RECIPROCAL STEREOTYPIC ATTITUDES HELD BY NURSES IN CLINICAL AND ADMINISTRATIVE SPECIALTIES

by

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TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

TABLE OF TABLES

TABLE OF FIGURES

Chapter 1

INTRODUCTION

The health care system today encompasses several decision-making arenas, two of which include those with a clinical, patient-centered focus and those with an administrative orientation. Clinical decisions are those primarily concerned with patients' actual health care while administrative decisions generally center around business decisions necessary to the functioning of the system. Historically, health care delivery has evolved around the concept that when large numbers of people could be cared for in a centralized facility, the health care practitioner could function better, being supplied by a central source for technological and collaborative resources (Kalisch & Kalisch, 1973). Over time, management of the central facility became the job of the health care businesspersons, while delivery of services to patients became the job of the clinician. Specialization had occurred.

Appropriately, the business of health care expanded under the expertise of those trained in economics, business administration, and organizational management. Meanwhile, the clinical services developed within the boundaries of medicine, nursing, psychology, social work and other clinical professions.

However, as delivery of health care grew into a multi-billion dollar enterprise, comprising nearly 8.3% of the Gross National Product in 1977 and showing a pattern of nearly 8% increase annually (Klarman, 1977), the economics of health care began to influence

and in some cases even determine clinical decisions rather than playing a largely supportive role to clinical services. For example, expense is cited as one of the major reasons that kidney patients do not have their own home dialysis units; the technology is available, it is cost that prohibits the home treatment. Whereas previously knowledge and technology limited treatment, today the limitations are often those of cost and resource allocation.

As a result of changes in the forces defining the boundaries of treatment, members of the nursing profession have begun to redefine the boundaries of their scope of practice. In nursing, the expansion continues, not only into areas of increased clinical expertise, but also into areas traditionally the realm of business managers. Since many clinical decisions now take shape in the context of problems of economics and business management, nurses, in reclaiming some administrative functions and redefining their scope of clinical practice are setting a standard to approach that of Florence Nightengale's broad approach to nursing care (Kalisch & Kalisch, 1973). Nurses are aware that the quality of care relates closely to parameters of business; how many nurses can work, how much new equipment can be bought or how often old equipment can be replaced, what range of services can be provided and even how many patients must be present in any delivery setting for that setting to continue operations.

Change or expansion of roles such as that now occurring in nursing creates internal tension within the groups involved (Clark, 1979). In part, this tension reflects normal adjustment to new conditions

or norms; however, it may be heightened by attitudes held by the groups involved toward each other. In the specific context of the expansion of nursing into more extensive management as well as into more varied clinical roles, nurses may begin to see themselves and each other differently, more as separate groups of clinicians and managers than as nurses. The following investigation outlines the growth of these two nursing roles and introduces a theoretical context through which the influences these two roles have on each other may be better understood. Empirical support is sought from a study proposed to test specific hypotheses drawn from theory and observations of nurses functioning in these two roles. Hopefully, this study will provide more insight into the dynamics of how nurses in expanded clinical and management roles view each other. The information gained may facilitate important collaboration between two groups within the nursing profession which are on the frontiers of professional redefinition in an era of rapid growth and change.

Review of the Literature

Specialization of the Nursing Role

Traditionally nurses are depicted as comforting persons who dress in white and tend the sick at the bedside. During the last decade, however, the nurse's role has been changing (Driscoll, 1972). Two major areas into which this expansion of the original limited bedside role has occurred have been into management and areas of increased clinical responsibility.

The nurse-manager has taken on the tools of power, money, control over organizations, and the ability to make influential decisions over others. The nurse-clinician, on the other hand, is fighting for the right to practice skills claimed by the medical profession, or to achieve status for skills that, traditionally, have been those of the hand-maiden, the servant, the self-sacrificing religious devotee, and the woman; supportive caring of the sick and counseling of the healthy seeking answers to basic health questions (Kalisch & Kalisch, 1973).

The growth of nursing into management areas is documented in the works of Merton (1969), Rodgers (1972), Grand (1973), and Stevens (1975, 1979). These authors and others write expressly for the nurse who needs to know more about managerial skills such as policy making (Ramey, 1973), budget planning (Pluhecek, 1970; Bauer, 1971) and decision making (Plachy, 1973). In care delivery settings these skills may take the form of justifying enlargements of the nursing budget, or assuming responsibility for the administration, budget,

clerical work, and overall coordination necessary for the functioning of a care delivery unit (Tirney & Wright, 1973; Wandelt & Phaneuf, 1972).

In contrast, the growth of nursing into expanded clinical roles (Walker, 1972; Bliss, 1975; Silver, 1977) emphasizes the practice of clinical skills such as physical assessment (Brown, 1977), teaching (Herman, 1977), and counseling (Aguilera & Messick, 1974). Nurse-clinicians sharpen skills needed in direct patient care, such as clinical services for increasing health (Kinlein, 1972). In the care delivery setting, these nurses apply these skills in a variety of clinical areas such as pediatrics (Burns, Lapine & Andrews, 1978; Ford, 1979), critical care (Barnett & Sellers, 1979), geriatrics (Henderson, 1978) and medical-surgical areas (Joel, 1979).

Economic theory casts "management" and "labor" as classical opponents, a conflict which appears duly re-enacted in the relations of nurse-managers and nurse-clinicians. Managers are in positions of authority such that they may make decisions directly affecting the practice of clinicians (Murray, 1972), such as hiring and firing practices within an organization, allocations of resources for clinical use, and actions as the major liaison between the clinical nurses and high-level, non-nurse administrators. Clinicians, on the other hand, are redefining their scope of practice and placing new demands on managers for time and resources required to offer self care training, health maintenance education, increased treatments for specific illnesses, greater follow-up for individual clients,

and larger referral and consultation networks. Nurse-clinicians also need physical space in which to carry out these tasks, time in which to perform them, sufficient authority to implement their increased responsibility and pay commensurate with their expanded role (Kraegel, Mouseau, Goldsmith & Aurora, 1974).

While both specialty groups may have interests in common, characteristic differences often overshadow the similarities. Thus, while each group may verbally appreciate the position of the other, i.e., managers can see that clinical needs must be met and clinicians can see that resources must be spent judiciously, behaviorally, each may respond most directly to pressures unique to his/her own functions, with resulting risk for misunderstanding and conflicts.

Another source of conflict between nurse-managers and nurse-clinicians stems from the observation that development and educational underpinnings for specialization have lagged behind expansion of the roles themselves (Kalisch & Kalisch, 1973). For example, a common difficulty faced by nurse-managers is that most often they have begun their careers as clinicians and have moved to management positions without specific additional training/certification. The extent to which moving to a management position constitutes change is revealed by observing that while entry into practice for the newly graduated nurse requires passing a clinically oriented written examination, entry into nursing management requires no examination, but instead, often occurs abruptly as a promotion up the organizational hierarchy into a non-clinical or less clinically oriented position.

Even top ranking nurse-managers are often promoted from among clinically trained professionals. By accepting a management position a nurse essentially changes careers. Yet, despite their non-clinical responsibilities, a survey of 1,172 directors of nursing showed that only 38% had received additional training in nursing service administration beyond their basic clinical preparation (Rowland, 1978).

Expansion of the clinical role often begins informally with an increase in clinical duties based on limits accepted by particular settings or medical providers. ICU nurses, for example, have traditionally held more independent roles which allowed them timely responses to rapid changes in patient health status. Thus, like their nurse-manager colleagues, clinicians also often begin a role expansion without formal training. Recent development of nurse practitioner programs and expanded nurse practice acts have encouraged formalized training and credentialing for skills nurses have been practicing, in some cases, for years. In sum, many nurse-managers and nurse-clinicians have begun role expansion with little traditional, formal advanced training to shape their redefinition of roles.

One possible consequence of the rapid pace of role expansion (and the associated relative dearth of formal institutional, legal and educational supports) is that nurse-managers and nurse-clinicians may often work in situations in which their competence is stretched to its limits and their legitimacy is subject to assault (American Journal of Nursing, 1977; Rowland, 1978). Under such frustrating

conditions, it would not be surprising if nurse-managers and nurse-clinicians were to suffer some loss in ability to respond flexibly and to perceive each other accurately. In short, as each group responds to its unique pressures, nurse-managers and nurse-clinicians may begin to see themselves more as "clinicians" and "managers" than as one group of nurses. An example of this shift in attitude appears in the confrontations developing when clinical nurses go on strike and nurse-managers must decide if they will support the strike or not. This kind of confrontation brings to a head the issue of whether or not nurse-managers are nurses or administrators. If nurse-managers identify with the clinical nurses on strike they may indeed strengthen their ties to clinical nursing; however, they may also alienate the hospital administration and thereby damage nursing's professional position of self-management within the organization. On the other hand, if the nurse-managers align themselves with the administration they will weaken ties with clinical nurses who see the nurse-managers as abandoning their cause to become more like non-nursing administrators. Unless communication remains open, these nurses may begin to see themselves as adversaries in the face of these and other similar pressures, rather than as one, mutually supportive group. An important consequence of such antagonism is that it may serve to further divide a profession that already faces internal dissent (Rogers, 1972; Young, 1972; Lynaugh, 1980; Bruehler, 1980).

The Role of Reference Groups

The possibility that nurse-clinicians and nurse-managers may see each other as separate and antagonistic even though they are both members of the same profession is consistent with existing theory on the formation and maintenance of attitudes. Hovland, Janis and Kelly (1953) point to the concept of reference groups as a factor in a person's perception of someone as one of "us", or one of "them", and as important in formation of attitudes and values which he/she accepts as guiding principles, especially when perceiving new or different kinds of social or interpersonal information. Schram (1961) indicates that while membership in a group, of itself, may not influence attitude, clear identification with specific reference groups can serve as an orienting point by which perceptions, information, and attitudes may be sorted. Sherif, Sherif and Nebergall (1965) write that in our present society the demands and goals originating in all the diverse groups one encounters enhance the importance of reference groups for modern man. It is hypothesized that the views of these reference groups are used by individuals to filter diversely overwhelming input. These authors continue by pointing out the need to study attitude and attitude formation in the context of specific reference group ties.

Specific functions of reference groups are outlined in more detail by Halloran (1976). Among the multiple functions of reference groups, two stand out as assisting the individual who must sort through many different kinds of input to finally establish his/her

own set of attitudes. First, reference groups offer a standard against which one compares oneself when making a self-judgment; this is the comparative function. Secondly, a reference group serves as a direct source of values and perspectives, or attitudes; this is the normative function. As part of this normative function, reference groups encourage more favorable attitudes toward group members and less favorable attitudes toward those outside or different from the group. The favorability of attitude toward one's own reference group is consistent with the homeostatic emphasis in the theories of Festinger (1963), Osgood (1957), Tannenbaum (1957), and others (Maccoby, 1961). This homeostatic emphasis points to the maintenance of internal consistency in attitude between a reference group and its members.

In spite of the importance of the concept of reference groups in attitude formation, the question of how one empirically determines these groups remains unanswered. Halloran (1976) acknowledges that this is a difficult and elusive area and states much work remains to be done on this subject of empirically determining the boundaries of reference groups. However, the difficulty in focusing on the concept of reference groups empirically should not, in Halloran's opinion, lead the researcher to discard reference group theory as a framework since it provides a wider explanation of attitude than is offered by theories which concentrate exclusively on intrapsychic functioning. According to Halloran, reference group theory helps explain the otherwise confusing observation that one can be a member

of a variety of groups, yet hold attitudes which remain consistent with a select few.

Existence of Stereotypes

One expression of the influence of reference groups on attitude formation appears in the occurrence of stereotypes. The concept of "stereotype" was popularized by Lippmann (1922) in his book, Public Opinion, which set the stage for empirical investigation of stereotypes (McCauley, Stitt & Segal, 1980). In this book, Lippmann makes a distinction between "the world outside and the pictures in our heads" (p. 1) and defines stereotypes as oversimplified pictures formulated in an attempt to see the world as more manageable and understandable than it really is. When extended to the perception of people, this tendency to oversimplify the world leads to the formulation of categories or groups into which individuals may be placed on the basis of a few heavily emphasized, broad, descriptive traits, perhaps to the neglect of important individual differences. According to Lippmann, the most pernicious and unfair generalizations are typically simplistic ones made about large and inherently varied groups of people.

Lippmann's work stimulated immediate interest in social stereotypes. Katz and Braly (1933) did the first definitive work in this area. A list of eighty-four adjectives, selected as representative of words most commonly used to describe other people, was given to students who were then asked to select those adjectives most closely describing Germans, Negroes, Irish, Italians and other ethnic groups.

For each ethnic group a cluster of representative adjectives was to be formulated. Results showed students chose consistent adjective clusters for each ethnic group. They also chose more favorable adjectives when rating themselves and those groups similar to themselves. Discussing their findings, Katz and Braly noted that the high reliability of the clusters suggested a broad-based verbal component of social stereotyping behavior. Their formulation appears consistent with contemporary reference group theory, especially the finding that students chose more favorable adjectives for selves and groups similar to themselves. Increased support for this hypothesis was published in Katz and Braly's 1935 and 1947 works.

Nearly twenty years later, Center (1951) replicated Katz and Braly's pioneering study using subjects from the University of California at Los Angeles and found 75-95% of the students identified and agreed with the ethnicity of the original Princeton adjective clusters. However, Gilbert (1951) replicated the same study at Princeton and found that, whereas in 1933 students had been content to use an average of five adjectives in their clusters, in 1951 they preferred to include nearly twelve items and to emphasize fewer negative extremes to give the overall ratings a more realistic, reasonable-sounding tone. More striking, according to Gilbert, was the students' irritation on being asked to make the ethnic generalizations using the adjectives, in comparison to the absence of any complaints from subjects in 1933. In his results, Gilbert interprets

the changes in approach to the stereotyping task as suggestive that stereotyping was fading as an active social force.

Thirty years later, Karlins, Coffman and Walters (1969) retested Katz and Braly's original work, using undergraduate students at Princeton, in an effort to determine whether Gilbert's hypothesis could be supported. Their results show that while subjects emphasized the type of adjective preferred in 1951, the overall content of the adjective clusters applied to specific groups was unchanged from the 1933 norms. Differences showed in the frequency with which descriptors were used that were based more on "cultural and historical realities than on fictitious characterizations or the prejudices of their parents" (p. 14). The trend in selecting twelve, as opposed to five adjectives, remained in 1969 as it had in 1951, as did subjects' reluctance to apply the adjectives as descriptors. Reviewing their results, Karlins, Coffman and Walters suggested that rather than disappearing, stereotyping was changing to reflect the more liberal attitudes of the times and that subjects' reluctance to use the adjectives in stereotyping did not reflect the decrease in stereotyping behavior as much as a shift in attitude or mode of expressing stereotyping. Stereotypes remained, according to these authors, but the process of making stereotypic judgments was less socially acceptable to subjects than in the 1930's.

Emergence of the Halo Effect

As stereotypic judgments become less acceptable to those making them, they begin to resemble a phenomenon described in 1920 by

Thorndike, the halo effect. The effect is generally defined as the influence of a global evaluation on the evaluations of another's attributes (Nesbett & Wilson, 1977). A global evaluation may alter the interpretation of someone else's actions, or the evaluation of their characteristics as a person. An example might be a teacher's report to parents that their child had been caught cheating on a test. If the parents replied that their child could not have been the one, that there must be some mistake, they would be showing that their overall positive regard for the child overshadowed the fact of the teacher's report. This overall positive regard for the child is the halo coloring the facts as presented by the teacher. The result is that the parents doubt the teacher's report. Thorndike, in describing the halo effect, hypothesized that this effect represented a fundamental inability of the perceiver to separate the influence of affective influences of global evaluations from more objectively verifiable perceptions; that it colored how one saw the world. As stereotypes become less blatant, their presence may become increasingly difficult to detect and their actions may become subtle so that they act, in effect, as a specific kind of halo effect, a halo effect of one group toward another.

Several studies have tested the presence of the halo effect in groups. For example, Miller (1970) found that people who were perceived as more physically attractive were ascribed more favorable personality traits than those seen as less attractive. In a similar study, Goldberg, Gottesdiener and Abramson (1975) presented photographs

to students to learn if perception of support for the women's liberation movement was associated with perceived attractiveness of the women. Thirty photographs of women were obtained, fifteen of whom strongly supported the movement, fourteen of whom had serious reservations about it, and one who was undecided. These photographs were rated for physical attractiveness by raters who were unaware of the actual political views of the women and no significant differences were found between those who supported the women's liberation movement, and those who did not. However, when raters were told that fifteen of the women supported the movement and fifteen did not, and were asked to guess which were which, the women identified as supporting the movement were those who had previously been identified as less attractive. It would seem that raters had a stereotype of members of the women's liberation movement as unattractive which influenced their choice of photographs.

Landy and Sigall (1974) found the halo effect to be operational even though sufficient information was available to allow for an objective assessment. These authors found that evaluation of an essay read by male college students was rated substantially higher when the alleged writer was an attractive woman as opposed to an unattractive one. Landy and Sigall report that the effect was very pronounced, especially when the quality of the essay was poor. In spite of the fact that subjects had the essay in hand to read for themselves and judge on its own merits, they persisted in varying ratings with the writers' perceived attractiveness.

Hypotheses

In accordance with the foregoing discussion, it is hypothesized that nurse-clinicians and nurse-managers identify with two separate reference groups and distinguish between "us" and "them" along a clinical-managerial continuum. Further, it is suggested that the presence of these two reference groups has contributed to the formation of stereotypes in the perceptions that nurse-clinicians and nurse-managers have of each other and that these stereotypes can be detected through verbal behavior. In accordance with the literature which demonstrates a reluctance of subjects to explicitly engage in verbal stereotyping tasks, it is hypothesized that the existence of stereotypes held by nurse-clinicians and nurse-managers toward each other will be detected best using techniques similar to those used in highlighting the halo effect. By patterning the investigation along the lines used in studying the halo effect, it is hypothesized that nurse-clinicians and nurse-managers will rate the performance of their own group more favorably than they will rate the performance of the other. The details of the method to be used and the specific predictions follow.

Specifically, it was predicted that:

1. Nurse-clinicians would rate characteristics of an individual identified as a nurse-clinician more favorably than they would rate the same individual when identified as a nurse-manager.

2. Nurse-managers would rate characteristics of an individual identified as a nurse-manager more favorably than they would rate the same individual when identified as a nurse-clinician.

Chapter 2

METHOD

Design

The design selected for the present investigation was chosen to overcome two problems. The first problem was subjects' anticipated resistance to overt stereotyping tasks as reported in the literature. The second problem was the investigator's need for a design allowing clear demonstration of the hypotheses. The design chosen presented a solution to both problems by offering a simple and indirect measure of stereotyping behaviors. In the present study a "standard stimulus" design (Goldberg, Gottesdiener & Abramson, 1975; Cohen, 1978; Sand & Kleiven, 1980) was adapted for use in detecting stereotypes held by nurse-managers and nurse-clinicians toward each other.

The standard stimulus in this study was a short vignette constructed to outline a brief dramatic situation that was ambiguous with regard to characteristics which might identify the vignette protagonist as either a nurse-manager or a nurse-clinician. The vignette was presented to groups of nurse-managers and nurse-clinicians under two rating conditions. In the first condition the protagonist was labelled a nurse-manager while in the second condition the same protagonist was labelled a nurse-clinician. In order to maintain the integrity of the design nothing was changed in the presentation of the vignette to subjects except the label of the protagonist. Subjects' task was to rate the vignette protagonist on ten global personality characteristics.

Assignment to vignette rating condition prior to any subject contact was through random assignment within occupational status.

One-half of the nurse-managers received vignettes with the protagonist labelled as nurse-manager while the second half of the nurse-manager group received vignettes with the protagonist labelled as nurse-clinician. Similarly, one half of the nurse-clinicians received vignettes with the protagonist labelled as nurse-manager while the second half of the nurse-clinician group received vignettes with the protagonist labelled as nurse-clinician. If the ratings given the vignette protagonist differed across subject groups as a combined function of the protagonist's change in label and the occupational status of the rater, then it would be possible to infer the existence of group stereotypes.

Subjects and Setting

Since each state in the union has the authority to enact its own nurse practice act, it was deemed advisable to reduce extraneous variance by sampling within a single state. The state of Oregon was selected for practical reasons related to ease of acquiring a comprehensive subject sample.

Subjects were selected based on the likelihood of divergence on a managerial-clinical continuum within the nursing profession. Sampling from extreme ends of the continuum was thought to increase the chances of finding differences in subjects' ratings, if indeed, differences in ratings existed when nurse-managers and nurse-clinicians rated each other.

For the purposes of the present study, "nurse-clinicians" were defined as nurses currently certified in Oregon as nurse practitioners under the 1977 Nurse Practice Act. These subjects reported more

than 50% of their work day was spent on clinical work (working directly with patients), described their present job as more clinical than administrative, and reported job titles consistent with clinical duties. "Nurse-managers", on the other hand, were defined as nurses currently working as top-level nursing administrators or managers. These subjects reported more than 50% of their work day was spent on administrative work (working directly with organizations), described their present job as more administrative than clinical, and reported job titles consistent with administrative duties.

The final sample for the present investigation consisted of a total of 107 subjects (44 nurse-managers and 63 nurse-clinicians). This final sample was drawn from an original mailing to 160 nurse-managers and 160 nurse-clinicians who had been randomly selected by computer from Oregon State Board of Nursing files of nurse administrators and nurse practitioners. Of the 320 subjects included in the original mailing, 155 or 48% returned study materials. A response rate of 48% is consistent with the findings of Polit and Hungler (1978) that response to mailed study materials averages approximately 50%. Of the 155 subjects returning the data, 48 were eliminated for one of two reasons. Either subjects returned incomplete ratings (10 nurse-managers and 21 nurse-clinicians) or subjects' responses left it unclear as to whether or not they were a nurse-manager or a nurse-clinician (13 nurse-managers and 4 nurse-clinicians).

Instruments

A one page vignette depicting a problem with an overlap into both clinical and managerial areas of expertise was developed. The

problem situation concerned implementing a clinical idea (senior day care) at a managerial stage of planning (introducing the idea to a committee for approval to continue planning). The applicability of this problem situation was that either a nurse-manager or a nurse-clinician could realistically have been the protagonist.

A positive-negative balance was achieved through the incorporation of a positive plan (everyone benefits) with a negative outcome (failure of the committee to approve the protagonist's plans). Stereotyping could occur through selective attention to any component of this balanced mix of information. Since the vignette contained as few value judgments as possible, any value judgments made incorporated subjects' attitudes.

The tone of the vignette was conversational and stated in the third person to provide a non-threatening backdrop against which subjects might more comfortably express their judgments (Koltuv, 1962). The third person style provided a setting for a "projective" stimulus by increasing the sense of personal distance between subjects and protagonist. Copies of the vignettes appear in Appendices C and D.

Rating Scale

A rating scale for evaluating the vignette protagonist included ten items drawn from a checklist of common adjectives used in stereotyping as specified by Katz and Braly (Karlins, Coffman & Walters, 1969). Subjects were instructed to apply the rating scale to the protagonist in the vignette without omitting any of the ten trait

adjectives in the scale. If in doubt as to how to mark an item, subjects were instructed to make their best choice.

The adjectives selected for the scale were from among the 84 contained in the Katz and Braly Adjective Checklist (Karlins, Coffman & Walters, 1969). These adjectives have been used for over 50 years in studies of stereotyping (Katz & Braly, 1933; Gilbert, 1951; Center, 1951; Karlins, Coffman & Walters, 1969; Brigham, 1971) and constitute an historical standard for detecting the verbal components of stereotyping between groups. Based upon this history of continued usage, it appeared most parsimonious to select items for the present study from the Katz and Braly list.

Choice of specific adjectives to be included in the present study was made on the basis of face-valid conceptual concordance with stereotypical images which appear likely to arise given the nature of the work, training and professional relationships of nurse-managers and nurse-clinicians. These images, in their extreme, were those of the nurse-manager as a pragmatic, organization-centered, cost-conscious businessperson; and correspondingly of the nurse-clinician as a nurturant, patient-centered, care-conscious health provider. These extremes constitute a composite drawn from personal experience as well as published descriptions (Pettingill, 1979; Bermosk & Porter, 1970; Jacox & Norris, 1977).

Since the early work in the 1930's was completed there have been documented cultural changes which affect the manner in which educated subjects are likely to use broad adjective descriptors. In particular

Karlins, Coffman and Walters (1969) have demonstrated that modern subjects are more likely to choose socially acceptable adjectives, even if other indirect measures suggest a private endorsement of stronger stereotypes. Consequently, all trait adjectives were drawn from among the 25 most positive of the 84 item Katz and Braly Adjective Checklist (Karlins, Coffman & Walters, 1969). The use of positively toned trait adjectives appeared, on face valid grounds, to be more socially acceptable than negatively toned trait adjectives. Incorporating positive descriptors in the rating scale enabled subjects to generate less favorable ratings while still feeling that their ratings constituted socially acceptable behavior.

A final selection of ten trait adjectives which were both positively toned and consistent with likely stereotypic images of subjects were included in the rating scale developed for this investigation. Ten was a logistically desirable number in terms of obtaining maximum subject cooperation and ease of data analysis; it was also consistent with observations of Gilbert (1951) and Karlins, Coffman and Walters (1969) that subjects prefer an average of about twelve items in adjective clusters for describing groups of people.

Each of the ten trait adjectives was presented in a Likert-type scale to provide subjects with maximal degrees of freedom in their responses (Cotton & Stolz, 1960; Sharon & Bartlett, 1969). The latitude provided by the Likert scale format increased options available to the rater in responding to the vignette, and hence maximized opportunity for projection of stereotypes (Ronan & Prien, 1966).

Although Lissitz and Green (1975) and Jenkins and Tabor (1977) have shown little or no increase in scale reliability when more than five scale points or response categories are used, it was desirable to include six points in the present study's scale. If there were an odd number of scale points (such as five) then there would be a "neutral" center point. However, with an even number of scale points there was no center point; this forced subjects to choose a point which leaned either toward the positive or negative pole of the scale, avoiding the loss of information which could have resulted from subjects who "fence-straddled". The complete scale as it was presented to subjects is reproduced in Appendix E.

Pilot Study

A pilot study was conducted to screen the vignette and rating scale procedure for unanticipated factors which might interfere with collection or analysis of data. Fifteen students and faculty in clinical and management disciplines at the University of Oregon Health Sciences Center School of Nursing participated as if they were actual subjects. As a result of this pilot study, trait adjectives in the rating scale were randomized so that more positive choices did not appear first, followed systematically by less positive choices later in the list.

Reliability Data

An overall reliability coefficient of alpha = .85 was obtained on the study sample when variance attributable to each item in the rating scale was compared to the overall variance. Alphas for the total scale with one item deleted ranged from .82 to .84.

Procedure

Each subject received the following items via mail; a cover letter, a copy of the standard vignette (one labelling condition per subject), a copy of the rating scale, a demographic data sheet and a stamped, self-addressed return envelope. The cover letter explained the nature of the investigation and how the information obtained was to be used (i.e., coded, analyzed and discussed for a master's thesis). Since subjects' responses could have been altered by an awareness that a measure of stereotyping behaviors was being sought, subjects were told that the task presented was one measuring "how nurses make decisions". Subjects were encouraged to participate, yet assured that refusal to do so carried no penalty and that all responses would remain confidential. Subjects were also told how they might obtain the results of the study upon its completion. Information sent to subjects is reproduced in Appendices A, B, C, D and E.

Seven days following the original mailing of the study materials to subjects a follow-up postcard was mailed encouraging those who had not responded to do so and thanking those who may have already put their responses in the mail. After the data were fully analyzed a debriefing packet was mailed to all subjects informing them of the results of the study and thanking them again for their participation. The debriefing contained an easily readable abstract of the study, an address to which further questions might be directed and a brief personal note expressing appreciation for assistance rendered. The debriefing packet was mailed to all subjects included in the original

mailing since it was not known who refused and who actually participated.

Data Analysis

Scoring Procedure

Each subject generated ten numbers, with each number representing a rating on one of the ten trait adjectives of the rating scale. Ratings ranged from 1 - 6 on a Likert-type scale, with 1 the least positive rating and 6 the most positive rating. Two scores were derived from these raw ratings.

Mean stereotypic score. The mean stereotypic scores were calculated as follows:

1. Summation of all ratings (ten traits) by a given subject (possible range from 10 to 60).
2. Calculation of the mean rating within each of the four subject groups (possible range of means from 10 to 60). The mean rating thus calculated was defined as the mean stereotypic score. The closer this score approached the upper limit of 60, the more positive it was; therefore, a higher score was more positive than a lower score.

Mean trait score. The mean trait scores were calculated as follows:

1. Summation of all ratings for a single trait across individuals in each of the four subject groups. Since there were ten traits on the rating scale, there were ten summations within each of the four subject groups (one summation per trait).

2. Calculation of the mean rating for each trait of the rating scale, within each subject group (possible range of means from 1 to 6). The mean rating thus calculated was defined as the mean trait score. The closer this score approached the upper limit of 6, the more positive it was; therefore, a higher score was more positive than a lower score.

Statistical Tests of Hypotheses

Mean stereotypic scores and mean trait scores were analyzed using 2 x 2 analyses of variance. With alpha set at $p < .10$, statistical significance was predicted for the interaction of subjects' occupational status (i.e., nurse-manager or nurse-clinician) with vignette rating condition (i.e., nurse-manager rated or nurse-clinician rated). In other words, ratings (mean stereotypic scores and mean trait scores) were predicted to vary as a function of both the occupational status of the "rater" and the labelled occupational status of the "rated". This interaction represents a restatement of the major hypothesis. No predictions were made for the effects of either occupational status or vignette rating condition when taken alone.

Chapter 3

RESULTS

Analyses of Mean Stereotypic Scores

Subjects' raw ratings were transformed into mean stereotypic scores according to the procedure described in "Methods". Inspection of mean stereotypic scores for the four subject groups (shown in Table 1) shows that, as predicted, nurse-managers rated the protagonist of the vignette more positively (higher) when the protagonist was identified as a fellow manager (mean stereotypic score = 43.5) than when the protagonist was identified as a clinician (mean stereotypic score = 40.7). Also, as predicted, nurse-clinicians rated the vignette protagonist more positively when the protagonist was identified as a fellow clinician (mean stereotypic score = 44.2) than when the protagonist was labelled a manager (mean stereotypic score = 41.9).

These group differences appeared as a significant ($p < .10$) interaction term (Table 2) when the mean stereotypic scores of the four subject groups were subjected to a 2 x 2 analysis of variance. The significant interaction term confirms the hypothesis that ratings of the vignette protagonist are a function of <u>both</u> the occupational status of the rater (i.e., manager or clinician) and the rating condition (i.e., whether the vignette protagonist was labelled a manager or clinician). The main effects of rater occupational status and vignette rating condition did not achieve significance (Table 2). This finding strengthens the interpretation of the interaction term since failure to show significant main effects indicates that neither the

Table 1

Mean Stereotypic Scores of Subject Groups

Group	Mean Stereotypic Score[a]	n[b]
Nurse-managers		
Nurse-manager rated	43.5 (7.1)	21
Nurse-clinician rated	40.7 (8.0)	23
Nurse-clinicians		
Nurse-manager rated	41.6 (9.3)	28
Nurse-clinician rated	44.2 (7.5)	35

Note. Mean stereotypic scores have a possible range from 10 (least positive) to 60 (most positive).

[a]Numbers in parentheses indicate standard deviations.

[b]Number of subjects per group.

Table 2

Analysis of Variance - Mean Stereotypic Scores

Source of Variation	ss[a]	df[b]	ms[c]	F	p
Rater's Occupational Status[d]	29.30	1	29.30	.46	n.s.[f]
Vignette Rating Condition[d]	4.30	1	4.30	.07	n.s.[f]
Interaction Term[e]	187.45	1	187.45	2.92	.10*
Error Term	6621.95	103	64.29	-	-
Total	6843.00	106	-	-	-

[a]sum of squares

[b]degrees of freedom

[c]means squared

[d]main effect

[e]Rater's Occupational Status x Rating Condition

[f]not significant

*Statistical significance achieved ($p < .10$).

rater occupational status nor the two vignette conditions, when taken alone, can be held accountable for variations in mean stereotypic scores. Variations in mean stereotypic scores, rather, can be traced to the influence of the interaction of the "rater" with the "rated". In other words, nurse-managers and nurse-clinicians do not systematically give different ratings regardless of whom they are rating, nor do nurse-managers and nurse-clinicians systematically receive different ratings independent of which nurses give the rating. Only when both factors occur in interaction is there a detectable effect on rating behaviors. Figure 1 graphically depicts the interaction term of the analysis of variance (Table 2).

Analyses of Mean Trait Scores

Subjects' raw ratings were also transformed on a group by group basis into mean trait scores according to procedures described in "Methods". Examinations of these raw scores represent a re-analysis of the subjects' ratings on a trait by trait basis, with the intent of identifying contributions of specific trait-adjectives to the overall finding of a significant interaction. Table 3 shows the mean trait scores of managers and clinicians who rated the manager protagonist vignette.

It was predicted that nurse managers would award higher (more positive) ratings under the manager protagonist vignette condition: comparison of means across the columns of Table 3 shows that this prediction was confirmed in eight of ten cases (see note on Table 3). That is, for eight of the ten traits, nurse-managers gave

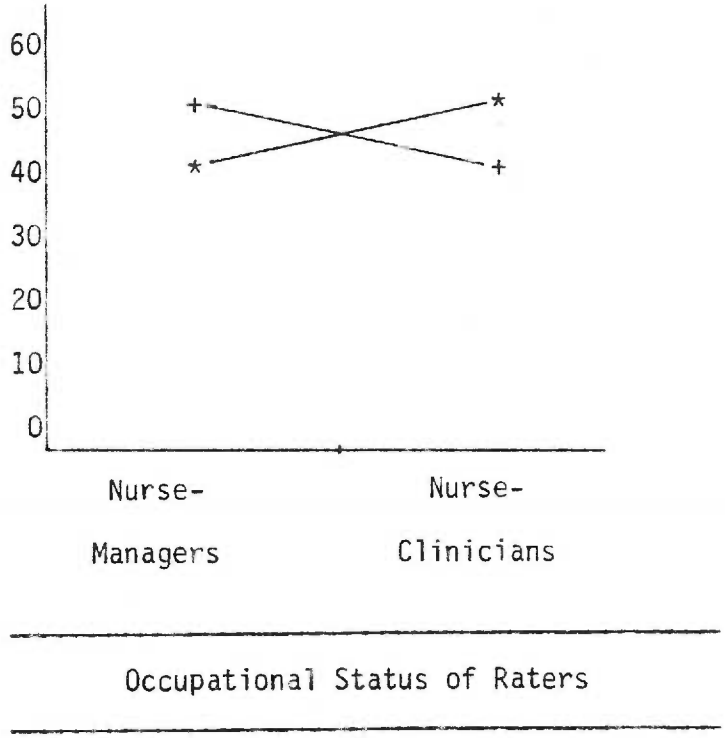

Figure 1. Graph of interaction of mean stereotypic scores by subject group.

*Vignette protagonist is labelled as a nurse-clinician.

+Vignette protagonist is labelled as a nurse-manager.

Table 3

Mean Trait Scores of Nurse-Managers and Nurse-Clinicians Rating the Nurse-Manager Protagonist Vignette

Trait	Rater's Occupational Status	
	Nurse-Manager	Nurse-Clinician
	Mean Trait Scores	
Kind	4.67	4.75
Efficient	4.52	4.43
Intelligent	4.52	4.32
Practical[a]	3.86	3.61
Sensitive	4.05	3.79
Industrious	5.38	4.93
Generous[a]	5.38	4.29
Imaginative[a]	4.38	4.18
Scientifically-Minded	3.90	3.64
Alert	3.38	3.68

Note. Ratings made by nurse-managers are higher than those made by nurse-clinicians for all traits except "kind" and "alert" (nurse-manager being rated).

[a]For these traits analyses of variance were significant at the $p < .05 - .06$ level.

nonsignificantly higher ratings to a protagonist who was identified as a fellow nurse-clinician than nurse-managers gave to a protagonist who was labelled a nurse-clinician.

Table 4 shows the mean trait scores of nurse-managers and nurse-clinicians who rated the nurse-clinician vignette. Under this condition, it was predicted that nurse-clinicians would award higher ratings, and comparisons of mean trait scores across columns shows that this prediction was confirmed in nine out of ten cases (see note on Table 4). That is, for nine of the ten traits, nurse-clinicians gave nonsignificantly higher ratings to a protagonist who was identified as a fellow nurse-clinician than nurse-managers gave to a protagonist who was labelled a nurse-clinician.

It was impossible to perform tests of significance on these two findings because there are not enough traits to permit a valid chi-square analysis. However, by shifting the focus of inquiry from the direction of the differences to the magnitude of the differences, analyses of variance became appropriate. Accordingly, 2 x 2 analyses of variance for each of the ten traits listed in Tables 3 and 4 yielded significant ($p < .05$ - $.06$) interaction terms for three traits: "practical", "generous", and "imaginative". The main effects of rater occupational status and vignette rating condition were not significant, as in the case in the analysis of variance reported for mean stereotypic scores (Table 2). The logic of interpreting these significant interactions and the non-significant main effects is identical to the reasoning applied to the interpretation of Table 2. That is, the results show that for the three traits of "practical", "generous" and

"imaginative" subjects' ratings are a function of both the occupational status of the rater (i.e., nurse-manager or nurse-clinician) and the vignette rating condition (i.e., whether the vignette protagonist was labelled a nurse-manager or a nurse-clinician). Numerical details of the significant analyses of variance for "practical", "generous" and "imaginative" are summarized in Tables 5, 6 and 7, respectively. The interaction term for each analysis is graphed following the appropriate table to highlight the significant findings (Figures 2, 3 and 4). It is recognized that repeated analyses of variance may lead to spurious results.

Table 4

Mean Trait Scores of Nurse-Managers and Nurse-Clinicians Rating the Nurse-Clinician Protagonist Vignette

	Rater's Occupational Status	
Trait	Nurse-Clinician	Nurse-Manager
	Mean Trait Scores	
Kind	4.77	4.70
Efficient	4.50	4.57
Intelligent	4.66	4.43
Practical[a]	3.83	3.13
Sensitive	3.80	3.22
Industrious	5.37	5.26
Generous[a]	4.51	4.26
Imaginative[a]	4.57	3.83
Scientifically-Minded	4.11	3.74
Alert	3.80	3.52

Note. Ratings made by nurse-clinicians are higher than those made by nurse-managers for all traits except "efficient" (nurse-clinician being rated).

[a]For these traits analyses of variance were significant at the $p < .05 - .06$ level.

Table 5

Analysis of Variance of Mean Trait Scores for the Trait "Practical"

Source of Variation	ss[a]	df[b]	ms[c]	F	p
Rater's Occupational Status[d]	1.73	1	1.73	1.15	n.s.[f]
Vignette Rating Condition[d]	.77	1	.77	.52	n.s.[f]
Interaction Term[e]	5.79	1	5.79	3.85	.05*
Error Term	154.83	103	1.50	-	-
Total	163.05	106	-	-	-

[a]sum of squares

[b]degrees of freedom

[c]means squared

[d]main effect

[e]Rater's Occupational Status x Rating Condition

[f]not significant

*Statistical significance achieved ($p < .10$).

Table 6

Analysis of Variance of Mean Trait Scores for the Trait "Generous"

Source of Variance	ss[a]	df[b]	ms[c]	F	p
Rater's Occupational Status[d]	.78	1	.78	.52	n.s.[f]
Vignette Rating Condition[d]	.61	1	.61	.41	n.s.[f]
Interaction Term[e]	5.45	1	5.45	3.65	.06*
Error Term	153.85	103	1.49	-	-
Total	160.73	106	-	-	-

[a]sum of squares

[b]degrees of freedom

[c]means squared

[d]main effect

[e]Rater's Occupational Status x Rating Condition

[f]not significant

*Statistical significance achieved ($p < .10$).

Table 7

Analysis of Variance of Mean Trait Scores for the Trait "Imaginative"

Source of Variance	ss[a]	df[b]	ms[c]	F	p
Rater's Occupational Status[d]	2.42	1	2.42	1.59	n.s.[f]
Vignette Rating Condition[d]	.00	1	.00	.00	n.s.[f]
Interaction Term[e]	5.78	1	5.78	3.79	.05*
Error Term	156.94	103	1.52	-	-
Total	165.14	106	-	-	-

[a]sum of squares

[b]degrees of freedom

[c]means squared

[d]main effect

[e]Rater's Occupational Status x Rating Condition

[f]not significant

*Statistical significance achieved ($p < .10$).

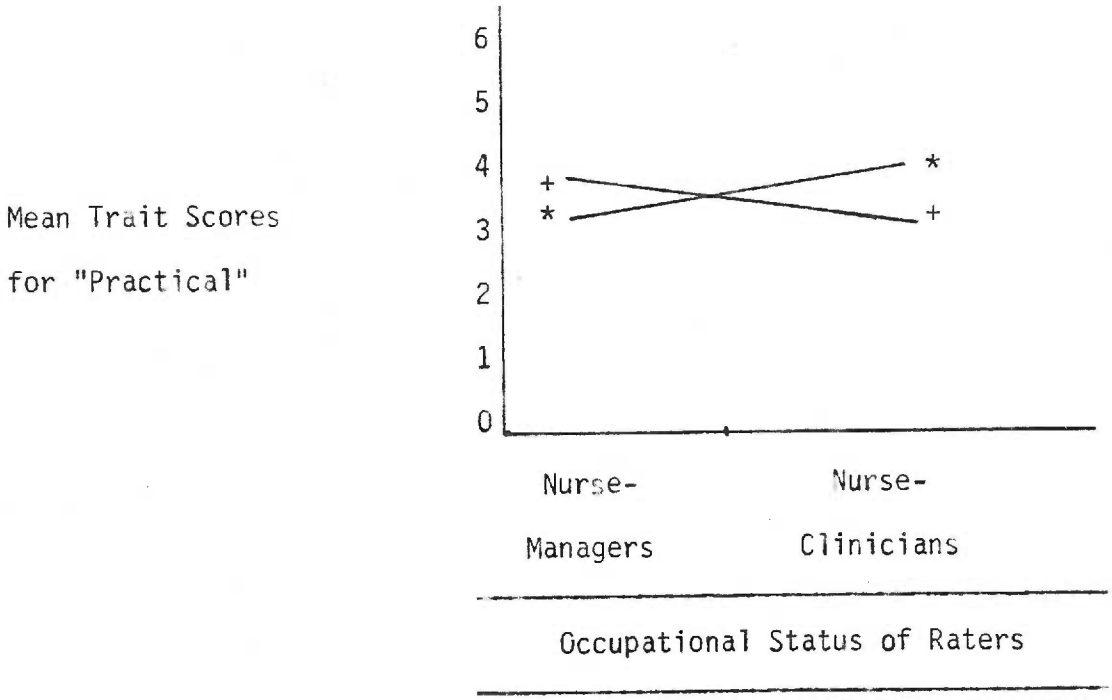

Figure 2. Graph of interaction of mean trait scores by subject group for the trait "practical".

*Vignette protagonist is labelled as a nurse-clinician.

+Vignette protagonist is labelled as a nurse-manager.

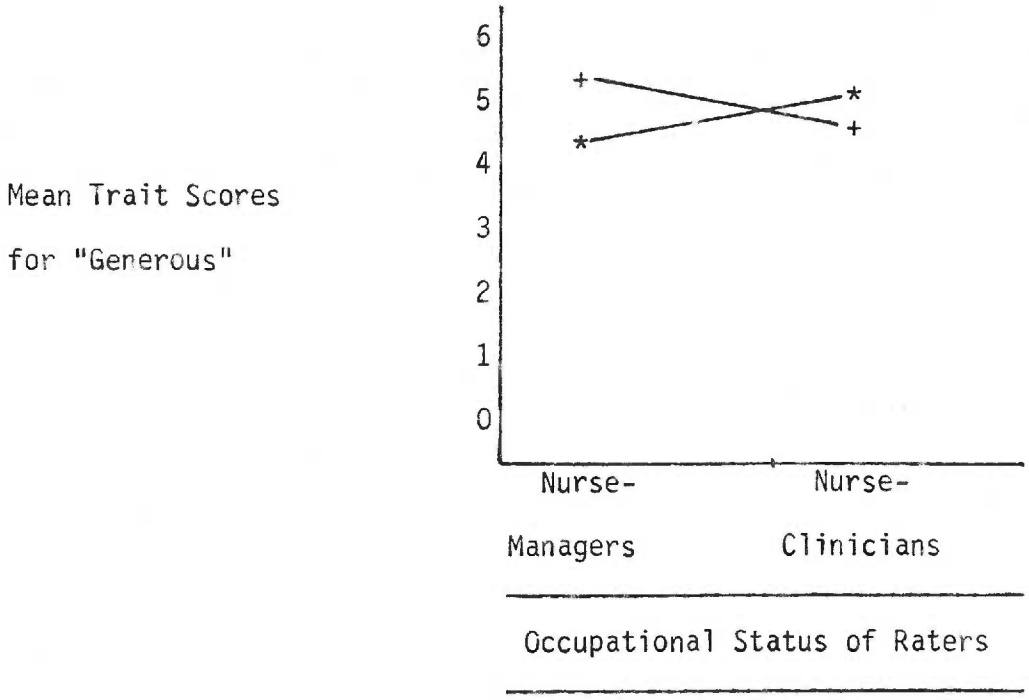

Figure 3. Graph of interaction of mean trait scores by subject group for the trait "generous".

*Vignette protagonist is labelled as a nurse-clinician.

+Vignette protagonist is labelled as a nurse-manager.

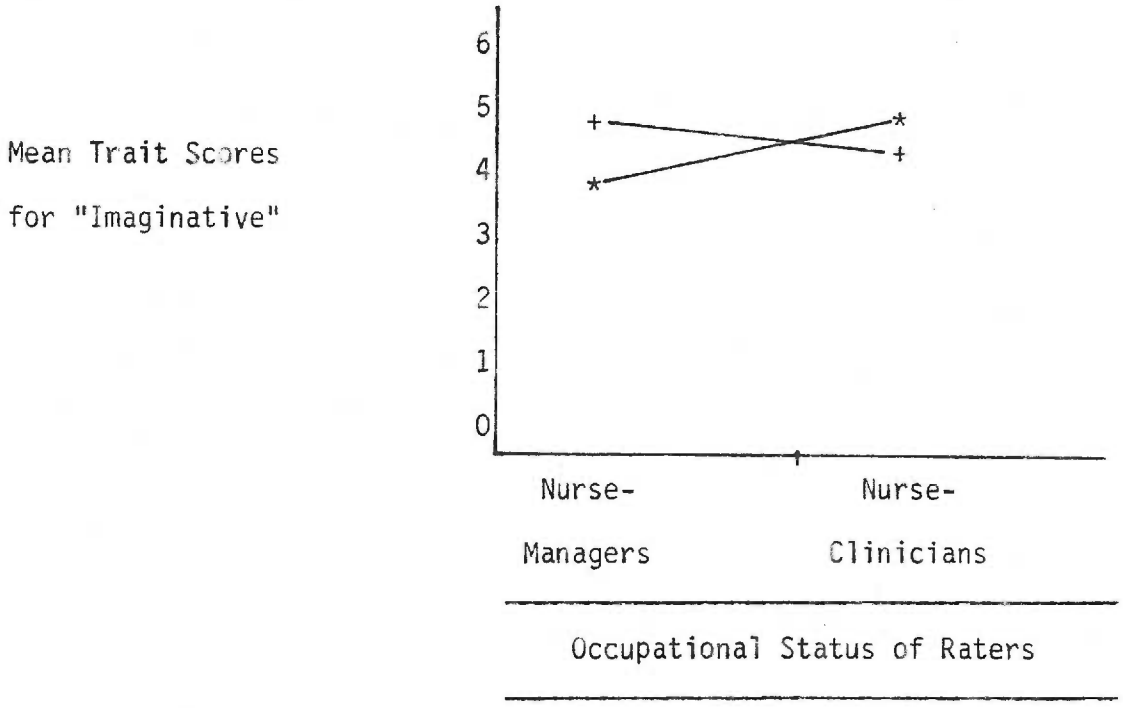

Figure 4. Graph of interaction of mean trait scores by subject group for the trait "imaginative".

*Vignette protagonist is labelled as a nurse-clinician.

+Vignette protagonist is labelled as a nurse-manager.

Chapter 4

DISCUSSION

In line with previous research which indicated that one function of reference groups is the interpretation of complex social realities into simpler forms (such as stereotypes), it was hypothesized that nurse-managers and nurse-clinicians would projectively rate the characteristics of a member of their own reference group (i.e., a fellow manager or clinician) more favorably than they would rate a nurse not from the same reference group. Results of this investigation offer modest support for this hypothesis. Major conclusions and supporting evidence are as follows:

Existence of Stereotyped Attitudes

Several lines of evidence converge in support of the conclusion that clinician and manager stereotypes do exist, and that they were operative factors influencing subjects' rating behavior in this study.

As predicted, comparison of mean stereotypic scores across subject groups (Tables 3 and 4) showed that managers and clinicians awarded higher ratings to themselves than to each other in 8/10 and 9/10 cases, respectively. This finding supports the predicted direction of the stereotyping effect.

Analysis of variance of the stereotypic scores (Table 2) showed the predicted interaction ($p < .10$) between rater occupational-status and vignette rating-condition. This finding indicates that merely changing the occupational status label of an unknown individual may significantly influence how that individual is perceived, with the precise nature of that influence in part a function of the perceiver's own occupational role (i.e., manager or clinician).

Nature of the Stereotypes

The present study was designed to detect only the gross presence/absence of a stereotype, and not to make fine qualitative distinctions. For example, the present data do not permit a choice among alternate hypotheses of the nature of the stereotypes: namely, do they represent an enhancement of self, a denigration of others, or both?

However, analyses by individual trait-scores (Tables 5, 6 and 7) offer some clues to the nature of stereotypic attitudes held by managers and clinicians toward each other. Of the ten rated trait-adjectives, managers and clinicians significantly tended to rate themselves as more practical, imaginative, and generous than they rated each other. Since the group of ten adjectives was selected to be relatively homogenous for "positiveness" (as determined by Karlins, Coffman & Walters, 1969), it appears reasonable to assume that some feature other than simple "positiveness" accounted for the emergence of "practical", "imaginative", and "generous" in this study. One possibility is that subjects found it easier to respond to <u>both</u> the negative and positive poles of these three traits, as compared to the remaining seven traits. That is, it may be easier to label someone as more or less practical, imaginative or generous, than it is to label someone as more or less intelligent, more or less kind, more or less scientifically-minded, etc. If this were the case, then subjects could have enjoyed subjectively increased degrees of freedom in responding to the traits of practical, imaginative and generous;

this increased subjective freedom would, in turn, be reflected in a greater range of responses to the rating scale, producing the significant effects which were, in fact, obtained.

A second possibility is that the specific information in the vignette contained facts which "pulled" for variance on these three traits as opposed to the remaining seven. Applying the same set of ten traits to several different vignettes could provide evidence to strengthen or weaken this hypothesis.

A third possibility is that "practical", "generous" and "imaginative" are key trigger words which have special significance for managers and clinicians because of some unique unspecified factors. If this were the case, one would expect that subjects would "zero in" on these three attributes regardless of the specific features of a vignette or protagonist.

When considering the possible significance of the traits "practical", "imaginative" and "generous", it is important to remember that nothing can be concluded from this study regarding the accuracy or completeness of these stereotype elements. That is, we know nothing of the actual behavior of managers and clinicians, since there were no specific measures of pragmatism, imaginativeness or generosity. Also, we do not know to what extent there may be other elements of a manager-clinician stereotype which were not uncovered in this study because relevant adjectives were not included among the ten selected for the rating checklist. Future studies might seek to answer these questions through direct measurement of behavioral correlates of

apparent stereotypic traits, and by replication of the present study with different lists of trait-adjectives.

Interpretive Cautions

The strength of the present conclusions is diminished by the marginal level of significance for the major finding ($p < .10$) and by the failure to achieve significance for more than three of the ten trait adjectives. External validity may be limited by the 52% mortality rate. However, given the absence of previous attempts to empirically assess stereotypes held by nurse-managers and nurse-clinicians toward each other, even a finding of marginal significance assumes importance. A follow-up to the present investigation might begin by retaining traits which showed the strongest differences between managers and clinicians and replacing trait-adjectives which did not elicit differences. Over time, repetition of such a "bootstrapping" process would produce a more refined list of traits which could more precisely characterize the nature of the stereotypes, and therefore would more easily elicit large inter-group differences.

Another possible criticism of the present study is based on the use of a single vignette as the projective stimulus. It could be argued that the specific trait differences (i.e., "imaginative, practical, generous") were pulled by some characteristic(s) of the vignette, rather than determined solely by the attitudes of managers and clinicians. However, if this were the case, then one would not expect to find differential responding by managers and clinicians (as was actually found in the ANOVA interaction), but rather would expect

similar responses across groups. An alternate implication of this criticism is that the present results could have been weakened, since differences between managers and clinicians could be washed out by similarities in response "pulled" by the vignette. Although the vignette was constructed to be as ambiguous as possible on its face, the possibility does remain that some nonobvious characteristics could have produced a biased result. The only definitive response to this question would involve replication of this study using a variety of vignettes, and then analyzing for differences attributable to particular vignettes.

Implications for Theory and Practice

In the introduction to this study it was argued that managerial and clinical stereotypes could be accounted for in terms of reference group theory (Halloran, 1976). According to this theory, reference groups have two major functions:

(1) to offer a standard against which to compare oneself (comparative function)

(2) to offer a direct source of values, perspectives, and attitudes (normative function).

Stereotypes may fulfill both the normative and comparative functions of a reference group. The boundaries of reference groups, and hence of their associated stereotypes, may vary along a continuum from unstructured/elastic/permeable to structured/rigid/impermeable.

One factor which should affect the characteristics of a reference group's stereotypes is the amount of actual contact between members

of the reference group and stereotyped individuals. As actual contact between members of different reference groups decreases, the stereotypes must necessarily be based on more indirect and ambiguous experience, and there is, theoretically, a greater possibility for distortion of attitudes.

This argument assumes importance in the present context because analysis of subjects' demographic characteristics (Appendix F) indicates that nurse-managers and nurse-clinicians may, in fact, have strikingly little face-to-face contact. This is an inference based on subjects' reported work settings. Thus, 71% of nurse-managers reported working in nursing homes or hospitals, while 88% of nurse-clinicians reported working in private or single provider settings, or outpatient clinics. Clearly, if nurse-managers and nurse-clinicians tend to find employment in different settings, there is little likelihood of significant daily contact. Indeed, relative isolation may be the rule. This implies that the source of stereotypic attitudes may not lie primarily in the actual interactions of nurse-managers and nurse-clinicians with each other; rather, an important experiential basis for stereotyped attitudes may lie outside the direct interactions of these groups.

In particular, it can be speculated that attitudes held by groups of nurses toward each other may mirror attitudes held toward specific groups of non-nurses. In their roles as managers and clinicians, nurses interact with many non-nursing managers (e.g., hospital administrators) and non-nursing clinical personnel (e.g., physicians). It

is conceivable that attitudes toward these non-nursing personnel become generalized to nursing personnel because of similarities of title or occupational role. Thus, if nurse-managers tend to view hospital administrators and other non-nursing managers in positive terms, and to view physicians and other non-nursing clinicians in relatively negative terms, these attitudes might find parallels in attitudes toward fellow nurses with similar occupational roles. Correspondingly, if nurse-clinicians tend to view physicians and other non-nursing clinicians in positive terms, and to view hospital administrators and other non-nursing managers in relatively negative terms, they too may generalize these attitudes to nurses who carry out analogous duties.

These speculations could be tested empirically by extending the paradigm of the present investigation to include non-nursing manager and non-nursing clinician labels for the vignette. We would then be in a position to assess the relative importance of generic identification as a nurse versus specific identification as a manager or clinician. That is, do the stereotypes vary if the vignette protagonist is still a manager or clinician, but is not also a nurse? The answer to this question might offer some insight into the extent to which attitudes held toward non-nursing groups may shape attitudes held by nurses toward each other.

In a more pragmatic vein, we may consider negative effects on nursing practice which might result from the effects of clinician-manager stereotypes. These include, but are not limited to, the following:

(1) When circumstances permit choice, managers and clinicians might choose to avoid dealing with each other, on the expectation that such interactions might prove unproductive. Thus, a group of clinicians attempting to organize a legislative lobby might fail to take advantage of the specialized human relations skills and social systems knowledge which a manager might contribute to the effort. Or, clinicians might devalue a spontaneous contribution of expertise from a manager.

(2) When managers and clinicians must deal with each other (as in discussing issues of salary, working conditions, etc.) negative stereotypes could interfere with the communication process and produce a dialogue in which the parties become more adversaries than partners.

(3) When managers and clinicians deal with members of their own reference groups, the influence of positive stereotypes might produce a failure to be adequately critical of one's colleagues. In a peer-review situation, positively-toned stereotypic attitudes might lead managers or clinicians to give their fellows false-positive ratings, thus undermining the usefulness of peer-review as a quality control mechanism.

Conclusion

A fifty year history of research has demonstrated that stereotyping is both a ubiquitous and persistent characteristic of human social interactions. However, while the process of stereotyping may be an unavoidable by-product of the mental processes involved in coping with complex social realities, the content of a particular

stereotype may be relatively responsive to changing social/environmental conditions. Consider, as an extreme example, the shift in American attitudes toward the Japanese people which has occurred over the last forty years. During World War II, negative stereotypes of persons of Japanese descent were so pervasively negative that thousands of individuals were imprisoned in detention camps simply because of their racial and ethnic background. Yet, now, forty years later, we regard the Japanese as friends, and the dominant stereotype, (as expressed in the popular press) is of a courteous and industrious people.

From this historical perspective it is not surprising to find evidence of stereotypic attitudes held by nurse-managers and nurse-clinicians toward each other. Nursing is no stranger to the effects of stereotypes. As a profession strongly identified with the "weaker sex", nursing has struggled to maintain an image of competence and autonomy. The present investigation adds a new dimension to this struggle, suggesting that the stereotyping process occurs within nurses themselves, as well as within individuals outside the profession. While this study does not support a claim that stereotypes held by nurses are a major negative factor, it also does not offer peace of mind to those who might like to dismiss the issue. To the extent that increased awareness may serve as an antidote to the negative effects of stereotyping, further research and dissemination of significant results would seem to be an important next step.

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APPENDIX A

APPENDIX A

Area Code 503 225-8317

Portland, Oregon 97201

UNIVERSITY OF OREGON

HEALTH SCIENCES CENTER

Good Morning. My name is Margaret Robbins and I am a graduate nursing student gathering information on how nurses make decisions. The purpose of this letter is to invite you to participate in this study. If you agree to participate, your input will help to further our understanding of how decisions made by nurses can make a vital difference in the delivery of health care services.

Why have I chosen you? First, your name was selected from a list of nurses practicing in the State of Oregon who function in an autonomous role. Second, nurses in roles such as yours are setting trends in nursing and showing nurses' ability to increasingly influence the health care system.

The enclosed materials include a brief (one page) story, a rating scale, and a demographic data sheet. These materials were designed to be as interesting as possible, and to take no more than ten or fifteen minutes to complete. To participate, all you must do is to read the story and follow the instructions on the rating scale and demographic data sheets, and then return the materials in the enclosed prepaid envelope.

All information will be number coded so that anonymity and confidentiality of your replies is assured. And, of course, you are free not to respond at all if you so choose.

If you wish to see a copy of the final report, it will be available through the School of Nursing at the University of Oregon Health Sciences Center at the above address. If you have any questions, please address them to:

Margaret Robbins, R.N.
Graduate Studies Department
School of Nursing
University of Oregon Health Sciences Center
Portland, Oregon 97201

The time you spend replying is much appreciated.

Thank you and have a good day.

Sincerely,

Margaret S. Robbins, R.N.

APPENDIX B

APPENDIX B

DEMOGRAPHIC DATA

Please answer the following questions. Your answers will remain confidential.

1) Highest nursing degree obtained?

A.D. (2 yrs.) ____ Diploma (3 yrs.) ____ Bachelors (4 yrs.) ____

Masters ____ Doctorate ____

2) Do you hold any non-nursing degrees? Yes ____ No____. If yes please list _____

3) What is your present work setting(s) (eg. hospital, industry, nursing home, group practice, school, academic/teaching) ? _____

_____

4) What is your present job title(s) ? _____

_____

5) How long have you worked in your present capacity, in either your present or any other setting? _____

6) Approximately how many hours do you work at the job described in item 4 per week?

Under 8 hours _____ 8-48 hours _____ Over 48 hours _____

7) Please estimate the percentage of your time, in an average day, that you spend in clinical activities (direct patient care) _____%

8) Please estimate the percentage of your time, in an average day, that you spend in administrative activities (working with the organization) _____%

9) If you had to label your present nursing duties as either clinical (direct patient care) or administrative (working with the organization), which label would you chose? (Please check only one)

Clinical _____ Administrative _____

10) In the best of all possible worlds, would your ideal job be: (Please check only one)

Clinical _____ Administrative _____

THANK YOU FOR YOUR TIME. PLEASE PLACE THIS SHEET AND THE RATING SCALE IN THE POSTAGE-PAID ENVELOPE INCLUDED WITH THIS MAILING AND DROP IT IN THE MAIL.

APPENDIX C

INSTRUCTIONS

Please read through the following story. When you are finished, turn the page and complete the rating scale according to directions. Thank you.

The following is a fictitious event.

Since first beginning work in Small Town, USA, M.L., Geriatric Nurse Practitioner, has noted a need for extended day care facilities for older citizens who, although living with their families, are unable to care for themselves during the day while family members are out of the home. As the Geriatric Nurse Practitioner, M.L. discusses a range of services with her co-workers, who suggest that senior day care would indeed meet a growing community need. Immediately, M.L. begins to outline the details of a senior day care program, investigating federal assistance plans, talking with families, and assessing existing community resources. Within a few weeks, M.L. has gathered enough information to present initial plans to her agency's project review committee for approval. (As the Geriatric Nurse Practitioner she serves on this committee and has no difficulty getting her proposal onto the agenda). Enthusiastically, she takes the floor and presents her findings: there is little apparent response from other committee members. M.L. continues, pointing out the multiple benefits of her plan -- the agency will receive additional funding, clients will receive needed services, and more senior citizens will be able to live at home. At this point, however, she notices three committee members (who are also active in local politics) exchanging heated whispers. When the presentation is complete, M.L. waits for questions and comments, but receives none. Instead, the chairperson glances around the room, praises the idea of senior day care, and states that the plan deserves more discussion time than is available at the moment, given the full agenda to be covered. As the meeting continues, M.L. absentmindedly fingers her name tag, with the title "Geriatric Nurse Practitioner", and ponders what to do next.

APPENDIX D

INSTRUCTIONS

Please read through the following story. When you are finished, turn the page and complete the rating scale according to directions. Thank you.

The following is a fictitious event.

Since first beginning work in Small Town, USA, M.L., Director of Nursing Services, has noted a need for extended day care facilities for older citizens who, although living with their families, are unable to care for themselves during the day while family members are out of the home. As Director of Nursing Services, M.L. discusses a range of services with her staff, who suggest that senior day care would indeed meet a growing community need. Immediately, M.L. begins to outline the details of a senior day care program, investigating federal assistance plans, talking with families, and assessing existing community resources. Within a few weeks, M.L. has gathered enough information to present initial plans to her agency's project review committee for approval. (As Director of Nursing Services she serves on this committee and has no difficulty getting her proposal onto the agenda). Enthusiastically, she takes the floor and presents her findings: there is little apparent response from other committee members. M.L. continues, pointing out the multiple benefits of her plan -- the agency will receive additional funding, clients will receive needed services, and more senior citizens will be able to live at home. At this point, however, she notices three committee members (who are also active in local politics) exchanging heated whispers. When the presentation is complete, M.L. waits for questions and comments, but receives none. Instead, the chairperson glances around the room, praises the idea of senior day care, and states that the plan deserves more discussion time than is available at the moment, given the full agenda to be covered. As the meeting continues, M.L. absentmindedly fingers her name tag, with the title 'Director of Nursing Services", and ponders what to do next.

APPENDIX E

APPENDIX E

RATING SCALE

Instructions:

After reading the preceding short story, please rate M.L. on the attributes listed below. Each attribute is followed by a scale numbered from 1 to 6. Given that 1 indicates "less" and 6 indicates "more", circle the number that you think best describes M.L. for each attribute.

How KIND is M.L.?	(less)	1	2	3	4	5	6	(more)
How EFFICIENT is M.L.?		1	2	3	4	5	6	
How INTELLIGENT is M.L.?		1	2	3	4	5	6	
How PRACTICAL is M.L.?		1	2	3	4	5	6	
How SENSITIVE is M.L.?		1	2	3	4	5	6	
How INDUSTRIOUS is M.L.?		1	2	3	4	5	6	
How GENEROUS is M.L.?		1	2	3	4	5	6	
How IMAGINATIVE is M.L.?		1	2	3	4	5	6	
How SCIENTIFICALLY-MINDED is M.L.?		1	2	3	4	5	6	
How ALERT is M.L.?		1	2	3	4	5	6	

When you have finished your ratings, please turn the page and check the appropriate information on the demographic data sheet.

APPENDIX F

APPENDIX F

Summary of Demographic Data

Data Sheet Item	Nurse-Managers	Nurse-Clinicians
Highest Nursing Degree		
A.D. (2 yr)	14%	2%
Diploma (3 yr)	25%	24%
Bachelor (4 yr)	30%	40%
Master	32%	35%
Non-nursing Degree		
Yes	25%	17%
No	75%	83%
Work Setting		
Nursing Home/Hospital	71%	-
Private Provider/Outpatient Clinics	-	88%
Other Setting	29%	12%
Time Worked		
Less than 5 yrs.	61%	48%
Between 5-10 yrs.	30%	44%
More than 10 yrs.	9%	8%
Hours Worked Per Week		
Less than 8 hrs.	5%	2%
Between 8-48 hrs.	64%	86%
More than 48 hrs.	32%	13%
Ideal Job		
Clinical Type of Work	14%	97%
Administrative Type of Work	86%	2%