not report mean values for individual items.

The purpose of this study was to determine the following: do the political activity, political involvement, and perceptions of the appropriateness of the political role for nurses will vary significantly between three groups of Alberta registered nurses involved in clinical, administration, and education practice areas, and what if any influence has age, years of experience in nursing, and education on the variances between groups. It was determined in that those nurses engaged in clinical practice differed significantly from nurses

Table 4.43

Comparison of Mean Scores of Selected Items on Appropriateness of Nurses' Role in Politics Scale between Alberta and Michigan Registered Nurses

ITEM	ALBERTA	MICHIGAN*
Political participation is very important for nurses.	4.20	3.39
Participation in politics is compatible with the nursing role.	4.12	3.71
Professional organizations have a role in making nurses politically effective.	4.09	3.26
Nurses should be encouraged to run for political office.	4.06	3.0
OVERALL MEAN SCORES	4.12	3.34

*Moore and Oakley (1983)

in administration and education. Nurses in education and administration had very similar responses to the scales used in this study. It is very important to note that when age, education, and years of experience in nursing were held constant, there were no significant differences between the three groups of nurses, F= .291 for the Involvement scale and F= .623 for the Role scale. It therefore can be argued that it is 'nursing' itself that produces high levels of political activity, political involvement, and the perceptions that the political role is appropriate for nurses.

Four variables, age, years of experience, university education, active AARN membership, and active union membership were entered into a multiple regression equation to determine if any relationship existed between the variables and the Political Involvement Scale, the Political Activity Scale, and the Appropriateness on Nurses' Role in Politics Scale. The multiple correlations for the various scales were as follows: Political Involvement = 0.06, Political Activity = 0.07, and Appropriateness of Nurses' Roles in Politics = 0.06. Stated in another way, 5.7% of the variability in Political Involvement Scores, 7% of the variability in Political Activity Scores, and 6.5% of the variability in the Appropriateness of Nurses' Roles in Politics Scale results from the effects of these variables. These variables had little effect on the scores obtained relating to political involvement, political activity, or perceptions of the appropriateness of nurses' roles in politics. Because of the amount of variability resulting from the effect of these variables, there was little or no predictive value. Gender was not found to be a significant independent variable when entered into

an analysis of variance equation with the three scales. There was no significant difference between female and male members of the sample. However there were probably too few men in the sample to draw conclusions about that result.

CHAPTER FIVE
CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The purpose of this study was to determine the political activity and involvement and perceptions of the appropriateness of the political role for registered nurses in Alberta and to determine the influence of selected variables on political participation. The sample was chosen from all registered nurses involved in administration, education, or clinical practice within the province. The most important finding of this study is the very high levels of political activity, political involvement, and the positive perceptions of the appropriateness of the political role for nurses. On three different scales this sample of Alberta nurses had higher levels than any other group of nurses reported in the literature.

While scores indicated positive involvement and high levels of activity, nurses engaged in clinical practice did score less positively on all three scales. Administration and education groups were very similar on all scales. Age, education, and years of experience had a small influence on the scores obtained on the three scales. However when age, education, and experience were held constant there were no significant differences between the three groups, indicating that the high levels of political activity and involvement are the result of the nursing role itself rather than the influence of the practice category. Insofar as practice category does indicate age, education, and years of experience it was a significant variable in the scores produced in the various scales. In all cases nurses in clinical practice

in this sample were less politically involved, less politically active, and had less positive perceptions of the appropriateness of nurses' roles in politics, though it is important to note that the clinical group did have positive scores on all three scales.

Limitations of the Study

This sample is representative of the practice groups from which it was drawn. Nurses involved in clinical practice far outnumber nurses in other practice categories, and therefore, their political activity, involvement, and perceptions of the political role are under–represented in a study which examined three equal groups. The degree of political activity and involvement measured in this study may have been altered by the effects of history due to the proximity of data collection to the 1993 provincial and federal elections and the general heightened political interest at that time. If this did occur it is likely that the effect would have been distributed randomly across all three groups.

Implications of this Study

The findings of this study have implications for Alberta politicians, nursing organizations, and nursing educators Alberta nurses have generally high levels of political activity and involvement and positive perceptions of the value of the political role for nurses. They vote in extremely high numbers and make efforts to be well-informed on political matters. However, as with

any group, nurses are first individual women and men, and secondly nurses. There is no reason to expect that nurses would vote as a block for any individual or party any more than any other occupational group in Canada. It is obvious that a nurse working in a small hospital in rural Alberta may feel very differently about the need for reduced government health care expenditures than another nurse working in acute care in a large hospital in Edmonton or Calgary.

Despite this it seemed clear from many unsolicited comments in this study that Alberta registered nurses are concerned with the maintenance and preservation of quality of health care in Alberta and Canada and that they strongly support the principles of the Canada Health Act. It may well be that threats to medicare become the impetus for collective political action for the 24,000 registered nurses in Alberta. These nurses vote in extremely high numbers in all elections and political leaders would be wise to listen and respond to this politically aware, active, and well-informed group. Such groups would be more likely to have their preferences pursued.

With strong leadership, nurses may have the opportunity to use politics to achieve their professional goals, however it is most unfortunate that funding cutbacks have decimated the ranks of nurses in all levels of administration. As mentioned previously, this group is among the best educated, most experienced, politically active and involved in Alberta nursing and their contribution and leadership in these times of rapid and radical change is missed. Who would be better able to speak with authority on the impact of health care cutbacks on overall patient care in the province?

Many nurses look to professional organizations for leadership and concerns were expressed for the political roles taken by the organizations representing professional nurses in Alberta. While it is impossible to expect an organization to meet the expectations of thousands of members, it is clear that nurses expect their professional organizations to assume an advocacy role for both quality patient care and the membership, especially in these times of funding cutbacks and layoffs. Strong leadership and role models are critical factors here. Nurses want a strong, clear voice to respond to government initiatives and to speak on their behalf. Nurses expect their leaders to reflect the concerns of nursing as a group and to exercise vigilance toward those important aspects of our health care system such as the Canada Health Act. Many were distressed by any type of adversarial relationship between the Alberta Association of Registered Nurses and the nursing unions.

Only 16% of the respondents to this study had received any type of political education as part of basic education, and many comments indicated that nurses felt unprepared for the political role. Whether additional elective courses may realistically be added to already crowded nursing curricula is questionable, but alternate strategies could be employed to raise the general level of knowledge and skills of students enrolled in educational programs. Two examples are letter writing assignments where students may acquire skill in writing letters to public officials and/or political leaders, and classroom discussions devoted to political trends and issues having impact on nursing and health care.

Recommendations for Study

An understanding of the political participation of registered nurses in Alberta has been gained in this study, there are, however, many new questions which arise from this work. This study did not control for the geographical location of the subjects. The rural/urban cleavage in attitudes, behavior, and voting is an important one in Alberta, and is especially relevant at this time. The current government came to power on the strength of the rural vote and health care cutbacks have affected urban hospitals much more than rural. Future studies need to be conducted to examine the influence of this variable. As this study was limited to three practice groups, further study is necessary to determine if the findings are applicable to nurses in other settings or to Canadian nurses in general. Comparison studies in other jurisdictions within Canada would give a better picture of this important aspect of the professional behavior of nurses. Comparisons with other population groups including other health professionals should be conducted. It would also be most worthwhile to study participation in areas where there is close cooperation between professional organizations and unions.

Summary

Three hundred and eighty-seven registered nurses from three categories of practice in Alberta responded to this survey of political activity, involvement, and perceptions of the appropriateness on nurses' political roles. Nurses in clinical practice were consistently less positive toward political participation than educators or administrators. Other variables were found to have minimal influence. When age, education, and years of experience were held constant differences between groups became insignificant, indicating that the nursing role itself produces high levels of political participation. Respondents provided additional unsolicited written comments indicating they expected nursing leaders to speak out with a strong, united voice about the issues of concern to Alberta nurses. Nurses represent an affluent, well-informed, and well-educated group of Albertans. Coupled with the high levels of involvement, activity, and positive attitudes toward political activism apparent in this study it may should be understood that nurses are potentially a powerful voting block and political lobby group in society given a sufficiently mobilizing issue.

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APPENDIX A

MEDIA RELEASE

HEALTH CARE CUTS

MEDIA CONFERENCE

Fear and apprehension have escalated following this week's government announcements of additional cuts to health care in Alberta.

Nurses and other health care providers are increasingly concerned about their declining ability to provide safe patient care.

For the first time ever in Alberta, three nurses' organizations, representing over 25,000 nurses, have joined voices to respond to these serious health care cuts.

The Alberta Association of Registered Nurses, the Staff Nurses Associations of Alberta and the United Nurses of Alberta agree that fundamental change is needed in the health care system, but strongly oppose restructuring the system around a fiscal agenda.

Health reform based on fiscal principles is not reform but a reduction in services.

Continuous down-sizing of the hospital and health care industry makes it impossible for nurses to provide the levels of care they are capable of giving.

Reducing the number of beds and services without increasing community-based health services is not the prescription for better health for Albertans.

The Alberta Association of Registered Nurses which is the professional and licensing body for registered nurses, and the two nurses' unions, the Staff Nurses Associations of Alberta and the United Nurses of Alberta invite you to a **media conference**:

DATE: Friday, July 16, 1993

TIME: 11:00 AM

PLACE: Mayfield Inn,
Meeting Room #4,
16615 109 Avenue,
Edmonton, Alberta

For further information please call:

Mary Pat Skene, President AARN	450-7231
Linda Sloan, President SNAA	439-3788
Heather Smith, President UNA	425-1025

MEDIA CONFERENCE

ALBERTA ASSOCIATION OF REGISTERED NURSES
STAFF NURSES ASSOCIATIONS OF ALBERTA
UNITED NURSES OF ALBERTA
July 16, 1993

PRESENTATION BY HEATHER SMITH, UNA PRESIDENT

IS THERE A FUNDING CRISIS?

Much has been said of late about a crisis in our health care system. Politicians and bureaucrats have spread the message that we can no longer afford the kind of health care system that has become a trademark of Canadian citizenship. A common assumption is that health care costs are soaring uncontrollably.

BUT IS THERE REALLY A FUNDING CRISIS?

In 1970-71 health care costs in Canada were 13.4% of government expenditures. Twenty years later, in 1990-91, they were exactly the same--13.4% of government expenditures. In real per-capita amounts, all consolidated health care costs in Canada (federal and provincial) have increased by only 4.4% during the past 25 years.

It is only 21 years since Alberta entered into the national medicare scheme. Although it took almost four decades to build a national health system, it is on the precipice of being dismantled.

The Canadian system "costs" 9.5% of the gross domestic product, while the United States spends 12.2% of their gross domestic product on health care. Close to 1/3 of the American population has either no coverage or inadequate coverage. Despite this cost difference, the Canadian system is under extreme pressure to cut our costs. Both Federal and Provincial governments want to shift the burden of responsibility and accountability from government to individual Canadians, individual Albertans.

Politicians alarmingly proclaim that Alberta spends 30% of the Provincial budget on Health Care. No one asks whether this is too much or too little. The subliminal message is that it is a horrendous and inappropriate amount. But is it too much? Is our health and well-being not worth 30% or our provincial income?

There are a number of reasons that Health accounts for 30% of the Provincial budget. When Alberta had financial resources in abundance, there was little concern that Alberta expended vast amounts on hospital construction, expansion and renovation. The toys of technology were purchased with little regard for cost or need.

But the days of abundance have passed. The value of oil has dropped. We are no longer rich. Alberta must decide on whether it wants to fund toys like Novatel or invest in the health of Albertans.

Unfortunately some of the cost control is beyond Alberta's influence - it rests with the Federal government. Whereas the Federal Government once shared

equally the cost of health care, the sharing has been eroded to the point that by the year 2000 Alberta will receive virtually no Federal dollars for health care or advanced education. Ottawa politicians seem to have chosen to fund helicopters over health care.

Other political decisions have increased stress on the system.

Although hospitals and other facilities receive a refund for a portion of GST costs, they are not totally exempt. Just to receive the exemption, resources (people and computers) must be dedicated to ensure exact accounting.

In 1987 and again in February of 1993, Federal legislation extended and enhanced patent drug protection. As a result drug costs have climbed at a rate far in excess of the cost of living. Many questions surround the utilization of drugs in Canada. Consider that 20% of hospital admissions of the elderly are drug-related.

Information is a powerful tool in our "high tech" society. There is increasing demand for immediate and accurate accounting and information. This has resulted in substantial investments in computer equipment and people.

There is a pressure to compete in a global economy - many consider that someone, somewhere else has the magic solution to increase productivity and trim costs. So a variety of guru's - "specialists" and "consultants" have been enlisted at considerable cost in an attempt to find that elusive perfect answer.

We have increased costs because we refuse to move from an institutional and illness-based health care system to a more holistic and community-based model.

There are several reasons that health care costs have continued to rise in Alberta. The escalating cost of drugs and supplies; the purchase of new technology; the privatization of laboratory services; and physician utilization have significantly impacted on overall costs.

But we want to dispel a myth. The myth is that health care costs are out of control because certain workers---nurses and their unions---have forced labour costs to escalate.

While there is no dispute that labour is a major part of the health care costs, labour encompasses a lot of categories. Labour includes nurses, instructors, salaried physicians, physiotherapists, pharmacists, radiology technicians, porters, housekeepers, laundry workers, chief executive officers, directors, payroll clerks, word processors, consultants and a host of others. Nurses are only one group of employees.

In Alberta, nursing costs have not continued to climb as a percentage of operating costs. In the face of rising salaries and benefits, nursing costs have remained flat in the last decade.

There is no crisis in health care. The crisis lies in the hearts of governments who allocate money on the basis of lobbying and political

influence. We condemn the skewed priorities of politicians who cut deficits by reducing our access to health care.

We are not calling for uncontrollable increases in health care dollars. As advocates for our patients, our families and ourselves, we are calling for the wise investment of Alberta tax dollars in a health care system which promotes the well being of Alberta citizens and is firmly built on the principles of the Canada Health Act.

UNA SNAA AARN PRESS CONFERENCE

PATIENT PROVIDER PERSPECTIVES

PREPARED BY LINDA SLOAN

ALBERTANS DO NOT PLAN TO BECOME ILL OR BE INJURED. IN GENERAL TERMS MANY OF US DO NOT THINK ABOUT ILLNESS OR THE IMPACT OF DISEASE UNLESS WE OR A LOVED ONE ARE FORCED TO EXPERIENCE IT.

IT MAY APPEAR TO THE GENERAL PUBLIC THAT $191 MILLION IS MERELY FAT THAT MUST BE TRIMMED FROM A BALLOONING SYSTEM. AS HEATHER HAS INDICATED THAT PERCEPTION MAY WELL BE GOVERNMENT FED. IN REALITY, AS MARY PAT HAS ILLUSTRATED RECURRENT REDUCTIONS HAVE OCCURRED BECAUSE OF THE LACK OF A SYSTEMATIC PLAN AND THE LACK OF FUNDAMENTAL CHANGE TO THE WAY HEALTHCARE IS DELIVERED.

IT MUST BE RECOGNIZED THAT THE PRODUCT OF THE HEALTHCARE INDUSTRY AFFECTS PEOPLES LIVES. NURSES ABILITY TO PROVIDE TIMELY ASSESSMENT, INTERVENTION AND TREATMENT TO PATIENTS IS PIVOTAL TO THE QUALITY OF THEIR RECOVERY AND THEIR FUTURE LIVES.

IT IS EMOTIONALLY DRAINING AND PROFESSIONALLY DEMEANING FOR NURSES TO CONTINUALLY PROVIDE CARE TO PATIENTS THAT IS BARELY ADEQUATE AND AT TIMES UNSAFE. MANY NURSES FEAR THAT THEY RUN THE RISK ON A DAILY BASIS OF HAVING THEIR LICENCE PLACED IN JEOPARDY BECAUSE OF THE FISCAL AND ADMINISTRATIVE RESTRICTIONS THE SYSTEM IMPOSES.

HOW DOES THIS MAKE PATIENTS FEEL? FOR ANY OF YOU WHO HAVE EXPERIENCED ILLNESS YOU WILL KNOW THAT THE ABILITY TO TALK ABOUT YOUR FEARS, TO UNDERSTAND THE PROCEDURE OR TESTS YOU WILL BE HAVING, TO HOLD A COMFORTING HAND, AND HAVE A SENSE OF TRUST IN YOUR PROVIDERS AND THEIR EXPERTISE IS AN INTEGRAL PART OF BECOMING WELL.

IF PATIENTS DID NOT REQUIRE THIS TYPE OF INTERVENTION, THEN PERHAPS AN ASSEMBLY LINE APPROACH TO HEALTHCARE WOULD BE ACCEPTABLE. NURSES HOWEVER DO NOT BELIEVE THAT IS WHAT ALBERTANS WANT OR NEED.

AS LEADERS IN THE PROFESSION OF NURSING AND IN THE INDUSTRY OF HEALTHCARE WE FEEL AN ALARM MUST TO RAISED TO THE PROCESS AND IMPACTS OF RECENT HEALTHCARE REFORMS. WE BELIEVE STRONGLY THAT THERE ARE OTHER WAYS AND MEANS OF MAKING HEALTHCARE DELIVERY MORE EFFICIENT WITHOUT SERIOUSLY RISKING PATIENTS LIVES.

OPENING STATEMENT - MARY PAT SKENE

PRESS CONFERENCE - AARN/SNAA/UNA
JULY 16, 1993

Nurses are concerned about the apparent lack of a systematic plan to address the fundamental restructuring of the healthcare system. We believe it is time to adopt a different approach to healthcare in Alberta. The recent announcement of drastic cuts does not make provision for fundamental change. Response will be based on the survival of the facility or service and not in meeting the healthcare needs of Albertans.

We believe that healthcare services should be available in every community and that registered nurses should play a greater role in delivery of these services. The immediate reaction to these recent cuts is to decrease the services of registered nurses. There is no move to shift resources to the community and it is our position that as the services in the acute care environments decrease, services provided in the community must increase.

We support and have continuously supported that community services must be fully established BEFORE changes are made to the services provided by hospitals and other healthcare institutions. Today this is not happening. In fact cuts are being made in the community as well as in the institutional environment.

The role of the registered nurse in the community is significant now and as this role increases, there would be a positive impact on the health status of the community. It would result in better home care and palliative care. Mental health services, ambulatory care and health promotion would increase. And we will be able to care for our elderly in a more dignified and personal

In restructuring the healthcare system, there must be a plan - a plan that ensures the five principles of the Canada Health Act. These principles are accessibility, universality, portability, comprehensiveness, and public administration. Broad financial cuts, without accountability for health services represents a serious threat to our healthcare system.

Patient and client need must be the focus as we restructure the system. Technology and technology assessment are key to this change, but they must not be the drivers. The driver must always be patient or client need.

The current funding focus is on hospitals and physicians and therefore individuals seeking care are directed to the most expensive resources for most healthcare needs. Nursing's focus on health promotion, prevention of disease and the total well-being of the patient or client would significantly reduce the demand on expensive health care resources while improving the quality of life of Albertans. Cutting budgets is a short term solution but our healthcare system and the people it serves deserve a long term plan.

In summary, we support:

1. fundamental restructuring of the healthcare system,
2. a broader range of community-based services,
3. an increased role for nurses in keeping with the degree of accountability we are clinically prepared to assume, and
4. a system that is driven by the needs of the patient or client and not by fiscal principles.

APPENDIX B

STAFF NURSES ASSOCIATIONS OF ALBERTA
STRATHCONA CENTRE
303 10333 - 81 AVENUE
EDMONTON ALBERTA T6E 1X2
TELEPHONE (403) 439-3788

August 25, 1993

Honourable Shirley McClellan
Minister of Health
127 Legislature Building
Edmonton, AB
T5K 2B6

Dear Honourable McClellan,

Please find attached a proposal developed jointly by the Alberta Association of Registered Nurses, the Staff Nurses Associations of Alberta and the United Nurses of Alberta representatives addressing workforce adjustment in nursing for the province of Alberta.

In light of your support for the expansion of community based services and cost effective alternatives in health service delivery, we believe this proposal will be of interest to you.

We would invite your comments and perspective on this proposal.

Sincerely,

Mary Pat Skene, President
Alberta Association of Registered Nurses

Linda Sloan, President
Staff Nurses Associations of Alberta

Heather Smith, President
United Nurses of Alberta

cc: Premier Ralph Klein
Honourable Diane Mirosh
Honourable Stockwell Day
Dr. Norm Wagner

PROPOSAL FOR WORKFORCE ADJUSTMENT IN NURSING

The majority of Albertans will likely, at least once in their lifetime, require the care of a registered nurse. The need for nursing care might arise from normal lifespan needs (eg. birth or death), from care needs necessitated by illness or from physician practice, which often involves the application of medical technology in an acute care setting. In these latter cases, nursing care must be available to continue to permit doctors to practice high technology care, e.g. transplant surgeries, cardiac therapies, etc. The more complex the health care problem, the better educated the nurse must be to foster a satisfactory health care outcome. Even with outstanding medical care, patients lacking appropriate nursing care die, or experience an unsatisfactory health care outcome. Thus, the care of registered nurses is vital to positive and effective health outcomes.

Hospitals were originally built in Canada to provide nursing care to patients. It was only later that the role of the hospitals shifted to become a workshop in which physicians could employ sophisticated medical technology for diagnosis and treatment, the most of which required the support of nurses to effect desired outcomes.

This shift in hospital mandate has served to drive up the costs of hospital and health care to a point where it is no longer affordable or cost effective. In an attempt to reduce costs to deal with provincial government cuts and the reduction of federal funding for health care, hospital beds have been closed, nurses have been released and patients are being sent home "quicker and sicker." While these early discharges lead to some cost savings for hospitals, a significant number of patients still require nursing care beyond that which family, friends, untrained or even trained aides can deliver.

Unless political decisions are taken to significantly reduce the utilization of high technology or to refuse to provide health care to those encountering normal lifespan events or illnesses, the need for qualified expert nurses will continue, only altered by the venue in which nursing care will be provided. As hospitals downsize, nursing care must be made more available at home or within a community setting (e.g. day hospitals).

This major and radical shift in venue for the provision of care could happen in one of two ways. Firstly, the transition could occur by the uncoordinated introduction of independent corporations of nurses making professional nursing services available to patients; services no longer available in hospitals. For these basic and essential nursing services consumers would have to pay out of pocket or suffer prolonged recoveries due to unavailable or delayed intervention. In addition, the proliferation of such corporations would make quality control within the industry unmanageable and lead to greater fragmentation of care. Further, consumers (particularly senior citizens) are not likely to view such abandonment by government in a positive light.

The second way in which a shift in venue might be accomplished is through a conscious decision by government to plan for an orderly transition of the provision of the bulk of nursing care into home and community, rather than in hospital. With consumer welfare in mind, an orderly plan

would ensure quality care as well as continuity of care since the services provided could more easily be linked to hospitals, outpatient clinics and other community services through formal networks of caregivers as presently occurs with the provision of home care. In short, the transition described above means enhancing the resources of home care so that the provision of basic and essential nursing care is made available to all Albertans.

To effect the transition of nursing care from hospital to home and community, a re-direction of dollars is needed both to expand the capacity to provide care and to assist the nurses moving from hospitals to communities to be oriented to the differing needs and demands of the provision of care in the community. Registered nurses place a high value on maintaining competence to practice and will require assistance to realign their knowledge and skills to practice in the community. Through the Universities, short courses (likely comprising modules of present courses) available in community nursing, could be provided to nurses moving from hospital to home care. Modest funding would be required for such purposes; funding in proportion to the need.

To ignore the need to facilitate the shift of basic and essential nursing services from hospital to home and community is to jeopardize the health of Albertans in a major way. Lacking nursing care, patients and their families too frequently experience unnecessary suffering and often encounter health problems which might have been prevented through early nursing intervention. The registered nurses of Alberta urge the Premier and his colleagues to take a longer, more compassionate, and preventative view towards patients, their families and consumers by ensuring that nursing care continues to be offered to the people of Alberta.

APPENDIX C

ALBERTA ASSOCIATION OF REGISTERED NURSES

11620 - 168 STREET
EDMONTON, ALBERTA
T5M 4A6
TELEPHONE (403) 451-0043
TOLL FREE IN ALBERTA
1-800-252-9392
FAX (403) 452-3276

FILE NO. 1500-08

November 12, 1993

Dear AARN Member:

I am writing to you to bring you up to date on the AARN position on the current expenditure cuts and on health care reform. In my new role as AARN President it is my intent to listen carefully to AARN members. I also need you to help publicize the AARN message.

Today, I have written to Premier Ralph Klein asking for an urgent meeting to address the serious concerns conveyed to us from registered nurses and patients alike. These concerns are a direct result of the deep cuts in expenditures in health. The absence of a clearly articulated plan to guide change is in our view unethical and unnecessarily harmful to patients who expect safe and competent care from registered nurses. Mr. Klein will be informed that stopgap measures are quick fixes driven by an effort to survive in the short term without due consderation for quality of care now or long term. Indeed, the rapid adjustments demanded of clients and RNs in response to cutbacks threaten all Albertans.

I, along with other members of the Provincial Executive Committee, continue to meet with policy makers, government, influential associations, and other organizations with the uncompromised message that Albertans need registered nurses to provide cost-effective quality care. I have enclosed a copy of my recent letter to the Editor which I sent to all the daily newspapers in Alberta.

I urge you as an AARN member to write to Premier Klein and share your concerns. Tell Mr. Klein any examples you have from your workplace that show the impact of funding cuts. Please indicate in your letter that registered nurses are a major part of the solution to the problems in Alberta's health care system. It will help us to monitor member response if you copy your letter to the AARN.

We also need your help in getting the AARN message out to other Albertans. We must work together and use the contacts we have where we live and work. Please talk to your families, friends, and neighbours about your concerns and encourage them to join you in writing to the Premier.

The AARN position on health care reform has not changed. We support planned, coordinated, fundamental reform that protects the five principles of the Canada Health Act, namely universality, comprehensiveness, portability, accessibility, and public administration. Further, the AARN seeks to ensure that in a reformed system, registered nurses are used to the full extent of their knowledge and skills. Nurses are currently underused. If more registered nurses were availabe in the community, the health care system could save money.

More...

We firmly believe that the delivery of all health services should be as close as possible to where people live and work. Right now when people think about health care, they usually think about going to a hospital or a nursing home. This has to change. We believe health promotion and illness prevention are also key to keeping Albertans healthy and more resources should be allocated to these services.

Registered nurses are not the problem. Rather, we are a major part of the solution to the problems in today's health care system. We also realize that fundamental change requires working together and we are going to be an equal partner in the process.

I will be visiting each AARN district in the near future. Please check your AARN Newsletter for dates of district meetings and information on other AARN initiatives in these challenging times.

Yours sincerely,

Lillian

Lillian Douglass, RN, PhD
President

* The Premier's mailing address:

- Honourable Ralph Klein
  Premier of Alberta
  307 Legislature
  Edmonton, ALberta
  T5K 2B6

APPENDIX D

This letter was sent to the following newspapers:

The Calgary Herald
The Calgary Sun
The Edmonton Journal
The Edmonton Sun
Grande Prairie Daily Herald-Tribune
Fort McMurray Today
Medicine Hat News
Red Deer Advocate
Lloydminster Times
Lethbridge Herald

November 12, 1993

Dear :

Health care cuts, wage roll backs, decreased quality of patient care.

These are the buzz words of health care reform. Unfortunately, instant deficit reduction has become more important than the needs of patients, families, and communities.

The Alberta Association of Registered Nurses (AARN) recognizes the need to decrease spending on health care. We believe that fundamental restructuring of the health care system is necessary to ensure quality, cost efficient care. However, change needs to occur throughout the system in a planned and coordinated way before deep cuts are made. By cutting now and not considering the ripple effect throughout the system, we run the risk of paying dearly later.

Nurses are becoming increasingly concerned about their ability to maintain safe care with heavier patient assignments, fewer registered nurses, and the added responsibility of overseeing the work of auxiliary health care workers. The position of the AARN has not changed. Albertans have a right to expect safe, competent, ethical care during fundamental restructuring of the health system. What is occurring in the name of reform is putting the health of patient and provider at risk.

Sincerely,

Lillian

Lillian Douglass
President
Alberta Association of Registered Nurses

APPENDIX E

Directions: Please check your response or fill in the blank line.

1. **Sex** [ ] Female [ ] Male

2. **Age** _____

3. **Marital Status** [ ] Married [ ] Separated
   [ ] Single [ ] Widowed
   [ ] Divorced

4. **Number of Children at home** _____

5. **Present Employment Status, employed in Nursing**
   [ ] on a regular basis
   [ ] on a casual or seasonal basis

   Employed in other than Nursing and
   [ ] seeking employment in nursing
   [ ] not seeking employment in nursing

   Not employed and
   [ ] seeking employment in nursing
   [ ] not seeking employment in nursing
   [ ] on L.O.A./Maternity/Parental Leave
   Start _____ End _____
   [ ] on Disability leave
   Start _____ End _____

6. **Average Number of Hours Worked per Week in Nursing**
   [ ] 0 - 15 hours/week
   [ ] 16 - 29 hours/week
   [ ] 30 - 40 hours/week
   [ ] 41+ hours/week

7. **Type of Employer Hospital/Institution**
   [ ] General Hospital
   [ ] Rehabilitation Hospital
   [ ] Psychiatric Hospital/Mental Health Centre
   [ ] Nursing Home/Long Term Care Centre
   [ ] Other Type of Hospital
   Community
   [ ] Home Care
   [ ] Community Health Agency
   [ ] Nursing Stations (Outpost or Nurse Clinics)
   [ ] Physician's Office/Family Practice Unit/Dentist's Office
   [ ] Business-Industry/Occupational Health
   [ ] Home for the Aged/Lodge

Other
[ ] Education Institution
[ ] Self employed/Independent Practice
[ ] Private Nursing Agency/Private Duty
[ ] Association/Government
[ ] Other (Please Specify) _____

8. **Present Position**
[ ] Staff Nurse/Community Health Nurse
[ ] Head Nurse
[ ] Clinical Nurse Specialist
[ ] Instructor/Professor
[ ] Supervisor/Coordinator
[ ] Assistant/Associate Director
[ ] Chief Nursing Officer/Director
[ ] Office/Industrial Nurse
[ ] Researcher
[ ] Consultant
[ ] Other (Please Specify) _____

9. **Primary Area of Responsibility**
[ ] Clinical Nursing
[ ] Nursing Administration
[ ] Nursing Education
[ ] Nursing Research
[ ] Other Nursing (Not included in above)(Please Specify).
_____

10. **Current Enrollment in Education Program, if applicable**
[ ] Baccalaureate Nursing
[ ] Master's Nursing
[ ] Doctorate Nursing
[ ] Baccalaureate Other
[ ] Master's Other
[ ] Doctorate Other

Studying
[ ] Full Time
[ ] Part Time

11. **Education Since Graduation from Basic Program In Nursing**
[ ] Post Basic Baccalaureate
[ ] Master's
[ ] Doctorate
[ ] Other Courses
[ ] None of the Above

Other than Nursing
[ ] Baccalaureate
[ ] Master's
[ ] Doctorate
[ ] None of the Above

12. Number of years employed in nursing: _____

13. Average annual family income of you and/or your spouse _____

14. Are you a member of a Nurses' Collective Bargaining Group? (eg. U.N.A., S.N.A., AUPE)

[ ] Yes [ ] No

15. Have you ever participated in a Nurses' strike?

[ ] Yes [ ] No

16. Are you a member of a political party?

[ ] Yes [ ] No

17. Are you active at the district or provincial level of the AARN?

[ ] Yes [ ] No

18. Are you a member of a professional specialty group in nursing?

[ ] Yes [ ] No

19. Please comment on any political activity engaged in by a professional group in which you have membership:

20. If you are a member of a Nurses' union, do you actively support the goals and activities of the union?

[ ] Yes [ ] No [ ] Not applicable

21. Have you been an officer or elected official in a Nurses' union?

[ ] Yes [ ] No

22. Do you regularly attend union meetings?

[ ] Yes [ ] No

23. Did you have a politically oriented course in your basic nursing education?

[ ] Yes [ ] No

Directions: In this section, I am concerned with knowing how you feel about elections and politics in general. Please read the following three statements and circle the response that most reflects how you feel.

24. I would like to know how strongly you felt about the importance of voting in past elections.

a. I cared a great deal about whether or not I voted.
b. I cared somewhat about whether or not I voted.
c. I didn't care too much about whether or not I voted.

25. Some people don't pay much attention to political campaigns. How about you?

a. I am very much interested.
b. I am somewhat interested.
c. I am not much interested.

26. Generally speaking, would you say that you personally care which party wins elections?

a. I care very much which party wins an election.
b. I care somewhat which party wins an election.
c. I usually care which party wins an election.
d. I don't care very much which party wins an election.
e. I don't care at all which party wins an election.

Directions: In this section, please indicate if you agree or disagree with the statement.

27. **I don't think public officials care much about what people like me think.**

[ ] Agree [ ] Disagree

28. **The way people vote is the main thing that decides how things are run in this country.**

[ ] Agree [ ] Disagree

29. **Voting is the only way that people like me can have any say about how the government runs things.**

[ ] Agree [ ] Disagree

30. **People like me don't have any say about what the government does.**

[ ] Agree [ ] Disagree

31. **Sometimes politics and government seem so complicated that a person like me can't really understand what's going on.**

[ ] Agree [ ] Disagree

32. **It isn't so important to vote when you know your party doesn't have a chance to win.**

[ ] Agree [ ] Disagree

33. **A good many local elections aren't important enough to bother with**

[ ] Agree [ ] Disagree

34. **So many other people vote in a national election that it doesn't matter much to me whether I vote or not.**

[ ] Agree [ ] Disagree

35. **If a person doesn't care how an election comes out he shouldn't vote.**

[ ] Agree [ ] Disagree

Directions: In this section we would like to know about your political activity. Please read each statement and circle if you have or have not participated in the activity during the past four years to the best of your recollection.

Check Y if your answer is yes, I have participated.
Check N if you answer is no, I have not participated.

36. Exposing oneself to political stimuli (newspaper, television, radio information). [ ] Y[ ] N

37. Voting in: a) National elections [ ] Y[ ] N
b) Provincial elections [ ] Y[ ] N
c) Local elections [ ] Y[ ] N

38. Initiating a political discussion. [ ] Y[ ] N

39. Attempting to talk another into voting a certain way. [ ] Y[ ] N

40. Wearing a campaign button or putting a sticker on the car. [ ] Y[ ] N

41. Contacting a public official or a political leader. [ ] Y[ ] N

42. Making a monetary contribution to a political party or candidate. [ ] Y[ ] N

43. Attending a political meeting or rally. [ ] Y[ ] N

44. Contributing time in a political campaign. [ ] Y[ ] N

45. Becoming an active member of a political party. [ ] Y[ ] N

46. Attending a political caucus or a strategy meeting. [] Y[ ] N

47. Soliciting political funds. [ ] Y[ ] N

48. Being a candidate for office. [ ] Y[ ] N

49. Holding public or party office. [ ] Y[ ] N

50. Ad hoc activities (community action, demonstrations, etc) [ ] Y[ ] N

Please specify:

Directions: In this section I would like to discover how you feel about the relationship between nursing and politics. Please read the following statements and circle the number which best describes how you feel about the relationship between nursing and politics.

The choices on the scale are as follows:

1 STRONGLY DISAGREE 2 DISAGREE 3 NOT SURE 4 AGREE 5 STRONGLY AGREE

51. Participation in politics is compatible with the nursing role.

1 2 3 4 5

52. Political participation is very important for nurses.

1 2 3 4 5

53. Professional organizations have a role in making nurses politically effective.

1 2 3 4 5

54. Nurses should be encouraged to run for political office.

1 2 3 4 5

55. Nurses lack political knowledge.

1 2 3 4 5

56. Family responsibilities make political participation by nurses difficult.

1 2 3 4 5

57. The professional goals of nursing (such as quality patient care and health promotion) can best be achieved through political action.

1 2 3 4 5

58. In the space below, please make any additional comments you wish about the need for political involvement and political activity of Registered Nurses in Alberta:

THANK YOU VERY MUCH FOR YOUR TIME AND CONSIDERATION!

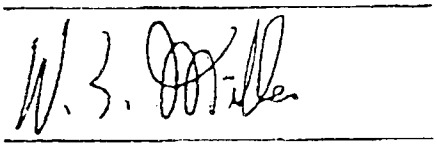
APPENDIX F

W. E. Miller, Ph. D.
Department of Political Science,
Arizona State University,
Tempe, Arizona
85281

Margaret Hadley, R. N.
9353 -87 Street,
Edmonton, Alberta,
Canada
T6C 3H8

Ms. Hadley,

In response to your recent request, I hereby grant you permission to use the Political Involvement Scale in your research.



W. E. Miller, Ph. D.

APPENDIX G

32-11 73 rd Street
Jackson Heights, New York 11370
USA
December 10, 1992

Margaret Hadley, R.N.
9353 87 Street
Edmonton, Alberta
Canada
T6C 3H8

Dear Ms. Hadley,

Please accept this letter as my permission for you to use the questionnaire developed for my research on political activity of nurses.

I wish you success in your forthcoming research and I would be very happy to read your findings when they are available.

Sincerely,

Joanna F. Hofmann, Ed.D., R.N.

APPENDIX H

Margaret Hadley, RN
9353 87 Street,
Edmonton, Alberta
T6C 3H8

June 7, 1993

Dear Colleague,

I am a candidate for a Master's in Nursing degree at the University of Alberta and I am undertaking a research project to determine the attitudes to politics and amount of political involvement existing among Alberta nurses. Your name has been randomly selected from the membership of the Alberta Association of Registered Nurses. Please take 15-20 minutes to complete the attached questionnaire on political activity and political involvement and return your completed questionnaire in the prepaid envelope at your earliest possible convenience.

This study is my research project and is being conducted at my expense. Although the AARN has allowed use of its mailing service, this does not constitute endorsement by the AARN of this research. Since your participation in this survey is completely voluntary, you are under no obligation to return the questionnaire. Your responses will be completely confidential and anonymous. I will have no way of identifying individuals from any completed questionnaires, and all information will be reported as group data only. The data collected in this study will be retained in a secure location for an indefinite period of time. Should further analysis of this data be contemplated, A new study proposal would be submitted for ethical review.

If you have any questions please telephone me collect at 466-6566 in Edmonton. My supervisor on this research project is Janet Ross Kerr, RN, Ph.D., Professor in the

Faculty of Nursing, University of Alberta, who may be contacted at 492-6253.

If you wish to be notified of the results of this study, I will be happy to send you an abstract describing the study results. Please indicate if you are interested in receiving an abstract. Thank you very much for your time, consideration and interest in our fellow nurses in Alberta.

Sincerely,

Margaret Hadley, RN
Master's in Nursing Candidate

APPENDIX I

REMINDER NOTICE

Dear Colleague:

Within the past three weeks you have received a questionnaire on the political activity of Alberta Registered Nurses. If you have already returned your questionnaire, I thank you very much for being part of my research project. If you have not yet responded, I would appreciate it if you would consider completing and returning your questionnaire to me.

Sincerely,

Margaret Hadley, RN.
Master's in Nursing Candidate

APPENDIX J

University of Alberta
Edmonton
Canada T6G 2G3

Faculty of Nursing
3rd Floor Clinical Sciences Building

Certification of Ethical Acceptability for Research Involving Human Subjects

---

NAME OF APPLICANT(S): Margaret Hadley, MN Candidate

TITLE OF PROJECT: "The Political Participation of Alberta "Registered Nurses"

The members of the review committee, having examined the application for the above-named project, consider the procedures, as outlined by the applicant, to be acceptable on ethical grounds for research involving human subjects.

13-05-27
Date

Louise Jensen
L. Jensen, RN, PhD
Chair
Ethics Review Committee

The Ethics Review Committee is a Joint Committee of
The Faculty of Nursing, University of Alberta
and
The Nursing Division, University of Alberta Hospitals

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UNIVERSITY OF ALBERTA

PEDIATRIC HEALTH-CARE PROFESSIONALS' PERCEPTIONS AND PRACTICES OF FAMILY-CENTRED CARE

BY

© NICOLE L. LETOURNEAU

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the MASTER OF NURSING DEGREE

FACULTY OF NURSING

EDMONTON, ALBERTA

FALL, 1994

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LETTER OF UNDERSTANDING BETWEEN INVESTIGATORS
FOR THE STUDY ENTITLED:

PAEDIATRIC HEALTH CARE PROFESSIONALS' PERCEPTIONS AND PRACTICES OF FAMILY-CENTRED CARE

This signed document represents our agreement that all raw data collected at each of three sites of this multi-site study belongs to the respective investigator at each site. As such, Beth Bruce owns her raw data, Christine Dennis owns her raw data, and Nicole Letourneau owns her raw data.

Each investigator may publish site-specific results of the study independently of the other two investigators. However, if this occurs, it must be noted in any publication that the site-specific results are part of a larger, multi-site study. Independent publication of any one investigator should acknowledge the other investigators of the larger study (i.e., this refers to an *acknowledgement* only, and not a requirement to share authorship on any independent publication). The investigators are committed to pooling the site-specific raw data in order to meet the objectives of the larger study; namely, to compare family-centred care perceptions and practices of health care professionals across 3 paediatric sites. Publication of the pooled results will occur as soon as possible after completion of the study, and in this circumstance authorship will be shared among the investigators.

This signed document also grants permission from Beth Bruce for Christine Dennis and Nicole Letourneau to use the copyrighted Family-Centred Care Questionnaire - Revised (FCCQ-R, 1993) for the purposes of this study. Beth Bruce will be acknowledged in any reference made to the FCCQ-R.

Beth Bruce — Nov 26/93

Beth Bruce — Date

Christine Dennis — Nov. 26th/93

Christine Dennis — Date

Nicole Letourneau — November 26, 1993

Nicole Letourneau — Date

UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR: Nicole L. Letourneau

TITLE OF THESIS: Pediatric Health-Care Professionals' Perceptions and Practices of Family-Centred Care.

DEGREE: Master of Nursing

YEAR THIS DEGREE GRANTED: Fall, 1994

Faculty of Nursing
3rd Floor, Clinical Sciences Building
University of Alberta
Edmonton, Alberta

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled PEDIATRIC HEALTH-CARE PROFESSIONALS' PERCEPTIONS AND PRACTICES OF FAMILY-CENTRED CARE submitted by Nicole L. Letourneau in partial fulfillment of the requirements for the degree of Master of Nursing.

M. Ruth Elliott

Dr. M. Ruth Elliott (Supervisor)

Dr. Jane Drummond

Dr. Herbert Northcott

Dr. Janice Lander (Chair)

August 18, 1994

DEDICATION

To Dean,

"If two were ever one, then surely we.
If ever man were loved by a wife then thee..."

To My Family,

My Mother: "You'd better start saving for university!"

My Father: "You should stay in Nursing."

ABSTRACT

The purpose of this study is to describe health-care professionals' ratings of their perceptions and practices of the components of family-centred care at the Alberta Children's Hospital in Calgary. An improved understanding of the ability of health-care professionals to practice family-centred care is essential to an accurate determination of the possible barriers to practice such as perceptual influences, organizational factors, and demographic variables. Subjects were asked to complete the Family-Centred Care Questionnaire-Revised (FCCQ-R) (Bruce, 1993) which measures perceptions and practices of family-centred care and presents open-ended questions about family-centred care. One hundred and seventy-one completed responses were obtained for a response rate of 36%. It was suggested by the findings that there is a significant difference between perceptions and practice of family-centred care ($p<.001$). Analysis of the demographic variables revealed that social workers and older subjects contributed positively to the scores obtained on the practice scale of the family-centred care questionnaire. Bachelor's prepared health-care professionals contributed positively to perception scores. In contrast, physicians and subjects with postsecondary education or a professional specialty as their highest level of education contributed negatively to the scores obtained on the perceptions scale of family-centred care. Staff members as opposed to educational or administrative staff also contributed negatively to perception scores. The findings suggest that the "dilemma of helping", education and knowledge, experience, financial and time constraints, staff position, communication and the organizational setting influence health-care professionals' abilities to practice family-centred care.

ACKNOWLEDGEMENTS

I wish to extend my heartfelt thanks to all those who have contributed to this thesis. I would especially like to thank my supervisor and mentor, Dr. M. Ruth Elliott, who has provided me with inspiration, insight and countless hours of support and encouragement. I would also like to thank my other committee members, Dr. Jane Drummond and Dr. Herbert Northcott for their time, advice and support.

I must also thank Beth Bruce, Dr. Judith Ritchie and Christine Dennis for their work and negotiation with a 'difficult' graduate student. The Alberta Children's Hospital, especially Laurie Wilson, Mary Perry, Mary 'the secretary', Nora Greenley, Dr. Gerald Goresky and Diane Ellingson deserve thanks.

Terry Taerum, Dr. Janice Lander, Dr. Louise Jensen and Cliff Kinsel provided invaluable statistical knowledge and advice.

Brent and Jana Wilson provided me with 'Maritime Hospitality' whenever I needed a place to stay in Calgary.

I also want to acknowledge the National Health Research and Development Program and the Canadian Nurses Foundation for providing financial support for this research.

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CHAPTER 1

INTRODUCTION

The Association for the Care of Children's Health in Bethesda, Maryland recently published a revolutionary document which defined the key elements of family-centred care (Shelton, Jeppson & Johnson, 1989). This document was prepared in response to the growing recognition by professionals that children's health care must be family-centred. Indeed, family-centred care has become a common goal among health-care professionals who work with children (Robinson, 1987). Family-centred care is a health care delivery model that seeks to fully involve families in the care of children through an approach that is respectful and supportive. When cared for in a system that promotes the practice of family-centred care, children experience less separation anxiety and maternal deprivation while parents' learning is enhanced (Palmer, 1993). However, some have questioned the viability of family-centred care in the workplace (Rushton, 1990; Odle, 1988).

Background

Beginning in the mid 1960's, pediatric health care leaders began to establish systems that recognized the emotional and developmental needs of children (Johnson, Jeppson, & Redburn, 1992). Previously, parents were forced to relinquish care for their children at the hospital doors (Brewis, 1986). Today, there is an understanding that the "unique and changing needs of the child demand that health care be organized and delivered in ways that support the whole child and the family" (Johnson, et al., 1992, p. 1). This represents a move from institution-centred care to family-centred care (Johnson, et al., 1992).

Historical Origins

The first hospitals for sick children were opened during the nineteenth century, but the majority of sick children continued to be cared for at home (Nethercott, 1993). Visiting in hospitals was restricted and the presence of families was felt to inhibit effective care (NAWCH, 1988). The change in perception of the importance of the family began with the Bowlby's (1951) work on the effects of maternal deprivation on infants and children. The Platt Report (1959) from England later recommended that parents should have unrestricted access to their children and that young children should be admitted with a parent. In 1987, the Surgeon General's Report from the United States outlined the elements of family-centred care with corresponding steps for action (Koop, 1987). Examples of

these elements included recognition that the family is the constant, sharing of unbiased and complete information with parents, and encouragement of normal patterns of living in the home and community.

Family-Centred Care

Perhaps as a result of the slow progression from institution-centred care to family-centred care, the concept of family-centred care in the pediatric setting has been historically difficult to define. Rushton (1990) indicated that "parents and professionals have been struggling to reach consensus" regarding the definition and implementation of the concept in practice (p. 68). Luciano (1972a) described the philosophy of family-centred care as giving recognition to the worth of the individual child as a member of the family. She further suggested that family-centred care include significant family members in establishing objectives to meet health care needs of the child. It implies a systematic approach to the identification and resolution of family needs in an environment conducive to therapeutic relationships. She described family-centred care as an "open system extending across all hospital services, each service having a particular effect on a hospitalization experience" (Luciano, 1972b, p. 75). Fond (1972) indicated that the goal of family-centred care was to maintain or strengthen the roles and ties of the family with the hospitalized child in order to promote normalcy of the family unit.

In the community health setting, Yauger (1972) was the first to define family-centred care as "the identification of problems and needs of a family and the provision of appropriate service for every member" (p. 320). Porter (1979) ventured a more complete description by defining family-centred care explicitly "as an open, multidimensional system of health management which acknowledges the inseparability of the individual from his [and her] family and environment and which effectively and efficiently utilizes the complementary skills of all members of the health team, including the client and his family" (p. 330). She also suggested that family-centred care activities depend upon a team which enjoys open communication and coordination of goal-directed efforts. Further, family-centred care requires creativity and flexibility, yet demands a systematic process to meet the dynamic needs of clients (Porter, 1979).

Rushton (1990) suggested that "a giant step toward...consensus regarding the definition of the term as well as the design of a family-centred approach to care...has been made by opening the lines of communication

between parents and professionals" in the guise of the Association for the Care of Children's Health (ACCH) (p. 68). As such, family-centred care was more clearly defined by the ACCH as:

> a philosophy of care that recognizes and respects the pivotal role of the family in the lives of children with special health needs. It is a philosophy that strives to support families in their natural caregiving roles by building upon their unique strengths as individuals and as families. It is a philosophy that views parents and professionals as equals in a partnership committed to excellence at all levels of health care. (Shelton, Jeppson & Johnson, 1987, p. 2)

Shelton, Jeppson and Johnson (1987 & 1989) describe eight equally important components of family-centred care. These include:

1. Recognition that the family is the constant in the child's life while the service system and personnel within those systems fluctuate.
2. Facilitation of parent/professional collaboration at all levels of health care.
3. Recognition of family strengths and individuality, and respect for different methods of coping.
4. Sharing of unbiased and complete information with parents about their child's care on an ongoing basis in an appropriate and supportive manner.
5. Encouragement and facilitation of parent-to-parent support.
6. Understanding and incorporating the developmental needs of infants, children, and adolescents and their families into health care delivery systems.
7. Implementation of appropriate policies and programs that are comprehensive and provide emotional and financial support to meet the needs of families.
8. Assurance that the design of health care delivery systems is flexible, accessible and responsive to family needs.

The Izaak Walton Killam Children's Hospital Family-Centred Care Committee (1992) as cited in Bruce (1992) subsequently modified these to include a ninth element of:

9. Implementation of appropriate policies and programs that are comprehensive and provide emotional support to meet the needs of staff. (Appendix A).

Formerly considered under element three, which stresses family individuality, the ACCH also recently expanded the concept of family-centred care to include "honouring the

racial, ethnic, cultural, and socioeconomic diversity of families" (Johnson et al., 1992, p. 3). Shelton et al. (1989) suggest that these broad elements propose a revolutionary shift in the treatment of children with disabilities in that the family, as the primary decision maker, becomes central to service delivery. Shelton et al. (1989) indicate that professionals and families must work together to balance medical recommendations with the priorities of families so that programs truly meet family needs and goals. In a family-centred approach to care, programs must be designed with the individuality of families in mind and with the flexibility to tailor services to the unique strengths of each child and family (Shelton et al., 1989).

Dunst, Trivette, Davis and Cornwell (1988a) suggested that the elements of family-centred care are based upon principles which are designed to promote self-determination, decision-making, capabilities, control and self-efficacy. Collectively, these attributes are said to reflect a sense of empowerment and an enablement model of helping. More recent literature has indicated that increased participation at all levels of health care has become a major goal of family-centred service systems (Hutchins & McPherson, 1991). Further, Dunst, Johanson, Trivette and Hamby (1991) referred to family-centred care as a combination of beliefs and practices that define particular ways of working with families that are consumer driven and competency enhancing. Nethercott (1993) examined the concept of family-centred independent of the work of the ACCH. She agreed that "family-centred care has several critical components" and outlined the skills necessary to practice family-centred care (p. 796). Nethercott suggests that a combination of education, practice and life skills enables nurses to practice family-centred care. McBride, Brotherson, Joanning, Whiddon and Demmitt (1993) outlined three major principles of family-centred care "that most encompass current values and practice" (p. 415). These include establishing the family as the focus of services, supporting and respecting family decision-making, and providing intervention services designed to strengthen family functioning.

Benefits

The benefits arising from parental participation in children's care in hospital are well recognized in the expository literature (George & Hancock, 1993; Green & Green, 1977; Harris, 1990; MacCarthy, 1957; Marriott, 1990; McElnea, 1971; Mason, 1978; Pass & Pass, 1987; Patterson, 1979; Spence, 1947 & 1951). Others have explicitly referred to the benefits of family-centred care (Arrango, 1990;

Bailey, McWilliam & Winton, 1992; Kelly, 1993; McKenzie, Kurtianyk, Kidd, Knowles & Lipman, 1993; Nissen, 1969; Odle, 1988; Robbins, 1987; Roberts & Magrab, 1991). Still others have described the implementation of a family-centred care model into the institutional setting (Burrows, 1972; Goodley. 1985; Korteland & Cornwell, 1991; Pike, 1989; Robbins, 1991; Shea-McAlveavey & Janusz, 1991; Siegel, 1982; Thompson, 1985).

Palmer (1993) indicates that parents' competence and confidence in dealing with childrens' illness increases when included as part of the health care team, because they feel useful and important. Increased interaction between parents and staff results in a lessening of communication gaps (Van der Schyff, 1979) and a greater likelihood of parents to share confidences and anxieties with staff (Palmer, 1993). Robbins (1991) indicates that family-centred care minimises the trauma of a hospital stay and allows an independence and quality of life that would otherwise be impossible to achieve.

Although family-centred care has received substantial recognition as a satisfying and useful experience for children and their families, it "has not found its rightful place in health centres or among health care workers" (Porter, 1979, p. 330). Many health-care professionals respect and support the idea of family-centred care, but few actually put it into practice (Blumenstein, 1986; Porter, 1979).

Barriers

The barriers to family-centred care are also well recognized in the expository literature (Ayer, 1978; Blumenstein, 1986; Dunst, Trivette, Davis & Cornwell, 1988a; Gill, 1987b; Meadow, 1969; Robinson, 1985). Rushton (1990) cited professional attitudes, understaffing, insufficient resources, and lack of administrative support as influencing the ability to provide family-centred care. Other factors included lack of training, adherence to child-focused practices, and a lack of clearly articulated set of procedures for family-centred care (Bailey, McWilliam & Winton, 1992). Further, Leavitt (1984) indicated that many professionals want to apply this knowledge, but are unable because of time or organizational constraints, lack of experience or practical preparation, and "a tenuous sense of legitimacy" about family participation (p. 84).

Health-care professionals often question parents' ability to participate in decision making, particularly when parental decisions are not congruent with their own (Rushton, 1990). Some professionals perceive that parental

involvement will place increased demands on them while they do not have the extra time needed to monitor parent performance (Eldar & Eldar, 1984). Professionals may mistrust parents' competence to contribute to the care of the critically ill child (Dunkel & Eisendrath, 1983). Thomas (1987) suggested that professionals may also fear loss of control over patient outcomes in the already unpredictable critical care environment if parent involvement is increased. Whatever the cause, when the health-care professional "assumes the role of expert caregiver at the expense of the parent, tensions build" and an unhealthy relationship is established between families and staff (Rushton, 1990, p. 70).

The Need for Research

In 1979, Porter suggested that the relationship between health-care professionals' orientation to family-centred care and clinical practice be studied to determine whether or not attitudinal factors underlie behaviour. In 1990, Rushton echoed this sentiment indicating a need to examine the attitudes of health-care professionals and administrators about the role of families in health settings. Roberts and Magrab (1991) contend that as institutions become more involved in family-centred care, research is needed to inform practice and training.

Results from this research are expected to provide insight into health-care professionals' perceptions of the barriers to practising family-centred care. They will also show to what degree family-centred care is practised and emphasize the importance health-care professionals attach to being able to practice family-centred care. This will help to clarify assumptions and questions about the viability of family-centred care for children, families and health-care professionals.

Purpose

The purpose of this study is to explore and describe health-care professionals' ratings of their perceptions and practices of the components of family-centred care at the Alberta Children's Hospital in Calgary in 1994. An improved understanding of the ability of health-care professionals to practice family-centred care is essential to determine with some degree of accuracy the possible barriers to practice such as perceptual influences, organizational factors, and demographic variables. This will provide a basis for the development of policies and programs to enable health-care professionals to practice family-centred care more effectively.

Research Question

What are pediatric health-care professionals' perceptions and reported practices of family-centred care?

Definition of Terms

Health-Care Professionals

Health-care professionals include staff employed as child life specialists, nurses, nutritionists, occupational therapists, pharmacists, physicians, physiotherapists, psychologists, respiratory therapists, social workers, and speech/language pathologists/audiologists.

Perception

The health-care professional's rating of the necessity of a given element of family-centred care as measured on the Family-Centred Care Questionnaire-R (FCCQ-R).

Practice

The health-care professional's rating of the extent to which a given element of family-centred care is currently included in everyday work as measured on the FCCQ-R.

Family-Centred Care

Shelton, Jeppson and Johnson (1987 & 1989) describe eight equally important components of family-centred care. These include:

1. Recognition that the family is the constant in the child's life while the service system and personnel within those systems fluctuate.
2. Facilitation of parent/professional collaboration at all levels of health care.
3. Recognition of family strengths and individuality, and respect for different methods of coping.
4. Sharing of unbiased and complete information with parents about their child's care on an ongoing basis in an appropriate and supportive manner.
5. Encouragement and facilitation of parent-to-parent support.
6. Understanding and incorporating the developmental needs of infants, children, and adolescents and their families into health care delivery systems.
7. Implementation of appropriate policies and programs that are comprehensive and provide emotional and financial support to meet the needs of families.
8. Assurance that the design of health care delivery

systems is flexible, accessible and responsive to family needs.

The Izaak Walton Killam Children's Hospital Family-Centred Care Committee (1992) as cited in Bruce (1992) subsequently modified these to include a ninth element of:

9. Implementation of appropriate policies and programs that are comprehensive and provide emotional support to meet the needs of staff. (Appendix A)

Objectives

1. To describe health-care professionals' perceptions of the extent to which the nine key elements of family-centred care are necessary to practice family-centred care.
2. To describe health-care professionals' reports of the extent to which the nine key elements of family-centred care are present in their practice.
3. To determine if a discrepancy exists between health-care professionals' ratings of the necessity of family-centred care and their rating of their practice of family-centred care.
4. To determine if the dependent variables of perceptions and practices of health-care professionals vary as an effect of the independent variables of professional group, age group, position, education, experience, and parental status (Bruce, 1993).

Conceptual Framework

This study and research instrument have been developed within the framework of family-centred care as proposed by the ACCH (Shelton et al., 1987 & 1989) and modified by the Family-Centred Care Committee at the Izaak Walton Killam Hospital for Children (1992) in Halifax, Nova Scotia (Appendix A).

CHAPTER II

REVIEW OF THE LITERATURE

Family-Centred Care

The concept of family-centred care and related topics such as parental participation and family involvement have been explored by an extensive review of the published research from nursing, medicine, psychology, education, and other related fields. Computer data bases including CINAHL, ERIC, HealthPLAN, MEDLINE, PsycLIT, and sociofile were searched. The review of the literature shows that there are many benefits and barriers to incorporating the family into children's health care.

Benefits of Family-Centred Care

The benefits of including families in the care of their hospitalized children are well demonstrated in the research. These benefits have been explored from a variety of perspectives and include effects on children, families and organizations.

Effects on Children

The effects of incorporating the family into the care of hospitalized children were studied long before the development of the more modern definitions of family-centred care. As a result, none of these early studies defined family-centred care or used the ACCH family-centred care model. More importantly, these studies created the convincing basis for the modern day acceptance of the importance of family-centred care for children. Indeed, many of the elements of family-centred care were derived from these early studies.

Reduced Maternal Deprivation

Spitz (1945) studied 164 children in long-term care institutions and compared them with children reared in families. Upon observing severe developmental retardation in the institutionalized children, the researcher stressed the "unique importance of [an] adequate and satisfactory mother-child relationship" (p. 72). Bowlby and Robertson investigated the effects of the separation of children from their mothers in early childhood on subsequent personality development (Robertson & Bowlby, 1952; Bowlby, 1953; Bowlby, 1960; Robertson, 1953). Based on four years of observations of forty-nine 1- to 4-year-olds undergoing separation experiences, the researchers concluded that the separation of young children from their mothers produces "much mental

ill-health" (Bowlby, 1953, p. 272). Bowlby (1953) outlined the essential nature of the maternal-infant bond and the need for an attachment-figure during hospitalization. He later warned that 'maternal deprivation' could result from parent-child separation or the denial of a warm, intimate and continuous relationship with the mother or nurturing person (Bowlby, 1957).

Reduced Separation Anxiety

Prugh, Staub, Sands, Kirschbaum, & Lenihan (1953) explored the psychologic effects of hospitalization on 100 children aged two to 12 years when separated and accompanied by parents. Findings suggest that children three years of age and younger are most susceptible to separation from the mother, although "separation anxiety" may also occur in older children (Prugh, et al., 1953, p. 101). Schaffer and Callender (1959) studied the effect of separation from parents on 76 hospitalized infants aged three to 51 weeks. The infants also illustrated separation anxiety consisting of "protest during the initial period of hospitalization, negativism to the staff,...withdrawal, and a period of readjustment after return home, during which a great deal of insecurity centering on the mother's presence was shown" (Schaffer & Callendar, 1959, p. 537).

Frankl, Shiere, and Fogels (1962) studied the effects of separation of the mother and pre-school child on 112 children in the dental office. The experimental and control conditions consisted of observations of children kept with and separated from their mothers respectively during treatment. It is indicated by the results that 96% of the children kept with their mothers responded positively to the treatment experience. In contrast, only 48% of children separated from their mothers during treatment responded positively. A study by Schulman, Foley, Vernon, and Allan (1967) of thirty-two 2- to 6-year old children admitted for tonsillectomy confirmed these results suggesting that "children accompanied during induction [of anaesthesia] were less upset than those who were separated" (p. 112). These results confirm other research findings on the negative psychological implications of parent-child separation during hospitalization (Illingworth & Holt, 1955; Jessner, Blom & Waldfogel, 1952; Kay, 1966; Plank, Caughey & Lipson, 1959; Vaughn, 1957).

Improved Health

Psychosocial outcomes.

Brain and Maclay (1968) studied 197 children under six years of age admitted to hospital with their mothers or

alone. They found "a significant reduction in the incidence of emotional and infective complications" in the experimental group admitted with their mothers (p. 279). Child behavioural disturbances such as disturbed nights, clinging behaviour, aggression, and crying were observed in 22% of the experimental group and 55% of the control.

Gillette, Hansen, Robinson, Kirkpatrick and Grywalski (1990) performed a study of outcomes of infants with suspected developmental delay. Infants were obtained through admission to a neonatal intensive care unit at an American children's hospital. The infants had moderate to severe bronchopulmonary dysplasia or neurologic dysfunction. Infants and families were randomly assigned to one of two treatment interventions. One intervention was called the 'transition team case management model' which provided education to families regarding the benefits of early intervention in health, multidisciplinary development and family support (n=12). This treatment may be considered to contain elements of family-centred care. The control intervention was assignment to the 'traditional discharge' and community follow-up routine (n=12). Data on the infants at discharge indicate that they were comparable on the developmental scores on the Batelle Developmental Inventory. A comparison of mean scores at six months of age on the Bayley Mental Developmental Index favours the transition team infants. Transition team infants mean score was 98.4, while traditional discharge infants mean score was 79.0, approaching significance (t=1.95, p=.06). The Bayley Psychomotor Developmental Index for transition team infants was also higher, but not significantly. The lack of statistical significance and small sample size suggests limitations of the applicability of these research findings.

Ramey, Bryant, Wasik, Sparling, Fendt and LaVange (1992) performed a study of the effect of early intervention on the cognitive, behavioural and health status of low birth weight premature infants. The 377 intervention families received pediatric follow-up, home visits, parent support groups, and a systematic educational program for the first three years of life. Again, the strong focus on educating and incorporating the family suggests elements of family-centred care. The control group of 608 families received the same pediatric follow-up and referral services only. It was suggested by the findings that the intervention group performed better cognitively than did the pediatric follow-up group and the degree of participation was positively related to cognitive development. The 36-month Stanford-Binet Intelligence Quotient mean score for the intervention group was 93.5, compared with 84.5 with the control group. Intelligent Quotients are considered to be in the borderline intellectual functioning category if between 71 and 85.

Scores greater than 85 are considered in the normal range. It is not known whether this finding is significant as the results might be related to other program factors such as amount of parental participation rather than to family-centred care.

Physical outcomes.

In their study described above, Brain and Maclay (1968) also found that the incidence of cross-infection and post-operative complications was 11% in the experimental group compared with 23% in the control group. This confirmed previous observations that cross-infection among infants could be reduced by allowing mothers to care for their children while in hospital (Pickerill & Pickerill, 1954).

In a more recent study, Menzies, Parkin and Hey (1985) studied the effect of family-centred care on the health outcomes of 27 infants not offered immediate surgery for paralytic lumbar meningomyelocele at birth. Normally, these infants are not expected to survive very long. In this study, family-centred care simply represented caring for their infants at home. Remarkably, infants not offered surgery and cared for in a traditional hospital setting had a mortality rate of 100% by one month of life (n=209), whereas infants not offered surgery and cared for in a family-centred environment had a mortality rate of 30% at one month (n=27). Twenty-seven percent have since survived to school age. "All are chairbound and incontinent, but none is intellectually retarded and many are no more handicapped than children offered immediate surgical treatment at birth" (p. 993). The authors suggest that the high survival rate among the infants cared for at home may be due to an early change of expectation amongst those caring for the infant.

Effects on Families

As a result of the early literature on the negative consequences associated with child-parent separation during hospitalization, researchers began to examine the possibilities presented by alternative forms of pediatric health care that more adequately incorporated the family.

Enhanced Learning

Craig and McKay (1958) were among the first to study the advantages of including parents, especially mothers in pediatric health care. They surveyed 560 admissions to a mother and baby unit and found that mothers learned much more readily about their children's health when included. Further, "doctors and nurses...learn to better appreciate

the outlook of the mothers and to understand their worries and problems" (p. 277). In spite of the anecdotal reporting of the findings, this study is included for its early attention to the topic. The importance of this study is also limited by its greater emphasis on unit demographics than benefits to mothers.

Subsequently, Yauger (1972) studied the effect of family-centred care on health knowledge of families in the public health setting. Yauger (1972) provides an early definition of family-centred care, although it is not known whether the study is limited to families with children. The researcher found no significant differences were found between the experimental and control families, although health knowledge scores were greater in the experimental families.

Verghese (1988) performed a study of attitudes of 94 family members of mentally ill hospitalized patients. Families were encouraged to stay in hospital with the patient where they obtained more information about the illness and participated in the care. Measures of attitudes toward illness before and after the stay indicated a marked degree of change in knowledge and attitudes on various aspects of mental health and illness. Improvements were noted in perception of mental illness ($p<.001$), knowledge of etiology, treatment ($p<.01$) and rehabilitation ($p<.05$). Unfortunately, the population is not particular to children and families, suggesting limitations.

More recently, Lewis, Salas, de la Sota, Chiofalo and Leake (1990) assigned epileptic children and their families to either a child-centred, family-focused experimental condition ($n=123$) or a control group ($n=113$). Children in the experimental group and their parents separately attended four one and a half hour sessions and then met together at the end of each session to share learning experiences. Control children and their parents attended three two hour sessions with a traditional lecture format followed by question and answers. The experimental condition may be considered to contain more elements of family-centred care. Experimental and control groups were provided with equal educational content about epilepsy and seizure management. The experimental group children which learned in a family-centred care environment had greater increases in knowledge in all areas ($p<.001-.05$).

Caro and Derevensky (1991) implemented a family-focused home-based intervention model with 16 families having infants with moderate or severe disabilities. The intervention may be considered to contain many elements of family-centred care. Qualitative analyses of familial

behaviours suggested skill enhancement. Evaluation of the intervention resulted in high levels of parental satisfaction, accelerated rates of progress by children with disabilities, and acquisition of functional skills by families. Because these findings may be related to other factors such as the home visiting component of the intervention, the success cannot be attributed solely to family-centred care.

Reduced Stress

Mahaffy (1965) studied the effect of incorporating parents (mothers) into their children's hospitalization for tonsillectomy and adenoidectomy. An experimental group of 21 parent-child units were provided with an experimental nurse who attempted to determine mothers' needs, provide help and information, answer questions, or discuss "anything which caused the mother to be confused or unhappy" (p, 14). The control group of 23 parent-child units were cared for by the hospital personnel. The experimental nursing effort to help mothers cope included elements of family-centred care. Results showed that the experimental group of two to 10-year-old children "had lower temperatures, pulse rates, and systolic blood pressures than the control group. Also they voided within a shorter period of time, took larger quantities of fluid more easily, and had a lower incidence of vomiting" (p. 17). Further, the experimental group of children recovered in four days to one week in contrast to recovery periods longer than one week for controls ($p<.005$). The experimental group also presented fewer behavioural problems such as crying and disturbed sleep than did controls ($p<.05$).

Skipper and Leonard's (1968) follow-up study of eighty 3- to 9-year-old children admitted to hospital for tonsillectomy and adenoidectomy confirm these results. Findings suggested that the experimental condition of increased nurse-family interaction significantly reduced mothers' stress levels assessed by a questionnaire administered to mothers following discharge. The researchers believed that increasing the nurse-family interaction enabled mothers to redefine hospitalization as a more positive experience, thus reducing the child's stress and resulting in changes in social, psychological, and physiological behaviours. Another follow-up study by Wolfer and Visintainer (1975) also confirmed these results in their study of 80 children and their parents between the ages of three and fourteen. In addition to the above noted changes in children, experimental group parents who received special preparation and supportive care had "significantly lower self-ratings of anxiety, rated information received significantly higher in adequacy, and were significantly

more satisfied with their care" (p. 253).

Schulman, Foley, Vernon and Allan (1967) studied the effect of the mother's presence during anesthesia induction on 32 children between two and six years of age admitted for tonsillectomies. Half of the children were randomly assigned to the treatment condition of mother accompaniment, and half to the control condition of mother separation. Two of the three covariance analyses of mood provided support for the hypothesis that children accompanied during induction were less upset than those who were separated. This difference approached statistical significance during the period prior to induction and was statistically significant during induction.

Lewis, Hatton, Salas, Leake and Chiofalo (1991) performed a follow-up study on the parents of epileptic children who were exposed to a child-centred, family-focused intervention discussed above under enhanced learning. Parents in the experimental (n=185) and control groups (n=180) were evaluated at five months post-intervention and it was indicated by the findings that experimental group parents and especially mothers were more likely than controls to report that they were less anxious (p=.001). Further, their anxiety as measured by the Taylor Manifest Anxiety Scale was significantly reduced (p=.01).

Better Quality Care

A study by Jackson, Bradham and Burwell (1978) examined 31 parents who agreed to stay with their child in hospital. Parents were surveyed upon admission and three days later to determine how they wanted to participate. Their responses were recorded in the care plan. It is suggested by the findings that parents felt more comfortable with medically related activities and showed more independence in child care three days after admission, showing evidence of learning and reduced stress. Further, 23 of the surveyed parents stated they were 'very satisfied' and the remaining eight stated they were 'satisfied' with the care. The small sample size and limited detail in the reporting of results suggest limited applicability of these findings.

Sainsbury, Gray, Cleary, Davies, and Rowlandson (1986) studied 32 families to determine the effectiveness of care-by-parent units. In response to a questionnaire, 100% of parents reported being grateful for the opportunity to participate. All parents reported feeling that their children benefitted from their involvement by being more settled and content.

Cleary, Gray, Hall, Rowlandson, Sainsbury, and Davies

(1986) performed a study of the effects of parent care in hospital on the lives of child patients. The researchers made 4225 observations of patients admitted to a 14-bed pediatric unit over a one week period. Findings suggested that children cared for by parents spent far less time awake alone, cried less, and slept less than those nursed unaccompanied. Children cared for by their parents were observed to interact with their parents in 90% of social contacts.

A recent study by Styba, Elaschuk, Jesse, and Cote (1992) confirmed that parents expressed a high degree of satisfaction with being able to care for their children in hospital. Responses to a questionnaire about parents' presence on a pediatric care-by parent unit found that 99% of parents (n=95) stated they would come back to the care-by-parent unit or recommend the unit to others, and 95% reported feeling comfortable with their child care responsibilities.

Weinstein, Faust, Mckee and Padman (1992) studied the effect of a family-centred care program on six-month to 17-year old severely asthmatic children and their families. This program focused on the child's and family's adaptation to severe asthma and the development of family-specific interventions to promote compliance with treatment regimens. It was shown by the results that 44 children admitted consecutively achieved a 93% reduction in days in hospital (p<.001), an 81% reduction in emergency care (p<.01), and "a significant reduction in corticosteroid bursts and improvement in" forced expiratory volume (p. 66).

Organizational Effects

Reduced Costs

Robinson, Shah, Argue, Kinnis, and Israels (1969) found that many more children (30%) than previously thought could be safely placed in parent-care environments while in hospital. Results from this study also show apparent savings "in one quarter of the hospital beds per year" based on earlier discharges and other "economic advantages" (p. 876). A study by Vermillion, Ballantine, and Grosfield (1979) concurred that "the parent care unit costs only 70% of the cost of a routine inpatient bed and thus appeals to advocates of cost containment and efficient utilization of hospital staff" (p. 321). They also found that the parent care unit enabled parents to overcome their fears of inadequacy and to develop expertise in the management of children's health care needs. Caldwell and Lockhart (1981) also found significant cost savings and a high level of parent satisfaction by instituting parent-care units. Evans

and Robinson (1983) found that average costs of patients treated on a care-by-parent-unit compared to similar patients treated in the inpatient nursing unit demonstrated considerable savings. It must be noted that all of these studies that demonstrate cost savings are performed on parent care units. Although this form of care incorporates aspects of family-centred care, it is not the only setting in which family-centred care takes place in hospitals. As a result, assessment of parent care units may not be the best way to measure the actual costs of implementing institution-wide family-centred care.

Job Enhancement

In a previously described study by Sainsbury, Gray, Cleary, Davies, and Rowlandson (1986), nurses were asked to respond to a questionnaire on their feelings about a new care-by-parent unit. Ninety-four percent or 30 out of 32 nurses indicated that their relationships with the parents were better and that they enjoyed their teaching and supervisory roles more in the care-by-parent unit than when they practiced in the traditional method. The author suggested that this indicates that the nurses' roles were enhanced and their job satisfaction increased. However, limited data is provided to support these assertions, and the tool is not described.

Most of the reviewed studies have not explicitly defined family-centred care and none used the family-centred care framework of the ACCH. In spite of this and other specified limitations, incorporating the family into the care of the pediatric client has been repeatedly demonstrated as effective. Effects include reduced maternal deprivation, reduced separation anxiety, improved health, enhanced learning, reduced stress, improved quality of care, reduced costs, and job enhancement.

Barriers to Family-Centred Care

In the research literature, the barriers to family-centred care are also well recognized. These include perceptions, education and knowledge, staff position and experience, organizational setting, time and personal availability, role negotiation and communication, costs, and parental and marital status. Again, many of the studies reviewed neither explicitly define family-centred care nor use the framework of the ACCH. However, all reviewed studies may be considered to contain elements of family-centred care.

Perceptions

Rosenbaum, King, and Cadman (1992) surveyed 88 senior clinicians and administrators in Ontario children's ambulatory treatment centres. They also surveyed 213 parents from organizations concerned with families of disabled children. Respondents were asked to rate in order of importance 22 components of care, such as "education/information", "advice on development", and "family-centred approach" (p. 105). It is suggested by the research findings that although the family-centred care component was highly rated by parents, it was less valued and thus infrequently offered by health-care professionals.

Knafl, Cavallari, and Dixon (1988) studied family-centred care activities by surveying 62 families of children undergoing short-term hospitalization and 47 pediatric nursing staff. While believing themselves to be practicing family-centred care, it was suggested by the findings that all nurses were focused on the child rather than the family. The nurses saw themselves as "giving information, teaching, supporting patients, and supporting parents" (p. 292). In contrast, the nurse was viewed by 45% of parents as giving information, 40% of parents as teaching, 33% of parents as supporting the child, and 14% as supporting the parents.

In a qualitative study by Berman (1991) 22 nurses were surveyed about their beliefs about family-centred care. Although 95% of the nurses expressed explicit support for the concept of family-centred care, some of their beliefs and practices suggested otherwise. For example, while 45% of nurses studied trusted parents to do tasks such as monitor the child's fluid intake and output, 55% believed that these tasks should not be delegated to parents.

Bruce (1992) concurred with these findings in a study of 147 registered nurses' perceptions and practices of family-centred care. "The nurses surveyed in this study reported that their everyday work did not match their perceptions of the activities necessary to provide family-centred care" (p. 41). Their total scores on the 'current practice' scales which measured the nurses' ratings of the family-centred care items provided in their everyday practice were significantly lower than were the scores on the 'necessary' scales which measured the nurses' ratings of the family-centred care items considered necessary in practice ($p=.000$). These scores were measured on a 5-point Likert scale and represent an average mean of 3.2 and 4.2 for each total scale respectively. Further, the nurses agreed with the essential elements of family-centred care; however, many did not see some aspects of care as nurses' work. For example, only 46% of the nurses surveyed believed

that all the elements of family-centred care constituted nurses' work. Elements of family-centred care such as "sharing information" and "developmental needs" were rated as nurses' work by 61% and 59% of respondents respectively. Further, although respondents indicated a reasonable knowledge of family-centred care, they reported that they were often unable to incorporate this knowledge into their practice. The researcher found that health-care professionals perceived that they performed family-centred care significantly less in their practice than they considered necessary. Bruce suggested that the health-care professionals' knowledge of family-centred care, institutional supportive measures, and perceptions of their roles in caring for families influence the implementation of effective family-centred care in a variety of settings.

McBride, Brotherson, Joanning, Whiddon and Demmitt (1993) performed a qualitative study of 15 families' and 12 professionals' perceptions of the implementation of family-centred services in early intervention programs. Fourteen professionals consisting of an occupational therapist, a social worker, and 12 childhood special educators took part. Findings from semi-structured interviews indicated that professionals had an understanding of the change in focus from child to family; however, incongruence was found to exist between family-centred attitudes and actual practice. This agrees with other previously cited research findings.

Robinson (1987) performed a qualitative study designed to explore parents's views when their chronically ill children were hospitalized. It is suggested by the findings that unacknowledged discrepancies in perceptual viewpoints may cause the relationships between family members and professional health care providers to become adversarial. This situation "negatively affects both the effectiveness of care and perceived satisfaction with care" (p. 181).

Thornes (1985) reported on a study of 244 intensive, surgical and special care baby units. The survey consisted of a postal questionnaire, visits and detailed interviews with 13.5 percent random sample of units. The response rate was 90% on the postal questionnaire. Although apparently a thorough study, the reporting of visit and interview results is more anecdotal than statistical. The researcher reports that "there is often a clear discrepancy between nurses' perceptions of parents' abilities to perform procedures alone and parents' perceptions of their own abilities" (p. 20). Webb, Hull and Madeley (1985) echoed this finding in a study of 80 parents and 54 pediatric staff. It is suggested by the researcher that "in most instances the pediatric staff thought that the parents could do more than they did, but parents thought that they could do even more than the staff thought (p. 177).

Bailey, Palsha, Simeonsson (1990) examined the extent to which 142 early interventionists felt competent in working with families, valued family roles, and were concerned about changing to family-centred practices. Surveyed subjects included educators, physical therapists, occupational therapists, speech/language pathologists, social workers and nurses. The typical professional endorsed 54.3% of their most valued roles as family roles. Nearly half (48%) rated the majority of most important roles as family related and 22% rated an equal number of child and family roles. Thirty percent endorsed a majority of child roles as their most valued, suggesting inconsistency in the practice of family-centred care activities.

Recent studies by Latter, Clark, Wilson-Barnett and Maben (1992) and Young (1992) also emphasized perceptions. Latter et al. (1992) studied 142 British acute care nurses not limited to the pediatric setting. The researchers found that 'patient education' and 'information giving' were felt to be occurring on a greater number of wards and significantly more frequently than 'encouraging patients and their families to participate in care'" (p. 164). Young (1992) in a historical study of changing attitudes towards families of hospitalized children found that "pediatric nurses, in particular, were slow to encourage family visiting and participation in care" (p. 1422).

In relation to perception, Porter (1979) studied the effect of professional role conception versus employee role conception in influencing 353 pediatric nursing and medical employees' implementation of family-centred care. Professional role conception encompassed such factors as "concern for the client", "competence based upon knowledge and skills", and "participation in decision making", while employee role conception was determined by factors such as "respect for administrative superiors", "adherence to official rules and procedures", and "competence based on experience" (p. 330). She found a positive, but weak relationship between professional role conception and likelihood of practising family-centred care. Further, the more inclined the individual was toward the employee role, the less likely the person was oriented to practising family-centred care.

Education and Knowledge

Level of Education

Supplementary findings from Porter (1979) suggested that respondents with masters' degrees tended to be least oriented to the employee role and those with diplomas or associate degrees tended to be most oriented, suggesting

that master's prepared staff were most oriented to practicing family-centred care. Among subgroups, the higher a nurse advanced in a professional career in terms of education and experience, the more oriented the nurse was to family-centred care.

Gill (1987a) studied attitudes of 273 staff nurses, head nurses, and nurse supervisors toward parent participation in pediatric care. It was indicated by the results that master's degree prepared nurses had significantly more accepting attitudes than did nurses with diplomas, associate degrees or bachelor's degrees in nursing ($p<.05$). This indicates that educational influences can alter perceptions and acceptance of family-centred care activities such as parent participation in care. Gill (1987a) suggested that "inservice and continuing education can assist nurses, physicians, and other health care personnel to explore...and examine the factors that may be influencing their attitude toward and behaviour with parents" (p. 150). These findings support previous findings by early researchers (Dunn, 1979; Siedl, 1969). Siedl found that nurses with higher education had increased support for parent participation. Dunn (1979) also found that nurses with less than a bachelor's degree demonstrated decreased support for parent participation in hospitalized child care. Further, a study by Humphry, Gonzalez and Taylor (1993) of 340 occupational therapists found that respondents who were not in direct service and those with degrees beyond a baccalaureate tended to have more positive attitudes about working with families.

Educational Content

Cochrane, Farley, and Wilhelm (1990) surveyed 73 educational programs with infancy specializations. Eight disciplines were studied and included nursing, nutrition, occupational therapy, physical therapy, psychology, special education, speech and language pathology, and social work. Faculty representatives were administered a questionnaire requesting information about the amount of education received in infant and family assessment and intervention and any plans for "increasing infant-family focus in the future" (p. 373). In baccalaureate programs, 97% of respondents perceived that students received adequate preparation with infants compared with only 36% with families. Ninety-two percent of master's program respondents perceived that students received adequate preparation with infants compared with only 23% with families. Eighty-seven percent of respondents indicated a need for training and educational materials for working with infants' families. It is suggested by these findings that lack of family-related content in educational curricula and

training materials pose barriers to the practice of family-centred care.

Bailey, Simeonsson, Yoder and Huntington (1990) concur with these findings. Surveys were conducted to determine the extent to which entry-level students in eight disciplines receive academic preparation and clinical experiences to provide services to infants and toddlers with disabilities and their families. Disciplines surveyed included nursing, nutrition, occupational therapy, special education, social work, special education, and speech and language pathology. The survey measured the mean number of clock hours of classroom instruction in six content areas. In 'normal and abnormal infant development', speech and language pathology scored highest at the undergraduate and master's level. In 'infant assessment and intervention', occupational therapy scored highest at the undergraduate level and speech and language pathology at the master's level. In 'family assessment and intervention', nursing scored highest at the undergraduate level and social work at the master's level. These three categories recorded the most clock hours for all disciplines. Other categories included 'interdisciplinary team process', 'case management' and 'values and ethics'. It was suggested by the findings that although considerable variability was found across disciplines, the average student receives little specialized information or practical knowledge relative to either the infancy period or to working with families.

Professional Discipline

In Porter's (1979) study, physicians had the lowest orientation to family-centred care and concern for the client ($p=.000$). Porter stated that "the image of physicians as traditionally focused on pathological conditions with the patient as the unit of medical care seemed to be further supported by the present findings" (p. 334).

In a previously described study by Bailey, Palsha, Simeonsson (1990) (see 'Perceptions'), 142 early interventionists were surveyed. In general, nurses and social workers scored higher than did educators and other health-care professionals on several dimensions of family-centred care. Further, for all the health-care professionals, ratings of skills in working with families were significantly lower than ratings of skills in working with children ($p<.03$).

Marvel and Morphew (1993) studied 251 videotaped resident-patient interviews to determine the level of family involvement in medical education and practice. This study

was not limited to pediatric residents and physicians. It was shown by the results that residents asked about family issues with individual patients or spoke directly to family members about medical concerns in 41% of interviews; however, planned family conferences or emotional support of family members seldom occurred. Attending physicians inquired about family information in only 6% of the one-on-one teaching consultations with residents. The researchers suggest the need for increased medical faculty development efforts in the area of family involvement.

Results from studies performed by Brown and Ritchie (1989 & 1990) suggest other barriers to effective family-centred care in practice. In a study of 25 pediatric nurses' descriptions of satisfying and dissatisfying relationships with parents of hospitalized children, results suggested that either the nurses did not have the knowledge of communication skills, conflict management and family-centred care to provide therapeutic, goal-oriented care for parents, or had difficulty utilizing that knowledge in practice (Brown & Ritchie, 1989). A second group of 25 pediatric nurses were studied to determine their perceptions of parent and nurse roles in caring for hospitalized children. Results indicated that often the nurses' need for control influenced the psychoemotional care provided for parents (Brown & Ritchie, 1990).

Bailey, Buysse, Edmondson and Smith (1992) studied 237 health-care professionals' perceptions of the current status of family involvement in early intervention programs in four American states. The health-care professionals consisted of teachers, therapists, psychologists, social workers, program administrators and agency administrators. Ratings of typical and ideal levels of family involvement are found to present substantial and highly significant differences ($p<.0001$). In identifying barriers to family involvement in early intervention programs, 36% of respondents identified family barriers such as lack of knowledge or skill. In contrast, only 15% mentioned professional barriers such as lack of knowledge or skills. The authors conclude that "professionals perceive a substantial discrepancy between how they currently involve families in early intervention programs and how families ideally should be involved" (p. 307).

Overall, education and knowledge have demonstrated effects on perceptions and practice of family-centred care in the areas of educational level, educational content, and professional discipline.

Staff Position and Experience

It is indicated by further findings from Porter's (1979) study (see 'Perceptions' and 'Education and Knowledge') that health-care professionals in the administrative group composed of department heads, supervisors, and head nurses were more concerned with loyalty to the public than with family-centred care issues (p=.007-.01). In contrast, Gill's (1987a) study (see 'Education and Knowledge') of 273 staff nurses, head nurses, and nurse supervisors found that supervisors had significantly more accepting attitudes than did other nurses (p<.01). Gill's findings are again supported by earlier research (Dunn, 1979; Siedl, 1969). Siedl (1969) found that nurses with administrative positions had more accepting attitudes toward parent participation. Further, Dunn (1979) found that nurses under 25 and over 38 years of age, nurses with less than a bachelor's degree and nurses spending less than 25% and more than 75% of their time in direct patient care demonstrated decreased support for parent participation in care.

A study by Bailey, Buysse, Smith and Elam (1992) focuses on the effect of experience on perceptions of incorporating the family into care. The article describes the perceptions of parent participation in a workshop designed to help professionals working in early intervention programs for young children with disabilities become more family-focused in their work. Two workshops were held, one in which parents were invited to attend along with professionals and one attended only by professionals. It is indicated by the results that parent presence influenced professionals' perceived need for increasing parent participation in programs. Parents and professionals who experienced parent presence were positive about the experience and professionals who attended the workshop without parents felt strongly that parents should have been there.

Organizational Setting

Porter (1979) (see 'Perceptions', 'Education and Knowledge' and 'Staff Position and Experience') also found that subjects who worked in pediatric wards were distinctly oriented to family-centred care while those in private medical clinics and public health departments were consistently found to be least oriented. Health-care professionals' perceptions were found to indicate the likelihood of practising institution-centred care as opposed to family-centred care.

Supplementary findings of Gill (1987a) (see 'Education

and Knowledge' and 'Staff Position and Experience') indicate that subjects who worked in one of two specific hospitals had more positive attitudes toward parent participation than did other subjects $p<.05$). Although an environmental link is recognized between attitude and parent participation, Gill (1987a) does not suggest reasons or describe institutional differences. Interestingly an earlier study, which supports Gill's findings, suggests that if the charge nurse on a ward was supportive of parent participation, the nurses on the ward would have a correspondingly higher acceptance level (Siedl, 1969)

It is indicated by Knafl, Cavallari and Dixon's (1988) study (see 'Perceptions') that "the work of the pediatric nurse was also influenced by the general way in which nursing care was organized on the unit" (p. 291). The researchers suggest that primary nursing care, which recognizes the nurse's professional expertise, is most suitable to the practice of family-centred care.

Bailey, Buysse, Edmondson and Smith (1992) (see 'Education and Knowledge') study 237 health-care professionals' perceptions of barriers to family involvement in early intervention programs, also found that 35% of respondents mentioned systemic barriers such as administrative policies or lack of resources.

In relation to physical barriers in the organizational setting, a study by Thornes (1985) (see 'Perceptions') documents that many pediatric units "do not provide even simple facilities that might add to the comfort and reduce the stress of parents who may spend many hours in the unit sharing nursing care" (p. 20). Thornes (1983) also performed an earlier study of the physical barriers to parental access in children's wards. It is shown by the results of a questionnaire that in 250 out of 887 wards surveyed (28%), children were nursed in adult wards with inadequate facilities for parents. Parental access to children was denied on operating day by 36 wards and "several banned parents for 36 hours" (p. 191). However, most of the wards surveyed (89%) could provide some sort of overnight accommodation for parents.

Time and Personnel Availability

A qualitative study performed by Hayes and Knox (1984) involved interviews with 40 parents of hospitalized children with long-term disabilities. The researchers wanted to explore "parents' perceptions of health-care workers' roles" (p. 334). It is suggested by the findings that parents' perceive health-care professionals as having difficulty making themselves available to families. Hayes and Knox

(1984) also found that "parental stress is attributable to the space between health care workers...and parents" (p. 333).

Mahoney and O'Sullivan (1990) surveyed speech pathologists, occupational therapists, physical therapists, social workers, nurses, and psychologists to examine the degree to which early intervention activities currently focus on the family. Forty percent of the sample reported spending no time with families during a typical week. Respondents reported successfully achieving goals set for many of their families, yet they also reported insufficient time for family services.

Park (1991) performed a qualitative study of parents' experiences during the hospitalization of their children. The researcher discussed parents' awareness of inadequacies in their child's care. While noticing that nurses are very busy, parents expressed anger at being ignored as a source of information and assistance. All of the parents also spoke of doctors' and nurses' lack of respect for parents' opinions.

Humphry, Gonzalez and Taylor (1993) surveyed 340 occupational therapists to determine extent and manner in which they work with families. It is indicated by the results that respondents identified time and scheduling difficulties as the biggest issue affecting their involvement with families of their clients.

Role Negotiation and Communication

Results from studies by Ogilvie (1990) and Callery and Smith (1991) also suggest that nurses have difficulty making themselves available to families. Ogilvie (1990) performed a qualitative study of nine families to explore the parental experience when a child is hospitalized for surgery. It was suggested by the findings that parents perceived nurses as having insufficient time to spend with individual patients or families. Suggestion is made for nurses to negotiate roles with families. Callery and Smith (1991), in a study of role negotiation between nurses and the parents of hospitalized children concur with this finding and emphasize that role negotiation is essential to effective family-centred care.

Congruent with these findings, Algren (1985) developed a questionnaire asking 20 parents of hospitalized children about "what the parent has been asked or told about their role" and "whether they would prefer to perform the task or have the nurse do it" (p. 7). It was shown by the findings that although the majority of mothers prefer to perform many

child-care activities, 60% of mothers reported that they had not received any communication from staff regarding their role with their child, and 70% stated that the nursing staff had not explained the role they could or should assume.

Saylor, Elksnin, Farah and Pope (1990) performed a study of the types of procedures that could be useful in maximizing the participation of families in early intervention programs for special-needs infants, toddlers, and preschoolers. Twenty-nine techniques for maximizing participation of families were rated by 64 early intervention professionals and 29 mothers of high-risk children and toddlers. Verbal praise and encouragement, written and resource materials were highly rated by the professionals, whereas mothers were significantly more likely to endorse tangible reinforcement and logistical support such as monetary rewards ($p<.0001$), social encouragement ($p<.01$) and mail reminders ($p<.01$). Interestingly, professionals reported that tangible reinforcement was seldom used and that they did not expect such techniques to be useful. These discrepancies suggest a communication gap between professionals and parents that must be addressed if family-centred care is to be implemented successfully.

Overall, these studies reflect communication gaps between professionals and families in both the hospital and community settings.

Costs

Economic constraints have been suggested as barriers to effective family-centred care. Mahoney, O'Sullivan and Dennebaum (1990), in a follow-up study of 503 mothers of birth to six-year old handicapped children in early intervention programs, found that "the need for family services was greater than that currently being received" (p. 133). Gunn and Nightingale (1989) reviewed services offered in the neonatal and obstetric units of a hospital in New Zealand. Results suggest that 61 extra full-time staff were needed to reduce the workload and enable the staff to practice family-centred care. The "policy of no increase of financial resources [which] must result in a reduction of services" prevents family-centred care from becoming a reality (p. 139).

Parental and Marital Status

Interestingly, Porter (1979) found that health-care workers without offspring were more oriented to family-centred care and the professional role than were subjects with offspring. In contrast, Gill (1987a) found that

subjects who were married or parents had more positive attitudes toward parent participation than other subjects. Siedl (1969) also found a relationship between being a parent and support of parent participation in care of hospitalized children.

In summary, while family-centred care has been shown to improve health, enhance learning and reduce stress, barriers to the practice of family-centred care by health-care professionals are many. Misperceptions of family-centred care related to lack of education or understanding are frequently cited barriers. Degree of professionalism, communication gaps and lack of skill or ability to use knowledge in practice have also been cited as problems. Health-care professionals may be affected by time constraints and difficulty making themselves available to families. Inadequate communication and lack of role definition between parents and professionals are other barriers. The organizational setting and costs also influence the practice of family-centred care. Finally, demographic variables including marital status, parental status, job position, health-care discipline and educational preparation are also cited as factors influencing family-centred care.

Summary

The benefits and barriers to the involvement of families in the care of children with special health needs are well demonstrated. These are clearly recognized in spite of the lack of research that specifically utilizes the family-centred care framework of the ACCH. Only one study utilized the ACCH family-centred care framework (Bruce, 1992) and many of the studies on family involvement were not performed in the pediatric health-care setting. There is a clear need for research using the family-centred care framework in the pediatric setting.

Discrepancies are noted throughout the literature. Cost is recorded as both a benefit and a barrier to the incorporation of family-centred care, indicating a need for rigorous research. In addition, staff position and parenting experience may or may not influence the acceptance of family-centred care in practice.

Perception clearly has an effect on health-care professionals' practice of family-centred care. However, the relationship between perception and other described barriers is unclear and needs to be examined. The many difficulties experienced by staff in practicing family-centred care also suggests a need for further study. It must be determined whether staff perceive family-centred

care according to the elements described by the ACCH. If perceptions are incorrect then this becomes a barrier to practice. If perceptions are correct and health-care professionals are still unable to practice family-centred care, the question 'why?' must be asked. Is this difficulty related to health-care professionals' educational level, experience, organizational setting, time constraints, or costs that lead to understaffing? Is it related to a lack of education about the various skills needed to practice family-centred care such as communication and role negotiation? The relationship between perceptions about family-centred care and practice must be determined to facilitate the incorporation of family-centred care into the clinical setting.

CHAPTER III

METHOD

Research Design

This study is descriptive in nature and involves surveying pediatric health-care professionals at the Alberta Children's Hospital of Calgary, Alberta utilizing a questionnaire specifically developed to measure perceptions and practices of family-centred care (Bruce, 1992). This approach is appropriate to the purpose of this study since little is known about the perceptions and practices of family-centred care by pediatric health-care professionals (Brink & Wood, 1989). Relationships between the independent demographic variables and the dependent variables of perceptions and practices of family-centred care were also examined.

This study represents part of a multi-site survey. The research is also conducted by Beth Bruce, MN, Research Associate, at the Izaak Walton Killam Hospital for Children in Halifax, Nova Scotia and by Christine Dennis, MN, Clinical Nurse Specialist, at the Children's Hospital of Western Ontario, in London, Ontario.

The Sample

The population of interest is health-care professionals employed in full-time or part-time positions at the Alberta Children's Hospital of Calgary, Alberta (N=696). This population included those employed in staff, education, and management positions. The sample (n=500) was stratified by profession to include child life specialists, nurses, nutritionists, occupational therapists, pharmacists, physicians, physiotherapists, psychologists, respiratory therapists, social workers, and speech and language pathologists and audiologists.

Subjects for the sample were selected using stratified systematic sampling with random start (Palys, 1992). The names and addresses of all health-care professionals were obtained from the Alberta Children's Hospital Nursing Resources and Payroll Departments. A list of the health-care professional population was prepared, and individuals separated by their professional group. Nurses accounted for 439 and all other health-care professionals accounted for 257 of the total population. The breakdown of the non-nursing professionals included child life specialists 11, nutritionists 10, occupational therapists 26, pharmacists 13, physicians 42, physiotherapists 37, psychologists 29, respiratory therapists 10, social workers 33, and speech and

language pathologists and audiologists 46. Because of the small sizes of the non-nursing professional groups, these total populations were surveyed. The nursing professional group's list was alphabetized and randomly sampled at a ratio of 243/439. In short, 243 nurses were randomly sampled and 257 non-nursing professionals were surveyed as total populations.

The Family-Centred Care Questionnaire-Revised (FCCQ-R) (Bruce, 1993) (Appendix B) was provided to a sample of 500 Alberta Children's Hospital health-care professionals and the final sample size was determined by the number of responding subjects. In consultation with the Thesis Committee, the resultant sample was time-limited to include those participants who responded by June 8, 1994. Casual staff and professional staff on leave of absence for any reason were excluded from the study. Upon return of the questionnaires, subjects who failed to respond to the demographic questions and/or had ≥10% missing data were excluded from the analysis of data.

External and Internal Validity

Brink and Wood (1989) indicate that the "ideal sample for a descriptive design is either a total available population or a sample drawn by means of probability sampling techniques from a target population" (p. 127). Both of these techniques were used in order to ensure generalizability or external validity in the description of population characteristics. The objective of descriptive studies is to describe the variables and look for significant relationships among the variables. However, attempts are not made to draw conclusions about the causal relationships from the data. Rather, hypotheses are formulated from statistically significant relationships, and these relationships are later tested in more controlled studies from which causal relationships might be developed (Brink & Wood, 1988). As such, Brink and Wood (1989) indicate that "internal validity is not an issue in descriptive designs because no attempts are made to examine causal relationships between variables" (p. 127).

Data Collection

Data were collected by surveying 500 subjects from the Alberta Children's Hospital. The data included responses to the FCCQ-R, a 45-item questionnaire developed in a previous study, an open-ended question sheet, and a demographic data sheet.

The Alberta Children's Hospital is a well-established tertiary-care facility that serves children and families

from southern Alberta, southeastern British Columbia, and southwestern Saskatchewan. It is the only self-contained pediatric tertiary-care centre in Alberta and one of three in Western Canada. The Alberta Children's Hospital provides the excellent environment to access a variety of health-care professionals who deal exclusively with children and families. It is also committed to a philosophy of family-centred care (Appendix C).

The researcher introduced the study at a series of meetings at the Alberta Children's Hospital. The first meeting was with the Director of Nursing, a hospital nurse researcher and a nurse educator. Logistical details were discussed and a hospital sponsor was assigned to the research. The study was presented at a second meeting of department directors and a third meeting of the entire nursing executive. Details were finalized such as obtaining a letter of support from the Director of Nursing and completing the hospital's administrative checklist for research projects. The researcher was initially informed that unofficial approval had been obtained from the Chair of the Alberta Children's Hospital Research Committee and that institutional ethical approval was not needed because of approval obtained from the University of Alberta Thesis and Ethical Review Committees. However, the institutional Research Committee reconsidered and the protocol was again reviewed and followed by official approval on February 28, 1994 (Appendix D). The protocol was forwarded to the Alberta Children's Hospital Conjoint Ethics Committee and final approval was obtained on March 21, 1994 (Appendix E). This enabled the study to commence on Tuesday, March 22, 1994. Prior to commencement, an announcement about the study (Appendix F) was placed in the hospital newsletter, and posted flyers (Appendix G) and information bulletins (Appendix H) were circulated throughout the hospital.

All subjects were reached through the hospital mail service. The first of three mailouts included a covering letter (Appendix I), the questionnaire (Appendix B), an addressed return envelope, and a postcard (Appendix J). The letter explained the study, emphasized the voluntary nature of participation, and identified the time frame and method for returning the completed questionnaire. The letter also assured subjects that anonymity would be maintained throughout the study and in the reporting of study findings and confidentiality would be maintained by reporting only group data. The postcard instructed subjects to return the postcard separately when they completed the questionnaire or if they wished to be removed from the mailing list. This prevented subjects who responded from receiving the second and third mailouts. The second mailing was on Tuesday, April 5, 1994, two weeks after the initial mailing.

Subjects who did not return postcards received a second package containing a questionnaire, new cover letter (Appendix K), and return address label which could be affixed to the outside envelope for reuse. The final mailing was on Tuesday, April 12, 1994, three weeks after the initial mailing. Again, subjects who did not return postcards received envelopes containing a letter (Appendix L). These final two letters reiterated the statements of the initial cover letter, thanked subjects who already responded, and reminded subjects who had not responded to do so promptly. The mailing of the second questionnaires and final letters was done in anticipation of improving response rates.

Instrument

The FCCQ-R (Bruce, 1993) (Appendix B) was selected for this study as it was designed to measure health-care professionals' perceptions and practices of family-centred care. The instrument is the only current and relevant instrument available for this purpose. A related instrument, the Family-Centred Care Scale designed by Porter (1974) is neither accurate nor complete in its reflection of current practice and is insufficiently comprehensive to be consistent with the conceptual framework (Bruce, 1993).

The FCCQ-R is a revised version of a tool developed by Bruce (1993) to study pediatric nurses' perceptions and practices of family-centred care. The instrument is based on the guidelines for family-centred care that were generated by the ACCH (Johnson et al., 1992), and by the IWK family-centred care committee (Bruce, 1993). The items are distributed over nine subscales that represent each of the nine elements of family-centred care (Bruce, 1993).

Through the FCCQ-R, health-care professionals are asked to identify (1) the extent to which each of the 45 items is included in their everyday work and (2) the extent to which each item is necessary to provide family-centred care (Bruce, 1993). The responses were rated on a 5-point Likert-type scale, ranging from "strongly agree" to "strongly disagree". The category of "not applicable" also enables subjects to respond appropriately when the item cannot be performed in everyday work. The open-ended portion of the questionnaire provides opportunity for health-care professionals' to record any comments or "suggestions of what is needed to enhance family-centred care". Subjects are also asked to comment on whether or not "there is a large difference between your everyday work and what is necessary to practice family-centred care" and to describe "instances in which you become child-centred instead of family-centred in your approach to care". As

well, staff members are requested to provide demographic data including age group, years of clinical experience in the institution, professional group, education, staff position, parental status, and department.

Validity and Reliability

Content validity of the instrument has been established by a thorough review by the Thesis Advisory Committee (Bruce, 1992) and the IWK Family-Centred Care Committee. All reviewers agreed that the items represented all the "direct care issues in family-centred care...[and] that each item was relevant to family-centred care (Bruce, 1992, p. 35). Construct validity was not assessed.

The 55-item Family-Centred Care Questionnaire (FCCQ) was initially tested on 124 nursing staff in a tertiary care centre and subsequently revised to the present 45-item FCCQ-R (Bruce, 1993). Test-retest reliability for the FCCQ was .88, and for each of the subscales ranged from .60 to .88 (Bruce, 1993). The internal consistency was greater than alpha=.90 (Bruce, 1993). The instrument has been revised based on the item analysis (Bruce, 1993). Items that fell below the criterion levels of r=.3 for inter-item correlations, r=.5 for item to subscale correlations, or r=.3 for item to total-scale correlations were examined for clarity of wording (Allen & Yen, 1979 as cited in Bruce, 1993). Those that were considered essential to the conceptual integrity of the scale were retained and reworded (Bruce, 1993). Items with item to total correlations of r<.36 were deleted in those subscales with more than five items (Bruce, 1993). The revised instrument consists of 45 items distributed over the original nine subscales (Bruce, 1993).

Discussed in the chapter on findings, further psychometric testing of the FCCQ-R was done using correlation and factor analysis in this study. The internal consistency reliability coefficient of the instrument was tested utilizing Cronbach's alpha (Polit & Hungler, 1983). A factor analysis was also performed to determine how the 45 items cluster.

Pilot Test

The instrument was pretested to ascertain its clarity, freedom from bias, and time requirements for completion (Polit & Hungler, 1983). A convenience sample of eight subjects was selected, three from the Master's of Nursing program at the University of Alberta, three from the Grey Nuns Hospital Pediatric Unit, and two from the University Hospital Pediatric Department in Edmonton, Alberta.

Subjects were students or employees experienced or working in pediatric areas. Pre-test subjects were asked for feedback about the structure of the questionnaire. For example, "Do you feel that the side-by-side structure of the 'current' and 'necessary' scales encouraged you to be consistent in your responses to each scale?" or "Do you feel that the side-by-side structure enabled you to think more clearly about discrepancies between your responses to the 'current' and 'necessary' scales?" All subjects reported that the side-by-side structure encouraged greater consideration of discrepancies between the "current" and "necessary" scales, although one respondent indicated that the side-by-side structure encouraged consistency in responses. Results of the pre-testing were incorporated into the initial FCCQ-R structure (Appendix M) and the resultant FCCQ-R used in the study (Appendix B). The introductory paragraph was clarified, additional underlining was added to highlight important points, the "not applicable" category was explained and added, the definition of "staff" was elaborated, the definitions of staff and family were added to each questionnaire page to facilitate understanding, and the "current" scale heading was changed to read "everyday work". Changes to the open-ended portion of the questionnaire include the addition of two questions allowing respondents to describe why "there is a large difference between...current practice and what...is necessary" and "instances in which [they] become child-centred instead of family-centred in [their] approach to care (Appendix B).

Data Analysis

The findings were analyzed according to the subscales representing the nine elements of family-centred care, and the total scale scores. Descriptive statistics were used to provide a summary of health-care professionals' perceptions of the extent to which the key elements of family-centred care are necessary to practice family-centred care, and the extent to which these are perceived as being present in their own practice (Bruce, 1993). Content analysis was used to describe the variety of responses received on the open-ended portion of the questionnaire.

Analysis of variance techniques were used to determine the variation between professional groups. Undersampled disciplines required weighting in the analysis of data. T-tests were also used to determine whether staff and management groups differ in their ratings of family-centred care component items currently practised and those necessary for family-centred care. The effect of the independent variables of position, profession, education, age group, and years experience on perceptions and practices of family-

centred care were analyzed using regression analyses. The independent variables found to contribute to perceptions and/or practices of family-centred care were used as covariates in two-way ANOVAs. The Scheffé test was used to control for experimental error rate that increases with multiple comparisons.

Ethical Considerations

Several methods were used to ensure the protection of human subjects in this study. Subjects for the sample were selected using stratified systematic sampling (Palys, 1992) involving a combination of random sampling and total populations. The study was introduced in the hospital newsletter and accompanied by flyers and information bulletins throughout the hospital. The voluntary nature of participation in this study was emphasized as well as the inability to identify participants or non-participants. There was no way to match returned questionnaires with subjects, thus ensuring anonymity. The benefits of participation to knowledge development and the lack of harm to subjects were also addressed. Contact telephone numbers were provided for subjects to access more information about the study. Subjects also had the opportunity of preventing responses to the open-ended data sheet from being quoted (Appendix B). Confidentiality was assured by reporting only group data in the publication or presentation of questionnaire results. Further, data were analyzed and presented in a way that ensures that no individual participant is recognizable. The subjects were given the names, addresses, and telephone numbers of people they may contact with questions. Returned questionnaires were considered adequate for consent (Bruce, 1993).

CHAPTER IV

FINDINGS

This exploratory descriptive study examined pediatric health-care professionals' perceptions and practices of family-centred care using the Family-Centred Care Questionnaire-Revised (FCCQ-R). Family-centred care is described as consisting of the nine elements developed by the Association for the Care of Children's Health (ACCH) and modified by the Izaak Walton Killam Hospital for Children in Halifax, Nova Scotia (see Appendix A). The results of the statistical analysis of the data, factor analysis and content analysis are described in this chapter.

The data were entered into the computer and checked by the researcher, re-checked by the researcher and an associate, and checked again by a third person in a random selection of 10% of the returned questionnaires. Statistical Package for the Social Sciences (SPSS) was used and the data were determined to be accurately recorded.

Description of the Sample

Final Sample Size and Description of Losses

Five hundred employees were sampled from the Alberta Children's Hospital (ACH) population of health-care professionals, including 243 nurses and all 257 non-nurses. The total population numbered 696, 439 nurses and 257 non-nursing health-care professionals. Twenty-two questionnaires were unobtainable in the sampled group because of maternity leaves, sick leaves, or cessation of employment at the ACH. This left a sample size of 478. Two hundred and sixteen subjects returned questionnaires for a response rate of 45%. After inspection, 33 questionnaires were removed from the study because more than nine questions were incompletely answered. Twelve more questionnaires were removed because of incomplete demographic information. The number of usable questionnaires was 171, reducing the completed response rate to 36%. The remaining questionnaires that presented with nine or fewer incomplete responses (exclusion criteria of cases with ≥10% missing data) were adjusted by substituting variable means for the missing data. This ensured that the results of the data analysis were not altered by excessive amounts of missing data. As a result, the elimination of cases from the data analysis was done to reduce the error that may have occurred through the insertion of variable means into cases with large amounts of missing data.

The original data file consisting of 216 cases was

compared with the final data file of 171 cases by factor analyses. Factor Eigenvalues, which identify the amount of variance explained by individual factors (Ferketich & Muller, 1990), and the percent of variance explained by each factor for each file were similar reflecting very little difference between the original file and the final file (see Appendices N, O, P and Q).

Sample Characteristics and Descriptive Data

The final sample consisted of 2.9% child life specialists (n=5), 43.3% nurses (n=74), 3.5% nutritionists (n=6), 7.6% occupational therapists (n=13), 1.2% pharmacists (n=2), 6.4% physicians (n=11), 9.4% physiotherapists (n=16), 8.2% psychologists (n=14), 4.7% social workers (n=8), 11.1% speech/language pathologists and audiologists (n=19), and 1.8% others (n=3) (see Appendix R, Figure 1). Table 4.1 shows that social workers had the highest mean total scores on the perceptions scale of the FCCQ-R indicating more accurate perceptions of family-centred care. Physicians had the lowest mean total scores on the perceptions scale (See Appendix R, Figure 2). Table 4.2 shows that social workers had the highest mean total scores on the practice scale of the FCCQ-R, while pharmacists scored lowest (See Appendix R, Figure 3). Unless otherwise stated, the number of cases always totals 171.

Table 4.1

Health-Care Professionals' Perceptions of Family-Centred Care: Mean Total Scores

Health-Care Profession	Mean Score	Standard Deviation	Cases
Child Life	194	11	5
Nurse	191	17	74
Nutritionist	184	6	6
Occupat. Th.	188	11	13
Pharmacist	182	13	2
Physician	179	20	11
Physiother.	188	13	16
Psychologist	191	12	14
Social Work	195	22	8
Speech/Lang.	190	13	19
Other	192	18	3

$F=.92$, $p=.51$

Table 4.2

Health-Care Professionals' Practice of Family-Centred Care: Mean Total Scores

Health-Care Profession	Mean Score	Standard Deviation	Cases
Child Life	166	7	5
Nurse	165	20	74
Nutritionist	161	18	6
Occupat. Th.	162	19	13
Pharmacist	142	38	2
Physician	154	17	11
Physiother.	158	17	16
Psychologist	166	22	14
Social Work	177	17	8
Speech/Lang.	158	24	19
Other	164	43	3

$F=1.26$, $p=.26$

Eighty-six percent ($n=147$) classed themselves as "Staff", 10.5% ($n=18$) as "Managers", 4.1% ($n=7$) as "Education", 3.5% ($n=6$) as "Administration" and 7% ($n=12$) as "Other". The percentages total greater than 100 because subjects were free to choose more than one response.

Appendix R, Figure 4A shows the frequencies of the dichotomous variables before recoding. These dichotomous variables were recoded into one multicategoric variable which maximized the contribution of the categories with lower frequencies of response (see Appendix R, Figure 4B). Not all responses could be taken into account lest the assumption of independence be violated.

Tables 4.3 and 4.4 show that health-care professionals who classed themselves as "Other" scored the highest on both the perceptions and practice scales while "Staff" scored lowest on perceptions and practice (see Appendix R, Figures 5 and 6).

Table 4.3

Perception Scores According to Area of Employment

Area	Mean Score	Standard Dev.	Cases
Staff	188	16	140
Education	198	17	7
Manager	192	13	16
Administrat.	195	12	6
Other	205	9	2

F=1.57, p=.18

Table 4.4

Practice Scores According to Area of Employment

Area	Mean Score	Standard Dev.	Cases
Staff	162	20	140
Education	168	30	7
Manager	168	19	16
Administrat.	169	26	6
Other	186	19	2

F=1.25, p=.29

Subjects "less than 31 years of age" constituted 17% (n=29) of the final sample, "31-40 years of age" were 42.7% (n=73), "41-50 years" were 32.2% (n=55) and "51-60 years" numbered 8.2% (n=14) (see Appendix R, Figure 7). Table 4.5 shows that subjects less than 31 years of age scored highest on the perceptions scale of the FCCQ-R while subjects aged 31 to 40 years scored lowest (see Appendix R, Figure 8). Table 4.6 shows that subjects between 51 and 60 years of age scored highest on the practice scale while subjects less than 31 years of age and between 31 and 40 years of age both scored lowest (see Appendix R, Figure 9).

Table 4.5

Perception Scores According to Age Group

Age Group	Mean Score	Standard Dev.	Cases
Less than 31	193	16	29
31 to 40	187	15	73
41 to 50	191	16	55
51 to 60	190	14	14

$F=1.36$, $p=.26$

Table 4.6

Practice Scores According to Age Group

Age Group	Mean Score	Standard Dev.	Cases
Less than 31	159	18	29
31 to 40	159	20	73
41 to 50	169	23	55
51 to 60	172	17	14

$F=3.5$, $p=.016$

Subjects' reported professional pediatric experience ranged from one to 32 years. Thirty-nine percent ($n=68$) had one to eight years of experience, 38.6% ($n=66$) had nine to 16 years of experience, 14.6% ($n=25$) had 17 to 24 years of experience and 7% ($n=12$) reported 25 to 32 years of experience at the ACH and/or another pediatric setting (see Appendix R, Figure 10). Tables 4.7 and 4.8 show that subjects with 25 to 32 years of experience had higher scores on both the perceptions and practice scales (see Appendix R, Figures 11 and 12).

Table 4.7

Perception Scores According to Years of Experience

Years Exper.	Mean Score	Standard Dev.	Cases
1 to 8	191	16	68
9 to 16	188	15	66
17 to 24	186	15	25
25 to 32	197	13	12

$F=1.8$, $p=.14$

Table 4.8

Practice Scores According to Years of Experience

Years Exper.	Mean Score	Standard Dev.	Cases
1 to 8	162	20	68
9 to 16	164	20	66
17 to 24	164	24	25
25 to 32	168	25	12

$F=.36$, $p=.79$

As their highest level of education, nineteen point nine percent ($n=34$) reported post secondary education, 42.1% ($n=72$) had bachelor's degrees, 7% ($n=12$) had a professional specialty, 25.7% ($n=44$) had master's degrees and 5.3% ($n=9$) had doctoral degrees (see Appendix R, Figure 13). Table 4.9 and 4.10 show that subjects with professional specialties as their highest level of education scored lowest on both the perceptions and practice scales, while subjects with doctoral degrees and bachelor's degrees scored highest on the perception scales respectively (see Appendix R, Figures 14 and 15).

Table 4.9

Perception Scores According to Highest Level of Education Obtained

Education	Mean Score	Standard Dev.	Cases
Postsecond.	185	17	34
Bachelor's	192	14	72
Specialty	177	18	12
Master's	192	14	44
Doctorate	195	10	9

$F=4.1$, $p=.0036$

Table 4.10

Practice Scores According to Highest Level of Education Obtained

Education	Mean Score	Standard Dev.	Cases
Postsecond.	163	19	34
Bachelor's	165	20	72
Specialty	153	21	12
Master's	164	21	44
Doctorate	164	27	9

$F=.87$, $p=.48$

Finally, 65.5% ($n=112$) reported being parents. Descriptive statistics revealed that parents and non parents had very similar scores although non parents had higher scores on both the perceptions and practice scales (see Tables 4.11 and 4.12).

Table 4.11

Perception Scores According to Parental Status

Parent	Mean Score	Standard Dev.	Cases
Yes	188	15	112
No	192	17	59

$F=2.25$, $p=.14$

Table 4.12

Practice Scores According to Parental Status

Parent	Mean Score	Standard Dev.	Cases
Yes	163	22	112
No	164	18	59

$F=.05$, $p=.82$

Major Findings

The total scale and subscale scores were calculated using the total sample. T-tests, ANOVAs, regressions, and chi-square tests were then performed to determine if any relationships existed between the independent variables and the dependent variables of perceptions and practice. Unless otherwise stated, statistical significance was set at $p \leq .05$.

Total Scale, Subscale and Item Scores

T-tests for paired samples were conducted on the total scale scores, both perceptions and reported practice and the subscales for perceptions and reported practice of family-centred care. According to Polit and Hungler (1983), disproportional sampling requires an adjustment to the data "in order to arrive at the best estimate of overall population values" (p. 422). As a result, weighting was used in the analysis of this data to account for the different sampling methods performed on nursing and non-nursing health-care professionals. The population proportions were calculated for nurses and non-nurses. As nurses represented 439 of 696 total staff, the nurses accounted for 63.1% of the population. This left the remaining 257 non-nurses with 36.9% of the population. The sample proportions were then calculated. Non-nurses accounted for 97 of the 171 subject sample (56.7%). Nurses accounted for 74 of 171 (43.3%). As a result, the percentages were divided to obtain weighting factors (i.e. 63.07/43.3=1.457 and 36.93/56.7=0.651). These weighting factors were then used in the analysis of data particular to the whole sample to enable generalizations to the population at large.

The mean total scale and subscale scores are presented in Table 4.13. The total possible score for the total scales is 225 and the total possible item score is 5 on the 5-point Likert scale.

Table 4.13

Perception and Practice Scale Scores

	PERCEPTION					PRACTICE				
	M	SD	ITEM MEAN	RANGE		M	SD	ITEM MEAN	RANGE	
				MN	MX				MN	MX
Total [a]	190	16	4.2	133	221	164	20	3.6	104	210
Subscale1 [b]	13	1.6	3.3	8	15	12	1.9	3	4	15
Subscale2 [c]	21	2.8	3.5	14	30	18	3.1	3	10	27
Subscale3 [d]	23	2.0	4.6	17	25	21	2.9	4.2	11	25
Subscale4 [e]	22	2.3	4.4	14	25	19	3.3	3.8	10	25
Subscale5 [f]	17	2.0	4.3	11	20	15	2.8	3.8	5	20
Subscale6 [g]	22	2.3	4.4	14	25	19	2.9	3.8	9	25
Subscale7 [h]	18	1.8	4.5	12	20	17	2.3	4.3	8	20
Subscale8 [i]	28	3.6	4.0	16	35	22	4.7	3.1	11	30
Subscale9 [j]	26	2.7	4.3	17	30	21	4.1	3.5	10	30

MN=Minimum, MX=Maximum
[a] t=17.22
[b] Family is constant, t=5.43
[c] Collaboration, t=12
[d] Individuality, t=12.5
[e] Information sharing, t=12.6
[f] Parent to parent support, t=12.3
[g] Development, t=10.7
[h] Emotional/financial support, t=10.5
[i] Health system design, t=15.2
[j] Staff support, t=15.7
(p<.001)

The item scores ranged from 1 to 5 for both the perceptions and practice scales on the FCCQ-R. Eleven items had ranges from 3 to 5 and all were from the perceptions scale. The lowest scoring items were items 4 "everyday work" (M=1.62, SD=.87) and "necessary" (M=1.52, SD=.87) which measured subjects' perceptions and practice of the second element of family-centred care or "collaboration".

Items 4 "everyday work" and "necessary" were the only reverse scored items as they were supposed to represent something other than family-centred care. The low mean item scores on items 4 "everyday work" and "necessary" suggests that the reverse scoring has limited effect. This raises questions about the reliability of the item if it was identified by respondents as representing the family-centred care element of "collaboration". The next lowest scoring item was item 34 "everyday work" (M=2.06, SD=.97) which referred to materials being available in both English and French. The highest scoring item was item 11 "necessary" (M=4.73, SD=.48). Eight items had mean scores of 4.6 or above and five of the items were from perceptions subscale 3 of the FCCQ-R which measures subjects' perceptions of the importance of the "family strengths and individuality" element. Item 2 "everyday work" was the highest scoring item from the practice scale and item 2 "necessary" was one of the highest scoring items overall. This item measured subjects' practice and perceptions of the importance of "determining the level of participation...that suits the family's needs best". See Appendix S.

Relationships Between Demographic Variables and Scores on the Perceptions and Practice scales

One-way analysis of variance (ANOVA) tests were used to determine the extent to which pediatric health-care professionals perceive family-centred care to be important and the independent variables of particular health-care profession, age, years of professional experience and highest level of education obtained. Statistically significant differences were found in bachelor's prepared (see Table 4.14) and older health-care professionals (see Tables 4.4 and 4.15). The Scheffé test was used to control for experimental error that increases with such multiple comparisons. In addition, T-tests were conducted to determine if differences existed between perceptions of family-centred care and the dichotomous independent variables of parental status and measures of hospital position including staff, education, manager, administration and other. No significant differences were identified. The measures of hospital position were also combined into staff and nonstaff (cases were counted as nonstaff before staff to maximize the number of nonstaff cases, Norusis, 1992) and t-tests showed no significant differences between staff and nonstaff health-care professionals. The same tests were performed using the dependent variable of practice and no statistically significant differences were found.

Table 4.14

One-Way Analysis of Variance of Perception Scores by Highest Level of Education Obtained

SOURCE	DEGREES OF FREEDOM	MEAN SQUARES	F RATIO	F PROBABILITY
Between Groups	4	919	4.06	.0036
Within Groups	166	226		

MEAN	GROUP	
176.7	Professional Specialty	
184.7	Post-secondary	
191.7	Master's Degree	
192.2	Bachelor's Degree	*
194.5	Doctorate	

(*) Indicates significant differences

Table 4.15

T-Test for Differences Between Older and Younger Subjects on Practice Scores

AGE IN YEARS	NUMBER	MEAN	SD
Less Than 41	102	159	19
41 and Older	69	169	22

T-TEST FOR EQUALITY OF MEANS

VARIANCES	DF	T-VALUE	2-TAIL SIG.
Unequal	169	-3.16	.002

DF=degrees of freedom

The independent variables (see Appendix B demographic sheet) were entered into regression equations after dummy coding of the nominal independent variables was completed (Munro & Page, 1993). This dichotomous coding method indicates that a case belongs "to the chosen group or not" (Munro & Page, 1993, p.206). The multicategoric variables, such as highest level of education obtained and health care profession were recoded and entered into multiple regression equations as groups, leaving out one variable which served as a comparison. Simple bivariate regressions were also performed on all the variables. A collinearity was found to exist between bachelor's education and some other combination of variables from the measures of the highest

level of education obtained.

Table 4.16 shows that the variables of post-secondary education, professional specialty, physicians and staff were found to contribute significantly to perception scores in negative correlations. Responses of subjects who reported having only post-secondary education or a professional specialty as their highest level of education obtained had lower scores on the family-centred care perceptions scale. Subjects who reported their area of employment as being solely staff not violating the assumption of independence, or who were physicians contributed negatively to the variance of scores on the perceptions scale. In other words, health-care professionals who reported being physicians or staff or who reported post-secondary education or a professional specialty as their highest level of education had lower mean total scores on the perceptions scale. Subjects who reported bachelor's education as their highest level of education obtained approached significance (Beta=.14, $\underline{t}$=.06) in the 2% positive contribution to the variance observed in perception scores.

Table 4.16

The Contribution of Significant Variables to Perception Scores in the Regression Equation

VARIABLE	VARIANCE EXPLAINED (%)	B	BETA	SIGNIFICANCE OF T
Postsecond. Education	2.4	-6.08	-.156	.0411
Professional Specialty	5.2	-13.8	-.228	.0027
Physicians	3.3	-11.4	-.181	.0179
Staff	2.7	-6.56	-.163	.0333

Table 4.16 shows that age and social workers' responses contributed significantly to positive practice scores on the FCCQ-R. In other words, older health-care professionals or social workers contributed positively to scores on the practice scale. Professional specialty (Beta=-.14, $\underline{t}$=.069) approached significance in the 1.9% contribution to the variance observed in the practice scores.

Table 4.17

The Contribution of Significant Variables to Practice Scores in the Regression Equation

VARIABLE	VARIANCE EXPLAINED (%)	B	BETA	SIGNIFICANCE OF T
AGE	5.5	.68	.234	.0021
SOCIAL WORK	2.3	14.8	.152	.0465

Secondary Findings

The findings of the regression analysis were examined using the Pearson chi-square test. The negative correlations between professional specialty and perceptions of family-centred care were examined to determine which professional groups reported having a professional specialty. Nine physicians, two nutritionists, one pharmacist and one physiotherapist reported having a professional specialty as their highest level of education. The null hypothesis that professional specialty is not related to health profession was not supported using the Pearson chi-square test ($p<.00001$) (Munro & Page, 1993). The negative correlations between subjects with only post-secondary education and perceptions of family-centred care were examined to determine which professional groups reported having only post-secondary education. Thirty-one nurses and one physiotherapist reported having only post-secondary education. The null hypothesis that post-secondary education is not related to health profession was also rejected by the Pearson chi-square test ($p<.0001$) (Munro & Page, 1993). In this study, health-care professionals who reported having post-secondary education as their highest level of education contributed negatively to the mean total scores on the perceptions scale. The Pearson chi-square test also rejected the hypothesis that age is not related to years of experience ($p<.00001$).

Two-way ANOVA tests were performed using the independent variables of age, post-secondary education, professional specialty, physicians and staff against the dependent variable of perceptions to determine if any of the variance could be explained by interacting variables. Two-way ANOVAs were also performed on the independent variables of age and social work with the dependent variable of practice to examine any covariance interactions. No significant interactions were found.

The professional groups were divided into nursing and non-nursing groups and compared with total scale scores on perceptions and practice of family-centred care. No

significant differences were found.

Overall, perceptions scores were found to be statistically significantly greater than practice scores. Bachelor's education was found to be statistically significantly different from all the other education levels and approached significance in the positive contribution to scores on the perception scale. Reported post-secondary education, professional specialty, physicians and staff were found to contribute negatively to perception scores. Older subjects were also found to be statistically significantly different than younger subjects in their positive contribution to scores on the practice scale. Social workers were found to contribute positively to practice scores. Although no significant interactions were found amongst the variables, professional specialty and post-secondary education were found to relate to a particular health-care profession from the Pearson chi-square tests.

Factor Analysis

A factor analysis was performed on the 171 cases to determine how the 45 items clustered. The internal consistency of the instrument was tested using Cronbach's alpha (Munro & Page, 1993).

Initially, the perceptions and practice scales factored into 11 and 14 factors respectively. Both scales were expected to contain nine factors (Bruce, 1992). Upon forcing the scales to cluster into nine factors, the perceptions and practice factors accounted for 57% and 54% of the variance respectively. The nine factors did not cluster according to the nine subscales. Factor 1 in the cluster analysis grouped around subscale 3 "individuality" of the perception scale. The remaining factors scattered amongst the remaining subscales for both perceptions and practice (See Appendices P and Q).

The results of the internal consistency reliability test for the perceptions and practice scales and subscales are described in Tables 4.18 and 4.19. The range of acceptable alpha reliability scores is conventionally considered to be $\underline{r} \geq .8$ (H. Northcott, personal communication, July 22, 1994). The total scale alpha reliability coefficients for both perceptions and practice scales are high. Subscales one "family is constant" and two "collaboration" have low alpha reliability coefficients and the remaining subscales have marginally acceptable alpha coefficients. These findings suggest that the subscale items are only moderately reliable measures of the elements of family-centred care.

Table 4.18

Perceptions Scale Internal Reliability Coefficients

SCALE	ALPHA
Total	.91
Subscale 1-Family is Constant	.23
Subscale 2-Collaboration	.52
Subscale 3-Individuality	.78
Subscale 4-Sharing Information	.67
Subscale 5-Parent Support	.65
Subscale 6-Developmental Needs	.72
Subscale 7-Emot./Fin. Support	.75
Subscale 8-Health System Des.	.70
Subscale 9-Staff Support	.76

Table 4.19

Practice scale Internal Reliability Coefficients

SCALE	ALPHA
Total	.92
Subscale 1-Family is Constant	.36
Subscale 2-Collaboration	.47
Subscale 3-Individuality	.72
Subscale 4-Sharing Information	.66
Subscale 5-Parent Support	.67
Subscale 6-Developmental Needs	.65
Subscale 7-Emot./Fin. Support	.63
Subscale 8-Health System Des.	.71
Subscale 9-Staff Support	.68

Content Analysis

The four open-ended questions at the end of the survey were examined by content analysis (see Appendix B). Fifteen subjects failed to respond to any of the open-ended questions, resulting in 201 completed surveys (response rate=93%). The original 216 cases were used for content analysis because the final data file of 171 cases did not

represent subjects who were removed from the original 216 cases. As a result, it was impossible to determine which cases should be eliminated from the content analysis. It may be assumed, however, that the content analysis sample was similar to the sample used in the analysis of data and that their responses were similar. Further, the likelihood of obtaining a richer variety of responses by using the original 216 cases was felt to outweigh the assurance of having the same sample.

Response rate varied among the four questions: Question 1 - 193/201 (96%) completed; Question 2 - 161/201 (80%) completed; Question 3 - 143/201 (71%) completed; Question 4 - 60/201 (30%) completed. Responses to Question 4, which asked subjects to "list any suggestions of what is needed to enhance family-centred care", frequently echoed the sentiments of the first three questions and was largely considered in that capacity. Other respondents to question four suggested structural improvements to the FCCQ-R.

Question 1 "Do you think there is a large difference between your everyday work and what you think is necessary to practice family-centred care? If so, why? If not, why?"

This discussion describes the statements of respondents who answered positively, negatively, or indecisively. Respondents who went into greater detail about "why" there is or is not a large difference echoed the responses many gave to question 3. As a result, these responses are discussed in the section on question 3, below.

"Yes, there is a large difference".

One hundred and eleven (58%) of the respondents answered "yes, there is a large difference". A typical positive response states: "Yes - dollars are what drive the system, not patient/family needs. To provide true family-centred care [sic] will take more money in certain areas, especially family support".

"No, there is not a large difference".

Forty-nine respondents (25%) answered "no, there is not a large difference". Typical negative responses include: "No. My experience at ACH...has been one of support for family-centred care" and "No, in this hospital we try to keep it a family-centred environment in our everyday work because we think it is necessary". Many negative respondents echoed the sentiments of positive respondents, for example: "At this point in time no. However, I am afraid that this will change with the current health care cutbacks in Alberta".

Indecisive.

Thirty-three (17%) respondents answered indecisively. A typical response deemed indecisive was "In my individual work with families, I have ample time and space to address family concerns confidentially. During outpatient clinic visits, there is little private space and opportunity to meet is limited".

Question 2: "If there are instances in which you become child-centred instead of family-centred in your approach to care, please describe."

Nine respondents (6%) indicated that they never become child-centred in practice. For example "I personally am always family centred but my program is not always so". A more common response was "These [family-centred care and child-centred care] are not interchangeable in my view. When I am child-focused...I must still take the family's perspective into account in order to maximize the success of my involvement and decrease the risk of sabotage". The remaining 94% of respondents described instances in which they become child-centred in practice.

Child's well-being at stake.

The most frequently cited instance (n=57) in which subjects reported becoming child-centred was when the "child's well-being is at stake". This involved instances of neglect or abuse, emergency or intensive care situations. Operating room professionals cited that child-centred care was frequently the norm.

Dysfunctional or absent families.

The second most frequently cited instance (n=52) of child-centred care was in cases of "dysfunctional families" or when "families are unable or unwilling to become involved". Examples included families that are unable to cope or parents who are unable to visit for geographical reasons. Subjects (n=15) also reported becoming child-centred in the approach to care in cases of "adoption, foster care or when the family is simply not involved". Many respondents indicated the strong advocacy needs of children in these situations.

Older children.

The third most frequently cited instance (n=18) when respondents reported becoming child-centred was in cases of older children. For example, in cases of "...older children who have and can express their aspirations and goals, their

concerns can supersede those of the family".

Professional judgement.

The last reason cited as being an instance in which health-care professionals become child-centred has been grouped into the category of "professional judgement" (n=10). Professional judgement occurs when the "family beliefs/values are contradictory to health/well being of [the] child - the centre needs to advocate for the child" or when the "parent upsets the child during a painful procedure". Other cited instances of professional judgement include assessments when the parent should not be present, as in cases of suspected abuse or psychological examination of the child.

Child's needs considered first.

Finally, some respondents (n=5) indicated that the "patient comes first - family requirements secondary" or that it was easier to cope with only the child's concerns. These respondents indicated that family-centred care was "not practical" as the "health care system is already overburdened" and that "psychosocial factors are of little importance". These responses suggest a lack of support, and perhaps misunderstanding of the concept of family-centred care.

Overall, most respondents that reported becoming child-centred indicated that the families' needs "would be met after the crisis" or are "considered in the context of the child".

Question 3: "Please list any suggestions of what is needed to enhance family-centred care."

These responses echoed the responses many gave to the first question of "why" there is a "large difference between your everyday work and what you think is necessary to practice family-centred care".

Financial resources.

By far, the most frequently cited suggestions or reasons for the large difference between subjects everyday work and what they thought was necessary to practice family-centred care were "financial resources" and provincial "politics" (n=60). These encompassed recent budget cutbacks that many respondents felt contributed to inadequate staffing levels and decreased staff expertise. Many respondents expressed concern that the cutbacks caused "bumping" and an "increase in part-time and casual staff"

that contributed to a decrease in expertise and continuity of care. As a result, lobbying the government or obtaining government support was suggested to enhance the practice of family-centred care.

Time.

Many respondents (n=44) reported that time constraints limited the ability to practice family-centred care. "Decreasing financial resources contribute to high census levels and inadequate staffing levels, putting time for adequately incorporating the family at a minimum".

Education.

Suggested frequently (n=40) were improvements in health-care professionals' education about family-centred care. This was recommended both at the university/college level and at the hospital level. Stronger orientations, hospital inservice programs and continuing education programs were highly recommended. Many respondents indicated that the lack of understanding and practice of family-centred care on many levels was related to lack of family-related content in educational programs. Subjects reported that the medical or acute care model limited the use and effectiveness of the family-centred care model. Some subjects (n=22) recommended improving "hospital-wide" support or "administrative support" for family-centred care and improving "multi-disciplinary coordination and communication". Other respondents (n=11) suggested "more community outreach" to move away from the medically-oriented model or an increase of "parent services or social work" services to fill the gap between subjects' everyday work and what they considered necessary to practice family-centred care.

Family participation.

Other respondents (n=34) suggested "encouraging and involving the family" as a suggestion for enhancing family-centred care. Care-by-parent units, involvement in team conferences and access to charts was recommended. Further, respondents suggested expanding the hours for treatment and increasing the flexibility of the system to accommodate families' schedules. Some recommended increasing resources for families, such as travel reimbursement or subsidized child care for siblings of children in hospital. Other recommended resources included greater access and availability of educational materials, such as videos and pamphlets for families.

Communication.

"Improving communication with the family" was frequently cited (n=18) as essential to encouraging and involving the family in setting goals and assessing the family situation appropriately. Physical barriers such as "inadequate space to communicate with family members in private" was also reported as problematic.

Overall, improved financial resources, increased staffing, more time with children and families, improved education of professionals, family participation, more resource materials, communication and physical space are suggestions to enhance the practice of family-centred care.

Question 4: "Please write any additional comments below."

Structural problems that subjects described in their responses to question four ranged from comments related to practice at the ACH to spelling corrections of the questionnaire. Many respondents (n=9) described problems responding to the questions related to the acute care and nonacute care aspects of their jobs. For example, some respondents suggested that they had difficulty responding to the questions because "some of the questions were somewhat inapplicable to the outpatient setting" or that many questions are "very dependent on setting (e.g. inpatient/outpatient) to which they are applied". Others found it difficult to answer many of the questions "due to the nonacute/acute care range of service offered within this setting". In response to item 25 which stated "direct care managers have an adequate knowledge in child development..." several respondents wanted to know what "direct care managers" were. In response to item 34 which asked if "all written material for families is available in French/English versions", several respondents indicated that the need for written materials is far greater in Spanish, Chinese, Vietnamese and other languages than French.

Summary

Health-care professionals described the degree to which the nine key elements of family-centred care are necessary to practice family-centred care as being higher than the degree to which the key elements are present in their practice. A statistically significant discrepancy was found to exist between health-care professionals' perceptions of the need for family-centred care compared with their practice of family-centred care. Perception scores of health-care professionals whose highest level of education was a bachelor's degree were statistically significantly higher than those with post-secondary, master's,

professional specialty and doctoral education. Factors contributing negatively to perception scores were post-secondary education, professional specialty, physicians and staff. Age was found to contribute positively to practice scores with subjects older than 41 years having statistically significantly greater scores than younger subjects on the practice scale. Health-care professionals who reported being social workers contributed positively to practice scores. Although no significant interactions were found amongst the variables, professional specialty and post secondary education were found to relate to the medical and nursing health-care professions respectively in the Pearson chi-square tests. The factor analysis revealed high alpha reliability coefficients for the total scale, yet relatively low subscale alphas. The content analysis described subjects' responses to the open-ended portion of the FCCQ-R and described instances when subjects reported becoming child-centred and their suggestions for improving the practice of family-centred care.

CHAPTER V

DISCUSSION

Although family-centred care has received substantial recognition as a satisfying and useful experience for children and their families, it "has not found its rightful place in health centres or among health care workers" (Porter, 1979, p. 330). Further, many health-care professionals respect and support the idea of family-centred care, but few actually put it into practice (Blumenstein, 1986; Porter, 1979). This discrepancy between health-care professionals' perceptions of family-centred care and the practice of family-centred care has been the focus of this study.

The purpose of this exploratory descriptive study was to determine health-care professionals' ratings of their perceptions and practices of the components of family-centred care (see Appendix A) at the Alberta Children's Hospital in Calgary between March 22 and June 8, 1994. Relationships between the independent demographic variables and perceptions and practice of family-centred care were also examined. Results from this research provide insight into health-care professionals' perceptions of the barriers to practising family-centred care. They also show to what degree family-centred care is practised and emphasize the importance health-care professionals attach to being able to practice family-centred care. This helps to clarify assumptions and questions about the viability of family-centred care in practice. The "dilemma of helping" (Dunst, Trivette & Deal, 1988a) is raised as a contributor to the discrepancy between health-care professionals' perceptions and practice of family-centred care.

This chapter discusses the study findings and analyzes them in relation to previous findings. Limitations and implications for practice, education and research are also examined.

Summary of Findings

Findings from this study revealed that health-care professionals described the degree to which the nine key elements of family-centred care are necessary to practice family-centred care as being higher than the degree to which the key elements are present in their practice. Health-care professionals whose highest level of education was a bachelor's degree contributed more positively to perception scores than those with post-secondary, master's, professional specialty and doctoral education. Factors contributing negatively to perception scores were post-

secondary education, professional specialty, physicians and staff. Age was found to contribute positively to practice scores with subjects older than 41 years having statistically significantly greater scores than younger subjects on the practice scale. Health-care professionals who reported being social workers contributed positively to practice scores. Although no significant interactions were found amongst the variables, professional specialty and post secondary education were found to relate to the medical and nursing health-care professions respectively in the Pearson chi-square tests. The factor analysis revealed high alpha reliability coefficients for the total scale, yet relatively low subscale alphas. The content analysis described subjects' responses to the open-ended portion of the FCCQ-R and described instances when subjects reported becoming child-centred and their suggestions for improving the practice of family-centred care.

Discussion of Findings

The findings from this study will be compared with similar results from previous research. As this study partially replicated a study by Bruce (1992) of nurses' perceptions and practices of family-centred care, the results from the present study will be compared with those of Bruce. Bruce found that perception scores were significantly higher than practice scores and that age and clinical position were significantly related to perceptions and practices of family-centred care. Nurses aged 41 to 50 had higher scores on the practice scale than the other age groups, while staff nurses had lower score on the perception scale than administrative or education nurses.

Perceptions

Perception scores were found to be statistically significantly greater than practice scores. In other words, health-care professionals reported being less able to perform family-centred care in practice than they considered necessary. This finding corresponds with findings from previous research (Bailey, Buysse, Edmondson & Smith, 1992; Berman, 1991; Knafl, Cavallari & Dixon, 1988; McBride, Brotherson, Joanning, Whiddon & Demmitt, 1993; Porter, 1979; Robinson, 1987; Rosenbaum, King & Cadman, 1992). In particular, Bruce's (1992) findings concurred with these findings in her study of nurses' perceptions and practices of family-centred care. "The nurses surveyed in this study reported that their everyday work did not match their perceptions of the activities necessary to provide family-centred care" (p. 41). Their total scores on the practice scale were significantly lower than were the scores on the perception scale. Mean item scores for the respective

perceptions and practice scales found by Bruce (M=4.2 SD=.35, M=3.2, SD=.4) were similar to mean item scores found in the study under discussion (M=4.2 SD=.35, M=3.6 SD=.4). It should be noted however that the mean item practice scores for both the subsample of nurses and the total sample were greater in this study than in Bruce's study of nurses. These findings indicate that although respondents indicated a reasonable knowledge of family-centred care, they reported that they were often unable to incorporate this knowledge into their practice. In other words, both studies support the notion that health-care professionals perceived that they performed family-centred care significantly less in their practice than they considered necessary. These findings imply a need to examine other causes than misperceptions of family-centred care to determine why health-care professionals are unable to incorporate family-centred care into practice.

Education and Knowledge

Bachelor's education was statistically significantly different than other education levels and approached significance in the positive contribution to the variance in perception scores. Post-secondary education was found to contribute negatively to perception scores. In other words, bachelor's educated health-care professionals had more positive perceptions of family-centred care while the post-secondary educated health-care professionals had more negative perceptions of family-centred care. These findings agree in part with Porter's (1979) finding that respondents with diplomas or associate degrees were least oriented to practicing family-centred care. Dunn (1979) also found that nurses with less than a bachelor's degree had decreased support for parent participation in care. In contrast, other researchers found that master's degree prepared nurses had significantly more accepting attitudes toward families than did nurses with diplomas, associate degrees or bachelor's degrees (Gill, 1987a; Humphry, Gonzalez & Taylor; 1993; Porter, 1979).

Scores from subjects who reported being physicians or who had a professional specialty as their highest level of education were found to contribute negatively to perception scores. This supports Porter's (1979) finding that physicians had the lowest orientation to family-centred care and concern for the client. Porter stated that "the image of physicians as traditionally focused on pathological conditions with the patient as the unit of medical care seemed to be further supported by the present findings" (p. 334). Marvel and Morphew (1993) also found that attending physicians rarely inquired about family information. The researchers suggested the need for increased medical faculty

development efforts in the area of family involvement.

Social workers were found to contribute positively to practice scores. Bailey, Palsha, Simeonsson (1990) found that nurses and social workers scored higher than did educators and other health-care professionals on several dimensions of family-centred care. Bailey, Simeonsson, Yoder and Huntington (1990) found that nursing and social work scored highest for classroom instruction in 'family assessment and intervention'.

Experience

This study found that increasing subject age positively contributed to scores on the practice scale. In particular, subjects older than 41 years of age were found to have statistically significantly greater scores than the combined other age groups. As expected, age was also found to be related to years of experience. In accordance with these findings, Porter (1979) found that the higher a nurse advanced in a professional career in terms of education and experience, the more oriented the nurse was to family-centred care. Bruce (1992) also found that older subjects between the ages of 41 to 50 had higher scores on practice scale of the family-centred care questionnaire. In contrast, Dunn (1979) found that nurses over 38 years of age demonstrated decreased support for parent participation in care. In spite of Dunn's (1979) findings, the results of this study support the assumption that the experience that comes with age positively contributes to the ability of health-care professionals to incorporate family-centred care in practice.

Staff Position

This study found that health-care professionals in staff positions as opposed to education or management positions scored more negatively on the perception scale. This corresponds with Bruce's (1992) finding that subjects who were in staff position had lower perception scores. This also agrees with previous findings that administrators, supervisors or subjects who were not in direct service have more positive attitudes about working with families (Dunn, 1979; Gill, 1987a; Humphry, Gonzalez & Taylor ,1993; Siedl, 1969). In contrast, Porter (1979) found that health-care professionals in the administrative group composed of department heads, supervisors, and head nurses were less concerned with family-centred care issues than other groups. In spite of Porter's (1979) findings, the results of this study appear to support the assumption that health-care professionals in staff positions have less positive perceptions of family-centred care activities. This finding

is troublesome as it suggests that the staff who work most closely with families and children have the least accurate perceptions and understanding of family-centred care.

Communication

In subjects' responses to the qualitative portion of this study, the need for communication with families was recognized as an important suggestion to enhance family-centred care. This confirms results from previous research (Brown & Ritchie, 1989 & 1990). This communication problem has been referred to as being related to lack of time (Ogilvie, 1990; Park, 1991) or related to lack of communication or role negotiation skills (Algren, 1985; Callery & Smith, 1991). Communication also appeared to play a role in maximizing family participation. This finding is also supported by research (Saylor, Elksnin, Farah & Pope, 1990).

Financial and Time Constraints

Overwhelmingly, subjects cited financial constraints as barriers or challenges to the practice of family-centred care in their answers to the qualitative component of the survey. This finding supports previous findings (Mahoney, O'Sullivan & Dennebaum, 1990; Gunn & Nightingale 1989). In relation to financial constraints, many subjects felt that time constraints prevented the practice of family-centred care. This supports many previous findings (Hayes & Knox, 1984; Humphry, Gonzalez & Taylor, 1993; Mahoney & O'Sullivan, 1990; Park, 1991).

Parental Status

No differences were found between health-care professionals based on parental status on both the perceptions and practice scales of family-centred care. Porter (1979) found that health-care workers without offspring were more oriented to family-centred care than were subjects with offspring. In contrast, Gill (1987a) and Siedl (1969) found that subjects who were parents had more positive attitudes toward parent participation than other subjects.

Organizational Setting

In the qualitative component of this study organizational factors were identified as influencing the way family-centred care was practised. Some respondents cited the importance of physical space, while others suggested a need for widespread managerial and administrative support for family-centred care. These

findings are supported by previous research (Bailey, Buysse, Edmondson & Smith, 1992; Gill, 1987a; Knafl, Cavallari & Dixon, 1988; Porter, 1979; Siedl, 1969; Thornes, 1985).

Limitations

The limitations of this study are discussed in terms of the validity and reliability of the FCCQ-R with recommendations for future use. The limitations to generalizability of the study findings are also addressed.

Family-Centred Care Questionnaire-Revised

The FCCQ-R was proposed to represent the nine elements of family-centred care (see Appendix A). The factor analysis results showed that the subscales were poor to fair measures of the nine elements of family-centred care; however the overall scale had good internal consistency reliability. Responding subjects also suggested that selected items were not suited to the setting in which they worked. For example, a typical respondent stated that "some of the questions were somewhat inapplicable to the outpatient setting". Modification of this tool is recommended before future usage.

Subscales one and two which measured "family is constant" and "collaboration" should either be reworded or eliminated. Rewording would better reflect the elements being measured while elimination would change the subscale nature of the questionnaire to reflect the overall practice of family-centred care. The subscales could also be reorganized according to the factor loadings obtained from the factor analysis and future tests of internal consistency reliability could test the new structure. Items should also be reworded, in particular item four which supposedly reflects something other than family-centred care. Few subjects made this distinction and the reverse scoring of item four may have contributed to the low internal consistency reliability of subscale two. Other subjects suggested that the questionnaire posed difficulty to health-care professionals who were not nurses or who worked in outpatient or non-acute care settings. Terminology such as "direct care managers" was confusing and unfamiliar to subjects at the ACH. Further, regional cultural differences were overlooked by the questionnaire as in item 34 which asked about "written material for families is available in French/English" only. This item would better represent regional cultural differences by asking if written material is available in the "families' first language". Respondents reported a need for materials in Chinese, Vietnamese and Spanish.

The validity of the tool was partially established by responses to the open-ended portion of the questionnaire. The qualitative data essentially reflected the overall result that perceptions of family-centred care are fairly accurate yet subjects are unable to practice family-centred care as well as they would like. Recall that 58% of respondents indicated that there was a "large difference between" their everyday work and what they thought was necessary to practice family-centred care. Some of the more frequently stated reasons for this difference were "time constraints", "provincial budget cutbacks", "acute care setting" and "physical barriers".

Overall, the FCCQ-R provided the best measure of perceptions and practice currently available. Further modification will enhance the reliability and validity of this tool for future use.

Generalizability

Non-nurse subjects were from total available populations and nurses were from a sample drawn by means of probability sampling from a target population to ensure generalizability or external validity in the description of population characteristics. Sampled subjects were asked to respond on a voluntary basis which may have introduced bias into the study findings. It is difficult to determine the direction of the bias; however, subjects did identify a discrepancy between perceptions and practice and most indicated that a "large discrepancy did exist". If the assumption is made that subjects who respond are subjects that are more likely to have a greater interest or knowledge of the practice of family-centred care, the results do not bear out this assumption.

The overall findings that perceptions of family-centred care are relatively positive, while the practice of family-centred care is less than desirable may be generalizable to the population of health-care professionals at the ACH. Generalizability to other pediatric facilities is less clear, given one's position on the random nature of the sampling. If one assumes that the sample obtained from the ACH was random in that the subjects sampled were any of the possible number of pediatric health-care professionals in the population that could have been working there at any given time, then the sample was random and the results are readily generalizable to other pediatric tertiary care facilities. In contrast, if one assumes that the sample obtained from the ACH consisted of total populations and samples from total populations are not random then the results are only generalizable to the ACH, and less so to other similar pediatric tertiary care facilities. The fact

that 25% of the total population of health-care professionals provided usable data for analysis gives this researcher confidence in the generalizability of findings to the total population at ACH and cautious generalizability to other similar pediatric settings.

Findings that were more specific to the health-care professions are viewed with guarded generalizability based on the smaller sizes of the subsamples. For example, the generalizability of the finding that physicians contributed to lower scores on the perceptions scale of family-centred care must be tempered by the knowledge that only 11 physicians' responses were used in the analysis of data. Further, the insertion of mean scores into the questionnaire for analysis may have introduced some bias into the results, given that the insertion of means occurred in part to account for subjects who did not perform certain aspects of family-centred care in their practice. This would pertain to subjects who did not have some specific questionnaire item in their job description. This reflects responding subjects' concern that some questionnaire items did not reflect their practice, but rather nursing or acute care practice (described above under "Family-Centred Care Questionnaire-Revised").

Implications of Findings

The perceptions and practices of family-centred care appear to be affected by education and knowledge, experience, staff position, financial and time constraints, communication, and the organizational setting. The quantitative portion of the study suggests that the "dilemma of helping" (Dunst et al., 1988a) may also influence the perceptions and practices of family-centred care. Further, the findings suggest that positive strides have been made by health-care professionals since the early days of family-centred care. A discussion of the effect of the cohort addresses these strides. The findings are then discussed in terms of the dilemma of helping, practice, education and research.

The Effect of the Cohort

A cohort has been defined as "a group of individuals who share a common experience within a defined period of time" (Woods & Catanzaro, 1988, p. 120). The cohort in this study may have been affected by the onset of family-centred care theory and practice that began in the 1970's. Indeed the first definition of family-centred care was recorded in 1972 (Yauger, 1972). Recall that older health-care professionals had more positive practices of family-centred care. Given the earlier findings of such researchers as

Dunn (1979) who found that older nurses had less positive attitudes toward family-centred care, these new findings suggest that positive change has occurred. The younger health-care professionals observed in Dunn's study who had more positive attitudes toward family-centred care would now be in the age group in this study that scored high on the practice of family-centred care.

Further, recalling that staff had more negative perceptions of family-centred care, this finding suggests that perhaps nonstaff had conversely more positive perceptions of family-centred care. Insufficient numbers of nonstaff were captured in this study to elaborate with any certainty (18%); however, it may be assumed that health-care professionals in nonstaff (i.e management, administration and education) positions had more seniority in terms of age and the corresponding years of experience. These years of experience may have also placed them into the cohort which was first exposed to family-centred care in the 1970's. These results provide evidence to indicate that positive strides have been made by health-care professionals since the 1970's.

The Dilemma of Helping

Dunst et al. (1988a) describe the "dilemma of helping which must be acknowledged by proponents of family-centred care" (p. 71). The dilemma of helping describes the disparity between the helping models typically employed by health-care professionals. It nas been suggested that the elements of family-centred care are based upon principles which are designed to promote greater family self-determination, decision-making, capabilities, control and self-efficacy. Collectively, these attributes are said to reflect a sense of empowerment or an enablement model of helping (Dunst et al., 1988a; Dunst, Trivette & Deal, 1988b). In contrast, the medical model of helping directs health-care professionals to assume the roles of evaluator and controller of treatment interventions that result in child and parental dependence upon health-care providers (Dunst et al., 1988a). Merton, Merton and Barber (1983) as cited in Dunst et al. (1988a) indicate that most health-care professionals have been socialized to believe that only they are capable of helping their clients. To suggest otherwise becomes a threat to health-care professionals' sense of competence. When this position is embraced by health-care professionals it is in direct conflict with the conditions necessary for more active involvement of parents in the care of their health-impaired children (Nelkin, 1987; Shelton et al., 1987).

The qualitative component of this study provided

examples to illustrate the dilemma of helping. Subjects stated that they become child-centred when the child's well being is at stake, families are absent or dysfunctional and when the child is older. Subjects also report that sometimes parents should not be present as in cases of suspected child abuse or during painful procedures. Some subjects believed that the child's needs are always considered first. Whether or not the child-centred instances are appropriate is not at issue. In these examples, health-care professionals do not share the special child care responsibilities with families, thus avoiding any challenge to their expertise.

Practice

The dilemma of helping provides an explanation for the discrepancy between perceptions and practice of family-centred care found in this study and described by others (Blumenstein, 1986; Bruce, 1992; Odle, 1988; Porter, 1979). Support for this explanation is obtained by the lower perception scores of physicians and subjects with only professional specialties or post-secondary education and the higher scores of bachelor's educated health-care professionals. These findings will be related to the dilemma of helping which occurs when conflict arises between the medical and enablement models of helping.

Physicians clearly follow a medical model of helping and subjects who reported professional specialties as their highest level of education were predominately physicians. The influence of the medical model of helping may have contributed to the lower perception scores of these groups.

All but one of the subjects who reported post-secondary education as their highest level of education were nurses. Post-secondary educated nurses are normally trained to function in the acute care setting where the medical model predominates. Again, the influence of the medical model of helping may have contributed to post-secondary educated health-care professionals' lower perception scores.

Nurses also made up the largest proportion of bachelor's educated health-care professionals. Bachelor's educated nurses are prepared to function in a wider capacity not limited to the medical model. The finding that bachelor's education positively contributed to perceptions of family-centred care is consistent with being able to utilize an enablement model of helping like family-centred care.

These conclusions suggest a need for continuing education such as inservice education and workshops for

health-care professionals faced with the dilemma of helping. Content on the principles and practice of family-centred care would be helpful to all health-care professionals. An increased amount of interdisciplinary collaboration and coordination could also help to rectify and prevent the dilemma from affecting families and staff. Further, policies and guidelines for the implementation of family-centred care would be appropriate to help prevent and resolve the dilemma of helping. The ACH is committed to a philosophy of family-centred care (see Appendix C); however, the philosophy is not operationalized. Operationalization of the concept and guidelines for practice could enhance the practice of family-centred care. As suggested by responses to the qualitative component of the study, the lack of family-centred care practice guidelines for staff may reflect a need for increased administrative support of family-centred care policies.

The qualitative findings also suggested that the practice of family-centred care was largely influenced by financial cutbacks and provincial politics which resulted in layoffs, bumping, inexperienced staff and insufficient time with clients. As a result, health-care professionals may need to become more active in their advocating role for families with children with special health-care needs. Health-care professionals may need to lobby the government and educate health-care consumers more actively in order to ensure that the health-care environment is one that supports the practice of family-centred care activities.

Education

Education was discussed briefly above in the recommendation of continuing education for health-care professionals. Dunst et al. (1988a) suggest that the education of health-care professionals plays an important role in determining the helping model that professionals use in practice. Others have suggested that there is not enough family-centred content in educational programs for health-care professionals (Bailey, Simeonsson, Yoder & Huntington, 1990; Cochrane, Farley, & Wilhelm, 1990). Still, health-care professionals may not have the skills necessary to practice family-centred care such as communication and conflict management skills (Brown & Ritchie, 1989 & 1990). In support of these findings, some subjects who responded to the qualitative component of the questionnaire suggested improving educational programs for health-care professionals. Formal educational programs for health-care professionals should be examined to evaluate the theoretical and practical content of family-centred care. Teaching and clinical experiences should emphasize the practice of family-centred care and the effective integration of family-

centred care with other helping models such as the medical model. In particular, given the proportionally larger numbers of nurses compared to the numbers of other health-care professionals functioning in the health-care system and the relatively low perception scores of post-secondary educated nurses, post-secondary nursing education programs should be examined with the intent of improving and better integrating family-centred care content into curricula.

Research

Results from this research suggest a need for more research in the ways that health-care professionals successfully integrate the medical and enablement models of helping. Dunst et al. (1988a) suggest that "with the exception of immediately life-threatening conditions...the use of the enablement model of helping will increase the likelihood of family-centred care for children with special health care needs becoming a reality" (p. 79). This assertion appears to support the views of many respondents who described the emergency and life threatening conditions in which subjects became child-centred in practice. Frequently, these subjects reported becoming family-centred immediately after the crisis. Realistic research and discussion of the integration of the helping models in practice may diffuse the dilemma and associated negative feelings such as guilt and confusion associated with adhering to either the medical or family-centred care models.

The practice of family-centred care in the acute care setting could also be compared with the practice of family-centred care in the community or outpatient settings, where it is assumed the medical model does not predominate. If a large difference is found to exist between the practice of family-centred care activities in the hospital and community settings, this would provide support for the theory that the dilemma of helping explains health-care professionals' inability to practice family-centred care. It would also stress the need to closely examine how the helping models can be better integrated in the acute care setting.

Research is also suggested to test the effect of education on the perceptions and practices of family-centred care. The education intervention could also be tested to determine its effect on the integration of the helping models in practice. A pre-test post-test design might be effective to determine the influence of education. Further, the educational intervention could encourage the use of interdisciplinary collaboration and likewise test the assumption that such collaboration fosters the perceptions and practice of effective family-centred care. Subjects

should be encouraged to operationalize conceptually family-centred care through interactive teaching methods such as role playing and brainstorming. The effect of widespread administrative support on perceptions and practices of family-centred care could also be examined by a pre-test post-test design. To demonstrate the optimal practice of family-centred care, families should be included in these studies.

Conclusions

In addition to the normally expected discrepancy between measures of ideal and real situations, the discrepancy between perceptions and practice of family-centred care was significant and large. The discrepancy between perceptions and practices of family-centred care may be explained by the dilemma of helping, education and knowledge, experience, staff position, financial and time constraints, communication, and the organizational setting. The effect of the cohort suggests that positive strides have been made by health-care professionals in their understanding of family-centred care. Further exploration of issues that contribute to or detract from the ability of health-care professionals to practice family-centred care is recommended. A realistic and improved understanding of the integration of the helping model of family-centred care and the medical model is encouraged in practice, education and research. This understanding will not only improve practice but work towards the achievement of excellence in the care of families and children with special health-care needs.

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