THE STATUS AND POTENTIAL OF PRIVATE DUTY NURSING AS PERCEIVED BY 126 PRIVATE DUTY NURSES IN THE STATE OF OREGON

by

Colleen Constance Carris Hughes, B.S.

A THESIS

Presented to the University of Oregon School of Nursing and the
Graduate Council of the University of Oregon Medical School
in partial fulfillment
of the requirements for the degree of
Master of Science

June 9, 1966

This Study Was Developed With the Financial Assistance of a Nurse Traineeship from the United States Public Health Service, Grant Number NT 35 - C7.

APPROVED:

[redacted]

(Professor in Charge of Thesis)

[redacted]

(Chairman, Graduate Council)

ACKNOWLEDGEMENTS

Grateful acknowledgement is made to Miss Lucile Gregerson for the patient guidance and expert critical comment received during the course of this research project.

Alvin Sherman and John Dailey were of great assistance in regard to the statistical development of this study. Mrs. Alberthia Fowler, Mrs. Helen Scott, Mrs. Margaret Letrud, and Mrs. Waneva Richardson are extended special thanks for their assistance and genuine interest.

Acknowledgement is also given to Mrs. Lorna Ullrich, Mrs. Margaret Rosson and Mrs. Patricia Dailey for giving generously of their time as a panel to assist in analysing and categorizing the third section of the study.

Grateful acknowledgement is made to Mrs. Bertha Byrne, Mrs. H. Yvonne Gardiner, Mrs. Nova Young, Miss E. Katherine Sears, Mrs. Dorothy Showalter, Mrs. Julie Anderson and Mrs. Eva Hansen for their interest and collaboration in this study.

The author holds a warm respect and gratitude for the private duty nurses who participated in the pilot study, upon which the opinionnaire was based, and for each private duty nurse in Oregon who participated in this study.

The writer is especially grateful to her husband, Harold

Hughes, and her children, Sharon, Thomas, Michael, Joe and Timothy for the encouragement and understanding patience during this endeavor.

c.c.h.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

Introduction to the Problem

"A profession is not a profession if
it leaves its destiny to others."
- Author unknown

The nurse in greatest demand during the 1920's was the private duty nurse. Burgess did a survey by questionnaire in 1926 under the auspices and with the guidance of the Committee on the Grading of Nursing Schools which concluded that approximately 54 per cent of all the nurses who answered did private duty. (16) The home, rather than the hospital, was the place seriously ill patients received care. (3, 16, 20, 22, 57)

For several decades, more nurses entered the field of private duty than any other field of nursing. (3, 11, 20, 57, 69, 75) In 1930, 55 per cent of all graduate nurses were reported to be in private duty nursing and 36 per cent in the institutional field. However, in 1951, 21 per cent of the professional registered nurses were private duty nurses, and 49 per cent were employed in hospitals and other institutions, excluding educators in schools of nursing. In 1963 the Surgeon General's Consultant Group on Nursing published a report stating that in 1962, in the United States, "three out of five

professional nurses serve on hospital staffs and thirteen per cent are engaged in private practice." (69) Later published statistics reported that the number of registered nurses increased by three nurses per 100,000 population and that all major fields of nursing practice showed gains in 1964 except private duty, which dropped five per cent. (6, 27)

Today, the 60,000 private duty nurses comprise the third largest group of professional nurses. Their numbers decrease as new fields of nursing open and as the average age of the private duty practitioner has gone from the forties to the fifties without replacement.

Essentially, private duty nursing is the "ideal" nursing as far as the nurse-patient and nurse-doctor relationships are concerned. Many older career private duty nurses defend their work as being the only kind of nursing implied in the term, "bedside nursing."

The private duty nurse is an independent practitioner and pays a high price for being so. She has none of the employer-paid benefits of regular employment such as vacations, sick leave, in-service education, insurance and other benefits. Most of the private duty nurses must pay fees to secure their cases from a professional registry or commercial registry. This may cost between $30.00 and $60.00 a year in addition to organizational membership dues. (3, 17, 20, 36, 53, 63, 64, 71)

Statement of the Problem

The number of private duty nurses in Oregon, as well as in the United States, has been decreasing steadily since 1910. (64) The advent of the depression of the 1930's and the two world wars caused many nurses to go into other fields of nursing.

In the Oregonian, Thursday, March 31, 1966, James Hall, then president of the Oregon Nurses Association, related statistics for 1960 and 1966. Hall said, "The number of private duty nurses in Oregon has decreased from 563 in 1960 to 357 in 1966, while the total number of registered nurses employed in the state increased by 640 during the same period." (33)

In the 1920's the majority of the private duty nurses were between 20 and 30 years of age. (16, 59) Today, the average private duty nurse is middle aged (about 45 years old), married, and has been actively engaged in nursing for 20 or more years. (20, 57, 64) The median age of all active registered nurses in the United States is 35. (6)

Nova Young, Executive Secretary and Registrar of District I, Oregon Nurses Association, wrote a brief 1965 Oregon survey which included the 142 private duty nurses on the registry at that time. In age assessment analysis, only three were in the 20-29 age group, seven in the 30-39 age group, thirty-two were 40-49,

fifty-four were 50-59, and thirty-eight were 60 years of age or older. Seventeen of these nurses were over 65 years of age and were available only for limited duty on a part-time basis. (78) Private duty does not seem to be attracting recent graduates.

Hospital nursing services have undergone marked changes in the past few decades. Facilities have been provided such as the recovery room for immediate post-operative care and intensive care units for the acutely ill and centralized nursing services for those most in need of expert care. It could be conjectured that services such as the above have had some influence on the patient's need for the one-to-one care previously provided by private duty nurses. However, private duty nursing was decreasing numerically before hospital facilities such as described above were available. Many explanations might be given concerning changes in an occupational field, but such explanations have no validity unless based on studies. A first step in a series of studies would be to seek opinions of the practitioners in the field under study.

Purpose of the Study

This study was undertaken for the purpose of:

1. identifying the characteristics of the private duty nurse in Oregon;
2. gathering information from private duty nurses concerning

the scope of their practice, including an identification of limitations, if any and reasons for same;

3. seeking comments from private duty nurses concerning what aspects were most enjoyed and least enjoyed;
4. obtaining opinions concerning the future of private duty as an occupational field; and
5. eliciting statements of ways whereby private duty nurses are helped by the Oregon Nurses Association and suggestions regarding ways whereby the Association can be of further assistance.

Justification for the Study

The many advances in medicine and surgery have influenced the practice of nursing. Health care facilities have changed to expedite the complex patient care provided in the modern hospital. The student nurse of today is experiencing the curricular impact of spiraling knowledge in all science fields. The nurse in this last half of the twentieth century needs many skills not expected of her forebears. Even if she is functioning in a situation where she has the advantage of in-service education, continuation or on-going study, advanced courses, and the like, she finds it difficult to keep abreast with the out-pouring of new knowledge. What, then, is the situation for private duty nurses? Within a few decades, private duty nurses

have decreased in number. A few studies have been made of private duty nursing, but little attempt has been made to investigate the problems stated by the private duty nurses, themselves.

Finer states that:

> Evaluation and appraisal of the performance of private duty nurses has been suggested from time to time by private duty nurses themselves, nursing services directors, and registrars. . .
>
> Whatever criticism there may be of the quality of private duty nursing, from whatever source, all concerned, with very few exceptions, admit the desperate need for the continuing services of private duty nurses. Recent studies of the future uses of private duty nurses' services--for the critically ill patients, for those who have had extensive surgery, and for human solicitude for the patient and the patient's family--emphasize our need to consider how to evaluate these services. (28)

In order to find out exactly what the private duty nurse feels about her private duty nursing practice, it is necessary to ask her to identify her job satisfactions; her job dissatisfactions, and her thoughts concerning the future of her field.

Abbreviations

The following abbreviations will be used throughout this study and are listed here for purposes of identification.

A.J.N.	means	American Journal of Nursing
A.N.A.	means	American Nurses' Association
I.C.U.	means	Intensive Care Unit

L.P.N.	means	Licensed Practical Nurse
O.N.A.	means	Oregon Nurses Association
P.D.N.	means	Private Duty Nurse
R.N.	means	Registered Nurse
V.A.	means	Veterans' Administration

Definitions

For purposes of the study, the following definitions have been adopted.

Commercial registry - a profit making employment agency, managed by non-nurses or nurses who charge a registration fee and a percentage of the nurse's earning from each job to which the agency assigns her. (22)

Free-lance nurse - a nurse who depends solely upon a group of physicians who use her service regularly for private duty jobs. She does not pay registry or placement charges. (22)

Functions - a general term for the natural, required, or expected activity of a person, or occupation. (29)

Private duty nurse - a registered professional nurse who independently contracts to give expert nursing care to

one patient. This permits the nurse to utilize professional knowledge and skills to the fullest extent and to assume responsibility for the total nursing care of the patient. (22, 56, 63)

Professional registry - a non-profit employment agency, managed by professional nurses, which has been sponsored and approved by the local professional nurses association (7, 22, 53)

Assumptions

For the purposes of this study, the following assumptions were made:

1. An opinionnaire is an effective device for eliciting honest opinions and answers to the questions asked. It is recognized that although opinions may be skewed or biased, the responses have pertinence to the study.
2. Private duty nursing is a specific branch of nursing which can be identified.
3. It was further assumed that the practitioners in a field are in optimal position to assess the present and future status of the field, hence their opinions have merit despite possible subjectivity.

Limitations

This study has been limited to:

1. Information that could be obtained from a mailed opionnaire submitted to a group of 220 private duty nurses throughout the state of Oregon, including 4 whose addresses were in Idaho, but who work in Oregon; the information was further limited to the 126 who responded.
2. Participants who were members of the Oregon Nurses Association for the year 1965 and for the months of January and February, 1966 in the private duty section.
3. Expressed opinions which represent the responses of the participants of this study. Wide-spread generalizations cannot be drawn regarding the findings of this study without further research.

There are unassessed variables which could have affected the responses of the participants. Among these are past personal experiences, the ability to express oneself in written communication, professional educational backgrounds, the structure of the private duty nursing program in the different districts and the lack of a professional registry in most districts.

Design for Research

Sources of Data

The primary sources of data were information obtained from an opinionnaire completed by 126 registered nurses employed in the private duty branch of nursing.

The secondary sources of data were obtained from the literature related to private duty nursing and job satisfaction.

Procedure

The steps whereby this study was developed may be described as follows:

1. The literature was reviewed to locate references concerning private duty nursing. It was anticipated that related studies could be located and a frame of reference established. From the literature, an historical review of the past was attempted, problems were identified, and trends noted.
2. Unstructured conferences were arranged with Oregon nurses familiar with the field of private duty nursing. The purpose of the conferences was to elicit comments concerning the trends in private duty nursing and the

need for studies. Those with whom conferences were held were not participants in the study. They were as follows:

a) Mrs. Bertha Byrne, Executive Secretary, Oregon Nurses Association.

b) Mrs. H. Yvonne Gardiner, Associate Executive Secretary, Oregon Nurses Association.

c) Mrs. Nova Young, Executive Secretary, District I, Oregon Nurses Association.

d) Miss E. Katherine Sears, former Executive Secretary, District I, Oregon Nurses Association.

3. Conferences with leaders in private duty nursing in Oregon were arranged to elicity assurance of their interest and collaboration plus their suggestions for the collection of data.

Conferences were sought with:

a) Mrs. Dorothy Showalter, Chairman, Private Duty Section, Oregon Nurses Association.

b) Mrs. Julie Anderson, Chairman Private Duty Section, District I, Oregon Nurses Association.

c) Mrs. Eva Hansen, former Chairman Private Duty Section, American Nurses' Association; currently Board Member American Nurses' Association.

Since these persons were participants in the study, the data collection tool was not discussed.

4. A statement of the problem selected for the thesis was formulated.
5. The problem was delimited, assumptions accepted for the study were stated and purposes were formulated. Since this study was apt to be largely a matter of seeking opinions and recommendations, it was recognized that the subjectivity of the responses might not lend itself to statistical analysis, hence there were no hypotheses to be tested.
6. The tool was submitted to a group of professional nurses with the request that they review the tool for format and context. Revisions were made as necessary.
7. A pilot study was conducted. This involved a group of private duty nurses in Vancouver, Washington. These nurses were not participants in the final study. Their responses were analyzed and no further revisions of the tool seemed necessary before using the data-collecting tool in the main study.
8. The opinionnaire was mailed, including a cover letter from the investigator explaining the study and seeking collaboration. The letter was countersigned by the

chairman of the Oregon Nurses Association, Private Duty Section and the thesis adviser. A stamped, addressed envelope for return was also enclosed.

9. The findings were transferred to key sort cards, then tabulated; tables constructed; the study described; and interpretations were made.
10. The responses from open-end items were categorized, using a panel of three nurses to reduce subjectivity and to reach a degree of agreement.
11. The study was summarized, conclusions drawn, and recommendations made for further study.

Overview of the Study

Chapter one includes an introduction to the broad problem, statement of the problem and purpose of the study. Assumptions, limitations and definitions for purposes of this study are set forth in chapter one. A review of the current literature and related research is presented in chapter two. An introduction, examination of the status of private duty nursing in the past, present and future, and report of research studies in private duty nursing comprise this chapter. Chapter three includes the methodology and findings of the study. This chapter describes the study, tabulates the findings and interprets same.

Summary, conclusions drawn, and recommendations for further study are included in chapter four of this report.

CHAPTER II

SURVEY OF LITERATURE AND RELATED STUDIES

Introduction

The literature related to this study has been divided into three groups, history of private duty nursing to 1950, including the history of private duty nursing in Oregon; private duty nursing since 1950; and trends in private duty nursing.

Private Duty Nursing in the United States

History of Private Duty Nursing

Private duty nursing ("Private duty nursing," Hospital "specialing" and "free-lancing" here used synonymously) was the one specialty in nursing between 1890 and 1930. During these forty years, more nurses entered private duty than any other field because there were few opportunities in other fields, and "specialing" did not demand or need preparation beyond the basic hospital training. (8, 11, 16, 42, 59)

Private Duty Nurses became an integral part of the American Nurses' Association in 1916. The organizational sequence of this section from 1910-1930 can be seen in Appendix A[1], History of the Organization of the Private Duty Section.

Goodnow reports that surveys done in the 1920's indicated that 10 per cent of all the sick were cared for in hospitals, 10 per cent had hired nurses for home nursing, and 80 per cent were cared for by their families or untrained neighbors. (31)

A surplus of school of nursing graduates, satisfactory as well as unsatisfactory, flooded the nation as private duty nurses. This was the "dumping ground" for all nurses whom the hospital did not wish to retain, those who did not take "post-graduate" work immediately, or those who had not definitely decided what they wished to do. The standards for these nurses were set up by the individual employer and the work as well as salary was irregular. Thus, private duty nursing became a job without supervision, with no security, no opportunity for advanced study, and with uncompensated experience.

As medicine and surgery became more complex, more patients sought hospital rather than home care. Hospitals seemed to prefer nurses with increased skills, more speed, and up-to-date methods. All state boards of nursing in the late 1920's recommended the employment of more general duty nurses. This actually absorbed some of the private duty group. (11, 16, 42, 59)

May Ayres Burgess in 1928, recorded the report by the Committee on the Grading of Nursing Schools. (16) This book, Nurses, Patients and Pocketbooks, deals primarily with private duty

nurses and their problems. Burgess states that,"Anyone calling herself a nurse can enter the private duty field in competition with all the others in it."

There were certain laws governing registration of nurses by 1928, however, no legislation was enacted to ensure that the "nurses" really had a few months in a school of nursing. Licensure was permissive even for those who had graduated from a school of nursing.

Burgess described the free-lance nurses of the era as:

a. Some of the finest women in the profession, who select private duty because they love it.

b. Many young girls who have gone into private duty not because they love it, but because they are attracted by the high initial earnings.

c. Most of the women who are not eligible to public health positions or institutional supervisory jobs.

d. The free lance individualists who avoid any form of group activity because they want to be their own masters.

e. The incompetent, the stupid, the graduates from schools so poorly run that they are not in fact schools at all.

f. Graduates of correspondence school courses in nursing.

g. So-called "practicals," students who failed or were expelled from training school; low grade women who see in private duty a chance to raise their social standing and who, in some cases have never been in a hospital; women who have been maids in hospitals and have picked up a smattering of nursing techniques. (16)

The eager conscientious private duty nurse with high ideals met economic and psychological pitfalls. She became overworked because she was dependable and skilled. She had no jury of peers to stimulate her and to keep her abreast of new techniques as did the public health nurse or institutional nurse. Her only contacts were the physician and the patient.

Burgess is quoted further regarding the problem areas of the private duty nurse:

> It seems clear, from the many pieces of evidence presented, that private duty nurses are suffering from three great handicaps.
>
> The first is that there is apparently already a serious overproduction of nurses and this overproduction is felt first in the private duty field because more nurses go into private duty than into either of the other main fields.
>
> The second difficulty is that private duty is open to all comers. The fine bedside nurse who honestly prefers private duty to any other field because she likes to give individual care to sick patients is obliged to face competition of a type unknown in either of the other fields.
>
> . . . . Finally, free lance work in any profession is almost inevitably hard on its workers. The freedom is alluring, but the free lance worker pays for that independence of action by lowered income, irregular employment, and extreme professional loneliness. (16)

Due to the Depression and World War II, the years between 1929 and 1949 present an abnormal picture and the whole private duty nursing area as well as other fields of nursing were affected.

Deming in 1949 related 12 advantages for engaging in private duty nursing practice. (22)

1. There is opportunity to meet interesting people.

2. It offers a variety of cases under a variety of conditions.

3. It offers occasional opportunities to travel.

4. It is a challenge to one's real nursing skill and adaptability.

5. There is frequently a chance to build up a desirable clientele among a group of doctors, thereby keeping rather steadily at work in congenial surroundings.

6. Work is usually under pleasant conditions.

7. Patients may become lifelong friends. It is not unusual for a nurse to be retained many months, even years, in one family.

8. Work is usually under the direction of well-qualified doctors.

9. If private practice is in the hospital, there is opportunity to keep abreast of new developments in nursing and to see the latest treatments and procedures.

10. Experience in private practice for a year or two is good basic experience for every professional nurse, if only to accustom her to home situations, to getting along with families (quite a different proposition from care of a patient in hospital environment), to developing her self-reliance and resourcefulness, and to nursing for private physicians.

11. The care of elderly, bedridden, or incapacitated persons who are not critically ill frequently makes an ideal occupation for professional nurses unable to carry the burden of acutely ill patients. The active professional life of nurses is proverbially short: in 1949 only 3.6 per cent of all employed nurses were over sixty years of age, and only 11 per cent were in the fifty to fifty-nine

> age group. The fact that many nurses who are now reaching retirement age have not been able to provide for their old age makes private duty as a companion or guardian in a private home particularly attractive.

12. The nurse is free to take a rest between cases.

In Oregon, there are only rare accounts of nursing in the state's history. Among these few books and papers is an unpublished masters thesis by Marjorie J. Boufford done at Oregon State College in 1951. In Boufford's A History of Nursing in Oregon, is some background information concerning private duty in the state of Oregon during 1890-1949. (11)

Boufford stated that before 1890, there were no schools of nursing in Oregon and only a handful of nurses from the east. As the population increased, so did the number of nurses. (11)

Larsell mentions that in 1890, Portland had 70,000 people and only three trained nurses. (42)

Boufford quotes an interesting rare record kept on a student private duty nurse at St. Vincent Hospital, school of nursing:

> Miss McDowell was the first student to be sent on special duty in the country. She was an excellent nurse and could be depended upon in the most trying situations. It was some time in the fall of 1896 that she was sent to one of the small valley towns on a typhoid fever case. She was isolated on a farm, and it rained incessantly during the three weeks she was there. The house was small and the family insisted on sleeping in the bedroom with the patient. They were horrified when she asked them to use the parlor for a bedroom and they flatly refused to do her bidding. There was further opposition when she asked for time off during the day to sleep. She was told that a trained nurse

> was not supposed to sleep, but Miss McDowell won her argument in this instance to the extent that she managed to take two hours rest on the parlor sofa each afternoon. At night there was not even time for a doze in a chair, for the patient was quite ill, with a high temperature and delirium. The treatment consisted of frequent doses of calomel, and in the care of the patient, numerous trips to the outhouse were necessary on the part of the nurse. This was hazardous journey by lantern light from the kitchen stoop over a line of narrow boards, and from which a misstep meant ankle deep in mud.
>
> At the end of the three weeks, the patient was sufficiently recovered for the nurse to return to the hospital. She sought redress for her hard work in presenting the patient with a bill for $3.00 per day, a graduate nurse's fee. The family refused to pay the bill. They told her that the Sisters owed them this service because they had roomed with them when they were in town collecting for the building of a hospital. (11, 72)

In the 1920 minutes of the Oregon State Board for Examination and Registration of Graduate Nurses it was stated that, ". . . . Hospitals must discontinue the practice of charging patients for special duty care by students." (47)

The depression in the 1930's left its mark on nursing history. Much needed improvements aided in curriculum changes and upgrading of entrance requirements. The 12 hour day became an 8 hour day in the wake of unemployed nurses.

Boufford reported:

> Private duty nursing occupied most of our nurses in the early days and it was a group of private duty nurses who organized the Oregon State Nurses Association. However, as hospitals, industry and population grew, nurses increasingly gave up independent practice and became part of a full-time staff and served many instead of just one

patient at a time.

> A separate section for private duty nurses was organized within the state association in 1932 to provide opportunity for the discussion of problems of special interest. The section started out with many fine projects. . . . (11)

A statewide study of nursing needs and resources was initiated by the State Board of Examination and Registration of Graduate Nurses and the Oregon State Nurses Association. The study was developed with professional assistance from the United States Public Health Service and was completed in 1949. Among the findings, the distribution of nursing personnel was reported as follows:

> A total of 6037 nurses were reported working in Oregon; of these 3478 were professional nurses and 2559 non-professional or practical nurses. Hospitals employed a total of 3578, public health agencies 135, doctors' office 890, private practice 904 and the veterans administration 346, industry 58 and 126 miscellaneous. (9)

There are only 357 private duty nurses in Oregon in 1966, just less than two decades past the 1949 study. (33, 52)

Young in the April, 1966 copy of The Oregon Nurse wrote an article concerning the problems of the District I Professional Registry. (77) There is only one professional registry in Oregon. Young said the average number of private duty nurses on the registry during 1965 was 150.

Young did some statistical work with the calls placed to the registry for private duty nurses. (77) She concluded that "a grand

total of 5,664 calls were placed with the Registry, averaging about 225 calls per month. Two thousand one hundred and forty-eight of these calls were not filled by the Registry, an average of 175 unfilled calls per month." She further stated, "Throughout the country, it seems the record is similar, with requests for services of private duty nurses far out-stripping the supply of services available."

Private Duty Nursing since 1950

Hughes, Couey, Hershey, Kasum and others agree that the private nurse contractor holds an unique position. (20, 21, 36, 38, 41, 43, 44)

The private duty nurse is a private contractor for a single patient in the hospital, nursing home, or private home, upon which she must depend for technical equipment, facilities, advice, and social satisfaction.

Whether employee or independent contractor, the private duty nurse is personally liable for harm caused by her negligence. Laws throughout the nation differ as to whether the private duty nurse is an "employee or independent contractor." (36, 43, 44, 63, 75)

Scott, a lawyer for the American Nurses' Association prepared a letter regarding established criteria for independent

contractor status. (62) He admitted that the courts have not clearly defined test for determining when a person is or is not an independent contractor, but he did list some criteria. See Appendix A[2].

The hospital may reserve the right to deny the hospital's facilities to a certain private duty nurse and interfere with her ability to earn a living. When this happens, the hospital can be considered liable.

The private duty nurse in the present era has come face-to-face with problem areas in her everyday practice. One of these problem areas is job satisfaction.

Couey and Stephenson state that "social acceptance of the private duty nurse in informal hospital groupings is particularly dependent upon the number and intensity of the nurse's contacts outside her room; yet most people prefer that she remain in her room at all times." (20)

Carroll, a psychologist, categorized and stated the motivating factors in human life as:

> 1. the need for emotional security; 2. the need for achievement or mastery; 3. the need for recognition or status; and 4. the need for physical satisfaction. (18)

Carroll's definition of satisfaction may be further defined as success, or recognition, or appreciation. This satisfaction, like happiness comes primarily from within one's self from the fulfillment of personal inner resources and is heavily conditioned

by many forces, by motives and by circumstances. (30)

The desire for new experience is the positive aspect of man's capacity for boredom. Any experience, if presented repeatedly and without respite, causes the human organism boredom. Varying amounts of change and variety of experiences become an everyday need. (23)

A sense of belonging, of understanding, and of being well-liked by his peer group, must be felt by the human organism because, just as boredom is the negative side of desire for new experiences, so loneliness is the antithesis of desire for response.

Brown stated in "The Science and Improvement of Patient Care," published in the American Journal of Nursing, September, 1956, that there was much confusion and overlapping of duties among professional nurses, practical nurses, and subsidiary personnel. (15)

Roe says:

> The fact that in our society, work is a major source if not the major source of autonomous satisfaction and that it may also be a major source of human satisfaction . . . . Many men have taken refuge in their work in the face of the most acute problems in family or personal relations and have been sustained thereby. To be unhappy in the work and frustrated by it, or to be without it, are major traumatizing situations. (23)

Esther Lucile Brown states that the traditional and inflexible nature of the formal social structure of the hospital frequently

causes a failure in supplying the basic needs of employees. (15)

In a study, "Factors Influencing Employee Morale," Worthy set up needs of the employee as such:

> Generally speaking, no one works at peak efficiency unless his deepest human needs receive some satisfaction in the work situation itself. Among the needs that can be met for workers only within a relatively small operating branch are the following:
>
> 1. A job that is meaningful in itself and that calls on the individual to use and develop potential capacities.
> 2. An opportunity to know what is done by other members in the unit, instead of being hemmed in by impersonal administrative systems. This means that each member can see where and how his job gets into the whole scheme of things.
> 3. Frequent contact with supervisors and executives, "flesh-and-blood people who can be liked or disliked for their own sakes and not judged solely on the impersonal results of their administrative actions or on the basis of myths about 'those guys in the front office'!" (77)

Roethisberger states that the desire for recognition is present in every normal individual. The manner in which we get recognition is determined by one's interactive living within a certain "cultural milieu." (60)

Neumiller, in an unpublished masters thesis, Job Satisfactions and Dissatisfactions as Expressed by 57 Staff Nurses in Five General Hospitals in Portland, Oregon concluded that "A true dilemma exists because there continues to be no precise delineation

of the scope of professional nursing versus the functions of non-professional personnel on the staff nurse level." (45)

As on all levels of hospital and office personnel there is conflict between individuals of different professional preparation, so there is conflict between the private duty nurse and the licensed practical nurse who engages in private duty nursing. Economic competition between these two groups of people often results. In the Statement of Functions, Standards and Qualifications for the Practice of Private Duty Nursing, one of the stated functions of registered private duty nurses is to "Guide the practical nurse or any other individual who is responsible for the continuation of the nursing care of the patient." (56) Hansen says, "As private duty nurses, we must acknowledge the practical nurse as a valuable member of the health team." (35)

Abdellah and Levine in Work-Sampling Applied to the Study of Nursing Personnel, said, "Personnel shortage tempts nurses to utilize practical nurses for relating skilled tasks while on the other hand, the graduate nurse seems to fear practical nurses as potential competitors." (1)

Lack of clarification of the functions and status symbols of the registered nurse and the practical nurse creates discord for both nurses and patients as there is increasing utilization of practical nurses.

Grivest says the competition of the practical nurse and the registered nurse remains high where "jurisdiction lines between the levels of personnel have not been sharply drawn." The graduate nurse in this type employment does not know her position and is in fear that she may have her job taken away from her by a practical nurse because the graduate nurse can not differentiate her job from that of the practical nurse. (32)

The private duty nurse receives her cases from one of the following sources: hospital registries, commercial registries or personal referrals from doctors, patients and other interested persons.

Membership in the professional organization is a requirement for private duty nurses but not for nurses in other fields of nursing. This is due largely to the need for membership in order to be accepted by a professional registry. (7, 17, 20, 22, 40, 41, 53, 71)

In August 1961, the American Nurses' Association did a study on Professional Registries. (7) Thirty-seven states of the forty-three which have registries were represented in the 116 returns.

This study revealed the following:

> Hospitals are major consumers of the services offered by private duty registry facilities. Although they are usually not employers of private duty nurses

> in the sense that they pay their fees, hospitals are instrumental in securing such nurses for their patients. Then, too, most private duty nurses work in the hospital rather than the home setting. According to data reported by nurses' professional registries, about 98 per cent of all the calls received for professional private duty care are for cases in hospitals. (7)

In addition to hospital expenses, the patient would have to pay $50 - $60 a day for nursing care for three shifts of private duty nurses. Although this is not exorbitant in terms of the work the private duty nurse is expected to do, it is an expense the patient has to bear as it usually is not covered by insurance. However, some insurance companies are beginning to write in private duty nurse coverage. (3, 17, 36, 64, 71)

Intensive care units have not removed the need of certain patients for private duty care; they merely provide the care for the acute problems of illness. This type of nursing care is given to a group of patients in the same unit by a staff or specially trained personnel.

Most private duty nurses feel that intensive care units have taken the "difficult" cases and have left the most seriously ill patients who are not ill enough to be in the intensive care unit but who still need private duty care. (73)

Trends in Private Duty Nursing

Porter, Rogers, Schutt, Wolfard and others, in looking

toward the future of private duty nursing, report that private duty nurses must seriously examine themselves before developing their program for the future. (54, 61, 64, 76)

Rogers wrote that nursing is "faced with evaluating its past and designing a new pattern compatible with future needs." (61) She further states, "efforts to maintain the status quo can only hinder intelligent planning of change. Knowledge, imagination, and creativity must be used to develop new concepts, to evaluate and revise traditional patterns, and to design new goals."

Nursing itself is changing, as well as the practitioner's role, in order to meet the challenge of the momentous shifts and advances of medical and social sciences. There are increasing demands for "specialized, personalized, and continuous care of the sick by the professional health personnel with whom patients can specifically identify." (73)

Smith said, "Progress is responsible for the death of some things and the birth of others."

> One can grow old in our profession or one can grow young. Growing old will happen without our effort, by allowing the years to pass, content with the daily routine. Growing young is achieved by accepting new ideas, new skills, new ways of doing, even though long cherished ways must be discarded. We do this in our dress, our make-up, our hair styling, and like it. We must do it in nursing. Nursing isn't growing old--it is growing younger, with her dressing, new make-up, and new styling. (66)

The R. N. carried two articles regarding private duty nursing which suggested that the future of private duty nursing was secure because of 1) the personal relationship with the patient, 2) the fact that the demand for their services bring them more calls than they can handle, 3) their pay is better than general duty nurses, and 4) the amount of freedom in selecting cases, time off and the ability to adapt working hours to meet family needs. (24, 26)

Barbara Schutt spoke to the private duty nurses at their convention at Miami Beach, Florida in 1960 concerning a plan for their future. Miss Schutt commented on the independent nature of the private duty nurse and her strong support of the American Nurses' Association:

> Frankly, it's time for you to stop worrying about your numbers and begin to worry about those who are in your group who probably shouldn't be there. The nature of nursing and the nature of society have changed--with a much more complex profession and a society demanding more for their dollars they pay for medical care in many different settings. Sections are now established as an essential part of the ANA and you have a stronger voice now than you have had when you were the only section and the largest section; you have your own budget, you have representatives on your boards and you are free to make your own pronouncements, and plan your own programs. (4)

Schutt complimented the private duty section on being the first nursing section to have an economic security program. "You have always had major economic problems because of the method of paying private duty nurses, because of your independence, because

you have no employer to give you partial compensation in fringe benefits such as vacations and social security. Unless a whole new system for financing medical care develops in this country, you will have some of the same problems in the future."

> It may well be that your source of income will shift so that more of it comes from insurance companies than directly from your patients. Your national organization has been working on this idea for some time, and the present mood of the country to have more health protection under voluntary insurance plans creates a hopeful economic situation for you. If more of our public can purchase private duty nursing service in this way, you must gear yourselves to using your professional organization in doing the kind of collective bargaining some medical associations now do with insurance companies. (64)

Schutt discussed the future aspects of implementing the second goal: recognition by the profession of superior performance in nursing. "If you can combine your independent nature and technical skills in caring for patients with the intellectual discipline which comes most easily from formal education, the private duty field can be one of the major sources of tomorrow's recognized practitioners." (64)

The private duty nurse has emerged from being the "mother surrogate" or "professional mother" to become the "completing element" in determining needs of her patients.

Porter directs her thoughts and reflections toward continuing education for the private duty nurse. (54) She visualizes a "general practitioner" and a "specialist" for the future. The general

practitioner will be the private duty nurse who will still accept any type of case, while the clinical specialist will have a specific type of service to render.

Wolford reports in the 1964 issue of Nursing Forum on a study undertaken for the period of one month by a nurse specialist at the University of California School of Nursing in San Francisco. (76)

The nurse specialist was assigned as "nurse" to six medical-surgical adult patients who had been referred to her by physicians participating in the project. The patients were assigned prior to their admission to the University medical center's hospitals. Two patients were cared for simultaneously. The "nurse" did not limit her practice to specific eight hour spans; being mobile, she moved "from the hospital wards, to patients' homes, to physicians' offices, to operating rooms - wherever the patients were when they needed her." (76)

The "nurse" became the hospital nurse, admissions clerk, public health nurse, teacher, and interpreter to the patient if necessary.

> From the point of view of society, a system of complemental nursing care would be in line with the increasing demand for specialized, personalized, and continuous care of the sick by professional health personnel with whom patients can specifically identify. It would make possible a stability of relationship which would promote a sense of security among patients and

lessen their anxiety.

> The plan further provides a framework in which the nurse specialist could practice a kind of nursing befitting her preparation and which would permit her to cut across the boundaries that compartmentalize nursing care according to the setting in which it is provided. Thus, it would offer additional dimensions to patient care rather than through the traditional channels of advancement--nursing education and administration. It also suggests itself as a way of providing opportunities for advanced theoretical study and clinical practice. (76)

This private duty nurse trend would not be the same exact concept as the private duty nurse of today. The patient would not "need" a nurse with him constantly. The outstanding feature of the private duty system--"the opportunity for the patient to have some professional person whom he knows and trusts by his side at crucial moments in his illness--should remain in the framework of existing nursing practice." (76)

Hiesinberg states, "Whether we like it or not, modern ways are going to alter and, in part, destroy traditional customs and values." (37)

Related Studies

The four studies done in the area of private duty nursing have been sponsored by the American Nurses' Association and American Nurses' Foundation, with assistance of researchers who sought to discover who goes into private duty nursing and why. (20, 21, 57, 67)

Spohn sought a nation-wide sample for a comprehensive survey. (67) She used a population of 39,000 nurses who were private duty nurse members of American Nurses' Association in 1953. She took every tenth name from the list for her sample. Her statistics were based on the 29% returns. It may be questioned whether conclusions based on such a small per cent of returns can be considered valid.

Spohn asked the following questions: 1) Who are the practitioners in the private duty field? 2) Why have they selected this field for practice? 3) What are their satisfactions and dissatisfactions? 4) What changes would private duty nurses like to see made to improve the practice in their field?

Spohn attempted to gather statistics relating to the facts that would explode myths about private duty. One such myth was the idea that private duty nursing was the "armchair" nursing, for the older nurse no longer able to do full time work in other fields. Spohn found that the older nurses were the ones who had worked many years in private duty nursing. A private duty nurse of 60 years or over had been actively engaged in nursing for 33 years with 70% of that time in private duty nursing. That would be approximately 23.5 years in private duty. The younger, under 30 years of age private duty nurse had spent 50% of her nursing career in private duty nursing.

The report revealed that the average private duty nurse was middle aged, about 45 years old, married and had been actively engaged in nursing for 20 years. Approximately 70% of all private duty nurses were under 50 years of age.

Spohn's findings revealed that "private duty nurses worked, on the average of about 200 days per year." She further stated, "Those nurses who depend on their earnings as private duty nurses for their support (and 58 per cent of the private duty nurses are in this category) work about 240 days per year." The hospital nurse who had sick leave and holiday time from the 264 work days a year would only vary within a 100 days of her sample.

Spohn discovered that nurses chose private duty nursing for two main reasons: 1) because of the nature of the nurse-patient relationship and the opportunities for giving "more direct, personal, bedside care, and, 2) 54 per cent because of the nurse herself, such as: convenient hours, desirable case load, better economic conditions. (67)

Couey and Stephenson sponsored by the American Nurses' Association did a study, The Field of Private Duty Nursing for the Georgia State Nurses' Association in 1955. (20) They attempted a pilot study of functions of the private duty nurse in the hospital environment. This study explored functional areas not included in prior American Nurses' Association function studies or, at least

not in such depth.

Couey and Stephenson used six research procedures to gather their data: 1) involvement of private duty nurses and tangent groups; 2) census questionnaires; 3) field work, which included field notes on observations and activities, interviews with private duty nurses, and interviews with others in the job realm of the private duty nurse. 4) job description diaries kept by private duty nurses; 5) work attitude questionnaire; and 6) manpower census forms.

Private duty nurses were found to perform activities in four areas of function.

1. The Human Relations Function

   This function includes all activities of the private duty nurse in her interpersonal and emotional relations with the patient and with all others concerned with the case.

2. The Clinical Function

   This function includes all activities of the private duty nurse which depend on medical and scientific knowledge and skill - the basic technological equipment.

3. The Institutional Function

   This function includes all activities of the private duty nurse in coordinating with routines and practices of the hospital, and with all hospital personnel.

4. The Socio-Professional Function

   This function includes all activities of the private duty nurse which are societal responsibilities that she discharges through her professional organization

and through her contract for nursing services. (20)

The private duty nurse in this study ranked the human relations function as the most important aspect of patient care rather than the clinical and institutional function which other groups of nurses and hospital personnel find more important. The human relations function involves the "ability of the private duty nurse to make correct and acceptable decisions regarding the patient and the people with whom she works."

This study had two basic recommendations for further research: 1) to explore the hypothesis that "analysis and evaluation of dynamic human relations components in private duty nursing yields descriptions of critical functions which are more valid and reliable than similar study of these functions through other research methods." and, 2) to repeat the pilot study in a different social context to discover any regional factors which might have influenced the definition of functions.

Suttell and Pumroy in 1956 did a similar study of the basic Couey pilot study in depth in a hospital environment of the District of Columbia. (57) Information was gathered on several aspects of the field of private duty nursing; 1) the private duty nurse as a professional working woman, 2) working conditions and facilities in hospitals, 3) the role of the private duty nurse as she sees it and as others see it, 4) the human relations aspects of private duty

nursing, and 5) sources of job satisfaction for the private duty nurse.

Three major sources yielded the information sought by this study, 1) the Nursing Services Bureau, factual information; 2) 13 hospitals in the District of Columbia; and 3) individuals working closely withthe private duty nurse, such as directors of nursing, hospital administrators, and staff nurses. Questionnaires, daily records and structured interviews were the research tools used.

Findings indicated that the average private duty nurse practicing in the hospitals of Washington, D. C. was married, 47 years old, a high school graduate, a registered nurse for 20 years, a private duty nurse for 13 years, a part-time employee, and absorbed in the "total bedside care" role of a nurse. In general there were no significant findings of satisfaction or dissatisfaction with the professional aspects of the job. Problem areas were: 1) education, a feeling that she was "out-of-date" and not familiar with new and specialized techniques and drugs; 2) lack of professional responsibility as far as weekend hours, night duty, holidays and leaving the case for convenience; 3) no unemployment, vacation or retirement benefits being self-employed; 4) lack of assistance from the Nursing Services Bureau or hospital when the nurse is abruptly and unreasonably dismissed from the case or when experiencing difficulty in collecting fees; 5) the cost of private duty nursing care is becoming too expensive for the average patient and,

6) private duty is not the interest of younger nurses.

Suttell and Pumroy further found:

> Facilities provided by the hospital are usually inadequate and inconvenient, but often no more so for the private duty nurse than for the hospital staff.
>
> Communication and orientation procedures provided by the hospital are ordinarily inadequate. The need for up-to-date written materials on procedures and policies was frequently expressed by private duty nurses and by nursing office staff. An especial source of problems appears to be the lack of definition of the authority and responsibility resting with hospital personnel and with the private duty nurse in total patient care. (57)

The human relations function was stressed as a frequent problem area. However, in tabulating the responses to job satisfaction items, it was found that in order of expressed satisfaction, these areas were: 1) patients and families, greatest. Seventy-two per cent of the total number of responses to items classified in this area indicated satisfaction; 2) physicians; 3) hospital nursing personnel; 4) the field of private duty nursing; 5) working conditions and hospital facilities; and 6) administrative and supervisory personnel, least. Fifty-three per cent of the total number of responses to items classified in this area indicated satisfaction. (57)

Couey and Couey, under a grant from the American Nurses' Association undertook a second study in Georgia. (21) They used an experimental research methodology for studying dynamics of

critical functions in the human relations area. Actually, this was a follow up study to the extensive research project on private duty nurses done in 1955. (20)

The researchers developed experimental workshops as a useful way to improve private duty nurses in their most important area, human relations, attitudes and skills. There were three workshops occuring simultaneously. In the "first" workshop, the private duty nurse participants used discussion and study of a manual; in the second, role-playing; and, in the third, participants practiced behind a one-way screen and made a movie. The results were the same regardless of the type of workshop attended. The material presented centered around the three problem areas: 1) interaction problems, group communications; 2) structure problems, group development; and 3) interpersonal problems, group relations.

The recommendations from this project were in concrete form. A tentative Workshop Manual for Private Duty was submitted for revision and the researchers recommended that workshops be supported by the American Nurses' Association for any state organization that wished to participate in this type of education. A sound movie was also submitted for use by the American Nurses' Association. The researchers asked for support from the American Nurses' Association to "set up a model private duty registry and

section in a selected community for study to test its components in an operational model." (21)

Summary of Literature Reviewed

For many years, private duty nursing was the largest occupational group of nurses. Nurses were either teachers in hospitals, supervisors or went into private duty.

With the social progress of the last 35 years and the great advances in medical science, not only has the patient's nursing needs changed but also nursing practice. Another aspect of the changing pattern of nursing care has been the rapid development of prepaid insurance plans. Some insurance plans include private duty nursing, however, most do not. People today expect to be adequately cared for by the hospital staff unless critically ill at which time intensive care units and private duty nurses are utilized. Patients and their families are apt to consider the private duty nurse fees high. On analysis this is not so but it is not always easy to interpret to the public.

The literature definitely reveals that the private duty nurses are becoming older, and that the younger nurses are finding other fields more attractive. However, some authors imply a continued need for private duty nurses, particularly those who acquire the competencies essential for the complexities of modern nursing.

Nurses graduating today have many occupational choices. Since most of these offer much more job security than private duty nursing, the other fields of nursing would seem to have more appeal. The younger nurse who would be interested in private duty has very little incentive to go into the field because of lack of security, no opportunity for promotion, static salary with no fringe benefits and therefore no incentive through salary increases to use and increase her competencies or to continue her education.

Few studies have been done which directly involve private duty nurses themselves as participants.

CHAPTER III

REPORT OF THE STUDY

Introduction

This study was undertaken for the purpose of identifying the characteristics of the private duty nurse in Oregon as a person. Information was sought concerning certain variables such as age, marital status, number and type of dependents, per cent of self-support and average number of days employment per month. From such data it was hoped that a profile could result. It was further proposed that information be gathered concerning the scope of the private duty practice of each participant. Information was requested concerning experience, nature of private duty nursing, particularly how cases were obtained, limitations to practice, if any, and reasons for same. The final purpose was to seek the participant's opinions regarding private duty nursing, specifically what aspects were most enjoyed and least enjoyed. Further opinions were sought regarding the future of private duty as an occupational field, how the Oregon Nurses Association assists the individual in her practice of private duty nursing and suggestions for additional assistance. The above is an elaboration of the objectives as stated in Chapter I.

The study was developed in accord with the steps outlined

in Chapter I.

The data collecting tool was designated as an opinionnaire in recognition of the high degree of subjectivity possible in some of the responses. There appeared to be ample justification for a tool of this type. According to the literature (10, 23, 60, 77), the opinions of occupational groups have merit in the pursuit of a study of the occupation.

The opinionnaire was divided into three parts, the contents of which were designed to obtain the information sought in the statement of objectives. Part I consisted of an individual history, divided into A, Personal Data, and B, Professional Information. Part II sought information concerning the scope of the participant's private duty nursing. There were inquiries into the length of experience, nature of private duty nursing, limitations to practice, if any, and reasons for same. Two items queried whether there had been cases in homes and/or nursing homes. Part III sought opinions regarding private duty nursing, the aspects most enjoyed, least enjoyed, and the future of private duty as an occupational field. There were two items regarding the Oregon Nurses Association, specifically seeking statements as to how the Association is helpful and suggestions as to how the Association can be more helpful. Under the main parts there were related sub-parts, all of which will be reported individually and in detail subsequently in this

chapter. The data collecting tool may be found in Appendix B.

Procedure

Preliminary Steps in the Procedure

A preliminary draft of the opinionnaire was formulated and reviewed by experienced professional nurses. Revisions and re-testing were continued until no further change was necessary. A pilot study was then made with a group of four private duty nurses (registered nurses) in Vancouver, Washington to determine if the opinionnaire was easily interpreted. Although two items were related to the Oregon Nurses Association, the pilot participants were instructed to respond as for Washington. No further revisions were needed. The findings of the pilot study were such that they could be categorized. No further revisions were needed. No data obtained in the pilot study were included in this final study.

From the Oregon Nurses Association, a mailing list was obtained of all private duty nurses.

The opinionnaire, including a cover letter from the investigator explaining the study and seeking collaboration was mailed to all members of the Oregon Nurses Association, Private Duty Section. The letter was countersigned by the chairman of the Oregon Nurses Association, Private Duty Section and the thesis

adviser (See sample in Appendix B). A stamped, self-addressed envelope for return was included.

Obtaining the Data

Two hundred and twenty opinionnaires were mailed to members of the Oregon Nurses Association, Private Duty Nurses Section in February, 1966. The opinionnaires were numbered 1 to 220, to correspond to a mailing list which was subsequently destroyed after the necessary per cent of returns was collected. No other means of identification of the opinionnaires was used.

There were 122 opinionnaires returned. Three had left private duty practice and returned blank opinionnaires. There remained 119 usable opinionnaires. Follow-up telephoning was attempted to secure a larger per cent of returns. There appeared to be a reluctance among some private duty nurses to participate in this type of study. Six more opinionnaires returned. The total number of usable returns was 126.

The number of usable opinionnaires was 57 per cent of the number distributed. This response was deemed large enough to provide the necessary data to conduct this study. Spohn's study in 1954 only yielded a 29% return. (67) Couey, in 1955, did a study on a 37% return from a survey of private duty nurses in Georgia. (20) Pumroy and Suttell had a 30% return in 1956, in their study

in the District of Columbia. (57)

There were private duty nurses in fifteen districts of the Oregon Nurses Association. There were no responses from two districts, but only one nurse was involved in each instance.

Table 1 has been constructed to show the state-wide distribution and return according to the districts of the Oregon Nurses Association.

Plan for Analysis

The data obtained were transferred to keysort cards from which separate tables could be constructed. Part III contained open-end responses which were tabulated and categorized by a panel of three nurses in addition to the investigator, to reduce subjectivity and to reach a degree of agreement.

The subjectivity of the responses did not yield the data to statistical analysis. Per cent and numerical distributions of data collected were used for tabulation.

Analysis of Data

Part I Individual History

Since this part of the study was primarily designed as a survey to obtain a profile of the private duty nurses in Oregon as

Table 1. Number of Opinionnaires Mailed and Number Returned by Private Duty Nurses According to Districts of the Oregon Nurses Association

District	Number of Opinion-naires Mailed	Number of Opinion-naires Returned
(1)	(2)	(3)
District #1, Portland	154	92
District #3, Salem	7	5
District #4, Medford	1	0
District #5, Eugene	25	12
District #7, Pendelton	2	2
District #8, Klamath Falls	13	4
District #9, Astoria	3	2
District #10, Coos Bay	1	1
District #11, Roseburg	1	1
District #12, Baker	1	0
District #14, Central Oregon	1	1
District #15, Hood River	1	1
District #19, Lincoln County	2	2
District #20, Malheur County	6	4
District #21, Hermiston	2	2
Total	220	129

well as their opinions regarding their nursing practice, Figures 1, 2 and 3 and Tables 2 through 4 present tabulations of such responses.

The first item under Part I, Section A, sought information regarding the age of the respondent. Spohn in 1954 found that the average age of the private duty nurses was 45 years. (67) Suttell and Pumroy, in 1956 found the median age of private duty nurses in the District of Columbia was 47 years. (57) Hughes, in 1958 stated the median age of the American Nurses in general was 35. (38) The American Nurses' Association survey in 1962 showed the median age of private duty nurses as 52.2 years. (55) The 1965 Facts About Nursing revealed that 50.7 % of nurses in the forty or over age group; this included three per cent which did not report their age. (6) However there were only 24.8 % in the fifty years or over age group.

In comparison to the literature, it appears that the private duty nurses participating in the Oregon study are older than the respondents of the reported studies.

Figure 1 shows the age distribution of the 126 participants of the Oregon study with the per cent of each age group.

The next item under Part I, Section A, sought information regarding the marital status of the Oregon private duty nurses. The number of single nurses was 14%, 60% of the nurses were

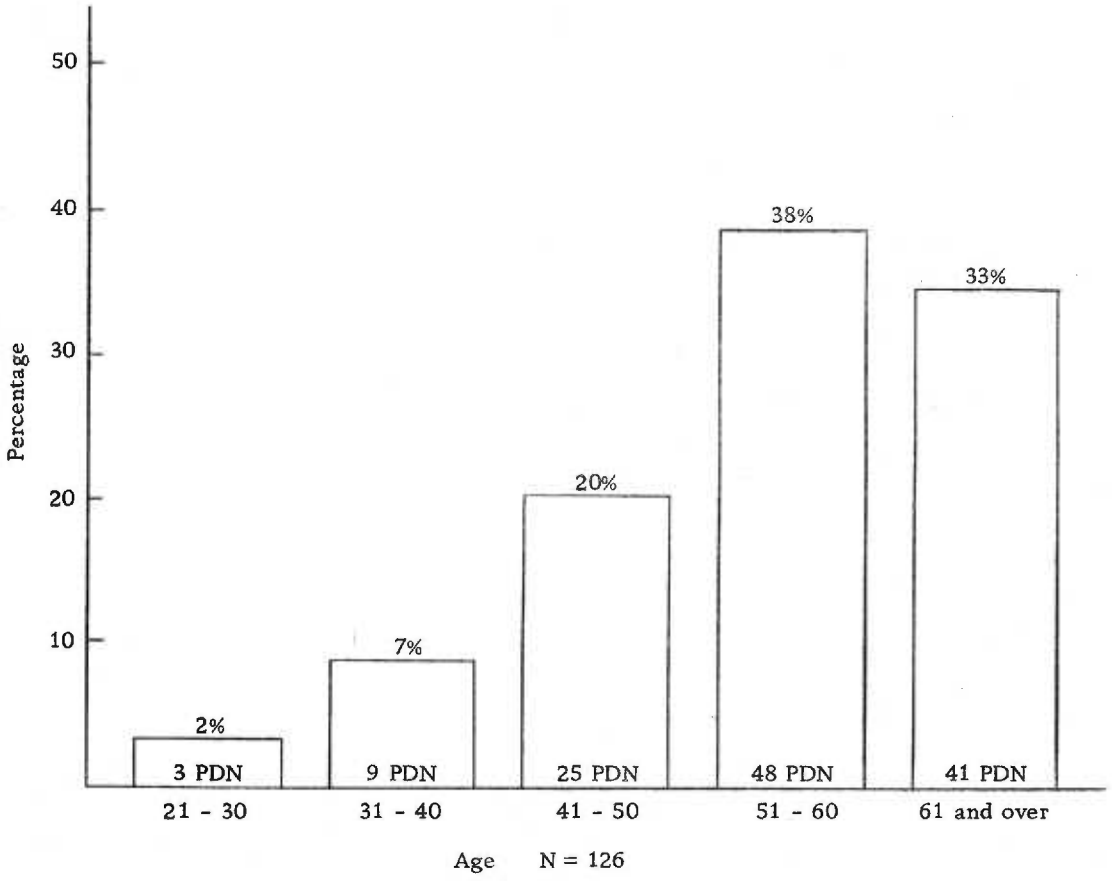

Figure 1. Distribution of 126 Private Duty Nurse Respondents by Age Group and Percentage in Each Group

married and 11% were widowed, 15% were divorced or separated.

The ANA Facts About Nursing for 1965 printed statistics concerning the marital status of the American private duty nurse. (6) It was reported that 19.4 % of the nurses were single, 60.6% were married, 10.5% were widowed, and 5.9% were divorced or separated, 3.6% did not answer the question.

The findings of this study vary somewhat from those reported above. The frequency distribution according to marital status has been shown in Table 2.

Table 2. Frequency Distribution by Number and Per Cent of 126 Private Duty Nurses According to Marital Status

	Frequency Distribution	
	Number	Percent
(1)	(2)	(3)
Single	18	14
Married	77	60
Widowed	12	11
Divorced or Separated	19	15
Total	126	100

The third item of Part I Section A, sought information regarding the number and type of dependents of the participants.

Fifty-five private duty nurses indicated that they had dependents in one or more of the following categories: children, parents, siblings, or others. One nurse responded that she did "animal welfare work," several said they had relatives which included a "blind brother," mother or a spouse, and one replied that she had the "support of the entire family." Seventy-one nurses did not respond to this question. It is not known whether this means they had no dependents of if the opinionnaire did not provide space for appropriate recording. The findings are shown in Table 3.

Table 3. Type and Number of Dependents of 126 Private Duty Nurses

Type of Dependent	Number
(1)	(2)
Children	35
Parents	6
Siblings	3
Others	4
Multiple Responses	7
No Response	71
Total	126

Item 4 under personal data sought information regarding the per cent of self support. This item was completed by 118 participants, however one response was discarded as the respondent gave more than one answer. One respondent replied that she only "worked to pay Dr. bills, buy, clothes, and things besides the necessities we couldn't afford otherwise."

This data revealed that 45% of the respondents indicated they were responsible for 75-100% of their income.

Figure 2 shows these findings.

The fifth item under Part I was concerned with the average number of days per month the respondents worked. Three did not answer the item; 89 people stated that they worked 10 or more days a month or a total of 80 or more hours a month.

Oregon's private duty nurses worked a similar pattern as reported in the studies of Moses (44) and Spohn (67). Among the Oregon nurses, 38 per cent worked 20 or more days per month; 32 per cent between ten and nineteen days; 27 per cent, less than ten days; the remainder did not respond to the item.

Figure 3 gives the number of days per month worked.

Table 4 shows a comparison made of the average number of days worked by the nurses with dependents and those without dependents. It was found that the only place where there was any noteworthy difference was among those without dependents who

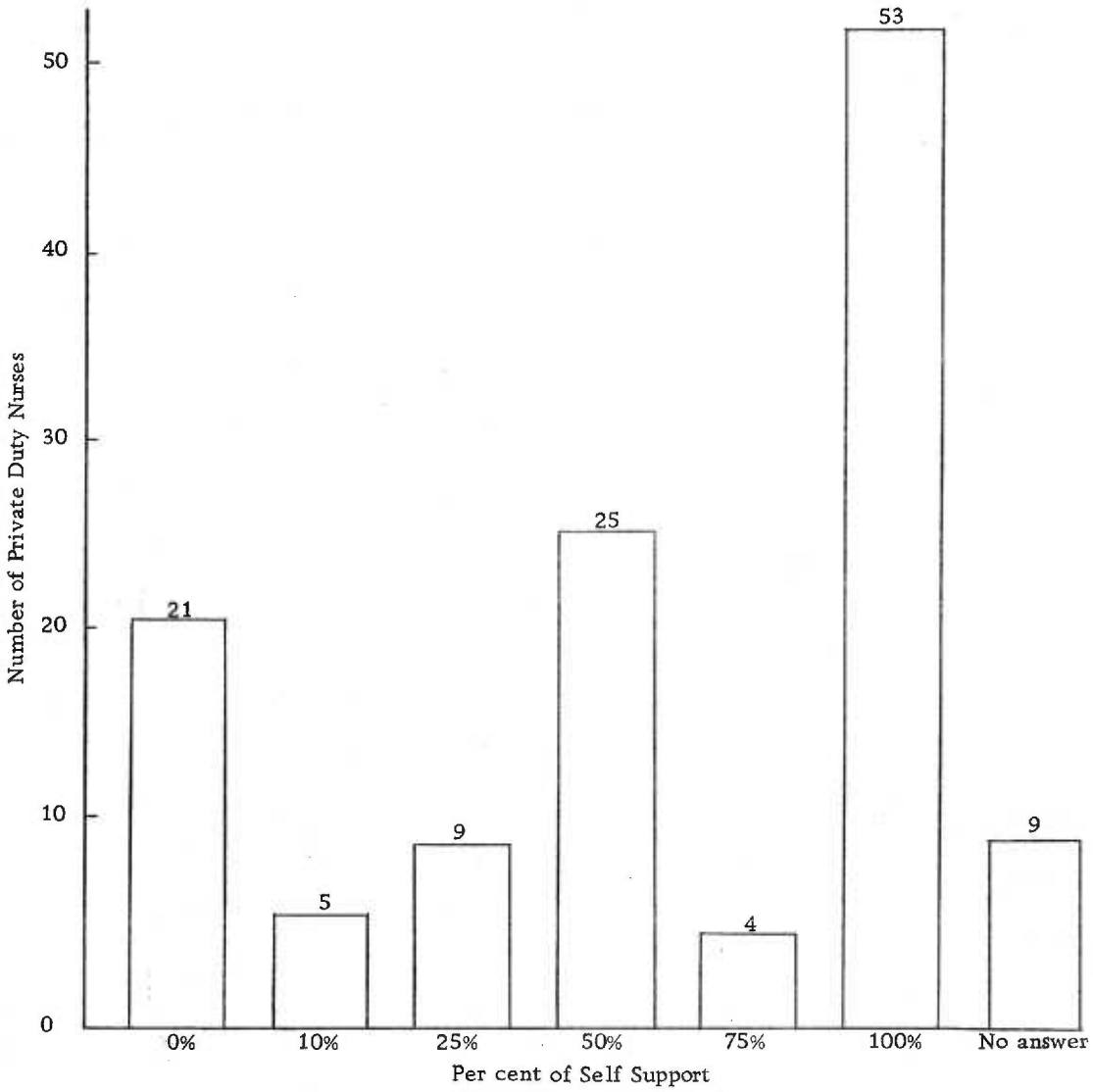

Figure 2. Responses of 126 Private Duty Nurses Regarding Per cent of Self-Support

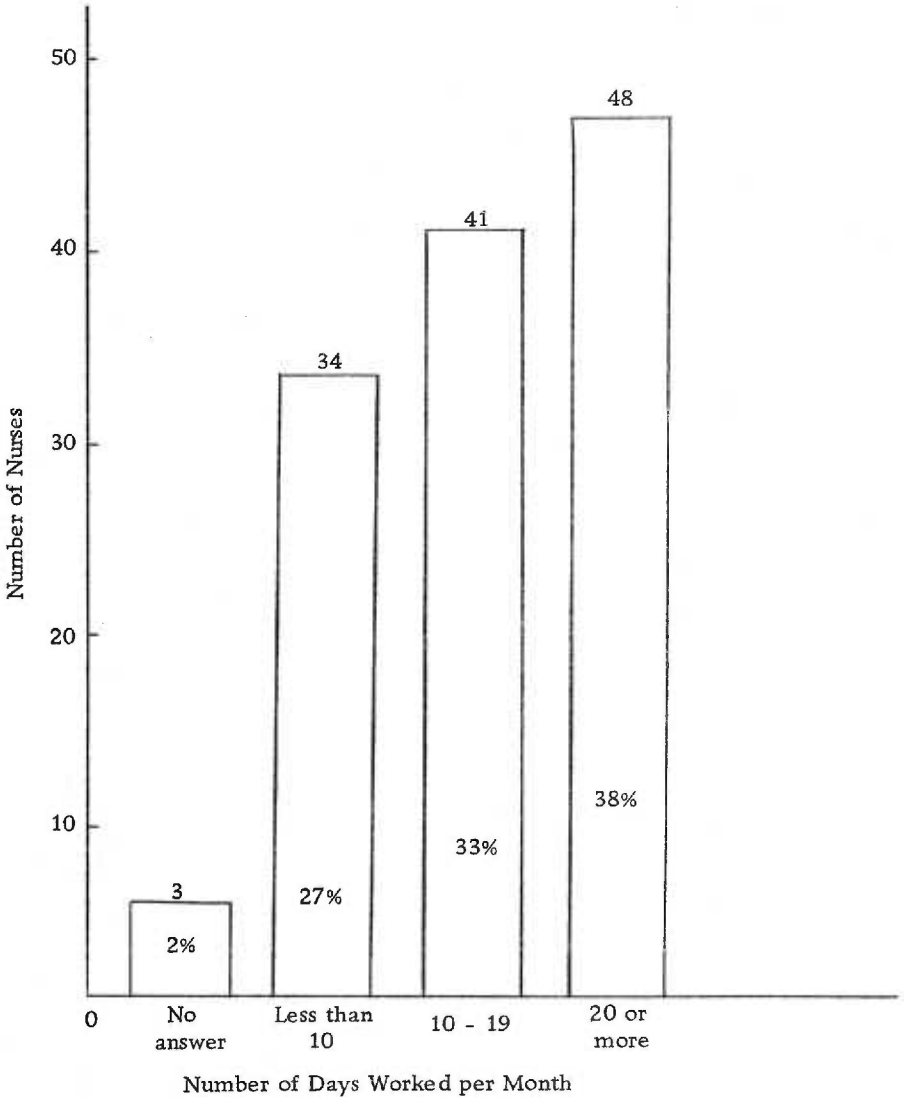

Figure 3. Percentage Distribution of the Number of Days Worked per Month by 126 Private Duty Nurses

were employed twenty or more days a month. For 75 respondents there seemed to be no difference in the amount of time worked, regardless of presence or absence of dependents.

Table 4. Comparison of the Number of Days Worked per Month by 55 Private Duty Nurses with Dependents and 71 Private Duty Nurses without Dependents

Number of Days Worked per Month	Distribution of Responses		
	With Dependents N = 55	Without Dependents N = 71	Total
(1)	(2)	(3)	(4)
Less than 10	17	17	34
10 - 19	20	21	41
20 or more	18	30	48
No Response		3	3
Total	55	71	126

Part I, Section B, item 1 sought information concerning the basic nursing preparation of the private duty nurse. The Surgeon General's report in 1962 revealed that "only 10% of all employed professional nurses held college degrees. (69) Diplomas or associate degrees were held by 90% of the nation's nurses; 7.9% held baccalaureate degrees; and 2.1% held a masters or higher degree."

Table 5 shows that 90% of the respondents in this study have a Diploma; 7% gave a Baccalaureate degree; and 3% gave no response.

Table 5. Basic Nursing Preparation of 126 Private Duty Nurses in Oregon

Basic Nursing Preparation	Distribution of Responses
(1)	(2)
Associate Degree	0
Hospital Diploma	113
Baccalaureate Degree	9
Masters Degree	0
No Response	4
Total	126

Another part of this item requested the year of graduation from the basic nursing program. It was found that the majority had been graduated between the years 1920-1939; the median year was 1932. The breakdown of responses showed that the three greatest responses were for those who were graduated between 1920-1949. The numbers were 42 between 1920-1929, 42 between 1930-1939, 28 between 1940-1949. Perhaps the most significant finding was that only two had been graduated in the past six years. Any occupational group that does not include as many young members

as those nearing retirement is not likely to be self-perpetuating.

Table 6 has been constructed to show the data concerning the year of graduation and the number in each group.

Table 6. Distribution of 126 Private Duty Nurses According to Year of Graduation from Basic Nursing Preparation

Categories of Years of Graduation	Frequency of Response
(1)	(2)
1916 - 1920	3
1920 - 1929	42
1930 - 1939	42
1940 - 1949	28
1950 - 1959	5
1960 - 1964	2
No Answer	4
Total	126

Item 2 under Section B sought information concerning study beyond the basic nursing program. It was learned that seven diploma school graduates had earned a baccalaureate degree. Forty-four other diploma nurses indicated further study by such comments as:

> "Psychology-Portland State-Principles of Teaching- U. of O. School of Nursing"

"Journal of Nursing and attend lectures-conventions and private duty educational meetings"

"O.R., Recovery Rm. and Central Supply"

"2 years college (Normal School graduate) before taking nurses course."

"Graduated from Mental Hospital in Brendeon, Man. Canada 1925"

"6 months post graduate at City and County Hospital Denver, Colorado"

"1 year-Obstetrics, including a course of Midwifery with Frontier Nursing Service, Wendover, Kentucky"

"Preventative Medicine"

"At University of Oregon. Had to quit because of illness in home"

"Post graduate-Womans Hospital in surgicial and Obstetrics in New York City 1916. Public Health Study, Henry St. Settlement, N.Y.C. Study arranged by Miss Lillian D. Wald. School Maternity Center etc. Dramatic Art-Ballard School of expression. Music-N.Y. College of music."

"Isolation affiliated with my hospital-Galt Hospital, Lethridge Alberta Canada"

"Head nurse, Ward Adm., R.C. classes. Take in all workshops."

"Short courses and institutes only."

"3 1/2 yrs. college after High School"

"Yearly seminars thru O.N.A."

"Short Public Health course at U. of O."

"Neurosurgery-John Hopkins Hosp.-Dr. Dandy-Psychiatric nursing-Friend's Hosp; Frankford, Penn."

"1 year at University of Washington"

"Post-graduate work in Pediatric and Contagious at Cook Co. Hospital, Chicago, Ill. (6 months)"

"Anesthesia"

"Attend workshops, special heart et cancer conventions and all inservice meetings that are made available to P.D. nurses"

"2 years Pre-Nursing (College course)"

"Six months surgery-1938"

"Dietetics at Standard-surgical nursing at Stanford and University of Calif."

"3 mo. Obstetrical Nursing"

"Junior Certificate and credits from O.S.U. --3 years college"

"A few scattered courses at the extension. I feel that consecutive years (many) in a teaching institution is additional study."

"U.O. extension courses in Psychology and Sociology"

"Try to attend any inservice programs given at hospital and special educational meetings given thru O.N.A."

"Post graduate work-anesthetics. Post graduate work-obstetrics and gynecology."

"3 yr. nursing affiliated with School of Liberal Arts, School of Medicine. 1 yr. University Study. 2 Refresher courses."

"Approximately 2 yrs. college from time to time. Two post graduate courses following graduation."

Five of the Baccalaureate group had stated further education by such comments as:

"1 year toward Masters in General Studies"

"course--3 months at Lying In Hospital, Chicago 1931 - Anesthesia 1 yr. University of Oregon Hospitals and Clinic 1943"

"Anesthesia, Lab, X-ray"

"Education and public health nursing"

"5 yr. course (60 months) included 12 months-public health nursing field work"

The responses of fifty-one hospital diploma nurses concerning additional education have been classified as shown in Table 7.

This completes the information sought in Part I. One of the purposes of this study was to develop a profile of the private duty nurse in Oregon. From the findings of Part I, it would appear that:

a. 91 per cent are above forty years of age, with 81 per cent above fifty years;

b. 86 per cent either are or have been married;

c. over half claimed no dependents;

d. 42 per cent said they were 100 per cent self-supporting, but one fifth said they did not support themselves at all;

e. only 38 per cent work an average of twenty or more days a month; more than one fourth work less than ten

Table 7. Distribution of Responses of 51 Hospital Diploma Graduates Concerning Additional Study

Additional Study	Frequency of Response
(1)	(2)
College Courses	
a) Prior to Nursing	5
b) After Nursing Program	11
c) Baccaulaureate Degree	7
Refresher Courses, Institutes	5
Public Health Nursing	3
Post Graduate Work	
a) Obstetrics	3
b) Anesthesia	3
c) Surgery, Recovery Rm.	2
d) X-ray, Lab	2
e) Dietetics	1
Miscellaneous	9
Total	51

days a month;

f. the presence or absence of dependents makes little difference in the amount of time worked with the exception of those without dependents who work 20 or more days each month;

g. the basic nursing preparation was obtained in a hospital diploma school with few exceptions;

h. the median year of graduation was 1932;

i. only two had been graduated since 1960; and

j. less than half of the diploma school graduates indicated additional study since completion of the basic nursing program.

Statements concerning the significance of the above will be included in the conclusions listed in Chapter IV.

Part II Scope of Private Duty Nursing

This part of the opinionnaire sought the number of years the private duty nurse had practiced nursing and the number of years that had been spent in private duty nursing.

Eight nurses practiced nursing less than 10 years; 27 between 10-20 years; 41 between 21-30 years; and 50 in more than 30 years. The amount of time actually spent in private duty nursing was 30 in the less than 10 year group; 45 in the 10-20 year

group; 29 in the 21-30 year group; and 22 in the more than 30 year group.

The data depicting the number of years of nursing practice and the number of years in private duty nursing are shown in Figure 4.

The first item under Part II, Section B sought information concerning how private duty cases were obtained.

The only professional registry in Oregon is located in District I, Portland. This was reflected in the responses given to item 1.

Sixty-eight nurses answered in more than one category such as the responses from three nurses who said that they occasionally had "patient's requests," one who said a "nurse's referral" and one who replied "friends of the family requested me." Five gave no responses.

The data from this item have been depicted in Table 8. As explained above, sixty-eight responded for more than one source, hence the number of responses exceeds the number of respondents.

Item 2 sought information relative to the limitation of practice to cases accepted, not accepted and reasons for same. It was found that over two-thirds stated limitations and an additional eleven per cent limited their practice but gave no reason for such. Only 17 per cent accepted all cases. Six participants did not

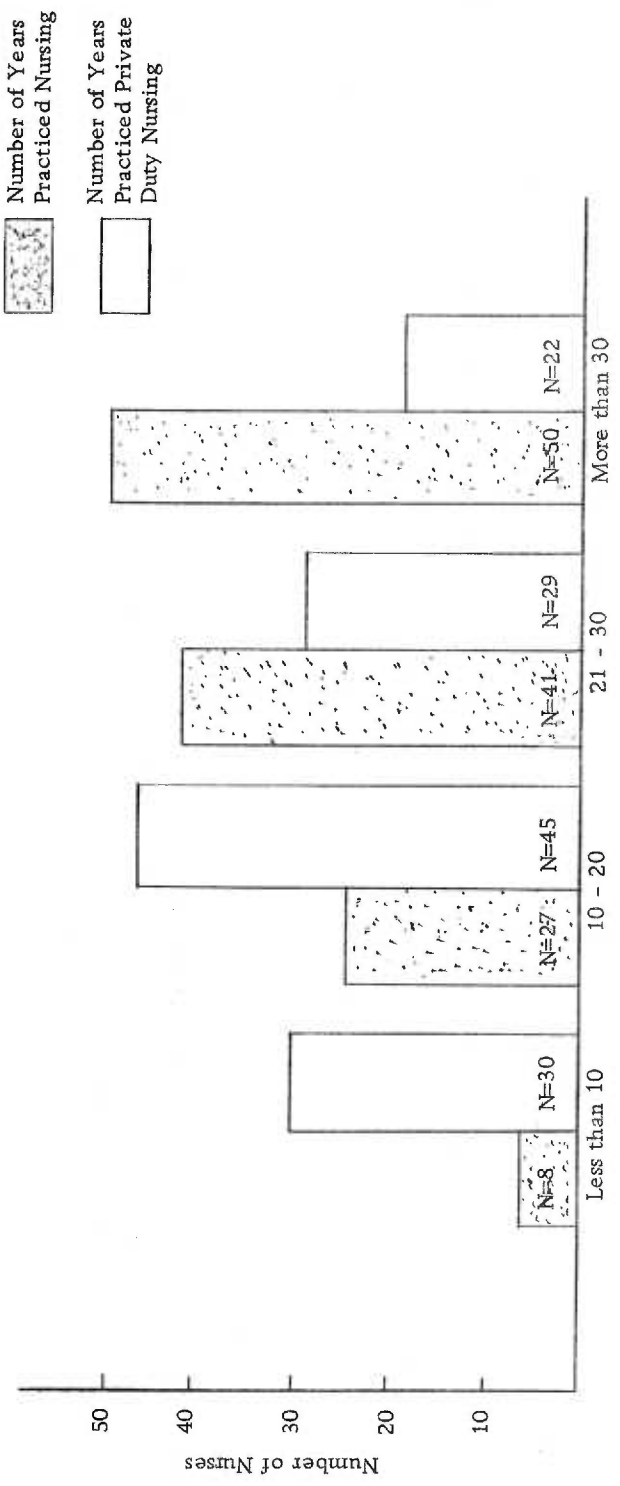

Figure 4. Distribution of Number of Years Spent in the Practice of Nursing and Number of Years Spent in the Practice of Private Duty as Stated by 126 Private Duty Nurses

respond. For purposes of tabulation the data were rank ordered according to numerical occurance. The data from this item have been shown in Table 9, p. 68.

Table 8. Responses of 126 Private Duty Nurses as to Source of Case Referrals

Source of Case Referrals	Distribution of Responses
(1)	(2)
Professional Registry	38
Commercial Registry	9
Hospital Registry	5
Doctor's Referral	3
Others	3
Multiple Answers	68
Total	126

Additional information was obtained in this item. The participants listed the type of cases they would or would not accept. As indicated above, 22 would accept any case, but others seem to limit their practice to one or more clinical areas. It would take further study to determine the reasons for many of the limitations because there were numerous responses giving "personal" as the basis for the limitation. Such explanation is simply impossible to interpret.

Six participants did not respond. The largest number, 35,

accepted medical-surgical cases. Many of the other listings could be classified as medical-surgical, hence it appears that most of private duty nursing is in that field.

Table 9. Number and Per cent of Responses of 126 Private Duty Nurses Relative to Acceptance or Limitation of Cases for Nursing Practice

Acceptance or Limitation of Cases	Responses	
	Number	Per cent
(1)	(2)	(3)
Had Limitations (gave reasons)	84	67
Accepts all Cases	22	17
Had Limitations (gave no reasons)	14	11
No Answer	6	5
Total	126	100

Table 10 has been devised to show the rank order listings of cases accepted as reported by the participants of this study.

A column was likewise provided for listing the cases not accepted. The largest numbers of cases not accepted were "isolation," "open heart," "Pediatrics," "Psychiatric," and "Alcoholics, Drug Addicts." A number of the participants furnished more than one comment hence the totals shown in Table 11

regarding cases not accepted by 98 private duty nurses exceeds the number of respondents. For purposes of tabulation data was rank ordered according to numerical occurance. (See Table 11, p. 70)

Table 10. Numerical Distribution of Types of Cases Accepted by 126 Private Duty Nurses

Cases Accepted	Number of Responses
(1)	(2)
Medical - Surgical	35
Any Case (No Limitation)	22
Orthopedic	10
Pediatrics	9
All surgical	6
Chest (Including Heart)	6
Open Heart	5
Psychiatric	5
Accidents	3
Alcoholics	3
GYN	3
Neuro surgery	3
Obstetrics (No Calls)	2
Suicide	2
Urology	2
E.N.T.	1
Miscellaneous	3
No Response	6
Total	126

Table 11. Numerical Distribution of Types of Cases Not Accepted by 98 Private Duty Nurses

Cases Not Accepted	Number of Responses
(1)	(2)
Heart - Chest	
(a) Open heart	26
(b) Heart	11
(c) Chest-Lung	12
Isolation	38
Alcoholics, Drug Addicts	15
Pediatrics	15
Psychiatric	15
Orthopedics	8
Obstetrics	7
Miscellaneous	6
Long Term - Chronic	4
Neurologic	4
Burns	3
Medical	1
No Response	14
Total	179

Information regarding the reasons for limitations is shown in the next table. It will be noted that no one gave reasons that would lead to the impression that the individual had reached such a point of expertness in some clinical field that inevitably her

practice would be confined to that field. Although 98 participants stated limitation to their practice, only 84 gave reasons for such limitation. Sample responses to this item may be found in Appendix D[1].

See Table 12 for the distribution of responses in rank order according to numerical occurance.

Table 12. Number and Per cent of Reasons for Limitation of Cases for Nursing Practice as Given by 84 Private Duty Nurses

Reason for Limitation	Frequency of Response	
	Number	Per cent
(1)	(2)	(3)
Lack of knowledge	32	39
Personal	24	29
Health	19	23
Children and family (in reference to isolation-staph)	7	8
Length of case	2	1
Total	84	100

Item three under Part II was concerned with the limitation of shifts. There were 102 who answered that they limited their shifts. It was not known which shift was prefered.

Table 13 shows the number of nurses who limit their

nursing practice to specific shifts and those who do not.

Table 13. Number and Per cent of 126 Private Duty Nurses Regarding Limiting Their Nursing Practice to Specific Shifts

Answer	Responses	
	Number	Per cent
(1)	(2)	(3)
Yes (I limit)	102	81
No (I do not limit)	21	17
No response	3	2
Total	126	100

This item also sought information regarding the reasons for the limitations. Since the majority are married, it is not surprising to find that household duties and family obligations constitute 53 per cent of the reasons. It should be recalled, however that over 80 per cent of the respondents were in the plus fifty year group and hence not likely to have small children as the reason for limitation. A classification of the reasons given are shown in Table 14. These data are depicted in rank order. Sample responses to this item may be found in Appendix D[2].

The next item had to do with the limitation of practice to specific hospitals. One did not reply. It was found that 59 per cent

do limit their practice to specific hospitals. It is possible that in many districts this response would have no significance. If there are only a few hospitals within commuting distance, the limitation is imposed on the nurse rather than by her. The data from this item are shown on Table 15.

Table 14. Number and Per cent of Responses of 102 Private Duty Nurses Regarding Reasons for Limiting Their Practice to Specific Shifts

Reasons for limitation	Responses	
	Number	Per cent
(1)	(2)	(3)
Household Duties and Family Obligations	54	53
Personal Reasons	23	22
Sleep Pattern	12	12
Health	9	9
Available Transportation	4	4
Total	102	100

The 74 who stated that they limited their practice to certain hospitals, listed reasons (in rank order) as shown on Table 16. Sample responses to this item may be seen in Appendix D[3].

Table 15. Number and Per cent of Responses of 126 Private Duty Nurses Concerning the Limitation of Their Nursing Practice to Specific Hospitals

Limitation to Specific Hospital	Responses	
	Number	Per cent
(1)	(2)	(3)
Yes (I limit)	74	59
No (I do not limit)	51	40
No response	1	1
Total	126	100

Table 16. Number and Per cent of Responses of 74 Private Duty Nurses Relating to Reasons for Limiting Their Practice to Specific Hospitals

Reasons for Limitation	Responses	
	Number	Per cent
(1)	(2)	(3)
Transportation Problem	25	34
Distance to Travel	17	23
Personal Preference	12	16
Limitation of Available Hospital	5	7
Parking difficulties	5	7
Work in Familiar Surroundings	5	7
Limitation of Own Skill	2	3
Miscellaneous	2	3
No Answer	1	0
Total	74	100

The last two items in Part II were related to having had private home and nursing home cases in the past year. Burgess, in 1920, stated that most of the private duty was done in the homes. (16) In Oregon it was found that 47% of the private duty nurses had had home cases and 31% had had nursing home cases in the past year. The findings of these two items can be seen in Tables 17-18.

Table 17. Number and Per cent of Responses of 126 Private Duty Nurses Concerning Whether or Not They Had Had Home Cases in 1965

Home Cases	Responses	
	Number	Per cent
(1)	(2)	(3)
Yes (had home cases)	59	47
No (did not have home cases)	66	53
No response	1	0
Total	126	100

This terminates Part II. A few comments can be added to those compiled at the end of Part I. Regarding private duty nursing in Oregon, it was found that:

a. 91 had practiced nursing more than twenty years with 50 of this number in practice for more than thirty years;

b. 96 had functioned as private duty nurses more than ten years, and of this number, 22 have been private duty nurses more than thirty years;

c. cases are largely obtained through a professional registry, hospital registry, or by doctor's referral;

d. 67 per cent place limitations on the type of cases they accept; another 11 per cent likewise limit but gave no reasons for such limitations;

e. 81 per cent place limitations that limit their practice to specific shifts;

f. 59 per cent limit their practice to specific hospitals;

g. 47 per cent have had home cases in this past year; and

h. 31 per cent have had nursing home cases in this past year.

The conclusions in Chapter IV will refer back to the above comments.

Table 18. Number and Per cent of Responses of 126 Private Duty Nurses Concerning Whether or Not They Had Had Nursing Home Cases in 1965

Nursing Home Cases	Responses	
	Number	Per cent
(1)	(2)	(3)
Yes (had nursing home cases)	39	31
No (did not have nursing home cases)	82	65
No Response	5	4
Total	126	100

Part III Your Opinions Regarding Private Duty Nursing

Part III sought the participants' opinions regarding private duty nursing. This part consists entirely of open end question.

The literature has reported numerous reasons why it is important for the population of any occupational group to identify their job satisfactions and dissatisfactions. Reference could be made to Neumiller's study in which staff nurses reported on their satisfactions as being related to performing direct patient care, good interpersonal relations, and achieving professional goals. (45) It will be noted that the private duty nurse respondents of this study made similar comments. The majority of their comments had to do with their involvement in nursing, rather than to personnel policies that were to their advantage. To illustrate there are 88 comments regarding direct patient care and only three in reference to salary.

Because of the nature of open-end responses, three experienced nurses plus the investigator reviewed all responses to the items in Part III and categorized them for the sake of tabulation. Sample responses to the first item may be found in Appendix E.

Many of the respondents provided comments that fitted several categories, hence the number of responses in Table 19 exceeds the number of respondents. Data were ranked according

to numerical occurance.

Table 19. Categorized Responses of 126 Private Duty Nurses Concerning Aspects of Private Duty Nursing They Enjoyed Most

Category of Response	Number of Responses
(1)	(2)
Total Nursing Care	48
One-to-One Relationship with Patient	40
Personal Satisfaction	31
Challenging Work	23
Flexible Schedule	20
Variety in Work (Techniques and Procedures)	17
Meet Interesting People	13
Other	12
Opportunity to Make Independent Judgments	11
Enjoy Private Duty	5
Good Salary	3
No Response	16
Total	239

It is of equal importance to ascertain what aspects of private duty nursing are enjoyed the least. Nineteen made no response. The majority of responses were in reference to the collection of fees, fatigue from long cases, non-nursing duties, patient's family interference, and waiting for cases. The negative attitudes of doctors, hospitals (no explanation was offered to identify who or what was the

source of the negative attitude) the general duty staff, and other private duty nurses, was cited in twenty-eight instances. Similar comments in the literature reveal the same sources of job dissatisfaction. (20, 21, 57)

As for the previous item, there were respondents who made comments that fit several categories, hence the listing for Table 20 will show more rank ordered responses than respondents. Sample comments are found in Appendix F.

In an occupational field that has the bulk of its population past middle life and a sizeable per cent approaching retirement, it is crucial to seek opinions concerning the future of the field. Rogers in her book, Educational Revolution in Nursing said,

> All nurses are entitled to the pride and satisfaction that comes with recognized achievement. Each person's contribution to health services is significant and meaningful. Only as expectations of performance are revised to be consistent with each nurse's preparation and ability can opportunities for achieving excellence become realistic. (61)

The responses of this study indicated that 42 per cent of the respondents had stated that they could forsee an "apparent future need" for private duty nurses, 36 per cent thought the future was questionable. Twelve nurses commented that the field is being preempted by intensive care units and by licensed practical nurses. Five nurses did not respond. Sample comments for this item may be found in Appendix G. The categorized responses are shown in

Table 21.

Table 20. Categorized Responses of 107 Private Duty Nurses Concerning Aspects of Private Duty Nursing They Enjoyed Least

Selected Category of Response	Number
(1)	(2)
Economic and General Welfare	
a) Collection of Fees	36
b) Lack of Fringe Benefits	18
Fatigue of Long Cases Without Relief	29
Negative Attitudes	
a) Doctors and Hospitals	17
b) General Duty Staff	7
c) Other Private Duty Nurses	4
Non-nursing Duties (Babysitting)	24
No response	19
Waiting for Cases	13
Patient's Family Interference	10
Eliciting Staff Assistance	9
Other responses	9
Professional Loneliness	9
LPN co-workers	6
Dislike of Emergency Calls	5
Total	215

"In what ways does the Oregon Nurses Association help you in your practice as a private duty nurse?" was the fourth open-end

question in Part III.

Table 21. Number and Per cent of Categorized Responses of 126 Private Duty Nurses Concerning the Future of Private Duty Nursing

Category of Response	Response	
	Number	Per cent
(1)	(2)	(3)
See Apparent Future Need	53	42
Future Questionable	45	36
Pre-empted by ICU and LPN	12	9
Apparent Need for Specialization	11	9
No Answer	5	4
Total	126	100

In the March 1949 issue of the American Journal of Nursing appeared an editorial which stated some of the findings of an ANA survey concerning the professional organization. (46) Respondents were asked what major functions performed by national association did they consider "really important." Their answers revealed that "a. setting and maintaining professional standards of nursing service, b. improving working conditions, c. working for better wages, and d. setting and maintaining professional standards of nursing

education" were the important functions. These were stated in rank order of importance.

"Educational opportunities," "fee regulation," and "legislation and negotiations" received the majority of comments. It should be noted that in response to how the Oregon Nurses Association helps, three said Oregon Nurses Association did not help. This paradoxical comment does not lend itself to interpretation. It should be recalled at this point that all participants in this study were members of the Oregon Nurses Association.

Sample comments made for this item may be found in Appendix H.

The categorized responses to this item are depicted in Table 22. The data were placed in rank order according to numerical occurance.

The next item sought suggestions of additional ways whereby the Oregon Nurses Association could be helpful to the private duty nurse. Seventy persons offered no response which meant that the suggestions were made by 56 nurses. Sample comments may be found in Appendix I.

In the categorized responses, it may be noted that the largest number requested more educational opportunities. In view of the small number who had had additional education following the completion of the basic nursing program, the request for more

educational opportunities should not be disregarded. Other categories of size consisted of suggestions such as insurance to pay wages, recruitment of nurses (it is not known if this is in reference to recruitment of private duty nurses), improved public relations, and reclassification of private duty nurses.

Table 22. Responses of 126 Private Duty Nurses Regarding Ways that the Oregon Nurses Association Helps in Private Duty Nursing Practice

Category of Response	Number
(1)	(2)
Educational Opportunities	24
Fee Regulation	21
Legislation and Negotiations	10
Professional Support	10
Standards and Qualifications	10
Professional Registry	9
Liability Insurance	8
Collection of Fees	6
Legal Advice	5
Other	5
Shorten Work Hours	5
Public Relations	4
No Response	4
O.N.A. Does Not Help	3
Professional Biography	2
Total	126

In common with the other open-end questions there were respondents who made comments that fit several categories.

Accordingly Table 23 which lists the suggestions (in rank order) contains more responses than respondents.

Table 23. Categorized Responses of 126 Private Duty Nurses Regarding Ways that Oregon Nurses Association Could Be Helpful in Their Practice

Categories of Suggestions	Responses
(1)	(2)
No Response	70
Improved Public Relations	
a) With Hospitals and Doctors	12
b) With General Duty Nurses	8
c) With General Public	6
More Educational Opportunities	21
Insurance Pay Wages	17
Recruitment of Nurses	16
Reclassification of Private Duty Nurses	11
Registry Through Hospital	9
Negotiations and Collection of Fees	7
More Research	7
Total	184

Space was left for additional comments. These may be found in Appendix J.

These comments were of such a miscellaneous nature as to be impossible to categorize or else they overlap with previous

tabulations. Accordingly no Table has been prepared for this information. The comments are amazingly revealing, often reflecting strong feelings. It is beyond the scope of this study to determine how situations described in the comments should be investigated. Recommendations will be made in Chapter IV.

This completes the report on the findings of the study. The next chapter will consist of a summary, conclusions based on the findings and recommendations for further study.

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS FOR FURTHER STUDIES

Summary

This study was undertaken for the purpose of: 1) identifying the characteristics of the private duty nurse in Oregon; 2) gathering information from private duty nurses concerning the scope of their practice, including an identification of limitations, if any and reasons for same; 3) seeking comments from private duty nurses concerning what aspects were most enjoyed and least enjoyed; 4) obtaining opinions concerning the future of private duty as an occupational field; and 5) eliciting statements of ways whereby private duty nurses are helped by the Oregon Nurses Association and suggestions regarding ways whereby the Association can be of further assistance.

Data were collected by a mailed opinionnaire sent to all members of the Private Duty Section of the Oregon Nurses Association. There were 126 usable returns which constituted 57% of the eligible participants. This exceeds the per cent of responses in any previous study of Private Duty Nurses reported in the literature.

Parts I and II of the opinionnaire sought information regarding the characteristics of the nurse and the scope of her practice. Details may be found in Chapter III. The summarized findings were

that the private duty nurse in Oregon is apt to be more than fifty years of age, probably now married, or has been, possibly without dependents, at least partially self-supporting, employed less than twenty days a month, a graduate of a diploma school of nursing in about 1932, with little, if any, education beyond the basic nursing course. It was further learned that private duty nurses had practiced nursing between 20 - 30 or more years and that they had functioned as private duty nurses most of that time. Their cases were largely obtained through an official registry. Nearly 80 per cent place some limitations on their practice, either in the type of cases accepted or rejected, or the specific shift during which they will work or the specific hospital in which they will function. Less than 50 per cent of the participants had had home cases in the past year and less than one third had had cases in nursing homes.

Part III elicited information regarding Private Duty nursing. The greatest number of comments regarding aspects of Private Duty most of them enjoyed were concerned with patient care. The comments regarding aspects least liked focused heavily on the collection of fees, fatigue, non-nursing duties, lack of fringe benefits, and waiting for cases. Over half of the participants were of the opinion that there was a future need for private duty nurses, but over one-third thought the future was questionable. The respondents indicated that the Oregon Nurses Association was helpful, mainly because of

the educational opportunities, fee regulation, professional support, standards and qualifications, legislation and negotiation. Additional assistance from Oregon Nurses Association was desired mainly in terms of more educational opportunities, insurance to pay wages, reclassification of private duty nurses, and improved public relations.

Additional comments were largely related to personnel policies and interpersonnel relations.

Conclusions

From the findings of this study, no extensive generalizations can be made. It is not known if the data received are as representative of the 41 per cent of the Oregon Nurses Association, Private Duty Section who did not respond as the 57 per cent who did participate. Neither is it known if those private duty nurses who are not members of the Oregon Nurses Association would have responded in such fashion as to change the data. The conclusions are accordingly based on responses derived from 126 participants.

1. The majority of the private duty nurses are in middle life with a sizeable number approaching retirement age. The number in the younger age brackets is not sufficient to insure that private duty nursing will be self-perpetuating.

2. Over four-fifths either are or have been married. This may account for the fact that only 42 per cent stated they were 100 per cent self-supporting.
3. Private duty nurses have assumed little individual initiative for up-grading themselves. The median year of graduation was 1932; the range was 1916-1964. A small number had obtained education beyond the basic nursing program.
4. About four-fifths of the nurses place limitations of some type on their practice. The rationale is difficult to interpret, particularly those reasons related to children given by respondents who graduated thirty years ago. It should be recognized that some limitation of place of employment is inevitable in the smaller communities where there may be only one hospital.
5. The comments relative to the most enjoyable aspects of private duty nursing reflected interest in the welfare of the sick; the comments regarding the least enjoyable aspects were related to employment practices.
6. The future of private duty nursing seemed questionable to about one-third of the respondents. More than half could foresee an apparent need but made no suggestions for ways to resolve the present dilemma of all too few

young nurses to replace those approaching retirement. The rationale of the comments seemed unrelated to the reports in the literature. To illustrate, such reasons for the decline in private duty nursing as "the advent of intensive care units," "licensed practical nurses doing private duty," and other such statements do not fully explain why the number of private duty nurses decreased long before intensive care units were developed or licensed practical nurses entered private duty nursing.

7. The participants appeared to recognize the advantages of membership in the Oregon Nurses Association. Their statements regarding the ways the Oregon Nurses Association had been helpful were related to the programs of the association.

8. The suggestions for additional assistance by Oregon Nurses Association seemed to be related to personnel policies rather than nursing practice with the exception of the requests for more educational opportunities. It is not known to what extent educational opportunities are available in communities where private duty nurses reside, nor how much these opportunities are utilized. From the comments, it would appear that the respondents look to the Oregon Nurses Association for making

"educational opportunities" available.

Recommendations for Further Studies

In view of the findings of this study it is recommended that:

1. Since only those nurses with no dependents worked enough days each month to equate to full-time employment, a study should be done to determine if this situation is due to lack of opportunity, choice, or to self-imposed limitations to the nurses' practice. In view of the number of unfilled calls for private duty nurses, it is important to determine if all able nurses are being employed to the optimum of their capacity.
2. In view of the paucity of education beyond the basic nursing preparation, the private duty nurses' request for more educational opportunities must not be ignored. It is accordingly recommended that studies be undertaken to ascertain the nature and scope of education to which the respondents made reference. These studies become of utmost importance in view of the many comments made by the respondents relative to self-imposed limitations placed on practice because they did not feel qualified to give the needed care. The availability of educational resources should also be investigated.

3. The participants verbalized freely concerning the least enjoyable aspects of private duty nursing, particularly the collection of fees. It is recommended that the private duty nurses undertake a study, perhaps under the auspices of their Section, to investigate modern collection systems.
4. In view of the numerous other comments reflecting on the unpleasant aspects of private duty nursing, it is further recommended that studies be instituted to ascertain what problems actually exist in the public relations between private duty nurses and hospitals, other nurses, physicians, patients and others. From such studies, recommendations might evolve for a better public relations program.

BIBLIOGRAPHY

1. Abdellah, Faye G. and Eugene Levine, "Work-Sampling Applied to the Study of Nursing Personnel," Nursing Research. 3:1:11-16, June,1954.

2. American Journal of Nursing (Editors), "Private Duty Nursing," American Journal of Nursing. 54:8:10, August,1954.

3. American Journal of Nursing (Editors), "Private Duty Nursing," American Journal of Nursing. 62:1:49, January,1962.

4. American Nurses' Association, Facts About Nursing, Statistical Summary 1960 Edition. New York: American Nurses' Association.

5. American Nurses' Association, Facts About Nursing, Statistical Summary 1962-1963 Edition. New York: American Nurses' Association.

6. American Nurses' Association, Facts About Nursing, Statistical Summary 1965 Edition. New York: American Nurses' Association.

7. American Nurses' Association, Study of Nurses' Professional Registries, Summary of Findings and Conclusions of American Nurses' Association Special Committee on Nurses' Professional Registries. August, 1961.

8. Barker, Burt Brown, Letters of Dr. John McLoughlin. Portland: Binfords and Mort. 1948.

9. Barnes, Edyth, Meeting the Needs for Nursing Service in Oregon: A Study of Nursing Resources. Needs and Educational Facilities. Unpublished Report, Oregon State Nurses Association. Portland, 1949.

10. Benne, K. D. and Warren Bennis, "Role Conflict in Nursing -- The Role of the Professional Nurse," American Journal of Nursing. 59:2:196-198. February,1959.

11. Boufford, Marjorie Johnson, A History of Nursing in Oregon. Unpublished Masters Thesis. Oregon State College. Oregon 1951.

12. Brown, Amy Frances, Research in Nursing. Philadelphia: W. B. Saunders Company. 1958.

13. Brown, Esther Lucile, Newer Dimensions of Patient Care. Part II. "Improving Staff Motivations and Competence in the General Hospital." New York: Russel Sage Foundation. 1962.

14. Brown, Esther Lucile, Nursing for the Future. New York: Russel Sage Foundation. 1948.

15. Brown, Esther Lucile, "The Social Science and Improvement of Patient Care," American Journal of Nursing. 56:9:1148-1150. September, 1956.

16. Burgess, May Ayres, Nurses, Patients and Pocketbooks. Committee on Grading of Nursing Schools. New York City. 1928.

17. California Nurses' Association, May 31, 1963 Procedure for Implementing the Clinical Private Duty Fee. California Nurses' Association. May, 1963.

18. Carroll, Herbert A., Mental Hygiene. New York: Prentice Hall. 1947.

19. Committee for the Study of Nursing Education, Nursing and Nursing Education in the United States. Goldmark Report. New York: MacMillan, 1923.

20. Couey, Elizabeth D. and Diane Stephenson, The Field of Private Duty Nursing. Georgia State Nurses' Association. American Nurses' Association. Montgomery, Alabama: Cadden Advertizing Agency. 1955.

21. Couey, Fred, and Elizabeth Couey, Human Relations in Private Duty Nursing. Georgia State Nurses' Association. American Nurses' Association. Atlanta, Georgia, 1956.

22. Deming, Dorothy, Careers for Nurses. New York: McGraw-Hill Book Company, Inc. 1949.

23. Dewey, Richard and W. J. Humber, The Development of Human Behavior. New York: The MacMillan Company. 1951.

24. Dudley, Martha, "Is Private Duty on the Way Out?", R. N. pp. 46-86. June 1959.

25. Editorial Staff, "Toward Real Continuity in Patient Care," Nursing Forum. 3:1:21-25. 1964.

26. Editorial Staff, "Will Tomorrow's Private Duty Nurse be College-Educated?", R.N. pp. 45-48. May, 1961.

27. Editorial News Briefs, R. N. pp. 23-24. March 1965.

28. Finer, Herman, "Evaluating the Private Duty Nurse's Performance," American Journal of Nursing. 56:12:1564-1566. December, 1956.

29. Friend, Joseph H. and David B. Guralnik, (Editors), Webster's New World Dictionary of the American Language. College Edition. Cleveland, Ohio: World Publishing Company. 1956.

30. Frank, Sister Charles Marie, "Satisfactions in Nursing Practice," Nursing Outlook. 62:10:5. May, 1962.

31. Goodnow, Minnie, Nursing History. Philadelphia: W. B. Saunders Company, 1953.

32. Grivest, Mart T., "A Personal Inventory of Supervisors, Head Nurses, and Staff Nurses in Selected Hospitals," Nursing Research. 58:7:77-79. July, 1958.

33. Hall, James B., "Nurses Group Okays Raise," The Oregonian. Thursday, March 31, 1966.

34. Hansen, Eva, "Challenge of Private Duty Nursing," Oregon Nurse. 66:1:8-9. March, 1966.

35. Hansen, Eva, "Guiding the Practical Nurse in Private Duty Care," American Journal of Nursing. 63:6:45-46. June 1963.

36. Hershey, Nathan, "The Private Duty Nurse," American Journal of Nursing. 64:5:23. May, 1964.

37. Hiesenberg, Werner, Physics and Philosophy. New York: Harper and Brothers. 1956.

38. Hughes, Everett C. and Helen MacGill Hughes, Twenty Thousand Nurses Tell Their Story. Philadelphia: J. B. Lippincott Company. 1958.

39. Hudson, Wellborn and Richard Simon, An Investigation of the Relation Between Nursing Activity and Patient Welfare. United States Public Health Service and the State University of Iowa. 1960.

40. _____, "In Sharp Focus: Nursing Problems in Greater Cleveland," R. N. pp. 42-46. October, 1956.

41. Kasum, Marjorie, "Registries and Intergroup Relations," American Journal of Nursing. 59:2:234-235. February, 1959.

42. Larsell, O., The Doctor in Oregon, A Medical History. Portland: Binfords and Mort. 1947.

43. Law Department of American Hospital Association, "The Law in Brief-Status of Private Duty Nurses," Journal of American Hospital Association. p. 18. August 1, 1958.

44. Moses, Evelyn, "The Cases in Private Duty," American Journal of Nursing. 60:12:1784-1785. December, 1960.

45. Neumiller, L. Esther, Job Satisfactions and Dissatisfactions as Expressed by 57 Staff Nurses in Five Selected General Hospitals in Portland, Oregon. Unpublished Masters Thesis. University of Oregon. 1963.

46. _____, "Nursing Service Standards Rank High in Nurses Opinions," American Journal of Nursing. 49:3:192. March, 1949.

47. Oregon State Board for Examination and Registration of Graduate Nurses. Minutes, 1920.

48. Oregon State Board of Nursing. Annual Report Based on Fiscal Year, July 1, 1960 - June 30, 1961. A Statistical Report. 1961 Edition.

49. Oregon State Board of Nursing, Annual Report Based on Fiscal Year, July 1, 1961 - June 30, 1962. A Statistical Report. 1962 Edition.

50. Oregon State Board of Nursing, Annual Report Based on Fiscal Year, July 1, 1962 - June 30, 1963. A Statistical Report. 1963 Edition.

51. Oregon State Board of Nursing, Annual Report Based on Fiscal Year, July 1, 1963 - June 30, 1964. A Statistical Report. 1964 Edition.

52. Oregon State Board of Nursing, Annual Report Based on Fiscal Year, July 1, 1964 - June 30, 1965. A Statistical Report. 1965 Edition.

53. Phenix, Florence L., "Financing a Registry," American Journal of Nursing. 58:10:1399-1400. October 1958.

54. Porter, Elizabeth K., "The Prospect Before You," American Journal of Nursing. 59:1:56-59. January, 1959.

55. _____, Private Duty Nurses Activities During January 1962. Pamphlet. American Nurses' Association Research and Statistics Unit.

56. Private Duty Nurses Section, American Nurses' Association, Functions, Standards, and Qualifications for the Practice of Private Duty Nursing. Pamphlet. New York: American Nurses' Association. 1963.

57. Pumroy, Shirley, and Barbara Suttell, A Study of the Functions of the Private Duty Nurse in the Hospital Environment of the District of Columbia. New York: American Nurses' Foundation, Inc. June, 1956.

58. Reid, Katherine and others, "Improving Clinical Proficiencies of Private Duty Nurses," American Journal of Nursing. 64:8:92-93. August, 1964.

59. Roberts, Mary, American Nursing. New York: MacMillan Company. 1954.

60. Roethlisberger, F. J., Management and Morale. Harvard University Press, Cambridge, Mass. 1946.

61. Rogers, Martha E., Educational Revolution in Nursing. New York: MacMillan Company. 1961.

62. Rummel, J. Francis, An Introduction to Research Procedures in Education. New York: Harper and Brothers. 1958.

63. Scott, William and Donald Smith, "Employee -- or Independent Contractor?" American Journal of Nursing. 49:3:67-68. March,1949.

64. Schutt, Barbara, and Thelma Ingles, Planning for the Future of Private Duty Nursing. Speeches at 42nd Convention of American Nurses Association. Miami Beach, Florida. May 4, 1960.

65. Sherrod, Esther, "Thoughts on Nursing," Nursing Forum. 63:3:7-12. 1963.

66. Smith, Olga, "Why Should I Belong to Utah State Nurses Association?", Ohio Nurses Review. pp. 8-9. March,1958.

67. Spohn, Roberta, A Study of Private Duty Nurses, Private Duty Section, American Nurses' Association. New York. September 15, 1954.

68. Spohn, Roberta, "Private Duty Nurses Study Themselves," American Journal of Nursing. 54:8:988-990. August,1954.

69. The Surgeon General's Consultant Group on Nursing. Toward Quality in Nursing. U. S. Department of Health, Education and Welfare, Washington, D. C. February, 1963.

70. Tennessee Nurses' Association, District I. Annual Reports 1965.

71. Tennessee Nurses' Association, District I. Policies and Procedures of Nurses Official Registry. March,1963.

72. _____, Vincentian, Portland, Oregon pp. 1. July, 1931.

73. Wagner, Richard, "How Does the Intensive Care Unit Affect Nursing Morale and Utilization?" Nursing Outlook. 6:5:286-288. May, 1958.

74. Weiss, M., Opportunities in Nursing Careers. New York: Universal Publishing and Distributing Corporation. 1964.

75. Werminghaus, Esther, "Your Stake in Private Duty Nursing," Today's Health. (Reprint) October, 1955.

76. Wolford, Helen G. "Complemental Nursing Care and Practice," Nursing Forum. 3:1:8-20. January, 1964.

77. Worthy, James C., "Factors Influencing Employee Morale," Harvard Business Review, 28:1:61-73. January, 1950.

78. Young, Nova, "Private Duty Nursing Service. . . Some Problems of Supply and Demand," Oregon Nurse. 31:1:66. March, 1966.

APPENDICES

APPENDIX A[1]

MISCELLANEOUS CORRESPONDENCE AND INFORMATION REGARDING PRIVATE DUTY NURSING

AMERICAN NURSES' ASSOCIATION
HISTORY OF THE ORGANIZATION OF THE PRIVATE DUTY SECTION

1910 - At the Thirteenth Annual Convention held in New York City, for the first time a session was given over to the Private Duty Nurses.

1912 At these four Conventions, a Program Session was given over to the Private Duty Nurses. A
1913 Committee was appointed each year to send suggested topics to the American Nurses'
1914 Association Program Committee for these sessions.
1915

1916 - In January of this year, the American Nurses' Association Board of Directors accepted the recommendation that provision be made in the American Nurses' Association By-Laws for the formation of Sections, this revision to be drawn up by Miss Sly, and if approved by the American Nurses' Association President, be sent out in time to be voted upon at the New Orleans Convention in April.

1916 - In April, at the Convention at New Orleans, the proposed revision of the American Nurses' Association By-Laws to include the formation of Sections was accepted.

1916 - At the Private Duty Session at the New Orleans Convention, Miss Ott, Chairman, announced the Revision of the American Nurses' Association By-Laws to include the formation of Sections. A Committee of Private Duty Nurses was appointed to draw up the By-Laws for this Section.

1916 - At the May meeting of the American Nurses' Association Board of Directors, it was decided that the Private Duty Section as formed with its officers, be accepted.

1917 - At the meeting of the American Nurses' Association Board of Directors in May, Miss Ott, Chairman of the Private Duty Section, read the By-Laws framed by the Private Duty Section Committee. These were approved and accepted by the Board of Directors.

1918 - At the Convention in Cleveland, the Private Duty Section By-Laws as drawn up by the Committee and approved by the American Nurses' Association Board of Directors were read and accepted at the Private Duty Section Meeting.

1924 - At the Convention in Detroit, proposed revisions to the Private Duty Section By-Laws were discussed at the business session of the Private Duty Section.

These By-Laws with the proposed amendments were presented to the Board of Directors. Due to a difference of opinion concerning these amendments, the Chairman of the Private Duty Section Revision Committee asked that consideration of the By-Laws with proposed amendments be postponed until a later date.

1926 - In January, the Board of Directors again took up the question of the Private Duty Section Rules and Proposed amendments. Since it was near the time of the Convention, these Rules and proposed amendments were tabled until the Convention in Atlantic City.

1926 - At the May meeting of the American Nurses' Association Board of Directors, the proposed amendments to the Private Duty Section Rules were again discussed. Since the amendments were not approved by the Board of Directors, this decision was returned to the Private Duty Revision Committee.

This decision of the Board of Directors was taken up at the Business Session of the Private Duty Section. The proposed amendment concerning the Advisory Council was omitted, since it had not been approved by the Board of Directors.

1929 - At the January meeting of the American Nurses' Association Board of Directors, a recommendation was accepted that the Chairman of all Sections be requested to attend the September meeting of the American Nurses' Association Board of Directors, and that a copy of the Rules of each Section be sent to Headquarters.

1929 - At the September meeting of the American Nurses' Association Board of Directors, a recommendation was adopted, that the rules of the four Sections be sent to the American Nurses' Association Revisions Committee to be brought in harmony with the American Nurses' Association By-Laws.

1930 - At the January meeting of the American Nurses' Association Board of Directors, the Revision Committee presented the revised copies of the American Nurses' Association Section Rules. The Private Duty Section Rules were accepted by the Board, and copies were sent to the officers of the Sections.

The term "By-Laws" changed to "Rules Governing the Sections" at the Board of Directors' meeting, January 1925.

rtm - 9-1-55

APPENDIX A[2]

AMERICAN NURSES' ASSOCIATION
PRIVATE DUTY NURSES SECTION

Excerpt from letter of February 17, 1959
from Mr. William C. Scott
re independent contractor status

While the courts have laid down no clear-cut test for determining when a person is or is not an independent contractor, the following seem to be the best established criteria:

1. The extent of control which, by agreement, the employee may exercise over details of the work.

2. Whether or not the person employed is engaged in a distinct occupation or business.

3. Whether in the locality the kind of work is usually done under the direction of an employer or by a specialist without supervision.

4. The amount of skill required.

5. Whether the employer or employee supplies the instrumentalities, tools and place of work.

6. The duration of the employment.

7. The method of payment.

8. Whether the work is part of the employer's regular business.

9. Whether or not the parties themselves believe they are creating the relationship of employer and employee.

APPENDIX A[3]

AMERICAN NURSES' ASSOCIATION, INC.
10 Columbus Circle
New York, N. Y., 10019

February 1, 1965

Mrs. Coleen Hughes, R. N.
18126 S. E. Tibbetts
Portland, Oregon 97236

Dear Mrs. Hughes:

Mrs. Eva Hansen is bringing you by hand most of the material to be obtained here at ANA headquarters on private duty nursing. You will see that there are two loan copies of studies which are now out of print. When you have finished with these will you please return them. The other materials are yours. In the publications list you will see that there are a couple of items which I have marked which also might be of use in your study.

There are two studies made of private duty nursing sometime ago but which are still pertinent. These are: A Study of Private Duty Nursing In Age Groups, which may be obtained from District Number 4, Texas Graduate Nurses' Association, 712 Medical Arts Building, Dallas, Texas; and The Field of Private Duty Nursing by Elizabeth D. Couey and Diane D. Stephenson, which may be obtained from the Georgia State Nurses' Association, 269-10th Street N.E., Atlanta, Georgia.

If I can find anything else which I think will be helpful to you I will let you know. Mrs. Hansen also has several suggestions of materials which she thinks you will probably find in the Oregon State Nurses Association office.

If I may make a comment about the title of your study, I would ask that you not take the negative side and say "Is Private Duty Nursing A Dying Career" but rather put the emphasis on how can we interest young nurses in private duty.

There is one more thing which might be of assistance to you. It is the experiment in California where the private duty nurses are attempting to upgrade their practice by establishing through their section economic security program and their section committee on practice, two classifications of private duty nurses - the clinical private duty nurse and the general private duty nurse. I'm sure the California Nurses Association would be glad to send you a copy of the directives which they have sent to their districts on the establishment of these categories. Also there may be some assessment of its results to date. The staff person working with the section on this is Hallie Harrington and the address is California Nurses' Association, 185 Post Street, San Francisco, California.

If you have any questions about private duty I would say that Mrs. Hansen could probably answer most of them, as she is a very knowledgeable person in the field. If I can be of further help I would also be glad to give you any assistance I can.

Sincerely yours,

Harriet S. Stambach, R. N.
Director
Private Duty Nurses Section

P. S. I might also say we are always pleased to have people interested enough in our field of practice to do research in it.

H. S. S.

APPENDIX B[1]

LETTER TO INDIVIDUAL PRIVATE DUTY NURSE PARTICIPANT

18126 S. E. Tibbetts Street
Portland, Oregon 97236
February 18, 1966

Dear

In partial fulfillment of requirements for a Master of Science degree at the University of Oregon School of Nursing, I am undertaking a study regarding the functions of the private duty nurse in Oregon.

Those who belong to the Oregon Nurses Association Private Duty Nurses Section have been selected as participants. You have been assigned a number which appears at the top of the Opinionnaire corresponding to your name on the mailing list. All information given is confidential and will in no way reflect on you or your specific occupational field. The mailing list will be destroyed upon completion of the study.

The enclosed Opinionnaire can be completed in about fifteen minutes. A stamped, self-addressed envelope is enclosed for your convenience. I would greatly appreciate having you return this completed Opinionnaire by March 2, 1966.

Upon completion, a copy of the study will be on file at the University of Oregon Medical School Library.

Thank you very much for your cooperation and willingness to participate.

Yours sincerely,

(Mrs.) Colleen C. Hughes

Let's cooperate with Mrs. Hughes in her survey. This completed study may help others decide to enter private duty, which to me is the most inviting field of nursing.

(Mrs.) Dorothy Showalter
Chairman
Private Duty Nurses Section
Oregon Nurses Association

Mrs. Hughes is a regularly enrolled graduate student at the University of Oregon School of Nursing. Any help you can give Mrs. Hughes to assist her in collecting data will be appreciated.

Lucile Gregerson
Associate Professor
Thesis Adviser

APPENDIX B[2]

OPINIONNAIRE

No. _____

The purpose of this study is to seek information regarding the functions of the private duty nurse in Oregon.

PART I

INDIVIDUAL HISTORY

The value of this study depends on your complete responses to each question. Mark an "X" opposite the one response which most clearly indicates your answer.

A. Personal Data

1. Age:

   a. 21-30 ____, b. 31-40 ____, c. 41-50 ____, d. 51-60 ____, e. 61 and over ____.

2. Marital status:

   a. Single _____, b. Married _____, c. Widowed _____, d. Divorced _____.

3. Dependents:

   a. Children ____, b. Parents ____, c. Siblings ____, d. Others ____.

4. Percent of self support:

   a. 0 ____, b. 10 ____, c. 25 ____, d. 50 ____, e. 75 ____, f. 100 ____.

5. Average number of days you work a month.

   a. Less than 10 _____, b. 10-19 _____, c. 20 or more _____.

B. Professional Information

1. Basic nursing preparation: Year of graduation _____.

   a. Associate Degree _____. b. Hospital Diploma _____.

   c. Baccalaureate Degree _____. d. Master's Degree _____.

2. Additional study: _____

_____

_____

PART II

SCOPE OF YOUR PRIVATE DUTY NURSING

A. Experience

1. Number of years that you have practiced nursing:

   a. Less than 10 ____, b. 10-20 ____, c. 21-30 ____, d. more than 30 ____.

2. Number of years you've been a private duty nurse:

   a. Less than 10 ____, b. 10-20 ____, c. 21-30 ____, d. more than 30 ____.

B. Nature of Your Private Duty Nursing

1. Cases obtained through:

   a. Professional Registry ____ b. Commercial Registry ____

   c. Hospital Registry ____ d. Doctor's Referral ____

2. Your practice limited to:

Cases you accept	Cases you don't accept
_____	_____
_____	_____
_____	_____

Reasons for limitations: _____

_____

_____

3. Your practice limited to specific shifts: Yes ____, No ____.

Reasons for limitations: _____

_____

_____

4. Your practice limited to specific hospitals: Yes ____, No ____.

Reasons for limitations: _____

_____

_____

5. Have had home cases in the past year: Yes ____, No ____.

6. Have had nursing home cases in the past year: Yes ____, No ____.

PART III

YOUR OPINIONS REGARDING PRIVATE DUTY NURSING

Answer the following questions in your own words as completely as possible. Attach additional pages if more space is needed.

1. What aspects of private duty nursing do you enjoy most?

2. What aspects of private duty nursing do you enjoy the least?

3. What do you think is the future of private duty nursing as an occupational field?

4. In what ways does the Oregon Nurses Association help you in your practice as a private duty nurse?

5. What suggestions do you offer for additional ways whereby the Oregon Nurses Association can be helpful to you in your practice as a private duty nurse?

6. Additional Comments:

Thank you for your assistance with this study. Please return this form on or before March 2, 1966 to:

Mrs. Colleen C. Hughes
18126 S. E. Tibbetts
Portland, Oregon 97236

APPENDIX C

RAW DATA

QUESTION	NUMBER OF PRIVATE DUTY NURSES	TOTAL
Part I Individual History		
A. Personal Data		
1. Age		
a. 21-30	3	
b. 31-40	9	
c. 41-50	25	
d. 51-60	48	
e. 61 and over	41	126
2. Marital Status		
a. single	18	
b. married	77	
c. widowed	12	
d. divorced or separated	19	126
3. Dependents		
a. children	35	
b. parents	6	
c. siblings	3	
d. others	4	
e. multiple responses	7	
f. no response	71	126
4. Percent of Self Support		
a. 0	21	
b. 10	5	
c. 25	9	
d. 50	25	
e. 75	4	
f. 100	53	
g. no answer	9	126

QUESTION	NUMBER OF PRIVATE DUTY NURSES	TOTAL
5. Average Number of Days You Worked a Month		
a. less than 10	34	
b. 10-19	41	
c. 20 or more	48	
d. no response	3	126
B. Professional Information		
1. Basic Nursing Preparation		
a. 1916-1920	3	
b. 1920-1929	42	
c. 1930-1939	42	
d. 1940-1949	28	
e. 1950-1959	5	
f. 1960-1964	2	
g. no answer	4	126
Median Year - 1932		
a. Associate Degree	0	
b. Hospital Diploma	113	
c. Baccalaureate Degree	9	
d. Master's Degree	0	
e. No Response	4	126
2. Additional Study		
a. yes	49	
b. no	77	126
Compilation of responses of Additional Study Completed by 51 Hospital Diploma Graduates		
a. college courses	16	
b. post graduate work	11	
c. baccalaureate degree	7	
d. refresher courses, institutes	5	
e. public health nursing	3	
f. miscellaneous	9	51

QUESTION	NUMBER OF PRIVATE DUTY NURSES	TOTAL
Part II Scope of Your Private Duty Nursing		
A. Experience		
1. Number of Years You Have Practiced Nursing		
a. less than 10	8	
b. 10-20	27	
c. 21-30	41	
d. more than 30	50	126
2. Number of Years You Have Been a Private Duty Nurse		
a. less than 10	30	
b. 10-20	45	
c. 21-30	29	
d. more than 30	22	126
B. Nature of Your Private Duty Nursing		
1. Cases Obtained Through		
a. Professional Registry	38	
b. Commercial Registry	9	
c. Hospital Registry	5	
d. Doctor's Referral	3	
e. Other	3	
f. Multiple answers	68	126
2. You Limit Your Practice to Specific Cases		
a. Had limitations (gave reasons)	84	
b. Accept all Cases	22	
c. Had limitations (gave no reason)	14	
d. No response	6	126
Compilation of responses to Cases Accepted in Nursing Practice		
a. Medical-Surgical	35	
b. Any case	22	
c. Orthopedic	10	
d. Pediatric	9	

(continued next page)

QUESTION	NUMBER OF PRIVATE DUTY NURSES	TOTAL
e. All surgical	6	
f. Chest (including heart)	6	
g. Open Heart	5	
h. Psychiatric	5	
i. Accidents	3	
j. Alcoholics	3	
k. GYN	3	
l. Neurosurgery	3	
m. Obstetrics (no calls)	2	
n. Suicide	2	
o. Urology	2	
p. E. E. N. T.	1	
q. Miscellaneous	3	
r. No response	6	126
Compilation of responses to Cases Not Accepted in Nursing Practice		
a. Heart-Chest	49	
b. Isolation	38	
c. Alcoholics, Drug Addicts	15	
d. Pediatric	15	
e. Psychiatric	15	
f. Orthopedic	8	
g. Obstetrics, Maternity	7	
h. Miscellaneous	6	
i. Neurologic	4	
j. Long term-chronic	4	
k. Burns	3	
l. Medical	1	
m. No response	14	179
Compilation of responses to Reasons for Limitations		
a. Lack of knowledge	32	
b. Personal	24	
c. Health	19	
d. Children and family	7	
e. Length of case	2	
f. No reasons for limitations	14	
g. No response to question	6	104
3. Your Practice Limited to Specific Shifts		
a. Yes	102	
b. No	21	
c. No response	3	126

QUESTION	NUMBER OF PRIVATE DUTY NURSES	TOTAL
Compilation of responses to Reasons for Limitations to Specific Shifts		
a. Household duties and family obligations	54	
b. Personal Reasons	23	
c. Sleep pattern	12	
d. Health	9	
e. Available transportation	4	102
4. Your Practice Limited to Specific Hospitals		
a. Yes	74	
b. No	51	
c. No response	1	126
Compilation of responses to Reasons for Limitations to Specific Hospitals		
a. Transportation problem	25	
b. Distance to travel	17	
c. Personal preference	12	
d. Limitation of available hospital	5	
e. Parking difficulties	5	
f. Work in familiar surroundings	5	
g. Limitation of own skill	2	
h. Miscellaneous	2	
i. No response	1	74
5. Have Had Home Cases in the Past Year		
a. Yes	59	
b. No	66	
c. No response	1	126
6. Have Had Nursing Home Cases in the Past Year		
a. Yes	39	
b. No	82	
c. No response	5	126
Part III Your Opinions Regarding Private Duty Nursing		
1. Compilation of responses to what aspects of private duty nursing do you enjoy most?		
a. Total nursing care	48	
b. One-to-one relationship with patient	40	

(continued next page)

QUESTION	NUMBER OF PRIVATE DUTY NURSES	TOTAL
c. Personal satisfaction	31	
d. Challenging work	23	
e. Flexible schedule	20	
f. Variety in work	17	
g. No response	18	
h. Meet interesting people	13	
i. Other	12	
j. Opportunity to make independent judgments	11	
k. Enjoy private duty	5	
l. Good salary	3	239
2. Compilation of responses to what aspects of private duty nursing do you enjoy least?		
a. Economic and general welfare	54	
b. Fatigue of long cases without relief	29	
c. Negative attitudes	28	
d. Non-nursing duties	24	
e. No responses	19	
f. Waiting for cases	13	
g. Patient's family interference	10	
h. Eliciting staff assistance	9	
i. Other responses	9	
j. Professional loneliness	9	
k. Licensed practical nurse co-workers	6	
l. Dislike of emergency calls	5	215
3. Compilation of responses to what do you think is the future of private duty nursing as an occupation?		
a. See apparent future need	53	
b. Future questionable	45	
c. Pre-empted by ICU and LPN	12	
d. Apparent need for specialization	11	
e. No response	5	126
4. Compilation of responses to in what ways does the Oregon Nurses Association help you in your practice as a private duty nurse?		
a. Educational opportunities	24	
b. Fee regulation	21	
c. Legislation and negotiations	10	
d. Professional support	10	

(continued next page)

QUESTION	NUMBER OF PRIVATE DUTY NURSES	TOTAL
e. Standard and qualifications	10	
f. Professional registry	9	
g. Liability insurance	8	
h. Collection of fees	6	
i. Legal advice	5	
j. Other	5	
k. Shorten work hours	5	
l. Public relations	4	
m. No response	4	
n. O. N. A. does not help	3	
o. Professional biography	2	126
5. Compilation of responses to what suggestions do you offer for additional ways whereby the Oregon Nurses Association can be helpful to you in your practice as a private duty nurse?		
a. No response	70	
b. Improved public relations	26	
c. More educational opportunities	21	
d. Insurance pay wages	17	
e. Recruitment of nurses	16	
f. Reclassification of private duty	11	
g. Registry through hospital	9	
h. Negotiations and collection of fees	7	
i. More research	7	184

APPENDIX D[1]

SAMPLE RESPONSES REGARDING REASONS FOR LIMITING PRIVATE DUTY PRACTICE

I. SAMPLE COMMENTS RELATIVE TO CASES NOT ACCEPTED

Verbatim quotes:

Consider myself technically and temperamentally disqualified.

No particular reason, except I have been busy enough with other medical and surgical cases.

I feel I could not cope with the constant strain of these cases.

Burn cases "bother" me mentally. Have taken few--thus lack experience. Isolation--have young child. Husband will not let me accept.

Had staph infection on arm soon after started doing private duty and lost 3 weeks duty. There is no one to support me but myself.

The group of doctors who request me for their pts. do about 1 open-heart a week so this keeps me busy.

Danger of carrying germs away. Too sympathetic. Interference of parents.

Because one surgeon keeps me busy on his cases as much as I care to work.

I prefer not to work with the two neurosurgeons caring for most of the head cases.

In order to do open heart P. O. care, it was necessary to do private duty.

I feel that I am not very sympathetic with the "drunk".

I have been trying for some time to find time to work in with the open heart team just to observe--but somehow just when I think I am all set to spend a day or two observing I get called for something else that just must have a nurse!

Think younger nurses should take the responsibilities as I have in the past.

I find lung and heart cases very difficult ones. I have no one to take care of me so I do not accept contagious cases.

Do not feel I had adequate training for heart and lung surgery as it was not done and short termed classes offered are not enough for heart and lung surg. Pediatrics I had fine training but after my own children seemed to "bring it home". Isolation due to my children and the poor isolation techniques in all hospitals.

Open heart--no experience. Isolation--had invalid in my home years and feel I did not want to run chance of their getting anything more.

With the best of technique there still is the worry in my mind of bringing home a bug to the children.

I do not accept isolation in communicable disease field as a special precaution to my family.

I try to limit my cases to that which I can handle in weight, less heart surgery. Isolation--prefer not. Heavy fracture cases--but I usually tell the registry I will try it unless they know there--it is too heavy a case. With my heart not fully up to par--I feel I can't afford to take Isolation cases.

Unable to take blood pressure because of wearing hearing aid.

Heart disease--(mastectomy left).

No lifting or heavy pulling or two much bending. Was paralyzed over 4 months from waist down so must be careful--had two spinal surgeries.

Health and age. I cannot cope with some situations that were possible several years ago!

Because I am not in the best of health and am over 65 years of age.

Because of an attack of Rheumatoid Arthritis last year.

Semi-retired. On S.S. Due to age (71 plus) physically unable to cope with long cases.

Unable to tolerate increased temp-humidity in room without becoming ill.

I don't take heart surgery because I haven't had any training for it and at my age there would be too much nervous tension.

My concept is that younger nurses with more up to date on later methods--better qualified.

Isolation--because I have contracted too many infections. Pediatrics, maternity, and mental because I have been away from active nursing in these fields so long that I feel I am not qualified.

I don't feel I have had adequate training in these field with recent advances. I took Isolation cases until I developed a dermatitis on my hands from strong solutions.

APPENDIX D[2]

II. SAMPLE COMMENTS RELATIVE TO SPECIFIC SHIFTS

Verbatim quotes:

Day time or very limited evening work. I do not want my work to interfere with my home life.

I work the same shift as my husband does.

To be home during evenings for making dinner for husband and daughter and to be home at night--husband has heart condition.

While my girls were young I worked 11 p. m. - 7 a. m. only to be at home mornings and afternoons. Past 2 years have worked 7 a. m. - 3 p. m. only because I felt entitled to it. Have tried to be flexible, however.

Household duties and family obligations.

I refuse 3 p. m. - 11 p. m. because I wouldn't see children. They need help with school work. The 7 a. m. - 3 p. m. shift works the best right now, with 3 teenage boys and husband. I can't sleep during the day, so had to quit nights.

Alternate day and swing shifts--corresponds to dependent demands in the home.

When the children were younger I did only 11 p. m. - 7 a. m. I would be home to get them off to school and home when they returned. Presently, I do 11 p. m. - 7 a. m. and 7 a. m. - 3 p. m. 3 p. m. - 11 p. m. does not work well with taking care of a family at home.

I find "nite duty" causes less complications at home (husband's meals, etc.).

Many years when children were young I worked nights. Due to family obligations, I have not worked PM's. Preferred days.

7 a. m. - 3 p. m. in consideration of my family to whom I also am indebted for their consideration of the many days I spend in association work and practice.

I have a family to cook for, and help my children with homework in evenings, when necessary. Also have meetings to attend as Scouts, Cubs, P. T. A., etc. in the evenings.

The last few years the hours at 7 a. m. - 3 p. m. have fit better into our family routine. I have school age children.

My husband is home nights to care for the children and the car is available nights for transportation.

In order to be home with my pre-schooler during his waking hours.

No baby sitting problems with 11 p. m. - 7 a. m. shift.

I find the night shift has worked out much better in my family situation.

Prefer days--have farm and because of wife's condition, I can't take nights unless someone stays with her.

My home conditions are better accommodated and I need a sleep pattern. However, I can and do work other shifts.

Because of sickness of family member. I had to stay on shift making it easier to care for them.

3 p. m. - 11 p. m. I need to be at home to take care of my child. My husband takes care of her in the evenings.

Feel better and obtain better rest.

I am not able to adjust my sleeping pattern to night duty, and evening shift corresponds to my husband's schedule better than day shift.

I live 20 miles from Portland and I do not sleep well at night if I have to get up for 7 a. m. shift as I must allow travel time.

My husband's work sometimes poses a transportation problem. Parking facilities are inadequate for the a. m. shift.

Had Heart surgery myself in 1959--so the afternoon shift, rather than to keep changing from the a. m. to the afternoon and evening. I take the afternoon shift--it fits into my rest better.

I used to have severe headaches upon awakening in the morning, so worked in afternoon. Now like the 3 p. m. - 11 p. m. shift.

Night blindness.

APPENDIX D[3]

III. SAMPLE COMMENTS RELATIVE TO SPECIFIC HOSPITALS

Verbatim quotes:

Traffic too congested at 7 a. m. to cross bridges. I depend on my husband to drive me. He must be at work at 8 a. m.

Because of transportation. I do not drive, and there is a great saving of time in taking cases closer to home.

I do not drive a car.

Live near the hospital and have no transportation otherwise.

I go to most all the city hospitals--a few distant ones are omitted because of winter transportation.

Travel by bus.

No transportation. Streets not safe for bus travel. Unable to pay taxi fares for long distances.

Before doing the open-heart cases I went to many different hospitals in Portland. Now I only work at 2 (where the open-heart cases are).

I get enough employment by working in the 3 hospitals close to my residence.

I work on the west side of town only because I live on the west side and find it more convenient.

Because of the surgeon I work for goes only to one, as a rule.

I can't start and I. V. (was never taught in school) thus I work where there's a separate I. V. dept.

Prefer working on east side because I have to leave home so early--St. Vincent--difficulty parking.

I work in most of the hospitals. Exclude medical school because of parking problem this shift.

I have to take the bus and hospitals across river take too long to get there with too many transfers to different buses.

(1) Travel distance to suburban hospitals. (2) Attitude of U. of O. hospital personnel toward private duty nurse.

To save travel time and gas mileage.

Do not want to drive that far from home to work. Then I get all I want at hospital here.

Effort to limit driving distance to under 30 miles per round trip.

White Salmon Hospital across river--am not registered in Washington.

Only one hospital within easy travel--5 mile distance Idaho-Oregon borderline. Too far to Boise Hospital--60 miles from my home.

Only one hospital in our town.

I prefer to work at St. Vincent's Hospital where I took my nurses training.

In the two hospitals I know where everything is located; thereby I can give the pt. better service and not wait for help from the staff.

I can work better in a hospital where I am acquainted with the location of equipment and procedures, staff and rules.

APPENDIX E

SAMPLE RESPONSES TO AN OPEN-END QUESTION CONCERNING ASPECTS OF PRIVATE DUTY NURSING MOST ENJOYED

Verbatim quotes:

I enjoy most, cases that are critically ill, and that through a miracle regain their health. I enjoy meeting some very interesting people--my patients and their families. I like private duty.

The challenge--new patient, doctor, hospital, machines, medications keeps one poised for the uneventful in recovery and gives work satisfaction of accomplishment in another area and a learning experience. Success helps public relations of P. D. nursing.

I enjoy the opportunity to know your patient as an individual person. I also like the fact that you have time to do a good job and give good bedside care. It is good to know the patient's family and their needs. You also have time to know your patient's illness and needs more thoroughly. You are able to understand the physician's concern and medical management more thoroughly.

Patient, nurse relationship--seeing a critically ill patient get better and feeling that maybe you have had a small part in it. Being able to take time off if I want to. I'm sort of a solitary person, therefore enjoy the "privacy" of having only one person to care for.

Direct personal contact with patient, specially the very young and old who need assurance and moral support. To instill confidence and prepare them for general duty nursing care.

I like challenging cases--as colostomys, burn cases and any case that keeps one busy. Amputees and paraplegic are very interesting. I particularly enjoyed my cases at the Medical School. There were many interesting treatments and new medications.

I find in this field of nursing a closer contact with the individual's needs. There are many cases where a great deal of rehabilitation is necessary and I find it rewarding to help these individuals to make new adjustments.

Becoming acquainted with and service to the "whole" nursing needs of the patient. The independent arrangement of the working schedule.

I feel I can give really good bedside nursing care, which I enjoy. I get acquainted with the patient and his family. I am not overworked and can handle what I am doing. I can work (usually) when I want to work. Feeling of accomplishment. I can be off during the summer when my children are home.

Making the patient comfortable--and this includes relieving his anxiety and fears, so that very often on my night shift he may be able to rest. Helping the patient's family to feel as comfortable as possible regarding this illness. The friendliness, helpfulness and goodwill generally offered by general duty staff to private duty nurses.

Independence from hospital as to routine and as to how many days. Just do not want to be completely tied to any one hospital. Direct patient contact with complete nursing care and the time to do the best.

I have the opportunity, I feel, of a greater earning capacity--if P. D. is not curtailed by some doctors and nurses are not called. Although a P. D. nurse works more days, but I can if necessary take off a few days if unexpected sickness arises. I enjoy the special care of a real sick patient and seeing the improvement to complete good health or as well as possible.

1. A decent salary.
2. Freedom to make your own nursing decisions.
3. Sufficient time to do total patient care well.

The personal care to a patient as I follow a motto "Don't go into a room to take care of a patient, go into a room, put yourself in the bed, and take care of you as you would want to be cared for in the same situation". This is impossible to do on general duty as today nurses have very little personal contact and nursing care to patients and only pass medications and make out long reports, and the Nurses Aides, Orderlies, Practical Nurses do all the bedside nursing. In P. D. the complete care is given by the P. D. Nurse and I do not have to record what others, that have had no training, have done. There is a great satisfaction in patient care in Private Duty.

I like both the medical and surgical, especially fresh surgical nursing cases, who recover so wonderfully from surgery. They are the most appreciative too.

I have thought this over off and on for several days and simply cannot think of anything. I enjoy nursing and that is that.

I enjoy all of it.

1. Personal contact with patient.
2. Able to give complete nursing care plus meeting other needs of patient. As many patients express it, they feel so secure when they have a special nurse, knowing that if anything should happen their needs would be taken care of immediately.
3. Although I work as steady as though I were doing general duty, I am not tied down in case of illness of the children and am free to choose my vacation time, etc.

The feeling of freedom and independence. Also enjoy getting better acquainted with the patient and the condition than one does in doing general staff nursing.

You can give more time to your patient. Being able to make your patient comfortable and at ease.

We are able to support ourselves, and are free to stay off call, if we do not feel so well. It is a pleasure to make our pts. comfortable as many pts. do not have additional individual care during the remaining 16 hours.

All medical and surgery cases.

Clean surgery, but I take all cases as they come up and go to most hospitals.

Being able to get closer to the patient. Having time to do the little things for the comfort and convenience of the pt. Doing routine care that ordinarily is left to aides. I enjoy people and like having time to know them.

Being able to take time off between cases if so desire. Having time to devote, the necessary time, to give better nursing care to the patient.

Have always enjoyed doing surgical nursing the most.

It was best for me in past because of work of caring for sick husband and mother. Could not physically carry on general duty and care for them. Feeling of more freedom and independence. Satisfaction in serving and helping seriously ill pts. improve.

Short cases. I have been most active in geriatric cases having had nursing home experience.

Individual contact with the pt. Illness has many facets. When a pt. is admitted to the hospital usually or 99% of the time with a physical ailment, he or she has also the mental part brought on by the actuality of the situation. Can we describe these as (a) worry of the financial (b) family cases (c) strange surroundings (d) fear of the outcome, etc., etc. If I personally were to give my opinion--I would suggest a P. D. Nurse for all pts. to acquaint them with their new surroundings, etc., in their first few days in the hospital.

To work when I desire.

1. Challenge to nurse pt. back to health.
2. To study case (symptoms--prognosis) and to encourage pt. and family.
3. Advantage I have in learning new drugs and their reaction on pts.

I like the freedom of hrs. and that I am in a sense working for myself. One in which there is a lot of nursing care involved. It is more of a challenge. I also like my cases to be varied for interest and a breadth of experience. I can do complete nursing care with P. D. and not be entangled with routine assignments.

1. The variety of pts. and cases.
2. Less paper work.
3. The time to understand the pt. better.

I feel a real satisfaction when an acutely ill pt. accident or other, shows enough improvement that it seems they have a chance of recovery. It is good to know I have had a part in it.

The opportunity to do bedside nursing and the chance to know pts. and their families.

One of the nicest things that is more rewarding doing P. D. nursing, is the personal satisfaction I get in caring for a critically ill pt. and gradually seeing the pt. recuperate. Nothing can compensate with the inner feeling of satisfaction I feel. Can choose hrs. I prefer to work and work when I wish and take off time between cases.

I enjoy the personal contact with pts. I feel private duty is the only true type of bedside nursing or nursing every aspect of a pt. open to an R. N. today.

The total nursing care which allows me:
1. The opportunity to practice nursing on an individual basis.
2. The expanded opportunity to execute independent judgments.
3. One to one relationship with others on the health team.

The personal contact that other nurses lose. The pts. problems are real and you have a close contact, you are more able to help in their emotional and spiritual problems. Nursing is more than giving shots and pills it is meeting (or trying to) meet all the needs of the pt. Sometimes the fear is greater than the pain. A pt. who only sees a nurse when she passes medication will not confide in this nurse. Nurses (as a whole) are too professional, they are losing the human touch. We can laugh at T. L. C. but I believe a close interest a lot of T. L. C. and understanding of this person's problems will sometimes go as far to his complete recovery as the medication and treatment. Too often the nurse is unable to pray with her pt. The minister or priest is called in (this should be) but if nurses were able to pray with her pts. sometimes she would be available when most needed and wanted. This is the dimension so often overlooked in nursing. The Love of God and the ability to reach the pts. needs with love and prayer.

Enjoy the challenge of seeing seriously ill pt. recover. Enjoy working with cooperative pts. and my fellow nurses who are loyal and cooperative.

The interpersonal relationship with the pts. Feeling of accomplishment. Challenge to do my best.

Being able to do extra care, as we have more time than general duty nurses have usually.

Being able to work when I want to, stay home or take time off as desired, yet keep up on nursing.

The challenge of different personalities, and to be able in our not so small way to fight disease.

I enjoy all aspects of private duty nursing. The direct contact with the pt. is why I have stayed in this field. Today when a special nurse is called in, 95% of the cases, the pt. is really serious and needs heavy nursing. There are very few baby sitting cases today. The rapid change in the medical and surgical field and its application keeps a good P. D. nurse on her toes. Secondly, there is time to give

each pt. your special, that extra nursing care each of us is taught to give and wants to give. Of course, I believe the most enjoyment is derived from the great satisfaction a P. D. nurse gets from being a very special part of a team responsible for the care and recovery of the pt. I do believe there is a much greater satisfaction from nursing in the P. D. field than in any other. It is the very reason why most of us enter the nursing profession--our great desire to care for the sick. I can think of no aspects that I do not like. I feel each one is a challenge.

Working directly with the pt. The feeling it gives me in being needed and being able to help and encourage a pt. in need of help.

Getting acquainted with new and different persons.

The challenge of the care of the critically ill pt. The assistance you can give the family of the pt. and the trust and dependence of the medical team on your nursing knowledge.

1. The close association with the pt. and his family.
2. Having time in most cases to do ideal nursing.
3. The personal satisfaction of seeing a pt. improve.
4. Knowing I have made the pt. more comfortable even when prognosis was poor.
5. Most pt. feel their private nurse is their personal representative in and out of the room.
6. I like people, especially old people.

I like the feeling of knowing I've done everything (Nursing care, etc.) I'm supposed to for my pt. when I go off duty. It's wonderful not to be rushed. I like being able to take off as many days as I want after finishing a case.

The need for constant nursing care, to the sick pt. --the response and the security that the pt. feels. Knowing that a nurse is with them, or the assurance the family has in the same respect. This being the need when I began my nursing and this was the field I entered and continued through most of the yrs.

New surgical procedures. Interesting people. I don't mean this in a snobbish way, but some prominent people who have accomplished a great deal I would not otherwise meet.

The "Completely Individual" nursing care which can only be done via P. D. because of the time element involved. (With multiple pts. on general duty staff nursing this "complete care" is impossible.)

I love bedside nursing. Personal contact with pt. Feeling of accomplishment when critical pt. is better or recovered.

While I am doing P. D. care as something to do I do not care for it.

Most work has been in accident cases in last five yrs.

Giving a pt. concentrated care.

I enjoy the actual bedside nursing contact with the pt. In P. D. nursing now the challenge is great because of the type of cases you get--95% of cases are critically ill and need constant nursing care. It is this aspect of challenge, keeping alert to new equipment, new methods of treatment and actually working with the pt. that I enjoy most about private duty nursing.

The satisfaction of understanding all the problems concerning the pts. recovery. This includes mental and spiritual as well as physical. This type of care and understanding is impossible on general duty.

Pt. contact. Acute conditions--requiring actual nursing care. Rehabilitation--teaching pt. self care.

Full pt. care. Personal contact with pt. Pts. are very ill and it's a challenge to help them.

I enjoy most the bedside care of each pt., being able to carry out the doctor's orders when written, meeting the pt's. family and meeting the pt's. mental and spiritual needs over and above his physical needs because I have more time with each pt.

The opportunity to give intensive bedside care and to work with interesting or unusual illnesses or procedures.

I prefer private duty nursing as I like having the complete care of the pt. The challenge it brings to meet the needs of pt. and family. I prefer the critically ill pt. and it gives me joy to hear a doctor and family say, "I'm so glad you're here".

Being able to give all the time necessary to a very ill patient. The satisfaction of giving competent care and of relieving anxiety in the pt. and the relatives and friends.

Giving proper bedside care and nursing. More personal contact with each patient. On each individual case there is something to learn no matter how small. One gathers experience and knowledge from the variety of cases and different personalities and characteristics of people.

After working in TB hospital 3-1/2 years I took P. D. nursing because the pay was more. I could work and support my family.

Have always liked bedside nursing, the satisfaction of seeing a critical pt. recover, with excellent care. Perhaps the challenge also.

I like P. D. case that I am moderately busy on and can be actual bedside nursing. I don't like to be rushed but do like to be kept moderately busy.

Free to be on or off as desired. Variety of cases. Learning about new equipment and techniques. Meeting people.

Bedside care and very sick pts. I like doing everything for the pt. myself. I don't want my pt. out of bed, but do enjoy seeing them progress and improve.

1. When the pt. requires special concentrated care.
2. The time to treat the person rather than the disease.
3. The satisfaction of helping the pt. to get well.

I prefer P.D. nursing because it gives me a feeling of closeness to people of which I enjoy and doing things for them. There is a great satisfaction in knowing my pts. are cared for properly when I leave. I like the feeling of freedom to be off work, as my finances will allow.

Being able to take total care of the pt. and give the care without hurrying.

Personal contact with the pt. is a great study in human relations. The pt. needs T.L.C. regardless of their station in life. It is the little things in life that are important, just as a frequent turn of a pillow, a fresh drink of water, maybe turn the bed so that the pt. may look out the window or into the corridor. These are so small to us but how important to the patient. To me a P.D. nurse not only administers to the physical but mental and spiritual aspects of the pt. I always like to think of a pt. as a guest in my home and after all he or she is a paying guest in the hospital.

The personal contact with the pt. The feeling of personally helping the pt. to recover. There is a challenge to do all in your power to help a pt. recover that others thought impossible.

Being able to organize and plan the work, the performance of pt. care vs. "pill rolling" and secretarial, phone answering service, the freedom of choice, greater variation in place of employment by going to different hospitals, home, etc. Having the time to do a thing correctly and have pride of workmanship.

Can give the care they need but don't get on Gen. Duty. The G.D. nurses claim we spoil the P.D. patients but I believe if the Surg. Pat. has proper care for first 24 hours they make a better recovery.

The constant change of persons and personalities and variety of cases. Never monotonous, each case slightly different, and being able to work as much or as little as desired.

Contact with patients and most doctors.

1. Time to give good nursing care to your pt.
2. Variety of work.
3. Opportunity to become acquainted with your patient as a person as well as a case, giving better insight into problems.
4. Flexibility of working hours and days.
5. Total pt. care.

1. I get a great deal of satisfaction in being part of a team that saves pts. lives, which a P. D. nurse does.
2. I enjoy meeting and knowing so many interesting people. A private duty nurse gets to know a pt. better as well as their relatives.

I prefer surgical nursing because you have a challenge, keep up on modern techniques and the cases aren't too long.

Surgical nursing interests me most and always has, easier to follow the recovery.

Every aspect and the busy 7-3 shift.

The contact with the pt. and the opportunity to give total nursing care.

I enjoy bedside nursing. It is a satisfaction to have helped an ill pt. with nursing and emotional security.

Working on one to one relationship with pt. Doing total pt. care. The hours, also lots of time off between cases if you want it without a lot of bother.

Those cases in hospitals which require new and old professional techniques.

Being able to work when, where and for whom I wish. Being able to give (usually) one pt. all the nursing care he or she requires. Usually enjoy knowing the family, meeting people from various social and financial and occupational backgrounds.

APPENDIX F

SAMPLE RESPONSES TO AN OPEN-END QUESTION CONCERNING THE ASPECTS OF PRIVATE DUTY NURSING LEAST ENJOYED

Verbatim quotes:

None that I can think of. If and when I am called there is a reason and in nursing, especially P. D., you can take care of the reason, if you truly like bedside nursing.

As I work nights, I rarely see the attending physicians or surgeons and feel somewhat at a disadvantage when there is no personal touch.

Mental cases.

Presenting bills, being on call, uncertainty of days of employment, risk of not being paid.

Baby sitting, however, such cases are few nowadays.

Possibly having to stay on a case too long without time off.

The things I like least about P. D. nursing is the lack of publica relations communications between doctors and hospital vs. patient and nurse. The uncertainty of not knowing the stability of the pt's. finances and the surprised look on pts. faces when they realize they have a private nurse to pay for. Many patients think the hospital will pay or the private nurse is a hospital employee. Some have been sold insurance policies by unscrupulous salesmen that the insurance will cover the P. D. nurses fees and it is usually a small portion, if any.

1. Baby sitting, cases which do not require much nursing care.
2. The attitude of all hospital personnel toward P. D. nurses. The students are taught that P. D. care is unnecessary and they resent us. This carries down to nurses aides and orderlies as well. Also many doctors refuse to have private duty nurses regardless of the load which the staff is carrying or the means or wishes of the patients.

Luxury nursing I DO NOT LIKE.

The one aspect of P. D. nursing that disturbs me more than anything is the inability to get relief for a day off. I personally am not able to work four or five weeks without time off and give good nursing care. Since I cannot get someone to relieve me I usually have to leave the case and thereby incur ill feelings from the pt's. family, the doctor and the pt. Also, I do not like being called on a case to just "baby sit". I possess many nursing skills and I like to use them.

I feel the attitude in the hospitals toward private duty nurses and their need is fast becoming one of hostility, and as the Salem Memorial Hospital printed in their hospital paper "the private duty nurse is becoming a vanishing breed". This shows the attitude which I feel is bad, I think there will always be a need for P. D. nurses

just as there is a need for G. D. nurses. I would much rather be on a case that keeps me busy, rather than one that requires very little nursing care--however, these cases as I said before are rare.

Being on call long periods. Working long periods without relief. Advantages of group insurance. Disadvantages of being self-employed (medical benefits, social security, no sick leave, etc.). Loss of wages--(pt. unable to pay).

Uncertainty of amount of work that will be available and when days off will be. Some cases were slow to pay, also.

Isolation case in two bed wards, as there is little room to work. I would rather work in a roomy six bed ward rather than a small two bed ward.

1. The necessity for working several weeks without a day off because of unavailability of relief nurses.
2. The P. D. Nurses Assn. meetings, which accomplish nothing and generally become a gossip session among the members who are mostly middle-aged to elderly nurses.
3. The difficulty often encountered in collecting fees (I have not yet received $1,800 earned last year caring for a burned patient).

Companion--baby sitting--no nursing.

The last minute call to come as soon as possible when you haven't slept a wink all day and expect to stay up all night. But I never turn one down unless I am ill.

A case that is a long one sometimes loses its flavor. Especially, since it is not always possible to get relief.

Differences of opinion when more than one Dr. is on case and how to cope with divergence of orders. Two much running around for supplies, medication and equipment. Relief nurse reporting late.

Often having too much waiting time on my hands between procedures (things I do enjoy some time). I dislike cases that last over a period of weeks without a night off.

1. Getting called for nights just as I retire or after getting to sleep.
2. Waiting to be paid.
3. Having to wait for relief from floor and making very late meal time.

But still I don't want any other type of nursing. I enjoy private duty very much.

Problems of fee collection. Difficulties in getting relief at times when on lengthy cases and the fatigue of an extended uninteresting case.

One could not live if one were depending upon revenue derived from P. D. Unreliability--difficult to plan other activities.

1. Trying to collect your bills. The families or pt. refuse to pay or are unable to do so.
2. No pre-arrangements are made by the hospital to secure payments following P. D. care.

When on a long case and have been working 7 days a week without any relief it is a little discouraging when unable to join one's family for an occasional weekend. Then too, when your services have been rendered efficiently you must wait months to be paid and then maybe have to take a deduction in pay.

The misunderstanding and lack of knowledge on the part of nurses in other fields and of the medical profession.

Going on a new case (1st few hours).

A terminal case or one in which there is not much need for a private duty nurse. There is not the satisfaction that your services have been worthwhile and the case is boring. Also, I don't like taking care of people with difficult personalities. There is a closer relationship than as a G. D. nurse.

Long lasting heart cases.

There are no fringe benefits--one has to work Sat. and Sun. if on a case, no paid health insurance, vacation time, etc. In other words no fringe benefits. I prefer G. D. really in an intensive care unit or recovery room.

Attitude of some G. D. Nurses toward P. D. Nurses. Some act like we must be a lazy lot or we would not be doing P. D., some resent giving us any help with our pts., regardless of how difficult the case may be. Very rarely do they volunteer to relieve us for a meal or a ten min. break (a lot of G. D. Nurses do not like us). Relatives once in a while. Collecting from families I know cannot afford us.

I do not care for "baby sitting" cases or cases that because they have money can afford the service of an R. N. I think this takes us out of the prof. status and puts us in the maid category. Another problem is that we are self employed, therefore, we do our own collecting--which often presents a serious problem, and a most embarrassing situation.

Not being able to get relief nurse and having to work weeks and even months without a day off.

I really do not have any dislike of P. D., only aspect which occasionally is unpleasant would be inability of collecting money from the pt. --which does occur in spite of all the insurances, etc.

Lack of courteous treatment by approx. 50% of G. D. Nurses. If you're not running your legs off every minute the attitude and often the comment to the pt., "Well, what do you need a special for?" Reluctance to assist special nurses in turning, lifting a heavy or difficult pt. and reluctance to relieve nurse for a meal or coffee at night.

1. The problem of income taxes (filing our estimate of wages, etc.).
2. Lack of contact with other nurses (not working with other nurses). I think it is a very "lonesome" type of nursing.
3. There are very few young nurses doing P. D. Nursing. I am 30 and I think I'm about the youngest on the Registry.

Night nursing.

1. Collecting.
2. It's difficult to plan free time for normal working hours.
3. When called on a new case the nurse doesn't know if she will be needed 1 day or indefinitely.

Complete disregard of pt. and his needs by institutional staff once the P. D. Nurse goes on the case. This is true in many places. Having to leave the pt. alone to hunt and secure equipment and supplies for treatments ordered. So many verbal orders, especially phone, from the doctor. Having to follow or precede a non-professional person engaged to care for same pt.

Cases where the pt. really needed only a companion.

The attitude of hosp. personnel and some of the younger Drs. that P. D. Nurses are only baby sitters. Most of the older Drs. still treat us with the respect we used to know. And it isn't pleasant working on a case with L. P. N. 's who do and say so many unethical things to the pt.

No work benefits. If you don't work you don't get paid.

Sometimes cases are monotonous and I haven't enough to keep me busy and I feel I'm really not needed.

a. A lack of side benefits:
    1. partial social security paid when have employer.
    2. holiday time.
    3. sick leave.
    4. vacation time.
b. Extra fees to pay to join registry.

Attitude of some doctors. Attitude of some P. D. Nurses.

Collection of bills--although this has never been too much of a problem, you sometimes have to wait quite a while to receive your pay.

I dislike the uncertainty of the work in P. D. Nursing. A nurse is never certain, what her monthly income will be.

I become very bored if actual nursing care is small and you become a servant. I make a very poor servant. I want to keep active in actual nursing.

1. Staying around and waiting for a call.
2. Do not like S. O. S. call.

3. Waiting to hear whether a night nurse has been called. This information should be relayed to the Dept. when Registry has filled the call.
4. Not being informed of correct diagnosis of pt. when called. (For instance I was called for an "acute abdomen" also given incorrect name of pt. The pt. was an alcoholic. No blame on the Registry for this big error.)

1. Resistive pts. that will not cooperate.
2. Pts. that require little care.
3. Practical Nurses as co-workers on a case, especially those that have a superior attitude.

Terminal cases, or chronic medical.

Rudeness of general duty nurses and not able to get help when one needs it.

Relatives.

It is very interesting with the exception of difficulty in collecting our pay. I myself have lost several $100 during the past years.

1. Collecting fees.
2. When one becomes a maid like empty ash trays and catering to pt. after bedside nursing has terminated.
3. In other words luxury nursing where you entertain pt. and catering to pt's. family.

The duration of cases.

I cannot think of any at this moment.

Occasionally being tied down to 7 days a week or unable to get a replacement, to get away for a vacation.

Not being paid.

Getting up in the A. M. --all other P. D. I do enjoy.

1. Not having regular days off.
2. Not being able to plan ahead and know just when you would be working.
3. Sitting waiting for phone to ring.

Lack of fringe benefits. The fact that the pt. or family are not always informed to the method that P. D. Nurses are paid.

Mostly the uncertainty of being on call. The attitude of Drs. in Eugene toward P. D. Nurses. The inability of getting scheduled help on hard cases (hospital).

Isolation.

Orthopedic.

In prolonging the life of old people, in particular to repeating surgery for C. A. where there is absolutely no hope, except suffering.

When I work so hard to help a pt. in his illness when I know that it is almost hopeless, yet we try to make him think he is getting better or will get better, then we up and lose him, it sure lets you down. But I still keep on in Private Nursing. I love it.

Too much family on some cases.

Going from place to place and never really belonging.

1. Boredom (at times) when you have a pt. who doesn't require nursing (needing more a maid than a nurse).
2. I do miss working with other nurses.
3. You do miss out on varied experiences and contacts you would make doing general duty.
4. I find it harder to keep up with the many new medicines.

The only aspect of P. D. Nursing I have found distasteful is being on call. Fortunately, I have had very little opportunity to become too discouraged by that.

I do not bother to try to remember, so how could I pin things, or aspects as you call it, down as enjoy most or enjoy least.

Nursing cases that I have answered on an S. O. S. call with the pt. ready to expire. Unpleasant type of nursing which I enjoy the least, period.

Collection problems. Some P. D. Nurses are not too well adjusted personality wise. Some are too old to do efficient care. Night duty nurses who have reputation of and do sleep on shift.

I can't honestly say I dislike any part of P. D.

Mental--isolation and contagious cases. Having asthma and bad throat and cannot wear a mask.

1. That the physicians do not call P. D. Nurses unless the pt. is critical and they themselves are worried about the prognosis.
2. Physicians have discouraged pts. from having P. D. Nurses even when pt. has requested same.
3. Pt. or his or her family are not consulted about P. D. N., nor told how P. D. N. are paid and when, in other words physicians call P. D. N. when they are concerned about the pt. regardless whether family or pt. can afford extra nursing care.

Relatives interfering and standing over me while caring for my pt. and trying to tell me every move I should make.

The constant time without days off. It becomes boring staying in one room. The insecurity of the financial needs being met.

The only disadvantage I see to P. D. N. personally are the long number of daysit is sometimes necessary to wrk in caring for one pt. because of the fact that relief nurses are not always available.

The hours of the shifts.

Occasionally one gets a case in which the family tries to give you instructions they want carried out, which are contrary to Dr's. orders. This can become a problem. There are occasions when pts. families must be billed over and over again. They don't seem to understand, even when told of procedure of payments due, or don't seem to care if they pay you or not.

The problem of obtaining relief on long cases. I feel there should be some one to arrange for relief when a private duty nurse needs it. It is hard for a nurse to make many calls which is always necessary in getting relief.

The sad fact that far too many P. D. N. should be retired, but have no retirement benefits to fall back on. No new nurses nourishing our registry and the P. D. N. has lost her prestige even among the hospital personnel and Drs.

The waiting when "on call". The lack of fringe benefits enjoyed by those steadily employed. The fluctuating income and not knowing how to plan a budget.

Long convalescence in a home is a bit trying at times. Just how much can we expect this pt. to improve in returning to normal life? This and other questions bother me.

1. Obtaining help from the staff.
2. The sense of "aloneness".
3. Presenting and collecting the bill.

1. Problem visitors.
2. Confinement to one room although I believe it is very requisite.
3. Finding someone to stay with the very ill pt. while nurse goes to lunch.
4. The seven day week, unable to find a relief nurse.

One of the least desirable aspects is the lack of regular days off, and there are times when there is a slack period in the demand for private duty nurses. Another aspect this is less desirable is the problem of having to collect directly from the pt. (There are times when a P. D. N. may not receive payment for her work.) It would be good if the financial part were settled and made clear before a P. D. N. is called on a case.

There is also less economic security in this field. There is no sick leave and no paid vacation. I feel most P. D. N. do not like the collection part of this work, because often the pts. are very ill and the families distraught. She must do this though to be able to meet her own obligations.

The fact that L. P. N. 's are doing P. D. for a fee in excess of their capability because of their lack of knowledge. This in my estimation is doing a great deal of damage

to the P. D. R. N. Doctors are asking for fewer P. D. N. and I feel that this is partly what is causing the lessening popularity of the nurse in this field and the fact that about 50% of the doctors think P. D. N. are overpaid, but I would like to see one of this percentage of doctors spend eight hours with some pts., the whole aspect of P. D. would change I'm sure. I do not think that most doctors realize we have no guarantee of employment and have to pay all of our fringe benefits.

Bill collecting!
1. I feel that the doctors who order special care for their pts. should explain the financial responsibility to the pts. family before a nurse is assigned.
2. Families who request P. D. N. should be told at the time of the request that P. D. N. are paid every three days or on a plan subject to approval by the nurse and the person responsible for the bill.
3. P. D. N. should not be ordered to give intensive care to a pt. because a hospital is short staffed, without first determining the financially responsible person. (Should the hospital itself assume this responsibility on a temporary emergency basis?--esp. when they are not able to cover this type of emergence because of limited personnel.)

1. Trouble among P. D. N. themselves--jealousy--lack of cooperation--one trying to "outdo" others on the case.
2. Following a P. D. N. who leaves the pt. and the room in a positive mess (usually the room, rather than the pt.). Dirty articles, linen, etc. left in room. Lack of tidyness. It takes an hour to clean up after some nurses I follow!

1. Inability to plan with family for definite days off.
2. The indefinite monthly salary.
3. Being "on call" and the sometimes lengthy "slumps".

Nursing cases that I have answered on an SOS call with the pt. ready to expire. Unpleasant type of nursing which I enjoy the least.

Sometimes when working for a new doctor or being sent into a dept. with the head nurse I do not know I have noted a lack of confidence shown by them to me, a special whom they do not know. We seem to have to prove ourselves at times when the aforementioned people do not know us. We are sometimes like foreigners. Occasionally also a member of the family or even the pt. himself becomes autocratic and start directing and suggesting the care and treatment of the pt. As one might suspect their ideas are not good but sometimes they are so determined that they persist and even with the nurse exercising all the diplomacy she possesses, it creates a disadvantageous situation. The reason that they do this, of course, is that they feel that since they are paying the special, she is under their employ and also under their direction to a certain extent. I have found this to be the case most often with certain nationalities when I have gone in to replace another nurse and am hence a "new" nurse on an "old" case. Also have found that some people would like to direct the nurse as a practical nurse, but their insurance will not pay for a practical so they hire a registered nurse and direct her anyway. I withdrew from one such case but the employer merely called our Professional Registry and was given a prompt replacement even though the Registry knew the existing situation of the wife (employer) "bossing" the R. N. as a practical and the insurance company paid the bill.

Going into a hospital where the G. D. N. (and there are quite a few) who treat a P. D. N. like an imposter or some strange being. Even some aides act the same. They are not friendly or helpful. The G. D. N. seem to wash their hands of the whole concern of pt., never come near to see how pt. is or how things are. When a pt. is real ill and cannot be left alone very seldom does a G. D. N. in charge ask when you want to go and eat or have a 5 or 10 minute break. I have many times had no lunch or supper until 8:00 p. m., and no one seemed concerned. They all have their meals and breaks for smokes, coffee and all. Also, very seldom if ever do they offer a hand to turn or lift a pt. Even a smile or being friendly would help, but these are at a premium. Some are helpful and friendly and I let them know I do appreciate them. I am a friendly person so when there is an unfriendly spirit a P. D. N. finds herself sort of in a lonely world.

APPENDIX C

SAMPLE RESPONSES TO AN OPEN-END QUESTION CONCERNING THE FUTURE OF PRIVATE DUTY NURSING

Verbatim quotes:

I feel that private duty will be done more by L. P. N. 's or Practical Nurses all the time. Intensive care units will cut down on some Private Nursing Services. The general rising costs of all medical care will naturally cut out some P. D. nursing.

I feel it is fading out of the picture rapidly--so many doctors these days are against P. D. nurses on their cases.

Good if the nurse keeps up with newer knowledge and techniques.

The P. D. nurse seems to be losing out to the L. P. N. 's. There is no difference in our uniform--the L. P. N. 's tell the pts. about their days in training and there are few pts. able to discriminate the L. P. N. and the R. N. --putting us in the same category.

It will always be available but not to the degree of the past because of extras added in the larger hospitals in "extensive ward" care.

"Private Duty" is a vanishing occupation. The public can't afford P. D. care unless they have insurance or are in the higher bracket of income. I could not live on what I make because--(1) Not enough cases in this size hospital; (2) Not able to collect fees.

None as it now stands.

I think our future is just what we make it. If we want to "sit" and be maids then I think our future isn't too good; however, there will always be a demand for a well-informed technical nurse--one who keeps abreast of the times and is willing to accept constructive criticism.

I think private duty nurses will be incorporated into the hospital staff and supplied to the pts. who need them. Homecare cases will be taken care of through the Public Health Nurses, V. N. A., Homemaker Service, etc.

The future of P. D. nursing is good, as there will always be patients, both critical and others, who need extras and continuous care, which the general staff nurses will not be able to give.

With the advancements in medical care and the setting up of specialized departments in hospitals it would seem that private duty nurses will have to become more specialized therefore limiting their practice to fewer types of cases.

At the present time in Portland the number of R. N. 's in this field seem to be decreasing and many more L. P. N. 's and practicals (especially L. P. N. 's) are entering private duty. In this past year frequently I have been the only R. N. on a case with L. P. N. 's and

sometimes L. P. N. 's weren't available. There have been many unfilled cases so there is much opportunity but with the present trend there are many more P. D. nurses retiring and going into other fields of nursing than there are those coming into P. D. With medicare pts. being hospitalized, it will most likely increase the nursing load of general duty nursing so I feel there may be an increasing demand for P. D. nurses in order to give proper care.

I am wondering about this, but feel that there will always be a need for private duty nurses. The fact that many hospitals call "aides" and "practicals" to do P. D. plus the intensive care units may not make as much work for R. N. 's doing P. D. nursing as before.

Doctors seem to ask for P. D. nurses less than they used to. If we want to keep busy we must specialize on certain kinds of nursing and give care that the doctors and public will know of our work and ask for us.

At present doesn't look too promising.

Private duty nursing in the future depends on the P. D. nurses of today. If we accept the challenge of expanding medicine and nursing and are both willing and able to cope with the demand for expertness that is required now and will have a greater demand in the future, then P. D. nursing will be a source of expert clinical practitioners.

I think there is <u>none</u>. Younger nurses are not going into the field. Intensive care units, etc., are taking over. Nurses do not like to do bedside nursing. People who need it can't afford it. Student nurses are not being trained to do P. D. nursing.

Future is unlimited. Problem is to match the right nurse to the situation. Also--to give nurses equal opportunity--example: why do the same nurses appear again and again on the long, lucrative cases? Others fill in a week with 3 or 4 short cases, which most of us do not prefer.

I think there will always be work and need for the P. D. nurse and as the nurses in the higher degree group all want to be supervisors and are not trained for or are not qualified for bedside nursing. It takes a more dedicated quality for bedside nursing and be they R. N. 's or L. P. N. 's, there will always be room for a good P. D. nurse where the need is growing greater instead of diminishing.

Right now the future is a changing one, as is all fields of nursing and most of medicine, I feel, due to Medicare. At the most, it is more unpredictable than in prior years. I feel personally that I should be aware of this change, be alert to any new job opportunities that would offer more than routine hospital employment. Also aware of the possibility that more nursing (degree level) education may be needed before I would or could find any other type of work in the inevitability of discontinuing in P. D.

I think very soon our Registry will have to fold. Eventually each hospital will have a list of nurses available for private duty.

More P. D. nursing being given L. P. N. 's. Some patients will always insist on R. N. 's for P. D. However, that number is decreasing. Medical profession advises patients "specials" are not necessary.

The standards for nurses in this field are very low. I have felt we do not have respect from the doctors and this I can understand. If our standards were high we would do a needed job of special nursing care which is almost a lost art.

Seems to be a dying field as so few of the younger graduates are entering it.

I personally feel that P. D. nursing has been at a low ebb for maybe half a dozen years. Due in some measure to an under-current of non-support from certain hospitals, personnel, and a few doctors. I would say enthusiasm is on the rise again.

With more insurance companies adding nursing care to their hospital and insurance plans, there should be a wider area of employment, for many people cannot afford to hire R. N. 's now.

Limited--due to development of recovery rooms--intensive care units, etc. --which I highly approve.

Patients need human contact; very ill need reassurance, cannot be given by a machine.

I think it is too confining for the young nurses. They need a 5-day week with holidays off. Private duty nurses never get the days off they want.

Private duty nurses will always be in demand to care for critical cases and cases where intensive care is required.

I think it will gradually diminish due to the fact that the doctors do not encourage it for patients and the younger nurses cannot see a secure future in this type of nursing financially. Patients will always wish for the extra care and security of a private duty nurse.

Special cases that need special care will always be with us. Intensive care will take over some of the cases, but not all. Practicals will take over some home cases, too, that formerly had R. N. 's.

It is now becoming specialized, with groups or teams of nurses trained to care for certain types of cases. There should be a scheduling ahead for many types of surgical post-op care. This might prevent the frantic call for special duty nurses on one or two busy days with requests for nurses unfilled. These same nurses who worked on one shift may wait on call, unemployed for two or three days. This is a real disadvantage to a full-time P. D. nurse.

Coming to an end. Less calls from doctors. Going to be taken over by L. P. N. 's.

Looks like P. D. nursing may decrease as the hospitals continue to add intensive care units and heart care wards.

It should be excellent if you don't limit yourself to hospital cases.

I think there is a need for P. D. nurses. Hospitals in our area are under-staffed and I feel the P. D. nurse has a place to fill in the care of seriously ill or critical patients.

If we do not have new and young grads entering P. D. I'm afraid our field will become very small.

It is dwindling but feel there always will be a place for a good P. D. nurse.

I feel there will always be a place for the P. D. nurse. Perhaps there will be fewer cases.

In general I would say that the future of P. D. nursing is poor. I would like to qualify that statement by saying I think the future is better for practical nurses than for registered nurses. However, I do feel that there will always be a place for the registered professional nurse who has kept up with new methods and techniques and availed herself of the opportunity of learning new procedures that are being done; such as open-heart surgery, intensive coronary care, etc. Those cases require special skills which only a qualified professional nurse is able to give.

There will always be need for interested R. N. 's for P. D. I. C. U. is not the complete answer to the critically ill. Have heard many of the patient's family say they would not leave their loved one on general duty.

I think it's on it's way out--being taken over by P. N. 's.

I am not sure at all because I have not thought much about it. Many things change so much. If hospitals do not have enough nurses, there is more need for private duty nurses. It appears there will be a shortage of nurses in some years to come. I expect to stay busy. Some people want P. D. nurses without needing them.

Good--as long as shortage of good bedside care exists.

I believe that P. D. nursing will always have an occupational field. However, the intensive nursing care which hospitals all over the United States are developing will eliminate to a great extent the profession of the private duty nurse, as I see it.

Should always be a need for the P. D. nurse. Seriously ill for a longer time than the intensive care units can keep them.

I am sure it is durable but perhaps the field will lessen as the telemetry electronic machines are perfected.

Very little in our area--most of our doctors feel P. D. nurses deprive their patients of depending on themselves--though we do not quite agree with that. This is a farm area and many do not have the money unless in critical cases where it is a real necessity. Private duty becomes a vanishing practice as time goes on--speaking of this area, of course. There are only four of us doing this type of nursing right now.

Until training schools change their format, I don't feel that P. D. has any future. No student nurse today has any desire to have very close contact with patients and their (as they see it) having intimate care.

P. D. nursing is going out in the small communities. You certainly wouldn't be able to make a living at it. Although I enjoy it more than any part of nursing.

With cooperation of Doctors it would be a fine future.

There will always be people who will want their own nurse.

Unless the fee is raised, I see no reason for any self-supporting girl entering this field.

Limited.

Very good.

I think it will always be in demand.

Most places (I have been in different parts of U. S. A.) are calling for less private duty nurses as time goes on but I believe Private Duty will never be completely replaced.

I believe it has a good future for younger graduates.

I think nurses should work for the hospitals from time to time to keep up on various new procedures.

There just isn't enough R. N. 's to take care of the need. They are needed so badly in general duty here that only a few are doing any private duty work.

Poor.

I do feel there will always be a need for P. D. nurses. The various intensive care units have cut down on the number of cases requiring P. D. nurses, but not eliminated them. The desire to have a registered private nurse give that extra special care will always be there.

I think there will always be some demand for P. D. nursing.

I think it may be a thing of the past, unless the doctors are better educated to the value of specialized bedside care. The doctors and hospitals should be instructed of the responsibilities the R. N. can take, in comparison to the L. P. N., P. N. and aides.

Questionable due to the increase of intensive care units and also who but the wealthy can afford special care?

If the theorists are right--it looks practically nil. However, there seems evidence to support hope that all the Intense Care Units, Medicare, I. B. M. machines, etc., leave a great gap that can be filled only by the P. D. nurse. Have known pts. who simply by personality couldn't conform to the intensive care idea.

The P. D. future will probably be just what private duty nurses are willing to make it--they all need to get behind the wheel-barrow and push, instead of riding--and let only a few do the "stick-togetherness". Many will not attend meetings--will not serve to help to keep the organized group together except when they have a complaint and then everyone is to blame but themselves.

It will be gradually phased out as it has in many cities over the country. Recovery room, intensive care units and emergency cardiac units will take over most of the patients who used to have private duty nurses.

I think there will always be a need for private duty nurses. The I.C.U. does not fulfill every need. Today P.D. field ranks second to general duty in the number of nurses employed therein. With more chest and heart surgeries being done, doctors seem to want more and more P.D. nurses.

I feel there is a great future for the P.D. nurse if we all band together and keep up the high standard of nursing that is expected of us. However, if we keep letting the petty things interfere and let the doctors feel P.D. nurses are not longer needed, the field will eventually be closed, due to doctors no longer ordering special duty nurses. We have to show our worth and keep active and alert and up-to-date.

Unless P.D. nurses specialize the section will die. Very few young nurses go into P.D. because it is not as glamorous and sometimes not as lucrative as other fields. I believe Medicare will have an effect on P.D. Some nurses believe it will be better because people will use extra money for nurses. Others believe it will absorb the P.D. nurse.

That there will always be some private duty, but that the intensive care units and recovery rooms will lessen the amount a great deal.

Probably less demanding than previous years because of intensive care units and recovery rooms being set up and utilized.

No doubt the field will continue to need more nurses than can be supplied, especially with medicare. If there is a severe depression, the P.D. nurse would have less work and suffer first and worse, however. Then many nurses not now working probably would return to work and people would not be able to afford a private nurse.

I do not care for desk or paper work. Like the direct sick room (one patient) nursing. To me that is where the real nursing aspect is--the results of good care.

There is a great future for the P.D. nurse if she is trained for <u>bedside care</u> and not trained as so many are today. <u>Do it yourself.</u> Why do the doctors have P.D. nurses for their families instead of Intensive Care? T.L.C.

There will always be patients who want personal attention, not able to be given by general nursing care. Critically ill pts. who need constant and immediate attention which can only be done by P.D. nurses who care for only one pt. at a time. People who enter hospitals that have plenty of money always want personal attention of P.D. nurses.

Very good for L.P.N. No future for R.N.

This is probably a question in the mind of anyone who has ever done P.D. nursing!! I feel convinced that intensive care units will not answer the problem of all seriously ill patients! Of course, financing P.D. care is a big problem--but I do not see why a pt. must pay hospital full price--if they have P.D. nurses!

Nurses will be required to specialize in order to compete in P.D. nursing.

I think there is going to be more of it, since the R.N. on general duty does no real nursing--only aides do it.

I don't believe it is too good although I think there will always be opening for good private duty nurses.

In this area--it is becoming more limited each year and perhaps that is true in other areas because of better nursing care procedures in hospitals--intensive care, etc. -- the use of the P.D. nurse will not be a good field to consider as such.

I think soon there will be no private-duty section (as such) due to the increase of Intensive Care units in our hospitals. I think patients who need special nurses will be sent to the I.C.U. departments. Already hospitals are using their general duty personnel to special patients. Also many hospitals are beginning to make plans for coronary care units besides their I.C.U. units.

Poor for an R.N. Intensive Care Units and L.P.N.'s and aides are too competitive.

I think P.D. will always have a very definite "niche" in nursing. Although it might not be as "big" a field as it has been, the public will continue to demand for "extra care."

I'm sure there will always be some people who will have specials regardless of the number of hospitals with intensive care units and cardiac recovery rooms. And there will be cases needing special care which do not come under either of these. If I were starting over I would not do P.D. for the simple reason that I have doubts about the future of it. There will always be some nurses who can't or don't want to work all the time who will do P.D. --and young nurses looking for part-time work to pay for further education will do it for a while.

If nurses themselves do not keep up on modern therapy, care of patients and in some way become better nurses as a group--I am afraid that, as a field, it will be one of the least desirable.

Not too good. Rising rates for P.D. nursing--installation of intensive care units to care for critical cases in more hospitals--medicare in near future, etc.

The intensive care units are relieving the situation now, but there will always be a need for the P.D. nurse.

I personally think private duty is a very poor future occupation. The income is indefinite, after you earn your money there is the problem in some cases of collecting it. Some say go off the case. Can you leave a critically ill patient that needs constant attention? I'm not a Florence Nightingale but I do have a heart. Where can you draw the line?

There will always be some, but it is dwindling.

I think it is a good future if nurses will accept cases as offered. If enough P. D. nurses are available. Bedside nursing has many rewards and we will hope to be in demand.

I never quite relax even though I work more than 20 days a month. I feel that P. D. nursing is going out. I feel that the doctors discourage P. D. because at the same time I feel one works very hard doing general duty. I came back to nursing 4 years ago and I floundered around unknowingly the first 2 years but once I went on private duty I gained so much needed confidence that I had lacked before.

With the shortage of R. N. 's on general floor duty the need for the P. D. nurse is just as great as ever.

Not much unless we upgrade ourselves, educate the Dr. 's to believe in our capabilities, and do something within our organization to keep L. P. N. 's and aides from taking over. (We come too cheap.) Also qualify the nurse for the case.

Generally guarded, but might be better than that as long as insurance companies will reimburse clients for P. D. nurses regardless of whether they were needed or not. Lots of families can talk doctors into ordering P. D. nurses when they aren't really needed, and some keep them <u>much</u> longer than necessary. Since there is sometimes a shortage of P. D. nurses, it would seem that there could be some means of determining whether a P. D. nurse was really needed or not and have her work where she is most needed.

I think in large cities there may be need for P. D. nurses. But with intensive care and more rapid recovery period, I find less call for P. D. nurses in my locality. As a result I have been doing general duty relief for the last fifteen years. In the last year had only 2 days of P. D.

I believe there will continue to be some need for private duty nurses for patients needing a great deal of care even though more intensive care units are being built. Also some wealthy individuals will want the extra service.

<u>Gloomy.</u> There will always be some call for P. D. nurses, but in most places will be difficult to make a living at it alone. Is too undependable. Is a good field for married nurses that only wish to work part-time and don't depend on their income.

Just great! I think it is ideal for a nurse who is looking for the interesting job to keep her on her toes. If you enjoy working with all the newest techniques you are sure to be called. All the specially watched patients are going to need special nursing! The floor nurse with a trayful of meds and pts. demanding, as they go, doesn't have the time.

There will always be some need for P. D. nurses. Those who feel they are a luxury very often change their minds when their family become acutely ill.

I feel that the R. N. 's will have a more difficult time in securing work due to L. P. N. and aides in the years to come.

I believe like the family doctor, the private duty nurse is being pressed to a place where she will not be able to function. The salary will become prohibited for most people. Most nurses do not enter the field because of lack of security.

I think there will be a great future for P. D. nurses, especially in larger cities, because of the way student nurses are being taught in supervisory work rather than actual bedside nursing. Patients expect R. N. 's to take care of them instead of nurses' aides, so actually the patient does not feel that he is getting the proper care or attention that they feel they should have.

I don't think there is any future for private duty nursing. The I. C. U. 's at the hospitals are rapidly doing away with the P. D. nurse--however, I still think the pts. improve more and there is less apprehension--with both the patient and the relatives--when they have a private nurse.

There should always be a place for the P. D. nurse--for many pts. on general duty care do not receive adequate and proper care for the seriousness of their illness--in spite of the increased cost of hospital care. <u>It is lacking proper care</u>. If we as P. D. nurses will go to all hospitals, take all cases, are dependable, give <u>good</u> nursing care--(I have seen poor care--by some) the doctors, hospitals and professional registry will find P. D. nurses are an absolute necessity for their pt. a few days, or more, to help restore health.

APPENDIX H

SAMPLE RESPONSES TO AN OPEN-END QUESTION CONCERNING ASSISTANCE OBTAINED FROM OREGON NURSES ASSOCIATION

Verbatim quotes:

In public relations with some M. D. s. Numerous misconceptions of P. D. N. have changed doctors favorable attitude toward P. D. to some very unfavorable attitudes, by a few tactless and inefficient R. N. s whom these doctors were in contact with.

I feel the P. D. N. are so fortunate, especially in Portland, to have O. N. A. We would have fallen by the wayside long ago had we not had such dedicated personnel and efficient group of members that have counselled us for keeping up with education facilities and many other aspects to keep the older nurses in progress with the newer concepts of a most unique field.

1. Lowered rates for liability insurance.
2. Work shops.

Through Professional Nurses Registry Organized Nursing helps, and backing as a profession.

We are able to call on the Ass'n. if we have any problems.

They keep a restriction on the qualification of professional nurses, so nurses that are unable to work at hospitals because of irregularities cannot enter the field of P. D. They help in increasing salary.

1. We have a good professional registry here in Portland, thanks to our O. N. A.
2. Recently (last month) we voted on a pay increase. The increase was a proposal through the O. N. A.

1. The keeping of a professional (up to date) biography. (A lot of my instructors have married, retired, passed away, at least have lost track of them. If contacted now, would probably not know who they were writing about.)
2. The Ass'n. offers many opportunities for all nurses to participate in their professional organization. Develops leadership.
3. They encourage education programs and one way is the lower subscription rate to the A. J. N.

Allowing me to select types of cases and hrs. preferred.

I was only doing P. D. a short time (4 hrs.) and had specific demands at one hospital.

Actually I was and still am disappointed in P. D. N. in this part of the country after moving from a large city where we had a registry and specials were always in demand. Here the doctors seldom order P. D. and it comes in streaks--you could go for a month and not have a case and then all at once, there are not enough R. N. s because they become discouraged when they go so long before being called on a case, so they take jobs in G. D.

I guess it is just that the nurses professional registry is under the O. N. A. and the registry and all its associates have been very nice to me.

I get all my work through the nurses registry.

I feel that no labor union can take over as long as we support the O. N. A. Am very much against unions in our profession.

Does not help, except through clinical sessions for continuing education. However, as a nurse in a rural area and 400 miles from urban center of Portland area, this becomes quite expensive. Local District has had two workshops, cancer and orthopedics, in the last two years.

It doesn't.

O. N. A. and A. N. A. could improve the status of P. D. V. A. does not consider years spent doing P. D. as any experience, even if you do open heart, vascular, lung and brain surg. nursing.

Feel of security if necessary to call on O. N. A.

In many ways. We nurses have an organization to guide us in difficult and unusual situations. It also looks out for betterment in pay (which most of our dear doctors do not agree on). In general I wonder what we would do to struggle along by ourselves.

Very little--some of the educational programs are good, but too often occur when I am working.

The O. N. A. has tried to raise the levels both professionally and financially.

Many ways, perhaps the most significant are the work shops and lectures that have been made available for us. They set standards for maintaining our profession and regulation of fees. (29 answers said basically the same thing, but they all named seminars and lectures first.)

I have been a member of O. N. A. and A. N. A. all my nursing career, so of course, I feel very strongly about it. I can think of many things O. N. A. can do and does for any P. D. N. who wishes it:

1. Several times during the year O. N. A. sponsors educational programs.
2. Counselling and placement service.
3. Improved insurance rates, liability, etc.
4. Pays elected delegates transportation to A. N. A. conventions.
5. The executive secretary or assoc. executive secretary are both ready and willing to discuss any problems, and offer guidance with the solutions.
6. Assistance and guidance in improved working conditions and salaries for the P. D. N.
7. Assistance in collecting unpaid bills by executive secretary of District I.

I think the District has improved nursing conditions in the past 40 years. The 20 hours were reduced to 12 hours, the 12 hours were reduced to 8 hours with a reduction of $2.50 a day. Gradually the O. N. A. has helped raise wages and standards. (27 answers were basically the same, with the naming of raise in pay first.)

Has done well to keep our standards high (16 answers essentially the same.)

Feel that they try to handle and deal with problems when presented.

I don't know very much about it. I haven't been very active in it as family takes much of my time, then too, I have worked mostly 3-11 p. m. shift and unable to attend meetings.

I have had several calls through their office.

All organizations need an ass'n. back of them.

Many ways.

Always lend a helping hand when needed.

I'm really not sure.

It helps me to have guide lines and these have been established by the O. N. A. The discussion of problems in any field always helps, I think.

The rules and regulations that were issued to me when I began P. D. were very helpful.

It benefits me in my work and all nurses should be members of O. N. A.

O. N. A. does a great job for us. The rules and regulations put down by the organization are all important in many ways. It helps keep us abreast of present times and looks to the future. It also works as an equalizer. Actually I should not call O. N. A. "it" as O. N. A. is me and you and all nurses belonging. We have educational programs for all different branches of nursing. Financial help for furthering our nursing education as individuals is available to those qualified. We (O. N. A.) offer positions in many branches of nursing. O. N. A. keeps up with the times in all phases and aspects for all those interested. O. N. A. gives us the opportunity to fight for our rights as professionals according to law. We also have the privilege to participate in making new laws. For a member of O. N. A., the opportunities are unlimited.

Bargaining for me.

I appreciate very much the wonderful service which I have received through the O. N. A. District I. It has been my happy privilege to have been an active member since July, 1954.

Possibly in more way than I will ever know.

Probably on the bargaining table to some extent. Why P. D. N. are the only nursing group compelled to belong to O. N. A. before practicing seems quite unfair. There are nurses employed in other fields of endeavor who are making more money and have many fringe benefits that P. D. N. does not have.

O. N. A. gives status and a sense of belonging as do all professional organizations. For personal reasons I am a dues paying member only.

I have not had to call on the registry for cases since I started P. D., but am sure it would be most helpful in securing cases for work. I belong to O. N. A. and use their billheads and when off of present long case will be joining the registry and participating in their activities. I prefer 3-11 p. m. shift which rarely gives you opportunity for any meeting. However, this does not mean you don't support it because you can't attend meetings. I am sure O. N. A. would be most helpful in securing nurses for P. D. and relief nursing.

Set up functions, standards and qualifications for each group of nurses. Provides professional registry in larger cities. Provides registry committee who hears complaints and has some regulating and screening duties. Assists in setting our fees so they are uniform throughout the state, and on occasion assists in collecting same. Represents us in the legislature and with problems with the hospital association. Provides educational material and programs conferences, etc. to add to our efficiency.

In determining standards and policies. Through educational meetings, Institutes, etc., of which years ago when I attended these your membership card was all that was needed. Now, one pays extra to attend--registration fee's now all the way from $5. 00-$10. 00 even though our dues did go up. I think somehow these should be free to members as it is these things that girls see as tangible.

In "public relations". With some M. D. 's. Numerous misconceptions of private duty nursing have changed doctors favorable attitude toward private duty to some very unfavorable attitudes, by a few tactless and inefficient RNs. whom these doctors were in contact with. . .

In setting adequate salary rates. Also in helping me to obtain liability insurance for nursing practice. In answering legal questions re: nursing practice.

Of course, I am directly benefited through the Registry. Although I haven't had the time to attend meetings, I'm sure they are educational. Also, they are responsible for pay increases in which all nurses benefit.

Mainly--in raising our pay to its present rate. Also--in stressing nursing as a "profession", it gives us prestige.

It has helped a great deal in the past and most of us feel and appreciate becoming better paid, however, as the salaries have increased, there has been less and less a demand for private duty nurses, some do not take the trouble and money to pay their dues--yet feel they will get a call if the demand presents itself. So far, I have been a full member as it takes only two days work, to pay the whole year's dues, each one of us who do private duty are married, and have our homes. No one could make a living, pay rent, or pay for a home, buy groceries and clothes, on earnings as a private duty nurse here. And now the salaries have gone up to $25. 00 per day. We certainly will get even fewer calls. This may present different problems in Eugene, Salem and Portland where there are more hospitals and more practicing physicians. Why could Oregon not go on record of not escalating nurses (private duty) salaries because California and Washington States do. We all know that as salaries are raised, so are groceries, clothes, etc., too. We should certainly draw a stop some place at least this seems only sensible. Some ONA members live on the Idaho-Oregon borderline, and the Holy Rosary Hospital, has less than 100 bed capacity. You can see how little

demand there is for private duty nurses charging $75.00 a day (24 hours) for three nurses. Unless they are for critical cases--often only two or three days work at the most. There are fewer and fewer calls in the last five years.

Probably on the bargaining table to some extent. Why PD nurses are the only nursing group compelled to belong to ONA before practicing seems quite unfair. There are nurses employed in other fields of endeavor who are making more money and have many fringe benefits that PDN do not have.

I know the ONA has been responsible for keeping working conditions, wages, etc. as good as they are and will be our only hope for future progress. I'm sure the P.D. nurses alone have never been strong enough to do this alone.

APPENDIX I

SAMPLE RESPONSES TO AN OPEN-END QUESTION SEEKING SUGGESTIONS FOR ADDITIONAL WAYS WHEREBY THE OREGON NURSES ASSOCIATION COULD ASSIST PRIVATE DUTY NURSES

Verbatim quotes:

I would like to see the O. N. A. institute some kind of a program for education of private duty nurse. Since the private duty nurse is not affiliated with any hospital they very often do not have the opportunity of familiarizing themselves with new equipment and techniques introduced in the hospital. One hospital recently gave a six week course of lectures and demonstrations on intensive coronary care and invited private duty nurses to attend--it was very informative and helpful. I think courses of this kind would be very beneficial and enable the private duty nurse to give better comprehensive nursing care.

I believe the O. N. A. is doing everything possible that they can for the Pr. Duty Nurse, and I am well satisfied. My thanks go out to them. They're tops.

I feel they do a very good job. Many of us need additional education and do not avail ourselves of the opportunities offered.

None. I think if a nurse lives up to the standards of nursing she will always be recognized, and helped by the state in which she works.

Have the hospital check on the nurses to see if she is an R. N. when coming on duty ...Discourage R. N. 's from calling nurses not registered in state or belonging to Assoc. or official registry.

I would like to see it made compulsory for all graduate nurses to join the association upon graduation. If this were so, our dues would not be as much and more nurses may contribute more in ideas and time.

Provide a better Registry Program--to back up the Nurses when trying to collect overdue bills--perhaps charge interest if not paid within a limited time.

Produce and circulate literature of the type of reading you are preparing in your present assignment.

More seminars and meetings....

Have more educational workshops.

O. N. A. can make studies and take action on matters of legislation affecting private duty nurses and nursing service to the public.

...We alone can raise our requirements--I do not feel O. N. A. can help us.

Every R. N..... pay O. N. A. dues yearly. The P. D. pays or she is not allowed to work.

More interesting reports on new methods and equipment.

Lower dues after retirement.

Possibly promote payment to be made by Health Ins. programs.

Explain the advantages of private duty care to the medical profession on a state level. This is too personal to be done well on the local level. A study on the needs for a private duty nurse might be interesting. This could be done if nurses were asked what types of cases they had last year.

I would like to see the O. N. A. take a survey of doctors in Portland and perhaps Salem and see what their attitude is toward private duty nurses. . . .

. . . . The Assn. should also work toward having the salaries of P. D. nurses paid by the hospital and then included in the hospital bill. The hospital would then maintain a greater interest in P. D. nurses and the standards of nursing care would become better.

Might emphasize that hospitals teach head nurses that private duty nurses with very critical patients ought to be given assistance if needed. Whether we get help or not sometimes depends on whether the head nurse is willing to see that assistance is rendered.

Better communication with doctors and hospitals for our benefits as well as theirs.

Aid in recruitment of younger nurses especially those who can work only part-time.

I <u>am</u> O. N. A. and every nurse should realize this is true. The organization can only do for you what you help it to do "give and you shall receive!"

Because of our independence in our practice, I believe the Private Duty Nurse needs her association more than other nurses. We must depend on the association for continuing educational programs and guidance in our practice. We may ourselves initiate plans but the organization is needed for fulfillment. . . .

Assoc. forms for signature of pt. or family--to assume financial responsibility before private nurse is called on case--check it to pts. or family's ability to pay.

. . . . I would suggest a form letter of some kind be sent to the doctors' offices covering the role of a private duty nurse. I recently talked to a doctor and there are many with this same opinion. His comment was "What do you girls do with all your money?" After I had explained to him we pay social security coverage, no sick leave, no paid vacations or holidays and a few other expenditures required of us he was a bit surprised to say the least. . . .

A better public relations program. . . . The teachers have done a masterful job at Public Relations. . . . Not that I think we need sympathy but I think it would be a good idea to let the public know most nurses work hard, have years of preparation, etc., and have disappointments as well as the great satisfactions. . . .

I think it would be good if O. N. A. could help in establishing a policy with hospitals whereby a private duty nurse would not be called unless the patient was able to afford such a service. It is hard for a nurse to try and collect on cases where there are no means. Most private duty nurses do not like to consider the financial side at all in giving nursing care, but they must meet their own living costs and obligations.

AGAIN I say, the Oregon Nurses Association cannot help individuals but as a group I feel they should offer some class or information to young nurses who went into training to learn to care for persons ill and after getting in, find very little bedside care and 90% theory and books and they could have gone to college as many had, and still have, a nurse as an "idol" and T. L. C., for the ill, but T. L. C. (tender loving care) for the ill, but T. L. C. is long forgotten and "Do it yourself" and "do the least you can do to get by with" is more prominent.

APPENDIX J

ADDITIONAL SAMPLE COMMENTS ELICITED BY PART III, ITEM 6 OF THE DATA COLLECTING TOOL

Verbatim quotes:

We are told that we are under the hospital's direction and responsible to the nurse in charge--this I believe is right. However, I have been flatly refused any assistance whatever on a delirious and dying patient who could not be restrained or sedated, would have stripped I. V. 's, O_2 and plunged from the bed had I left her. When I asked a head nurse at the... hospital to send someone in to watch the patient while I ordered blood, etc. or else have them do the necessary errands for me, she told me that private duty nurses were being paid well and she had no intention doing "our work". She gave me no help whatever.

Maybe this is aside from the point but I think the assoc. and hospitals should in some way get student nurses back to patient care--no student wants to care for patients--it's all left to aides and P. N. 's and the patients are neglected.

I think there will always be a place for some private duty nurses. I do believe if we are not qualified to take care of all types of patients we should be placed on limited call for whatever type we can handle. Some of the older nurses are really unable to do hard cases like burns. Some have not kept up in techniques enough for all types but there are still places where they can be very useful.

While all other students are encouraged to go to college and get more and more degrees, nursing drags along behind and never will become truly professional. As far as I know the doctors are not advocating shorter courses to meet the demand for more doctors. Instead they reluctantly allow technicians to take over some of their duties.

Most of the R. N. 's that were on that registry are working in the hospital doing general duty some on a part-time basis in order that the hospital has around the clock staffing. It is impossible here to get private duty nurse for the most critical ill pt. with any reliability.

Nurses on case loyalty to one another. Each nurse should build confidence in nurse to follow--to patient to add to his security. It is alright to build pts. confidence in herself but not to the expense of other nurses on case.

If private duty nurses were paid by hospital instead of patient, the standards would be higher, also there are some girls who are not as neat appearing and therefore not a good representative of their profession. This might improve under the above arrangement.

Hospitals are starting special services such as intravenous therapy and inhalation therapy which leaves the nurse frustrated. We like to do these things for our pt. because the pt. is used to us and because we can arrange our work better. We are grateful for having their expert advice; however, will this "assembly line" technique hasten the demise of the Private Duty Nurse?

I intend to bring up our low standards at the next Private Duty Section meeting. We have speakers at these meetings with valuable information--the attendance is poor. You can special till you're 100 years old. Previously the hospitals can send in complaints and nothing is done. This is not right. We should keep up on our nursing and practice it. We have something to offer-but we aren't doing it.

The average age of P. D. nurses is too old and there are those who are not capable. I think it is wrong that these people are not screened and sent out according to their abilities. Hospitals should be visited by the registry once a month, asking for an evaluation of the private duty R. N. 's--those who cannot take B. P. or care for tracheostomy or foster frame, etc. should be compelled to learn or not have the nerve to ask for $22. 00 every shift and then want a raise.

I think when there are two small towns so close together there whould be a registry or some one other than the hospitals to contact when you are available for private duty. That aides not be allowed to do private duty unless ordered by the doctor. That private duty nurses pay an extra fee to belong to the private duty section, if they want to specialize and be kept active enough so that methods of nursing and medications are not all strange to her, even if she works part-time general duty.

That any private duty nurse have had some general duty or practiced in the field of nursing at least part-time for a year. (For instance a doctor's wife who is not allowed to work but is an R. N. so has not kept up with her nursing procedures or contact with patients, but will occasionally take a case and knows nothing of the procedures in this hospital or how to act toward a patient.

I too have turned to doing general duty but on my days off make myself available for special duty because of such little demand in this area--I hope that I can again make private duty my entire career as I too enjoy it considerably. I might have to move to a larger city where private duty is more in demand and have thought of Portland as a possibility.

There are things we can do to improve relationship between hospital nurses and ourselves. We can pay closer attention to the different requests made upon us by the different hospitals--there are times when we can cooperate a little more, even among ourselves. Like reporting on duty on time and taking over any unfinished work there may be to do without griping. Medicare may improve P. D. --too soon to know. With the increased work load everywhere, those who possibly can afford nurses may indulge because the floors are so very busy. I'm sure there will always be some demand for T. L. C.

I do think fees are too high and that the general (average) public would feel encouraged to use more P. D. nurses if they weren't so far out of their reach. One supervisor said to me when fees were, I think, $13. 50--"Aren't you ashamed to charge people so much"--didn't feel so sensitive about it as now. With a ward (which in my student days was $3 a day, and better nursing service) at $30 a day--it doesn't seem right to bankrupt people to just return them to a former state of health. Perhaps more home nursing service.

Might I say that I enjoy Private Duty Nursing especially when there is a challenge. Also I have made such wonderful friends throughout these years and have even taken care of children and grandchildren of former patients.

The General Duty R.N.'s do not make arrangements for meals or even time to go to the bathroom. A critical pt. can't be left alone. No one comes near unless you call for help and then they seem to resent being asked. On night duty the staff members are very willing to help (the main reason for my doing nights only).

When the pt. enters the hospital he pays for board, room and general care--so why isn't he considered as part of the responsibility of the General duty to see that the pt. is getting care needed. And realize that P.D. is extra cost to the patient, i.e., so

1. the pt. pays for general duty first.
2. he pays extra for P.D.
3. he returns to General Duty.

Why isn't it important that a P.D. has her meals and why can't they too have a coffee break and the arrnagements made for this. These are the complaints of the day and p.m. shifts by P.D.R.N.'s. This feeling of being an "outsider" is felt thus resulting in resentment.

I do P.D. because I enjoy it and want to "keep up" with nursing trends. I'm too old to go back to Gen. Duty. Ha. Ha.

I don't think the P.D. nurse should be expected to work 8 hours without a coffee break--the same way the staff does and the staff should arrange for your pt's. coverage at such times.

Sometimes one almost feels as though an apology has to be made for our presence here.

I feel, someway, somehow and sometime nursing will revert to nursing instead of trying to make junior Doctors out of nurses. Private Duty to me is not any different than what I always wanted to be since I was very young, and said to my parents, "I want to be a Nurse". In Private Duty you are privileged to be a nurse and I mean a Real Nurse. In other fields this is not available as nursing care comes after reports and bookwork. The nursing educators should look into or make surveys that are definitely confidential such as this, and visit student nurses, not one or two, but every student and they would find many girls that want to do bedside care, these girls want to learn to do what they started out to be, "A Nurse". Many instructors of student nurses, that I know personally, have gotten out of training in June, and in September are instructing students bedside nursing which they had not done, since they had done what they were teaching. No matter in any field and definitely in nursing, you can't teach how to make a patient comfortable and take care of and foresee their needs if you don't know how yourself, except, by the book.

I feel Private Duty Nursing will be greatly in demand as in the years to come, "Care" and "Nursing" is the big factor and when Medicare is ironed out, those who are entitled and are financially able will more so want Professional Nurses, not Nurse Aides and Practical Nurses, as these will be all that the hospitals will offer as their staff, and by then I hope T.L.C. comes back in Nurses' Training.

I graduated from Holy Cross Hospital in Salt Lake City, Utah in 1926. I did Private Duty Nursing for about a year and then got married. We worked twelve hours for $5.00 a shift and I worked nights.

After I was married we lived in the country and I didn't do any nursing for over eight years while I was having my family of four children. Before my fourth child was born we were living in American Fork, Utah about twenty miles out of Salt Lake. I started back to nursing by helping out in a small hospital in American Fork. I would help the night nurse with deliveries as many of the babies were born in the wee hours. The night nurse would send the sheriff after me before I got a phone. It was

during the depression and the only work my husband could get was W. P. A. which wasn't enough.

I specialed a colored boy twelve hours a day and got a check for $91.00 from the State, that brought us out to Oregon. One of my brothers had started contracting cement work and promised my husband a job if we would come to Oregon.

I went on the Nurses Professional Registry for Private Duty Nurses and have been for over twenty eight years. At that time work was very slow and being an out of town nurse made it worse as the hospitals would favor their own nurses. I couldn't register in the state because I had only had two years of high school which was all that was required at the time I trained. There were several nurses that had the same problem. We had to go to night school at the Old Lincoln High School. I worked nights and tried to take care of my home, which was rough. I just couldn't ever sleep in the day time even when I was in training. I would average about three hours a day and was tired all of the time. I would stay home between cases. I just couldn't work the swing shift as it took me away from home when my children were home which isn't good, and I would have to get up early in the morning. They were so short of nurses during the War that they let us take an Aptitude Test and they passed us as high school graduates. I worked nights for ten years or more while my children were young. I got so I couldn't sit while my patients were sleeping so I have worked days ever since.

I have been very fortunate over the years to have many wonderful people to take care of. I have had many good long cases with very little time off, which is good for me as it is too easy to stay home between cases as I always have plenty to do at home.

My husband has Hypertention and Angina of the heart and hasn't been able to work for twelve years or more. I enjoy my work and always have. I have had many desperately sick patients and have been able to help some of them back to health which is the greatest satisfaction in nursing. I learn something new on every case and have made many wonderful friends. I feel that I can make a surgical case last longer because I help a person with their needs. I have taken patients home from the hospital and helped them at home until they were able to be on their own. I don't mind doing anything in reason which wouldn't be classed with nursing... but it is the help they need.

I have had to slow down the last few years. I have always liked Private Duty Nursing. It has worked out real good for me. When I have finished a long case or been with a very sick patient I stay home for a while and do something different as there is so much nervous tension to nursing. I have always been very thankful for my profession which has made it possible for us to have a nice home and many comforts.

Typed by Gwen Hansen and Eula Weathers

AN ABSTRACT OF THE THESIS OF

Colleen C. Hughes

for the Master of Science in Nursing

Date of receiving this degree: June 9, 1966

Title: The Status and Potential of Private Duty Nursing as Perceived by 126 Private Duty Nurses in Oregon

Approved [redacted]

Lucile Gregerson, Associate Professor in Charge of Thesis

THE PROBLEM

This study was undertaken for the purpose of identifying the characteristics of the private duty nurse in Oregon as a person. Information was sought concerning certain variables such as age, marital status, number and type of dependents, per cent of self-support and average number of days employment per month. From such data it was hoped that a profile could result. It was further proposed that information be gathered concerning the scope of the private duty practice of each participant. Information was requested concerning experience, nature of private duty nursing, particularly how cases were obtained, limitations to practice, if any, and reasons for same. The final purpose was to seek the participants' opinions regarding private duty nursing, specifically what aspects were most enjoyed and least enjoyed. Further opinions were sought regarding the future of private duty as an occupational field, how the Oregon Nurses Association assists the individual in her practice of private duty nursing and suggestions for additional assistance.

DESCRIPTION OF THE PROCEDURE

The data collecting tool was designated as an opinionnaire with recognition of the high degree of subjectivity possible in some of the responses. Data were collected by a mailed opinionnaire sent to all

members of the Private Duty Section of the Oregon Nurses Association. There were 126 usable returns which constituted 57% of the eligible participants. The data were tabulated and analyzed in accord with the stated purposes of this study.

FINDINGS

The summarized findings were that the private duty nurse in Oregon is apt to be more than fifty years of age, probably now married (or has been), possibly without dependents, at least partially self-supporting, employed less than twenty days a month, a graduate of a diploma school of nursing in about 1932, with little, if any, education beyond the basic nursing course. It was further learned that private duty nurses had practiced nursing between 20-30 or more years and that they had functioned as private duty nurses most of that time. Their cases were largely obtained through an official registry. Nearly 80 per cent place some limitations on their practice, either in the type of cases accepted or rejected, or the specific shift during which they will work or the specific hospital in which they will function. Less than 50 per cent of the participants had had home cases in the past year and less than one-third had had cases in nursing homes.

The greatest number of comments regarding aspects of private duty nursing most enjoyed were concerned with patient care. The

comments regarding aspects least liked focused heavily on the collection of fees, fatigue, non-nursing duties, lack of fringe benefits, and waiting for cases. Over half of the participants were of the opinion that there was a future need for private duty nurses, but over one-third thought the future was questionable. The respondents indicated that the Oregon Nurses Association was helpful mainly because of educational opportunities, fee regulation, professional support, standards and qualifications, legislation and negotiation. Additional assistance from the Oregon Nurses Association was desired mainly in terms of more educational opportunities, insurance to pay wages, reclassification of private duty nurses, and improved public relations.

Additional comments were largely related to personnel policies and interpersonnel relations.

CONCLUSIONS

From the data obtained, the following conclusions might be drawn:

1. The majority of the private duty nurses are in middle life with a sizeable number approaching retirement age. The number in the younger age brackets is not sufficient to ensure that private duty nursing will be self-perpetuating.
2. Over four-fifths either are or have been married. This may account for the fact that only 42 per cent stated they

were 100 per cent self-supporting.

3. Private duty nurses have assumed little individual initiative for up-grading themselves. The median year of graduation was 1932; the range was 1916-1964. A small number had obtained education beyond the basic nursing program.
4. About four-fifths of the nurses place limitations of some type on their practice. The rationale is difficult to interpret, particularly those reasons related to children given by respondents who graduated thirty years ago. It should be recognized that some limitation of place of employment is inevitable in the smaller communities where there may be only one hospital.
5. The comments relative to the most enjoyable aspects of private duty nursing reflected interest in the welfare of the sick; the comments regarding the least enjoyable aspects were related to employment practices.
6. The future of private duty nursing seemed questionable to about one-third of the respondents. More than half could foresee an apparent need but made no suggestions for ways to resolve the present dilemma of all too few young nurses to replace those approaching retirement. The rationale of the comments seemed unrelated to the reports in the literature. To illustrate, such reasons for the decline in private

duty nursing as "the advent of intensive care units", "licensed practical nurses doing private duty", and other such statements do not fully explain why the number of private duty nurses decreased long before intensive care units were developed or licensed practical nurses entered private duty nursing.

7. The participants appeared to recognize the advantages of membership in the Oregon Nurses Association. Their statements regarding the ways the Oregon Nurses Association had been helpful were related to the programs of the Association.

8. The suggestions for additional assistance by the Oregon Nurses Association seemed to be related to personnel policies rather than nursing practice with the exception of the requests for more educational opportunities. It is not known to what extent educational opportunities are available in communities where private duty nurses reside, nor how much these opportunities are utilized. From the comments, it would appear that the respondents look to the Oregon Nurses Association for making "educational opportunities" available.

Based on the findings and conclusions of this study, the following recommendations for further study were made:

1. Since only those nurses with no dependents worked enough days each month to equate to full-time employment, a study should be done to determine if this situation is due to lack of opportunity, choice, or to self-imposed limitations to the nurses' practice. In view of the number of unfilled calls for private duty nurses, it is important to determine if all able nurses are being employed to the optimum of their capacity.
2. In view of the paucity of the education beyond the basic nursing preparation, the private duty nurses' request for more educational opportunities must not be ignored. It is accordingly recommended that studies be undertaken to ascertain the nature and scope of education to which the respondents made reference. These studies become of utmost importance in view of the many comments made by the respondents relative to self-imposed limitations placed on practice because they did not feel qualified to give the needed care. The availability of educational resources should also be investigated.
3. The participants verbalized freely concerning the least enjoyable aspects of private duty nursing, particularly the collection of fees. It is recommended that the private duty nurses undertake a study, perhaps under the auspices of their Section, to investigate modern collection systems.

4. In view of the numerous other comments reflecting on the unpleasant aspects of private duty nursing, it is further recommended that studies be instituted to ascertain what problems actually exist in the public relations between private duty nurses and hospitals, other nurses, physicians, patients and others. From such studies recommendations might evolve for a better public relations program.