

FACTORS RELATING TO MEASURES OF INFORMATIVENESS
AMONG SURGICAL-UNIT NURSES

by

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CHAPTER I

INTRODUCTION

The experience of hospitalization, whether for surgical or medical reasons, involves stressful and tension-producing situations. Many procedures that patients experience during the course of diagnosis and treatment can be viewed as threatening. Meyers (1964) maintains that any new event which encroaches on an individual arouses tension. She suggests, furthermore, that giving a patient specific information upon which he can structure an impending event is basic to helping him reduce that tension. In the case of the surgical patient, by being informed of preoperative and postoperative procedures and having his questions answered and misconceptions corrected, he is able to attach meaning to events, with consequent reduction of tension.

Preoperative preparation of the surgical patient is an acknowledged portion of the surgical-unit nurse's scope of practice. Although everyone who comes in contact with the patient has some impact on him, and although in a specific way the anesthesiologist and surgeon perform essential functions in the management of the patient's condition, it is the nurse who, hour by hour, day by day, has the opportunity to provide information to help the patient cognitively

structure his forthcoming experience in an accurate and acceptable fashion. While medical and nursing literature contain documentation of the justification for such preparation, the ramifications of its implementation, and the value of different approaches, there is a scarcity of verification that surgical-unit nurses are performing this function.

In light of the recognized need for patient preparation, why is it not being done? Do nurses vary in the value they place on informing patients? Is it a function of the nurse's individual style of coping with anxiety-arousing situations? Or, are there factors operating in the hospital setting that restrict the nurse's functioning in this area?

Review of the Literature

The review of the literature centers around two major themes: (1) the necessity for adequate preoperative preparation, and (2) deterrents to the provision of such preparation. Included in the first section will be the importance of patient education, the role of the nurse, a discussion of patients' concerns and informational needs, the results of specific preparatory programs, and approaches to preoperative preparation. The second section will contain the characteristics of current preparation, nurses' dissatisfaction with their teaching efforts, the effects of attitude and personality traits, and the role of organizational variables.

Need for Adequate Preoperative Preparation

The following quotations are representative of the concepts reported in the literature relative to the stress involved in hospitalization in general, and in surgery in particular.

Patients who enter hospitals are frequently, if not generally, people in trouble. There is 'something wrong' with them that requires diagnosis, treatment, or both. That very fact, even though they may not be in pain, is often sufficient to arouse anxiety about their imminent hospital experience, what the diagnostic tests will show, and whether they will be really cured, left with physical disabilities, or faced with the likelihood of too early a death. (Brown, 1965, p. 6)

A patient entering the operating room for a major surgical procedure very likely is embarking on one of the most significant and potentially threatening experiences in his life. His chances for an uneventful convalescence and full restoration of health are influenced greatly by the adequacy of his preoperative care. (Dumas, Anderson, & Leonard, 1965, p. 18)

Leaders in the health care professions realize that effective patient care requires that "patients have a better understanding of health information than they frequently have had in the past" (Dodge, 1969, p. 502). Research has shown that the more patients know about their conditions, the more likely they are to cooperate in their treatment (Goodrich & Schwartz, 1959; Heinzelmann, 1962; Pratt, Seligmann, & Reader, 1957). Conversely, inadequate understanding has been shown to result in deleterious consequences; one such outcome--stress--has been found to relate to such things as

childbirth complications, congestive heart failure, and glaucoma (Chambers & Reiser, 1953; Davids & DeVault, 1962; Zimet & Berger, 1960).

Patient education is becoming recognized as an essential component of health care. Among the recommendations made by the Task Force on Patient Education, the following refer to hospitals and health professionals:

- a. Accept the premise that the patient has an inalienable 'right to know' the status of his health; the nature of an existing health problem; what community health resources are available to him and his family; and what he can do, if possible, to prevent recurrences.
- b. Encourage and make provisions for patients to take an active participatory role in their own care to the extent they choose and are able to do so. (1974, p. 1).

Current health care related literature reflects these concerns. Hospital association publications have indicated that health care systems are more responsive to the rights and needs of consumers (Schlesinger, 1973), and that "hospitals and other health care institutions have an obligation to promote, organize, implement, and evaluate health education programs" (Fylling & Etwiler, 1975, p. 95). While symposiums on patient education have been included in nursing journals (Smyth, 1971; Storlie, 1973), an editorial in a medical association publication suggests that effective health care cannot be given without the cooperation of an informed and involved patient (Etwiler, 1972).

The nurse has a unique opportunity to play a vital role in patient education. Because of close and frequent contact, the nurse is the member of the health team who can facilitate understanding of health principles and practices (Pohl, 1973). Redman (1972) contends that every nurse-patient interaction has the potential for patient teaching. "For example, each time she is with a patient, the nurse is assessing his needs, some of which she can meet by providing him with information, clarifying his thinking, reflecting his feelings, or teaching him a skill" (p. 7).

Considerable study has been devoted to the role of identifiable variables in patients' responses to surgical procedures (Andrew, 1970; Carnevali, 1966; Cassady & Altrocchi, 1960; Corman, Hornick, Kritchman, & Terestman, 1958; Janis, 1958; Sheffer & Greifenstein, 1960; Wolfer & Davis, 1970). Utilizing preoperative interviews to ascertain patients' concerns regarding their surgeries, Cassady and Altrocchi (1960) found that 34 of 40 patients verbalized one or more concerns. Although there was some variability in the kinds of concerns voiced, most could be classified in one of the following categories: death, diagnosis, discomfort, helplessness, socio-economic, disabling, and the unknown.

Corman et al. (1958) reported an incidence of preoperative fear in 80 per cent of their study population. Thirty-four of the 43 patients interviewed expressed preoperative apprehension; 15 patients

verbalized fears related to their disease or hospitalization; 21 patients expressed fears regarding anesthesia; and 17 patients presented specific fears related to surgery. Supporting the work of Corman and his associates, Sheffer and Greifenstein (1960) found that 92 per cent of the 100 adult patients questioned postoperatively demonstrated measurable degrees of fear and tension in relation to anesthesia and surgery.

Carnevali (1966) combined the findings of three studies--two compared patients' and their nurses' perception of concerns, while in the third the concerns expressed by patients facing serious surgery were compared with the concerns shown by patients facing less serious surgery. The sources of concerns reported by patients in the three studies were similar to those previously cited in the literature. While discomfort and pain were mentioned most frequently, the category of "the unknown" was ranked second by the total population of the three studies. Additional findings of the first two studies revealed what nurses perceived the patients to be concerned about preoperatively. Although most nurses were not aware that so many patients had concerns regarding discomfort and pain, they were quite accurate in perceiving patients' worry about the unknown--recognizing it in 13 of the 14 patients who reported it.

Finally, 76 female patients and 70 male patients, who had undergone major surgery, were given a variety of instruments

designed to assess their preoperative fear and anxiety and their post-operative adjustment and recovery. Among the principal findings, at least 30 per cent of the female patients and 15 per cent of the male patients reported a high degree of fear and anxiety the night before surgery. Wolfer and Davis (1970) point out that self-ratings of fear and anxiety are most likely underestimates of the actual situation "because the ratings are subject to two possible response sets: 'social desirability' in the form of an unwillingness to publicly admit fear, and 'denial' of anxiety as a coping technique" (p. 407). To the extent that either of these response sets is operating, the percentages reported could be considered conservative.

Johnson (1972) has demonstrated that structuring patients' expectations can decrease their tension and make them more comfortable during stressful events. Schmitt and Wooldridge (1973) agree that informing the patient of impending events can decrease tension, but they emphasize that the information provided should be that deemed helpful by the patient. Results of studies conducted to identify types of information desired by patients have been reported by Brambilla (1969), Dodge (1969, 1972), Erickson (1969), and Weiler (1968).

Dodge (1969) described a study that attempted to examine patients' perceptions of their cognitive needs. A verbally administered open-ended interview was utilized with 116 patients,

approximately midway in their hospitalization, to determine the type of information they felt should be given to patients. Results indicated that patients were particularly concerned with questions of diagnosis and the etiology of their conditions. Questions relating to the seriousness of their conditions were followed by those regarding the effects on their future; not only did they want to know what temporary activity restrictions would be imposed, but they wanted to know probabilities of being able to resume their life styles. Allied with the above was a concern with the time element involved, and the importance of being told the kind of care that was or would be needed.

Forty-five per cent of the patients in Dodge's study had had surgery, while 55 per cent were treated medically. Although both groups tended to seek the same information relevant to planning for immediate and long-range goals, surgical patients were more concerned about activity restrictions, success of care received, and total recovery time, while medical patients placed more emphasis on information regarding their medications and how they could participate in their care.

An additional investigation by Dodge (1972) explored the extent to which patients and nurses agree on the types of information patients need. The nursing sample consisted of 37 registered nurses and 29 practical nurses; the 140-patient sample was composed of half surgical and half medical patients, half males and half females. Patients and

nurses agreed that it is highly important that patients be informed about the nature of their illness, how long it will last, and how they can be involved in their care. Both groups were in agreement that it is important that patients be informed of what symptoms to expect and the type of care they would need. Moderate importance was attributed to the patients being informed of specific details of what to expect during tests, regarding anesthesia, and so forth. Finally, little importance was attributed to information relating to cost of care.

Informational needs of patients having cardiac surgery have been related by Brambilla (1969) and Weiler (1968). Twenty patients scheduled to have cardiac surgery were interviewed by Brambilla two days prior to surgery; 17 of the 20 were interviewed on three consecutive days postoperatively. Analysis of questions asked revealed that the greatest preoperative needs pertained to information about recovery room and the intensive care unit, followed by information regarding the operation. Greatest postoperative needs related to information about patients' activities following discharge. Utilizing a questionnaire, Weiler requested 100 patients, who had experienced open-heart surgery, to evaluate their preoperative instruction and to rate information given from very important to not helpful. Eighty-three per cent of the patients considered their preoperative preparation adequate. As to who had given the most helpful instructions, 42 patients indicated a nurse, 34 patients reported a physician, and

15 patients indicated a nurse and doctor combined. Patients rated the following areas of instruction as most important: deep breathing and coughing technique; information describing intensive care; information regarding pain, chest tubes, and oxygen; information about seeing a priest, rabbi, or minister; and, visiting hours and communication of information to relatives. Items considered least helpful included touring the postoperative cardiovascular unit and meeting the personnel, and the approximate time that the monitor, urinary catheter, blood, and intravenous fluids would be continued.

Erickson (1969) employed focused interviews with 21 adult patients, three to five days following major pulmonary surgery, to identify the information patients found to be most helpful during their hospitalization. At least four kinds of general information emerged as being advantageous in assisting patients to cope with their surgical experience: preparation for impending events, explanation of operative results, instruction for self-help, and assurance of quality care.

A positive relationship has been demonstrated, in a number of studies, between psychological preparation and instruction during the preoperative period and reduction of stress, as measured by a patient's postoperative physiological responses. Investigators have used a variety of measures of postoperative conditions, such as postoperative vomiting, urinary retention, amount of analgesics

required, postoperative activity, and length of hospitalization (Dumas & Leonard, 1963; Egbert, Battit, Welch, & Bartlett, 1964; Healy, 1968; Schmitt & Wooldridge, 1973).

Dumas and Leonard (1963) used experimental and control patients to test the hypothesis that the use of a particular nursing approach preoperatively would result in a decreased incidence of postoperative vomiting. "The experimental treatment was essentially a process of nursing directed toward helping the patient attain a suitable psychological state for surgery" (p. 12). The experimental patients, in addition to receiving routine physical preparation, were visited prior to surgery and accompanied to the operating room by the nurse-investigator. A pilot study and two replications revealed consistently that the experimental patients had a lower incidence of postoperative vomiting than control patients.

A group of physicians from the departments of Anesthesia and Surgery at a large eastern hospital (Egbert et al., 1964) studied the effectiveness of preoperative suggestion and instruction, coupled with repeated episodes of encouragement, in reducing the severity of postoperative pain following intra-abdominal surgery. Using 97 patients in control and experimental groups, the "special-care" patients were told what to expect postoperatively; they were taught how to take deep breaths, how to relax, and how to move so as to obtain maximum comfort following surgery. Finally, they were told to

request medication if they could not achieve a reasonable level of comfort. Such individually instructed patients required fewer narcotics postoperatively and were discharged from the hospital 2.7 days earlier than the control patients.

Healy (1968) conducted a comparative study of 321 patients admitted for elective surgery over a four-month period. The 181 patients comprising the experimental group received individual pre-operative instructions regarding coughing, turning, deep breathing, leg exercises, and an explanation of any specific procedures peculiar to each operation. Among other results reported, data showed that 135 patients in the experimental group went home three to four days prior to the expected day of discharge, while only three patients in the control group were discharged prior to the anticipated date.

And finally, Schmitt and Wooldridge (1973) were able to report extensive favorable outcomes from the intervention of extra preparation with randomly selected matched control and experimental groups of 25 patients each. The evening prior to surgery the experimental patients participated in a small group session where they discussed fears and concerns and received information regarding what to expect and how they could aid in their recovery. Measurement of physiological, verbal, and interactional variables revealed the following results:

Experimental patients reported that they slept better and experienced less anxiety the morning of surgery; they recalled more facts about their experiences on the day of

surgery, and their recollections less often involved fearful and unpleasant images; they experienced less operative urinary retention, required less anesthesia; they required less pain medication, returned more rapidly to oral intake, and were discharged sooner. (p. 108)

Numerous approaches to the preoperative preparation of the surgical patient can be found in nursing literature. Some authors describe programs unique to specific groups of surgical patients, such as gynecologic patients (Merkatz, Smith, & Seitz, 1974), or patients undergoing open-heart surgery (Brambilla, 1969). Some advocate structured over unstructured teaching (Lindeman & Van Aernam, 1971), while others are proponents of group instruction rather than a one-to-one approach (Lindeman, 1972; Mezzanotte, 1970; Park, 1972).

In addition, a variety of nurses are becoming involved in the patient's preparation: Shetler (1972) reported a program of preoperative visits by operating room nurses; Levine and Fiedler (1970) detailed a preoperative teaching and information program conducted by the recovery room-intensive care unit nursing staff; Merkatz et al. (1974) described group and individual preoperative preparation by a team of three clinical nurse specialists; and finally, Healy (1969) outlined an "all-encompassing program of care and instruction for the surgical patient" (p. 37), which centers around the unit nurse, who plans the program and utilizes resource people from surgery,

recovery, intensive care, respiratory therapy, or another nursing unit specializing in the necessary postoperative care.

However, whether the preoperative preparation is done by the operating room nurse, the recovery room nurse, the intensive care unit nurse, or the surgical unit nurse, whether patients are taught individually or in groups, or whether the teaching is the responsibility of one person or a team, the primary objectives prevail: reduce the patient's tension, elicit his cooperation and assistance, and as a result hasten his recovery.

Summing to this point, a review of the literature has revealed that patient education is an essential component of health care, and more specifically, that preoperative preparation is a necessary element in surgical intervention. Studies have not only demonstrated that the surgical patient is anxious and has informational needs preoperatively, but that specific interventions implemented preoperatively have resulted in favorable outcomes postoperatively as measured by certain verbal, physiological, and interactional variables. While many approaches to the preoperative preparation of the surgical patient have been reported, and although nurses functioning in a variety of capacities have become involved in different aspects of the preparation, the literature is consistent in supporting the value of preparing the patient and is unmistakably clear in acclaiming the nurse's unique opportunity to assume a vital role in such preparation.

Deterrents to Adequate Preoperative Preparation

Although Redman (1974) has pointed out that "nursing has long been committed to a caring and instructional role" (p. 4), available literature does not indicate that this commitment has always been actualized (Leach, 1964; Pohl, 1965; Skipper & Leonard, 1968).

Studies cited in the previous section, illustrating the value of preoperative preparation, suggest that a variation from what constitutes "routine care" proved to be beneficial. The care received by the "control group" was presented as indicative of the quality of care currently being given in that situation. For example, both Dumas and Leonard (1963) and Schmitt and Wooldridge (1973) used the term "task-oriented" to describe the routine nursing care received by the control patients. Lindeman and Van Aernam (1971)--in exploring the effects of structured and unstructured teaching--maintained that two characteristics of unstructured teaching were inconsistency and vagueness, as each nurse taught "what, when, and how she intuitively felt was adequate and correct" (p. 331). And, in recent research involving patients from two separate hospitals, Hegyvary and Chamings (1975a) not only explained that the control group received no instructions from the investigators, but added "observation and patient reports indicated that some nurses in each hospital sporadically gave preoperative instructions" (p. 31).

In a study conducted in Oregon, Leach (1964) surveyed 80 adult patients to determine if the responsibility for preoperative preparation was being fulfilled by the registered nurse. A checklist was administered postoperatively to patients who were responding, rational, and not in critical condition; all patients had had surgery within ten days preceding the interview. Findings indicated that the registered nurse provided 30 per cent, or more, of the instruction for 14 of the 80 patients surveyed, while furnishing 50 per cent, or more, of the preparation for only three patients. The most frequent items of instruction, in rank order, were "(1) preoperative hypodermic, (2) sleeping pill, (3) nothing by mouth after surgery, (4) nothing by mouth before surgery, and (5) the surgical prep" (p. 65). While four of the five items related to the preoperative phase of preparation, none dealt with the patient's participation postoperatively.

It has been said that "the age of patient education is upon us, and we're not ready" (Redman, 1975, p. 19). Indeed, there is evidence that some nurses do not feel prepared to do patient teaching (Dodge, 1961; Lindeman, 1973; Pohl, 1965). In a study designed to gather data regarding teaching activities of nursing practitioners in a variety of practice settings throughout the United States, Pohl (1965) reported the following among major findings: although the majority of the total study population felt teaching was the responsibility of the

nurse, that they wanted to teach and enjoyed it, and that teaching was as vital as other aspects of their practice, they expressed dissatisfaction with both the quality and quantity of their teaching.

Lindeman (1973) has spoken to the fact that while nurses were encouraged as early as 1941 (Dripps & Walters) "to initiate selected activities preoperatively as a means of enhancing their benefits to the patient postoperatively" (p. 515), more than 30 years later, "preoperative teaching is still, in many instances, determined by the individual nurse and her external pressures and based upon intuition and past experience" (p. 515). In outlining the process involved in developing a preoperative teaching program, Lindeman related that despite the fact "the staff were in total agreement that all registered nurses should teach" (p. 516), it was obvious that not all registered nurses were teaching. Reasons cited for failure to engage in preoperative teaching included "lack of time and feelings of insecurity regarding the teaching role" (p. 516).

Psychological research (. . .) suggests that the person who feels himself inadequate for some reason or other is often less willing to communicate with others--presumably because of a fear of exposing his ignorance. . . . To the person who feels inadequate, situations which require him to tell what he knows are threatening, and he prefers to avoid them. Denying their importance is the one way of avoiding them more easily. (Dodge, 1961, p. 214)

Research based on the above views attempted to determine if the nurse who perceives herself as a psychologically strong individual

differs in her belief, regarding the importance of informing patients, from the nurse who perceives herself as a relatively weak person.

. . . data provided support for the notion that willingness to keep patients medically informed is related to certain aspects of the self-picture--in particular, to a feeling of personal adequacy or psychological strength. (p. 216)

Hill, Taylor, and Stacy (1963) recognized that the clinical settings available in nursing are so diverse in their requirements that the personality characteristics of those attracted to them may vary.

It seems reasonable to expect that one or more personality traits would be essential to function well within the general field of nursing and that additional, different traits would be required for different nursing specialities. (p. 668)

Utilizing the Edwards Personal Preference Schedule (EPPS), Navran and Stauffacher (1957, 1958) were able to show that nurses differ from "women in general" in certain personality traits that relate to their profession.

. . . psychiatric nurses differ significantly from 'college women in general' (. . .) on seven variables. The nurses have higher scores on Order, Deference, Endurance, and Aggression, and are lower in Autonomy, Affiliation, and Exhibition. (1957, p. 111)

. . . general medical and surgical nurses differ significantly from (. . .) 'college women in general' on at least eight variables. The nurses have higher average scores on Order, Deference, and Endurance, and are lower on Affiliation, Autonomy, Succorance, Exhibition, and Dominance. (1958, p. 65)

Comparing the EPPS scores of 196 neuropsychiatric (NP) nurses with the EPPS scores of 167 general medical and surgical (GMS)

nurses, Navran and Stauffacher (1958) found that although both groups have a great deal in common, there are qualitative and quantitative differences.

Order, Deference, and Endurance are the most prominent characteristics for both groups (and in the order named for both), but the GMS nurses are significantly more orderly and deferent quantitative differences [indicate] that GMS nurses are much more work-oriented than people-oriented. They are more impersonal than their psychiatric colleagues (Order, Deference), more timid and less able to direct or lead others (Aggression, Abasement, Dominance), and less interested in contacts with men (Heterosexuality). (p. 65)

Raskin, Boruchow, and Golob (1965) employed a factor analysis of 24 personality and nursing-attitude variables to differentiate nurses from various treatment settings. The factor labeled Leadership Skills contained the greatest number of significant variables and accounted for the largest percentage of total variance. While neuropsychiatric (NP) nurses scored higher than two of the three general medical and surgical (GMS) nursing groups on Leadership Skills, there were also differences between orthopedic nurses and nurses caring for patients with tuberculosis, and between operating room nurses and the other general medical and surgical (GMS) groups. As a result, Raskin et al. concluded that "it is necessary to go beyond the NP, GMS distinction and probe for idiosyncratic characteristics within a particular nursing setting" (p. 187).

Work by Lentz and Michaels (1959, 1960, 1965) affords this further distinction, their three-part study being based on the hypothesis that fundamental differences exist between the attitudes and personalities of nurses who prefer surgical and those who prefer medical nursing. Part one of the report disclosed obvious differences.

The nurse who is strongly interested in medical nursing is much more intrigued by psychological aspects of patient care than is the surgical nurse. This being the case, she requires time to become acquainted with her patient, to talk with him. This means that she will require a quieter work situation and a slower turnover of patients. The surgical nurse, on the other hand, appears less interested in psychological factors. To her good nursing presumably means technical proficiency, speed. The patient with problems may be a problem to her, he interferes with getting her work done at the level of excellence she has set for herself. (1959, p. 196)

The second aspect of the study revealed that nurses who expressed a preference for medical nursing received the best peer ratings with respect to nurse-patient relations, while those who had indicated preference for surgical nursing received the highest ratings on technical skills (1960).

The final stage of the total study examined personality variables of medical and surgical nurses, using the Edwards Personal Preference Schedule (EPPS), to facilitate comparison of results with those previously reported in the literature. While Navran and Stauffacher had established that neuropsychiatric nurses responded differently to the EPPS than did a matched group of medical-surgical

nurses, it was Lentz and Michaels' contention that grouping medical and surgical nurses together obscured dissimilarities between them and that they would, in fact, be found to differ from each other on the EPPS. Specifically, it was anticipated that scores of medical nurses would compare more closely with those of the neuropsychiatric group than with those of nurses who preferred surgical nursing, the assumption being that medical nurses, like psychiatric nurses, are more "people-minded."

On ten out of 15 variables, scores of the medically inclined group fell between the neuropsychiatric and the surgical nurses. Where differences were great enough to be statistically significant, the variable being measured seemed closely related to the element of people-mindedness. For example, on the variable 'introception' (the need and interest in analyzing motivations) neuropsychiatric nurses scored highest, the medical group next, and surgical nurses had the lowest scores. Introception seems highly related to an individual's capacity to handle the psychological aspects of nursing. (1965, p. 46)

The evidence provided by the studies cited above seems to strengthen the hypothesis that "nursing specialities may call for specific personality types" (Lentz & Michaels, 1965, p. 48).

An integral component of an individual's personality is his characteristic manner of dealing with stress. Lazarus (1966) maintains that the manner in which an individual copes with stress is dependent on stable dispositions to utilizing one or another type of coping process. According to Byrne (1964) there is a great deal of evidence to support the concept that "individuals may be placed along

a continuum with respect to their characteristic learned response to threatening stimuli; avoiding mechanisms define one end of this continuum and approaching mechanisms the other" (p. 212). While avoidance involves use of defenses designed to remove the threat from awareness, such as denial and repression, approach behavior refers to tendencies aimed at reducing the threat by clarifying the implications of the situation, such as intellectualization and sensitization (Lazarus, 1966).

Investigators have studied coping style in relation to such things as physical illness (Byrne, Steinberg, & Schwartz, 1968), medical diagnosis (Schwartz, Krupp, & Byrne, 1971), recovery from surgery, with and without preparatory instruction (Andrew, 1970), and information desired by surgical patients (Robinson, 1972). Of particular relevance to the purposes of this review of the literature are the findings reported by Andrew and Robinson.

Utilizing a sentence-completion test, Andrew (1970) divided 40 patients, scheduled for similar surgery, into three coping styles. Subjects whose responses were stereotyped, and who denied feelings, were called "avoiders;" subjects whose responses were personalized, and who readily acknowledged feelings, were called "sensitizers." Subjects with middle scores were called "neutrals."

A short audio-tape presentation--covering the origins of hernias, the danger of delaying surgical intervention, and the

preparation for and consequences of surgery--was used as a stress-reduction method. It was hypothesized that patients whose preferred coping style was characterized as "sensitizers" would welcome information, which would result not only in reduced stress, but less need for medications and a shorter recovery. "Avoiders" were expected to improve least, while "neutrals" were anticipated to improve an intermediate amount. Results, however, indicated that "neutrals" improved most, recovering with fewer medications and in less time when instructed, while "avoiders" required more medications when instructed and "sensitizers" were unchanged, whether receiving instruction or not.

Robinson (1972) used a similar sentence-completion test, to identify coping style, in a study of 19 male patients who were hospitalized for major abdominal surgery. "Copers" were individuals whose preferred defense was that of intellectualization, while "avoiders" seldom used intellectualizing defenses, but relied more on repression and denial. "Neutrals" were individuals who did not specifically utilize intellectualization or avoidance defenses.

The primary purposes of Robinson's study were to investigate the amount and type of information desired by patients experiencing major abdominal surgery, to identify if a relationship exists between desired information and the patient's coping style, and to explore the relationship of desired information, coping style, and certain

demographic variables such as age, education, and number of previous surgeries or hospitalizations. To determine the type and amount of information desired, each patient completed a Likert-type Preoperative Information Rating Scale (PIRS) containing information and descriptions of events which might be discussed with surgical patients preoperatively. Three types of information were included in the PIRS: Group I - statements clarifying patient's role; Group II - statements clarifying health team member's role; and, Group III - statements designed to increase the patient's knowledge and understanding of events associated with his care.

Although no significant relationship was demonstrated between coping style and amount of information desired, or between coping style and information included in Groups II and III, a significant relationship was found between coping style and Group I information; "avoiders" rejected information related to patient role more frequently than either "copers" or "neutrals." Neither education, nor previous surgeries or hospitalizations, were significantly related to desire for information. Age was inversely related to a desire for information, and a significant secondary interaction proved to be the inverse effect of the number of days from admission to interview on the desire for information.

A multiple $R = 0.80$, $p < .05$, was obtained when amount of information desired was correlated with the independent

variables of coping style; age; education; previous hospitalization and surgery; and the number of days from admission to interview. Variables of age ($R = -0.44$) and days from admission to interview ($R = -0.61$) accounted for 55% of the variance. Therefore, the best predictor of desire for information was not one variable, but a group of variables. Included in this group of variables was coping style. The question of how much, and in combination with what other variables coping style contributes to information seeking, still needs to be answered. (pp. 24-25)

While no studies can be located investigating the coping style of the health team member preparing the patient for surgery, should not the question be asked, how much does coping style contribute to information giving? Is there a relationship between the coping style of the nurse and the amount of preoperative preparation imparted?

Nurses have cited a variety of factors in the clinical setting that are deterrents to their teaching role. Results of Pohl's national survey of the teaching activities of the nursing practitioner showed that "the most frequently mentioned factors in the work situation which interfere with teaching were lack of time, heavy work load, and understaffing, all of which tend to be persistent problems in many health agencies" (1965, p. 11).

Schweer and Dayani (1973) maintain that poor hospital management and insufficient staffing cause a heavy work load with consequent frustration and lack of time. While pointing out that these conditions alone are tremendous obstacles to patient teaching, they claim the quality of teaching is significantly effected by nursing administration's

"lack of providing emphasis on patient education and defining expectations of personnel " (p. 175).

A leading nurse-educator (Redman, 1972) contends that the nurse's role in health teaching has not been clearly defined, particularly as it relates to the degree of independence with which she can function. Contributing factors seem to be lack of clear allocation of responsibility among personnel regarding who should fulfill the teaching needs, as well as poor communication among members of the health team.

Furthermore, Redman (1974) has included "physician dominance" as a major issue in patient education. "Because of the natural dominance of this group in the fields of health and disease, it is difficult for an approach with which they are not familiar to gain legitimacy" (p. 4). While physicians control the prerogative to share information with patients in such key areas as diagnosis, treatment, and prognosis, "this information is often a prerequisite to independent or follow-up teaching viewed as the prerogative of the nurse" (p. 4).

An extensive study, reported by Hegyvary and Chamings (1975a, 1975b), found that hospital organization has an effect on outcomes of patient care. Patients undergoing abdominal hysterectomy in either of two test hospitals were randomly assigned to one of three groups. Groups 1 and 2 were experimental groups and Group 3 was the control group; Group 1 received oral instructions while Group 2 received the

same information in booklet form. Four measures were used to determine level of stress preoperatively, and five postoperative outcomes were selected as dependent variables. The study explored the effect of background variables, preoperative stress, the provision of preoperative instruction, and the organizational context of the delivery of care on postoperative patient care outcomes. "The only variable found to be consistently related to patient care outcomes was the organizational setting in which care is delivered" (1975b, p. 42). Substantial differences were found between the organizational variables in the two hospitals.

. . . the picture in Eastside was one of numerous conflicts, perceived inaccessibility and lack of visibility of nursing leaders, lack of leadership emphasis on clinical activities of nurses, lack of understanding among departments, and lack of coordination of services. In Westgate, nursing leaders at every level had frequent contacts with the unit staff and maintained more patient-centered expectations of the nursing staff, activities of different services seemed well coordinated, and there was a consistently expressed unity of purpose in the direction of patient care. (1975b, p. 42)

Summarizing the second half of the literature review, "routine" preoperative preparation tends to be characterized by such terms as vague, unstructured, inconsistent, determined by external pressures, based on intuition and past experience, given sporadically, and dealing with the preoperative phase rather than how the patient can participate postoperatively. One reason cited for the fact that the instructional role has not been actualized is that some nurses do not feel prepared

to do patient teaching; others voice feelings of insecurity regarding the teaching role. Research has demonstrated the effects of the attitude and personality traits of the nurse and the coping style of the patient; the possibility of a relationship between coping style and information giving has been raised. Finally, a variety of organizational variables have been suggested as possible deterrents to the nurse's teaching role; included in this category are such factors as lack of time, heavy work load, understaffing, lack of clarification of role, physician dominance, and nursing administration's lack of providing emphasis on patient education and patient-centered expectations of the nursing staff.

Purpose of the Study

The purposes of this study were (1) to investigate the degree of informativeness of the surgical-unit nurse, (2) to examine the surgical-unit nurse's philosophy toward preoperative preparation, (3) to ascertain if a relationship exists between the nurse's coping style and the amount and type of information she imparts, and (4) to study the relationship of degree and types of informativeness, philosophy toward preoperative preparation, coping style, and various demographic variables such as basic educational preparation and years of nursing experience.

CHAPTER II

METHODOLOGY

Subjects

The sample of subjects for this study was drawn from a designated group of the registered nurse staff of a 500 bed teaching hospital. All registered nurses on two adjacent general-surgical units, who had an opportunity to prepare patients for surgery, were invited to participate. Thirty-one nurses meeting these criteria volunteered; however, one chose not to complete a portion of the data collecting instruments and consequently was not retained. The final study subjects were 30 registered nurses who routinely care for patients preoperatively.

Data Collecting Instruments

Four instruments were utilized in the collection of data: (1) Demographic Schedule, (2) Information Philosophy Scale, (3) Staff Information Questionnaire, and (4) Revised Repression-Sensitization Scale. The Demographic Schedule was patterned, in part, after that designed by Vetsch (1972). All demographic variables were recorded by subjects at the time of completion of the other instruments. See Appendix A for Demographic Schedule.

The Information Philosophy Scale and Staff Information Questionnaire were designed and tested by Carlson and Vernon (1973), who have determined reliability and validity values for both instruments. The principal investigator was contacted for permission to utilize these instruments (see Appendix B).

The Information Philosophy Scale (IPS) consists of six statements regarding the amount of information to be given to surgical patients. Each statement was answered according to a Likert-type five-point scale, ranging from "strongly disagree" to "strongly agree." See Appendix C for Information Philosophy Scale.

The Staff Information Questionnaire (SIQ) consists of 70 items representing topics which might be used in the preoperative preparation of surgical patients. A scale ranging from 0 to 100 per cent was placed at the right of each item. The subjects completing the questionnaire were asked to estimate the percentage of patients with whom they discuss each topic; percentages were estimated only for the number of patients for whom the item was relevant. For scoring purposes, the percentages were rounded to an 11-interval scale, ranging from 0 to 10. The SIQ contains the following ten subscales:

- (1) Condition of the Patient and Specific Information about Surgery;
- (2) Preoperative Procedures; (3) Postoperative Nausea; (4) Intensive Treatment and Recovery Room; (5) Postoperative Discomfort and Relief; (6) Anesthesia; (7) Suctioning; (8) Postoperative Procedures;

(9) Postoperative Medications; and (10) Drainage Tubes. See Appendix D for a description of the SIQ subscales. A total information score and ten subscale scores were calculated, for each subject, by summing the appropriate groups of items scored, as indicated above. Total scores and scores on each subscale were converted to standard scores with a mean of 50 and a standard deviation of 10; standard scores of 55 and above were regarded high, 45 to 54 in the moderate range, with those below 45 considered low. See Appendix E for Staff Information Questionnaire.

The Revised Repression-Sensitization Scale (R-S Scale) consists of 127 cross-validated items of the original 182 item scale, which was derived from the Minnesota Multiphasic Personality Inventory. The R-S Scale was designed to measure a continuum of psychological defenses that range from anxiety-avoidance behavior to anxiety-approach behavior; avoidance behavior employs defenses such as repression and denial to remove a threatening situation from awareness, whereas approach behavior utilizes defenses such as sensitization and intellectualization to reduce the threat by clarifying the implications of the situation. Responses to the test items were marked as "true" or "false," with a high score demonstrating "sensitization" and a low score indicating "repression." For purposes of analysis in this study, scores were converted to standard scores with a mean of 50 and a standard deviation of 10, and the

following groupings were incorporated: individuals with standard scores of 55 and above were designated sensitizers, those scoring 45 to 54 as neutrals, and persons obtaining scores below 45 as repressors. Reliability and validity studies of this scale have been conducted by Byrne (1961) and by Byrne, Barry, and Nelson (1963). See Appendix F for Revised Repression-Sensitization Scale.

Design and Data Collection Procedure

The study was exploratory, descriptive in nature and non-experimental in design. A nonprobability, purposive sample was surveyed through the use of four data collecting instruments. Permission to conduct the study was obtained from the Director of Nursing Service. Data collecting sessions were held on the nursing units at times convenient for the subjects, so that each participant completed the instruments while "on duty." Standardized instructions were utilized at all sessions to insure reliability of this method.

Analysis of Data

Following scoring of all instruments, raw data were arranged in tables and punched on Hollerith cards. Relationships between degree and types of informativeness, philosophy toward preoperative preparation, coping style, and demographic variables were assessed by zero-order correlation analysis and multiple regression analysis.

Standard scores, means, standard deviations, and correlations were calculated via computer or desk calculator.

CHAPTER III

RESULTS

Demographic Characteristics of the Subjects

The study population consisted of 30 registered nurses, 29 female and one male, all of whom were employed full-time. Seven obtained their generic preparation in a diploma school of nursing, ten graduated from an associate degree program, while 13 held a bachelor of science degree. Ranging in age from 22 to 61 years, the study population's mean age was 29.7 years. Nursing experience ranged from 2 months to 35 years, with a mean of 5.4 years. (See Appendix G for demographic data per individual subject.) Separated into two respective nursing units, subjects were found to be comparable with respect to number, educational preparation, age, and years of nursing experience. See Table 1. Subjects on the two units differed, however, in that nurses on Unit 2 utilized a "Pre-operative Teaching Check List," while the Unit 1 nursing staff maintained no structured method of preoperative preparation. See Appendix H for Preoperative Teaching Check List.

Table 1

Comparison of Number, Educational Preparation,
Mean Age, and Mean Years of Experience of
Study Population on Two Nursing Units

Unit	N	Educational Preparation			Mean Age	Mean Years of Experience
		Diploma	A.D.	B.S.		
1	15	3	5	7	29.8	5.5
2	15	4	5	6	29.7	5.3

Degree and Types of Informativeness

The surgical nurse's degree of informativeness was determined by the total score on the Staff Information Questionnaire (SIQ). Scores ranged from 190.5 to 647.5, with a raw score mean of 479.61 and a standard deviation of 95.27. Grouped standard score values of SIQ scores demonstrated how this study population could be viewed in relation to degree of informativeness. Although 13 nurses were included in the moderate category (standard scores of 45 to 54), one-third of the total study population, N = 10, possessed a high degree of informativeness (standard scores of 55 and above); only seven nurses were found to have a low degree of informativeness (standard scores below 45). Similarly, grouped standard score values of subscale scores revealed types of information being conveyed to patients preoperatively. See Table 2. Though differences were shown to exist

Table 2

Frequency Distribution of Grouped Standard Staff
Information Questionnaire Subscale Scores

Subscale	Number of Standard Subscale Scores		
	Low	Moderate	High
1 Condition & Surgery	10	10	10
2 Preoperative Procedures	6	15	9
3 Postoperative Nausea	9	8	13
4 Intensive Treatment & Recovery Room	9	10	11
5 Postoperative Discomfort & Relief	9	12	9
6 Anesthesia	9	13	8
7 Suctioning	9	8	13
8 Postoperative Procedures	7	12	11
9 Postoperative Medications	8	9	13
10 Drainage Tubes	7	11	12

Note. Low = below 45; Moderate = 45 to 54; High = 55 and above.

among the distribution of subscale scores, these differences were admittedly small. While subscale 2 Preoperative Procedures received the least number of low scores, subscale 6 Anesthesia received the fewest high scores; conversely, subscale 1 Condition of Patient and Specific Information about Surgery received the greatest number of low scores, while subscales 3 Postoperative Nausea, 7 Suctioning, and 9 Postoperative Medications received the most high scores. Further inspection of "low" scores showed subscales with the

least number of scores, in rank order, were (1) subscale 2 Pre-operative Procedures, (2) subscales 8 Postoperative Procedures and 10 Drainage Tubes, and (3) subscale 9 Postoperative Medications. The information included within these subscales constitutes that most frequently imparted during preoperative preparation.

Philosophy and Coping Style

The nurse's philosophy toward preoperative preparation was exemplified by the Information Philosophy Scale (IPS) score. Raw scores ranged from 18 to 30, with a mean of 22.9 and a standard deviation of 3.19. Converted to standard scores and utilizing the same convention for grouping as described above, grouped standard score values of IPS scores showed that the largest number of nurses (N = 12) comprised the category labeled moderate, with more nurses claiming a philosophy of low informativeness (N = 10) than those professing a philosophy of high informativeness (N = 8); however, two-thirds of the total study population (N = 20) subscribed to a philosophy of either high or moderate informativeness.

The score on the Revised Repression-Sensitization Scale (R-S Scale) disclosed the nurse's coping style. Scores ranged from 10 to 52, with a raw score mean of 27.36 and a standard deviation of 12.83. Grouped standard score values of R-S Scale scores indicated the study population was composed of nine nurses who utilized anxiety-avoidance

behavior and nine nurses who utilized anxiety-approach behavior, while 12 nurses did not exclusively employ either extreme coping mechanism.

Zero-Order Correlation Analysis

The degree of informativeness (total SIQ score) and types of information imparted (individual subscale scores) were analyzed in relation to six independent variables: (1) age; (2) educational preparation; (3) nursing experience; (4) philosophy toward preoperative preparation; (5) nurse's coping style; and (6) nursing unit. The .05 confidence level ($r = .36$, $df = 28$) was selected for determining significance. See Table 3.

Age, educational preparation, and years of nursing experience failed to correlate significantly with any of the individual subscale scores or with the total SIQ score. However, philosophy toward preoperative preparation was shown to be statistically significant not only to the total SIQ score ($r = .60$), but to subscales 1 Condition of the Patient and Specific Information about Surgery ($r = .45$), 3 Postoperative Nausea ($r = .46$), 5 Postoperative Discomfort and Relief ($r = .42$), 7 Suctioning ($r = .40$), 8 Postoperative Procedures ($r = .61$), and 10 Drainage Tubes ($r = .63$). In addition, philosophy approached significance in both subscale 2 Preoperative Procedures ($r = .31$) and subscale 6 Anesthesia ($r = .35$).

Table 3

Zero-Order Correlations of Six Variables to Staff Information Questionnaire Scale: Subscales and Total

Scale: Subscales and Total	Variable				
	Age	Education	Experience	Philosophy	R-S Scale Unit
Subscales					
1 Condition & Surgery	-.11	.03	.02	.45*	.18 .01
2 Preoperative Procedures	-.02	-.11	.08	.31	.18 .26
3 Postoperative Nausea	.10	-.09	.01	.46**	.37* .36*
4 Intensive Treatment & Recovery Room	-.09	-.16	-.05	.29	.10 .24
5 Postoperative Discomfort & Relief	.07	-.11	.12	.42*	.34 .16
6 Anesthesia	-.27	.06	-.29	.35	.09 .25
7 Suctioning	-.01	.04	-.01	.40*	.01 -.16
8 Postoperative Procedures	.04	-.04	.02	.61**	.42* .18
9 Postoperative Medications	-.10	.12	-.18	-.14	.06 .32
10 Drainage Tubes	-.09	-.24	-.08	.63**	.34 .14
Total	-.08	-.08	-.04	.60**	.33 .22

* $p < .05$; ** $p < .01$

The nurse's coping style, as determined by the R-S Scale score, related significantly with subscale 3 Postoperative Nausea ($r = .37$) and subscale 8 Postoperative Procedures ($r = .42$), while approaching significance on subscale 5 Postoperative Discomfort and Relief ($r = .34$), subscale 10 Drainage Tubes ($r = .34$), and the total SIQ score ($r = .33$). And the final variable, nursing unit, had a significant relationship with only one subscale, subscale 3 Postoperative Nausea ($r = .36$), but approached significance on subscale 9 Postoperative Medications ($r = .32$) as well.

None of the six independent variables were found to be significantly correlated with subscale 2 Preoperative Procedures, subscale 4 Intensive Treatment and Recovery Room, subscale 6 Anesthesia, or subscale 9 Postoperative Medications.

Multiple Regression Analysis

Assessing the effects of the six previously listed independent variables in relation to the total SIQ score, as a dependent variable, resulted in a significant multiple correlation. Similarly, a significant multiple correlation was obtained when the six independent variables were assessed in relation to scores on subscales 3, 6, 8, and 10. The .05 confidence level was chosen for determining significance for both multiple correlations ($F = 2.45$) and partial correlations ($r = .40$, $df = 23$).

A multiple correlation (R) of .75 ($F = 4.85$) was obtained when "Degree of Informativeness" (SIQ score) was examined in relation to the independent variables. See Table 4. Philosophy toward preoperative preparation, nursing unit, years of nursing experience, and the nurse's coping style accounted for 54 per cent of the total variance. The remaining two variables, age and educational preparation, improved explanation by only 2 per cent. Philosophy was found to be significantly related ($r = .69$) to the SIQ score.

Table 4

Multiple Regression of Six Variables in Relation
to Degree of Informativeness (SIQ Score)

Variable	Degree of Informativeness (SIQ Score)		
	Multiple Correlation	Cumulative Variance	Partial Correlation
Philosophy	.60	.36	.69**
Unit	.68	.47	.39
Experience	.72	.52	-.25
R-S Scale	.74	.54	.21
Age	.74	.55	.13
Education	.75	.56	-.09

Note. Multiple $R = .75$; $F = 4.85$; $p < .01$

**
 $p < .01$

A multiple correlation (R) of .80 ($F = 6.89$) resulted when information regarding "Postoperative Nausea" (subscale 3) was studied in relation to the independent variables. See Table 5. The best predictors that the nurse will discuss this information were philosophy, unit, coping style, age, and experience. These five variables determined 63 per cent of the total variance, with the remaining variable, educational preparation, adding only 1 per cent. Philosophy ($r = .71$), unit ($r = .57$), and age ($r = .56$) were positively correlated, while experience had an inverse relationship ($r = -.54$).

Table 5

Multiple Regression of Six Variables in Relation
to Postoperative Nausea (Subscale 3)

Variable	Postoperative Nausea (Subscale 3)		
	Multiple Correlation	Cumulative Variance	Partial Correlation
Philosophy	.45	.21	.71**
Unit	.64	.41	.57**
R-S Scale	.68	.47	.29
Age	.69	.48	.56**
Experience	.80	.63	-.54**
Education	.80	.64	.13

Note. Multiple $R = .80$; $F = 6.89$; $p < .01$

**
 $p < .01$

The second subscale resulting in a significant multiple correlation involved "Anesthesia" (subscale 6), with R of .67 ($F = 3.19$). See Table 6. Once more philosophy, experience, unit, age, and coping style were responsible for 44 per cent of the total variance, with education adding only 1 per cent. Philosophy ($r = .58$) and unit ($r = .43$) had positive correlations, while experience was again negatively related ($r = -.43$).

A multiple correlation (R) of .79 ($F = 6.48$) was produced when information regarding "Postoperative Procedures" (subscale 8) was assessed. See Table 7. The six variables combined for 63 per cent of the total variance. Philosophy ($r = .73$) and coping style ($r = .41$) were both significantly correlated.

Finally, R of .83 ($F = 8.51$) was obtained when information regarding "Drainage Tubes" (subscale 10) was analyzed. See Table 8. The first five variables accounted for 68 per cent of the total variance, while age increased the variance by only 1 per cent. Two variables, experience ($r = -.44$) and education ($r = -.47$) were inversely correlated to information about "Drainage Tubes," with philosophy positively correlated ($r = .77$).

In each of the above discussed multiple regression analyses, philosophy toward preoperative preparation emerged as the prime predictor; however, a combination of not less than four variables accounted for the larger portion of the total variance. Therefore, the

Table 6

Multiple Regression of Six Variables in Relation
to Anesthesia (Subscale 6)

Variable	Anesthesia (Subscale 6)		
	Multiple Correlation	Cumulative Variance	Partial Correlation
Philosophy	.35	.12	.58**
Experience	.53	.28	-.43*
Unit	.63	.39	.43*
Age	.65	.42	.19
R-S Scale	.66	.44	-.21
Education	.67	.45	-.14

Note. Multiple R = .67; F = 3.19; $p < .05$

* $p < .05$; ** $p < .01$

Table 7

Multiple Regression of Six Variables in Relation
to Postoperative Procedures (Subscale 8)

Variable	Postoperative Procedures (Subscale 8)		
	Multiple Correlation	Cumulative Variance	Partial Correlation
Philosophy	.61	.37	.73**
R-S Scale	.72	.52	.41*
Unit	.75	.56	.36
Education	.75	.56	.17
Age	.76	.57	.39
Experience	.79	.63	-.35

Note. Multiple R = .79; F = 6.48; $p < .01$

* $p < .05$; ** $p < .01$

Table 8

Multiple Regression of Six Variables in Relation
to Drainage Tubes (Subscale 10)

Variable	Drainage Tubes (Subscale 10)		
	Multiple Correlation	Cumulative Variance	Partial Correlation
Philosophy	.63	.40	.77**
R-S Scale	.70	.49	.21
Unit	.73	.53	.33
Experience	.76	.57	-.44*
Education	.82	.68	-.47*
Age	.83	.69	.17

Note. Multiple R = .83; F = 8.51; p < .01

* p < .05; ** p < .01

best predictor of degree of informativeness, and that the nurse will discuss information regarding postoperative nausea, anesthesia, postoperative procedures, or drainage tubes, was not one variable, but a group of variables. Those variables appearing most frequently in the top four positions of the stepwise multiple regression analyses were philosophy (five out of five), unit (five out of five), and coping style (four out of five).

Percentage of Patients Adequately Prepared

Estimations of the percentage of patients each nurse "has time to prepare as fully as she thinks is necessary" ranged from 0 to

100 per cent, with a mean of 51.4 and a standard deviation of 29.4. Mean percentages by units differed, in that subjects on Unit 1 reported 41.47 per cent while those from Unit 2 estimated 61.33 per cent. Further delineation, by educational preparation, appears in Table 9.

Table 9

Unit Mean Percentages and Combined Mean Percentages
of Patients Adequately Prepared:
by Educational Preparation

Educational Preparation	Unit Mean Percentages		Combined Mean Percentages
	Unit 1	Unit 2	
Diploma	30.00 (N = 3)	66.25 (N = 4)	50.71 (N = 7)
Associate Degree	36.00 (N = 5)	65.00 (N = 5)	50.50 (N = 10)
Baccalaureate	50.28 (N = 7)	55.00 (N = 6)	52.46 (N = 13)

Unit 2 values exceeded those of Unit 1 for each of the three types of educational preparation. In addition, while baccalaureate graduates on Unit 1 reported a higher percentage than graduates of either the diploma or associate degree programs, the reverse was true on Unit 2, diploma and associate degree graduates reporting a higher percentage than baccalaureate graduates. The combined mean percentages of both units, for graduates of each educational program, were strikingly similar: diploma, 50.71 per cent; associate degree,

50.50 per cent; and baccalaureate, 52.46 per cent. Table 10 contains a summary of factors limiting this study population's preoperative preparation of surgical patients; lack of time, heavy work load, and understaffing were identified as the major deterrents, by 25 of the 30 subjects.

Table 10
Factors Identified as Deterrents to
Preoperative Preparation

Deterrent	N
Lack of time, heavy work load, understaffing	25
Poor communication among members of health team	5
Lack of knowledge regarding surgical procedures	5
Patient's level of apprehension	5
Numerous interruptions: examinations, X-ray, ECG, etc.	4
Patient's level of mentality	3
Doctor's wishes regarding amount of information told	1
Some patients are on other units preoperatively	1
Surgical intensive care staff does preoperative teaching	1
Unexpected emergency surgery	1

CHAPTER IV

DISCUSSION

In contrast to the scarcity of evidence in nursing literature that surgical-unit nurses are providing preoperative preparation for the surgical patient, results of this study not only suggest that nurses are performing this function, but identify factors that contribute as well as those that restrict the nurses' implementation of such preparation. Two-thirds of the nurses surveyed, by instruments designed to assess the informativeness of persons caring for patients undergoing surgery, subscribed to a philosophy of high or moderate informativeness; all but seven nurses' self-reported degree of informativeness ranked in the high or moderate categories. These findings are contrary to the surgical nurses described by many investigators (Dumas & Leonard, 1963; Hegyvary & Chamings, 1975a; Lindeman & Van Aernam, 1971; Schmitt & Wooldridge, 1973), who tended to be task oriented and only sporadically involved in preoperative instruction.

Although the preparation provided by this study population involved much of the information suggested by researchers to assist the patient in cognitively structuring impending events (Erickson, 1969; Hegyvary & Chamings, 1975a; Meyers, 1964; Schmitt & Wooldridge, 1973), one area not included in the information most

frequently conveyed was that pertaining to postoperative discomfort and relief. In addition to a discussion of the possibility of postoperative pain, the cause of such discomfort, and available medication, other facets of this concept include exercises the patient may be asked to perform, how and why the exercises will be beneficial, and what body positioning and exercises the patient may do for himself to relieve pain or other discomfort. Advantageous results of preoperative discussion regarding use of exercises and positioning have been reported by Healy (1968) and Lindeman and Van Aernam (1971). Egbert et al. (1964) and Mezzanotte (1970) also stressed the importance of exercises and added an explanation of the pain that could be expected as well as suggestions about its control; Egbert and his associates maintained that they "were able to reduce the postoperative narcotic requirements by half" (p. 827). In light of the reported research in this area, the omission of information germane to postoperative discomfort and relief would seem to constitute a weakness in the preparation of the presurgical patient by the nurses in this study.

Of the variables examined for their possible relationship to degree and types of informativeness, the individual's philosophy regarding preoperative preparation was found to be of primary importance. The nurse's philosophy of informativeness (IPS score) was statistically significant in relation to the overall SIQ score and to

six of the ten subscales, as well as approaching significance on two of the remaining subscales. These findings corroborate those of Carlson and Vernon (1973), in that their subjects' IPS scores were significantly correlated with the SIQ score and two of the subscales, while approaching significance on two additional subscales. As expected, philosophy was also the prime predictor in each of the multiple regression analyses resulting in significant multiple correlations.

A relationship was shown to exist between the nurse's coping style and certain types of information she imparts, specifically that pertaining to postoperative procedures and postoperative nausea. Furthermore, R-S Scale scores approached significance on information relative to postoperative discomfort and relief, drainage tubes, and the total information score. Nurses whose preferred defense utilized attempts to clarify the implications of a situation tended to supply the patient with information that would prepare him for what otherwise could be interpreted as threatening situations; informed of what he would experience as well as procedures that would be performed, the nurse increased the probability that the patient was better prepared to cope with the postoperative period. Nurses who employed anxiety-avoidance behavior, rather than anxiety-approach behavior, reported fewer instances of including this type of information in their pre-operative preparation.

Robinson (1972) discovered that the best predictor of amount of information desired preoperatively by surgical patients, was not one variable, but a group of variables that included coping style. Similarly, the present study demonstrated that the best predictor of amount of information given preoperatively by nurses caring for surgical patients, was not one variable, but a group of variables that included coping style. Unlike Robinson's findings, however, where coping style was not included in the variables accounting for the major percentage of the total variance, the present study revealed that coping style contributed to the principal portion of the total variance. Moreover, coping style was included in the variables accounting for the larger percentage of variance when assessing its predictive effects on types of information provided, specifically that of postoperative procedures, drainage tubes, and postoperative nausea.

The variable of nursing unit was also found to be a contributory factor in the amount of preparation provided. The nurses on each unit were comparable in all respects examined, except for the utilization of a teaching check list by nurses on Unit 2; yet the effect of this difference was reflected in both the total degree of informativeness and the percentage of patients estimated to be adequately prepared. The mean degree of informativeness of nurses on Unit 1 was 458.87, while that for Unit 2 nurses was 500.37; likewise, Unit 1 nurses estimated adequately preparing an average of 41.47 per cent of their

patients, while nurses from Unit 2 reported an average of 61.33 per cent. Although the use of a check list is not a sophisticated method, it does offer a systematic approach, structuring the preparation to be provided.

Lindeman and Van Aernam (1971) contend that while preoperative teaching may mean different things to different nurses, nevertheless "in many hospital settings, nursing personnel are expected to do preoperative teaching without a definite statement of what preoperative teaching includes" (p. 320). In a comparative investigation of the effects of unstructured and structured teaching of coughing and deep breathing exercises, the ability of subjects to cough and deep breathe postoperatively was significantly improved and the average length of hospitalization was significantly reduced "by the implementation of the structured preoperative teaching method" (p. 332). Mezzanotte (1970) and Park (1972) have also praised the results of an organized program of instruction.

Nursing unit was significantly related to the content of subscale 3 Postoperative Nausea and approached significance in relation to information in subscale 9 Postoperative Medications. Like philosophy, nursing unit played an important role in the prediction of total degree of informativeness and the areas of anesthesia, postoperative procedures, drainage tubes, and postoperative nausea.

A breakdown by educational preparation, of percentages of patients estimated to be adequately prepared, disclosed intriguing data. Educational preparation had no significant effect when the study population was viewed in total; examination by unit, however, revealed marked differences. Functioning on a unit without a structured system, baccalaureate graduates were apparently able to act independently, and thus far exceed those from other educational programs; but, on a unit utilizing a systematic procedure, diploma and associate degree graduates surpassed the baccalaureate nurses, whose percentages had also increased.

Despite the philosophy of informativeness exhibited by these surgical nurses, they reported being restricted to preparing only 51.4 per cent of the presurgical patients to the extent they considered desirable. "Lack of time, heavy work load, and understaffing" led the list of factors identified as deterrents to the provision of pre-operative instruction. This finding is in agreement with Pohl's (1965) observation that these situations were the most frequently mentioned, by nationally-polled nursing practitioners, as obstacles to patient teaching. Schweer and Dayani (1973), Merkatz et al. (1974), and Lindeman (1973) have likewise cited these conditions as limitations.

The legitimacy of two additional deterrents named is supported in the literature: the barrier of "poor communication among members

of the health team" coincides with the opinion of Redman (1972) and the conclusions reached by Pohl (1965), and the impediment of "lack of knowledge regarding surgical procedures" corresponds with the contentions of Schweer and Dayani (1973). However, the authenticity of "patient's level of apprehension" and "patient's level of mentality" as hindrances to preoperative preparation lacks substantiation from the literature. While "level of apprehension" seems to constitute an indication for preparation, "level of mentality" would seem to evoke an individualization in approach to preparation. Could it be that subjects inhibited by the "patient's level of apprehension" or the "patient's level of mentality" are the surgical nurses typified by Lentz and Michaels (1959, 1960, 1965) as not being "people-minded?" Is the patient with a problem, as these investigators have suggested, a problem to the surgical nurse?

The present study is believed to be the first attempt to utilize the instruments designed by Carlson and Vernon (1973) with a study population consisting entirely of registered nurses. Although use of a nonprobability, purposive sample and the design of this study negate generalization of the findings, scores reflected by the subjects of this study could serve as a basis of comparison for further investigation into factors relating to measures of informativeness among surgical-unit nurses. For, while the variables examined here--age, educational preparation, nursing experience, philosophy toward

preoperative preparation, nurse's coping style, and nursing unit with and without a teaching guide for preoperative preparation-- accounted for 56 per cent of the variance in assessing the nurse's degree of informativeness, 44 per cent of the variance is yet to be determined.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

Although preoperative preparation of the surgical patient is recognized as an integral element of the surgical-unit nurse's scope of practice, nursing literature has failed to document that these nurses are performing this function. The availability of recently developed instruments, to measure the informativeness of hospital staff members, provided an opportunity for such documentation. Therefore, 30 registered nurses routinely caring for surgical patients, on two general-surgical units of a 500 bed teaching hospital, were surveyed through the use of four data collecting instruments: Demographic Schedule, Information Philosophy Scale (IPS), Staff Information Questionnaire (SIQ), and Revised Repression-Sensitization Scale (R-S Scale). The purposes of the study were to examine (1) the nurse's philosophy toward preoperative preparation and her self-reported degree of informativeness in her contacts with pre-surgical patients, and (2) how degree and types of informativeness may be related to selected parameters of the nurse, such as philosophy, coping style, and certain demographic variables. All

data collecting instruments were completed at sessions held on the nursing units while the participants were "on duty."

The independent variables of age, educational preparation, nursing experience, philosophy toward preoperative preparation, nurse's coping style, and nursing unit with and without a teaching guide for preparation were tested for their possible relationship to the dependent variables of degree of informativeness (SIQ score) and types of information imparted (ten subscale scores which comprised the total SIQ score). Data were analyzed by means of zero-order correlation and multiple regression. Significant multiple correlations were obtained in relation to the SIQ score and to four of the ten subscale scores.

Scores on the instruments designed to evaluate the informativeness of individuals revealed that 20 of the 30 nurses subscribed to a philosophy of moderate or high informativeness, with 23 of the 30 reporting a moderate or high degree of informativeness in their preoperative preparation of the surgical patient. Analysis of the content reported to be imparted to the presurgical patient indicated that this study population, as a whole, was conveying the information contained in the areas examined, with the exception of that pertaining to postoperative discomfort and relief.

Philosophy, coping style, and nursing unit were found to have significant zero-order correlations and proved to be the principal

predictors in the multiple regression analyses resulting in significant multiple correlations. Nurses with a philosophy of high informativeness, who tended to utilize coping mechanisms that attempt to clarify implications of a threatening situation, and who functioned on a nursing unit with a structured approach, were more informative, than other nurses, in their preoperative preparation of the patient.

This study population estimated they were restricted to instructing only 51.4 per cent of the presurgical patients to the extent they considered desirable. The leading deterrents to the provision of adequate preoperative preparation, cited by 25 of the 30 nurses surveyed, were lack of time, heavy work load, and understaffing.

Conclusions

The present study has suggested that (1) a nurse's philosophy toward informativeness is indicative of the amount of information she imparts, (2) a structured approach to preoperative preparation fosters informativeness, with resultant increase in the number of patients prepared, and (3) the provision of preoperative instruction is influenced by external pressures.

The first two conclusions concur with previous research and current thinking, and as such have implications for preoperative preparation of the surgical patient. The third, while in agreement with the findings of other investigators, may be significant only from

the standpoint that nurses continue to cite lack of time, heavy work load, and understaffing as primary limitations. Although the literature has shown there are methods of preparing patients that can be utilized to circumvent these obstacles, it appears in practice that they are not being implemented.

The findings and conclusions of this study are limited by the use of a nonprobability, purposive sample and a nonexperimental design that did not include an objective measure of the preparation reported.

Recommendations for Further Study

On the basis of the present study, it is suggested that the following recommendations be considered:

(1) Subsequent attempts to identify factors relating to nurses' informativeness could explore additional variables, such as the patient variables of age, sex, diagnosis, prognosis, and ethnic background or life style differing from that of the information provider.

(2) Relevant to the effect of a structured approach to preoperative preparation: (a) replicate the present study, with comparison of nurses using an unstructured system to those utilizing a more sophisticated method than a teaching check list, and (b) investigate the informativeness of graduates, with different educational preparations, before and after the implementation of a structured approach to preoperative preparation.

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APPENDICES

APPENDIX A

Demographic Schedule

Demographic Schedule

Instructions: Please indicate or supply appropriate response.

1. Age: _____
2. Sex: Female _____ Male _____
3. Marital status:
_____ Single
_____ Married
_____ Separated, divorced, widowed
4. Basic educational preparation (please indicate year):
_____ Associate degree
_____ Diploma
_____ Baccalaureate or higher degree
_____ Other, please specify
5. College courses completed beyond basic preparation (please list): _____

6. Classes taken in patient teaching (Inservice, etc.) (please list): _____

7. Highest level of education completed (please indicate year):
_____ Associate degree
_____ Diploma
_____ Baccalaureate in nursing
_____ Baccalaureate in other field
_____ Master in nursing
_____ Master in other field
_____ Other, please specify
8. Current position:
_____ Staff nurse
_____ Charge nurse
_____ Assistant head nurse
_____ Head nurse
_____ Other, please specify

9. Present employment: Full-time _____ Part-time _____
10. Years of nursing experience: _____

APPENDIX B

Correspondence

2854 S. E. Walnut Street
Milwaukie, Oregon 97222
July 21, 1975

David T. A. Vernon, Ph.D.
Associate Professor
Department of Psychology and School of Medicine
University of Missouri
Columbia, Missouri 65201

Dear Dr. Vernon:

Currently enrolled in the Graduate Program at the University of Oregon School of Nursing, I am designing a research proposal and am interested in utilizing the instrument referred to in your May-June, 1973, Nursing Research article, "Measurement of Informativeness of Hospital Staff Members." This letter is to request a copy of the Staff Information Questionnaire, as well as the Information Philosophy Scale, and any instructions necessary for the administration of these portions of the instrument. If you do not have copies available for distribution, would you be so kind as to advise me how they may be obtained.

In addition, have you or others conducted further work on this instrument since your Nursing Research article? If so, how might these data be obtained?

Thank you for your assistance in this matter. If at all possible, would you please rush this information to me at your earliest convenience.

Sincerely,

(Miss) Patricia Wilson

Miss Wilson is currently a full-time student in the Graduate Program at the University of Oregon School of Nursing. Any assistance that you may give her would be greatly appreciated.

May Rawlinson, Ph.D.
Associate Professor of Nursing
Research Adviser

APPENDIX C

Information Philosophy Scale

Information Philosophy Scale

To what extent would you agree or disagree with each of the following statements:

1 Strongly Disagree
 2 Disagree
 3 Neutral or no opinion
 4 Agree
 5 Strongly Agree

1. A surgical patient should be told everything he will experience; in the long run it works out better that way.
2. Many surgical patients can be told too much, even in routine cases
3. In general, the amount of information given to surgical patients should be kept to a minimum
4. In general, surgical patients should be told only what they ask to know
5. In general, surgical patients should be told only what the doctor thinks they should know.
6. Most patients don't want to hear (or know about) the unpleasant things which happen to them during their treatment

7. What per cent of the patients do you have time to prepare as fully as you think is necessary? _____
 8. Please list any factors that you feel restrict you in the preparation of patients. _____
-
-

APPENDIX D

Description of Staff Information
Questionnaire Subscales

Description of Staff Information Questionnaire Subscales*

Subscale 1: Condition of Patient and Specific Information about Surgery.

Sixteen items include information about the patient's condition, the necessity for surgery, the benefits and risks of surgery, who will be involved in surgery, the location and kind of incision, how long the patient will be hospitalized, and so forth.

Four items have high negative factor coefficients; these items concern being NPO prior to surgery and preoperative medication. Staff members who are likely to give information represented in the items with high positive factor coefficients are extremely unlikely to give the information included in the four negative items.

Consists of items 1, 2, 3, 4, 5, 6, 7, 8, 9, 15, 16, 23, 24, 37, 41, and 91.

Subscale 2: Preoperative Procedures.

Seven items deal with preoperative enemas, shaving the surgical area, and the time of arising on the day of surgery. Consists of items 14, 17, 18, 19, 25, 26, and 27.

Subscale 3: Postoperative Nausea.

Two items concern the possibility of and reasons for postoperative nausea. Consists of items 57 and 58.

Subscale 4: Intensive Treatment and Recovery Room.

Four items concern intensive treatment, the reasons for it, and the amount of time the patient will spend in recovery room and intensive treatment. Consists of items 51, 52, 53, and 54.

* Variables were not numbered in sequence from 1 to 70, which accounts for item numbers exceeding 70. (The instrument was originally designed with 76 items, but six were eliminated from the subscales, by Carlson and Vernon, because of commonalities below 0.20.)

Subscale 5: Postoperative Discomfort and Relief.

Ten items deal with the pain and discomfort that the patient might experience postoperatively, exercises, ambulation, body positioning, and analgesic agents. Consists of items 55, 56, 83, 86, 87, 88, 89, 90, 92, and 93.

Subscale 6: Anesthesia.

Seven items concern the general sequence of events in the operating room, the kind of anesthesia, the method of induction, and sensations during induction. In addition, some items concern the possibility of intravenous therapy or insertion of various tubes. Consists of items 36, 38, 39, 40, 42, 67, and 68.

Subscale 7: Suctioning.

Two items include information regarding the possibility of and reasons for nasopharyngeal suctioning. Consists of items 63 and 64.

Subscale 8: Postoperative Procedures.

All 11 items in this subscale concern the postoperative period except those which deal with reasons for preoperative medication. Information includes events that will or may occur and why, such as the checking of blood pressure, pulse, and respirations, the administration of intravenous feedings and oxygen, and waking up in the recovery room. Consists of items 20, 21, 43, 49, 50, 59, 60, 69, 70, 71, and 72.

Subscale 9: Postoperative Medications.

Two items concern postoperative medications. Consists of items 84 and 85.

Subscale 10: Drainage Tubes.

Nine items concern various types of tubes that may be inserted, such as urinary catheters, chest or abdominal drainage tubes, and levine tubes, and reasons for their insertion. Consists of items 61, 62, 65, 73, 74, 75, 76, 77, and 78.

APPENDIX E

Staff Information Questionnaire

Staff Information Questionnaire

Instructions: We are interested in what various professional groups discuss with surgical patients prior to surgery. Please answer each item below from the viewpoint of your own practice. On each item, put a slash mark (/) across the line at the point which best describes the per cent of patients with whom you discuss the topic in your pre-operative contacts.

In addition, please place a check mark in the box on the far right if you feel that discussion of the topic is primarily someone else's responsibility.

Should be
discussed
by others

A. General topics:

1. What the patient's condition is 0 . 20 . 40 . 60 . 80 . 100%
2. How the patient's condition came about 0 . 20 . 40 . 60 . 80 . 100%
3. Why the patient needs surgery 0 . 20 . 40 . 60 . 80 . 100%
4. How the surgery will (or may) help the patient's condition 0 . 20 . 40 . 60 . 80 . 100%
5. The positive benefits surgery will (or may) bring to the patient 0 . 20 . 40 . 60 . 80 . 100%
6. The risks involved in having surgery (if there are substantial risks) 0 . 20 . 40 . 60 . 80 . 100%
7. The consequences of not having surgery 0 . 20 . 40 . 60 . 80 . 100%
8. That the surgery will be very safe (if indeed this is the case) 0 . 20 . 40 . 60 . 80 . 100%

Should be
discussed
by others

9. Features of patient's condition which indicate that the surgery will be safe and successful 0 . 20 . 40 . 60 . 80 . 100%

B. Topics concerning the preoperative period:

14. What time the patient will arise on the day of surgery 0 . 20 . 40 . 60 . 80 . 100%

15. That the patient will be NPO for a given time prior to surgery 0 . 20 . 40 . 60 . 80 . 100%

16. Why the patient will be NPO for a given time prior to surgery 0 . 20 . 40 . 60 . 80 . 100%

17. That the patient will receive an enema (or enemas) 0 . 20 . 40 . 60 . 80 . 100%

18. Why the patient will receive an enema (or enemas) 0 . 20 . 40 . 60 . 80 . 100%

19. When the patient will receive an enema (or enemas) 0 . 20 . 40 . 60 . 80 . 100%

20. That the patient will have preoperative sedation 0 . 20 . 40 . 60 . 80 . 100%

21. Why the patient will have preoperative sedation 0 . 20 . 40 . 60 . 80 . 100%

23. How the preoperative medication will make the patient feel 0 . 20 . 40 . 60 . 80 . 100%

Should be discussed by others

- 24. When the preoperative medication will be given. 0 . 20 . 40 . 60 . 80 . 100%
- 25. That the surgical area will be shaved 0 . 20 . 40 . 60 . 80 . 100%
- 26. Why the surgical area will be shaved 0 . 20 . 40 . 60 . 80 . 100%
- 27. When the surgical area will be shaved 0 . 20 . 40 . 60 . 80 . 100%

C. Topics concerning what will happen during surgery:

- 36. The general sequence of events which occurs when the patient enters the operating room. 0 . 20 . 40 . 60 . 80 . 100%
- 37. Who will be involved in the surgery 0 . 20 . 40 . 60 . 80 . 100%
- 38. What kind of anesthesia the patient will have. . . 0 . 20 . 40 . 60 . 80 . 100%
- 39. How the anesthesia will be administered 0 . 20 . 40 . 60 . 80 . 100%
- 40. What kind of sensations patient will have during induction 0 . 20 . 40 . 60 . 80 . 100%
- 41. What will be done during surgery and including such things as location of incision, kind of incision, kind of closure, what will be excised, etc. 0 . 20 . 40 . 60 . 80 . 100%
- 42. Insertion of any I. V. s, tubes, etc. which may be necessary 0 . 20 . 40 . 60 . 80 . 100%

Should be
discussed
by others

43. Why I. V. s, tubes, etc. are necessary 0 . 20 . 40 . 60 . 80 . 100%

D. Topics concerning what will happen immediately after surgery:

49. That the patient will wake up in recovery 0 . 20 . 40 . 60 . 80 . 100%

50. Why the patient will wake up in recovery 0 . 20 . 40 . 60 . 80 . 100%

51. How long the patient will be in recovery 0 . 20 . 40 . 60 . 80 . 100%

52. That the patient will go to Intensive Care (if necessary) 0 . 20 . 40 . 60 . 80 . 100%

53. Why the patient will go to Intensive Care (if necessary) 0 . 20 . 40 . 60 . 80 . 100%

54. How long the patient will be in Intensive Care 0 . 20 . 40 . 60 . 80 . 100%

55. That the patient will feel pain (if this is "normal") 0 . 20 . 40 . 60 . 80 . 100%

56. Why the "post-operative" pain is "normal" (if indeed it is) 0 . 20 . 40 . 60 . 80 . 100%

57. That the patient will feel nauseated (if this is the case) 0 . 20 . 40 . 60 . 80 . 100%

58. Why the patient will feel nauseated (if this is the case) 0 . 20 . 40 . 60 . 80 . 100%

59. That the patient may have an I. V. set up 0 . 20 . 40 . 60 . 80 . 100%

Should be
discussed
by others

60. Why the patient may have an I.V. set up 0 . 20 . 40 . 60 . 80 . 100%
61. That the patient may have drainage tube, etc. (if necessary). 0 . 20 . 40 . 60 . 80 . 100%
62. Why the patient may have drainage tube, etc. (if necessary). 0 . 20 . 40 . 60 . 80 . 100%
63. That nasopharyngeal suctioning may be necessary 0 . 20 . 40 . 60 . 80 . 100%
64. Why nasopharyngeal suctioning may be necessary 0 . 20 . 40 . 60 . 80 . 100%
65. That the patient will have to go without food and water for awhile after surgery 0 . 20 . 40 . 60 . 80 . 100%
67. That the patient will feel numbness in his back and legs (if this is the case) 0 . 20 . 40 . 60 . 80 . 100%
68. Why the patient will feel numbness in his back and legs (if this is the case) 0 . 20 . 40 . 60 . 80 . 100%
69. That oxygen may be administered following surgery 0 . 20 . 40 . 60 . 80 . 100%
70. Why oxygen may be administered following surgery 0 . 20 . 40 . 60 . 80 . 100%

Should be
discussed
by others

71. That blood pressure, pulse, and respirations will be checked frequently immediately after surgery 0 . 20 . 40 . 60 . 80 . 100%

72. Why blood pressure, pulse, and respirations will be checked after surgery 0 . 20 . 40 . 60 . 80 . 100%

73. That a levine tube may be inserted (if it is likely) 0 . 20 . 40 . 60 . 80 . 100%

74. Why a levine tube may be inserted (if it is likely) 0 . 20 . 40 . 60 . 80 . 100%

75. That chest or abdominal drainage tubes may be inserted 0 . 20 . 40 . 60 . 80 . 100%

76. Why chest or abdominal drainage tubes may be inserted 0 . 20 . 40 . 60 . 80 . 100%

77. That a urinary catheter may be inserted (if it might be) 0 . 20 . 40 . 60 . 80 . 100%

78. Why a urinary catheter may be inserted (if it might be) 0 . 20 . 40 . 60 . 80 . 100%

E. Topics concerning the postoperative period:

83. What discomfort the patient may expect to feel 0 . 20 . 40 . 60 . 80 . 100%

Should be
discussed
by others

- 84. What medication the patient will receive . . . 0 . 20 . 40 . 60 . 80 . 100%
- 85. Why the patient will receive this medication . 0 . 20 . 40 . 60 . 80 . 100%
- 86. The cause of any discomfort the patient might feel 0 . 20 . 40 . 60 . 80 . 100%
- 87. That the medical staff can be readily summoned in case of need 0 . 20 . 40 . 60 . 80 . 100%
- 88. Exercises, etc. which the patient may be asked to perform 0 . 20 . 40 . 60 . 80 . 100%
- 89. How and why the exercises will be beneficial . 0 . 20 . 40 . 60 . 80 . 100%
- 90. The narcotics and sedatives which will be available on request to relieve pain and how often these may be requested 0 . 20 . 40 . 60 . 80 . 100%
- 91. How long the patient will have to be in the hospital 0 . 20 . 40 . 60 . 80 . 100%
- 92. When the patient will be expected to get up . . . 0 . 20 . 40 . 60 . 80 . 100%
- 93. Exercises, body positioning, etc. which the patient may do for himself to relieve pain or other discomfort 0 . 20 . 40 . 60 . 80 . 100%

APPENDIX F

Revised Repression-Sensitization Scale

Revised R-S Scale

This inventory consists of numbered statements. Read each statement and decide whether it is true as applied to you or false as applied to you.

You are to mark your answers on the answer sheet provided. If a statement is TRUE or MOSTLY TRUE, as applied to you, circle the letter T. If a statement is FALSE or NOT USUALLY TRUE, as applied to you, circle the letter F.

Remember to give YOUR OWN opinion of yourself. Do not leave any blank spaces if you can avoid it.

In marking your answers on the answer sheet, be sure that the number of the statement agrees with the number on the answer sheet.

OPEN THE BOOKLET AND BEGIN.

Revised R-S Scale

1. I wake up fresh and rested most mornings.
2. My hands and feet are usually warm enough.
3. My daily life is full of things that keep me interested.
4. There seems to be a lump in my throat much of the time.
5. Once in awhile I think of things too bad to talk about.
6. At times I have fits of laughing and crying that I cannot control.
7. I feel that it is certainly best to keep my mouth shut when I'm in trouble.
8. I find it hard to keep my mind on a task or job.
9. I seldom worry about my health.
10. I have had periods of days, weeks, or months when I couldn't take care of things because I couldn't "get going."
11. My sleep is fitful and disturbed.
12. Much of the time my head seems to hurt all over.
13. I am in just as good physical health as most of my friends.
14. I prefer to pass by school friends, or people I know but have not seen for a long time, unless they speak to me first.
15. I am almost never bothered by pains over the heart or in my chest.
16. I am a good mixer.
17. I wish I could be as happy as others seem to be.
18. Most of the time I feel blue.
19. I am certainly lacking in self-confidence.
20. I usually feel that life is worthwhile.
21. It takes a lot of argument to convince most people of the truth.
22. I think most people would lie to get ahead.
23. I do many things which I regret afterwards (I regret things more or more often than others seem to).
24. I have very few quarrels with members of my family.
25. My hardest battles are with myself.

26. I have little or no trouble with my muscles twitching or jumping.
27. I don't seem to care what happens to me.
28. Much of the time I feel as if I have done something wrong or evil.
29. I am happy most of the time.
30. Some people are so bossy that I feel like doing the opposite of what they request, even though I know they are right.
31. Often I feel as if there were a tight band about my head.
32. I seem to be about as capable and smart as most others around me.
33. Most people will use somewhat unfair means to gain profit or advantage rather than to lose it.
34. Often I can't understand why I have been so cross and grouchy.
35. I do not worry about catching diseases.
36. I commonly wonder what hidden reason another person may have for doing something nice for me.
37. Criticism or scolding hurts me terribly.
38. My conduct is largely controlled by the customs of those about me.
39. I certainly feel useless at times.
40. At times I feel like picking a fist fight with someone.
41. I have often lost out on things because I couldn't make up my mind soon enough.
42. It makes me impatient to have people ask my advice or otherwise interrupt me when I am working on something important.
43. Most nights I go to sleep without thoughts or ideas bothering me.
44. I cry easily.
45. I cannot understand what I read as well as I used to.
46. I have never felt better in my life than I do now.
47. I resent having anyone take me in so cleverly that I have had to admit that it was one on me.
48. I do not tire quickly.
49. I like to study and read about things that I am working at.

50. I like to know some important people because it makes me feel important.
51. It makes me uncomfortable to put on a stunt at a party even when others are doing the same sort of things.
52. I frequently have to fight against showing that I am bashful.
53. I seldom or never have dizzy spells.
54. My memory seems to be all right.
55. I am worried about sex matters.
56. I find it hard to make talk when I meet new people.
57. I am afraid of losing my mind.
58. I frequently notice my hand shakes when I try to do something.
59. I can read a long while without tiring my eyes.
60. I feel weak all over much of the time.
61. I have very few headaches.
62. Sometimes, when embarrassed, I break out in a sweat which annoys me greatly.
63. I have had no difficulty in keeping my balance in walking.
64. I wish I were not so shy.
65. I enjoy many different kinds of play and recreation.
66. In walking I am very careful to step over sidewalk cracks.
67. I frequently find myself worrying about something.
68. I hardly ever notice my heart pounding and I am seldom short of breath.
69. I get mad easily and then get over it soon.
70. I brood a great deal.
71. I have periods of such restlessness that I cannot sit long in a chair.
72. I dream frequently about things that are best kept to myself.
73. I believe I am no more nervous than most others.
74. I have few or no pains.
75. I have difficulty in starting to do things.
76. It is safer to trust nobody.

77. Once a week or oftener I become very excited.
78. When in a group of people I have trouble thinking of the right things to talk about.
79. When I leave home I do not worry about whether the door is locked and the windows closed.
80. I have often felt that strangers were looking at me critically.
81. I drink an unusually large amount of water every day.
82. I am always disgusted with the law when a criminal is freed through the arguments of a smart lawyer.
83. I work under a great deal of tension.
84. I am likely not to speak to people until they speak to me.
85. Life is a strain for me much of the time.
86. In school I found it very hard to talk before the class.
87. Even when I am with people I feel lonely much of the time.
88. I think nearly anyone would tell a lie to keep out of trouble.
89. I am easily embarrassed.
90. I worry over money and business.
91. I easily become impatient with people.
92. I feel anxiety about something or someone almost all the time.
93. Sometimes I become so excited that I find it hard to get to sleep.
94. I forget right away what people say to me.
95. I usually have to stop and think before I act even in trifling matters.
96. Often I cross the street in order not to meet someone I see.
97. I often feel as if things were not real.
98. I have a habit of counting things that are not important such as bulbs on electric signs, and so forth.
99. I have strange and peculiar thoughts.
100. I have been afraid of things or people that I knew could not hurt me.
101. I have no dread of going into a room by myself where other people have already gathered and are talking.
102. I have more trouble concentrating than others seem to have.

103. I have several times given up doing a thing because I thought too little of my ability.
104. Bad words, often terrible words, come into my mind and I cannot get rid of them.
105. Sometimes some unimportant thought will run through my mind and bother me for days.
106. Almost every day something happens to frighten me.
107. I am inclined to take things hard.
108. I am more sensitive than most other people.
109. At periods my mind seems to work more slowly than usual.
110. I very seldom have spells of the blues.
111. I wish I could get over worrying about things I have said that may have injured other people's feelings.
112. People often disappoint me.
113. I feel unable to tell anyone all about myself.
114. My plans have frequently seemed so full of difficulties that I have had to give them up.
115. Often, even though everything is going fine for me, I feel that I don't care about anything.
116. I have sometimes felt that difficulties were piling up so high that I could not overcome them.
117. I often think, "I wish I were a child again."
118. It makes me feel like a failure when I hear of the success of someone I know well.
119. I am apt to take disappointments so keenly that I can't put them out of my mind.
120. At times I think I am no good at all.
121. I worry quite a bit over possible misfortunes.
122. I am apt to pass up something I want to do because others feel I am not going about it in the right way.
123. I have several times had a change of heart about my life work.
124. I have a daydream life which I do not tell other people.
125. I have often felt guilty because I have pretended to feel more sorry about something than I really was.

126. I feel tired a good deal of the time.

127. I sometimes feel that I am about to go to pieces.

APPENDIX G

Demographic Data per Individual Subject

Demographic Data per Individual Subject

Number	Sex		Age	Education			Experience (in months)	Employment		Unit		
	F	M		Dip.	A.D.	B.S.		Full	Part	1	2	
01	X		26				X	048	X		X	
02	X		24	X				018	X		X	
03	X		25		X			018	X	X		
04	X		29	X				084	X		X	
05	X		32		X			036	X		X	
06	X		23				X	018	X		X	
07	X		44	X				228	X		X	
08	X		22				X	018	X		X	
09	X		61	X				420	X	X		
10	X		23				X	002	X	X		
11	X		44		X			012	X	X		
12	X		26		X			030	X	X		
13	X		27		X			006	X	X		
14	X		22	X				018	X	X		
15	X		23				X	007	X	X		
16	X		24				X	024	X		X	
17	X		23				X	005	X		X	
18	X		23				X	002	X		X	
19	X		22				X	008	X	X		
20	X		23				X	006	X		X	
21	X		52	X				384	X	X		
22	X		28		X			012	X	X		
23	X		22		X			006	X		X	
24	X		28		X			048	X		X	
25	X		23				X	006	X	X		
26		X	33		X			054	X		X	
27	X		22				X	006	X	X		
28	X		37		X			030	X		X	
29	X		23				X	006	X	X		
30	X		58	X				372	X		X	
Totals:	29	1		7	10	13			30	0	15	15

APPENDIX H

Preoperative Teaching Check List

PREOPERATIVE TEACHING CHECK LIST

Nursing
Initials

-
1. Knowledge of your surgery
 2. Family presence
 3. Previous surgeries
 4. Preps for surgery
 - a. Evening
 - b. Morning
 5. Medications
 - a. Evening
 - b. Morning
 6. Operating room
 7. PAR-SICU or CRR ?
 8. Postoperative routine
 - a. Pain medications
 - b. Activity
 - c. Diet
 - d. Frequency of vital signs
 - e. Voiding
 - f. Lethargy
 - g. Equipment
 9. Staff availability
 10. Possibilities of room change


AN ABSTRACT OF THE CLINICAL INVESTIGATION OF

PATRICIA MARIE WILSON

for the Master of Nursing

Date of receiving this degree: June 11, 1976

Title: FACTORS RELATING TO MEASURES OF
 INFORMATIVENESS AMONG
 SURGICAL-UNIT NURSES

Approved: 
 (Professor in Charge of Clinical Investigation)

Preoperative preparation of the surgical patient is an acknowledged portion of the surgical-unit nurse's scope of practice. While nursing literature adequately documents the need for such preparation, there is a scarcity of evidence that nurses are performing this function.

Thirty registered nurses, who routinely care for surgical patients, were surveyed through the use of four data collecting instruments: Demographic Schedule, Information Philosophy Scale (IPS), Staff Information Questionnaire (SIQ), and Revised Repression-Sensitization Scale (R-S Scale). The purposes of the study were to examine (1) the nurse's philosophy toward preoperative preparation and her self-reported degree of informativeness in her contacts with presurgical patients, and (2) how degree and types of

informativeness may be related to selected parameters of the nurse, such as philosophy, coping style, and certain demographic variables. All data collecting instruments were completed at sessions held on the nursing units.

The independent variables of age, educational preparation, nursing experience, philosophy toward preoperative preparation, nurse's coping style, and nursing unit with and without a teaching guide for preparation were tested for their possible relationship to the dependent variables of degree of informativeness (SIQ score) and types of information imparted (ten subscale scores which comprised the total SIQ score). Data were analyzed by means of zero-order correlation and multiple regression. Significant multiple correlations were obtained in relation to the SIQ score and to four of the ten subscale scores.

Scores on the instruments designed to evaluate the informativeness of individuals revealed that 20 of the 30 nurses subscribed to a philosophy of moderate or high informativeness, with 23 of the 30 reporting a moderate or high degree of informativeness in their preoperative preparation of the surgical patient. Philosophy, coping style, and nursing unit were found to have significant zero-order correlations and proved to be the principal predictors in the multiple regression analyses resulting in significant multiple correlations. Nurses with a philosophy of high informativeness, who tended

to utilize coping mechanisms that attempt to clarify implications of a threatening situation, and who functioned on a nursing unit with a structured approach, were more informative, than other nurses, in their preoperative preparation of the patient.

This study population estimated they were restricted to instructing only 51.4 per cent of the presurgical patients to the extent they considered desirable. The leading deterrents to the provision of adequate preparation, cited by 25 of the 30 nurses surveyed, were lack of time, heavy work load, and understaffing.

Conclusions drawn from the present study were (1) a nurse's philosophy toward informativeness is indicative of the amount of information she imparts, (2) a structured approach to preoperative preparation fosters informativeness, with resultant increase in the number of patients prepared, and (3) the provision of preoperative instruction is influenced by external pressures. Recommendations for further study were suggested.