A Comparison of Nursing Role Conceptions Among
Baccalaureate Nursing Students, Their Nursing Faculty, and
Clinical Nurse Mentors

Michele Lynn Musella
Old Dominion University

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A COMPARISON OF NURSING ROLE CONCEPTIONS AMONG
BACCALAUREATE NURSING STUDENTS, THEIR NURSING FACULTY,
AND CLINICAL NURSE MENTORS

by

Michele Lynn Musella
B.S.N. June, 1972, University of Maryland

A Thesis Submitted to the Nursing Faculty of Old Dominion
University in Partial Fulfillment of the
Requirements for the Degree of

Master of Science

Old Dominion University
May, 1987

Approved by:

Linda L. Davis (Director)

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Karen Smith
ABSTRACT

A COMPARISON OF NURSING ROLE CONCEPTIONS AMONG BACCALAUREATE NURSING STUDENTS, THEIR NURSING FACULTY, AND CLINICAL NURSE MENTORS

Michele Lynn Musella
Old Dominion University, 1987
Director: Dr. Linda L. Davis

This descriptive study focused on the bureaucratic, professional, and service role conceptions of nurses. It was hypothesized that there are significant differences in the ideal and actual perceptions of these role orientations among baccalaureate nursing students, their nursing faculty, and their clinical nurse mentors. The three subscales of Pieta’s 1976 Nursing Role Conception Scale (NRC) were used. The results of a discriminant analysis indicated significant differences in professional and service nursing role conceptions among students and both their nursing faculty and clinical mentors (p<.000). An evaluation of the reliability and validity of the NRC revealed that selected instrument items need to be revised and refined for more internal consistency and to reflect more contemporary content validity.
Then said a teacher, Speak to us of Teaching,
   And he said:
   No man can reveal to you aught but that which already
   lies half asleep in the dawning of your knowledge.
   The teacher who walks in the shadow of the temple,
   among his followers, gives not of his wisdom but rather
   of his faith and his lovingness.
   If indeed wise he does not bid you enter the house of
   his wisdom, but rather leads you to the threshold of your
   own mind.

   I wish to thank Dr. Linda Davis, my mentor, for her
   patience, guidance, and research expertise. I wish also
   to thank Dr. Helen Yura, my nurturer, for facilitating
   the "met" state of many of my human needs and Karen Smith,
   my friend, for her tireless efforts. Many thanks to the
   students and their mentors for their participation, the
   members of CLIA for their assistance, and a special
   acknowledgement to my family for their support and tolerance
   of the "unmet" state of many of their human needs.
# TABLE OF CONTENTS

LIST OF TABLES ................................................................. v
LIST OF FIGURES ............................................................... vi

Chapter

1. INTRODUCTION ............................................................... 1
   Purpose ............................................................................. 1
   Problem Statement ......................................................... 2
   Theoretical Framework ..................................................... 7
   Definition of Terms ........................................................ 14
   Assumptions and Limitations ............................................. 16
   Review of Literature ......................................................... 17
   Hypotheses ......................................................................... 27

2. METHODOLOGY ................................................................. 29
   Research Design ............................................................. 29
   Sample ............................................................................ 30
   Setting ............................................................................ 31
   Tool ................................................................................. 32
   Procedure ......................................................................... 34

3. RESULTS ........................................................................... 46
   Analysis ........................................................................... 47
   Findings ........................................................................... 57

4. DISCUSSION ................................................................. 59
   Conclusions .................................................................... 64
   Recommendations .......................................................... 68

BIBLIOGRAPHY ................................................................. 71
<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>NURSING ROLE CONCEPTION SCALE</td>
<td>80</td>
</tr>
<tr>
<td>B.</td>
<td>DEMOGRAPHIC DATA SHEET (Baccalaureate Nursing Students)</td>
<td>92</td>
</tr>
<tr>
<td>C.</td>
<td>DEMOGRAPHIC DATA SHEET (Faculty and Clinical Mentors)</td>
<td>94</td>
</tr>
<tr>
<td>D.</td>
<td>LETTER TO PARTICIPANTS (Baccalaureate Nursing Students)</td>
<td>96</td>
</tr>
<tr>
<td>E.</td>
<td>LETTER TO PARTICIPANTS (Faculty Mentors)</td>
<td>98</td>
</tr>
<tr>
<td>F.</td>
<td>LETTER TO PARTICIPANTS (Clinical Mentors)</td>
<td>100</td>
</tr>
<tr>
<td>G.</td>
<td>LETTER TO CHAIRMAN OF SCHOOL OF NURSING</td>
<td>102</td>
</tr>
<tr>
<td>H.</td>
<td>LETTER TO DIRECTOR OF NURSING</td>
<td>104</td>
</tr>
</tbody>
</table>
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Internal Consistency Coefficients for the NRC Scale</td>
<td>41</td>
</tr>
<tr>
<td>2. Faculty Mentor Demographic Data</td>
<td>47</td>
</tr>
<tr>
<td>3. Clinical Mentor Demographic Data</td>
<td>48</td>
</tr>
<tr>
<td>4. Possible and Actual Subscale Score Ranges of the NRC</td>
<td>49</td>
</tr>
<tr>
<td>5. Ideal and Actual Reliability Analysis for the Bureaucratic, Professional, and Service Scales of the NRC</td>
<td>49</td>
</tr>
<tr>
<td>6. Combined Scale Reliabilities for the NRC Scale</td>
<td>51</td>
</tr>
<tr>
<td>7. Individual Mean Scores for Baccalaureate Nursing Students, Faculty Mentors, and Clinical Mentors on the NRC Subscales</td>
<td>54</td>
</tr>
<tr>
<td>8. Results of Discriminant Function Analysis for Baccalaureate Students, Faculty, and Clinical Mentors on Five Subscales of NRC</td>
<td>55</td>
</tr>
<tr>
<td>9. Standardized Canonical Discriminant Function Coefficients</td>
<td>56</td>
</tr>
</tbody>
</table>
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figures</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Model for Development of Nursing Role Conceptions of Baccalaureate Nursing Students</td>
<td>13</td>
</tr>
</tbody>
</table>
Chapter 1

Introduction

Reality shock in nursing may be described as the cumulative conflict, characterized by despair and avoidance, experienced by neophyte nurses upon entering the work force and discovering that the practice of nursing is often very different from the role for which they have been prepared. The controversy about reality shock that has evolved over the last 40 years pervades nursing. According to Kramer (1974), reality shock is common in nursing because the goals of nursing service and educational organizations differ, nurse educators become removed from nursing practice, and nursing service personnel have unrealistic expectations of newly appointed baccalaureate graduate nurses. Resultant role conflicts experienced by new nurse graduates are often difficult to resolve and may impede their progress toward nursing professionalization (Kinney 1985). Prior to 1974, a significant portion of nursing research focused on professional nursing role conceptions among students and staff nurses, and students and their faculty to determine if nursing student role discrepancies which lead to reality shock existed (cf. Corwin 1960, Davis and Olesen 1964, Kramer 1968). If nursing is to advance as a profession it is important to determine whether role discrepancies perceived by nursing students exist today.

Purpose

This study had two purposes. The first was to examine
bureaucratic, professional, and service nursing role conceptions of senior baccalaureate nursing students, their faculty, and clinical mentors. For these three groups the conceptions of the ideal role of the nurse, of the actual practiced role of the nurse, and the differences between these conceptions were examined. To assess these role conceptions the Nursing Role Conception Scale (NRC) developed by Pieta (1976) was used. It was anticipated that information would be provided about factors related to reality shock in senior nursing students. This tool had not been evaluated since its development in 1976; therefore, the second purpose of this study was to explore the current reliability and validity of this tool.

**Problem Statement**

Reality shock has been defined to exist when there is a gap between what the nurse has been taught is the role of nursing and what is learned to be the actual practice of the role (Kramer 1974). Kelly (1985) cited reality shock in nursing as a source of deep-seated job dissatisfaction. Reality shock has been proposed as a causal factor in nurse turnover rates, which have ranged in recent years from 70% to as high as 200%, within the first year of employment (Seybolt 1986). According to Kelly, the current high rate of nursing absenteeism is a reflection of some of the problems experienced by new nurse graduates. Castillo and Corona (1979) proposed that nurses will leave the profession if unable to cope in the 'real world', and continue to leave the profession until the problem of transition is resolved.
During the formal years of professional education, socialization is a major factor in the development of a professional self-identity. Students experience role assimilation at different rates and in varying degrees as a result of values emphasized by faculty, clinical mentors, and the profession (Hardy 1978). The resultant role conceptions influence the graduate's ability to function in their new status. Corwin (1961) suggested that there are at least three dominant conceptions of nursing: an office, a profession, and a calling. He noted that the profession's central purpose of maintenance of standards and values is in direct contrast to bureaucratic efficiency which is primarily task oriented and devoted to carrying out procedures. Kramer (1974) found that conflicts of loyalty emerge for nurses between the professional system into which many nurses are socialized and the bureaucratic system under which most professionals work. She proposed that a greater congruence of behavioral expectations, norms, and values between nursing's educational and administrative organizations leads to an easier transition from neophyte to professional nurse.

A noticeable amount of nursing research prior to 1974 focused on nursing role conceptions and the conflict resulting when ideal and actual professional and bureaucratic conceptions did not mesh. Despite the lack of current research, this conflict seems to persist as does the apparent discord between nursing service and nursing education values.
Johnson (1980), a nurse educator, stated that at one point in the history of nursing, when all nursing education occurred in hospital-based diploma programs, the two worlds of education and service were not estranged. In 1978, 73% of all new nurse graduates were from college-based programs, compared to 1968 when 65% were products of diploma programs (Lysaught 1979). The control of nursing education has shifted from hospitals to academic institutions resulting in a diluted association between the two systems. Johnson proposed that service facilities are becoming intolerant of education's resistance to help resolve problems of staffing and maintenance of high quality care. Nurse administrators have questioned the benefits reaped by allowing education the use of their clinical facilities (Johnson 1980).

Wagner (1980) assessed nursing education from a nurse administrator's point of view. Although not supported by empirical data, she maintained that nursing education consciously broke away from nursing service in the 1950's because "it feared nursing service personnel would have a bad influence on education" (p.557). Since that time, the health care industry has increased in complexity, placing greater demands on nursing education to prepare nurses for work in these complex settings. Wagner has proposed that nursing education falls short of attaining this goal.

Riddell and Hubalik (1981) proposed that both education and
nursing service own the responsibility for bridging the gap. Kramer (1974) indicated similar disputes occur in business, education, and social work. Riddell and Hubalik (1981) suggested that the bulk of the responsibility belongs to education since it prepares the future leaders who inevitably will bring about change. Nursing service has the responsibility of decreasing role deprivation since reality shock begins shortly after employment. The authors concluded that there is a gap between the two systems which can be resolved only by collaboration.

Not all the literature supports the contention that this conflict has only negative connotations. Theobald (1985) suggested that despite the chasm between service and education, nursing does have a future. The author stated that "as a profession nursing must agree whether nursing education should be married to or divorced from nursing service" (p.48). The belief is that if this separation should occur both systems would benefit. It is Theobald’s opinion that if practicing nurses are qualified and nursing students supernumary, a reduction in the cost of the operational work force to nursing service and a reduction in the number of students and faculty required by nursing education could occur. Theobald proposed that the end result would be improved patient care which, according to Kramer (1974), has been sacrificed by the occurrence of reality shock.

It is important to reexamine the nursing role conceptions of nursing students, their faculty, and their clinical mentors and see
if incongruencies exist today. There is considerable furor in current nursing literature over issues such as entry into practice and the appropriate level of education required for certification as a specialist. Diploma, associate degree, and baccalaureate nursing education programs are being called to justify their continued existence. At a time when nursing must assess educational expenditures, it would seem extremely important to determine the success of efforts made to imbue neophytes with a strong sense of professional identity. By determining whether professional nursing role conception discrepancies exist, educational strategies to resolve such differences may be developed. This study is a first step in exploring whether such discrepancies exist currently. Thus, this study sought to explore whether nursing role conception discrepancies existed between the neophytes for the profession (senior nursing students), the educators for the profession (the nursing faculty), and the practitioners for the profession (the staff nurse practicing in the health care system). It is important to compare these three groups to each other because the faculty mentor endeavors to inculcate in the student aspects of the functionalist perspective and the clinical mentor facilitates professional role socialization through the interactive approach. Is the educational process by which role dimensions are learned dominant, or is the interactional approach where the student learns by observation more dominant? One way to determine this is by the use of the Nursing Role Conception Scale.
(NRC) which purports to explore and measure the individual’s stated commitment to professional, bureaucratic, and service role conceptions. The instrument’s underlying theoretical framework is adult role socialization (Clausen 1968) which proposes that role conceptions are formed and transformed during the socialization process. It is therefore appropriate to examine nursing role conceptions of nursing students and their role socializers using the NRC.

**Theoretical Framework**

The theoretical framework for this study was role theory which depicts a variety of concepts that predict how one performs in a specific role and under what conditions role behaviors are expected. According to Hardy (1978), the functionalist and the interactionist approaches are two perspectives from which role learning and performance may be studied. The assumption that roles are fixed positions within society to which certain demands and expectations are attached and enforced by sanctions is the premise for the functionalist perspective. The interactive approach is derived from the interpretation of behavior in response to the symbolic acts of others. The major differences between the two approaches are that functionalists conceive social action as learned responses exchanged during socialization and augmented by significant others as peers, teachers, or employers and the interactionist approach proposes that individuals engage in social actions with others and select, organize, and interpret cues in their environment (Hardy 1978).
Roles may be viewed as social facts transmitted by a process of socialization. According to Brim (1968), the process of socialization deals with the learning of social roles, norms, and values. The goals of socialization are the attainment of some form of competence in adult performance deemed acceptable by society, and an internalized responsibility to continue participation in society. Society uses socializing agents to transmit the kinds of learning that have ultimate relevance for adult role performance (Brim 1968). The socialization process is often viewed to imply that the socializee is encouraged to conform to the values and norms transmitted by the socializing agent. It is assumed that these values and norms are internalized and became behavioral standards in the absence of internal or external sanctions (Brim 1968). From a role perspective, socialization is viewed as a continuous and cumulative process in which behaviors and role prescriptions attached to the various statuses within the social structure are learned experiences (Brim 1968).

The content of socialization is acquired through the simultaneously occurring process of interactional and learning processes that involve different factors of socialization (peers, parents, teachers, employers) (Hardy 1978). Role theorists have made two assumptions: 1) roles are learned through social interaction and 2) individuals act in accordance with role behaviors expected of their particular status (Hardy 1978). A prerequisite of role learning is the capacity of taking another's
role and performing it from the other's standpoint. In doing this the individuals learn their own responses to others and to those with whom they interact. In the socialization process the individuals learn which image of themself to present in specific situations that is most consistent with their appropriate adult status within society. This enables them to enact this role with commitment and competency (Brim 1968).

Students interact with both faculty members and a clinical mentor as well as learn from them what the ideal professional nursing role. Role socialization likely involves both the functionalist and the interactionist perspectives for nursing students. It is important to explore which force is dominant in the development of professional role by neophyte nurses as one means of evaluating the efficacy of nursing education and the influence of nursing practice.

Miller (1971) contended that role conceptions are a consequence of adult socialization comprised of professional and organizational socialization processes. The focus of professional socialization is the acquisition of attitudes, knowledge, skills, and values which reflect the standards of the profession and are emphasized during the educational phase. Professional socialization occurs during the initial stages of an individual's career and is a requisite for career commitment and preparation for organizational socialization. When the individual begins a career, the bureaucratic setting entered may be very different from that
for which he has been prepared. Organizational socialization results after employment as a result of associations with peers and superiors as the individual learns to work within institutional policies. Learning and situational adjustments happen during the organizational socialization phase (Miller 1971).

According to Hinshaw (1977), socialization into a new role is usually an unconscious process. It occurs as a chain of events and involves these phases:

1) Transition from anticipatory expectation of role to specific expectations of role as defined by the societal group.

2) Attachment to significant others in the societal system milieu; labeling incongruencies in role expectations.

3) Internalization, adaptation, or integration of role values and standards. (p. 2)

Resocialization or the conversion process among nursing students was described by Hinshaw (1977) as:

**Stage One. Initial innocence:** students enter the profession with an image of what they expect to become and how they should behave, often based on public stereotypes. Most have had some degree of a "serving humanity" mentality, with emphasis on touching and doing. In the educational system, they are praised for presenting an analysis of the
action more than the action itself.

**Stage Two.** Recognition of incongruity: students sharing their concern can begin to recognize what is different from their expectations.

**Stage Three and Four.** "Psyching out" and role simulation: those individuals who want to continue in nursing must identify appropriate behaviors and role model them. Soon those behaviors become part of those person's own repertoire of how to act.

**Stage Five and Six.** Provisional and stable internalization. First, nurses vacillate between behaviors now attached to the new professional imagery and those reflecting previous lay imagery. But as they become more comfortable in practicing those behaviors and have increasing identification with nurse-teacher role models, they move to stage six, in which the imagery and behavior of the newly socialized nurse-student reflect the professionally, educationally approved model. (pp. 5,6)

Health care delivery depends on the enactment of a number of roles. Role occupants have expectations for themselves and other health care professionals. The process of becoming a health professional involves aspects of both occupational and adult socialization (Hardy 1978). Factors influencing this process are the individual's perceptions of positive and negative consequences
of job factors such as income, accessibility, and the fit of the job to their skills and personalities. The goal of professional institutions is to instill into their students the behaviors, norms, and values necessary for occupational survival (Hardy 1978). This is achieved through a formal educational process and an informal internalized ethical code established to guide the practice of the professional role. The net result is the development of new images, expectations, behaviors, and beliefs related to the individual’s self conceptions and those that others have of them. These changes are both internal and external involving the individual, their role set, and the combined effects of their interactions (Hardy 1978).

The acquisition of a role conception by a student in a health profession is reflected in the views espoused by their faculty and other members of the profession (Kramer 1968). Faculty serve as mentors for students during their formal education and it was determined that neophyte nurses hold role conceptions congruent with their faculty (Pieta 1976). After graduation the neophyte who has been socialized into the profession by a faculty mentor, will be socialized into the bureaucratic system by a clinical mentor.

The creation of a role is a cumulative process learned through interaction with primary socializing influences from a variety of resources. Thus, the following model depicts the proposed development of Nursing Role Conceptions of Baccalaureate Nursing Students (Figure 1).
Figure 1. Model for Development of Nursing Role Conceptions of Baccalaureate Nursing Students.

- Norms, Values
- Beliefs
- Faculty Mentors

- Norms, Values
- Beliefs
- Clinical Mentors

- Professional Socialization

- Organizational Socialization

ADULT SOCIALIZATION

- Childhood Socialization

Nursing Role Conceptions

- Norms, Values
- Beliefs
- Significant Others

- Norms, Values
- Beliefs
- Peers

→= influencing factors
This model depicts the development of a professional nursing role as an evolutionary process. It begins with the student learning norms and values which serve as the foundations for the perceived professional, bureaucratic, and service role conceptions. Influencing factors are the initial interrelationships with faculty and peers and later, with clinical mentors. The values, norms, and beliefs imbued are further influenced throughout the process of professional socialization during formal education, then during organizational socialization as the neophyte enters the bureaucratic system. The formation of these professional nursing role conceptions is initially affected by factors occurring throughout childhood socialization and the conceptions are refined and modified during adult socialization.

**Definition of Terms**

1. **Actual professional nursing role conception**: a set of expectations that nurses perceived to be practiced in the nursing role.

2. **Ideal professional nursing role conception**: a set of expectations that nurses perceived should exist in the nursing role.

3. **Role Discrepancy**: the extent to which the perception of ideal role conception and actual role conception differed.

4. **Bureaucratic role conception**: a primary loyalty of the nurse to the hospital and to hospital administration. For the purpose of this study Pietas’s scale on bureaucratic role conceptions which measures adherence to rules, routines, and punctuality was used.
5. Professional role conception: a primary loyalty of the nurse to the nursing profession. For the purposes of this study Pieta's professional role conceptions which emphasizes nursing education programs being offered by institutions within the system of higher education was used. Values such as active participation and membership in the professional association and commitment to formal knowledge and to continued learning as the basis of the profession were stressed.

6. Service role conception: a primary loyalty of the nurse to the client as a recipient of humanitarian services. For the purpose of this study Pieta's scale on service role conceptions was used. It measured nursing as conceived to be a calling which suggested caring for the patient as a person. Nurses engaged in administering direct nursing care to patients from which they received personal satisfaction. The values emphasized included service to humanity, compassion, dedication, and understanding.

7. Senior generic baccalaureate nursing students: students in their last year of baccalaureate nursing education who had no previous nursing education or experience.

8. Clinical Mentor: a person in the clinical setting who worked closely with baccalaureate nursing students and was identified as a significant clinically oriented nursing role model by the senior baccalaureate nursing student.
9. **Faculty Mentor**: a professional nurse in the academic setting who taught nursing in a baccalaureate degree program and was identified as a significant educationally oriented nursing role model by a senior baccalaureate nursing student.

**Assumptions and Limitations**

For the purposes of this study it was assumed that perceptions of actual and ideal professional nursing role conceptions of senior generic baccalaureate nursing students were formed and transformed during the process of educational and clinical socialization.

The limitations of this study were:

1) This study was limited to senior generic baccalaureate nursing students and their faculty mentors in one southeastern university of 15,000 students, as well as the clinical mentors they identified from one 210-bed acute care community hospital in the area. Generalizing the results of this study to other baccalaureate nursing students, faculty, schools of nursing, or universities should be done with caution.
2) It was beyond the scope of this study to look at factors associated with childhood socialization and adult socialization as well as those associated with peers and significant others.
3) It was beyond the scope of this study to compare the performance of the nursing role with the individual’s perceptions of their ideal and actual role conceptions of nursing.
Review of Literature

Current empirical studies of professional role conceptions in nursing are limited. This review of literature focused on those studies reported in the literature of professional and bureaucratic socialization, the formation and transformation of nursing role conceptions, and role discrepancies among nursing students. The interrelationships of these variables and their resultant effects on nursing practice were examined.

Socialization. Cohen (1981) proposed a developmental model of professional socialization for nursing based on the Theory of Concept Development (Harvey, Hunt, and Schroder 1961), the Theory of Human Development (Erikson 1963), and the Theory of Social Influence (Kelman 1961/1971). Cohen proposed a four-stage model. Her premise was that a student sequentially experiences each of the four stages and that positive resolution of all stages is necessary for satisfactory socialization (Cohen 1981). The stages are: 1) Unilateral Dependence where the individual is reliant upon external controls and limits set by authorities, 2) Negative/Independence where the individual questions the concepts presented thereby reducing external controls, 3) Dependence/Mutuality where cognitive rebellion is replaced by realistic evaluations, and 4) Interdependence where the individual gains the capacity to exercise independent judgement (Cohen 1981).

McCain (1985) believed it is of critical concern to understand the development of professional role behaviors, yet little is known
about this process. To explore this, she administered Cohen's Professional Socialization Staging Scale to 422 baccalaureate nursing students. Results showed there were no significant differences among students at different levels of baccalaureate nursing education for the first three stages. For the Stage 4 subscale, baccalaureate students with concurrent work experience in nursing related fields had lower subscale scores than those not working. McCain concluded that concurrent work experience enhances the socialization process. Findings did not support the model because the students did not evidence progression through the four developmental stages; thus, the validity of the model for professional socialization may be questioned. Neither reliability nor validity data were reported. McCain stated that subject response bias invalidated the study data.

**Professional and Bureaucratic Socialization.** The problem of reality shock was studied extensively between 1960 and 1974 and three questions on preprofessional socialization may be seen throughout the literature (cf. Corwin 1960, Davis and Olesen 1964, Kramer 1968). These questions were: What image or expectations do students have of the nursing profession? To what extent do students' professional, bureaucratic, and service role conceptions mirror those of their faculty or practicing nurses? Are there differences in the role conceptions among these groups?

In 1960 R. G. Corwin, a sociologist, proposed that nursing as an emerging profession has also been subject to bureaucratization.
According to him, professionalization and bureaucratization are major trends in which nursing identity is often fused. In terms of the development of nursing as a profession there is a strong undercurrent of bureaucratization because nurses are members of organizations (ie. hospitals).

Kramer (1974) has compared the characteristics of a profession and a bureaucracy to clearly show the differences for nursing.

**Characteristics of a Bureaucracy**

- Specialized of roles and tasks.
- Autonomous rational rules.
- Overall orientation to rational, efficient implementation of specific goals.
- Organization of positions into hierarchial authority structure.
- The impersonal orientation of contacts between officials and clients.

**Characteristics of a Profession**

- Specialized competence having an intellectual component.
- Extensive autonomy in exercising this special competence.
- Strong commitment to a career based on a special competence.
- Influence and responsibility in the use of special competence.
Development of training facilities that are controlled by the professional group. Decision making governed by internalized standards. (p. 15)

According to Ketefian (1985), perspectives emerging from research indicate those committed to professional orientations differ distinctly from those committed to bureaucratic orientations. An individual's perceptions and performances are believed to be influenced by the distinct attitudes inherent in each of these orientations (Ketefian 1985).

**Nursing Role Conception Formation.** Corwin conducted several studies examining role conceptions and perceptions of student and graduate nurses. In 1959 Corwin, Taves, and Haas compared 238 graduate staff nurses, head nurses, and junior and senior nursing students in hospital-based diploma and college degree programs on the basis of job satisfaction and nursing images. Their hypothesis was that the levels of job satisfaction and favorableness of nursing image would be higher among students than among nursing graduates. The findings supported the hypothesis, implying that impressions neophyte nurses bring with them to the work setting are not entirely realistic. They concluded that conflicts between the nurse's professional status and bureaucratic office often result in conflicts in loyalty and lead to disillusionment in new nurse graduates.
Corwin was also interested in the formation and transformation of role conceptions in nursing students. He developed a Nursing Role Conception Scale (NRC) in 1960 during an era when the religious institutions that once dominated nursing were being challenged by bureaucratization and professionalization. Corwin wanted to provide a clearer understanding of the ways that nursing role conceptions were formed and transformed, and their effects on future goals and performance of nurses. He designed the NRC to measure the respondent's acceptance of and commitment to hospital bureaucracy, perceptions of nursing as a profession, and perceptions of client welfare (Corwin 1961). He proposed that contradictions inherent in the work setting encountered by the neophyte after graduation resulted because teachers projected their fantasies and ideals upon their students (Corwin 1961). After graduation the student became a bureaucrat and experienced cross-pressures between school and work that create role conflicts as well as discrepancies between ideal conceptions of the role and perception of the reality (Corwin 1961). Corwin concluded that differences existed between professional and bureaucratic role conceptions of nurses with hospital-based and college-based education. Among 296 nurses studied it was noted that baccalaureate students maintained high professional role conceptions more often than did diploma nurses, contributing to increased role conflict. Diploma nurses tended to modify their professional role conceptions after graduation while baccalaureate
students increased their bureaucratic conceptions. This pioneering work by Corwin in the field of professional nursing role conceptions has lost some of its applicability with age as seen in studies by Pieta (1976) and Minehan (1977), who indicated a need to update the Nursing Role Conception Scale.

In a study that examined professional and bureaucratic socialization, Davis and Olesen (1964) studied images of nursing among 75 baccalaureate students. The intent was to determine the empirical validity of commonly accepted student socialization propositions to ascertain their relevance for this group. In a longitudinal study, a 19-item questionnaire was used, reflecting changes in nursing images resulting from cultural exposure and bureaucratic versus professional orientations to nursing. The findings indicated that whatever important changes occurred in the student’s images of nursing and self, these images were consummated and stabilized by the end of the first year. The authors concluded these student’s images tended to be individualistic and innovative rather than bureaucratic in nature. They also determined that these images were influenced by the nursing faculty.

Kramer (1970) conducted a longitudinal study of 79 graduates from three baccalaureate programs and administered Corwin’s tool at graduation, three months after beginning employment, and three months later. Findings indicated that following employment bureaucratic conceptions increased and professional ones decreased. The participants in this study who did not make these transitions
left nursing more often then those who changed. Those who left
nursing by changing jobs because of dissatisfaction, or by
returning to school, showed greater role deprivation than those
remaining on the job for six months. Kramer indicated this
resulted from the antithetical nature of the bureaucratic and
professional roles. She proposed that to deliver high quality
nursing care both professional and bureaucratic roles were needed,
and nurses able to recognize this need were deemed successful and
most likely to remain in nursing.

Bevis (1973) reexamined all three conceptions in a study with
106 baccalaureate prepared nurses to correlate role conception and
continuing education practices. The results indicated no
significant relationship between the professional and bureaucratic
role conception and continuing education. The service role
conception did show a significant relationship. The professional
and service roles when combined, significantly influenced the
nurse’s participation in continuing education. The service and
bureaucratic role conceptions when considered jointly showed
conflict. This conflict was not evident when professional and
service role conceptions were considered jointly. The findings
indicated the importance of the service role conception.
Interrelationships occurring when the roles were examined in
combination showed results not present when the roles were examined
alone.
Prior to 1974, few studies revealed differences in nursing role conceptions among nursing students from diploma, associate degree, and baccalaureate education programs. However, several studies (cf. Pieta 1976, Kinney 1985, and Ketefian 1985) after this date found major differences in nursing role conceptions among graduates of the different levels of educational programs.

In 1976, Pieta revised Corwin's NRC and administered the resultant version to 838 nursing students and their faculty from diploma, associate degree, and baccalaureate degree nursing programs. The data indicated that the revised tool was reliable and valid. The findings showed role discrepancies for all groups for bureaucratic, professional, and service role conceptions and led to modifications and change in nursing education programs and nursing practice, such as cooperative education, the development of tools to determine student role discrepancies and techniques for assisting educators in the resolution of these discrepancies.

Minehan (1977) also speculated that the theoretical formulations underlying the role conception scale developed by Corwin in 1961 were outdated. She proposed that nursing role conceptions are multidimensional in nature rather than three separate and distinct roles. Minehan developed a new nursing role conception scale and administered it to 42 practicing nurses to explore reliability and validity. Construct and criterion-related validity were not established. Minehan suggested that there have been changes in current values and beliefs which are the
foundations for nurse role conceptions. Her findings supported the need to revise Corwin's questionnaire.

Kinney (1985) used Corwin's NRC to reexamine the professional, bureaucratic, and service role conceptions of 101 new baccalaureate nursing students. In addition the relationships of three personality variables (ego development, sex typing, and assertiveness) and role conceptions were studied. Findings showed that nurses could hold the three role components with equally high regard. Kinney concluded that this demonstrated the increased complexity of professional nursing role conceptions.

Ketefian (1985) used the Pieta NRC and a moral behavior tool to study 217 registered nurses with various types of education. Her findings suggested that a high professional score indicated high moral behavior. Ketefian concluded that role conflict has an adverse effect on moral behavior and if professional and bureaucratic orientations are both viewed highly, there are less conflicts in the work setting. Ketefian proposed that education is significant to role socialization and that socialization orientations must be developed in school and maintained throughout the work experience.

This review of literature identified the existance of professional nursing role discrepancies among students, educators, and practicing nurses. It substantiated the fact that a gap between nursing education and nursing practice in the past has led to role conflict for neophyte nurses.
Since 1974, little empirical data are available to determine whether the dilemma of role conflict in baccalaureate nursing graduates still exists. Nor are data available describing the comparisons of the role conceptions of faculty and clinical mentors and their effects on professional nursing role conceptions of senior generic baccalaureate nursing students. As these groups provide primary professional and bureaucratic socialization for students into the nursing profession, it is important to examine their professional nursing role conceptions. It is also important to see how closely nursing students mirror these conceptions to determine the potential for experiencing reality shock upon employment. This study sought to provide current information concerning the conceptions of nursing students, their faculty as mentors, and their clinical colleagues as mentors.

Despite a wealth of commentaries supporting the belief that there are discrepancies between nursing education and nursing practice leading to role conflict and reality shock in neophyte nurses little current empirical data are available. This study provided data on both areas of concern. No empirical data are available to corroborate the belief that the Nursing Role Conception Scale (Pieta 1976) is current and relevant. This study also sought to explore the reliability and validity of Pieta's 1976 tool to determine whether the instrument has contemporary reliability and validity.
Role conflict among nurses is a problem that involves nurse educators, administrators, and practitioners. New graduates need to be prepared for the realities of nursing in all types of settings. Nursing’s fullest potential in the delivery of health care is contingent upon the congruence of education and nursing service. It is important to determine if this potential is being realized and that the functioning of nurses can be enhanced for the future. This study sought to explore these factors.

**Hypotheses**

This study tested the following hypotheses:

1) There will be no significant differences between senior generic baccalaureate nursing students, their faculty, and clinical mentors on their ideal and actual conceptions of Professional Nursing Role.

2) There will be no significant differences between senior generic baccalaureate nursing students, their faculty, and clinical mentors on their ideal and actual conceptions of Bureaucratic Nursing Role.

3) There will be no significant differences between senior generic baccalaureate nursing students, their faculty and clinical mentors on their ideal and actual conceptions of Service Nursing Role.

Chapter 2 is a description of the methodology of the study. It explains the research design used, identifies the study population, the sample used, and the setting. Pieta’s Nursing Role
Conception Scale, the reliability and validity of the research instrument, and a brief description of the pilot testing of Pieta's tool with a representative group of students, faculty members, and practicing nurses is included. Chapter 2 also presents the procedures for data collection in the actual study and describes the process for data analysis in which multivariate techniques and inferential statistics were used to determine group differences.
Chapter 2

Methodology

The purpose of this research study was to analyze the similarities and differences of ideal and actual bureaucratic, professional, and service nursing role conceptions as perceived by senior baccalaureate students, their faculty, and clinical mentors. The study also sought to explore the current reliability and validity of Pieta’s Nursing Role Conception Scale.

Research Design

The research design for this study was a descriptive survey. The descriptive survey is a nonexperimental approach used to conduct research. According to Polit and Hungler (1983), nonexperimental designs are used to explore or describe phenomena and do not entail the manipulation of study variables. The descriptive design is used to provide facts about study variables but offers no rationale and cannot be used to determine causality. According to Polit and Hungler (1983), "a survey is designed to obtain information from populations regarding the prevalence, distribution, and interrelations of variables within these populations" (p.188).

There are a number of advantages and limitations in the use of this design. The advantages in using the nonexperimental descriptive survey design are that often experimentation is costly and unfeasible. This design is an efficient method of collecting large quantities of data in a relatively short period of time. One
limitation is that causality cannot be proved. The use of the survey to collect data is limited by the willingness of the subjects to participate.

The nonexperimental descriptive survey design was the most appropriate design to use for this research. It was not the purpose of this study to manipulate variables. Nor was it the intention to attempt to prove that the conceptions held by students, faculty, and clinical mentors were a direct result of socialization experienced in the classroom and in the clinical practice setting. This study was designed to provide a description of the data collected and compare the nursing role conceptions held by three different groups. The descriptive survey design was implemented through use of a questionnaire entitled Nursing Role Conception Scale (NRC) (Appendix A).

Sample

There were three targeted populations for this study. The first target population for this study was senior generic baccalaureate nursing students from one National League for Nursing accredited Bachelor of Science in Nursing program who had clinical experience in a specific acute care hospital in the Southeastern coastal region of the United States. The accessible population consisted of those senior generic baccalaureate nursing students who had clinical experience in a specific acute care hospital in the area. The second target population was faculty members who taught junior or senior generic baccalaureate nursing students in
the academic setting. The accessible population was the faculty identified by the accessible population of nursing students as significant academic role models. The third target population was practicing staff nurses who worked closely with baccalaureate nursing students in the clinical area. The accessible population was clinical mentors identified by the accessible population of nursing students and deemed significant clinical mentors. The nursing students selected for the actual study were generic seniors in the final phases of their baccalaureate nursing educational socialization, who had no previous nursing experience, and were not previously used in the study. The faculty who participated in the study were professional nurses in the academic setting and taught nursing in the baccalaureate degree program. The clinical mentors who participated were registered nurses who worked closely with baccalaureate nursing students in the clinical setting.

A purposive strategy was used to select the student sample. Selection of the faculty and clinical mentor sample was based on identification by the student of a faculty member and a clinical mentor who was seen as a significant influencing factor.

Setting

There were two settings for this study. Data were collected from senior baccalaureate nursing students in a southeastern university of 15,000 full time and part time students. The self-administered questionnaire was distributed to the baccalaureate
students in a classroom environment and individually to identify the faculty and clinical mentors. Data were also collected from the identified faculty mentors. The second setting was a 210-bed southeastern acute care hospital in which the baccalaureate nursing students had their medical-surgical clinical experience. The forms were administered individually only to the identified clinical mentors.

Tool

Background. Permission was obtained to use Corwin’s Nursing Role Conception (NRC) Scale (Appendix A) revised by Pieta (1976). The NRC is a self-administered questionnaire consisting of 34 items on two 5 point (strongly agree to strongly disagree) Likert-scales. These items are in the form of hypothetical situations in which the nurses might find themselves. The respondent is first asked to indicate the extent to which the situation should be practiced in nursing (ideal) and then to which extent the situation is actually practiced in nursing (actual). The items are organized into three subscales: bureaucratic (12 items), professional (10 items), and service role concept (12 items). The format of Corwin’s NRC was modified (Pieta 1976) by changing the questions in each situation into statements. The situation descriptions were also revised, and new situation descriptions were developed. The revised tool was designed to examine nursing role conceptions as perceived by senior nursing students from diploma, associate degree, and baccalaureate degree nursing education programs and
their faculties and by head nurses in nonprofit, general hospitals (Pieta 1976).

**Scoring.** Scores for scale items are obtained by converting the five Likert-style responses ranging from "strongly disagree" to "strongly agree" to numerical values of 1-5 respectively. Scores range from 12-60 for the bureaucratic and service scales, and 10-50 for the professional scale. Respondents are asked to indicate the extent to which the situation should be the ideal for nursing. The arithmetic sum of the item responses comprises the total score for each respondent, providing a normative score. The higher the score, the greater the role orientation commitment. An index of role deprivation is derived as follows: Respondents are asked to judge the extent to which situations actually occur, which provides a categorical score. The role deprivation index is determined by subtracting the normative score from the categorical score on each item. Positive role discrepancy indicated that respondents perceive a situation not existing to the extent to which they feel it should, and negative role discrepancy indicated that respondents feel the situation exists to a greater extent than it should (Pieta 1976).

**Reliability.** Pieta (1976) reported internal consistency reliabilities of .84 for the bureaucratic scale, .63 for the professional scale, and .58 for the service scale after administering the tool to 838 nurses. Test-retest coefficients were calculated during a pilot study, conducted by Pieta, with one
week intervening between testing. A coefficient of .92 was found for the entire instrument, .83 for the bureaucratic scale, .86 for the professional scale, and .81 for the service scale.

Validity. Pieta (1976) had addressed content validity by having items classified with regard to whether they fit bureaucratic, professional, or service roles. A panel of nursing experts agreed that the final 34 items measured the role conceptions for which they were designed. Pieta also reported criterion-related validity as assessed in a study by Corwin (1960) using three groups of nurses: collegiate nurse faculty members (n=15), nurses in administrative positions (n=17), and nurses with a religious commitment (n=16). Nurse faculty obtained the highest mean score on the professional role conception scale. Nurses in administrative positions in hospitals had the highest mean score on the bureaucratic role conception scale. Nurses with a religious commitment had the highest mean on the service role conception scale.

Procedures

Protection of Human Subjects. After receiving approval for the research proposal by the Thesis Committee and the Protection of Human Subjects Committee, letters were sent to the Chairman of the School of Nursing and the Director of Nursing of an acute care hospital in the area. Permission to conduct the study was granted by both facilities. The Chairman of the School of Nursing and the Director of Nursing served as contact and liaison persons.
Meetings were arranged to determine protocol for data collection. Data collection involved a three phase process.

In phase one, protocol for data collection convenient for the primary group, the baccalaureate nursing students, was established initially as they identified potential faculty and clinical participants. A notice was then posted on the bulletin board for those senior nursing students who had their clinical experience in the area hospital used in the study; they were invited to participate in the study. Two separate times and places were designated for data collection during the first week of fall semester. Students were assured confidentiality and told that each questionnaire was assigned a number to identify responses by group. The students were afforded the privacy of their classroom. The researcher explained that the study may have no direct benefit to them but the risk was minimal. They were told that their standing in school would not be affected whether or not they participated. The student's decision to complete the forms was considered consent for participation in the study. The packets containing a cover letter, data sheet, and questionnaire were completed and collected (Appendix A, B, C). Respondents provided the names of faculty and clinical mentors on the demographic data sheet for matching to facilitate statistical analysis. In phase two, faculty mentors and phase three, clinical mentors were individually approached by the researcher about being identified as a significant role model by a baccalaureate nursing student and
invited to voluntarily participate in the study. The potential for biasing these individuals’ responses by the announcement that they had been selected as significant role models must be acknowledged; however, the potential for bias was spread equally across the groups of faculty and clinical mentors. The mentors were given the same explanation as the students and assured confidentiality. The packets were distributed and collected over a one-week period. Two meetings provided data from 20 student respondents who identified five different clinical and five different faculty mentors. Data collection was completed within 4 weeks.

Pilot Study

Background. Prior to the actual study, a pilot study was conducted. According to Fox and Ventura (1983), a pilot study consists of those procedures used to gather informal data from small samples of subjects similar to those participants in the larger study. A pilot study also affords the researcher an opportunity to pretest the study instrument to determine its effectiveness, reliability, and validity. During the pilot study, the researcher can glean information about methodological procedures selected such as research design, method of data collection, and statistical analysis procedures. Information on potential problems, approximate cost of data collection, and study feasibility becomes available during the pilot study. After the pilot test is conducted, the researcher has the opportunity to reassess the methodological aspects of the study and make necessary changes to increase efficiency.
According to Fox and Ventura (1983), there are a number of criteria for conducting a pilot study. Some of these include allowing enough time prior to the actual study for data collection and trying different approaches to select those most appropriate. It is recommended that the actual study not begin until sufficient instrument reliability and validity are reestablished, methodological problems are refined, and data analysis is tested. If using a homogeneous population, a pilot sample size of 10 to 20 subjects is sufficient.

After considering these criteria the pilot study was conducted over a three week period to: 1) evaluate the tool's content and face validity, 2) evaluate the readability of the NRC scale and its directions, 3) retest tool internal consistency, and 4) seek suggestions, recommendations, or criticism concerning the Nursing Role Conception Scale.

Validity. Prior to the administration of the tools in the pilot study validity of the NRC was reassessed. According to Polit and Hungler (1983), the validity of an instrument refers to the "degree to which an instrument measures what is supposed to be measured" (p. 394). Content validity deals with "the sampling adequacy of the content area being measured" (p. 395). There are no specific measures to determine content validity; it is usually based on expert judgment. The use of a blueprint to plot specific content areas was helpful in determining adequate content representation. For this study a panel of four nurse experts were
asked to assess the tool for contemporary content and face validity. The panel consisted of two nurse educators and two nurse administrators. One educator and one administrator suggested the content of some of the situations needed updating. It was recommended that two of the situations be reworded as they were confusing. Face validity, which refers to the overall readability and ease in understanding of the tool’s directions and questions, was also explored in the pilot study phase. The expert panel believed the directions were clear and concise. One expert suggested changing the Likert-scale to four choices and eliminate the undecided category.

According to Dick and Haggerty (1971), construct validity is an "indication of the relationship between a theory and actual test performance" (p.93). For this study construct validity was not reassessed; however, the panel determined after examining each item, that all 34 items were at least somewhat relevant to the three scales to which they were assigned. Two experts suggested that the definition for the service scale be revised since nursing perceived as a 'calling' may no longer be appropriate.

These suggestions were noted but no changes were made in the instrument at this point.

Reliability. Prior to testing the reliability of the instrument frequency data were collected on individual test items. Measures of central tendency and item variability were examined. These data provided information to determine the type of statistics to be used during data analysis. Likert-scales yield ordinal level data.
If the shape of data reveals a normal distribution then the data may be treated as interval for the purposes of a number of statistical tests (Nunnally 1973). The frequency data were examined and it was determined that the data met the requirements for a normal distribution in that most item means were within one standard deviation of the scale mean of 3. Even though means, medians, and modes were not equal in all cases, the differences among them were less than .7 and frequently less than .4. As a result, the data were treated as interval level for the purposes of reliability analysis.

For the purpose of the pilot study, data for all three groups were combined. This was done to facilitate statistical analysis. With small sample sizes, nonparametric statistics are used. It was anticipated that the study sample would be larger and parametric statistics would be used if the data were shown to be normally distributed. The combining of the data increased the sample size and allowed the use of parametric statistics for the pilot study.

There were two components to the instrument. Data about age and gender as well as the identification of their faculty and clinical mentors were gathered from the baccalaureate nursing students' demographic data sheet (Appendix B). The demographic data sheet developed for faculty and clinical mentors (Appendix C) included information about the level of nursing educational preparation, number of years of nursing experience, age, gender, area of current nursing expertise, and number of years of
experience working with baccalaureate nursing students. For clinical mentors specifically, the sheet included the percentage of time spent performing nursing related activities. The participants (n=21) completed the demographic data sheet and the 34 item NRC scale. The NRC contains two sets of responses for each of the 34 situations for a total of 68 responses.

The next step was reassessment of instrument reliability. According to Polit and Hungler (1983), "reliability of an instrument is the degree to which it measures an attribute it is supposed to be measuring" (p. 385). If an instrument is a reliable measure it "maximizes the true score component and minimizes the error component" (p. 385). There are three types of reliability a researcher seeks. Test-retest reliability determines the instrument’s stability over time. For this a correlational computation assesses numerically how reliable the test is. Internal consistency refers to the homogeneity of the instrument subparts and determines how consistently these subparts measure the attribute in question. The Cronbach’s alpha or coefficient alpha is a useful index for assessing internal consistency of an instrument. Equivalency is another means of estimating the reliability of an instrument. It is assessed when two alternative forms of the same tool are used. Equivalency determines if the two forms measure the same attribute.

For this research a one-time administration of a single instrument indicated retesting reliability using Cronbach’s alpha
to seek internal consistency. Internal consistency of the NRC scale revealed reliability coefficients of .42 for the bureaucratic subscale, .55 for the professional subscale, and .74 for the service subscale (n=21). This indicated an average degree of internal consistency for the service scale but insufficient evidence to state the bureaucratic and professional subscales were internally sufficiently consistent. Because of the small pilot study sample, the decision was made to explore the reliability of the tool further with a larger sample size at the time of the actual study. Then a determination to use those scales for hypothesis testing would be made if the subscales for the professional and bureaucratic role conceptions were sufficiently internally consistent to lend themselves to statistical analysis of differences between the three groups.

Reliability evaluations were done for the actual and ideal bureaucratic, professional, and service scales of the NRC. The internal consistency of the six subscales was computed using the Cronbach coefficient alpha formulation. (See Table 1).
Table 1

Internal Consistency Coefficients for the NRC Scale

<table>
<thead>
<tr>
<th></th>
<th>Ideal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional (n=21)</td>
<td>.80</td>
<td>.75</td>
</tr>
<tr>
<td>(10 items)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bureaucratic (n=21)</td>
<td>.62</td>
<td>.20</td>
</tr>
<tr>
<td>(12 items)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service (n=21)</td>
<td>.11</td>
<td>.83</td>
</tr>
<tr>
<td>(12 items)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Results indicated high internal consistency for both actual and ideal professional, and actual service subscales, a slightly low internal consistency reported for the ideal bureaucratic subscale, and unacceptable internal consistencies for the actual bureaucratic and ideal service subscales.

Since one of the purposes of this study was to retest reliability of this unrefined tool, the items were regrouped. Reliability was sought for the actual professional, bureaucratic, and service (APBS) items and ideal professional, bureaucratic, and service (IPBS) items. Unfortunately, internal consistency reliabilities did not improve significantly. The APBS alpha equaled .80 and the IPBS alpha equaled .20. It was decided to leave all scales intact and retest internal consistency during the actual study despite the low reliability scores. Those subscale scores remaining low would not be used for data analysis.
Protocol. For the purposes of conducting the pilot study, baccalaureate graduates in pursuit of the Master of Science with a concentration in Nursing degree were individually approached for voluntary participation. The following was the protocol for the pilot study. The researcher approached the students about voluntary participation and the packets containing the cover letter, demographic data sheet, and questionnaire were distributed. The tools were completed in private. One graduate student participant did not return the questionnaire which provided a sample of 13 students. Information from the student demographic data sheets provided the rest of the pilot sample by identifying four faculty and four clinical mentors. The identified faculty members were individually approached for voluntary participation. All four faculty mentors completed and returned the packets. The Director of Nursing of an area acute care hospital was contacted to obtain permission for pilot data collection. Once permission was granted the identified clinical mentors were individually approached for voluntary participation. All four identified clinical mentors completed and returned the packets. The total population for the pilot study was 21 participants.

Pilot study participant's responses to the NRC. The participants of the pilot study indicated that the NRC was easy to read but that the directions should be changed to state "situations in which nurses might find themselves " rather than "herself". Seven of the participants felt the scoring section
needed revision, as doubt existed as to where to place the answers. All participants spent less than the allotted 30 minutes to complete the scale. Comments were provided by 16 participants. Ten had difficulty with question #2 stating that it would indicate the withholding of information. Four believed situation #3 violated hospital policy and suggested an example of the routines to be modified mentioned in the situation would provide clarification. Situation #9 was determined currently inappropriate by three participants since hospital rules no longer indicate showers must be taken in the morning. Six participants disliked situation #10 because they believed more than longevity should be considered for promotion. Three participants stated that item #14 should be updated to state "inservices" rather than "conferences" and to indicate by whom these were conducted as this would influence the answer selection. Revision suggestions for situations #16 and #17 included eight participants specifying that these routines performed caused no adverse effects to the client. Four participants indicated situation #25 was unclear and their answer depended upon the violation observed. Ten respondents suggested that situation #26 needed updating to include current administrative nursing responsibilities. These findings suggest that the tool itself may not represent current nursing situations encountered by practicing nurses. The suggestions were noted but no changes were made.
Data collection for the actual study took place during the first three weeks of the fall semester. The final sample included a subset of senior generic baccalaureate nursing students, nurse faculty, and clinical mentors.

Data Analysis

The Statistical Package for the Social Sciences version-X (SPSSX) for computer assisted analysis was used during the study. Descriptive statistics as well as difference testing statistics were used to analyze study data.

In Chapter 3, data collected on role conceptions and role discrepancies of senior generic baccalaureate nursing students, their faculty, and clinical mentors are presented. The chapter lists and shows the results of testing the hypotheses that guided this investigation. It presents a reexamination of reliability coefficients of the three scales.
Chapter 3

Results

This research study was designed to compare the similarities and differences of perceived ideal and actual bureaucratic, professional, and service nursing role conceptions of senior baccalaureate nursing students, their faculty, and clinical mentors. A second purpose of this research was to evaluate the current reliability and validity of Pieta’s Nursing Role Conception (NRC) Scale.

The study sample was obtained in a three-phase process and was comprised of 20 baccalaureate nursing students, five different identified faculty, and five different identified clinical mentors. After participant selection and voluntary consent were achieved, the students and their mentors completed the demographic data sheet and Pieta’s NRC Scale. The tool measured the respondent’s commitment to bureaucratic, professional, and service role orientations. A Likert scale with numerical values of one (strongly disagree) to five (strongly agree) was used to assess ideal and actual perceptions of the 34 item scale. Participants were asked to indicate the extent to which they felt the situation presented should be the ideal for nursing and then the extent to which this same situation was perceived to actually exist in nursing practice. The higher the scale score, the higher the commitment to the nursing role conception.
Analysis

Description of the Sample. The first accessible population were senior baccalaureate nursing students from one southeastern university of 15,000 students who had clinical experience in one specific acute care hospital during the last semester of their junior year of nursing education. Descriptive data obtained from this group of 20 revealed a mean student age of 22.45 years with a range of 20 to 32 years and of the 20 participants, only one was a man.

The second accessible population was faculty members who taught the baccalaureate nursing students in the academic setting and were identified by the students as significant faculty mentors. Descriptive data on these five faculty members are reflected in Table 2.

Table 2
Faculty Mentor Demographic Data

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>Range</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>5</td>
<td>(33-37)</td>
<td>34.60</td>
</tr>
<tr>
<td>Years Nursing Experience</td>
<td>5</td>
<td>(7-16)</td>
<td>13.40</td>
</tr>
<tr>
<td>Years Working with BSN students</td>
<td>5</td>
<td>(1-8)</td>
<td>4.20</td>
</tr>
</tbody>
</table>
The faculty participants were all female, Masters prepared in Nursing, and their current area of nursing experience was in the academic setting. As seen in Table 2, the mean age for this group was 34.60, mean number of years of nursing experience was 13.40, and mean number of years working with Baccalaureate nursing students was 4.20 years.

The third accessible population was practicing nurses who worked with the baccalaureate nursing students in the clinical setting and were identified as significant clinical mentors. Descriptive data on this group of five are reflected in Table 3.

Table 3

Clinical Mentor Demographic Data

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>Range</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>5</td>
<td>(30-35)</td>
<td>33.20</td>
</tr>
<tr>
<td>Years Nursing Experience</td>
<td>5</td>
<td>(9-15)</td>
<td>12.00</td>
</tr>
<tr>
<td>Years Working with BSN students</td>
<td>5</td>
<td>(3-13)</td>
<td>6.40</td>
</tr>
<tr>
<td>Percent/day Direct Care</td>
<td>5</td>
<td>(0-85)</td>
<td>50.00</td>
</tr>
<tr>
<td>Percent/day Administration</td>
<td>5</td>
<td>(0-75)</td>
<td>28.00</td>
</tr>
<tr>
<td>Percent/day Supervising Care</td>
<td>5</td>
<td>(0-25)</td>
<td>12.00</td>
</tr>
</tbody>
</table>

The clinical mentors were women, two were diploma-prepared, one had an associate degree, and two were baccalaureate-prepared.
Four stated their current area of clinical concentration was acute care and one stated that chronic care was the area of concentration. As seen in Table 3, the mean age among this group was 33.20, average number of years working in nursing was 12, and mean number of years working with baccalaureate students was 6.40. On the average, 50% of their day was spent providing direct patient care; approximately 28% of their day was spent administratively; and about 12% of their day was spent supervising others giving patient care.

**Testing research hypotheses.** Prior to hypotheses testing, subscale score ranges were determined and tool reliability was evaluated to determine performance of the bureaucratic, professional, and service scales. The results are presented in Tables 4-6.

**Table 4**

**Possible and Actual Subscale Score Ranges of the NRC**

<table>
<thead>
<tr>
<th>Scale</th>
<th>n</th>
<th>Possible Range</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideal Bureaucratic  (IBUR)</td>
<td>51</td>
<td>(12-60)</td>
<td>(26-49)</td>
</tr>
<tr>
<td>Actual Bureaucratic (ABUR)</td>
<td>51</td>
<td>(12-60)</td>
<td>(33-47)</td>
</tr>
<tr>
<td>Ideal Professional  (IPRO)</td>
<td>51</td>
<td>(10-50)</td>
<td>(36-50)</td>
</tr>
<tr>
<td>Actual Professional (APRO)</td>
<td>51</td>
<td>(10-50)</td>
<td>(17-39)</td>
</tr>
<tr>
<td>Ideal Service       (ISER)</td>
<td>51</td>
<td>(12-60)</td>
<td>(46-60)</td>
</tr>
<tr>
<td>Actual Service      (ASER)</td>
<td>51</td>
<td>(12-60)</td>
<td>(29-53)</td>
</tr>
</tbody>
</table>
As seen in Table 4, the bureaucratic and service subscales scores had a possible range of 12-60 and the professional subscales scores had a possible range of 10-50. The IBUR, APRO, and ASER subscales scores had a fairly wide range indicating scale variability. The ranges of scores for the ABUR, IPRO, and ISER subscales were much narrower.

The senior baccalaureate nursing students had subscale mean values for the ideal and actual responses ranging from 28-44. The faculty mentors had subscale mean values for the responses ranging from 25-55 and clinical mentors had values ranging from 32-54. Table 5 shows the reevaluation of scale reliability using the Chronbach’s alpha.

Table 5
Ideal and Actual Reliability Analysis for the Bureaucratic, Professional, and Service Scales of the NRC

<table>
<thead>
<tr>
<th>Scale</th>
<th>n</th>
<th>Items</th>
<th>Ideal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bureaucratic</td>
<td>51</td>
<td>12</td>
<td>.61</td>
<td>.09</td>
</tr>
<tr>
<td>Professional</td>
<td>51</td>
<td>10</td>
<td>.74</td>
<td>.70</td>
</tr>
<tr>
<td>Service</td>
<td>51</td>
<td>12</td>
<td>.59</td>
<td>.76</td>
</tr>
</tbody>
</table>

The results of the reliability reevaluation indicated adequate internal consistencies for the IPRO, APRO, and ASER scales. The IBUR and ISER scales performed less adequately and the ABUR performed poorly, indicating little internal consistency among these items.
Table 6 shows the combined ideal and actual scale reliabilities.

Table 6

**Combined Scale Reliabilities for the NRC Scale**

<table>
<thead>
<tr>
<th>Scale</th>
<th>n</th>
<th>Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bureaucratic</td>
<td>51</td>
<td>.37</td>
</tr>
<tr>
<td>(24 items)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>51</td>
<td>.47</td>
</tr>
<tr>
<td>(20 items)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>51</td>
<td>.71</td>
</tr>
<tr>
<td>(24 items)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>.71</td>
</tr>
<tr>
<td>(68 items)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When actual and ideal subscales were combined, internal consistencies for the total bureaucratic scale were low, indicating little overall consistency of the items. The total professional scale performed better, showing limited internal consistency among scale items. The service scale reliability indicated this scale was internally consistent. The total tool performed well indicating overall internal consistency. As a result of the reevaluation, the ABUR subscale was not used in hypothesis testing due to poor reliability.
According to Nunnally (1978), data which show a normal or near-normal shape may be treated as higher level data for the purposes of correlational analysis. Scrutiny of the range of scores and measures of central tendency showed a near-normal distribution; thus, the ordinal data were treated as interval level for the purposes of analysis.

The hypotheses for this research were:
1) There will be no significant differences between senior generic baccalaureate nursing students, their faculty, and clinical mentors on their ideal and actual conceptions of Professional Nursing Role.
2) There will be no significant differences between senior generic baccalaureate nursing students, their faculty, and clinical mentors on their ideal and actual conceptions of Bureaucratic Nursing Role.
3) There will be no significant differences between senior generic baccalaureate nursing students, their faculty, and clinical mentors on their ideal and actual conceptions of Service Nursing Role.

To test these hypotheses, a discriminant analysis was performed on each of the group’s responses. This multivariate technique is an extension of the multiple regression model (Polit & Hungler 1983). Discriminant analysis makes predictions about membership in categories or groups. The purpose is to distinguish the groups from one another on the basis of a set of independent variables available for prediction purposes.

A regression equation called a discriminant function is developed for a categorical dependent variable with independent
variables that are either categorical or continuous. In discriminant analysis, a stepwise approach can be used to enter predictors into the equation. The analysis produces an index known as Wilks' lambda ($\lambda$). This index designates the proportion of variance in the dependent variable unaccounted for by the predictor variables. The advantage of a discriminant analysis is that it permits multiple hypothesis testing about group membership and group differences in one multivariate procedure, thus avoiding an inflation in the alpha probability levels (Reid 1982).

In Table 7, the discriminant analysis reveals group means and standard deviations by subscale. Because of the smallness of the faculty mentor and clinical mentor sample groups, these groups were weighted by four to be equal to the student sample for the discriminant function analysis.
Table 7

Individual Mean Scores for Baccalaureate Nursing Students, Faculty Mentors, and Clinical Mentors on the NRC Subscales

<table>
<thead>
<tr>
<th>Group</th>
<th>IBUR</th>
<th>IPR</th>
<th>APRO</th>
<th>ISER</th>
<th>ASER</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSN (n=20)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>42.95</td>
<td>44.85</td>
<td>28.70</td>
<td>51.00</td>
<td>36.95</td>
</tr>
<tr>
<td>S.D.</td>
<td>3.24</td>
<td>3.03</td>
<td>4.47</td>
<td>4.55</td>
<td>5.07</td>
</tr>
<tr>
<td>Fac. (n=5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>36.40</td>
<td>46.80</td>
<td>25.60</td>
<td>55.20</td>
<td>38.20</td>
</tr>
<tr>
<td>S.D.</td>
<td>5.90</td>
<td>1.77</td>
<td>5.26</td>
<td>3.21</td>
<td>5.04</td>
</tr>
<tr>
<td>Clin. (n=5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>43.00</td>
<td>40.80</td>
<td>32.80</td>
<td>54.20</td>
<td>45.80</td>
</tr>
<tr>
<td>S.D.</td>
<td>4.45</td>
<td>3.00</td>
<td>4.61</td>
<td>2.09</td>
<td>4.07</td>
</tr>
</tbody>
</table>

As evidenced in Table 7, the baccalaureate nursing students differed from their faculty and clinical mentors on IBUR, APRO, and ASER.

The first research hypothesis explored if differences existed on the conception of professional commitment between the three groups. The second hypothesis explored if differences existed on the conception of bureaucratic commitment between the three groups. The third hypothesis explored if differences existed on the conception of service commitment between the three groups. Table 8 indicates the discriminant function analysis for the three groups.
on the five subscales of the NRC which were sufficiently internally consistent for hypothesis testing.

Table 8

Results of Discriminant Function Analysis For Baccalaureate Students, Faculty, and Clinical Mentors on Five Subscales of NRC

<table>
<thead>
<tr>
<th>Function</th>
<th>Eigenvalue</th>
<th>Percent of Variance</th>
<th>Canonical Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2.52</td>
<td>75.65</td>
<td>0.85</td>
</tr>
<tr>
<td>2</td>
<td>0.81</td>
<td>24.35</td>
<td>0.67</td>
</tr>
</tbody>
</table>

Wilk’s Lambda | CHI-Squared | D.F. | Significance |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0.16</td>
<td>101.93</td>
<td>10</td>
<td>0.00</td>
</tr>
<tr>
<td>0.55</td>
<td>32.68</td>
<td>4</td>
<td>0.00</td>
</tr>
</tbody>
</table>

As may be seen in Table 8, the two possible discriminant functions which the analysis yielded were both significant. Table 9 shows where the groups differed on the subscales.
Table 9
Standardized Canonical Discriminant Function Coefficients

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Function 1</th>
<th>Function 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBUR</td>
<td>0.47</td>
<td>0.58</td>
</tr>
<tr>
<td>IPRO</td>
<td>-0.87</td>
<td>0.26</td>
</tr>
<tr>
<td>APRO</td>
<td>-0.45</td>
<td>0.83</td>
</tr>
<tr>
<td>ISER</td>
<td>0.21</td>
<td>-0.67</td>
</tr>
<tr>
<td>ASER</td>
<td>1.01</td>
<td>-0.54</td>
</tr>
</tbody>
</table>

As seen in Table 9, under Function 1, the ASER subscale (actual service) had the highest coefficient indicating the groups differed most on this subscale. Under Function 2, the APRO subscale had the next highest coefficient indicating actual professional was the second area where the groups differed.

Therefore, the first null hypothesis that proposed no differences existed on the conception of professional nursing role was rejected. Significant differences existed among the groups on professional nursing role \((p<0.00)\). As a result of the discriminant function analysis, there were no significant differences among the groups on the conception of bureaucratic nursing role. The second null hypothesis which explored whether differences existed on the conception of bureaucratic nursing role was not rejected. Hypothesis three, which explored if differences existed on the service nursing role, was also rejected.
Significant differences were discovered to exist among the groups on service nursing role \((p < .00)\).

Three T-tests were conducted to determine if role discrepancies existed among the baccalaureate nursing students as a group on bureaucratic, professional, and service nursing role. According to Polit and Hungler (1983), a purpose of a t-test is to test for differences in group means. The results of the t-tests indicated there were significant differences among the students' scores between IBUR and ABUR, IPRO and APR, and between ISER and ASER \((p < .00)\).

To determine if significant differences existed between the five faculty and five clinical mentors on the individual subscales a Mann-Whitney U non-parametric test was done. According to Polit and Hungler (1983), this test compares differences in some characteristic seen by two independent samples using ordinal level data. This test was used because of the smallness of the two unweighted samples. The results of this test indicated significant differences existed between the groups on the IPRO and ASER subscales \((p < .05)\).

**Findings**

Analysis of the data for this study revealed significant differences in professional and service nursing role conceptions among the groups. There were no significant differences in bureaucratic nursing role conceptions among the groups. Among the students as a group, there were significant differences on the
conceptions of bureaucratic, professional, and service nursing role. Faculty and clinical mentors differed significantly on the ideal professional subscale and the actual service subscale.

Comparison of the demographic variables provided some interesting data. On the variable of age, there was a difference of only 1.40 years among faculty and clinical mentors. The number of years of nursing experience for both types of mentors was similar, as was the number of years working with baccalaureate nursing students.

Chapter 4 presents a discussion of these findings and the implications for nursing. Recommendations for further research are also suggested.
Chapter 4

Discussion

The purposes of this study were to explore whether differences existed in bureaucratic, professional, and service nursing role conceptions among senior baccalaureate nursing students, their faculty, and clinical mentors using Pieta’s 1976 NRC scale and to evaluate the tool for reliability and validity.

The results of the discriminant function analysis revealed statistically significant differences among the three groups on professional nursing role and service nursing role, but no significant differences on the bureaucratic nursing role.

Professional Role Conception

According to Corwin (1960), the professional role conception indicates a loyalty to nursing as a profession. Values stressed include a commitment to continuing education and membership in professional organizations. According to Kramer (1974), professional values, i.e., internalized standards and coordination, and peer control and authority structure are antithetical to those espoused by a bureaucracy to which practicing nurses have traditionally shown loyalty (Kramer 1974).

It was hypothesized that there would be significant differences among the three groups on the concept of professional role. The faculty mentor group had higher mean role commitment scores on the ideal professional subscale than students or clinical mentors, indicating they placed a higher value on the ideal
practice of the role than on the actual practice of the role. Examination of the student groups’ scores showed that they highly valued the ideal professional role conception and most closely mirrored their faculty mentors on this role conception.

The scores on the actual professional subscale indicated less of a commitment to this orientation. Clinical mentors by group, scored highest on the actual professional subscale but lowest on the ideal professional indicating a higher valuing of the actual practice of the role than of the ideal practice of the role. The faculty mentor group had the lowest mean scores on the actual professional subscale, indicating a lower priority placed on the actual practice of the role.

Findings of this study showed the faculty placed the greatest value on the idealized aspects of the professional role of the nurse. These findings support the conclusions of Corwin (1960), Kramer (1970), and Pieta (1976) who indicated nursing faculty are more idealistic in their orientations than practicing nurses and that students are likely to mirror their faculty’s values.

**Bureaucratic Role Conception**

The bureaucratic role conception indicates a loyalty of the nurse to the hospital and hospital administration (Corwin 1960). According to Kramer (1974), task analysis of a bureaucracy indicates specialized skills are learned on the job, loyalty is to the organization, and external standards are maintained through
rules and regulations. Corwin (1960), Kramer (1970), and Pieta (1976), found that practicing nurses place a higher value on the bureaucratic role conception than do faculty and nursing students.

For this study significant differences were anticipated among the groups on the bureaucratic nursing role. Clinical mentors scored highest as a group on the ideal bureaucratic subscale indicating they placed greater value on adherence to hospital policies. Faculty mentors had the lowest ideal bureaucratic subscale scores. Group mean scores of the baccalaureate students were most similar to those of their identified clinical mentors.

It was surprising that significant differences were not found on ideal bureaucratic role in the discriminant analysis. Considering the age and experiential differences between students and mentors and the potential differences between faculty who traditionally adhere to professional orientations, and clinical mentors who are thought to ascribe to bureaucratic ones, differences were anticipated. It is possible that no differences were found because the bureaucratic role was sanctioned by both types of mentors. It is also possible that the commitment to this orientation has been internalized by the student population. This may indicate the beginning of a bicultural viewpoint on the part of the students. Biculturalism has been explained as the ability of a nurse to blend the best of both worlds. The bicultural person knows and understands the rules, deliberately breaks them for the improvement of patient care, and willingly accepts the responsibility for doing so (Kramer 1974).
These findings support those of Corwin (1960), Kramer (1970), and Pieta (1976) who indicated that practicing nurses are more bureaucratically oriented than educators. Since the actual bureaucratic subscale showed low internal consistency (alpha=.09), statistical conclusions were not drawn about group differences.

**Service Role Conception**

The service role conception indicates a nurses' loyalty to the patient (Corwin 1960). Values emphasized are compassion, dedication, and understanding. According to Corwin (1960) and Pieta (1976), faculty are removed from the clinical setting and have less direct patient contact than practicing nurses. As a result, practicing nurses can be expected to place a higher value on the service role conception.

It was hypothesized that there would be significant differences among the groups on the concept of service role. The faculty mentor group mean scores were higher than the student and clinical mentor groups indicating the faculty mentors placed higher values on the belief that the nurse should care for the patient in humanitarian terms. The baccalaureate student subscale scores for the ideal service subscale indicated that as a group, they were highly committed to ideal service role conception but less so than either group of mentors.

On the actual service subscale, student group mean scores were lowest of the three groups indicating less value placed on the actual practice of the role. Clinical mentors scored highest on
this subscale indicating a high value placed on the actual practice of this role. These findings support those of Corwin (1960), Kramer (1970), and Pieta (1976) who indicated that practicing nurses show highest commitment to the actual practice of the service role because of the increased amount of time spent with the patient and their identified reasons for practicing nursing. These authors proposed that educators are more committed to the ideal practice of the role due to the idealistic nature of education. The low mean student scores supports findings of Corwin (1960) and Pieta (1976) that as a result of socialization, students often mirror the idealistic views of their faculty.

Three t-tests determined whether discrepancies existed among the student group on the ideal and actual nursing role conceptions. The data showed that significant differences did exist between ideal and actual conceptions on the bureaucratic (p=.007), professional (p=.000), and service (p=.000) scales. This indicated that the baccalaureate students as a group perceived that there were significant differences between nursing roles as they should be practiced and actually were practiced. According to Corwin 1960, Kramer 1970, and Pieta 1976; role discrepancies have been identified as precursors of reality shock. Therefore, the finding of role discrepancies in this group of baccalaureate nursing students suggests the potential for reality shock upon employment after graduation.
When faculty and clinical mentors responses were compared, data indicated that these two groups differed significantly on the ideal professional and actual service subscales which indicated differences in their perceptions on these orientations. This supports findings of Corwin 1960, Kramer 1970, and Pieta 1976, which indicate that educators' and practicing nurses' ideal and actual role orientations are often diametrical.

**Conclusions**

The statistical findings showed that the generic baccalaureate nursing students differed significantly from their mentors on both professional and service nursing role. In addition, discrepancies between ideal and actual conceptions on all three role orientations were found in this sample. These data support the findings of Corwin (1960), Kramer (1974), and Pieta (1976) and indicate that the potential for reality shock in this population exists.

According to Bandura (1963), "models who are rewarding, prestigious, and competent, who possess high status, and who have control over rewarding resources are more readily imitated than are models who lack these qualities" (p. 107). According to the functionalist perspective, students are socialized by faculty mentors during formal education and tend to display similar behaviors and values (Hardy 1978). The interactionist perspective contends that an individual garners and interprets information made available through social interaction.
When examining group mean subscale scores, the data showed that students' scores most closely mirrored those of their faculty on all but the ideal bureaucratic subscales and more closely mirrored those of clinical mentors on the ideal bureaucratic subscale. It would appear that the functionalist perspective dominated the development of these baccalaureate nursing students' role conceptions to a greater degree than the interactionist perspective. It should be noted that the clinical mentors' educational backgrounds differed from the faculty mentors and they reported that they spent little time teaching students. These data give credence to Corwin's (1960) premise that educators project their ideals upon their students during formal education and it is only after full-time entry into the work force after graduation that the neophyte is exposed to increased bureaucratization by clinical mentors. Corwin suggested that it is this situation which creates role conflicts and may lead to discrepancies between ideal and actual nursing role conceptions of new nurse graduates.

The student group scores indicated higher valuing of the ideal bureaucratic, ideal professional, and ideal service subscales, with lower perceptions of actual bureaucratic, actual professional, and actual service role. This suggests that the initial impressions of neophyte nurses may not be entirely realistic as Corwin has proposed.

Pieta (1976) found similar results when examining diploma, associate degree, and baccalaureate nursing students and their
faculties. Pieta proposed this was related to faculty's relatively minimal association with hospital staff and actual time spent in working in hospitals. Pieta suggested that students are taught little about administrative tasks and are not provided with opportunities to develop such skills. This suggests that educators do not perceive the bureaucratic role to be very important. Kramer and Schmalenberg (1976) proposed this occurrence to be a function of 'biculturalism'.

The NRC Instrument

The results of this study clearly indicated that the NRC needed to be revised. Reliability data for the six subscales showed adequate internal consistency for the ideal and actual professional and actual service subscales, inadequate reliability for the ideal bureaucratic and service subscales, and little internal consistency for the actual bureaucratic subscale. These data indicate that some of the situations on the scales may not measure the same characteristic and lack homogeneity.

According to Polit and Hungler (1983), "if an instrument is not perfectly accurate, then the measures it yields can be said to contain a certain degree of error" (p.383). The obtained score has a true component and an error component. A high error component indicates an unreliable tool and limits generalizability. The results of reliability evaluation of the NRC indicated that some subscales may have high error components and are not internally consistent. These subscales were not used in hypothesis testing.
Considering the results of the content validation phase of the pilot study, there is evidence to suggest that certain situations no longer reflect contemporary nursing. For example, in one situation high priorities were placed on nurses completing requisitions and ordering supplies. In the last decade the increased use of computers has eliminated many of these as nursing responsibilities. Current trends indicate increased administrative responsibilities for nurses. Changing NRC situations to reflect this role function would make the NRC content more contemporary. Therefore, it is concluded that the NRC needs revision prior to further administration.

Role Theory as a Model for Study of Role Conceptions

Role theory which incorporates childhood and adult socialization components, appeared appropriate for this research. Nursing role conceptions are an end product of the student's progression through the socialization process. It was not the intent of this study to examine those components of childhood socialization and determine how they influence the acquisition of nursing role conceptions. It was the intent to explore the acquisition of these conceptions as the result of organizational and professional socialization which was influenced by faculty and clinical mentors.

The research model depicting the development of baccalaureate nursing role conceptions described the factors responsible for influencing student role formation. It is proposed that the
factors that operate to influence norms, values, and beliefs during childhood socialization directly affect elements of adult socialization. It may be questioned whether the functionalist or interactionist perspectives or a blend of both, operate to influence students' internalization of nursing role. The results of this study indicate that while faculty play a dominant role in molding students' beliefs about nursing role, clinical mentors also contribute significantly. It would appear that both perspectives are crucial to the development of a nursing student's nursing role conception formation.

Further addition to the theoretical research model might be the examination of those variables that influence childhood socialization, as they are proposed to be the foundations for adult socialization, and ultimately nursing role conception development. Hinshaw (1977) has proposed that role socialization is an unconscious process which involves six phases. While it was beyond the scope of this study to explore this hypothesis, further information on the step-by-step socialization of the nursing student is needed in order to assess the socialization level.

Recommendations

As a result of this research, several recommendations are suggested.
1) During tool evaluation it was determined that three of the subscales did not perform adequately. It is suggested that the NRC be revised to make it more reliable and content valid for contemporary nursing situations and practices.
2) After instrument revision, this study should be replicated, utilizing a large random sample of baccalaureate nursing students from different schools of nursing to determine whether the differences found in this study exist across more heterogenous groups. It might be helpful to first administer Cohen's professional socialization scale in order to determine students' current socialization level and then Pieta's NRC, to determine if and where discrepancies exist.

3) Another recommendation would be to survey baccalaureate prepared clinical mentors to see if differences exist among groups with more homogeneous educational backgrounds for clinical mentors.

4) A longitudinal study with students at the sophomore level, again as juniors, and as seniors would permit exploration of whether role conceptions change over time.

5) A replication of Kramer's 1968-1970 longitudinal study might be useful to explore whether changes in role conceptions occur after employment. Kramer found professional conceptions decreased and bureaucratic ones increased over time. Both Kramer (1970) and Ketefian (1985) proposed that both conceptions are important and should be maintained over time.

6) A broader range of demographic data might explain how demographic characteristics of socialization level, childhood and adult socialization factors, previous nursing experience, and educational background, may contribute to role formation and transformation.
The findings from this study have implications for nurse educators as well as practicing nurses. By determining whether discrepancies in nursing role conceptions exist in student populations, educational strategies can be developed to help resolve such differences. If further studies have similar results, these findings would have implications for nursing practice in view of the trend to require the baccalaureate degree as the minimum preparation for the professional nurse. Baccalaureate graduates able to resolve role discrepancies potentially may experience less role conflict upon employment. This could result in increased job satisfaction, decreased absenteeism, increased efficiency, and decreased turnover in hospital settings.

The results of this study indicate that these 20 students were at risk for developing reality shock because of the disparity between their conceptions and those of their mentors. While the use of one group of students, faculty and clinical mentors suggests caution in generalizing to other students and their mentors, these groups may be comparable to others in the United States.

The NRC, when significantly revised, could be a first step in identifying the potential for experiencing reality shock by neophytes. With increasing turnover rates the effects of reality shock face both nursing education and nursing service who, through collaborative efforts, can minimize this problem and enhance nursing for the future.


INSTRUCTIONS: This section consists of a list of 34 situations in which a nurse might find herself. You are asked to indicate both:

(A) The extent to which you think the situation should be the ideal for nursing.

(B) The extent to which you think the situation actually exists in the hospital.

Notice that two statements require answers for each situation. Consider the statements of what should be the case and of what is actually the case separately; try not to let your answer to one statement influence your answer to the other statement. Give your opinions; there are no "wrong" answers.

Indicate the degree to which you agree or disagree with the statement by checking one of the alternative answers ranging from: STRONGLY AGREE, AGREE, UNDECIDED, DISAGREE, and STRONGLY DISAGREE.

STRONGLY AGREE indicates that you agree with the statement with almost no exceptions.

AGREE indicates that you agree with the statement with some exceptions.

UNDECIDED indicates that you could either "agree" or "disagree" with the statement with about an equal number of exceptions in either case.

DISAGREE indicates that you disagree with the statement with some exceptions.

STRONGLY DISAGREE indicates that you disagree with the statement with almost no exceptions.
HERE IS AN EXAMPLE:

Registered nurses in Hospital 2 consider the patient's physical, social, and psychological needs when developing a plan of nursing care.

A. This is the way nurses should plan nursing care.  

B. This is the way nurses actually do plan nursing care.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BE SURE TO PLACE A CHECK MARK AFTER BOTH STATEMENTS A AND B ACCORDING TO YOUR DEGREE OF AGREEMENT WITH IT.

SITUATION

1. One head nurse at Hospital F insists that all procedures be performed as described in the procedure manual.

A. This is what a head nurse should do.

B. This is what a head nurse actually does.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Registered nurses at Hospital W are encouraged to discuss with patients as much about their conditions as the nurse believes would be best for the patient to know.

A. This is what nurses should do.

B. This is what nurses actually do.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The nursing staff at Hospital Y modified the hospital routines and procedures to meet the needs of the patients.

A. This is what nurses should do.

B. This is what nurses actually do.

4. The nursing staff at Hospital O are encouraged to read new drug and treatment brochures and memoranda.

A. This is what nurses should do.

B. This is what nurses actually do.

5. Mrs. B was to have a quart of high protein liquid to drink during a 24 hour period. The registered nurse spaced this treatment to provide the patient with small amounts during the daytime so Mrs. B. would not be disturbed during the night.

A. This is what nurses should do.

B. This is what nurses actually do.

6. In Hospital Y a registered nurse refused to do anything which she believed might jeopardize the welfare of her patients regardless of who told her to do it.

A. This is what nurses should do.

B. This is what nurses actually do.
7. At Hospital A the rules state that registered nurses are to report for duty at least 10 minutes before the hour. One registered nurse cannot report until five after the hour because of the schedule for the bus she must ride to work. Because she is always late, she is not being considered for promotion.

   A. This is what **should be done**.
   B. This is what **actually is done**.

8. Preparing work schedules of staff is the responsibility of the supervisor of Hospital G. Registered nurses are given the opportunity to request their working hours and days but the hospital's needs always take precedence.

   A. This is the way it **should be**.
   B. This is the way it **actually is**.

9. At Hospital B the rules clearly state that patients may only take showers in the morning. The registered nurses enforce this rule even when the patients request otherwise.

   A. That is what nurses **should do**.
   B. This is what nurses **actually do**.

10. Head nurses and supervisors at Hospital A when evaluating registered nurses for promotion consider the nurse's length of experience on the job to be important.

    A. This is what **should be considered important**.
    B. This is what actually is considered important.
1. In Hospital Y a physician ordered a patient to sit up in a wheelchair twice a day. The registered nurse caring for the patient believed that the patient was not ready to sit up in the wheelchair. The nurse discussed the patient's condition with the physician.

A. This is what nurses should do.

B. This is what nurses actually do.

2. Registered nurses from Hospital M attend conferences outside of the hospital to learn about new techniques and to increase their knowledge of various topics.

A. This is what nurses should do.

B. This is what nurses actually do.

3. The head nurses and supervisors at Hospital R, when evaluating registered nurses for promotion, consider the nurses' membership in the professional association to be important.

A. This is what should be considered important.

B. This is what actually is considered important.

4. Conferences are conducted at Hospital N with the nursing staff to review new techniques and procedures.

A. This is what should happen.

B. This is what actually happens.
15. The head nurses and supervisors at hospital U, when evaluating registered nurses for promotion, consider the nurses' ability to plan nursing care based upon the patient's needs to be the most important.

A. This is what should be considered most important.

B. This is what actually is considered most important.

16. A registered nurse in Hospital E, although she administers excellent nursing care, is not being considered for promotion because she does not carry out hospital routines as established.

A. This is the way it should be.

B. This is the way it actually is.

17. In Hospital X patient B was scheduled for a physical therapy treatment at 9 a.m. The patient experienced some abdominal discomfort after eating breakfast so the registered nurse rescheduled the treatment.

A. This is what nurses should do.

B. This is what nurses actually do.

18. One registered nurse at Hospital K follows all hospital routines even though she disagrees with several of them.

A. This is the way a nurse should function.

B. This is the way most nurses actually do function.
19. The regulations at Hospital D state that patients are to be transported to their cars via wheelchair upon discharge. Patient Y had been walking about for several days prior to being discharged but the registered nurse had the nurse's aide transport him to his car in a wheelchair.

A. This is what the nurse should do.
B. This is what a nurse actually does.

20. Registered nurses at Hospital H may only assign the duties to the practical nurse, nurse's aide, and orderly which are described in their respective job descriptions.

A. This is what nurses should do.
B. This is what nurses actually do.

21. Hospital Q attempted to recruit and employ only registered nurses who were educated in programs sponsored by a college or university which is equipped to teach the supportive biological and social science courses as well as the nursing science courses.

A. This is what hospitals should do.
B. This is what hospitals actually do.
SITUATION

22. Registered nurses in Hospital O subscribe to and read professional journals and other professional material to keep abreast of new techniques and knowledge.

A. This is what nurses should do.

B. This is what nurses actually do.

23. Registered nurses at Hospital L attend inservice meetings at the hospital even when they are not required to attend.

A. This is what nurses should do.

B. This is what nurses actually do.

24. Mrs. K had difficulty sleeping during the night so the registered nurse allowed her to sleep in the morning even though, according to the routine at Hospital Z, Mrs. K should have been awakened at 7 a.m.

A. This is what a nurse should do.

B. This is what a nurse would actually do.

25. The policies at Hospital C state that any violation of hospital regulations must be reported. Head Nurse A observed registered nurse X violating a hospital regulation and reported the incident to the supervisor.

A. This is what a head nurse should do.

B. This is what a head nurse would actually do.
26. Registered nurses at Hospital J place a high priority on maintaining the patient's record, completing requisitions, and ordering supplies.

A. This is what nurse should do.
B. This is what nurses actually do.

27. Registered nurses in Hospital V are respected by their peers for taking the time to talk with patients in an attempt to allay any of the patient's anxieties which could affect the patient's recovery.

A. This is what nurses should do.
B. This is what nurses actually do.

28. The head nurses at Hospital F when evaluating registered nurses place considerable emphasis on the nurses' ability to make decisions based upon scientific principles.

A. This is what head nurses should do.
B. This is what head nurses actually do.

29. Registered nurses at Hospital X spend the majority of their time administering direct care to the patients.

A. This is what nurses should do.
B. This is what nurses actually do.
### SITUATION

30. Regulations at Hospital K state that all patients must have their baths and treatments completed by 10 a.m. Registered nurses who complete their assignments in this time are considered valued employees.

A. This is the way it should be.
B. This is the way it actually is.

31. One registered nurse at Hospital T, while distributing dinner trays to the patients, approached Mrs. J who began to cry. The nurse got another nurse to distribute the trays, pulled the curtain around the bed, and sat down and talked to Mrs. J.

A. This is what nurses should do.
B. This is what nurses actually do.

32. Registered nurses in Hospital M are active members of their professional nursing association.

A. This is the way it should be.
B. This is the way it actually is.

33. The registered nurse at Hospital Q demonstrate their ability to relate nursing practice to the scientific principles which they learned in school.

A. This is the way it should be.
B. This is the way it actually is.
34. The registered nurses at Hospital W work with the patients in developing the plan of care to be used by the nursing staff.
   
   **A.** This is what nurses **should do.**
   
   **B.** This is what nurses **actually do.**
APPENDIX B
DEMOGRAPHIC DATA-BACCALAUREATE STUDENTS
Appendix B
Demographic Data Sheet
(Baccalaureate Nursing Student)

Directions: Please complete all sections.

Age at last birthday: (Fill in)

Gender: ( ) Female
( ) Male

PLEASE BE ASSURED THAT NAMES OF ROLE MODELS ARE USED EXPLICITLY FOR MATCHING
PURPOSES TO FACILITATE DATA ANALYSIS. AS SOON AS NUMERICAL MATCHING IS
COMPLETED THE NAMES WILL BE REMOVED AND NO FURTHER IDENTIFICATION WILL BE
POSSIBLE.

Identify by name the person in the academic setting (a faculty member) seen
as a significant nursing role model:

Identify by name the person in the clinical setting (other than the clinical
instructor) seen as a significant nursing role model and the name of the
clinical setting:

Clinical Mentor:

Specify name of clinical facility:

Specify unit of clinical facility:
Appendix C
Demographic Data Sheet
(Faculty and Clinical Mentors)

Directions: Faculty Mentors please complete section I. Clinical Mentors please complete all sections.

Section I. For Faculty and Clinical Mentors.
Age at last birthday: ________________________

Gender: (  ) Female
(  ) Male

Highest completed level of education: (Check one only)
(  ) Diploma in nursing
(  ) Associate degree in nursing
(  ) Baccalaureate degree in nursing
(  ) Master’s degree in nursing
(  ) Doctoral degree in nursing
(  ) Other, specify ________________________________

Total number of years of work experience as a Registered Nurse: __________
(Round off to nearest even year)

Area of most current nursing experience: (Check one only):
(  ) acute care (  ) chronic care (  ) ambulatory care
(  ) home care (  ) community nursing (  ) academic nursing
(  ) other, specify ________________________________

Total number of years working with baccalaureate nursing students:
(Round off to nearest) __________ years __________ months

Section II. For clinical mentors. On a typical day, identify the percent of time spent performing the following responsibilities:
(  ) Providing direct client care
(  ) Supervising the giving of direct client care
(  ) Participating in administrative activities
(  ) Other functions, specify ________________________________

100%
Appendix D
Letter to Students

Dear Senior Baccalaureate Nursing Student,

I am currently a graduate nursing student at Old Dominion University. One of the requirements is to conduct a research study. The purpose of this study is to explore the opinions that professional nursing students, faculty, and clinical mentors have on nursing as a profession.

Your participation is important to the success of this study. Your willingness to give your valuable time to this research is greatly appreciated. I hope you will find this experience both interesting and worthwhile.

You are asked to fill out the attached demographic sheet and questionnaire. This will take about 30 minutes of your time. On the demographic data sheet you will be asked to identify a faculty and clinical role model for matching to facilitate statistical analysis. The information you provide on both forms will be kept confidential. Each questionnaire is assigned a number to identify responses by group. Please do not sign your name on this form. Please answer the questions as objectively as possible. This is not a test and there are no right or wrong answers. Your answers will not be shared with the faculty. Only descriptive data for the total sample will be presented in aggregate form. Responses will be reviewed and analyzed by the researcher. At the completion of the study the data will be stored in a safe place. When you have completed the forms please deposit them in the locked box in the front of the room.

This study may be of no direct benefit to you but the risk is minimal. It may take some of your time and may make you stop and think but it has the potential to improve the quality of nursing education in the future. You are free to decline to participate or withdraw at any time. Your standing at school will not be affected whether you choose to participate or not. Your decision to complete these forms will be considered consent for participation in the study.

My research advisor is Dr. Linda Davis. If you have any questions or comments you may contact me at 440-4297 (Old Dominion University).

A copy of the results of the study may be obtained upon request. We will gladly talk with you to answer any questions. Thank you for your participation.

Sincerely,

Michele Musella, B.S.N
Graduate Nursing Student
Old Dominion University
APPENDIX E
LETTER TO PARTICIPANTS—FACULTY MENTORS
Dear Nurse Faculty Member,

I am currently a graduate nursing student at Old Dominion University. One of the requirements is to conduct a research study. The purpose of this study is to explore the opinions that professional nursing students, faculty, and nursing service role models have on nursing as a profession.

Your participation is important to the success of this study. Your willingness to give your valuable time to this research is greatly appreciated. I hope you will find this experience both interesting and worthwhile.

You have been identified as a faculty role model by a senior baccalaureate nursing student. You were identified by name for matching to facilitate statistical analysis. As soon as numerical matching is accomplished all names will be omitted and will not appear in any written materials regarding the research. You are asked to fill out the attached forms. Please answer the questions as objectively as possible. This is not a test and there are no wrong answers. Please do not sign your name on these forms. Each questionnaire is assigned a number to identify responses by group. Your answers will be kept confidential. Responses will be reviewed and analyzed by the researcher. Only descriptive data for the total sample will be presented in aggregate form. At the completion of the study the data will be stored in a safe place. When you have completed the forms please deposit them in the locked box in Ann Brown’s office. I will return in one week to collect the forms.

The study may not benefit you directly but the risk is minimal. It may take some of your time and may make you stop and think but it has the potential to improve the quality of nursing education in the future. You are free to decline to participate or withdraw at any time. Your standing at work will not be affected whether you choose to participate or not. Your decision to complete the forms will be considered consent for participation in the study.

My research advisor is Dr. Linda Davis. If you have any questions or comments you may leave your name and number with Ann Brown.

A copy of the results of the study may be obtained upon request. We will gladly talk with you to answer any questions. Thank you for your participation.

Sincerely,

Michele Musella, B.S.N.
Graduate Nursing Student
Old Dominion University
Appendix F
Letter to Clinical Mentor

Dear Colleague,

I am currently a graduate nursing student at Old Dominion University. One of the requirements is to conduct a research study. The purpose of this study is to explore the opinions that professional nursing students, faculty, and clinical mentors have on nursing as a profession.

Your participation is important to the success of this study. Your willingness to give your valuable time to this research is greatly appreciated. I hope you will find this experience both interesting and worthwhile.

You have been identified as a clinical mentor by a senior baccalaureate nursing student. You were identified by name for matching to facilitate statistical analysis. Once numerical matching is accomplished all names will be omitted and will not appear in any written materials regarding the research. You are asked to fill out the attached demographic data sheet and questionnaire. Please answer the questions as objectively as possible. This is not a test and there are no wrong answers. Please do not sign your name on these forms. Each questionnaire is assigned a number to identify responses by group. Your answers will be kept confidential. Responses will be reviewed and analyzed by the researcher. Only descriptive data for the total sample will be presented in aggregate form. At the completion of the study the data will be stored in a safe place. When you have completed the forms please deposit them in the locked box in the office of the Director of Nursing Service. I will return in one week to collect the forms.

The study may not benefit you directly but the risk is minimal. It may take some of your time and may make you stop and think but it has the potential to improve the quality of nursing education in the future. You are free to decline to participate or withdraw at any time. Your standing at work will not be affected whether you choose to participate or not. Your decision to complete the forms will be considered consent for participation in the study.

My research advisor is Dr. Linda Davis. If you have any questions or comments you may leave your name and number with the nursing department at Old Dominion University. The phone number is 440-4297. I will gladly talk with you to answer any questions.

A copy of the results of the study may be obtained upon request. Thank you for your participation.

Sincerely,

Michele Musella, B.S.N.
Graduate Nursing Student
Old Dominion University
APPENDIX G
LETTER TO CHAIRMAN OF SCHOOL OF NURSING
Appendix G
Letter to Chairman of School of Nursing

Chairman of School of Nursing
Old Dominion University
Norfolk, Virginia 23508

Dear Dr. Linda L. Davis,

As part of my research entitled: A Comparison of Nursing Role Conceptions Among Baccalaureate Nursing Students, their Nursing Faculty, and Clinical Nurse Mentors, I would like to present the Nursing Role Conception Scale and a demographic sheet to the senior baccalaureate students and their faculty members and leave a locked box in Ann Brown's office. Participation of the baccalaureate nursing students will be an important part of my study. If they choose to participate they will be asked to give approximately 30 minutes of their time during the first week of the fall 1986 semester to complete the tool and demographic sheet at a prearranged time and place. The students will be identified by number so confidentiality is assured. They will complete the forms at their seats. On the demographic data sheet they will be asked to identify a faculty role model by name for matching to facilitate statistical analysis. As soon as numerical matching is accomplished all names will be omitted and will not appear in any written materials regarding the research so faculty can be assured of confidentiality as well. After completion the students may deposit the forms in the locked box placed at the front of the room. The forms will be kept in the locked box and no one else will have access to the information. The faculty will be approached individually and will be asked to complete the forms at their leisure and in the setting of their choice. They will be asked to deposit them in the locked box in Ann Brown's office and informed that the researcher will return in one week to collect the forms.

Results of the data will be analyzed and interpreted by myself. All data will be stored in a safe place.

Enclosed please find a copy of the questionnaire and demographic sheet that will be administered. May I have permission to access these groups for my research and place a locked box in Ann Brown’s office?

I will gladly meet or talk with you to answer any questions. Thank you for your time and cooperation.

Sincerely,

Michele Musella, B.S.N.
Graduate Student
Old Dominion University
Appendix H
Letter to Director of Nursing

Director of Nursing
General Hospital
City, State, Zip Code

Dear Director of Nursing,

I am currently a graduate nursing student at Old Dominion University. One of the requirements is to conduct a research study. This study is designed to explore perceived role conceptions of professional nursing students, faculty, and clinical mentors. As part of my research I would like to present the Nursing Role Conception scale and a demographic sheet to the clinical mentors who have been identified by the baccalaureate nursing students. Their participation is important to this study. They have been identified for matching to facilitate statistical analysis. As soon as numerical matching is accomplished all names will be omitted and will not appear in any written materials regarding the research. If they choose to participate individual arrangements will be made for them to complete the forms. After administration I will return in one week to collect the forms. I would like to place a locked box in a centrally located area to allow participants to deposit the forms after completion. After collection the forms will be separated and the demographic sheets will be kept in the locked box. No one else will have access to the information. Participants will be identified by number so confidentiality is assured.

The data will be analyzed and interpreted by myself and stored in a safe place. Results of the study will be available upon request.

Enclosed please find a copy of the letter, questionnaire, and demographic sheet that will be administered. May I have permission to access this group for my research?

My research advisor is Dr. Linda L. Davis. If you have any questions or comments you may leave your name and number with the nursing department at Old Dominion University. The phone number is 440-4297. I will gladly meet or talk with you to answer any questions. Thank you for your time and cooperation.

Sincerely,

Michele Musella, B.S.N.
Graduate Student
Old Dominion University