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LEVEL II



STRESSFUL SITUATIONS OF AIR FORCE NURSES
RECENTLY GRADUATED FROM PRE-SERVICE
BACCALAUREATE PROGRAMS IN NURSING
AS IDENTIFIED BY CRITICAL
INCIDENT TECHNIQUE

AD A101833

by

ALAYNE LUCILLE BARTLETT, R.N., B.S.N.

A Project Presented to the Graduate Faculty of Saint
Louis University School of Nursing and Allied
Health Professions, Department of Nursing,
in Partial Fulfillment of the
Requirements for the Degree
of Master of Science
in Nursing

1980

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Abstract

A descriptive survey was conducted to determine whether stressful situations were experienced by Air Force Nurses recently graduated from pre-service baccalaureate programs in nursing during their first twelve (12) months on active duty and within their first eighteen (18) months in nursing; and if they occurred, could the nurse identify them using critical incident technique. Subjects were Air Force Nurses from general hospitals, regional hospitals, and medical centers of the United States Air Force who met the prescribed criteria, were randomly selected by the Directors of Nursing Services, and agreed to participate in this study. The stressful situations were identified by means of an open-ended questionnaire administered at Air Force medical facilities throughout the continental limits of the United States.

The development of the questionnaire included a review by a panel of experts and a pilot test on a sample of six (6) subjects from the eastern and western areas. The pilot test subjects were employed in hospital settings similar to the population sampled in the final questionnaire.

The data analysis consisted of four (4) general sections. The first section examined and analyzed personal data associated with type of nursing unit, length of time in nursing, age, geographical location, race or ethnicity, hospital size, sex, and attendance/non-attendance of USAF Nurse Internship Program. The

second section analyzed the five (5) categories under which critical incidents were classified for each of the subjects. This was presented in a percentage of frequency per response breakdown for each subject. The third section of analysis examined whether or not the subjects identified and described all of the stress present in a given situation. In this section subjects were compared in a percentage breakdown of subjects who did and subjects who did not identify all of the stress present in a given situation. In the last section of analysis, subjects were categorized according to: (1) type of nursing unit; (2) months in nursing; (3) age; (4) geographical location; (5) race or ethnicity; (6) hospital size; (7) sex; and (8) attendance/non-attendance of USAF Nurse Internship Program. Comparisons were made across the levels of each of eight (8) variables with regard to: (1) clinical uncertainty (or ambiguity); (2) competency gap (in self); (3) staff-centered conflicts (including generation gap/competency in others); (4) professional-bureaucratic conflict; and (5) other. These comparisons were carried out using a one-way ANOVA. All tests were conducted at the 0.05 level.

The results of the data revealed that in 118 situations described by the subjects 75 situations, or 63.6% of the total number of situations had all of the stress identified and described. The remaining 43 situations, or 36.4% were unable to identify and describe all of the underlying stressors.

Further results of the data revealed significant relationships between the following:

1. Clinical uncertainty (or ambiguity) and geographical location with the greatest stresses having been experienced by subjects in the eastern area, while western area subjects experienced the least stresses. ($P < 0.05$).
2. Staff-centered conflicts and non-attendance of the USAF Nurse Internship Program ($P < 0.01$).
3. Stresses related to "other" factors and non-attendance of the USAF Nurse Internship Program ($P < 0.01$).
4. Competency gap (in self) and the size of the hospital with the greatest stresses being experienced by subjects assigned to general hospitals, while the least stresses were experienced by subjects assigned to regional hospitals ($P < 0.05$).
5. Staff-centered conflicts and the sex (females) of subjects ($P < 0.05$).
6. Professional-bureaucratic conflicts and the sex (males) of subjects ($P < 0.05$).

These are statistically significant, therefore it is surmised that this was due to a determining factor and not the result of chance.

These remaining thirty-four (34) category/variables were analyzed and determined to be not significant at the 0.05 level since all remaining factors exceeded this 0.05 level of significance.

Further results of the data analysis revealed that Air Force Nurses do experience stressful situations during the first twelve

(12) to eighteen (18) months and that 94.9% of the stressful situations described could be categorized into one (1) of the four (4) categories identified by this investigator. The remaining 5.1% of responses fell under the remaining category "other," since no characteristics could be identified within those situations that would allow for their being placed in one of the earlier four (4) categories.

The findings of this study supports much of what has been identified in the review of literature. Not only does this research support those views of authors who describe this period of transition from student nurse to graduate nurse as a stressful one, but also identifies and describes a population not measured previously, i.e., Air Force Nurses. These findings support the need to educate managers/administrators, educator (both pre-service and inservice), practitioners (those actually providing care), and these students to the realities of stress, stressful situations, and reality shock; with its very serious ramifications. Each of the aforementioned individuals can and should play an active role in the alleviation of this long-standing problem within the nursing profession.

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TABLE OF CONTENTS

Abstract	i
Committee Page	v
Table of Contents	vi
List of Tables	viii
Chapter One	1
Chapter Two	14
Chapter Three	35
Chapter Four	104
Appendices A & B	131
Appendix C	134
Appendix D	136
Appendix E	139
Appendices F, G, & H	141
Appendix I	146
Appendix J	148
Appendices K, L, & M	150
Appendix N	155
Appendix O	156
Appendix P	158
Appendix Q	160
Appendix R	163
Appendix S	166
Appendix T	168

Appendix U	170
Appendix V	172
Appendix W	175
Appendix X	236
References	265
Vita Auctoris	271

LIST OF TABLES

Table 1	21
Table 2	29
Table 3	35
Table 4	36
Table 5	37
Table 6	37
Table 7	38
Table 8	39
Table 9	39
Table 10	40
Table 11	40
Table 12	41
Table 13	44
Table 14A	49
Table 14B	49
Table 15A	50
Table 15B	51
Table 16A	51
Table 16B	52
Table 17A	53
Table 17B	53
Table 18A	54
Table 18B	55

Table 19A	55
Table 19B	56
Table 20A	57
Table 20B	57
Table 21A	58
Table 21B	59
Table 22A	59
Table 22B	60
Table 23A	61
Table 23B	61
Table 24A	62
Table 24B	63
Table 25A	64
Tabel 25B	64
Table 26A	65
Table 26B	65
Table 27A	66
Table 27B	67
Table 28A	68
Tabel 28B	68
Table 29A	69
Table 29B	69
Table 30A	70
Table 30B	71
Table 31A	72
Table 31B	72

Table 32A	73
Table 32B	74
Table 33A	75
Table 33B	75
Table 34A	76
Table 34B	77
Table 36A	78
Table 36B	78
Table 37A	79
Table 37B	79
Table 38A	80
Table 38B	81
Table 39A	82
Table 39B	82
Table 40A	83
Table 40B	83
Table 41A	84
Table 41B	85
Table 42A	86
Table 42B	86
Table 43A	87
Table 43B	88
Table 44A	89
Table 44B	89
Table 45A	90
Table 45B	90

Table 46A	91
Table 46B	92
Table 47A	93
Table 47B	93
Table 48A	94
Table 48B	95
Table 49A	95
Table 49B	96
Table 50A	97
Table 50B	97
Table 51A	98
Table 51B	98
Table 52A	99
Table 52B	100
Table 53B	100
Table 53A	101

Introduction

There has been an increasing emphasis by numerous professional nursing agencies, educators, and the federal government to prepare nurses at the baccalaureate level. These agencies are preparing for the future by imbuing nursing students with the vision, knowledge, and pre-requisite skills needed to function autonomously and collaboratively with others in the health care system.

This investigator believes that many young graduate nurses, upon beginning their first work experiences, are confronted with a very real dilemma. This dilemma involves assimilating the "ideal" into the "real" work situation. This new graduate often possesses some abstrusive theories, abundant knowledge, and unpracticed skills that are realistically applicable in practice, yet, actually actually lacks those practical skills and that knowledge needed to function effectively in the health care setting. The result is a dichotomy of "ideal" versus "real" which in turn leads to stress, stressful situations, difficulty in socialization, and reality shock.

This study was undertaken to identify the presence and note the frequencies of stressful situations recounted by these recently graduated Air Force Nurses.

Review of Literature

The literature reviewed for this study covered the following areas: (1) stress, or the general adaptation syndrome, (2) job

dissatisfactions, (3) discontinuity between nursing education and nursing service, and (4) reality shock.

The concept of stress, or the general adaptation syndrome as developed by Selye (1956, 1965, and 1975), was adapted from the concept of homeostasis by Cannon (1939, and 1963) is now a fundamental concept in the biological and social sciences.

In general, within this concept, there appears to be a common principle (Sells, 1970), involving biochemical, physiological, psychological and group behavioral processes in reaction to injury; illness; environmental extremes; task demands; threats to person, prestige, or continued survival; interpersonal relations, and group activities.

At this level generality vanishes. Most so-called stress mechanisms are highly specific. Their action is dependent upon the simultaneous occurrence of other responses whose effect may combine or partially cancel each other (Sells, 1970). Motivation, group support or pressure, level of physiological adaptation to the situation, conditioning and prior experience in the situation, expectations and confidence in one's reactions, competency, equipment, associates and supervisors, all represent additional variables that may affect the responses that occur. For almost every stimulus variable there is a continuum from activation to response facilitation, to impairment, to disorganization, and these levels may follow a time course; thereby increasing the complexity of the multivariate problems (Sells, 1970).

According to Janis (1958) there is no generally agreed upon

definition of stress. According to Cohen (1967) stress is one of those peculiar terms which is understood by very few when an operational definition is desired that is sufficiently specific to enable precise testing of certain relationships.

The most common approach to a definition of stress is to accept the concept of specificity; to find value in identifying a class of specific reaction mechanisms involving noxious stimulation, impairment of function, and associated states.

At the biological level stress is generally conceptualized as an insulting agent that is external to the organism, to which the organism responded (Sells, 1970). The stressor is therefore, something that happens to the organism. It is the result of the interaction of an individual's personal qualities with the situation in which that individual happens to be at that moment (Bates and Moore, 1975). Stress levels are therefore conceptualized as being the result of a combination of the individual's ability to cope and the difficulty of the situation itself.

Psychologists vary on the issue of whether stress is an external entity or a state of the organism (Sells, 1970). Weitz (1966) believes that stress is a stimulus variable. Appley and Trumbull (1967) take the position that stress is best conceived as a state of the total organism under extenuating circumstances, rather than an event in the environment. Sells (1966 and 1970) believes that a "state of the organism" is more appropriate than either external or internal loci, since it is an interaction of the two that produces the state. He believes that the latter is

more consistent with the data of behavior. This theory incorporates or integrates most of the psychological (and physiological) stress phenomenon encountered during the preceding 25-30 years.

Briefly stated:

1. The individual is called upon in a situation to respond to circumstances for which it has no adequate response available. The unavailability of an adequate response may be due to physical inadequacy, response absent from the individual's response repertoire; lack of physical training, equipment, or opportunity to prepare.
2. Consequences of failure to respond effectively are important to the individual. Personal involvement in the situations can be defined in terms of importance of consequences to the individual (Sells, 1970).

Stress intensity depends on the importance of the individual's involvement and the individual's assessment of the consequences of one's ability or inability to respond effectively to the situation.

The onset of stress (Sells, 1970) is to be determined and understood in terms of the various situations, not in terms of the stimulus parameters (covered earlier); or of the personality profiles of the participants, although these are relevant. In every case, it is important to recall this in terms of the individual's ability to make an effective response and assessment of the consequences of failure.

Studies on job dissatisfactions in nursing are numerous: Bullock in 1954, Hughes in 1958, Johnson in 1966 and 1970, Kramer

in 1974, Bates and Moore in 1975. Bullock (1954) states:

This dissatisfaction. . .is associated with various factors related to occupational role and functions as perceived by the young general duty nurse.

Abdellah and Levine (1958) suggested for exploration the following hypotheses, which were a result of their study identifying areas of dissatisfaction:

Professional nursing personnel. . .are concerned with "getting the job done." Because of many pressures, such as mounting bookwork and increased treatments, nurses tend to meet the physical needs of the patient first. The less tangible activities required to meet the emotional needs of the patient may take second place. . .Nurses give priority to carrying out the doctors orders. . .When nursing time is reduced the quality aspects of nursing care. . .such as explaining care to patients and taking time to answer their questions. . .are omitted.

Areas of discontinuity between nursing education and nursing service identified with the reality shock period are increased responsibilities for new graduates (American Nurses' Association, 1956 and 1964; Abdellah, 1957; Deutscher, 1959; Elliott and Cahill, 1959) and their preparation for ideal practice which varies from those found in reality (Gorham and Lichtenstein, 1957; Deutscher, 1959; Ingles, 1960; Johnson, 1966 and 1970; and Kramer, 1974). Ingles (1960) indicates:

. . .in many situations more is required of nurses than they can possibly accomplish. This inevitably means compromise. This compromise often means the difference between good patient care and adequate patient care. Nurses who have been educated to give optimum patient care and who want to give optimum patient care may find little satisfaction in providing adequate patient care.

Kramer (1974) feels that a "sociological immunization" is re-

quired as a timely vaccination for this dilemma.

With the mixture of childhood and adult socialization, it is clear that the new graduate is ill-prepared attitudinally and behaviorally to enter this type of work scene (Kramer, 1974).

Equipped with a high professional and a low bureaucratic orientation, Kramer (1974) sees the new graduate having:

a bushel basket of shoulds and a paper bag of skills, techniques, and role specific behaviors and because of the lack of pre-socialization into the work-related values, the nurse is a prime candidate for massive role conflict.

Kramer believes that something must be done to protect and safeguard those professional values during that crucial phase of role transition, when, hopefully, the neophyte will be able to operationalize them into nursing practice.

The findings of Bates and Moore (1975) agree that nursing educators have taught those scientific skills that are valued by the society; but, so far, have done little to develop those skills of the student which will help them to deal with emotional and stressful situations. As a result, the new graduate feels overloaded with work and unable to influence administrative decisions or conflicting demands. It is felt that a reorganization and reduction of work-load is essential to enable the front-line people to continue working effectively. Too much time and energy is being spent in dealing with stress and not enough time is being spent in dealing with actual accomplishment of task. In system terms, too much energy is expended for system maintenance and insufficient energy is freed for goal achievement (Bates and

Moore, 1975).

According to Brown (1948), nurses want the opportunity to provide nursing care as they believe it should be provided.

On the other hand, other studies indicate the presence of a hiatus between what nurses verbalize as constituting good nursing care and what they actually do in practice (Christ, 1956; Reisman and Rohrer, 1957; and Hughes, 1958). Others contend that there is no "gap" between education and practice (Randall and May, 1961). This investigator found no current research, studies, or literature to support the contrary aspect of the argument.

When the new graduate leaves the role of nursing student and assumes the role of nurse practitioner, a period of transition occurs. Abdellah and Levine (1958), Deutscher (1959), McKinney and Ingles (1959), Johnson (1970), and Kramer (1974) refer to this period of transition as one of "reality shock." Often the new graduate finds a discrepancy between what was learned as a student and what the new nurse discovers in the actual practice of nursing. This discrepancy is associated with a dichotomy of ideal and actual practice situations.

The kind of "reality" of importance in the phenomenon "reality shock" is the work situation as perceived, experienced, and shared by groups of nurses. It is true that no two people experience reality in the same way; how can one discuss reality shock when the realities that comprise this construct are so varied? If taken from the psychological perspective (Kramer, 1974) of exploring the uniqueness of each person's experiences,

the researcher will find more differences than similarities. Yet, because nurses are social beings, working, and being socialized into systems that have more commonalities than differences, shared perceptions, and realities occur (Kramer, 1974).

"Shock," as used in the construct of reality shock refers to the total social, physical, and emotional responses of a person to the unexpected, unwanted, or undesired; and in the most severe degree, to the intolerable (Kramer, 1974).

The shock is manifested in a variety of ways. The shock may result in frustration. This frustration has been identified as the broad result of the status and the role conflict associated with the transition from nursing student to nurse practitioner, as was noted earlier. Frustration connotes tension. The terms "frustrated", "tense", and "anxious" are associated by nurses with the term "stress." Weitz (1968) identifies eight common types of stressful situations: (1) speeded information processing, (2) environmental extremes, (3) perceived threat, (4) disturbed psychologic balance, (5) isolation, (6) confinement, (7) group pressure, (8) frustration and blocking. It is the latter aspect of stress, blocking, which is under consideration in this study, particularly because of the implications of a resultant decrease in quality of performance.

The importance of stressful situations in nursing was recognized by Diamond and Fox (1960), Johnson (1966, 1968, and 1970), Kramer (1974), Bates and Moore (1975). An extensive review of literature with respect to a theory of human behavior, the indiv-

idual, the situation, reactions to stress, effects of stress on function efficiency, relationships between reactions to stress and psychological factors can be found in their studies.

Stress occurs when a motivated individual seeking to achieve a goal, has to overcome a block at some point; thus making achievement of that goal difficult or doubtful. Basic to an individual's perception of a situation as stressful or not is the "individual's personality structure. . . identification patterns. . . and value systems (Haggard, 1949)."

How can stress or stressful situations be measured? What components are necessary for the situation to be described as stressful? Stress tests have been constructed (Anastasi, 1959); laboratory criteria developed (Selye, 1956; Janis, 1958; and Busowitz, 1959); psychological behavior manifestations categorized (Janis, 1958); but these, obviously, were not feasible for purposes of this study.

As was stated earlier by Janis (1958) and Cohen (1967), there is no generally agreed upon definition of stress that will allow for precise testing of certain relationships. It is the individual who determines for that individual what is and is not stressful (Janis, 1958). A definition of stress and stressful situations will, in reality, depend on the nurses' connotation of a stressful situation and in their own perception of the situation as it meets this connotation.

In 1953, Bridgeman noted that in order to define functions which nurses should be prepared to perform and the degree of pro-

ficiency required for beginning practice, it is necessary to discover what are some of the areas of difficulty encountered by the professional nurse in the early period of practice as a graduate. There is a need to study this new graduate during the early service experiences in order to gain understanding about this role conflict (McKinney and Ingles, 1959; Lambertson, 1960; Johnson, 1966 and 1970; and Kramer, 1974).

Statement of the Problem

With the emphasis on a liberal education for nursing (Russell, 1960; American Nurses' Association, 1964; National League for Nursing, 1976; and the Department of Defense, 1976) the trend is for more nurses to be prepared in pre-service baccalaureate nursing programs. As a result, it is necessary to study this graduate early in this practice if the profession is to identify those incidents which result in frustration or stress. This investigator believes that this becomes an absolute necessity if the profession is to retain the new nurse, alleviate the stressors, prevent further disillusionment, and exodus.

In light of researchers who have indicated the presence of a "gap" between education and practice, this investigator focused attention on those stressful situations which occurred during the transition period from nursing student to nurse practitioner. These investigators were Abdellah and Levine (1958), Diamond and Fox (1960), Johnson (1966 and 1970), and Kramer (1966, 1968, 1972, and 1974).

Rationale for this study was based on the principle that the

alleviation of stresses will encourage nurses to remain in nursing, not become frustrated and disillusioned with their profession, and thereby improve the quality and quantity of patient care that is provided.

The theoretical framework for this study included the concept of stress/reality shock and the role of educators/administrators in stress reduction.

Although large numbers of articles and books were somewhat dated, it is of special note that the literature of that period pertained to what is being discussed in current literature. Brown (1948), Abdellah and Levine (1958), Johnson (1966 and 1970), Kramer (1966, 1968, and 1974), Kramer and Baker (1972), Bates and Moore (1975) continue to document that same dichotomy of ideal versus real in the recently graduated baccalaureate nurses. The stress resulting from this dichotomy continues to the present.

Purpose

It was the purpose of this investigator to study stressful situations which occurred in the practice of nursing in the Air Force as recounted by nurses within their first twelve (12) to eighteen (18) months after graduation from pre-service baccalaureate nursing programs.

Research Questions

The research questions were:

1. Do recently graduated Air Force Nurses experience stress during their first twelve (12) months on active duty?
2. Do these stressful situations fall within the five (5) pre-

established categories?

3. Were these nurses able to perceive all of the stress in the situation?
4. Does the nurse's sex affect the nature of stressful situations?
5. Does the number of months of employment since graduation affect these stressful situations?
6. Does the clinical unit in which these nurses currently are employed affect these stressful situations?
7. Does age of the nurses affect the nature of stressful situations?
8. Does race or ethnic origin affect the nature of stressful situations?
9. Does geographical location affect these situations?
10. Does hospital size affect the nature of stressful situations recounted?
11. Does attending the USAF Nurse Internship Program affect the nature of these situations?

Assumptions

Assumptions upon which this study were based include:

1. Nurses who were graduates of pre-service baccalaureate nursing programs had been taught the concepts of optimum patient care.
2. There would be stress provoking (or inducing) situations during the subject's first twelve (12) to eighteen (18) months in nursing practice.
3. There would be stress provoking (or inducing) situations

during the nurses' first twelve (12) months on active duty.

4. Those nurses participating in this study would be capable of identifying situations which were stressful to themselves.
5. The individuals participating in this study would be capable of recalling those situations which provoked (or induced) stress in themselves.

Methodology used in this study is described in Chapter II.

Chapter II

Research Design

This project was designed to identify those elements inherent in the practice of nursing within the Air Force, that play a major part in the recently graduated baccalaureate nurse's perceptions of stress and stressful situations during their initial active duty tour. This study is descriptive in nature, utilizing a mailed questionnaire as the tool for data collection. According to Notter (1974) descriptive research is defined as being present-oriented research that seeks to accurately describe what is and to analyze those facts obtained in relation to these problems under study.

Operational Definitions

To achieve the purpose of this study, research designed by Deutscher (1959); McKinney and Ingles (1959); Diamond and Fox (1960); Corwin (1962); Kramer (1966, 1968, 1972, and 1974); Johnson (1966 and 1970); Tenbrink (1968); Kramer and Baker (1971); Kramer, McDowell, and Reed (1972) was used. The following operational definitions were accepted:

1. Practice of Nursing: . . .any professional service requiring the application of the principles of nursing based on the biological, psychological, and social sciences; such as responsible supervision of patients, requiring skill in the observation of symptoms and reactions and the accurate re-

ording of the facts, and carrying out of treatments and medications as prescribed by a licensed physician. . .and the application of nursing procedures as involved in the understanding of cause and effect in order to safeguard life and health of a patient and others (The State University of New York, 1959).

The practice of nursing in this study, referred to the actual involvement of these nurses in providing for the patient's care within their clinical settings.

2. Pre-service Baccalaureate Programs in Nursing: a program in an institution of higher learning that was acceptable to the Surgeon General, United States Air Force, awarding a baccalaureate degree, in which these students were prepared for the practice of nursing.
3. Situation: the combination of circumstances at any given moment; state of affairs; the sum total of stimuli that act on an organism at a given moment (Webster's New World Dictionary, 1968).
4. Stress: a state or condition of strain, pressure; especially a force exerted upon a body, that tends to strain or deform a shape; tension; strain exertion (Webster's New World Dictionary, 1968). This term may be restricted to a physical force and physical systems or extended to psychological systems and forces (English and English, 1958).
5. Stressful Situations: a social setting or combination of circumstances which may be characterized by an interaction

in which these subjects were involved, plus that element of interference with the achievement of goals regarding provision of optimal patient care.

The psychological reactions to tension in some form usually associated with stressful situations. Feelings of tension could be described by such words as: anxious, tense, nervous, frustrated, frightened, upset, excited, worried, angry, pressured, apprehensive, distressed, uncomfortable, disturbed, confused, uneasy, et cetera.

Freedom was allowed for subjects to describe those situations they perceived to be stressful to themselves.

6. Recently Graduated: referred to that period of time from the completion of requirements for a degree from an institution of higher learning, at the baccalaureate level, up to that point where these individuals were within twelve (12) to eighteen (18) months after that date and still within their first twelve (12) months of active duty in the United States Air Force.
7. Identified: to show to be a certain person or thing; fix the identity of; to show to be the same as something or someone assumed, described, or claimed; under consideration (Webster's New World Dictionary, 1968).
8. Optimum Patient Care: providing hospitalized individuals with the best possible care for their physical, psychological, physiological, biological, safety, belongingness, esteem, esteem from others, emotional, spiritual, and self-actualization

needs. To maintain that individual in a state of homeostasis. According to Maslow (1954) these categories all must have been met; however, not necessarily in the sequence mentioned.

9. Air Force Nurses: Those individuals who have completed the prescribed baccalaureate level nursing programs that were acceptable to the Surgeon General, United States Air Force, have submitted applications through appropriate channels, were selected by the board of review and selection, and were commissioned to serve on active duty as officers, at selected Air Force medical facilities within the continental limits of the United States on a full-time basis. Full-time employed in a military pay grade or rank and assigned against a Department of Defense authorized manning slot or position.
10. Critical Incident Technique: A method of obtaining data from study subjects' written reports of previous experiences or incidents in their lives which were related to the matter under study (Notter, 1974).

Consists of a set of procedures for collecting direct observations of human behavior in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles (Flanagan, 1954).

By an incident is meant any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act (Flanagan, 1954).

To be critical, an incident must occur in a situation

where the purpose or intent of that act seems fairly clear to observers and where its consequences are sufficiently definite to leave little doubt concerning its effects (Flanagan, 1954).

Instrumentation

The data gathering tool that was used for this study was the open-ended questionnaire requesting descriptions of these critical incidents from subjects. This type of questionnaire is one in which the content is structured by the investigator; but, the respondent is free to answer in his/her own words and is permitted to structure the answers as desired (Festinger and Katz, 1953; Notter, 1974). This open-ended questionnaire afforded these subjects the opportunity to express themselves more freely, while at the same time serving as a guide to these individuals in recognizing those types of situations that were requested by this investigator.

Preparation of the open-ended questionnaire used for this study began with a careful review of literature on stressful situations and stress in nurses. Diamond and Fox (1960) utilized an incident schedule based on the critical incident technique, which described a feeling or reaction and provided space for students to write a description of a recent event that resulted in the described feeling or reaction. Bates and Moore (1975) used a similar form of the one used by Diamond and Fox to describe stress and stressful situations in hospital personnel. This investigator developed the tool used in this study based on a mod-

ified adaptation of the two ideas of Diamond and Fox (1960) and Bates and Moore (1975). Since subjects received this questionnaire by mail, an orientation or introduction to this study was felt to be necessary for them. Included in this orientation were some of those modifiers used in both of the aforementioned studies.

Since this study was limited to those situations involving patient care, directions for completing this questionnaire stipulated that fact. These answer sheets requested recalling and describing situations related to patient care which these individuals found to be particularly stressful to themselves. In an attempt to facilitate data analysis, four (4) questions were asked of these subjects in relation to each of the three (3) situations that were requested. These same questions were asked on all three (3) sheets of this questionnaire, with only a minor rewording of those instructions at the beginning of each sheet as subjects progressed from sheet to sheet.

This questionnaire was submitted to a panel of experts who reviewed the questionnaire and suggested that three of these nine items have their brief instructions reworded. Experts believed that those items were relevant to this survey and its intent. This panel consisted of individuals assigned to the Air Force Military Personnel Center (AFMPC/MPCYPS), Research and Measurement Division, Randolph Air Force Base, Texas 78148. Content validity was established by this panel of experts.

This questionnaire consists of four (4) questions about three (3) situations. The nature of these questions was such that

this investigator surmised that these questionnaires would be relatively short and capable of being sorted into brief categories.

A limitation of these categories was made by this investigator due to the possibility of at least as many different responses or reactions as there were respondents. Based on this review of literature, the aspect of commonalities among these response categories were identified. This investigator believed that there would be sufficient numbers of commonalities among those responses recalled by participants to allow for categorization and classification. This investigator found this to be a fact (see Table I). There were sufficient numbers of commonalities to allow this investigator to classify and categorize those responses received into one of those five categories. Reactions were categorized under the following major areas:

- A. Clinical Uncertainty or Ambiguity
- B. Competency Gap (in self)
- C. Staff-centered Conflict (includes Generation Gap/Competency in Others)
- D. Professional-Bureaucratic Conflict
- E. Other

Insert Table I about here

These categories were identified in research conducted by Scott (1966), Gardner and Rowan (1968), Kramer and Baker (1971), and Kramer (1974).

Clinical uncertainty (or ambiguity) referred to the fact that

Table 1

	AA Clinical Uncertainty or Ambiguity	BB Competency Gap (In Self)	CC Conflicts (Gen- eration Gap/ Competency-Others)	DD Professional Bureaucratic Conflicts	EE Other	Totals
Number of Situations Each Category	14	12	41	45	6	118
Percentage of Total	11.9	10.2	34.7	38.1	5.1	100.0%

numerous graduates were surprised by their lack of precision or certainty in their clinical practice since graduation. These findings were contrary to their school experiences. Clinical practice by its nature is ambiguous, since psycho-social and medical knowledge are incomplete and variables involved in the application of this knowledge to the clinical situation are numerous and very complex. This new graduate nurse, as a practicing clinician, is confronted with more ambiguous, unexplored, and unexplained situations than ever before, during school (Kramer, 1974). This might be termed the technical aspect of nursing.

Competency gap refers to that of new graduates; excludes that of other nurses and physicians. This new nurse must quickly develop this ability to acquire knowledge in the informal setting. Part of this problem results from this new nurse having had little previous experience in that type of situation or setting. Expectations and sources were made quite clear to students in school settings. Closure of this gap between knowledge acquisition in structured and unstructured settings should become the primary focus, at that point in time. According to Kramer (1974), one would simply have had to ask questions. This aspect has been called "the knowledge aspect of nursing" (Kramer, 1974).

Staff-centered conflict is the third area of concern. This related specifically to: other nurses, supervisors, ancillary personnel, L.P.N's, doctors, and other allied health personnel. This factor takes into account both (1) generation gap; and (2)

factors of attitudes, beliefs, and behaviors (Kramer, 1974).

"Generation gap" occurred as either a direct or an indirect result of this nurse's drive for competency. This young nurse poured all of that energy into work, set high expectations for the future, and was eager to prove individual worth. This very eagerness and zeal disturbs the equilibrium and stability that the older employee has come to enjoy. The result is a withdrawal of this young nurse from those situations since this young nurse is less established and will eventually find another job. It is the greatest protagonists in young nurses fleeing the field (Kramer, 1974). This might be referred to as the people factor, or the human aspect.

Professional-Bureaucratic conflict is the fourth area. Scott (1966) described this phenomenon as a "whole-task work system" versus the "part-task work system." Professional conflict related to a whole-task system. Bureaucratic conflict related to the part-task system. When broken down into their characteristics one can better understand the concepts of "whole-task versus part-task" systems. Bureaucracy is characterized by the following:

1. Specialization of roles and tasks.
2. Autonomous rational rules.
3. Overall orientation to rationale, efficient implementation of specific goals.
4. Organization of positions into a hierarchical authority structure.
5. The impersonal orientation of contacts between officials

and clients (Kramer, 1974).

The part-task work system is characterized by the following:

1. Few skills required, particularistic in nature.
2. Specialized skills learned on the job.
3. Loyalty to the organization.
4. Evaluation through work output.
5. Hierarchical control and authority structure.
6. External standards through rules and regulations.
7. Control and organization by an official who is removed from the workers.
8. Development of a layer in the organization whose major purpose is to maintain the organization (Kramer, 1974).

Commonalities definitely exist between these bureaucratic conflicts and part-task work systems as one can see from a comparison of these two lists of characteristics, immediately preceding.

The following lists compare common characteristics within these two remaining systems or concepts, the professional category and then followed by those characteristics of the "whole-task work system" Professions are characterized by the following:

1. Specialized competence having an intellectual component.
2. Extensive autonomy in exercising this very special competence.
3. Strong commitment to a career based on a special competence.
4. Influence and responsibility in the use of special com-

The dominant form of socialization taking place in schools of nursing today is that of professional (whole-task) systems. Students are taught to take care of the whole patient. They are taught that these patients should receive comprehensive care and that these students should attempt to satisfy or meet those needs of the total family. Students are not taught to look at all of those tasks that go into the care of a patient and analyze these tasks in terms of their degree of resistance, and then decide which worker is best and most economically prepared to accomplish each task. This whole-task approach to the socialization of student nurses creates a marked problem in delegating tasks to others (Scott, 1966; Kramer, 1974).

The last category covered was "Other." This was used to account for all those situations that were described by these respondents, but were not characterized by any of the preceding variables.

Other studies utilized in the development of the content area and dimensions of the questionnaire that was used for this study, involved a review of literature on stress, stressful situations, and reality shock (Janis, 1958; Selye, 1958, 1965, and 1975; Johnson, 1966 and 1970; and Kramer, 1974); and with nursing care in the hospital setting (Bates and Moore, 1975). Patient care was limited to planning, implementation, and evaluation of care in which these participants were in some way involved (Kramer, 1974). The general introduction of this study made use of terminology which approximated that terminology used by these nurses in

describing the terms stress or stressful situations.

Proposal Approval

The proposal for this study was submitted to this investigator's program manager at the Air Force Institute of Technology-Civilian Institutions, Medical (AFIT-CIM) at Wright-Patterson Air Force Base in Ohio. The program manager submitted this proposal via the chain-of-command through appropriate channels at that same location. This proposal was then forwarded for appropriate actions, review, content validity established and assignment of an Air Force project number at the United States Air Force Military Personnel Center--Research and Measurement Division (AFMPC/MPCYPS) Randolph Air Force Base, Texas 78148. The survey control number assigned (15 May 1979) to this survey was USAF SCN 79-85 (see Appendices A and B).

Upon having been approved and having had an Air Force project number assigned, this survey and Project number was returned to this investigator via the already mentioned channels for action.

This proposal having been approved was then submitted to the Committee on Human Research and Investigation at Saint Louis University and was approved for the protection of human subjects (see Appendix C).

Pilot Study

A pilot study was conducted to determine whether or not inter-coder reliability existed. This pilot test was used to help determine if the instrument used was reliable, or not. This panel of experts consisted of a Wing (level) Chief Nurse, a Chief

Nurse of an Aeromedical Evacuation Squadron, and the Director of Nursing Services of a Medical Center within the United States Air Force.

This pilot test consisted of the questionnaire having been administered to n=6 subjects, or 17 critical incidents.

Categories were set up by this investigator for that panel of experts to code these open-ended questionnaires into. This panel was given an explanation and summary of this study, provided with directions for participation in the pilot study, given a copy of the proposal, provided with copies of the questionnaires, and given a full opportunity to have any questions the experts had answered for them. Each was provided with an understanding of what these categories consisted of and were given an opportunity to code these categories independent of this investigator. This investigator returned to each member of that panel of experts within a prescribed period and picked up completed materials. This investigator then proceeded to code these same situations into categories independent of that panel of experts already completed categorization. These materials were then compared to determine whether or not inter-coder reliability existed. This was done in an attempt to lend validity to this investigator's use of this tool and this coding system.

It was pre-determined that if inter-coder reliability was at least 0.75, that the entire sample questionnaire would be sent to subjects.

The results of this pilot test concluded that there was inter-coder reliability. The results of this pilot study indicated that there was a 0.8039 correlation between the panel of experts and this investigator. The tool and coding were determined to be valid. There was inter-coder reliability between that panel of experts and this investigator (see Appendix D).

Questionnaires were then mailed to these subjects for administration at their respective locations throughout the continental limits of the United States.

Sample and Setting

Forty-five (45) registered professional nurses involved in planning, implementing, or evaluating patient care; assigned to general hospitals (50 beds or larger), regional hospitals, and medical centers within the continental limits of the United States were participants in this survey.

Data Collection

Data was collected for this study utilizing a mailed questionnaire. The value of mailed questionnaires was discussed by Flanagan (1954) and Notter (1974):

In situations when the observers are motivated to read the instructions conscientiously, this technique seems to give results which are not essentially different from those obtained by the interview method. Except for the addition of introductory remarks, the forms used in collecting these critical incidents by means of mailed questionnaires are about the same as those used in group interviews.

There were no simple formulas available that would determine the number of critical incidents that would be necessary to identify common elements and percentages, from within situations that

were described. A homogeneity of properties was felt to be a necessary item within this sample.

This investigator determined that 150 critical incidents would be necessary to identify commonalities or, a homogeneity of properties. Each individual was requested to identify three (3) situations that subjects felt were particularly stressful to themselves. They were to limit those situations to their clinical settings. Based on this pre-determined need for 150 critical incidents and this request for three (3) situations per respondent, it was determined that fifty (50) participants would be needed.

Upon receipt of the survey control number, this investigator wrote to each of these eight (8) Command Nurses within the continental limits of these United States to enlist their support and the cooperation of their respective commands, in this survey (Appendix E). These commands were:

1. ADCOM - Aerospace Defense Command
2. AFLC - Air Force Logistics Command
3. AFSC - Air Force Systems Command
4. ATC - Air Training Command
5. SAC - Strategic Air Command
6. MAC - Military Airlift Command
7. TAC - Tactical Airlift Command
8. USAFA - United States Air Force Academy

Each command nurse received a brief describing this study and providing clarification of the purpose and method of this study (see Appendices F, G, H.) Each command nurse received a response

sheet and a self-addressed, stamped envelope (see Appendix I). Each command nurse was asked to provide the names, titles, and medical facility addresses of Chief Nurses/Directors of Nursing Services within their respective commands who met the prescribed criteria for participation in this survey.

As each of these command nurses' affirmative responses were received, each Chief Nurse/Director of Nursing Services that was identified was sent a letter of explanation, a brief introducing them to this survey, and a request for their participation (see Appendices J, K, L, and M). Chief Nurses/Directors of Nursing Services cooperation and participation consisted of identifying that number of nurses on their respective nursing staffs who met the prescribed criteria for participation, as described in the brief. They were asked to identify that number on enclosed self-addressed, stamped postcard and return it to this investigator. This investigator, upon receipt of that response, mailed out a respective number of questionnaires to that Chief Nurse/Director of Nursing Services, for distribution to those individuals who met the prescribed criteria for participation in this survey. Utilizing this method of identification and distribution system allowed for participants to maintain anonymity throughout this survey.

The numbers of questionnaires mailed to each command were as follows:

1. ADCOM - none (no hospital of sufficient size to participate)

2. AFLC - eight (8)
3. AFSC - forty (40)
4. ATC - twenty-one (21)
5. SAC - thirteen (13)
6. MAC - twenty (20)
7. TAC - fifteen (15)
8. USAFA - none (no nurses met the prescribed criteria for participation)

Questionnaires consisted of a cover sheet (see Appendix N), a letter of introduction (see Appendix O) to this topic and included a written summary of the nine (9) elements of informed consent, a copy of the Privacy Act Statement (see Appendix P) which was in accordance with Air Force Directives, a General Introduction to this Study (see Appendix Q) which included both general and specific directions for this survey, a Sample response sheet, for purposes of clarification (see Appendix R), three (3) situation sheets with instructions (see Appendices S, T, and U) and last was the personal data sheet (see Appendix V). Each personal data sheet was followed by a self-addressed, stamped envelope for return to this investigator. Each questionnaire indicated that no one was to sign his/her name and individuals described in their stressful situations were to be identified by role designation, not by name. This was requested to ensure anonymity of participants. Suspense dates were assigned to insure an expected return date, for this investigator's purposes of accountability.

As questionnaires were returned to this investigator, they were typed on separate cards and coded for identification purposes. When data collection was completed, these cards were sorted into at least one of four major categories based on the content of those responses. A fifth category was developed to account for all possible responses, it was titled "Other." This was felt necessary by this investigator in order that all possible responses could be categorized and accounted for in analysis of this data. A response was placed in that fifth category when it did not appear to have any of the identifying characteristics of any of four (4) major categories.

A total of 117 questionnaires were mailed to eighteen (18) different Air Force Bases within the continental limits of the United States (CONUS). Forty-five (45) completed questionnaires with 118 stressful situations described, were returned to this investigator as of 30 September 1979.

Data Analysis

Data analysis consisted of four general sections. Section I pertained to personal data. Personal data was analyzed and presented via a variable-frequency-percentage breakdown within those questions.

Section II consists of an analysis of those five categories under which critical incidents were classified for these subjects. This was done via a percentage of frequency per response breakdown.

Section III consists of an analysis and presentation of sub-

jects' perceptions of stress. Each subject's responses were examined to determine whether or not that subject identified and described all of the stress present in a given situation. This data is presented using a percentage breakdown.

Last, Section IV, stresses are analyzed according to personal data variables. Comparisons were made across the levels of these variables of classification with regard to their perception and knowledge of stress/stressful situations. Comparisons across those levels of:

1. type of nursing
2. length of time in nursing
3. age
4. geographical location
5. race or ethnicity
6. hospital size
7. sex
8. internship/attendance/non-attendance

That variable not compared was that of marital status. Comparisons across the levels of variables were carried out using a one-way ANOVA. Each variable was summarized as to significance/non-significance. All tests were conducted at the 0.05 level. The results of the analyses appear in Chapter III.

Chapter III

Presentation and Analysis of Data

Forty-five (45) respondents were categorized based on sample characteristics regarding type of nursing unit, length of time in nursing, age, geographic location, race or ethnicity, hospital size, sex, and whether or not the nurse attended the USAF Nurse Internship Program. The following tables present those numbers and percentages of subjects within each of the aforementioned categories.

Types of nursing units of this sample as based on n=45 subjects indicated that 11.0% of these subjects were working in medical units; another 22.0% were working in surgical units; and those remaining 67.0% were working in specialized units (see Table 3).

Table 3

A Comparison of Frequency and Percentages
of Nurses in Relation to Nursing Units

Nursing Unit	Subjects	Percentage of Total
Medical Units	5	11.0%
Surgical Units	10	22.0%
Specialty Units	30	67.0%
Total n=45		100.0%

Of those nurses surveyed, 67.0% were from specialized units. Table 4 identifies and lists a further breakdown of these specialty units and numbers of subjects within each of those specialty units.

Table 4
Identification of Specialty Nursing
Units and Number of Subjects Within Each
Specialty Area

Specialty Nursing Unit	Subjects
Psychiatric/Mental Health	3
Oncology	3
Obstetrics-Gynecology	3
Operating room	3
Pediatrics (all aspects)	3
Critical Care (ICU,CCU,ER)	5
Orthopedics (all aspects)	4
Thoracic/C.V./Vascular Surgery	5
Infection Surveillance	1
Total	n = 30 (67.0%)

Of those nurses surveyed, 4.0% of these subjects were within their first six (6) months after having graduated from their respective generic programs in nursing; while 45.0% had graduated six (6) to twelve (12) months prior to having completed this survey. It was found that 51.0% were over twelve (12) months out of

their generic program; but less than eighteen (18) months of nursing practice (see Table 5).

Table 5
A Comparison of Subjects' Lengths
of Time After Graduation
(Response Percentages)

Time Frame	Subjects	Percentages
0 - <6 months	2	4.0%
6 - 12 months	20	45.0%
>12 - 18 months	23	51.0%
Totals	n = 45	100.0%

Of those nurses surveyed, 73.3% were from the 20-24 year age group; while 24.5% were from the 25-29 year age group. It was found that 2.2% of the nurses were from the 30-34 year age group (see Table 6).

Table 6
A Comparison of Subjects' Ages

Age Groups	Subjects	Percentages
20-24 years of age	33	73.3%
25-29 years of age	11	24.5%
30-34 years of age	1	2.2%
Totals	n = 45	100.0%

There was an equitable distribution of subjects, based on

geographical location. Results demonstrated that of those nurses who were surveyed, 35.6% of these nurses were from the western states area; 37.7% of these nurses were from the central states area; while the remaining 26.7% of these nurses were from the eastern states area (see Table 7).

Table 7

A Comparison of Subjects' Geographical
Locations from Within the Continental Limits
of the United States
(Response Frequency and Percentages)

Geographical Location	Subjects	Percentages
Western States	16	35.6%
Central States	17	37.7%
Eastern States	12	26.7%
Totals	n = 45	100.0%

It was discovered that 84.4% of this sampled population identified with the caucasian/white race or ethnic origin; 11.1% of these nurses identified with the negroid/black race or ethnic origin; while the remaining 4.5% of these nurses identified with the mongolian/oriental race or ethnic origin (see Table 8).

Insert Table 8 Here

The sixth variable considered was that of whether or not this sampled population had attended the USAF Nurse Internship Program.

Table 8

A Comparison of Subjects' Race/Ethnic Origin

Race/Ethnic Origin	Subjects	Percentages
Caucasian/White	38	84.4%
Negroid/Black	5	11.1%
Mongoloid/Oriental	2	4.5%
Total	n = 45	100.0%

The survey demonstrated that 68.9% of these subjects had attended the USAF Nurse Internship Program; while the remaining 31.1% of these subjects had not attended the USAF Nurse Internship Program (see Table 9).

Table 9

A Comparison of USAF Nurse Internship
Attendance/Nonattendance

USAF Nurse Internship Program Attendance	Subjects	Percentages
Yes	31	68.9%
No	14	31.1%
Total	n = 45	100.0%

The seventh variable considered was that of hospital size/category. It was discovered that 6.7% of this sampled population worked in general hospitals; 35.6% of these nurses worked in re-

gional hospitals; while the remaining 57.7% of these nurses worked in medical centers (see Table 10).

Table 10

A Comparison of Hospital Size/Categories of Subjects

Hospital Size/Category	Subjects	Percentages
General Hospitals	3	6.7%
Regional Hospitals	16	35.6%
Medical Centers	26	57.7%
Total	n = 45	100.0%

The last variable considered from this personal data sheet was that of subjects' sex. This survey showed that 11.1% of this samples population were male; while the remaining 88.9% of this sampled population were female (see Table 11).

Table 11

A Comparison of Subjects' Sex

Sex	Subjects	Percentages
Male	5	11.1%
Female	40	88.9%
Total	n = 45	100.0%

This next section of data presentation and analysis examines how each subject responded to stress and stressful situations, based on these pre-established five (5) categories. Those char-

acteristics are presented using a table that identifies each subject, that number of critical incidents/situations, and that percentage of time each subject responded to these pre-established five categories. These percentages are based on the numbers of critical incidents provided by each subject. The following list identifies those variables/pre-established categories to be considered on each subject::

AA = percentage of time subject responded to clinical uncertainty (or ambiguity).

BB = percentage of time subject responded to competency gap (in self).

CC = percentage of time subject responded to staff-centered conflicts (including generation gap and competency of others).

DD = percentage of time subject responded to professional-bureaucratic conflict.

EE = percentage of time subject responded to "other" factors (see Table 12).

Table 12

Subject, Number of Situations,
and Percentage of Total Responses Each Nurse
Responded to Categories of Stress/
Stressful Situations

Subject	Situations	AA	BB	CC	DD	EE	Category Totals
---------	------------	----	----	----	----	----	--------------------

1	3	.00	.331/3	.331/3	.331/3	.00	100.0%
2	2	.00	.00	.00	.00	.00	100.0%
3	3	.00	.331/3	.331/3	.331/3	.00	100.0%
4	3	.331/3	.00	.331/3	.331/3	.00	100.0%
5	3	.331/3	.00	.331/3	.00	.331/3	100.0%
6	3	.331/3	.331/3	.331/3	.00	.00	100.0%
7	3	.00	.67	.00	.33	.00	100.0%
8	3	.00	.33	.00	.67	.00	100.0%
9	3	.331/3	.00	.331/3	.331/3	.00	100.0%
10	2	.00	.00	1.00	.00	.00	100.0%
11	3	.00	.00	.00	1.00	.00	100.0%
12	3	.00	.00	1.00	.00	.00	100.0%
13	2	.00	.00	1.00	.00	.00	100.0%
14	3	.33	.00	.67	.00	.00	100.0%
15	3	.33	.00	.00	.67	.00	100.0%
16	3	.00	.00	.33	.67	.00	100.0%
17	3	.00	.00	.33	.67	.00	100.0%
18	3	.67	.33	.00	.00	.00	100.0%
19	3	.00	.331/3	.00	.331/3	.331/3	100.0%
20	1	.00	.00	1.00	.00	.00	100.0%
21	1	.00	.00	.00	1.00	.00	100.0%
22	2	.50	.00	.00	.50	.00	100.0%
23	3	.00	.00	.00	.67	.33	100.0%
24	3	.00	.00	.67	.33	.00	100.0%
25	3	.00	.00	1.00	.00	.00	100.0%
26	3	.00	.00	.00	.33	.67	100.0%

27	3	.00	.00	1.00	.00	.00	100.0%
28	1	.00	.00	.00	1.00	.00	100.0%
29	3	.33	.67	.00	.00	.00	100.0%
30	3	.331/3	.00	.331/3	.331/3	.00	100.0%
31	3	.00	.00	.00	1.00	.00	100.0%
32	3	.00	.00	.00	1.00	.00	100.0%
33	2	.00	.00	.50	.50	.00	100.0%
34	3	.00	.00	.33	.67	.00	100.0%
35	1	1.00	.00	.00	.00	.00	100.0%
36	3	.00	.331/3	.331/3	.331/3	.00	100.0%
37	2	.00	.00	.00	1.00	.00	100.0%
38	3	.00	.00	.67	.00	.33	100.0%
39	3	.00	.00	1.00	.00	.00	100.0%
40	3	.331/3	.331/3	.00	.331/3	.00	100.0%
41	1	.00	.00	.00	1.00	.00	100.0%
42	2	.00	.00	1.00	.00	.00	100.0%
43	3	.00	.00	.00	1.00	.00	100.0%
44	3	.00	.00	.67	.33	.00	100.0%
45	3	.331/3	.00	.331/3	.331/3	.00	100.0%

n=118 n=14 n=12 n=41 n=45 n=6

This next section data analysis examines whether or not all of that stress present in those critical incidents provided by subjects was perceived by those nurses. These factors will be reported using a frequency-percentage breakdown (see Table 13).

Table 13

A Comparison of Subjects' Ability or Inability to Perceive
All of Stresses Present in Identified Critical Incidents

All Stress Described	Situations	Percentage
yes	75	63.6%
no	43	36.4%
questionable	.0	0.0%
Total Situations	n =118	100.0%

Based these findings, listed in table 13, it was discovered that 63.6% of these subjects were able to perceive all of those stresses that were present in those critical incidents provided by subjects; while the remaining 36.4% of these subjects were unable to perceive all of the stresses that were present in these subjects' critical incidents. There were no critical incidents provided by these subjects in which this investigator found that subjects' ability to perceive and identify all of these stresses, questionable.

This last section of data analysis examines the extent to which certain characteristics of these subjects is related (or unrelated) to their perception of stress and stressful situations.

Hypotheses were formulated which identified relationships between experiencing stress in each of the following categories and personal data variables. These hypotheses will be tested at the 0.05 level.

This first category relates to clinical uncertainty (or ambiguity):

1. Type of nursing unit nurses are employed in will/will not make a difference in experiencing stresses related to this category.
2. Length of time (months) in nursing will/will not make a difference in experiencing stresses related to this category.
3. Age of nurse will/will not make a difference in experiencing stresses related to this category.
4. Geographic location will/will not make a difference in experiencing stresses related to this category.
5. Race or ethnicity will/will not make a difference in experiencing stresses related to this category.
6. Attendance/non-attendance of USAF Nurse Internship Program will/will not make a difference in experiencing stresses related to this category.
7. Hospital size will/will not make a difference in experiencing stresses related to this category.
8. Sex of these nurses will/will not make a difference in experiencing stresses related to this category.

This second category relates to competency gap (in self):

1. Type of nursing unit will/will not make a difference in experiencing stresses related to this category.
2. Length of time in nursing will/will not make a difference in experiencing stresses related to this category.
3. Age of Nurse will/will not make a difference in experiencing

stresses related to this category.

4. Geographic location will/will not make a difference in experiencing stresses related to this category.
5. Race or ethnicity will/will not make a difference in experiencing stresses related to this category.
6. Attendance/non-attendance of USAF Nurse Internship Program will/will not make a difference in experiencing stresses related to this category.
7. Hospital size will/will not make a difference in experiencing stresses related to this category.
8. Sex of these nurses will/will not make a difference in experiencing stresses related to this category.

This third, pre-established category relates to staff-centered conflicts:

1. Type of nursing unit will/will not make a difference in experiencing stresses related to this category.
2. Length of time in nursing will/will not make a difference in experiencing stresses related to this category.
3. Ages of nurses will/will not make a difference in experiencing stresses related to this category.
4. Geographic location will/will not make a difference in experiencing stresses related to this category.
5. Race or ethnicity will/will not make a difference in experiencing stresses related to this category.
6. Attendance/non-attendance of USAF Nurse Internship Program will/will not make a difference in experiencing stresses

related to this category.

7. Hospital size will/will not make a difference in experiencing stresses related to this category.
8. Sex of these nurses will/will not make a difference in experiencing stresses related to this category.

This fourth pre-established category relates to professional -bureaucratic conflicts:

1. Type of nursing unit will/will not make a difference in experiencing stresses related to this category.
2. Length of time in nursing will/will not make a difference in experiencing stresses related to this category.
3. Ages of nurses will/will not make a difference in experiencing stresses related to this category.
4. Geographic location will/will not make a difference in experiencing stresses related to this category.
5. Race or ethnicity will/will not make a difference in experiencing stresses related to this category.
6. Attendance/non-attendance of USAF Nurse Internship Program will/will not make a difference in experiencing stresses related to this category.
7. Hospital size will/will not make a difference in experiencing stresses related to this category.
8. Sex of these nurses will/will not make a difference in experiencing stresses related to this category.

The fifth, and last, pre-established category relates to "other" factors. These hypotheses are:

1. Type of nursing unit will/will not make a difference in experiencing stresses related to this category.
2. Length of time in nursing will/will not make a difference in experiencing stresses related to this category.
3. Ages of nurses will/will not make a difference in experiencing stresses related to this category.
4. Geographic location will/will not make a difference in experiencing stresses related to this category.
5. Race or ethnicity will/will not make a difference in experiencing stresses related to this category.
6. Attendance/non-attendance of USAF Nurse Internship Program will/will not make a difference in experiencing stresses related to this category.
7. Hospital size will/will not make a difference in experiencing stresses related to this category.
8. Sex of these nurses will/will not make a difference in experiencing stresses related to this category.

In order to test these forty (40) statistical hypotheses, a series of forty (40) one-way ANOVA's were conducted. These results are included in Tables 14A-53B.

A one-way ANOVA was conducted testing this first hypothesis. These results are included in Tables 14A and 14B. The overall F-test was found to be not statistically significant at the 0.05 level ($F_2, 42=0.395, P>0.05$), suggesting that experience stress due to clinical uncertainty (or ambiguity) was not related to that type of nursing unit within which subjects were employed.

subjects from this "surgical units" category exhibited the highest level of stress from experiencing clinical uncertainty (or ambiguity) with a mean of $\bar{X}=0.1830$. The next highest group was the "medical unit" nurse who exhibited a mean of $\bar{X}=0.1320$. Finally that group scoring the lowest level of stress was that of the "specialized unit" nurse who exhibited a mean of $\bar{X}=0.1103$ (see Tables 14A and 14B).

Table 14A

A Comparison of Experiencing Stress
From Clinical Uncertainty (or Ambiguity)
Across the Types of Nursing Units

Group	Sample Size	Mean	SD
Medical Units	5	0.1320	0.1807
Surgical Units	10	0.1830	0.2543
Specialized Units	30	0.1103	0.2195

Table 14B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Clinical Uncertainty (or Ambiguity)
Across the Types of Nursing Units

Source	DF	SS	MS	F
Between Groups	2	0.0397	0.0198	0.395 (ns)

Within Groups	42	2.1096	0.0502
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Total	44	2.1492	
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ns (not significant > 0.05 level)

This second hypothesis was tested using the one-way ANOVA. These results are provided in Tables 15A and 15B. The overall F-test was found to be not significant at the 0.05 level (F_2 , $42=211$, $P>0.05$), suggesting that experiencing stress due to competency gap (in self) was not related to that type of nursing unit within which subjects were employed. "Medical unit" subjects exhibited the highest level of stress from experiencing a competency gap with a mean of $\bar{X}=0.1320$. The "surgical unit" category exhibited the next highest level of stress with a mean of $\bar{X}=0.0990$. Finally that group scoring the lowest level of stress was that of the "specialized unit" category. These subjects exhibited a mean of $\bar{X}=0.0777$ (see Tables 15A and 15B).

Table 15A

A Comparison of Experiencing Stress
From Competency Gaps (In Self)
Across the Types of Nursing Units

Group	Sample Size	Mean	SD
Medical Units	5	0.1320	0.1807
Surgical Units	10	0.0990	0.1594
Specialty Units	30	0.0777	0.1897

Table 15B
 Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Competency Gaps (In Self)
 Across the Types of Nursing Units

Source	DF	SS	MS	F
Betw. Groups	2	0.0141	.0070	0.211 (ns)
W/in Groups	42	1.4029	.0334	
Total	44	1.4170		

ns (not significant >0.05 level)

This next hypothesis was tested using the one-way ANOVA. These results are included in Tables 16A and 16B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.498, P>0.05$), suggesting that experiencing stress due to staff-centered conflicts was not related to that type of nursing unit within which subjects were employed. Those nurses in the "specialty unit" category exhibited the highest level of stress from experiencing staff-centered conflicts with a mean of $\bar{X}=0.3660$. The "medical unit" category experienced the next highest level of stress with a mean of $\bar{X}=0.3320$. Finally that group exhibiting the lowest level of stress was that of the "surgical unit" category with a mean of $\bar{X}=0.2330$ (see Tables 16A and 16B).

Table 16A

A Comparison of Experiencing Stress
From Staff-Centered Conflicts
Across the Types of Nursing Units

Group	Sample Size	Mean	SD
Medical Units	5	0.3320	0.4083
Surgical Units	10	0.2330	0.3534
Specialty Units	30	0.3660	0.3624

Table 16B

Summary Analysis of Variance
For the Comparison fo Experiencing Stress
From Staff-Centered Conflicts

Source	DF	SS	MS	F
Between Gps	2	0.1327	0.0663	0.498 (ns)
Within Gps	42	5.5986	0.1333	
Total	44	5.7313		

ns (not significant >0.05 level)

This fourth hypothesis was tested using the one-way ANOVA. These results are included in Tables 17A and 17B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.316, P>0.05$), suggesting that experiencing stress due to professional-bureaucratic conflict was not related to that type

of nursing unit within which subjects were employed. Those nurses in the "surgical unit" category exhibited the highest level of stress from professional-bureaucratic conflict with a mean $\bar{X}=0.4830$. The "medical units" category exhibited the next highest level of stress with a mean of $\bar{X}=0.3980$. Finally that group exhibiting the lowest level of stress was that of the "specialty units" category with a mean of $\bar{X}=0.3773$.

Table 17A

A Comparison of Experiencing Stress
From Professional-Bureaucratic Conflicts
Across the Types of Nursing Units

Group	Sample Size	Mean	SD
Medical Units	5	0.3980	0.3656
Surgical Units	10	0.4830	0.4195
Specialty Units	30	0.3773	0.3451

Table 17B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Professional-Bureaucratic Conflicts
Across the Types of Nursing Units

Source	DF	SS	MS	F
Betw. Gps	2	0.0839	0.0419	0.316 (ns)

Within Gps	42	5.5717	0.1327
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Total	44	5.6556	
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ns (not significant >0.05 level)

The next hypothesis was tested using a one-way ANOVA. These results are included in Tables 18A and 18B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=1.228$, $P > 0.05$), suggesting that experiencing stress due to "other" factors was not related to that type of nursing unit within which subjects were employed. Subjects from the "specialty units" category exhibited the highest level of stress from experiencing "other" types of conflicts with a mean of $\bar{X}=0.0663$. Both remaining categories "medical units" and "surgical units" were not measurable since both had a mean of $\bar{X}=0.000$, due to insufficient numbers of responses.

Table 18A

A Comparison of Experiencing Stress
From Other Types of Conflicts
Across the Types of Nursing Units

Group	Sample Size	Mean	SD
Medical Units	5	0.0	0.0
Surgical Units	10	0.0	0.0
Specialty Units	30	0.0663	0.1611

Table 18B
 Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Other Types of Conflicts
 Across the Types of Nursing Units

Source	DF	SS	MS	F
Between Groups	2	0.0440	0.0220	1.228 (ns)
Within Groups	42	0.7965	0.0179	
Total	44	0.7965		

ns (not significant >0.05 level)

The sixth hypothesis was tested and these results are provided in Tables 19A and 19B. This overall F-test was found to be not significant at the 0.05 level ($F_2, 42=3681, P > 0.05$), suggesting that experiencing stress due to clinical uncertainty (or ambiguity) was not related to the length of time in nursing. Subjects from the "< 6 months" category exhibited the highest level of stress from clinical uncertainty (or ambiguity) with a mean of $\bar{X}=0.5000$. Subjects from the "6-12 months" category exhibited the next highest level of stress with a mean of $\bar{X}=0.1410$. Finally that group exhibiting the lowest level of stress was the ">12 to 18 months" category with a mean of $\bar{X}=0.0861$.

Table 19A
 A Comparison of Experiencing Stress

From Clinical Uncertainty (or Ambiguity)
Across the Different Lengths of Time in Nursing

Group	Sample Size	Mean	SD
0-6 months	2	0.5000	0.7071
6-12 months	20	0.1410	0.2110
>12 months	23	0.0861	0.1482

Table 19B

Summary Analysis fo Variance
For the Comparison of Experiencing Stress
From Clinical Uncertainty (or Ambiguity)
Across the Different Lengths of Time in Nursing

Source	DF	SS	MN	F
Between Groups	2	0.3205	0.1603	3.681 (ns)
Within Groups	42	1.8287	0.0435	
Total	44	2.1492		

ns (not significant >0.05 level)

This seventh hypothesis was tested and these results are provided in Tables 20A and 20B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.562, P>0.05$), suggesting that experiencing stress due to a competency gap (in self) was not related to the length of time in nursing. Subjects

from the "6-12 month" category exhibited the highest level of stress from a competency gap (in self) with a mean of $\bar{X}=0.1160$. The ">12 to 18 months" category exhibited the next highest level of stress with a mean of $\bar{X}=0.0722$. Finally that remaining category "<6 months" was not measurable, statistically speaking, with a mean of $\bar{X}=0.000$ due to insufficient numbers of responses to analyze.

Table 20A

A Comparison of Experiencing Stress

From Competency Gap (In Self)

Across the Different Lengths of Time in Nursing

Groups	Sample Size	Mean	SD
<6 months	2	0.0	0.0
6-12 months	20	0.1160	0.1952
>12 months	23	0.0722	0.1727

Table 20B

Summary Analysis of Variance

For the Comparison of Experiencing Stress

From Competency Gap (In Self)

Across the Different Lengths of Time in Nursing

Source	D.F.	SS	MS	F
Between Groups	2	0.0369	0.0185	0.562 (ns)

Within Groups	42	1.3801	0.0329
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Total	44	1.4170	
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ns (not significant >0.05 level)

This eighth hypothesis was tested and these results are included in Tables 21A and 21B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.226, P>0.05$), suggesting that experiencing stress due to staff-centered conflicts was not related to the length of time in nursing. Subjects from the "< 6 months" category exhibited the highest level of stress from staff-centered conflicts with a mean of $\bar{X}=0.5000$. Subjects from the "6-12 months" category exhibited the next highest level of stress with a mean of $\bar{X}=0.3330$. Finally that group exhibiting the lowest level of stress was the "> 12 to 18 months" category with a mean of $\bar{X}=0.3178$.

Table 21A

A Comparison of Experiencing Stress

From Staff-Centered Conflicts

Across the Different Lengths of Time in Nursing

Group	Sample Size	Mean	SD
< 6 months	2	0.5000	0.7071
6-12 months	20	0.3330	0.4327
> 12 months	2.3	0.3178	0.2707

Table 21B
 Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Staff-Centered Conflicts
 Across the Different Lengths of Time in Nursing

Source	D.F.	SS	MS	F
Between Gps	2	0.0611	0.0305	0.226 (ns)
Within Gps	42	5.6702	0.1350	
Total	44	5.7313		

ns (not significant >0.05 level)

This ninth hypothesis was tested and these results are provided at the 0.05 level ($F_2, 42=1.694, P > 0.05$), suggesting that experiencing stress due to professional-bureaucratic conflicts was not related to the length of time in nursing. Those nurses in the ">12 to 18 month" category experienced the highest levels of stress from professional-bureaucratic conflict with a mean of $\bar{X}=0.4626$. It was discovered that those nurses in the "6-12 month" category exhibited the lowest level of stress with a mean of $\bar{X}=0.3750$. Finally that remaining category "<6 months" was not measurable, statistically, due to insufficient numbers of responses to analyze that factor. That mean was $\bar{X}=0.000$.

Table 22A
 A Comparison of Experiencing Stress

From Professional-Bureaucratic Conflicts
Across the Different Lengths of Time in Nursing

Group	Sample Size	Mean	SD
< 6 months	2	0.0	0.0
6-12 months	20	0.3750	0.4324
>12 months	23	0.4626	0.2764

Table 22B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Professional-Bureaucratic Conflicts
Across the Different Lengths of Time In Nursing

Source	DF	SS	MS	F
Between Gps	2	0.4222	0.2111	1.694 (ns)
Within Gps	42	5.2333	0.1246	
Total	44	5.6556		

ns (not significant $P > 0.05$ level)

This tenth hypothesis was tested and these results are provided in Tables 23A and 23B. Overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.286, P > 0.05$), suggesting that experiencing stress due to other types of conflicts was not related to length of time in nursing. Results demonstrate that

those subjects in the ">12 to 18 month" category exhibited the highest level of stress due to "other" factors, having a mean of $\bar{X}=0.0578$. Subjects who experienced the lowest level of stress were in the "6-12 months" category with a mean of $\bar{X}=0.0330$. Finally the "< 6 months" category was not measurable due to insufficient numbers of responses to allow for analysis of data, with a resultant mean of $\bar{X}=0.000$.

Table 23A

A Comparison of Experiencing Stress

From Other Types of Conflicts

Across the Different Lengths of Time in Nursing

Group	Sample Size	Mean	SD
< 6 months	2	0.00	0.00
6-12 months	20	0.0330	0.1016
>12 months	23	0.0578	0.1637

Table 23B

Summary Analysis of Variance

For the Comparison of Experiencing Stress

From Other Types of Conflicts

Across the Different Lengths of Time in Nursing

Source	DF	SS	MS	F
Between Groups	2	0.0107	0.0053	0.286 (ns)

Within Groups	42	0.7858	0.0187
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Totals	44	0.7965	
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ns (not significant $P > 0.05$ level)

This eleventh hypothesis was tested and these results are provided in Tables 24A and 24B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.946, P > 0.05$), suggesting that experiencing stress due to clinical uncertainty (or ambiguity) was not related to the age of these subjects. This survey demonstrated that those nurses who experienced the highest level of stress from clinical uncertainty (or ambiguity) were "20-24 years" of age and had a mean of $\bar{X}=0.1558$. Subjects in the "25-29 years" category exhibited the lowest level of stress with a mean of $\bar{X}=0.0600$. Finally the "30-34 years" category was not measurable due to insufficient responses to allow for analysis. It had a mean of $\bar{X}=0.000$.

Table 24A

A Comparison of Experiencing Stress
From Clinical Uncertainty (or Ambiguity)
Across the Different Age Groups

Group	Sample Size	Mean	SD
20-24 years	33	0.1558	0.2423
25-29 years	11	0.0600	0.1335
30-34 years	1	0.00	0.00

Table 24B

Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Clinical Uncertainty (or Ambiguity)
 Across the Different Age Groups

Source	D.F.	SS	MS	F
Between Groups	2	0.0926	0.0463	0.946
Within Groups	42	2.0566	0.0490	
Total	44	2.1492		

ns (not significant $P > 0.05$ level)

This twelfth hypothesis was tested and these results are included in Tables 25A and 25B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.325, P > 0.05$), suggesting that experiencing stress due to a competency gap (in self) was not related to the age of these subjects. This survey demonstrated that the highest stress levels were exhibited by the "25-29 years" category showing a mean of $\bar{X}=0.1209$. Subjects in the "20-24 years" category exhibited the lowest stress levels resulting from a competency gap (in self) having a mean of $\bar{X}=0.0803$. Finally those subjects in that remaining category, "30-34 years", were not included in this data analysis due to insufficient numbers of responses to measure. The mean was $\bar{X}=0.000$.

Table 25A
 A Comparison of Experiencing Stress
 From Competency Gap (In Self)
 Across the Different Age Groups

Group	Sample Size	Mean	SD
20-24 years	33	0.0803	0.1667
25-29 years	11	0.1209	0.2249
30-34 years	1	0.00	0.00

Table 25B
 Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Competency Gaps (In Self)
 Across the Different Age Groups

Source	DF	SS	MS	F
Between Groups	2	0.0216	0.0108	0.325 (ns)
Within Groups	42	1.3954	0.0332	

Total 44 1.4170

ns (not significant $P > 0.05$ level)

This thirteenth hypothesis was tested and these results are provided in Tables 26A and 26B. The overall F-test was found

to be not significant at the 0.05 level ($F_2, 42=0.589, P > 0.05$), suggesting that experiencing stress due to staff-centered conflicts was not related to the age of the subjects. Those nurses experiencing the highest levels of stress from staff-centered conflicts were in the "30-34 years" category with a mean of $\bar{X}=0.6700$. The next highest level was experienced by the "20-24 years" category with a mean of $\bar{X}=0.3424$. Finally the least amount of stress was experienced by the "25-29 years" category with a mean of $\bar{X}=0.2727$.

Table 26A

A Comparison of Experiencing Stress
From Staff-Centered Conflicts
Across the Different Age Groups

Group	Sample Size	Mean	SD
20-24 years	33	0.3424	0.3488
25-29 years	11	0.2727	0.4101
30-34 years	1	0.6700	0

Table 26B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Staff-Centered Conflicts
Across the Different Age Groups

Source	DF	SS	MS	F
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Between Gps	2	0.1565	0.0782	0.589 (ns)
Within Gps	42	5.5748	0.1327	

Total	44	5.7313		
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ns (not significant $P > 0.05$ level)

This fourteenth hypothesis was tested and these results are provided in Tables 27A and 27B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.942, P > 0.05$), suggesting that experiencing stress due to professional-bureaucratic conflict was not related to the ages of these subjects. Those nurses who experienced the highest level of stress due to professional-bureaucratic conflict was the "25-29 years" category with a mean of $\bar{X}=0.4845$. Subjects who experienced the lowest level of stresses were in the "20-24 years" category exhibiting a mean of $\bar{X}=0.3882$. Finally the "30-34 years" category was not measurable due to insufficient numbers of responses to allow for analysis. The resultant mean was $\bar{X}=0.000$.

Table 27A

A Comparison of Experiencing Stress
From Professional-Bureaucratic Conflicts
Across the Different Age Groups

Group	Sample Size	Mean	SD
20-24 years	33	0.3882	0.3459

25-29 years	11	0.4845	0.3980
30-34 years	1	0.00	0.00

Table 27B

Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Professional-Bureaucratic Conflicts
 Across the Different Age Groups

Source	DF	SS	MS	F
Between Groups	2	0.2428	0.1214	0.942 (ns)
Within Groups	42	5.4128	0.1289	
Total	44	5.6556		

ns (not significant $P > 0.05$ level)

This fifteenth hypothesis was tested and these results are provided in Tables 28A and 28B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=2.702, P > 0.05$), suggesting that experiencing stress due to other types of conflicts was not related to the ages of the subjects. Those nurses who experienced the highest levels of stress due to other types of conflicts were "30-34 years" of age, with a mean of $\bar{X}=0.3300$. The next highest level of stress was experienced by the "25-29 years" category with a mean of $\bar{X}=0.0600$. Finally, the lowest

levels of stress were experienced by the "20-24 years" category with a mean of $\bar{X}=0.0303$.

Table 28A
A Comparison of Experiencing Stress
From Other Types of Conflicts
Across the Different Age Groups

Groups	Sample Size	Mean	SD
20-24 years	33	0.0303	0.1284
25-29 years	11	0.0600	0.1335
30-34 years	1	0.3300	

Table 28B
Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Other Types of Conflicts
Across the Different Age Groups

Source	DF	SS	MS	F
Between Groups	2	0.0908	0.0454	2.702 (ns)
Within Groups	42	0.7057	0.0168	
Total	44	0.7965		

ns (not significant $P > 0.05$ level)

This sixteenth hypothesis was tested and these results are included in Tables 29A and 29B. The overall F-test was found to be significant at <0.05 level ($F_2, 42=0.015, P < 0.05$), suggesting that experiencing stress due to clinical uncertainty (or ambiguity) is related to that geographical location to which subjects are assigned. Results demonstrated that those nurses who experienced the highest level of stress due to clinical uncertainty were in the "eastern states" category with a mean of $\bar{X}=0.1383$. The next highest level of stress was exhibited by those nurses in the "central states" category with a mean of $\bar{X}=0.1271$. Finally this survey showed that the least amount of stress was exhibited by those nurses in the "western states" category with a mean of $\bar{X}=0.1238$.

Table 29A

A Comparison of Experiencing Stress
From Clinical Uncertainty (or Ambiguity)
Across the Different Geographical Locations

Group	Sample Size	Mean	SD
Western States	16	0.1238	0.1650
Central States	17	0.1271	0.2731
Eastern States	12	0.1383	0.2228

Table 29B

Summary Analysis of Variance

For the Comparison of Experiencing Stress
From Clinical Uncertainty (or Ambiguity)
Across the Different Geographical Locations

Source	DF	SS	MS	F
Between Groups	2	0.0015	0.0008	0.015*
Within Groups	42	2.1477	0.0511	
Total	44	2.1492		

* (P < 0.05)

This seventeenth hypothesis was tested and these results are indicated in Tables 30A and 30B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.547, P > 0.05$), suggesting that experiencing stress due to a competency gap (in self) is not related to the geographical location to which subjects are assigned. It was discovered that those nurses who exhibited the highest level of stress due to a competency gap was the "western states" category of subjects with a mean of $\bar{X}=0.1244$. Subjects from the "eastern states" category experienced the next highest level of stress with a mean of $\bar{X}=0.0825$. Finally this survey demonstrated that the lowest level of stress was exhibited by the subjects from the "central states" category with a mean of $\bar{X}=0.0588$.

Table 30A

A Comparison of Experiencing Stress
From Competency Gap (In Self)
Across the Different Geographical Locations

Group	Sample Size	Mean	SD
Western States	16	0.0180	0.547
Central States	17	0.0588	0.1766
Eastern States	12	0.0825	0.1492

Table 30B
Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Competency Gap (In Self)
Across the Different Geographical Locations

Source	DF	SS	MS	F
Between Groups	2	0.0360	0.0180	0.547 (ns)
Within Groups	42	1.3810	0.0329	
Total	44	1.4170		

ns (not significant $P > 0.05$ level)

This eighteenth hypothesis was tested and these results are included in Tables 31A and 31B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.246, P > 0.05$),

suggesting that experiencing stress due to self-centered conflicts is not related to geographical location to which subjects are assigned. Results demonstrated that subjects who experienced the highest level of stress were from the "western states" category with a mean of $\bar{X}=0.3844$. It was discovered that the "eastern states" category subjects exhibited the next highest level of stress with a mean of $\bar{X}=0.3050$. Finally this survey showed that the "central states" category subjects exhibited the lowest level of stress from staff-centered conflicts with a mean of $\bar{X}=0.3035$.

Table 31A

A Comparison of Experiencing Stress
From Staff-Centered Conflicts
Across the Different Geographical Locations

Group	Sample Size	Mean	SD
Western States	16	0.3844	0.3641
Central States	17	0.3035	0.3551
Eastern States	12	0.3050	0.3884

Table 31B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Staff-Centered Conflicts
Across the Different Geographical Locations

Source	DF	SS	MS	F
Between Groups	2	0.0664	0.0332	0.246 (ns)
Within Groups	42	5.6649	0.1349	
Total	44	5.7313		

ns (not significant $P > 0.05$ level)

The nineteenth hypothesis was tested and these results are provided in Tables 32A and 32B. This overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.247, P > 0.05$), suggesting that experiencing stress due to professional-bureaucratic conflicts was not related to the geographical location to which subjects were assigned. Those subjects who experienced the highest levels of stress from professional-bureaucratic conflict were in the "central states" category with a mean of $\bar{X}=0.4506$. It was discovered that the next highest level of stress was exhibited by the "eastern states" category with a mean of $\bar{X}=0.3883$. Finally this survey demonstrated that the lowest levels of stress were experienced by the "western states" category of subjects with a mean of $\bar{X}=0.3638$.

Table 32A

A Comparison of Experiencing Stress
From Professional-Bureaucratic Conflict
Across the Different Geographical Locations

Group	Sample Size	Mean	SD
Western States	16	0.3638	0.3351
Central States	17	0.4506	0.3482
Eastern States	12	0.3883	0.4228

Table 32B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Professional-Bureaucratic Conflicts
Across the Different Geographic Locations

Source	DF	SS	MS	F
Between Groups	2	0.0657	0.0329	0.247 (ns)
Within Groups	42	5.5898	0.1331	
Total	44	5.6556		

ns (not significant $P > 0.05$ level)

This twentieth hypothesis was tested and these results are given in Tables 33A and 33B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=1.482, P > 0.05$), suggesting that experiencing stress due to "other" types of conflicts was not related to geographical location. Those nurses who experienced the highest level of stress due to "other" types of conflicts were in the "eastern states" category with a mean of

$\bar{X}=0.825$. It was discovered that the lowest level of stress was exhibited by the "central states" category with a mean of $\bar{X}=0.0588$. Finally the remaining category "western states" was not statistically measurable due to insufficient numbers of responses. The mean was $\bar{X}=0.000$.

Table 33A

A Comparison of Experiencing Stress
From Other Conflicts
Across the Different Geographical Locations

Group	Sample Size	Mean	SD
Western States	16	0.0	0.0
Central States	17	0.0588	0.1766
Eastern States	12	0.825	0.1492

Table 33B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Other Conflicts
Across the Different Geographical Locations

Source	DF	SS	MS	F
Between Groups	2	0.0525	0.0262	1.482
Within Groups	42	0.7440	0.0177	

Total 44 0.7965

ns (not significant $P > 0.05$ level)

This twenty-first hypothesis was tested and these results are included in Tables 34A and 34B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.922, P > 0.05$), suggesting that experiencing stress due to clinical uncertainty (or ambiguity) is not related to race or ethnicity. Those nurses who experienced the highest level of stress due to clinical uncertainty (or ambiguity) were in the "negroid/black" category with a mean of $\bar{X}=0.234$. Results demonstrated that the lowest level of stress was exhibited by the "caucasian/white" category with a mean of $\bar{X}=0.1218$. Finally the remaining category "mongolian/oriental" was not statistically measurable due to insufficient numbers of responses to accomplish data analysis. The resultant mean was $\bar{X}=0.000$.

Table 34A

A Comparison of Experiencing Stress
From Clinical Uncertainty (or Ambiguity)
Across the Different Races or Ethnicities

Group	Sample Size	Mean	SD
Caucasian/White	38	0.1218	0.2101
Negroid/Black	5	0.2340	0.1458
Mongolian/Oriental	2	0.0	0.0

Table 34B

Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Clinical Uncertainty (or Ambiguity)
 Across the Different Races or Ethnicities

Source	DF	SS	MS	F
Between Groups	2	0.0904	0.0452	0.922 (ns)
Within Groups	42	1.0589	0.0490	
Total	44	2.1492		

ns (not significant $P > 0.05$ level)

This twenty-second hypothesis was tested and these results are provided in Tables 35A and 35B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.214, P > 0.05$), suggesting that experiencing stress due to a competency gap (in self) is not related to race or ethnicity. It was discovered that the "mongolian/oriental" category exhibited the highest level of stress from a competency gap (in self) with a mean of $\bar{X}=0.1650$. This survey showed that the "caucasian/white" category exhibited the next highest level of stress with a mean of $\bar{X}=0.0874$. Finally that group exhibiting the lowest level of stress was the "negroid/black" category with a mean of $\bar{X}=0.0660$.

Table 36A
 A Comparison of Experiencing Stress
 From Staff-Centered Conflicts
 Across the Different Races or Ethnicities

Group	Sample Size	Mean	SD
Caucasian/White	38	0.3326	0.3617
Negroid/Black	5	0.2660	0.4345
Mongolian/Oriental	2	0.5000	0.2404

Table 36B
 Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Staff-Centered Conflicts
 Across the Different Races or Ethnicities

Source	DF	SS	MS	F
Between Groups	2	0.0782	0.0391	0.291 (ns)
Within Groups	42	5.6531	0.1346	
Total	44	5.7313		

ns (not significant $P > 0.05$ level)

This twenty-fourth hypothesis was tested and these results are provided in Tables 37A and 73B. The overall F-test was found

to be not significant at the 0.05 level ($F_2, 42=0.284, P > 0.05$), suggesting that experiencing stress due to professional-bureaucratic conflicts is not related to race or ethnicity. Those nurses who were in the "caucasian/white" category exhibited the highest stress levels due to professional-bureaucratic conflict with a mean of $\bar{X}=0.4205$. It was discovered that the "mongolian/oriental" category exhibited the next highest level of stress with a mean of $\bar{X}=0.3300$. Finally results demonstrated that the "negroid/black" category exhibited the lowest level of stress with a mean of $\bar{X}=0.3000$.

Table 37A

A Comparison of Experiencing Stress
From Professional-Bureaucratic Conflicts
Across the Different Races or Ethnicities

Group	Sample Size	Mean	SD
Caucasian/White	38	0.4205	0.3757
Negroid/Black	5	0.3000	0.2991
Mongolian/Oriental	2	0.3300	0.00

Table 37B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Professional-Bureaucratic Conflicts
Across the Different Races or Ethnicities

Source	DF	SS	MS	F
Between Groups	2	0.0754	0.0377	0.284 (ns)
Within Groups	42	5.5802	0.1329	
Total	44	5.6556		

ns (not significant $P > 0.05$ level)

This twenty-fifth hypothesis was tested and Tables 38A and 38B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=1.336, P > 0.05$), suggesting that experiencing stress due to other factors is not related to race or ethnicity. This survey demonstrated that the "negroid/black" category exhibited the highest level of stress due to "other" factors with a mean of $\bar{X}=0.1340$. Subjects in the "caucasian/white" category exhibited the next highest level of stress with a mean of $\bar{X}=0.0347$. The remaining category "mongolian/oriental" category was not statistically measurable due to insufficient numbers of responses; the resultant mean was $\bar{X}=0.000$.

Table 38A

A Comparison of Experiencing Stress
From Other Factors
Across the Different Races or Ethnicities

Group	Sample Size	Mean	SD
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Caucasian/White	38	0.0347	0.1026
Negroid/Balck	5	0.1340	0.2996
Mongolian/Oriental	2	0.0	0.0

Table 38B

Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Other Factors
 Across the Different Races or Ethnicities

Source	DF	SS	MS	F
Between Groups	2	0.0476	0.0238	1.336 (ns)
Within Groups	42	0.7489	0.0178	
Total	44	0.7965		

ns (not significant $P > 0.05$ level)

The twenty-sixth hypothesis was tested and these results are included in Tables 39A and 39B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 43=2.064, P > 0.05$), suggesting that experiencing stress due to clinical uncertainty (or ambiguity) is not related to attendance/non-attendance at the USAF Nurse Internship Program. Results demonstrated that the "attended internship" category exhibited the higher level of

stress due to clinical uncertainty (or ambiguity) with a mean of $\bar{X}=0.1608$. It was demonstrated that "no internship" category exhibited the lower stress level with a mean of $\bar{X}=0.0593$.

Table 39A

A Comparison of Experiencing Stress
From Clinical Uncertainty (or Ambiguity)
Across the Attendance/NonAttendance
at USAF Nurse Internship Program

Group	Sample Size	Mean	SD
Attended Internship	31	0.1603	0.2409
No Internship	14	0.0593	0.1543

Table 39B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Clinical Uncertainty (or Ambiguity)
Across the Attendance/NonAttendance
at USAF Nurse Internship Program

Source	DF	SS	MS	F
Between Groups	1	0.0985	0.0985	2.064 (ns)
Within Groups	43	2.0508	0.0477	
Total	44	2.1492		

ns (not significant $P > 0.05$ level)

This twenty-seventh hypothesis was tested and the results are given in Tables 40A and 40B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 43=0.195, P > 0.05$), suggesting that experiencing stress due to a competency gap (in self) is not related to attendance/nonattendance of the USAF Nurse Internship Program. Results demonstrated that the "attended internship" program exhibited the higher level of stress from a competency gap (in self) with mean of $\bar{X}=0.0965$. It was demonstrated that the "no internship" exhibited the lower stress level with a mean of $\bar{X}=0.0707$.

Table 40A

A Comparison of Experiencing Stress
From Competency Gaps (In Self)
Across the Attendance/NonAttendance
at USAF Nurse Internship Program

Group	Sample Size	Mean	SD
Attended Internship	31	0.0965	0.1961
No Internship	14	0.0707	0.1405

Table 40B

Summary Analysis of Variance
For the Comparison of Experiencing Stress

From Competency Gaps (In Self)
 Across the Attendance/NonAttendance
 at USAF Nurse Internship Program

Source	DF	SS	MS	F
Between Groups	1	0.0064	0.0064	0.195 (ns)
Within Groups	43	1.4106	0.0328	
Total	44	1.4170		

ns (not significant $P > 0.05$ level)

This twenty-eighth hypothesis was tested and these results are included in Tables 41A and 41B. The overall F-test was found to be significant at the < 0.05 level ($F_2, 43=0.0000, P < 0.01$), suggesting that experiencing stress due to staff-centered conflicts is related to attendance/nonattendance at USAF Nurse Internship Program. This survey showed that the "no internship" category exhibited the higher stress level due to the attendance/nonattendance USAF Nurse Internship Program with a mean of $\bar{X}=0.3329$. Subjects from the "attended internship" category exhibited the lower level of stress with a mean of $\bar{X}=0.3326$.

Table 41A

A Comparison of Experiencing Stress
 From Staff-Centered Conflicts
 Across the Attendance Non-Attendance

at USAF Nurse Internship Program

Group	Sample Size	Mean	SD
Attended Internship	31	0.3326	0.3851
No Internship	14	0.3329	0.3141

Table 41B

Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Staff-Centered Conflicts
 Across the Attendance/NonAttendance
 at USAF Nurse Internship Program

Source	DF	SS	MS	F
Between Groups	1	0.0000	0.0000	0.0000*
Within Groups	43	5.7313	0.1333	
Total	44	5.7313		

* (P < 0.01)

This twenty-ninth hypothesis was tested and these results are given in Tables 42A and 42B. This overall F-test was found to be not significant at the 0.05 level ($F_{2, 43}=1.159, P > 0.05$), suggesting that experiencing stress due to professional-bureaucratic

conflicts was not related to the ages of these subjects. Results demonstrated that those subjects who exhibited the higher stress level from professional-bureaucratic conflict were the "no internship (nonattendance)" category with a mean of $\bar{X}=0.4886$. Those subjects in the "attended internship" category exhibited the lower level of stress with a mean of $\bar{X}=0.3645$.

Table 42A

A Comparison of Experiencing Stress
From Professional-Bureaucratic Conflicts
Across the Attendance/NonAttendance
at USAF Nurse Internship Program

Group	Sample Size	Mean	SD
Attended Internship	31	0.3645	0.3690
No Internship	14	0.4886	0.3307

Table 42B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Professional-Bureaucratic Conflicts
Across the Attendance/NonAttendance
at USAF Nurse Internship Program

Source	DF	SS	MS	F
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Between Groups	1	0.1484	0.1484	1.159 (ns)
Within Groups	43	5.5071	0.1281	

Total	44	5.6556		
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ns (not significant $P > 0.05$ level)

This thirtieth hypothesis was tested and these results are included in Tables 43A and 43B. The overall F-test was found to be significant at the < 0.05 level ($F_2, 43 = 0.009, P < 0.01$), suggesting that experiencing stress due to other types of conflicts was related to attendance/nonattendance of the USAF Nurse Internship Program. Results demonstrated that the "no internship (nonattendance)" category exhibited the higher stress level due to "other" factors with a mean of $\bar{X} = 0.0471$. Subjects in the "attended internship" category exhibited the lower level of stress with a mean of $\bar{X} = 0.0429$.

Table 43A

A Comparison of Experiencing Stress
From Other Factors
Across the Attendance/NonAttendance
at USAF Nurse Internship Program

Groups	Sample Size	Mean	SD
Attended Internship	31	0.0429	0.1426
No Internship	14	0.0471	0.1198

Table 43B
 Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Other Factors
 Across the Attendance/NonAttendance
 at USAF Nurse Internship Program

Source	DF	SS	MS	F
Between Groups	1	0.0002	0.0002	0.009*
Within Groups	43	0.7963	0.0185	
Total	44	0.7965		

* (P < 0.01)

This thirty-first hypothesis was tested and these results are included in Tables 44A and 44B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=1.256, P > 0.05$), suggesting that experiencing stress due to clinical uncertainty (or ambiguity) was not related to hospital size. Results demonstrated that the "general hospital" category subjects exhibited the highest level of stress, related to clinical uncertainty (or ambiguity), with a mean of $\bar{X}=0.2200$. It was discovered that those subjects who were in the "medical center" category exhibited the next highest level of stress with a mean of $\bar{X}=0.1596$. Finally

those subjects who exhibited the lowest level of stress were in the "regional hospital" category with a mean of $\bar{X}=0.0619$.

Table 44A

A Comparison of Experiencing Stress
From Clinical Uncertainty (or Ambiguity)
Across the Different Hospital Sizes

Group	Sample Size	Mean	SD
General Hospitals	3	0.2200	0.1905
Regional Hospitals	16	0.0619	0.1330
Medical Centers	26	0.1596	0.2600

Table 44B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Clinical Uncertainty (or Ambiguity)
Across the Different Hospital Sizes

Source	DF	SS	MS	F
Between Groups	2	0.1213	0.0607	1.256 (ns)
Within Groups	42	2.0279	0.0483	
Total	44	2.1492		

ns (not significant $P > 0.05$ level)

This thirty-second hypothesis was tested and these results are included in Tables 45A and 45B. The overall F-test was found to be significant at the 0.05 level ($F_2, 42=0.030, P < 0.05$), suggesting that experiencing stress due to a competency gap (in self) is related to hospital size. It was demonstrated that those nurses who were in the "general hospital" category exhibited the highest level of stress due to a competency gap (in self) with a mean of $\bar{X}=0.1100$. Subjects in the "medical center" category with a mean of $\bar{X}=0.086$. Finally this survey demonstrated that the "regional hospital" category exhibited the lowest level of stress with a mean of $\bar{X}=0.0825$.

Table 45A

A Comparison of Experiencing Stress
From Competency Gap (In Self)
Across the Different Hospital Sizes

Group	Sample Size	Mean	SD
Large Hospital	3	0.1100	0.1905
Regional Hospital	16	0.0825	0.1476
Medical Center	26	0.0896	0.2016

Table 45B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Competency Gap (In Self)

Across the Different Hospital Sizes

Source	DF	SS	MS	F
Between Groups	2	0.0020	0.0010	0.030*
Within Groups	42	1.4150	0.0337	
Total	44	1.4170		

* (P < 0.05)

This thirty-third hypothesis was tested and the results are in Tables 46A and 46B. Overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.818, P > 0.05$), suggesting that experiencing stress due to staff-centered conflicts is not related to hospital size. Results demonstrated that those subjects who were in the "general hospital" category exhibited the highest level of stress from staff-centered conflicts with a mean of $\bar{X}=0.5533$. Subjects in the "regional hospital" category exhibited the next highest level of stress with a mean of $\bar{X}=0.3644$. Finally those nurses who were in the "medical center" category exhibited the lowest level of stress with a mean of $\bar{X}=0.2877$.

Table 46A

A Comparison of Experiencing Stress
From Staff-Centered Conflicts
Across the Different Hospital Sizes

Group	Sample Size	Mean	SD
General Hospitals	3	0.5533	0.3868
Regional Hospitals	16	0.3644	0.3567
Medical Centers	26	0.2877	0.3638

Table 46B

Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Staff-Centered Conflicts
 Across the Different Hospital Sizes

Source	DF	SS	MS	F
Between Groups	2	0.2148	0.1074	0.818 (ns)
Within Groups	42	5.5165	0.1313	
Total	44	5.7313		

ns (not significant $P > 0.05$ level)

This thirty-fourth hypothesis was tested and these results are included in Tables 47A and 47B. The overall F-test was found to be not significant at the 0.05 level ($F_{2, 42} = 1.286, P > 0.05$), suggesting that experiencing stress due to professional-bureaucratic conflicts is not related to hospital size. Those nurses who exhibited the highest level of stress were in the "regional hospital" category with a mean of $\bar{X} = 0.4681$. It was discovered

that the "medical center" category exhibited the next highest level of stress from professional-bureaucratic conflict with a mean of $\bar{X}=0.3969$. Finally those subjects in the "general hospital" category exhibited the lowest level of stress with a mean of $\bar{X}=0.1100$.

Table 47A

A Comparison of Experiencing Stress
From Professional-Bureaucratic Conflicts
Across the Different Hospital Sizes

Group	Sample Size	Mean	SD
General Hospitals	3	0.1100	0.1905
Regional Hospitals	16	0.4681	0.3410
Medical Centers	26	0.3969	0.3748

Table 47B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Professional-Bureaucratic Conflicts
Across the Different Hospital Sizes

Source	DF	SS	MS	F
Between Groups	2	0.3264	0.1632	1.286 (ns)
Within Groups	42	5.3292	0.1269	

Total 44 5.6556

ns (not significant $P > 0.05$ level)

This thirty-fifth hypothesis was tested and these results are indicated in Tables 48A and 48B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 42=0.675, P > 0.05$), suggesting that experiencing stress due to other types of conflicts was not related to the hospital size. Results demonstrated that the "medical center" category subjects exhibited the highest level of stress due to "other" factors with a mean of $\bar{X}=0.0638$. Subjects who exhibited the lowest level of stress were in the "regional hospital" category with a mean of $\bar{X}=0.0206$. Finally the remaining category "general hospital" was not measurable due to its insufficient numbers of responses to allow for analysis (mean $\bar{X}=0.000$).

Table 48A

A Comparison of Experiencing Stress

From Other Types of Conflicts

Across the Different Hospital Sizes

Group	Sample Size	Mean	SD
General Hospitals	3	0.0	0.0
Regional Hospitals	16	0.0206	0.0825
Medical Centers	26	0.0638	0.1637

Across the Different Sex Groups

Group	Sample Size	Mean	SD
Male	5	0.2000	0.4472
Female	40	0.1200	0.1840

Table 49B

Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Clinical Uncertainty (or Ambiguity)
 Across the Different Sex Groups

Source	DF	SS	MS	F
Between Groups	1	0.0284	0.0284	0.577 (ns)
Within Groups	43	2.1208	0.0493	
Total	44			

ns (not significant $P > 0.05$ level)

This thirty-seventh hypothesis was tested and these results are included in Tables 50A and 50B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 43=1.378, P > 0.05$), suggesting that experiencing stress due to a competency gap (in self) is not related to the subjects' sex. The survey demonstrated that the "female" category exhibited the higher level of stress

due to a competency gap (in self) with a mean of $\bar{X}=0.0995$.

Those subjects who were in the "male" category could not be measured and analyzed due to insufficient numbers of responses (mean $\bar{X}=0.000$).

Table 50A

A Comparison of Experiencing Stress
From Competency Gap (In Self)
Across the Different Sex Groups

Group	Sample Size	Mean	SD
Male	5	0.00	0.00
Female	40	0.0995	0.1876

Table 50B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Competency Gap (In Self)
Across the Different Sex Groups

Source	DF	SS	MS	F
Between Groups	1	0.0440	0.0440	1.378 (ns)
Within Groups	43	1.3730	0.0319	
Total	44	1.4170		

ns (not significant $P > 0.05$ level)

This thirty-eighth hypothesis was tested and these results are included in Tables 51A and 51B. The overall F-test was found to be significant at the 0.05 level ($F_2, 43=0.045, P < 0.05$), suggesting that experiencing stress due to staff-centered conflicts is related to the subjects' sex. This survey demonstrated that the "female" category exhibited the higher level of stress due to staff-centered conflict with a mean of $\bar{X}=0.3368$. Those subjects in the "male" category exhibited the lower level of stress with a mean of $\bar{X}=0.3000$.

Table 51A

A Comparison of Experiencing Stress
From Staff-Centered Conflicts
Across the Different Sex Groups

Groups	Sample Size	Mean	SD
Male	5	0.3000	0.4472
Female	40	0.3368	0.3554

Table 51B

Summary Analysis of Variance
For the Comparison of Experiencing Stress
From Staff-Centered Conflicts
Across the Different Sex Groups

Source	DF	SS	MS	F
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Table 52B

Summary Analysis of Variance
 For the Comparison of Experiencing Stress
 From Professional-Bureaucratic Conflicts
 Across the Different Sex Groups

Source	DF	SS	MS	F
Between Groups	1	0.0054	0.0054	0.041 *
Within Groups	43	5.6502	0.1314	

Total 44 5.6556

* (P < 0.05)

This fortieth hypothesis was tested and these results are included in Tables 53A and 53B. The overall F-test was found to be not significant at the 0.05 level ($F_2, 43=0.145, P > 0.05$), suggesting that experiencing stress due to "other" factors was not related to the subjects' sex. Results demonstrated that those subjects who were in the "male" category exhibited the higher level of stress due to "other" factors with a mean of $\bar{X}=0.0660$. Subjects in the "female" category exhibited the lower level of stress with a mean of $\bar{X}=0.0415$.

Table 53B

Summary Analysis of Variance
 For the Comparison of Experiencing Stress

From Other Types of Conflicts
Across the Different Sex Groups

Source	DF	SS	MS	F
Between Groups	1	0.0027	0.0027	0.145 (ns)
Within Groups	43	0.7938	0.0185	
Total	44	0.7965		

ns (not significant $P > 0.05$ level)

Table 53A

A Comparison of Experiencing Stress
From Other Types of Conflicts
Across the Different Sex Groups

Group	Sample Size	Mean	SD
Male	5	0.0660	0.1476
Female	40	0.0415	0.1346

The following hypotheses were found to be significant or true:

1. Experiencing stress due to clinical uncertainty (or ambiguity) is related to that geographical location to which nurses were assigned. The order of this significance is eastern states, central states, and last,

- western states (Sixteenth Hypothesis).
2. Experiencing stress due to staff-centered conflicts is related to non-attendance (no internship) in the USAF Nurse Internship Program (Twenty-eight Hypothesis).
 3. Experiencing stress due to "other" factors or conflicts is related to non-attendance (no internship) in the USAF Nurse Internship Program (Thirtieth Hypothesis).
 4. Experiencing stress due to a competency gap (in self) is related to hospital size. The order of this significance is general hospitals, medical centers, and last is the regional hospital (Thirty-second Hypothesis).
 5. Experiencing stress due to staff-centered conflict is related to the subjects' sex. The order of significance is first that of the female and then, male (Thirty-eighth Hypothesis).
 6. Experiencing stress due to professional-bureaucratic conflicts is related to the subjects' sex. The order of its significance is first, the male and then, female (Thirty-ninth Hypothesis).

Presentation and Analysis of data contained within this chapter included:

1. Categorization of subjects according to: type of nursing units, specialty areas, length of time after graduation, age, geographic location, race or ethnicity, attendance/non-attendance of USAF Nurse Internship Program, size of hospital, and subjects' sex.

2. Categorization of stressful situations according to: clinical uncertainty (or ambiguity), competency gap (in self), staff-centered conflicts, professional-bureaucratic conflicts, and "other." These categories were listed by: AA, BB, CC, DD, and EE; respectively.
3. Perceptions of personal stresses in stressful situations.
4. Analysis of personal data as related to categories of stressful situations.

Chapter IV will discuss further the analysis of data and implications of these findings, while identifying limitations, recommendations, and conclusions of this study.

Chapter IV

Discussions and Recommendations

Summary of Findings

The purpose of this study was to identify and describe recently graduated Air Force Nurses' perception, identification, and description of stress and stressful situations; through use of the critical incident technique and a mailed questionnaire. In addition, this questionnaire was developed to elicit information pertaining to personal data associated with this subject's type of nursing unit, time (or months) in nursing, age, geographical location, race or ethnicity, attendance/nonattendance in the USAF Nurse Internship Program, size of hospital, and sex. These results will be discussed with respect to variables, frequencies, and percentages that were previously presented. Further discussion of these results will examine subjects' perception, identification, and description of all those stresses which were present in their critical incidents. There will be a further discussion of those hypotheses which proved to be significant for this study.

In those questionnaires which were returned to this investigator, subjects' description of stress and stressful situations, has proven that stress does affect these recently graduated Air Force Nurses within their respective clinical settings. Results demonstrated that in 118 stressful situations described by these subjects, 75 situations or 63.7% of this total number of des-

cribed situations had identified all of those stresses which were present; while those remaining 36.4% of these subjects were unable to identify all of their stresses.

Further results revealed a significant relationship among the following six (6) variables and characteristics. The first set of data involved the sixteenth hypothesis. These data revealed a significant relationship between clinical uncertainty (or ambiguity) and geographic location with the greatest stresses being experienced by those nurses in the eastern states area, while western states area nurses experienced the least amount of stresses ($P < 0.05$). This is statistically significant, therefore it was surmised that this was due to a determining factor and not a result of chance. The second set of data involves the twenty-eighth hypothesis. These data revealed a significant relationship between staff-centered conflicts and nonattendance in the USAF Nurse Internship Program ($P < 0.01$). This is statistically significant, therefore it was surmised that this was due to a determining factor and not a result of chance. The third set of data involved the twenty-ninth hypothesis. These data revealed a significant relationship between stress related to "other" factors and nonattendance in the USAF Nurse Internship Program ($P < 0.01$). This is statistically significant, therefore it was surmised that this was due to a determining factor and was not a result of chance. The fourth set of data was related to the thirty-second hypothesis. These data revealed a significant relationship between a competency gap (in self) and the size of the hospital,

cidents that would allow for their being placed in one (1) of the four (4) preceding categories.

Discussion of Findings

This study attempted to identify, describe, and analyze the potential sources of stress and stressful situations within the typical clinical setting, as they were perceived by recently graduated Air Force Nurses. The health care setting has for quite some time been viewed by social scientists, biological scientists, and health care professionals as a setting where stress is resident. A review of literature revealed numerous factors which possess the potential for creating stress in the clinical setting for student nurses and recently graduated nurses, as well as for those experienced nurses.

This study was designed to determine if, and what types of stressful situations, which the literature identified with this clinical setting were perceived, identified, and described by these recently graduated Air Force Nurses. The twelve (12) questionnaire items which dealt with a variety of stressful factors and personal variables, were collectively perceived as stressful by the forty-five (45) subjects in the sampled population.

This finding may be explained by the fact that the subject of stress in the clinical setting has been sufficiently discussed in the literature, possibly mentioned in the classroom setting, and finally experienced; and therefore, nursing has gained an awareness of its nature and some of its implications in the health care setting. Within these settings selected for this study five

assumptions were made that: (1) nurses who were graduates of pre-service baccalaureate nursing programs had been taught the concepts of optimum patient care; (2) there would be stressful situations during these first twelve (12) to eighteen (18) months in nursing practice; (3) there would be stress inducing situations during these nurses' first twelve (12) months on active duty in the Air Force; (4) the nurses participating in this study would be capable of identifying situations which were stressful to themselves; and (5) that, individuals participating in this study would be capable of recalling those situations which induced stress in themselves. Such assumptions credit the involved individuals with success at effectively assessing stressors within their work settings and effectively intervening, dealing with, and coping to nullify those potentially immobilizing effects of the stressors.

Research revealed that all subjects who responded understood the type of information sought by this investigator. It further indicated that in all of those subjects who responded, there were no indications that subjects were embarrassed to record situations which were stressful to them.

This research revealed that the subjects had a general knowledge of stress and that in fact, many of those subjects were aware of the multitudinous factors interrelating within a given situation creating more than one stress, in the numerous critical incidents which were recounted. This was noted in the data determining whether or not the subjects had identified all of the stresses present in a given situation that was recounted for this

investigator. Data revealed that 63.6% of these nurses were able to identify all of the stresses in a given situation. This was compared to these remaining 36.4% who were unable to identify all of those stresses that were recounted for this investigator. This investigator found, on review of those 36.4% who were unable to identify all of the stresses in their situations, that there was a threat to that individual's self-esteem, self-concept, a feeling of confusion, and frustration. This may relate to what literature identified as a failure of interpersonal competence in a new subculture. This was noted and supported by Argyris (1968) and Kramer (1974). This lack of self-confidence is often misinterpreted by numerous manager/administrators and may well be masking the underlying problem or issue. That issue is that this nurse is suffering from a lack of "interpersonal competency," which comes through to others and self as a lack of self-confidence.

Research findings also contradicted some previous postulates regarding stressors to which these recently graduated Air Force Nurses were exposed. Events and factors within a particular nursing unit which were perceived as stressful by nursing and social scientists, might fail to exist within the cognizant realm of these nurses. There may be priorities of concern which demand total expenditure of energy on the part of an individual's emotional adaptation to a given critical incident. Extraneous conditions which were perceived by observers and investigators to complicate an individual's emotional/psychological adjustment may,

in fact, be nonsignificant to that subject.

Additional findings from this study lead to further speculations. Stressful situations within these nurses' respective clinical settings, which threatened these nurses' abilities to adjust to their socialization into the profession and the Air Force, may have existed yet remained undetected as a result of uncontrolled variables. One such variable could have been peer and family pressures against that nurse's entering active duty in the Air Force. This variable was found by this investigator to be a significant factor during recruiting duty and in most cases, that final determining factor as to whether or not nurse applicants took the oath of office and were commissioned. This stereotype of the military nurse has only, today, begun to fall by the wayside; becoming a part of the past. This is believed to be due to the changing role of women in this society and culture.

Another uncontrollable variable which could have affected these nurses' perception and reaction to stressful situations lies in the fact that a prolonged reaction to stress, precipitated by factors outside of their clinical settings may have triggered some incident in that clinical setting, that this individual was heretofore unaware of or ordinarily would not have perceived as being stressful.

A third uncontrollable variable might have been the accumulation of many smaller stresses which culminate, resulting in one very large stressful situation.

The fourth variable, which might have been significant to

these situations, that although uncontrollable, is that of these subjects' past experiences with any given situation or incident (operant conditioning). The more frequent the exposure to that type of situation, the more familiar it will become to the individual and a result of this exposure could lead to its becoming less stressful. This individual will have past experience and knowledge to base their reactions to that stressor and appropriate responses will have been built-up in their repertoire of responses, to effectively handle that situation. The contrary could also be a factor. The less the exposure, the greater the perceived stress.

A fifth variable which is uncontrollable is that of one's own perceptions. Each individual perceives each of the stressors within the context of their own being. What is stressful for one individual may be perceived as life-threatening to another.

Still other variables exist which are uncontrollable. These are: one's own motivation, goals, expectations, and confidence; existing support systems for the individual; and one's own views of competency and how that individual views himself/herself within that context.

This study failed to find a significant relationship between the sources of stress and the independent variables of nurses' type of nursing unit, number of months in the practice of nursing, age, and race or ethnicity. This differs from research conducted by numerous authors during the mid-1950's and into the mid-1960's, as has been identified in this study's review of literature. This investigator found this to be related, potentially, to one or any

combination of the following: (1) more rapid maturation of the younger generation, due to the fast pace of the times; (2) mass media informing the public; (3) an indication of some anticipatory socialization within the pre-service or generic programs; (4) managers/administrators have begun to define precisely what it is that they need in nurses who practice in their clinical settings; (5) educators have begun listening more closely to what these managers/administrators have begun to say, concerning their needs in nurses preparation; (6) inservice education and internships have become necessities, not luxuries, for this transition period for the recently graduated nurses; (7) practitioners have become aware of stress and are beginning to aid these individuals in making this transition, smoothly, hopefully pre-empting the stresses becoming full-blown confrontations or crises; (8) there is more feedback and feed-forward beginning to take place; and (9) the civil rights/equal opportunity movement have changed attitudes and policies.

This study failed to find a significant relationship for the variable "type of nursing unit." This study's findings contradict some of the previous postulates regarding stressors involving different types of nursing units. Events and factors within the Air Force medical facility are such that all nurses either during their orientation or internships are exposed to all factes of Air Force Nursing, as are available at that particular medical facility. Clinical rotations for specified periods of time (idiosyn- cratic to each institution) are mandatory for all recently grad-

uated nurses, in that clinical setting. This provides each of these new nurses with a broad exposure and background upon which to base future actions and reactions. This variable may have been nonsignificant due to these nurses having had experiences in that same type of setting while having worked after graduation but prior to entering active duty in the Air Force; or having had exposure to these situations while still a student, which allowed them to adapt to those types of stresses or situations. Still another factor which may affect the non-significance of this variable involves the factor of a highly selective screening process that these subjects have been subjected to, prior to their selection and commissioning. These individuals have been thoroughly investigated and evaluated. For each of these subjects there may have been four or five more nurses that were not selected for commissioning. Competition is both selective and keen. Five to six nurses actively compete for each of the commissions that is projected to become vacant at some later date. Therefore, it may be surmised that these subjects are a part of a select few who have the potential or ability to make positive adaptations (readily) to changing situations. This has become necessary for these nurses since they can expect change approximately once every three years, or in the event of war/hostile actions, or in support of presidential directives.

The next variable found to be non-significant by this study, was that of the number of months in nursing. This both concurs and contradicts the literature, depending on which point of view

20-52 years, as compared to that in the civilian nursing population with an age range of 18-70 years. The reason for the age range being more limited for this Air Force group was set in Congressional Law. Mandatory retirement for commissioned officer's is 52 years with only minor exceptions which are set forth in that law. The result is a more homogeneous group value-wise, economic-wise, and situation-wise; as opposed to the civilian nursing population with its very diverse interests and backgrounds.

The last independent variable for the non-significant section, was studied in relation to total stress perception and was the factor of race or ethnicity. No significant relationship was found to exist between the total stress perceived and the race or ethnicity of the subjects. This contradicts much of what little literature was available on the topic. This would lead this investigator to speculate that this might be due to an interplay of factors. The federal government is an equal opportunity employer, who advocates a "best person for the job" philosophy. Promotions and job security, not usually seen for minority groups within the civilian population affords the minorities an added positive factor to their adaptation, adjustment, and environment. The factor of equal pay for equal work, black, white, or otherwise; is a definite factor in alleviation of stresses. These minorities find themselves in that same homogeneous group alluded to earlier. The opportunity for advancement (both vertically and horizontally), improved opportunity for travel, emotional security (job and situational), economic security, equal opportunity for formal and

informal nursing, and military education as well as the potential of a retirement benefit program.

The race or ethnicity variable might take into consideration the fact that this individual has an education that places them (potentially) economically on an equal footing with other races, places them in the middle income group (or better), socialization with both military and nursing peers; in contrast to the civilian sector where this factor, regardless of education, may be contrary to what is actually experienced (in spite of this being federal law).

Those four (4) remaining variables which proved to be significant, for purposes of this study, were: (4) geographical location; (6) attendance/non-attendance in the USAF Nurse Internship Program; (7) hospital size; and (8) the sex of the subjects.

The first of the variables that was found to be significant, was studied in relation to total stress perception and geographical location. This study found a significant relationship between clinical uncertainty (or ambiguity) and the geographical location of these subjects. The findings of this research identified eastern states area nurses as having exhibited the highest stress levels. Central states area nurses experienced the next highest stress levels; while those nurses in the western states area exhibited the least or lowest levels of stress ($P < 0.05$).

This finding might be substantiated and explained by the fact that those individuals in the eastern states area, whether they are nurses or other professions, tend to have a more traditional-

ist (or conservative) viewpoint; whereas, the more conventional (or liberal) attitudes, mores, policies, and practices abound in the western states area. There was a progression of this factor from east to the west. This was exhibited in the progression of the statistics with the east having experienced the greatest stresses and a progression across the country to the west where the stress experienced was least.

The next variable that was found to be significant for purposes of this study was the relation to total stress perception and attendance/non-attendance in the USAF Nurse Internship Program. In the case of this variable there were two significant relationships found to be statistically significant, these were: (1) there was a significant relationship between staff-centered conflict and non-attendance in the USAF Nurse Internship Program; and (2) there was a significant relationship between "other" factors and non-attendance in the USAF Nurse Internship Program. Both factors were significant at the $P < 0.01$ level indicating that this was due to a determining factor and not the result of chance.

These findings were substantiated in some of the more recent literature. This was substantiated from the standpoint that there was some form of formal anticipatory socialization or formal socialization that was necessary if there was to be the alleviation of stress, stressful situations, and reality shock. The resultant non-attendance in USAF Nurse Internship Programs was identified to be significant thus, substantiating what was identified in the literature.

These findings not only substantiate, but lend further credence to the argument for educators (both inservice and pre-service) to begin programs of anticipatory socialization and socialization, respectively to alleviate some of those stressors and potential stressors.

The next variable found to be significant for purposes of this study was the relation to total stress perception and hospital size. These data revealed that: "there was a significant relationship between competency gap (in self) and the hospital size." This factor was found to be significant at the $P < 0.05$ level of significance, indicating that this was due to some determining factor and not a result of chance. The findings of this research identified general hospitals as having the highest levels of stress, exhibited by their nurses. The medical center category exhibited the next highest level of stress; while those individuals in the regional hospital category exhibited the lowest levels of stress.

These findings might have been explained by the fact that general hospitals were the smallest category of medical facility that was studied. The significance lies in staffing and the limited number of specialties available to socialize these recently graduated Air Force Nurses. More specifically, this type of medical facility does not have a full-time inservice education coordinator (as a rule) since manning (staffing) does not permit. The result would be that there was a nurse within that medical facility that is carrying two full-time positions, the nurse's

own job, plus that of the inservice education coordinator. The results of this type of a situation are evident.

The consequences of this situation existing are clear. A considerable amount of the socialization of these recently graduated Air Force Nurses is left to chance, delayed, or even in a few cases, completely stalled. The implications of this situation or problem are numerous and serious, for the Air Force and the Nurse Corp, in general. Delayed socialization of these recently graduated nurses can only result in a potential delay or deterioration of health care services to the consumer, with reference to both quantity and quality. With adequate staffing of the inservice education department, complete support of all personnel, managers, administrators, staff members, and the recently graduated nurses; this problem has been alleviated although not rendered completely insignificant. This entire process will have enhanced the efficiency and effectiveness of that product to the consumer.

The remaining, and last variable was found to be significant for purposes of this study and was the relation to total stress perception and the sex of these subjects. The data revealed that there was a significant relationship between two variables, which were: (1) data found that staff-centered conflict and the sex (female) of subjects were related; and (2) that professional-bureaucratic conflict and the sex (male) of subjects were related.

Through an extensive review of literature that factor or variable relating to sex of subjects substantiated the first

finding; however; no literature could be found relating to the second factor's significance, much less the presence of information relating to male nurses. Both areas were found to be statistically significant at the <0.05 level of significance. It was surmised that this was due to a determining factor and not a result of chance.

These findings might be indicated in the fact that both individuals were striving for excellence in the provision of health care to the consumer. In the case of the female and staff-centered conflict, this female was out to prove herself; while striving for competency. It is this very drive for competency, these high expectations, this excess energy, and zeal to prove herself that disturbs the equilibrium and stability the older nurses and employees have come to enjoy. It is something that is really ill-defined and subtle, pressure and conflict of the very work of socialization. This is something that is difficult to deal with since much of it comes from feelings, attitudes, and nonverbal cues on the part of these recently graduated nurses. This might have been due to the female rivalry that exists in most work settings dominated by females. There is a certain comradeship yet, a healthy competition that exists among these females. Perhaps, some of this may have had an impact on those situations recounted by the recently graduated Air Force Nurses in this study.

Those findings relating to professional-bureaucratic conflict and males, indicate that these problems may relate to role. This researcher believes that the role of the male has been that of

the dominant individual and this variable has come into play with this factor. Males, in a historical perspective, have played the dominant role since the beginning of time. Within the structure of the nursing profession, one finds this role in a complete reversal of the usual perspective. These males are used to being the boss; however, in the nursing profession males are in the minority. This reversal within a non-traditional field for males creates some difficulty for these males; however, with time and the introduction of more males into this profession, this existing situation should change. Much of what these males experience is in direct contrast or even conflict with those societal norms, values, and expectations of these males and the role of males. There was also the aspect of having been taught how best to accomplish a specified task and once within that clinical setting these "shoulds" come into direct conflict with those teachings. There is a resultant dichotomy of "ideal" versus "real," or what might also be referred to as that professional-bureaucratic conflict.

Limitations

This investigator viewed the limitations of this mailed questionnaire, prior to its mailing, as follows:

1. Not all subjects in this sample would return the questionnaire.
2. Some of these subjects might not answer all of those questions contained in the questionnaire, resulting in the invalidation of their responses.
3. There would be difficulty in wording and constructing

those questions contained in that questionnaire so all subjects would interpret these questions in the same way.

4. There was the possibility that subjects might answer these questions in the way they believed the investigator might want them to answer.

It was hoped that by maintaining the anonymity of these subjects, that this latter limitation would be avoided.

This investigator found that, items one (1) and three (3) were, in fact, true; however, items two (2) and four (4) were unfounded. All returned questionnaires were completed. Each of the subjects' replies were unique to that individual. This was believed to have been substantiated in the fact that two questionnaires were returned to this investigator, indicating that they had experienced no stresses that might have been associated with their respective positions or surroundings. This fact was contrary to the intent of this study.

This investigator suggests that this study be followed by another investigation with a larger sampling of Air Force medical facilities within the continental limits of the United States, a sampling of all designated hospitals, general hospitals, regional hospitals and medical centers; as well as numbers of subjects within these settings. The original target of fifty (50) questionnaires was not attained; however, the number of returned questionnaires was sufficient to identify commonalities among those critical incidents described by these subjects. Thirty-eight and one-

half percent rate of return of completed questionnaires was attained. There were four (4) other questionnaires returned to this investigator. Two of those questionnaires were returned, as requested in the instructions, to this investigator unmarked and without comment. Those remaining two (2) questionnaires had notes attached indicating that neither individual had experienced stress or stressful situations during their tenures in the Air Force. They further indicated that they both were "impressed" and "encouraged" by the quality of care that had been provided within their respective clinical setting and within their medical facilities.

It was interesting for this investigator to note that only forty-nine (49) questionnaires, in total, were returned to this investigator. The instructions contained in the letter of introduction requested that individuals return questionnaires unmarked if they decided not to participate in this study. The over-all return rate of answered and unanswered questionnaires was forty-one and eighty-eight hundredths percent (41.88%) of the total questionnaires that were mailed to potential subjects.

In mailing introductions, briefs, and requests for participation to the eight (8) command nurses, all eight (8) replied; however, only seven (7) agreed to participate in this survey. The eighth command nurse sent regrets due to the fact that command had no medical facility of fifty (50) beds or more.

There are varying situations in nursing, ranging from satisfying to stressful. This study was limited to those which were

found to be stressful. These stressful situations were limited to the clinical setting of general hospitals, regional hospitals, and medical centers within the continental limits of the United States in relation to providing, planning, or evaluating patient care, in which that subject was in some way involved.

The element of time within which this situation was to have been recalled was limited to a period of one month prior to the date of that subject completing this questionnaire. The number of situations recalled by these subjects was limited to three (3).

The primary limitations of this study focused upon the uncontrolled variables which have previously been discussed. The major variable that was of concern was that of the subjects' individual interpretation of what was and what was not stressful to that individual. Individual perceptions were used as the determinant of whether or not a situation was stressful.

Implications

In a review of this study as a preliminary to abstracting and drawing implications, a plethora of ideas emerged. In order to bring logic to this material, it was decided to present just those main implications.

A nurse's whole reason for being is to improve the health of the consumer entrusted to that nurse's care. Ultimately all activity must be measured against this criterion, whether this care is provided for this health care consumer within the hospital setting, or not. The effect of stress, stressful situations, and reality shock can and will, ultimately, have their impact on

this consumer as well.

This project has contributed to our knowledge of stress, stressful situations, and reality shock in today's recently graduated Air Force Nurses. Not only did this research support those views of authors who described this period of transition from student nurse to graduate nurse as a stressful period, but it identified and described a population not previously measured, i.e., Air Force Nurses. These findings support the need to educate the nursing practitioners (those individuals actually providing health care), managers, administrators, educators (both pre-service and inservice), and students to the realities of stress with its very serious implications, or consequences. Each of these aforementioned individuals can and should play an active role in the alleviation of stress, stressful situations, and reality shock.

This data analysis alludes to the increased and continued education of all of those individuals mentioned in the preceding paragraph, to those areas that were considered to have been indicators of increased stress in these recently graduated nurses. Utilization of this information might aid in the alleviation of some of the involved stresses.

Although stress will never be fully eradicated, with proper handling its impact on this recently graduated nurse can be lessened. Manager/administrators can define precisely what it is that they need within the health care setting and educators can thus take this definition, thus enabling them to prepare the student more realistically for actual practice and an anticipatory

socialization into the profession of nursing. Practitioners can then take this recently graduated nurse and socialize this individual into the profession and that particular clinical setting within which that individual happens to be found. This will be done while fully utilizing internships and continuing inservice education programs that have been developed by these inservice educators. All of this will take place because nurses will have a much better understanding of why the recently graduated nurses react as they do to the various stresses and to what, specifically, these nurses find as the greatest stressors. This student having begun this anticipatory socialization within the school setting, will have a more realistic picture of what the nursing profession is all about and can thus, successfully traverse this gap from school to actual practice more easily and under less stress.

The ultimate goal being lessened stress, smoother successful transitions into practice, lessened degrees of reality shock, and retention of this recently graduated nurse in the nursing profession rather than disillusionment and ultimately, exodus.

This project is but one example of nursing research that will help to build a body of knowledge which will improve and enhance both the health care consumer and the nursing profession, in toto.

Recommendations

Based on the findings and implications of this study, the recommendations for further studies are:

provide content, ideas, and incentives for nurse practitioners, managers, educators, and administrators to facilitate the socialization process of these recently graduated Air Force Nurses. If this can be accomplished, the results will be socialization with the lowest possible levels of stress, improved health care to the consumer, and the prevention of disillusionment and exodus from the nursing profession.

United States Air Force Institute of Technology-Civilian Institutions-Medical at its operating location at Saint Louis University, Department of Nursing-Graduate School with the Project Number-USAF SCN 79-85. These findings, opinions, and assertions contained herein are the private ones of this author and are not to be construed as official or reflecting the views of the Air Force Institute of Technology, the Department of the Air Force, or the Department of Defense.

This research was conducted and reported herein were conducted in accordance with AFITR 53-1, AFR 12-35, the Department of Health, Education, and Welfare; and the Saint Louis University Investigational Review Board.

Appendices A & B
Request For Survey Approval From
United States Air Force

MPCYPS

27 Apr 1979

Request for Survey Approval (Capt Bartlett)

AU/EDV

1. The "Air Force Nurse Stressful Situation Survey" is approved and issued USAF SCN 79-85, expiration date 29 June 1979. Questions 1, 5, 7 and 10 in the personal data section should be modified to delete the "please check one" instruction.
2. This survey has been coordinated with AFMPC/SG. At the completion of the project Capt Bartlett is to forward a copy of the report to AFMPC/SGCN.
3. Please direct questions to Mr Germadnik, AUTOVON 487-6122/2849.

FOR THE COMMANDER

Cy to: HQ ATC/EDV

Willibrord T. Silva, Lt Col, USAF
Chief, Research & Measurement Div

1st Ind, AU/EDV

TO: AFIT/ED

Forwarded for your information and action. Please assure that a copy of Captain Bartlett's report is provided to AU/EDV upon completion.

JOHN T. MEEHAN
Chief, Evaluation & Research
Directorate of Education

FROM: AFIT/EDV

15 May 1979

SUBJECT: Request for Survey Approval (Capt Bartlett)

TO: AFIT/CIM (Capt Paulsen)

The attached AFMPC letter is forwarded for your information and action. Request you advise Capt Bartlett to furnish this office with three copies of the final report. We will forward copies to AFMPC/SGCN and AU/EDV.

SONYA S. TRUBSHAW, Major, USAF 1 Atch
Plans & Evaluation Division AFMPC/MPCYPS Ltr, 27 Apr 79
Directorate of Educational Plans
& Operations

Appendix C
Approval From Institutional
Review Board Human Research
Committee

May 18, 1979

Alayne L. Bartlett, R.M., B.S.N.
School of Nursing
St. Louis University

Dear Ms. Bartlett:

Subject: IRB #2488: Stressful Situations of Air Force Nurses
Recently Graduated from Pre-Service Baccalaureate
Programs in Nursing as Identified by Critical Incident
Technique

Your proposal involving human subjects with the above title was reviewed and approved by the Institutional Review Board at its meeting on May 15, 1979.

Approval is for one year, after which time it must come before the Board for annual review. If the protocol changes within the approval period, it must also go before the Board for approval.

Consent forms will be maintained in your department's office for a period of three years. A final report to the IRB that the project has been completed would be appreciated.

If you have any questions regarding the above information, please call this office at 664-9800, extension 106.

Sincerely,

B. E. Penrose
Executive Secretary
Institutional Review Board

BEP:lm

cc: Pauline Kimmenich, Ph.D.

Appendix D

Pilot Study

Appendix D

Pilot Study

*Key:

AA = Clinical Uncertainty or ambiguity

BB = Competency Gap (in self)

CC = Staff-centered Conflicts (includes Generation Gap/
Competency in Others)

DD = Professional-Bureaucratic Conflict

EE = Other

Subject/Situation	Investigator	Expert 1	Expert 2	Expert 3
1/I	BB	BB	BB	BB
II	DD	DD	DD	DD
III	CC	CC	EE	CC
2/I	DD	DD	DD	DD
II	CC	CC	BB	CC
4/I	CC	CC	CC	CC
II	DD	DD	DD	DD
III	AA	AA	CC	AA
5/I	AA	AA	AA	AA
II	EE	EE	DD	EE
III	CC	CC	DD	CC
6/I	BB	BB	AA	BB
II	CC	CC	BB	CC
III	AA	BB	AA	AA

19/I	DD	AA	DD	DD
II	BB	BB	AA	BB
III	EE	EE	EE	EE

Results: Concur/Total = 41/51

 Validity = 0.8039

Appendix E
Letter to Command Nurses

12312 Inletridge Drive #8
Maryland Heights, MO 63043
1979

Dear

I am an AFIT sponsored graduate student at Saint Louis University, working on my Master's Degree in Cardiovascular Nursing. I have selected for my research topic, stressful situations of Air Force Nurses recently graduated from pre-service baccalaureate programs in nursing as identified by critical incident technique. An enclosed brief will clarify the purpose and method of this study.

In the interest of nursing research, I am respectfully requesting the participation of your command in this study.

If you agree, your participation would include the provision of a list of the names and addresses of chief nurses in hospitals (50 beds or more), regional hospitals, and medical centers within your command. The enclosed sheet and self-addressed envelope is provided for the listing purpose.

The survey has been approved by AFMPC/MPCYPS, AFMPC/SG, and AFMPC/SGCN at Randolph AFB, Texas. It has been designated USAF SCN 79-85.

As provided by the Privacy Act of 1974, all participants will be assured complete protection of that act. The information in the study is to be used for nursing research purposes only and no information will be specifically identified on any individual who agrees to participate. Anonymity will be maintained throughout the survey. The questionnaires will be mailed directly to me and since there is no means of identification declared in the questionnaire, this can be well assured.

Your cooperation in this study will be gratefully appreciated.

Sincerely,

ALAYNE L. BARTLETT, Captain, USAF, NC
Graduate Nursing Student

ATCH (3):

1. Brief
2. Response List
3. Self-addressed envelope

Appendices F, G, & H
Brief to Command Nurses

TOPIC: "Stressful Situations of Air Force Nurses Recently Graduated from Pre-Service Baccalaureate Programs in Nursing as Identified by Critical Incident Technique."

PURPOSE: To describe stressful situations occurring in the practice of nursing in the Air Force as recounted by nurses during their first twelve (12) months on active duty in the Air Force and within twelve (12) to eighteen (18) months of graduation from pre-service baccalaureate programs in nursing.

RESEARCH OBJECTIVES:

1. To assess the types of situations Air Force Nurses find stressful during their first twelve months on active duty.
2. To assess the methods used by the nurses to deal with these situations.
3. To assess the perceptions and feelings of these nurses to these situations.
4. To determine if the factor of months of employment in nursing since graduation relates to the nature of stressful situations recounted.
5. To determine if the factor of clinical unit relates to the nature of stressful situations recounted.
6. To determine if the factor of age relates to the nature of stressful situations recounted.
7. To determine if the factor of sex relates to the nature of stressful situations.
8. To determine if the factor of race or ethnic origin relates to the nature of stressful situations recounted.
9. To determine if the factor of geographical location relates to the nature of stressful situations recounted.
10. To determine if the factor of hospital size relates to the nature of stressful situations recounted.
11. To determine if the factor of attendance at the USAF Nurse Internship Program relates to the nature of stressful situations recounted.

12. To determine if the factor of marital status relates to the nature of stressful situations recounted.

SCOPE AND LIMITATIONS: There are varied situations in nursing, ranging from satisfying to stressful. This study has been limited to stressful situations, only. These stressful situations will be limited to the clinical setting in general hospitals, regional hospitals, and medical centers. These stressful situations must be related to providing, planning, and/or evaluating direct patient care in which the individual is involved in some way. The element of time for the situation to be recounted has been limited to a period of one month preceding the respondent accomplishing the questionnaire. The number of situations to be recounted by each respondent has arbitrarily been limited to three.

The individual interpretations of stressful situations are expected to vary. The individuals' perceptions are to be the determining factors as to whether the situation is stressful, or if they even recognize all of the stress involved in the situation.

The study is further limited by the fact that a prolonged reaction to stress, precipitated by factors outside of the clinical setting may trigger some incident in the clinical setting and the individual involved may not be aware of or ordinarily would not perceive it to be stressful to himself or herself.

ASSUMPTIONS:

1. Nurses who are graduates of pre-service baccalaureate programs in nursing have been taught the concepts of providing optimum patient care.
2. There will be stress provoking (or inducing) situations during the nurses' first twelve (12) months on active duty.
3. There will be stress provoking (or inducing) situations during the nurses' first twelve (12) to eighteen (18) months in nursing.
4. The nurses in the study will be capable of identifying situations which are stressful to themselves.
5. The nurses who participate in the study will be capable of recalling those situations provoking (or inducing) stress in themselves.

METHODOLOGY: The method to be used in this study is to be that of critical incident technique. This technique is a procedure for gathering certain important facts concerning behavior in

defined situations. This will allow for this author to make inferences and predictions about an individual's actions or acts.

TOOL: The data gathering tool to be used in this study is the open-ended questionnaire. The content will be structured but the respondent will be free to answer in their own words and will be permitted to structure their response, as desired.

SELECTION OF SUBJECTS: The subjects who agree to participate in this survey will be voluntarily participating, and have to meet the following criteria:

1. Participants must be graduates of pre-service baccalaureate programs in nursing acceptable to the Surgeon General, USAF.
2. The graduates must have no prior nursing experience or military experience (no experience prior to graduation from their BSN program).
3. The individual must be within their first 12 months of active duty.
4. The subjects must be currently working in general hospitals, regional hospitals, or medical centers within the Air Force.
5. Subjects must be within their first 12-18 months of graduation from their pre-service baccalaureate programs in nursing.
6. Age, sex, race or ethnic origin, marital status, geographical location, and attendance at an internship program will be collected; however, will not be considered as necessary criteria for selection.

FULL DESCRIPTION: A descriptive survey will be conducted to determine whether stressful situations are experienced by Air Force Nurses recently graduated from pre-service baccalaureate programs in nursing during their first twelve months on active duty and within their first twelve to eighteen months in the practice of nursing. If they occur, can this nurse identify the stressful situations using critical incident technique. It is hoped that a sample of fifty (50) Air Force Nurses from large hospitals, regional hospitals, and medical centers within the Air Force, who meet the prescribed criteria and are randomly (and voluntarily) selected by the Director of Nursing Services, will participate. The stressful situations will be identified by the earlier mentioned open-ended questionnaire administered at Air Force

medical facilities throughout the Continental United States and returned anonymously by the participant in a self-addressed stamped envelope to the investigator.

The study will examine what factors are influential to the recently graduated nurses' perception and identification of stress, stressful situations, and reality shock; and, if these factors are a positive or negative influence on that situation. The study will also examine if these stressful situations during this transition from student nurse to graduate nurse will allow the individual to adapt to the new role and environment. Finally, the study will determine whether coping mechanisms are developed and attempt to identify the consequences of reality shock.

The data will be pilot tested, content validity has already been established by AFMPC/MPCYPS (Research and Measurement Division), and inter-coder reliability will be established using a panel of experts. Data analysis will attempt to report frequency, percentages, and performance by using the Chi-Squared (X^2) Test of Homogeneity of Properties.

Appendix I
Response List to Command
Nurses

Response List

<u>CHIEF NURSE</u>	<u>HOSPITAL NAME & ADDRESS</u>	<u>HOSPITAL DESIGNATION</u> (i.e., Hospital, Regional Hospital, or Medical Center.)
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Appendix J
Letter To Chief Nurse/Director
Of Nursing Services

12312 Inletridge Drive #8
Maryland Heights, MO 63043
1979

Dear

I am an AFIT sponsored graduate student at Saint Louis University, working on my Master's Degree in Cardiovascular Nursing. I have selected for my research topic, stressful situations of Air Force Nurses recently graduated from pre-service baccalaureate programs in nursing as identified by critical incident technique. An enclosed brief will clarify the purpose and method of this study.

In the interest of nursing research, I am respectfully requesting the participation of those nurses on your nursing staff, who meet the prescribed criteria. I have received permission from AFMPC/MPCYPS, AFMPC/SG, AFMPC/SGCN, and your command nurse to include your hospital in my research. The survey control number is USAF SCN 79-85.

If you agree, your participation would include identifying the number of nurses on your staff who meet the prescribed criteria. The enclosed self-addressed postcard is provided for that purpose. I will then mail to you the number of questionnaires to correspond to the number of nurses you identified on the postcard, to hand out to those individuals who agree to participate in the study. They will mail them directly to me once they have completed the questionnaire. There will be a self-addressed stamped envelope included with each questionnaire for that purpose.

As provided by the Privacy Act of 1974, all participants will be assured the complete protection of that act. The information is to be used for nursing research purposes only, and no information will be specifically identified on any individual who agrees to participate. Anonymity will be maintained throughout the study. This is possible since I do not know the participants, no means of identification is declared on the questionnaire, and they are mailed directly back to me.

Your cooperation will be gratefully appreciated.

Sincerely,

ALAYNE L. BARTLETT, Captain, USAF, NC
Graduate Nursing Student

ATCH (2):
1. Brief
2. Self-Addressed Postcard

12. To determine if the factor of marital status relates to the nature of stressful situations recounted.

SCOPE AND LIMITATIONS: There are varied situations in nursing, ranging from satisfying to stressful. This study has been limited to stressful situations, only. These stressful situations must be related to providing, planning, and/or evaluating direct patient care in which the individual is involved in some way. The element of time for the situation to be recounted has been limited to a period of one month preceding the respondent accomplishing the questionnaire. The number of situations to be recounted by each respondent has arbitrarily been limited to three.

The individual interpretations of stressful situations are expected to vary. The individuals' perceptions are to be the determining factors as to whether the situation is stressful, or if they even recognize all of the stress involved in the situation.

The study is further limited by the fact that a prolonged reaction to stress, precipitated by factors outside of the clinical setting may trigger some incident in the clinical setting and the individual involved may not be aware of or ordinarily would not perceive it to be stressful to himself or herself.

ASSUMPTIONS:

1. Nurses who are graduates of pre-service baccalaureate programs in nursing have been taught the concepts of providing optimum patient care.
2. There will be stress provoking (or inducing) situations during the nurses' first twelve (12) months on active duty.
3. There will be stress provoking (or inducing) situations during the nurses' first twelve (12) to eighteen (18) months in nursing.
4. The nurses in the study will be capable of identifying situations which are stressful to themselves.
5. The nurses who participate in the study will be capable of recalling those situations provoking (or inducing) stress in themselves.

METHODOLOGY: The method to be used in this study is to be that of critical incident technique. This technique is a procedure for gathering certain important facts concerning behavior in defined situations. This will allow for this author to make inferences and predictions about an individual's

actions or acts.

TOOL: The data gathering tool to be used in this study is the open-ended questionnaire. The content will be structured but the respondent will be free to answer in their own words and will be permitted to structure their response, as desired.

SELECTION OF SUBJECTS: The subjects who agree to participate in this survey will be voluntarily participating, and have to meet the following criteria:

1. Participants must be graduates of pre-service baccalaureate programs in nursing acceptable to the Surgeon General, USAF.
2. The graduates must have no prior nursing experience or military experience (no experience prior to graduation from their BSN program).
3. The individual must be within their first 12 months of active duty.
4. The subjects must be currently working in general hospitals, regional hospitals, or medical centers within the Air Force.
5. Subjects must be within their first 12-18 months of graduation from their pre-service baccalaureate programs in nursing.
6. Age, sex, race or ethnic origin, marital status, geographical location, and attendance at an internship program will be collected; however, will not be considered as necessary criteria for selection.

FULL DESCRIPTION: A descriptive survey will be conducted to determine whether stressful situations are experienced by Air Force Nurses recently graduated from pre-service baccalaureate programs in nursing during their first twelve months on active duty and within their first twelve to eighteen months in the practice of nursing. If they occur, can this nurse identify the stressful situations using critical incident technique. It is hoped that a sample of fifty (50) Air Force Nurses from large hospitals, regional hospitals, and medical centers within the Air Force, who meet the prescribed criteria and are randomly (and voluntarily) selected by the Director of Nursing Services, will participate. The stressful situations will be identified by the earlier mentioned open-ended questionnaire administered at Air Force medical facilities throughout the Continental United States and returned anon-

ymously by the participant in a self-addressed stamped envelope to the investigator.

The study will examine what factors are influential to the recently graduated nurses' perception and identification of stress, stressful situations, and reality shock; and, if these factors are a positive or negative influence on that situation. The study will also examine if these stressful situations during this transition from student nurse to graduate nurse will allow the individual to adapt to the new role and environment. Finally, the study will determine whether coping mechanisms are developed and attempt to identify the consequences of reality shock.

The data will be pilot tested, content validity has already been established by AFMPC/MPCYPS (Research and Measurement Division), and inter-coder reliability will be established using a panel of experts. Data analysis will attempt to report frequency, percentages, and performance by using the Chi-Squared (X^2) Test of Homogeneity of Properties.

Appendix N

Cover Sheet to Survey Questionnaire

STRESS



Appendix O

Letter to Survey Participants

12312 Inletridge Drive #8
Maryland Heights, MO 63043
1979

Dear Respondent,

As an AFIT sponsored graduate nursing student at Saint Louis University, I have chosen as the topic of my Master's research, stressful situations of Air Force Nurses recently graduated from baccalaureate programs in nursing as identified by critical incident technique. The phrase, critical incident technique, might better be described as the recalled description of an event. The enclosed introduction and instructions will clarify the study for you.

In the interest of nursing research, I am respectfully requesting your cooperation and participation in this survey.

As provided by the Privacy Act of 1974, you will be assured the complete protection provided by this act. This information is to be used for nursing research purposes only, and no information can be released or identified on any individual who agrees to participate. Absolute anonymity will be maintained throughout the study.

It is essential that you be as specific as possible in identifying the situations you describe. The information collected from the survey will be used to make inferences and predictions about responses and reactions, and to identify problem areas within Air Force nursing. Participation in this survey is entirely voluntary. No adverse actions of any kind may be taken against any individual who elects to participate in this survey. If at any time you wish to cease participation in this survey, you are free to do so. If you desire further information or clarification concerning this study and survey I will be more than happy to respond and provide you with what may be necessary.

Please return the completed questionnaire to me in the self-addressed stamped envelope by 1979. If you decide not to participate in the survey, please return the questionnaire unmarked.

These elements of informed consent to the assurance given by Saint Louis University to the United States Department of Health, Education, and Welfare to protect the rights of persons who participate in research.

Your cooperation in describing stressful situations as fully and as frankly as possible is all that is requested of you, for your participation in this survey.

Sincere thanks for your cooperation.

Sincerely,

ALAYNE L. BARTLETT, Captain, USAF, NC
Graduate Nursing Student

ATCH (5):

1. Privacy Act Statement
2. Instruction Sheet
3. Sample Response Sheet
4. Questionnaire
5. Self-Addressed Envelope

Appendix P

Privacy Act Statement

Privacy Act Statement

In accordance with paragraph 30, AFR 12-35, Air Force Privacy Act Program, the following information about this survey is provided.

- (A) AUTHORITY:
- 10 U.S.C. 8012, Secretary of the Air Force: Powers and Duties, Delegation by.
- (B) PRINCIPLE PURPOSE:
- This survey is being conducted to test and evaluate levels of stress in USAF Nurses during the first 12-18 months on active duty after graduation from school.
- (C) ROUTINE USE:
- Survey will be used to make inferences and predictions about individual responses or reactions and to identify problem areas within Air Force nursing. No respondent will be identified in any way.
- (D) Participation in this survey is entirely voluntary.
- (E) No adverse actions of any kind may be taken against any individual who elects to participate in any or all of this survey.

Appendix Q

The Questionnaire

General Introduction to the Study

The Questionnaire

General Introduction to the Study

Several authors have referred to the transition period from a school of nursing to the actual practice of nursing as a period of "reality shock." Some writers have indicated that it is during this transition period that nurses find a discrepancy between the "ideal" and the "actual" nursing situation.

In an effort to discover some of the situations which contribute to making the transition period one of "reality shock," the focus of this study is on situations which are stressful to the Air Force Nurse.

The term "stressful" has many connotations. Certain reactions are identified with stressful situations, for example; feelings of being anxious, tense, nervous, frightened, upset, excited, worried, angry, pressured, distressed, apprehensive, uncomfortable, disturbed, frustrated, confused, uneasy, et cetera. Physiological reactions may or may not occur in the form of sweating or trembling hands, et cetera.

All people react differently, but these are the kinds of emotional and physical reactions which nurses and nursing students report they experience most commonly in stressful situations. Any one of these reactions or a combination, may be present in the situations you describe. The fact remains, the situation IS stressful if it seems stressful to you.

and the Aerospace Medical Association, Flight Nurse Division.
She is currently enrolled in the Graduate School of Saint Louis
University pursuing the degree of Master of Science in Nursing.

GENERAL DIRECTIONS:

1. The situations described must be ones in which you are involved.
2. The situations described must be limited to occurrence within the hospital setting.
3. The situation described must be related to direct patient care, for example; planning, giving, or evaluating patient care.
4. The situation described must have occurred within the last thirty days.

SPECIFIC DIRECTIONS:

1. You are requested to describe three (3) stressful situations.
2. Please refer to the other persons in the situation, not by name, but by role designations, such as: the patient, the head nurse, the technician, the doctor, the attending physician, the intern or resident, et cetera.

The following sheets are provided for your descriptions of the situations and are labeled Situation I, Situation II, and Situation III. A sample response sheet precedes the three situation sheets, for clarification.

Appendix R
Sample Response Sheet for
Questionnaire

Sample Response Sheet
for Questionnaire

1. What was the situation:

It is really upsetting when I try to do little things for patients and all you get is rebukes and more complaints.

2. What happened in the situation?

A patient was admitted with cancer of the lung, amongst other medical problems. He used to be frightened at night because he would become so terribly dyspneic. I knew him from another floor. He asked for a cup of coffee, so I got it for him. The technicians had the nerve to say that I was spoiling him.

3. What was your reaction?

I was very upset and angry!

4. How did you feel?

I was very upset and angry because I was only trying to make the patient more comfortable.

Another Sample Response

1. What was the situation?

I was called down by the supervisor for not having a report in on time.

2. What happened in the situation?

I was with a patient who was very apprehensive and frightened about what was going to happen to him in the hospital. I was

explaining things to him. I was helping him to understand what was going to happen when I was told to report to her office, immediately. I really wasn't in a hurry, since I felt the patient had a greater need at that particular moment. As a result, when I finally arrived at her office, I really caught it. Next time I'll be sure to have the report in on time. As a result, I handle that supervisor very carefully now.

3. What was your reaction?

I was very angry and very frustrated.

4. How did you feel?

I really was very upset to think that a report took precedence over the patient's needs at that time.

Appendix S
Situation I Sheet for Questionnaire

Appendix T
Situation II Sheet for Questionnaire

SITUATION II:

Recall another situation which occurred during the last month which you would describe as "stressful."

Relate this situation to direct patient care, for example; planning, giving, or evaluating the care of a patient.

Describe the situation and relate exactly what happened. **BE SPECIFIC!**

1. What was the situation?
2. What happened in this situation?
3. What was your reaction?
4. How did you feel?

Appendix U

Situation III Sheet for Questionnaire

Appendix v

Personal Data Sheet for Questionnaire

Personal Data

1. On what unit in the hospital setting are you currently working? For example: operating room, pediatrics, obstetrics, outpatient clinics, ICU, CCU, et cetera. If in the medical and/or surgical area, please specify if it is a specialized clinical area; such as, urology, orthopedics, cardiovascular, et cetera.
 A. Medical Unit ___ B. Surgical Unit ___ C. Specialty ___
2. How many months have you been employed in nursing since graduation?
 A. < 6 months ___ B. 6-12 months ___ C. > 12 but < 18 ___
3. What is your current age?
 A. 20-24 years ___ B. 25-29 years ___ C. 30-34 years ___
4. What geographic region of assignment are you presently serving a tour of duty?
 A. (North or South) West _____
 B. (North or South) Central _____
 C. (North or South) East _____
5. What is your race or ethnic origin?

6. Did you ever attend the USAF Nurse Internship Program?
 A. Yes ___ B. No ___
7. What is your current marital status?
 A. Married ___ C. Widowed ___ E. Separated ___
 B. Single ___ D. Divorced ___
8. What size hospital are you presently assigned to? What is its designation?
 A. General Hosp. ___ B. Regional Hosp. ___ C. Medical Center ___

9. What is your sex?

A. Male ____

B. Female ____

THANK YOU FOR YOUR TIME, EFFORT,
AND COOPERATION.

Appendix W
Subjects' Responses to
Questionnaire

Subject 1:

A. Situation I

1. I was the narcotic and medication nurse on a 20 bed ward. We had an RN from the ICU helping us out for the day. She took a phone call and told me the doctor wanted a particular patient medicated for a diagnostic procedure. Instead of looking at the original med order myself, I asked this nurse what was to be given. She told me Demerol 50 mg & Vistaril 50 mg. The order (after I checked it) was for Vistaril only.
2. After giving the Demerol and Vistaril I noted the error, informed the doctor, and informed the nurse in charge. The nurse in charge had heard the ICU nurse give me the order for Demerol and Vistaril and backed me up. However, I realized it was my responsibility to check the med orders.
3. First, I was mad at the ICU nurse for giving me wrong information--then I was mad at myself for not actually checking the orders.
4. Mad, upset, embarrassed.

B. Situation II

1. It was the weekend. I was the only nurse on for the day shift and there was only one technician working with me. The ward was full and we were extremely busy.

There was one particular patient (a 40 yr. old female with possible diverticulitis) who was constantly complaining--for example telling me that I should clean the floor in her room and dust the window sills because these things were dirty.

2. I became quite mad. This patient probably required the least amount of physical care; there were many other patients whom I had to do things for, and I knew I was a nurse, not a maid. I developed a headache. As the woman continued to complain I felt the urge to tell her off. The technician knew I was upset and urged me not to tell off this patient because it wasn't worth it.
3. I was angry and frustrated. At first, I wanted to tell this woman where she could go. Then, as the day progressed I just wanted my shift to end so that I could go home.
4. Angry, upset, frustrated.

C. Situation III

1. I was working the day shift (the busiest shift) during the week and a nurse who was to be in charge was assigned to work with me. I had the least amount of time on this ward and this nurse had never worked on this ward before. I was particularly looking forward to orienting this nurse. She kept following me around, asking questions of everything I did, kept on leaving the ward (for "appointments")--that meant I was doing

all the work which was usually done by two nurses plus more. Also, that was the day a new ward clerk starting working on our ward.

2. I was becoming upset. I would have rather worked by myself. This nurse must have sensed my apprehension in working with her as she mentioned something to this effect. However, she continued with her behaviors the entire time (the whole week) we worked together. Our usual charge nurse was on leave so I couldn't discuss the matter with her (this new nurse was our charge nurse). I mentioned the situation to some of the other nurses on the ward during the beginning of the week, but nothing was done to change or relieve the situation.
3. I was upset and felt like I was getting the bad end of a deal. How could the charge nurse go on leave knowing that I would have to put up working with a new charge nurse and a new ward clerk who had basically no previous orientation to our ward.
4. mad, upset, frustrated

As you can tell, (probably) from my three situations, I'm not really thrilled with Air Force Nursing.

Subject 2:

A. Situation I

1. It was very upsetting being put down by a surgeon because I followed the nursing procedures and policies for the O.R.

2. The surgeon walked in the O.R. Room, just after the patient had been returned to the supine position after the spinal and been injected, and demanded the I leave to get the patient a face mask (the type worn by room personnel) while he scrubed. When I refused to leave the patient and the CRNA at that moment I was taken to the O.R. Supervisor.
3. This made me quite upset and angry.
4. This upset me to realize that this surgeon still thought of the O.R. Nurse as a go-fer rather than as a professional.

B. Situation II

1. I was called into the O.R. Supervisor's office and reamed out for not having instruments for the ophthalmologist to use during a special procedure.
2. I had just finished a Dacryocysto rhinostomy when the O.R. Supervisor very curtly asked me to come into her office. She proceeded to ream me out in front of the rest of the staff. She did not have all of the information pertaining to the incident (the instrument had not been ordered by her, at the time), nevertheless I was still made to look a little incompetent. She would not listen to me when I told her that we had substituted another instrument so that the surgery would not be delayed.

3. I was very angry.
4. This made me very angry for several reasons; for example; 1) I let it adversely affect my dealings with the following patient, 2) she did not collect all information before acting, 3) she chastized me in front of the other staff members.

Subject 3:

Situation I

1. A doctor screamed at me in front of visitors and patients about something for which I was not responsible even though I was in charge.
2. A suspected bleeding ulcer patient was admitted during the day. After I came on duty, the doctor came screaming after me because the patient did not have milk at his bedside. I believe that the people who took the orders were responsible. He yelled that I was a lousy nurse and what nerve did I have to be in charge of the ward. The patients and visitors lost confidence in me and it affected the way I cared for the patients. Two days later, an EKG was done and the patient had an acute myocardial infarction and not an ulcer. I lost all the confidence and respect I had for the doctor.
3. I was angry.
4. I was disappointed that the patient had been misdiagnosed. The similarity between patients with ulcers and infarctions is obvious and the doctor should have or-

dered an EKG in the beginning.

Situation II

1. This is an example of how you just don't get around to do things on evenings.
2. The ulcer patient was ordered gelusil and milk every half hour. They take it themselves. This patient was not doing it and I had no time to check on him. Then, the patient told the doctor he was not getting his gelusil and milk and the doctor blamed me because I was in charge.
3. Anger.
4. Frustrated.

Situation III

1. I am usually assigned to the SURG.-GI department but once last week I was called to special a patient in intensive care unit.
2. This patient had a tracheotomy and a cut-down and vital signs every fifteen minutes. We know the principles, even if we haven't always done the procedure. All you have to do is stop and think and it comes back.
3. My first reaction was--this is it.
4. Spastic. But then, I was OK, after I stopped and thought

Subject 4:

Situation I

1. Physician thought nurses or technicians were hiding an

incident with an injured, elderly patient.

2. On physician rounds a pt. on IV heparin was found with scratches on his right side of face and also a large hematoma on right cheek. At this point all nurses were unaware of any incident occurring. Bed rails were pulled and pt. is very weak. Possibility of pt. falling out of bed and then getting back into bed were slim. Physician felt nurses had seen incident but not reported one.
3. 1) Angry--I didn't believe we have a nurse or technician at that time who would not report an incident. Also the physician is being unreasonable to expect this pt. could put himself back into a bed after falling--
2) Disbelief, Guilty--It was addressed to me as if I was to blame.
Reaction: told physician my thoughts, filled out incident report.
4. I felt the emotions outlined above. Also low self-esteem --These doctors think I'm lousy. I retaliated with "I'm not responsible, no incident has occurred while I've been on duty."

Situation II

1. Pt. was possibly contaminated with infection by poor nursing action.
2. Pt.'s angiocath inserted into his jugular vein was pulled out 1-1/2 to two inches. I promptly reinserted

and called physician. Physician stressed that I had been wrong in reinserting the cath due to infectious contamination. I fully agreed.

3. Told myself I would never push a catheter in but instead call physician and meanwhile tape catheter at the point it is pulled out. I was angry with myself and wished I had thought out my actions.
4. Anger, Guilt. I possibly contaminated this man. At this point I felt irresponsible and unable to carry responsibility that goes with nursing. I felt "if only" I had followed my first instincts I would have phoned the physician first. Low Self Esteem--This doctor knows I am a poor nurse.

Situation III

1. Wife requested that pt. not be given information concerning his possible diagnosis until she was present. Pt. was demanding information of dz process.
2. Pt. was found to have possibly malignant megeloma or lymphoma. Pt. was capable of handling information about prognosis and treatment. Wife stated she did not want him to know unless she was present. (Wife tends to be generally overprotective.)
3. I discussed with physician if he wanted pt. to read information covering both disease processes. After an affirmative answer, I obtained information for the pt.

4. As if I betrayed the wife, but was right in my decision to help educate the pt.

Subject 5:

Situation I

1. I was staying with a pt. who was going downstairs for a brain scan. Routinely the nurse does not stay with pt.--we were not busy at the time.
2. Pt. was on stretcher, began to have major seizure. All I could do was keep him from harming himself. (Pt. had no history of seizures.)
3. I became very shaky and (was told) pale. Continued to tremble for about 1/2 hr. after incident.
4. Frightened! What if there'd been no nurse or experienced tech with pt? The tech doing the brain scan didn't know what to do. I feel this is a situation that needs to be looked into and someone experienced should remain with pt.

Situation II

1. A new Lt. was being sponsored by me and had called me about going apartment hunting that day. I said I guess it was alright.
2. Commander called me asking where my sponsee was. I told her and she proceeded to "tell me off" about the girl not having processed in yet.
3. I was very upset. We were not given instructions on what our sponsees were supposed to do when they got here.

4. I feel we should have been given some sort of direction concerning sponsoring someone else, when we are so new in the AF game ourselves.

Situation III

1. A med was not given at 1800, as pt. not in room. Was forgotten and not given later (eve. shift).
2. Next day; a nurse brought it to my attention and I simply told her it was forgotten. According to another nurse, this first nurse accused me of not giving "half my meds" that evening. This other nurse told me that nurses will do this (put down another, or attempt to get her in trouble) to get ahead.
3. I was shocked that people could be so cruel. I guess I'm too honest and have high values; but to step on someone's fingers just to climb further up the ladder is cruel and unfeeling.
4. Like people really don't care about other people. If this happens between nurses, how do these nurses treat their pts? I can only hope I do not become cold, callous and catty!--just to get ahead. People's feelings are more important.

Subject 6:

Situation I

1. I was new on base in a new dept. (O.B) and assisting in my first delivery. The others present were head

nurse & myself. The delivery was moving very fast and little time for prep. of del. room was available.

2. The head nurse described me several items which needed doing. I was finished with all but one she said pour the betadine in the basin so I poured some and asked if it were enough; she couldn't see from where she was on the other side of the table so I instinctively reached down on THE STERILE FIELD & tilted the basin so she could see.
3. I immediately realized I had contaminated a sterile field. I really panicked because I knew there was no time to reassemble the field.
4. I felt very incompetent/humiliated and embarrassed to admit I have a BSN when something like this happens. The head nurse was kind & understanding after she had informed me of the error.

Due to the situation being so new to me & the tension of the rapid delivery sitting I felt intimidated by many internal & external forces. I really felt silly.

Situation II

1. Same as #1 being new hosp. military setting. Recovery Room--during orientation week the recovery room was short staffed & our Inservice director decided to give us some OJT. Being the only BSN I felt like I was under constant scrutiny.--Pt. hernia repair became active in R. Room.

AD-A101 833

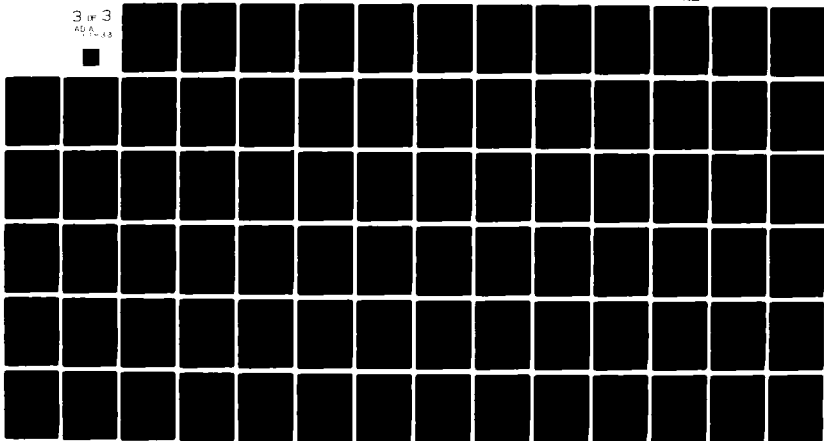
AIR FORCE INST OF TECH WRIGHT-PATTERSON AFB OH
STRESSFUL SITUATIONS OF AIR FORCE NURSES RECENTLY GRADUATED FRO—ETC(U)
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2. The pts were to receive routine R. Room observations (vitals, etc.). I had remembered the basics from school but never worked R.R. & was a little hesitant. The anesthetist came to check pt. upon seeing an active pt stated "why didn't you pg. me?"
3. I became angry because the pts' signs were stable, the activity was not excessive he remained in bed without restraints and I felt he was in no immediate jeopardy. I had stated to the other nurse that the pt. seemed quite active & his level of awareness could be better.
4. Angry, upset, intimidated because I felt my judgment was worth nothing & I had endangered a patient. The pt. became alert & there was no difficulty to follow. I still feel the scene was uncalled for & there wasn't any additional medication given during the "agitated" phase of pt.

Situation III

1. Another day in Labor & Delivery. I was orienting on nights (barely taking care of myself on this new shift) everything I did took great effort + the fact it was all so new. Pt. delivers myself & Charge nurse present another pt. meanwhile is moving quickly & will soon deliver. The other nurse is busy watching pt. so for a time I'm alone in D. Room with Paper Work!
2. There were hundreds (it seemed) of forms to complete &

I had briefly seen them before but never done any of them alone. The other nurse was very busy & left me only for brief periods but she did see that everything was completed correctly nonetheless.

3. I felt helpless; I should have known some of the info. I froze up & was afraid I'd write in something incorrectly. It was between chance and error or don't do anything & I had to do something.
4. Scared, helpless and like I was no help at all. I felt like the poor Charge nurse was doing everything herself & I was more hinderance than help. I was reassured tremendously though & the Charge nurse really did bolster my self-confidence which recently has hit an ALL TIME LOW!

Subject 7:

Situation I

1. A pt. was on Vironex (tube feeding), which was being regulated through an IVAC. Due to the rate which the doctors had prescribed, the IVAC prevented the Vironex from running in as scheduled, despite the fact that the IVAC was set at the highest rate possible. I took the Viro off the IVAC to regulate it myself. Either it was set too fast for the doctors or a tech opened it up more, but I got yelled at for having the Viro off the IVAC pump, and running in so fast.
3. I explained why I had done what I had done.

4. Angry and frustrated. ("You can't trust me to regulate the Viro myself?")

Situation II

1. A 35 y.o. pt. was admitted with CA of the stomach, which we later found had spread throughout her body. She was always either very uncomfortable or in much pain. It was a busy day.
2. This pt. needed a pain shot so I took one in. She started talking, saying she had been told she only had 3 months to live. She started crying. (I started crying.)
3. I started crying also, & took her hand, & listened for about 15 min., then said I had to go but would come back later.
4. I felt rushed, because there was so much to do. I felt terribly sad for this woman, & also for her husband & 8 yr. old son.

I felt unable to express my feelings to the other nurse on duty in order to get emotional support. (She, earlier in the day, had gotten irritated at me for a mistake I had unwittingly made.)

Situation III

1. A 50 y.o. pt. had an SVG (sphenous vein graft) X 3 about a week before this incident.
2. He started walking to the nurses' station and got dizzy, & experienced angina. He lay down, took a Nitro. I was

called. I took his vitals, evaluated him clinically, notified the M.D. 30 minutes later, when giving report, the nurse (in her 50's--well experienced) said I should have done an EKG at the time.

3. It was the straw that broke the camel's back--3 or 4 people that day had chastised me for administrative & nursing matters & here was one more criticism on top of everything else. I had thought it unnecessary to do an EKG, yet from my 2 months experience on the floor & her 30 years in nursing I couldn't help but listen.
4. Frustrated--perhaps I should have done an EKG. I felt as if I were being hounded that day about mistakes.

Subject 8:

Situation I

1. This is something that really bothers me. The cancer patients on my floor. This is stressful and discouraging. There's no time to give comfort measures to these people, just give them demerol and morphine.
2. So many patients die. Three died in one day. We're only human beings. Nurses are human, some people forget that. It's so difficult to settle patients on this floor. A lot of patients have emphysema and especially at night get so apprehensive. If we only could do something for them. We want to do so much for them but we can't.
3. It's upsetting and discouraging. I'm glad to be sent to other floors, even though I'm not a prn nurse. Just

to get away from so much death.

4. Discouraged and concerned.

Situation II

1. This bothers me. I had been taught how to do sterile dressing and found that they weren't being done correctly.
2. I found myself doing dressings sloppily. I had tried several different approaches and failed to maintain aseptis and gave in to the way they were being done. Some of us new grads got together and we all talked about our concern over the patients' welfare and thought about what we could do since we all had given in. But we felt, why buck them? Then, I saw another nurse using a method of her own which was good and I've adopted it.
3. I was concerned over the patients' well being.
4. Frustrated and upset because I had given in.

Situation III

1. This night I was responsible for 2 wards--a total of 63 patients. I had 3 techs.
2. A patient became acutely ill--he had a history of respiratory problems. The only oxygen we had was the emergency. There was no bed for him anywhere and we weren't equipped to handle his respiratory problem if an emergency arose. We couldn't even roll the bed up.
3. Upsetting.
4. Frustrated.

Subject 9:

Situation I

1. This was my first night alone in Labor:Del. The RN who had oriented me to L & D was in the Nursery & could not leave. This was to be my first delivery with me as the only RN present.
2. I kept going over the procedure in my mind. My biggest concern seemed to be if I had the pitocin drawn up in plenty of time! The whole thing went without mishap--not real smooth--but was soon over!
3. I was scared to death: I also knew that I was "proving myself" to those I was to be working with from now on.
4. During the delivery I felt very disorganized: didn't know quite what to do with myself. After it was over I realized everything went well. I was proud of myself & felt confident I could handle a similar situation without so much anxiety.

Situation II

1. As a student & for the three mo. I worked as a civilian nurse I was responsible for housekeeping chores. After a delivery I offered to help the techs clean up!
Mistake--.
2. The techs laughed right in my face. The chief nurse let me know that was not my duty.
3. I felt insulted that my sincere request had been taken so lightly.

I was angry that such a little thing was blown out of proportion.

I have not offered since; probably will not.

4. Embarrassed, humiliated.

I guess I was just trying to show I was not above cleaning so I felt personally defeated.

Situation III

1. I was working nights. When not too busy AM care is to be done by nights. I was giving the first bed bath to a post-op patient. As always this pt. took more time than I had anticipated. The day shift was there and waiting for report. I was 5 min. late.
2. The Charge Nurse reminded me I was late & stood at the desk peering down the hall waiting for me. One of the nurses told me the Charge Nurse insists on promptness.
3. I was sure the Charge Nurse felt me unorganized. At a time when I was trying so hard to show her I was capable of taking charge of a floor I did not need little inconveniences to prove otherwise.
4. I felt pressured to perform well & worried about how others' perceived me.

I felt stupid for holding up report for a dumb bed bath!

Subject 10:

Situation I

1. Another nurse & I had a disagreement over when to accept a patient from the intensive care unit.

2. I wanted to get the patient admitted so he would not be stuck in ICU any longer. The other nurse said that the ICU staff was just trying to take advantage of us.
3. I was angry.
4. I felt that the other nurse was being lazy and the patient was the one to suffer from it.

Situation II

1. I had a disagreement with a nurse over if a patient should get a pain medication.
2. A post-op patient was asking for Demerol and the other nurse stated that he was 2 days out of surgery and should only receive tylenol #3. She did not think that some patients have lower pain thresholds.
3. Frustrated.
4. I felt like the other nurse had no empathy. I felt torn between the staff & the patient.

(I'm sorry; I could only think of two situation.)

Subject 11:

Situation I

1. A T & A post-op came back & was bleeding, we had an admission who needed an IV right away, and the M.D.'s were writing orders right & left & wanted some orders done right away. Thus resulting--a mess!
2. I told the M.D.'s the I needed to help the T & A post-op bleeder and that I would get to the other things after. The M.D.'s consequently got mad!

3. I was angry at the M.D.'s and overwhelmed by the situation.
4. I was upset that the M.D.'s would not see the priorities in the situation & could only see what they wanted for their patients. I also was upset that the M.D.'s did not help & start the IV on the patient when seeing the chaos I was in.

Situation II

1. I had 4 post-op's come by within 30 minutes. It was zoo-ey. It was the change of shift.
2. The post-ops came by & I made sure all the M.D.s' orders were carried through and I was then going to take off the orders & put them in the Kardex. The nurse coming on was mad cause I hadn't taken off the orders--I had regarding the patient just not into the Kardex.
3. I was angry.
4. I was angry that the nurse would think that it was more important to hve the orders on the Kardex than that the patient was taken care of.

Situation III

1. I was giving patient care and the M.D. wanted me to get the developing solution for guaiac stools specimen.
2. I said that the developing solution was in a certain room & if not there the tech could get some. He was mad!
3. I was angry & mad.

4. I was angry that he felt that it was beneath him to do the test himself and wanted me to run around doing that thus not being able to give patient care.

Subject 12:

Situation I

1. I was taking care of another leukemia pt. In this case a 15 y.o. girl who threatened suicide just 2 days prior.
2. We had had a lot of deaths on the ward lately & she was scared.

We had felt that she had heard much of the idle chatter between nurses & doctors at the nurses' station about the deaths & that had prompted her suicide note.

2 days later the doc were discussing the most recent death with the 15 y.o. in their presence. I watched her turn white.

3. I was in another room pouring meds & watching them thru the window. When I realized what they were talking about I tried to signal thru the window to cut it. They ignored me.

I was angry.

4. I felt they undid all the good they had accomplished in the last 2 days in their discussions with her.

I also felt pretty useless. All my work was down the drain too.

Situation II

1. Another one of my leukemia pts. was being taken for a

Florida and die in peace near his family. For this I was rebuked. They started the chemo & 2 days later the pt. arrested & died. His wife flew back immediately to WHMC to claim the body & must now pay the expenses to have him shipped back (USAF will not assume this cost). She is in hock up to her eyebrows from this expense & the numerous trips.

3. I was angry & frustrated.
4. I felt the only interest the doctors held for this man was in experimentation & their track record!

Subject 13:

Situation I

1. I am new to the floor (2 mos). I had my own team of pts yet an extra nurse on duty decided she would assist me. Her assistance consisted of taking over as team leader more or less. Neither of us really knew what the other had/hadn't done for pts.
2. Consequently, an IV bag of chemotherapy was hung rather late on a pt. She insisted that I should have hung it.
3. Anger!
4. I felt confused & angry. I couldn't understand why hanging the chemotherapy was suddenly my responsibility when she had been doing or assisting with everything else.

Situation II

1. I had my own team again & I was performing all the tasks I thought I was responsible for.

2. I was accused of not changing a fresh post-op messy dressing. The accuser changed the dsq, told me she did it & that I should have done it (in a demeaning tone). The next day the surgeons were angered because the dressing had been changed / nurse.
3. Initially anger.
4. Incompetent at first until I saw the pt. the next day & he told me what the surgeons had said.

Subject 14:

Situation I

1. I had just arrived on the floor to which I was assigned and was given a patient with second degree burns over 40% of his body. I hadn't even been introduced to another staff member or oriented to the floor!
2. I took my assignment very graciously, however, inside I could feel my heart begin to pound, and nervous shaking all over my body. I had never taken care of a patient with burns.
3. I became angry, frustrated, and regretful of the whole idea of nursing. I told the nurse giving assignments that I had never worked with a burn patient before. She simply replied with "That's OK, someone will help you if you need it."
4. I couldn't believe "they" would just "throw me onto the floor" like that. I wanted to run out of the hospital and cry from the fear and frustration but I knew I had

to accept my assignment and do my best by relying on the patient to guide me with his care.

Situation II

1. I was told one thing by one charge nurse and something quite different by another!
2. I was asked to give an In-Service and very anxiously accepted the challenge. My charge nurse told me that I could use the Medical Library anytime during working hours to complete research and compile my presentation. Within a few days our unit was closed and I was moved to another floor. When I asked to go the Med. Library one morning I was practically "yelled at" by the charge nurse over the thought.
3. I was very angry and confused. How could they encourage me to better myself and others in the quality of patient care and deny one the time to research material?
4. I was upset mostly because I felt there was a lack of communication between the two charge nurses. I felt that my previous charge nurse should have explained that I was given the opportunity to attend the Med. Library for preparation of my In-Service. I think it's a pretty good reason to leave the floor for two hours! After all, we would all benefit from this.

Situation III

1. I was a little upset when I asked a doctor to remember something and he became angry and defensive.

2. The doctor had ordered stat blood for culture and sensitivity. The blood was drawn and sent to the lab immediately. Upon close inspection of his orders I saw that he added an order for a WBC to be drawn without bringing it to our attention thus making one stick the patient again for more blood. I told the doctor and he replied with "I meant to tell you but you probably don't believe me anyway!"
3. I was angry to think that a doctor doesn't think of the patient and that he would have to be stuck again only because he forgot to tell us that he added this one order.
4. I was upset over this because the doctor took on a very defensive attitude. All he needed to do was apologize and show some effort towards the idea that he'd try not to do it again. He didn't have to take it out on me by stating that I probably didn't believe him when he said he meant to tell me. I did believe him but that wasn't the point.

Subject 15:

Situation I

1. The family just hit me in tears. It was one of those days. I was cov. another unit & nurse in charge.
2. They asked me about the patient who was just admitted. You don't know. You say "You'll have to see the doctor," and you don't see the doctor. In school, we learned

Situation III

1. This was very upsetting to me--that I should be impatient with a patient.
2. A man had a TUR and had a myocardial infarction during surgery. He was very sick and very uncomfortable and his family were concerned and very worried. The patient complained of chest pain, I started the oxygen and gave morphine. But I was worried about what I was doing. The feeling on the ward about him was that this patient is a pest and is coarse and difficult to care for. There are so many elements here which interplay. The head nurse made a comment about this patient's religion and I didn't like it--but maybe that affected me too. I was beginning to be very impatient and I was at my wits end with all the complaints of the patient and his family.
3. Frustration, ignorance and fear about the emergency situation.
4. Why should I have this impatience about this patient?

Subject 16:

Situation I

1. A post op total hip patient was not turned, C & DB \bar{q} 2°.
2. While passing meds, a patient asked me if she could please be turned because she was extremely uncomfortable --not turned in 12 hrs, had an elevated temp. 101°. I was very busy, \bar{c} a 43-bed ward & being the only nurse,

I asked a tech to make sure she was turned. I went back 4 hrs. later & she was still on her back. I couldn't find the original tech, but got some others & turned her.

3. Anger & frustration, felt bad for the patient.
4. I felt the nursing care was inadequate, I was incompetent for not checking up on it. But on the whole, I felt extremely frustrated that I couldn't delegate a duty & checking up on it & didn't have time to do both. I felt pressured.

Situation II

1. Too busy to minister to patient's psychological needs.
2. Two patients on the 43-bed ward where I was the only nurse were extremely upset--one about her Ca diagnosis & one about impending surgery. Every time I sat down to try to talk to one of them, a technician or ward clerk would come to get me for telephone or pain med etc. & these 2 patients got the feeling I was too busy for their "petty" needs.
3. I was upset, frustrated, felt incompetent.
4. I was upset & frustrated because I really wanted to give both patients emotional support, they needed someone & no one had time for them, because of physical needs of other patients. I feel emotional needs are just as important, but we barely seem to have time for physical needs.

Situation III

1. Resident got mad at me for not knowing where a patient's x-rays were when I had just gotten to work.
2. Was making rounds \bar{c} resident. He was upset that an aspect of pt. care was not being carried out as he had ordered (order was misinterpreted by previous nurse) & I didn't know where the patient's x-rays were.
3. I was angry, upset, felt I was being unjustly accused on both counts.
4. I don't feel it's a nursing duty to either transcribe orders nor to keep track of pt's x-rays. It is nursing duty to carry out orders. However, in this situation, none of it was my fault; I was angry & upset.

Subject 17:

Situation I

1. This is another situation which was stressful in that I was not able to sit down and talk with a patient. It was just impossible because of the paper work. I don't mind being a sounding board--all patients need somebody to just sit and listen.
2. This particular patient was paranoid and was an extreme problem. He asked me "Why don't women like me?" He kept asking and started talking to me. I had to leave because I had to get the 24 hour report in. I went back to the patient, but it wasn't the same level of understanding.
3. This kind of thing happens quite a few times. It's more

or less becoming routine.

4. I feel very badly because I'm not able to give the care I'd like to give and it disturbs me.

Situation II

1. I was working in the psychiatric service.
2. We had a patient who was a diabetic and an old psychiatric patient, but he had a lot of medical problems. The doctor said most of his problems were psychiatric and he minimized his medical problems. It's upsetting, when you don't know if the patient is reacting to his medical or his psychiatric problems or both.
3. I thought the medical problems were minimized.
4. I felt upset.

Situation III

1. I was interrupted when I was talking with a patient. I was responsible for 53 patients on 2 units.
2. A young schizophrenic paranoid was on intensive psychoanalysis. One day, he was feeling down in the dumps and started talking with me which was unusual because he never talked for long periods of time. After a while he became more relaxed and then I was called to the phone. There was an emergency on the other ward and I was getting an admission. The rapport with the patient I was talking with was completely lost.
3. I was disappointed and frustrated.

Subject 18:

Situation I

1. I was asked to put an NG tube in one of the patients. It was the first NG tube I ever put in.
2. I was about to start to put it in and the doctor (intern) came in the room and stood behind me. While I was putting it down, he told me to put down as fast as I could because I was putting it down too slow.
3. It made me more nervous having him in back of me instructing me. My preceptor was also in the room at the time.
4. I was mad that he came in the room at the time because he knew I was going to be putting the NG tube in.

Situation II

1. A pt. came in \bar{c} Subacute Cholecystitis and was in pain! She's very apprehensive about being in the hospital. She has little faith in hospitals (her family has had some minor mishaps in hospitals & also she saw some movie "Hospital" that has influenced her attitude toward Medical Personnel).
2. I was asked to put an IV (angio) and she had poor veins and also IV's, especially angio's, are not my specialty. Her family was in the room making comments about needles & IV's. Needless to say, I was nervous & I didn't get the IV started.

3. I was mad that I didn't ask her family to leave. It also made me feel very nervous.
4. I was nervous. Also I felt like I failed for not starting the IV.

Situation III

1. I received a "total care" pt. from the ICU that night. He was on many meds. I gave him his 6 PM meds late (1 hour).
2. I thought his next meds were for 2200 but at 2130 I was checking to see what meds I had to give him & I noticed they were for 2000, not 2200. Then when I went to get the IV mixture med, we didn't have it. I then had to mix his meds.
3. I was quickly got his meds ready & hung them.
4. I felt nervous & was upset that I misunderstood, or I should say, mixed up the time of the med administration.

Subject 19:

Situation I

1. Setting: 48 bed surgical/orthopedic ward
day shift
3 nurses; but one got ill and left 2
6 surgeries scheduled
2. As you can note from the above, we were severely understaffed on this day. The phone was ringing off the hood, physicians in \bar{c} new orders, in addition to surgeries, daily consults etc. caused utter turmoil. Be-

sides feeling swamped by my own work load I was responsible for the pt. case being provided by med. techs.

3. At first, I tried to keep up with the work load, but it was quite evident in a short period of time that it was impossible. I became really anxious over the fact that I couldn't keep up and I tried to speed up my work production. That still was ineffective--so I told myself to give it a good go--and that's all anyone can do.
4. Frustrated, anxious, and upset about the quality of patient care that was being delivered on the ward. But then I realized that it was a situation over which I had no control--so it was one of the things to accept that day. After I came to this conclusion, my productivity remained the same but my anxiety, frustration level was very low.

Situation II

1. Pt. required blood.
2. I was responsible for care to this pt. (in addition to 20 others). Had never administered blood before although I had had the theory behind this procedure in school. It was a busy A.M. I felt the other nurses would think I was supposed to know how to administer blood already. I had to ask how to do it and one nurse just shook her head sid to side as if to say, "Are you for real?"
3. Felt like crying because I had a ton of things to do-- plus this! So, when this nurse shook her head--my initial

reaction was that of feeling really dumb. Just wanted to crawl through the floor.

4. She made me really feel incompetent both as a nurse and as a person by her gesture.

Another nurse--not much older than myself--seemed to realize the situation so we hung the blood together that day.

Situation III

1. A pt. required blood to be drawn. A med. tech. was uncertain how to do the procedure--he came to me for help. I had previously drawn blood several times, but at the time did not feel competently skilled to instruct another individual. (I was scared I'd blow the vein.)
2. I did some teaching prior to going to pt. bedside and then we went through the process together.
3. I felt more calm after instructing the tech.
4. After the blood was drawn successfully my sweaty palms were no longer sweaty.

Subject 20:

Situation I

1. This is something that's stressful to me and this happens all the time. You know, it's not the big things, but the little things that grind away at you and make you feel what's the use? that say things about patients who are dying in front of the patients. We were always taught in nursing school that the last thing to go is

hearing.

2. This patient was a man who was always very neat and was in the hospital with gangrene and this attendant said, "Oh my goodness, look at those dressings!" There was a terrible odor to the dressings, but can you imagine how this man felt when he heard that? Another time, an aide helped me turn a patient who was cold and clammy and commented "Did you feel his skin?" When we got outside, she said, "I know I shouldn't have said it." But she knew and she said it anyway. And people who say in front of the patient who is still barely alive, "Which undertaker are you going to get?"
3. It really gripes me. I try to teach my aides but still they know and still they do it.
4. Angry and what's the use? (Presence of reaction.)

Subject 21:

Situation I

1. A tech telling a nurse to leave the room because of her behavior.
2. A young boy came into the emergency room with a bad laceration on the knee. Will, another nurse intern and I were with the pt. The tech came into scrub the knee before suturing. He seemed very rough to the child since we had only been in the ER three days. The other nurse & I were very upset. The tech saw the other intern making faces and sent her out of the room.

3. I was very angry and upset.
4. I wish I would have had the power then to tell the tech to get out of the room, but since I am a nurse intern and he has worked ER for a while he knew the right way. I just wished he could have handled the situation better.

Subject 22:

Situation I

1. I was on nights again. Everything seems to happen on nights. There were 34 patients and 3 critical patients. I was the only nurse with one tech. This was another case of where I was sent to a unit I wasn't familiar with. There were many orders to be carried out for the 3 critical patients.
2. The IV infiltrated, patient was confused. I couldn't get started with my own work until 2:00, with the relief nurse and her friends trying to finish up her work. There was another patient I was worried about who had suicidal tendencies.
3. I wanted to get rid of everyone to get started. I was very concerned because I didn't know the patients and worried over the patient with suicidal tendencies.
4. I felt very pressured. I felt I had neglected the other patients. (Presence of reaction.)

Subject 23:

Situation I

1. During a 2-1/2 week period when I was acting charge

nurse, our ward clerk did not come to work. This left me with many responsibilities and tasks which I was unprepared to handle, specifically, manifesting patients for Air Evacuation back to their own base.

2. Our ward clerk had supposedly manifested 3 people the day prior, with only the final paperwork to be accomplished. I called for the fill-in clerk to finish this before the 1000 o'clock deadline. One patient, I was told by our ward clerk, was completely done so I just gave the other two charts to the ward clerk. At 1010 he informed me that the third patient was not finished and would not be leaving that day as planned.
3. I was angry at our ward clerk for not accomplishing her duties and telling me she had. I was angry at the other clerk for not telling me before the deadline that more work was needed and finally I was upset with myself for not recognizing the process was not completed and resentful that the fillin ward clerk seemed quite unconcerned about it even though we had an angry patient to content with.
4. I felt I was being expected to compromise my time on administrative matters which I knew very little about while there was in addition pressing patient care needs to attend to. This was extremely frustrating to me and I remember wondering why I had bothered to go to nursing school when it seemed like I need a more clerical back-

ground to function as a "nurse".

Situation II

1. Again as acting charge nurse we had a patient with us, a diabetic being treated for diabetic retinopathy. I was also working alone on a Tuesday on a 34 bed surgical ward with a heavy surgery schedule.
2. The patient becomes very insistant that I find out why a consult that was sent only a few hours before had not been answered yet. She seemed to be at the nurses' station every 15 minutes even though she was told that it usually takes 1-2 days for a consult to be scheduled and answered by the appropriate clinic or service.
3. I became somewhat annoyed at her insistance and told the patient that I would not call anyone today concerning the consult, that she had no reason for the insistance and if there was something she was concerned about I would spend time talking with her but she would no longer interrupt me while I was charting or talking with another patient or instructing a technician on a task or procedure which needed to be done.
4. I felt anger towards the patient for what I felt was manipulative behavior. I also felt frustrated that I was working alone and did not have the time to adequately explore the pt.'s feelings and meet her need for reassurance that she would be cared for.

Situation III

1. A patient wanted to go out on pass but his dr. was unavailable as he was in surgery.
2. The particular patient had been somewhat demanding in the past and at this time was 5 days post op for wide excision of a malignant Melanoma with a skin graft progressing well in the early stages of healing. The pt. requested that I call the surgeon to see if he could go out on pass.
3. I denied the patient's request giving the reason that #1, I felt it was not in the pt.'s best interest to leave the hospital, that to do so could compromise the success of the skin graft and #2, that type of a request was not something I would interrupt a surgical procedure for.
4. I felt that the pt. was attempting to push me around or intimidate me. Also I remember feeling I frequently feel in such situations that I, as a nurse, am looked upon more as a messenger or "gopher" than a professional practitioner.

Subject 24:

Situation I

1. A labor patient came in at 4:00 A.M. Her last labor lasted 4 hours.
2. The patient went from 4-6 cm by 0500 A.M. The physician was notified, and informed of the patient's first short

labor. He was irritated at being called and came in 15 min. later angry because I had supposedly called him too soon!

3. I was upset, I had trouble thinking clearly because of his anger. He wanted the "other nurse" to help him instead of me.
4. Terrible.

Situation II

1. Labor patient came in @ 0530. She had a short first labor so I attempted to get her ready for delivery.
2. I failed to have all "paperwork" in correct order by the end of shift. I was "counceled" for not organizing my time correctly.
3. Anger and hurt because the IV had been started, she had been prepped, given an enema and monitored all within an hour so it was just I had no time to roganize paper-work.
4. Humiliated at being "counceled" for something so trivial.

Situation III

1. A patient came in early labor at night so I prepared her for delivery admitted her, prepped her gave her an enema.
2. I did not call Dr. up because she was in early labor and he had gotten upset at an earlier date for being called too soon. I got "counceled" for not calling him.
3. Anger & frustration. I felt like I did what was best.

4. Like any decision I make seems to be the wrong one according to charge nurse.

Subject 25:

Situation I

1. I was blamed for an incident that I had nothing to do with except I was trying to correct the situation.
2. I saw a dry IV when I was walking down the hall, coming onto the floor. When I got to the desk, no one was around so I went ahead and started to set up another bottle for this patient. However, it wouldn't drip and I could only assess that the line had been dry long enough to cause it to clot. As I was gathering the equipment to re-start the IV, I found the team leader for that team (I was on the other team) and she blamed me for letting it clot off.
3. Frustration and anger.
4. I was angry both because the other nurse had let an IV run dry long enough to clot off, and because she blamed me. If she had wanted me to watch her team or her IV's she should have told me. I was frustrated because I had only tried to remedy the situation when I could have just as easily kept on walking and ignored the whole thing.

Situation II

1. I was put down because I brought something to the doctor's attention that he wasn't interested in.

2. A patient under my care dislocated her shoulder while getting out of bed. A couple minutes later, while I was being summoned, she managed to put it back in on her own. Upon questioning she said it had happened before and that her doctor didn't know about it. However, when I brought it to the doctor's attention, he just walked by me and said "She should have told me! But, just as well as I don't have time for that anyway."
3. Anger & confusion.
4. I was angry at the physician's indifference, and at his rudeness. I was confused as to what and when should I bring something to the physician's attention?!

Situation III

1. I was blamed for not taking off an order.
2. I had taken off some orders from a patient's chart and had returned it to the chart rack. The next day a physician if a certain test had been performed that as the patient was going home as soon as it was completed. I said I knew nothing of the test and asked if there had been an order. The physician had ordered it, but after I had taken off the other orders, and he had not tagged the chart but had entered it in tiny print above my signature on the order sheet and then returned the chart to the rack.
3. I was angry and indignant that the physician thought I was fool enough not to be able to see what he had done.

4. I could see he had squeezed in his last order, and then on top of that, had not told anyone. I was angry as well, that his inconsideration caused the patient to remain in the hospital another night.

Subject 26:

Situation I

1. A 15 yr. old suicide attempt victim was being admitted to Pediatric Ward. She was depressed & upset after a visit from her doctor who questioned her. She did not want to answer the admission physical & history.
2. The mother, in a hostile tone in her voice stated she didn't need to answer because it was already on the chart.
3. I was upset and felt that the mother didn't have to react in the manner she did.
4. Hurt!!

Situation II

1. A 3 yr. old, admitted with 2nd & 3rd degree burns of feet, was playing and later he cursed me (calling me a _____!!). He was a possible child abuse victim.
2. I ignored the kid in a manner of fact behavior and went outside of the door.
3. The kid immediately put his hand over his mouth and thought that I was going to come back and whip him.
4. I figure the kid had picked it up from his parents and just didn't know better.

Situation III

1. Two sisters, age 6 months & 22 months both admitted
to failure to thrive. Minimal developed for their age.
Parents wanted to take them home against the advice of
the doctor & hospital staff. The nurse in charge felt
she should be allowed to leave the next time without
calling the doctor as ordered.
2. The first day the parents were encouraged to leave the
kids but the next day they were released. A positive
child neglect case.
3. I felt they should be allowed to stay by court law
but also realize enough proof was not available.
Kids appeared happy when they D/C but they didn't know
what they were being deprived of.
4. Upset and felt I needed to reach out and help these
kids. Worried and thought about them for days!!

Subject 27:

Situation I

1. Assuming a leadership role in planning for patient
care.
2. A head nurse told me, "Nobody likes a leader, remember
that." So, I'm kind of nasty, but when techs don't
take pride in their work, I really get riled. They do
the minimal just to get by.
3. It's aggravating.
4. I don't like to be nasty just to get good patient care.

Situation II

1. The head nurse was orienting me to evenings. I was told to pour the meds, then the head nurse identified the patients and left. She handed me the keys and went to lunch. I had 20 keys.
2. A patient went into convulsions. The doctor was there and asked for sodium amytal and I didn't know where to find it. He kept shouting and I was fumbling through the keys. I called the supervisor and he knew which key. Also, I was thinking, what if the doctor wasn't here, what is the nursing care of a patient with convulsions? I had never seen a patient in convulsions, what if I was alone? If you asked me now, I could tell you, but, then I was so pressured I couldn't think at all. The one catheterization I did, was long after I had the principles and I didn't remember a thing. I still wonder where the urinary meatus is.
3. Frustration.
4. Inadequate.

Situation III

1. A patient was on isolation for hepatitis.
2. The tech came out and told me that the patient told her that we were the only ones who were using isolation technique. The doctors and other staff were dashing in and out without any precautions.
3. I didn't know what to tell the tech or the patient.

4. Upset and frustrated.

Subject 28:

Situation I

1. (Physician asked me to sit in on female pt. physical)
Felt inadequate in delegating responsibilities to some of the techs.
2. Physician asked me to sit in on female pt. physical.
While on my way to linen closet for a sheet (tech was sitting at desk), a pt. asked for a new K-pad because hers was leaking. I told her (she was walking in hall) to ask tech at desk. When I returned from linen closet the tech had a sheet in the room and was with pt. As nurse intern, I had been trying to help in some physicals to brush up on my own assessment skills.
3. I was somewhat angry and frustrated. This particular had been somewhat of a problem in floor by leaving early, leaving the floor, etc. I feel I didn't do anything to help correct situation.
4. Inadequate that I couldn't just tell this tech to do something and then felt it was too petty to argue over. Then felt I should have been more assertive.

Subject 29:

Situation I

1. I was newly assigned to our Thoracic/Vascular ward.
There are specific protocols to be followed for these categories of pre op pts. This situation deals \bar{c} type

+ cross matching a patient for bypass surgery. The protocol says 7u packed cells 8 units whole blood type + cross. The Captain (Male RN) I worked with took a message from the blood bank regarding the specific amounts of each (WB/BC) to be crossed + matched--crossed + held. I re-did the request slips according to the message. (The pt. involved was on my team.)

2. When I reported to duty the next day and was immediately informed by our civilian night nurse that an incident report had been written on me and the blood requests. When the pt. was taken to the OR the protocol required blood units were incorrect. It was stated I filled out the requisitions in error and the surgeon was furious. The appropriate number of type + crossed Whole Blood + packed cells was made available therefore the pt. did not become endangered.
3. Initially embarrassment at making such an error. Then my response was to ask the nurse telling me of this error what was actually put aside for this pt. and what was supposed to be. I asked her to clarify what the protocol required. I took the incident report and gave it to my charge nurse.
4. Embarrassed at making such a mistake. I wished that I felt more comfortable & knowledgeable in dealing with the thoracic & vascular surgery protocol. I questioned that my lab requests were so messed up, I guess doubting

that I could have made such an error, c paperwork.

Situation II

1. Changing an abdominal dressing on a post op female pt., 36 yr.
2. The pt. was demanding that her wound be cleansed differently than I planned to do. She moaned when I tried very gently to remove her packing. When I completed the dressing she gave me a snide remark about what I had just done.
3. I did not enjoy caring for her but I smiled and replied courteously to her. Cleaned up my dressing supplies and left the room very quickly.
4. Annoyed that this pt. appeared so unappreciative of the nursing care I tried to give her.

Situation III

1. This involves a pt. who has been on our floor 2 mos. A pt. (female, Japanese) with terminal cancer of stomach was having severe hematuria. The urologists had done a cystoscopy and traumatised her bladder. On our surgical unit we were giving her bladder irrigation to reduce her clotting and pain.
2. She was complaining of severe cramping & sensations of having to empty her bladder. I explained to her that the foley catheter would take care of her urination needs. I irrigated her foley but could not clear the clots. I asked for her doctor to check her out because

she was so extremely uncomfortable. He too irrigated the foley, met resistance and ended up removing the foley.

3. I was upset by this patient's discomfort. I had tried to assess her needs and felt inadequate.
4. Emotional drained that this patient who I had grown fond of, was in such horrible agony from the foley. I felt relieved that the doctor was calm and pleasing in dealing with both me and the patient.

Subject 30:

Situation I

1. I got upset one night when I could not get a doctor to see a patient who was having a drug reaction.
2. A patient was admitted as a medical hold RON because he was not seen as fit to fly because of a reaction to Haldol. The flight surgeon brought him to the floor & said the psychiatrist on call knew he was being admitted. Finally, I called the psychiatrist who didn't know anything about it. He said this was a medical problem--to call the medical resident. I did this & he finally came up after an hour & a half. Meanwhile, the patient would stop breathing for like 10 seconds, hadn't urinated since the night before, etc.
3. I was getting more & more pissed off as the night wore on.
4. I was angry that the psychiatrist didn't care enough

about the patient to come see him. The flight surgeon dumped him off & the medical resident really didn't want to see him either. He really didn't belong to anyone--so no one felt responsible for him, except me.

Situation II

1. A lady was to be admitted for attempted suicide. She is the wife of an AD Lt. Colonel.
2. A lot of the bullshit that went on here wouldn't have happened if she wasn't the wife of a Col. She was an hysteric who wasn't really going to kill herself, but everyone catered to her. She didn't want to be admitted but was talked into it. After staying 30 minutes she took off. Well, the roof fell in. Various brass called up wanting to know why the hell we let her leave. (It was an emergency involving the pt. in situation I).
3. I was angry that this hysterical lady meant so much to the brass simply because she is the wife of a Colonel.
4. I was angry. They (the brass) are so hypocritical. I mean, if this lady happened to be an E-1 or something, there wouldn't have been any uproar.

Situation III

1. We had a patient on the floor who screamed for an entire 8 hr. shift.
2. The patient came up from a medical floor because of management problems. She had phlebitis with a manic-depressive illness on the side. She would yell all the

time. She didn't want anything, she would just yell. You could be standing right at her and she would still yell for nurse.

3. I was frustrated and angry.
4. I was frustrated because she didn't really want anything, but she wouldn't quit yelling. It was upsetting all the other patients. It really sounded like a psych floor when she was there.

Subject 31:

Situation I

1. This happens so many times, that other patients have to tell me that things are going wrong because they don't want to bother me because they think I'm too busy. That's what I'm there for.
2. There is a patient who has Ca of the pancreas with metastasis--he gets demerol and thorazine every three hours, and another patient with metastatic Ca and he gets demerol and phenergan every three hours and they don't call me because they know I'm so busy. The patient vomits and doesn't tell me because he thinks I'm too busy. I told him I want to be there when he or anyone vomits. He becomes choked and needs my presence. I've instructed other patients to tell me any time this or anything happens as long as there are some patients who won't tell me. I make it a point to be punctual and get back to the patients for their pain medications.

If anything delays me, I explain why.

3. It's terribly aggravating.
4. Almost uncontrollable anger that I have to be so busy that I can't be with the patients when they need me, and they feel they are bothering me.

Situation II

1. I didn't have time to talk with a patient because I was rushing to.
2. A minister had a brain tumor and woke up very lucid and stated, "I'm going to have a craniotomy--the brain is a very delicate organ." I answered, "Yes, you are going to have the surgery and it is a delicate organ." I had to leave to do other things. This was a golden opportunity I couldn't take advantage of. As soon as I had a few minutes, I went back to him, but it was lost, and we couldn't recapture that previous opportune moment.
3. Extreme frustration.
4. I was very upset.

Situation III

1. I was being oriented to evenings by the head nurse. There were 46 patients. I was put on meds.
2. I didn't know the patients. I didn't have time to talk with them. I can't get organized in a setting like that. There was a patient with Ca of the spinal cord on a Stryker frame and he was a personality problem--

complaining all the time. I didn't know him and I couldn't do anything to help him.

3. My hands are tied. I feel badly because I can't give the care I want to give.
4. Is it worth trying?

Subject 32:

Situation I

1. Sat. day shift. Myself and a reserve nurse who was unfamiliar with the floor, the patients, routine procedures were the 2 nurses on duty with two medical corpsmen (technicians). I had only started working on this unit 2 weeks earlier and this was my first day in charge of the floor.
2. Doctors made rounds \bar{c} the result of many orders to be taken off, including one order to begin hyperalimentation on a 15 y.o. female pt. \bar{c} Crohn's Disease who had just been transferred to the floor that morning. My concentration in taking off orders & accomplishing the routine work was continually disrupted by the reserve nurse's constant questions; questions someone familiar to the floor would not have had to ask.
3. This situation existed because a staff nurse had called in sick. Great frustration at the inefficiency of the nursing care because of my need to concentrate so hard in managing the floor and the bombardment of questions. Thus, patient care suffers, is not as thorough as it

should be due to inefficiency.

4. I battled \bar{c} my own feelings. At the same time that I tried to be patient & calm in orienting the reserve nurse & answering questions, I began to feel angry & resentful & answered her too curtly & \bar{c} impatience. I was angry that I had been "put" in a situation that I was not better able to cope with.

Situation II

1. Working evening shift on a surgical floor, census 32 patients. I am the only nurse on \bar{c} 2 medical corpsmen, 10 patients \bar{c} IV's & IV-antibiotics, 3 post-op pts. (fresh).
2. Two more patients were admitted within 2 hrs. time. IV's had to be checked, pain meds were requested by 2 patients, IV meds & 8 PM meds had to be passed. Beds had to be switched for the 2 admissions, orders had to be taken off on the admissions.
3. Overwhelmed! Everything had to be done at once. Priorities had to be made, and then revised, and revised again. Difficulty in finishing one task of importance before a more urgent task arose.
4. Angry & frustrated by my situation at present and with the understanding that this situation is commonly confronted on evening shift. Staffing for evening is chronically short and pt. care suffers terribly!!
Their needs cannot be met efficiently, within a reasona-

ble amount of time, nor as completely.

Situation III

1. Night Shift. Central Supply closed, Pharmacy closed.
In need of meds which were not on the unit does cart or in stock supply. I need IV solutions which had been low on evening shift.
2. When supplies run out on nights it becomes necessary to start calling around the hospital to find supplies on other units. Usually the item can be found, occasionally not.
3. Disgusted & annoyed at the poor management of supplies and the waste of time spent hunting for supplies which should be available. Irritated by the "red tape" surrounding gaining entrance to the pharmacy at night.
4. Angry at this "system." Contrasting the AF set-up \bar{c} that of a civilian hospital I worked in before in which pharmacy & central supply were open at night and/or supplies were at hand on the floor more frequently than not. This situation, too, deprives the pt. of good & efficient patient care. The time hunting for needed items could be spent meeting pt. needs. I am not hoping for an ideal & perfect setting but one in which efficiency, good management prevail.

Subject 33:

Situation I

1. I was working in the premature nursery when my aide

took a break without informing me. I was in charge. A baby went bad, and I was unable to call for help because I was so busy trying to do something for the baby.

2. This situation happened twice this evening. The first time I was lucky, a doctor walked in the door. Usually, they don't come near the place. I was just lucky. He took over. The second time, the aide was not there either, and I was charting when I looked at the baby and he was black. I had to decide whether to stay here at the desk and call for help or go to the baby. I went to the baby, carried out the emergency orders, then called for help. The baby expired before help came. It was 45 minutes before a doctor came to pronounce the baby dead. Then, we couldn't get in touch with the baby's family. It was a mess. The doctors in pediatrics were terribly busy, two children died that evening in pediatrics.
3. I was surprised at first at the aide leaving. Then I was very upset and annoyed that I couldn't manage to get any help.
4. I felt that I had neglected the other babies in my concern for the sick one. I told the supervisor not to send me that aide any more, I'd rather work alone.

Situation II

1. Just the other night, I had six babies, one had hyaline membrane disease and he was in isolation and the other

baby had a scalp vein IV running. Of course, they were at opposite ends of the nursery. I was so busy running between the 2 sick babies that I could not look at the other four.

2. The IV infiltrated and it never should have. I had to decide--shall I let that IV infiltrate or do I suction this baby? I had vital signs to check every hour on both babies and they needed a lot of care. I was all alone. I had planned to call the supervisor. After dinner, they sent me a L.P.N. I wouldn't have minded so much being alone if I knew someone was coming. When she got there, she took care of the four, and I took care of the two sick babies. Do you know, I never even saw those four babies?
3. I was not doing what I should have been doing in caring for the other babies. I really neglected them. I was upset about this and felt pressure because of it.
4. I was ready to leave and I wanted to, but then there would be nobody to care for the children, but I was ready to leave, if they hadn't sent somebody.

Subject 34:

Situation I

1. I was in O.B. in labor and delivery. We did an emergency C-section on one of our patients.
2. We moved the patient into our 2nd delivery room which

is for C-sections. I was in the room mostly to observe but to assist as needed as well. The room was very disorganized. The suction machine didn't work. When the anesthesiologist or surgeons asked for things, we had a difficult time finding them.

3. I was frustrated and embarrassed.
4. I was frustrated because I was new to the area and didn't know where things should be. It was embarrassing that the room was so disorganized and the suction didn't work. The situation was critical and we weren't able to respond with the smoothness we should have.

Situation II

1. My first day shift on a medical ward. I had my own team of 15 patients to care for. I had 3 technicians working under me.
2. The day was very busy with patients going between various tests and treatments. There are 3 services of doctors up at various times on the ward writing orders. There were lots of medications to give. One patient was in respiratory isolation and getting IV meds every 1-2 hours. There were several admissions, discharges, and transfers. The amount of paperwork for charting was large and consumed quite a bit of time. The IV meds were also time consuming. I hardly saw any of the rest of the patients and found it hard to be sure that all the treatments were done.

3. I was overwhelmed and really frustrated.
4. I felt like I had not spent quality time with my patients. I am accustomed to a total care/primary care nursing situation. It's difficult to be placed in a position of so much paperwork and so little patient contact. It's hard for me to give my nursing responsibilities to a technician.

Situation III

1. I had a patient who had pneumonia. She was to get percussion and postural drainage every 4 hours.
2. I had made sure the tech. caring for her knew about the percussion and postural drainage and had asked at noon if it was done for the morning and at 1500 if it was done for the afternoon. Both times the tech said she had done the treatment. The patient said she hadn't gotten her treatments at all.
3. I was in a situation of not knowing who to believe or what to chart. The patient was reliable and oriented. I could see no reason why she wouldn't tell the truth if she'd had the treatment.
4. I was angry that the tech had said she had done the treatments when she hadn't. We could have found someone to do it if she had let me know she couldn't get it done.

Subject 35:

Situation I

1. I was orienting, I came on the shift, and there was much to be done: getting pt's admitted, doctors notified, vitals & exams done, meds, etc.
2. As I had small idea of what order or number of things to do, I had to draw heavily on the co-worker; eventually the chaos was conquered, piece by piece.
3. 1st-tunned vision, visceral tension, impaired hearing, light perspiration.
2nd-dependent recourse to the co-worker; execution of obvious priorities.
4. Wanting to do my job irreproachably, the initial view of many duties and the threat of impending pt arrivals immobilized my thinking (frank shock). As I was new, I was uncertain of what/when/how to do, and was relieved for the presence & expertise of co-worker.

Subject 36:

Situation I

1. I was filling in on a medical unit. There were several seriously ill patients. I was in charge.
2. I didn't know the patients and had the insulin syringe in the patient's arm and I don't know what made me ask his name again, but I did, and it was the wrong patient. The barcelets don't always stay on too long. Another patient had tremors and I didn't know if this was a radical change in him or just the usual.

3. Anxiety.
4. I felt anxious.

Situation II

1. I was asked to be in charge on another floor one evening--it was set up much differently from my own. 34 semi-private rooms, 6 private, 3 corridors, med., surg. and Gastro-Int., 3 order books and quite busy. I merely had to sit at the desk and post orders and do other charge duties--no patient care.
2. I agreed but with misgivings--everything went rather smoothly actually, but I was in a constant state of stress the whole evening--worrying because I didn't know the patients and wasn't able to really supervise the care they were getting.
3. I felt very nervous and worked at a very rapid rate. I felt unsure of myself and not in control of the situation.

Situation III

1. What's really stressful to me is all the administrative responsibilities and red tape we have. The ward secretary is the most important person on the ward.
2. A phone call came from X-ray that the gall bladder pictures were bad on a patient and that they were to be repeated tomorrow with a double dose of tablets. The ward secretary forgot to mention about the double dose and the patient had to go through all that discomfort

and miss breakfast and have another repeat X-ray, just because she forgot. I was in charge and felt very badly.

3. My reaction was that I'd like to wring her neck.
4. It was upsetting because the patient had to go through the procedure again.

Subject 37:

Situation I

1. Receiving pressure from the front nursing office on lack of written pt. care plans.
2. A few discharge charts were returned lacking care plans & the Ass't Chief Nurse verbally admonished all working nurses.
3. We tried to explain the heavy load we'd been working on & the large number of recent admissions.
4. Angry; put upon, underserving of complaint.

Situation II

1. Dr. refused to transfer a fresh post-op pt. to ICU.
2. Pt. was brought back from R.R. early in eve; had unorthodox procedure under general anesthesia. He was not waking up as expected, urine out-put was low despite urecholine, lungs very congested. Rising BP & P. M.D. ordered q15" vital signs & q1⁰ u/o, and we had 3 staff people & 24 other patients.
3. I kept calling him at home until he finally came to see

the pt. & transferred him.

4. Angry, felt as though my judgment wasn't regarded as sound.

Subject 38:

Situation I

1. A physician was going in to do a dressing change on an infected patient.
2. I followed to observe--neither the physician or Cpt. Nurse (Reservist) were following the Isolation Guidelines posted on the door.
3. I called the physician to the side and pointed out where his lab coat was hanging in a contaminated area. I called the nurse to the side and reinforced our policies.
4. I felt glad that I was there and glad that they could see their errors and were willing to comply--I worried about what happens when I'm not around.

Situation II

1. I observed a dentist with large white spots on his right arm.
2. I approached the dentist to find out what he had. He had poison ivy that was actively oozing and looked as though it could be infected.
3. I told him I'd have to check with his supervisor to see if he should be working and asked him if he felt he should be working. He said no he didn't. The supervisor sent him to the dermatologist. The area was cul-

tured and adequately covered.

4. Frustrated that a Cpt. would not have the sense to do this himself and that the Col. who knew of the problem would not have done so. I'm a Lt. Culture grew Staph Aureus.

Situation III

1. Visitors reported to nurses' station "like the sign on the door said" before entering isolation room. Nurses said "Ok wash your hands" and left it at that.
2. I followed visitors to room. Found that this was their first visit. Did not know proper way to wash hands or other procedures. Instructed visitors.
3. Instructed Cpt. & Lts. on need for confirming knowledge of visitors and teaching when necessary.
4. Worried about what happens when I'm not around.

Subject 39:

Situation I

1. It is really frustrating & upsetting to me to see a Dr. not use sterile or isolation procedure when going into an isolation room.
2. The Dr. had ordered isolation on a pt. and then when he had a procedure to do when in green steriles he just walked in--no gown or gloves.
3. I caught him at the door and asked him to put a gown & gloves on. And when I insisted he did put a gown on but no gloves.

4. Very frustrated--as we as nurses & techs are expected to gown & glove and even to do all procedures the best we can in these--even use tape & gloves.

Situation II

1. When Drs. or anyone do not change needles before sticking a pt. another time.
2. Dr. missed the vein & could not get the blood so he stuck the pt. a couple of times & did not change the needle.
3. I offered him another needle but he said it was O.K.
4. Very frustrated because & all my education of staph. & germs I know what happens or could happen & a contaminated needle especially straight into the blood stream.

Situation III

1. The I & O sheets continually get out of order & have many errors on them. We have explained to the tech's many times the importance of accurate I & O's. The nurses have to spend time straightening these out.
2. Tech's forget to write amounts down or total it wrong.
3. To explain the importance of I & O's but after the hundredth time it gets hard.
4. Angry. This is not good care for the pt.

Subject 40:

Situation I

1. A patient in uremia was to be given a stat dose of digitoxin, "IM". I read the order fast, saw the "IM"

but couldn't quite make out what it was, so went ahead and gave the med. p.o.

2. I gave the med. orally, then returned to the order book to sign it off. It was then that I realized what "IM" was. I then remembered that the patient had had an emesis earlier in the day.
3. I think my first reaction was one of fear. Not so much fear for the patient (as it should have been) but fear of what the Dr. would say.
4. I also felt somewhat anxious--wondering whether the patient would be able to retain the pill.

Situation II

1. I was working on a ward and was sent to the special nursing unit and told to special a patient who had heart surgery. I had never cared for a patient who had open heart surgery although we had it in class.
2. The evening nurse explained the equipment and actually very little was required of me all night. I found that you just have to use your head. In the morning, the doctor explained it all in detail.
3. At first, I was floored when I saw all the machinery around the patient, but after I knew what it was all about, I was OK.
4. Pretty frustrated at first.

Situation III

1. This happened when I was filling in. It involves

visitors.

2. A woman came up to me and asked, "How is my husband?" And you don't know because you didn't take care of him the day before or the day before that, so you really don't know. You have to say, "I'm new here." The visitor just looks at you as if you don't know anything. Visitors need support and this makes them apprehensive about the kind of care the patient is getting. They feel the patient is just anonymous, and he is.
3. I feel badly about not being able to give the support.
4. I feel guilty--that maybe I should have found out more about the patient.

Subject 41:

Situation I

1. We were exceptionally busy with a bunch of real "sickies". I was asked to cover the night shift because the nurse who was scheduled came into the E.R. quite sick. I had just finished (was about to) evenings. The supervisor came and asked if I would since they could find no one else to work. Reluctantly, I agreed.
2. It was pretty quiet until about 0330 when one of our real "sickies" decided to arrest on us. We called a "Code Blue" and worked feverishly on the patient until the team arrived. I was already exhausted and really not at a peak mentally. Since I was the only R.N. I had to ignore the other patients for almost two hours

while we worked on the patient. I knew I had the others to care for as well but couldn't get away to do what was necessary.

3. I was very frustrated and upset with myself because I couldn't get away, had ignored patients, who really needed attention too! I really felt inadequate, helpless, and guilty (as well as exhausted) because I was pulled two directions. I knew it was important that I saw that the other patients were just as important.
4. Frustrated, upset, guilty, helpless and exhausted.

Subject 42:

Situation I

1. I was in charge of evening shift on the ward. Two Amn. medical technicians & on L.U.N. were working with me at the time. The L.U.N. had just got her job back through Civil Service & her congressman. (My first experience working \bar{c} the L.U.N.).
2. I had to continuously look for the L.U.N., & ask her to do routine pt. care. She was either on the phone, or taking a coffee break. During the shift she asked, "Do you expect us to be constantly working? Just because you can't get a break you think we shouldn't be allowed to sit down! Well, I can't take this constant moving, because I have ulcers."
3. Very distressed & angry.
(I was so angry, I went to a back room & cried.)

4. I questioned my leadership abilities. I thought, I was expecting too much from the people I worked with. Then, I really thought about the situation & I realized that the 2 AF techs & I were doing our work as well as the L.U.N.'s tasks. I became more angry at the L.U.N. for acting unprofessional by having total disregard for the pts. & fellow workers.

Situation III

1. While working \bar{e} another nurse on the ward, she began discussing her feelings about other nurses who work with us.
 2. The nurse started talking about a fellow nurse's capabilities, & her personality. (Gossip.)
 3. uncomfortable.
 4. I felt uneasy, because the nurse expected me to agree \bar{c} her re third person. I changed the subject.
- Also, I became upset because this seems to occur quite a bit on the ward.

Subject 43:

Situation I

1. I was reprimanded for reporting off late.
2. I was passing medications when I was called to another patient's room by a tech--his suprapubic catheter had plugged and the irrigating fluid flushing the catheter had become disconnected. The nurse coming on was upset because of the "chaos".

3. I was upset.
4. I was upset because I was only one person trying to do two things at once and still get done in time for report.

Situation II

1. I was told I spent too much time passing medications.
2. A patient had 2 IV meds to be give through a heparin lock piggyback, along with a continuous IV. Upon coming into the room the piggyback was not running--the lock was blocked. Also the patient hadn't disconnected his other IV when getting in and out of bed, needing it to be reconnected and checked for flow.
3. Angry and frustrated.
4. What was I to do--the IV's needed immediate attention and the supervisor could only react by saying I spend too much time talking to patients. I like talking to the patients when I care for them--but time requires that I do my work and get it done.

Situation III

1. I was asked what I had been doing on the floor that I couldn't help with new admissions.
2. I had about 17-20 patients on my side with the usual surgical items of dressings, IV's, hemovacs, and limited self-ambulation. I was able to do 2 of the admissions, but there were 9 altogether. The supervisor and secretary were handling the desk, yet I wasn't handling enough admissions along with my regular load.

3. I was astonished.
4. I felt it wasn't good enough that I was keeping up with my patient load and was able to do an admission when I had a free moment. I thought I was doing a good job caring for the needs of my patients.

Subject 44:

Situation I

1. A patient with ascites had arrested.
2. A patient who was just admitted the day before was having rapid, shallow respirations, tachycardia, pallor & clammy hands. I called the doctor because of the presenting symptoms and the family was constantly seeking my attention. They kept telling me he looked sick and asked me to do something! CXR, CBC & ABG's were done but while awaiting results, the patient arrested in front of distraught wife & daughter.
3. I was very frustrated, pressured and frightened.
4. I felt guilty because I couldn't do much for the patient even though I called the chaplain to talk to the family before patient had arrested. He was also terminally ill (discovered on autopsy).

Situation II

1. Making appointment for a patient and asst. chief nurse saw me.
2. I was calling down for an appointment because the pa-

tient was being discharged right away. The clerk was busy with stack of orders to take off. The asst. chief nurse saw me at that particular time. She told my charge nurse to tell me that I was not supposed to do what a ward clerk did. She did not communicate that finding to me when she saw me.

3. Upset.
4. Very upset because asst. chief only saw that certain scene without finding out the circumstances. I originally had taken off the order the day before when ward clerk was ill but could not get in touch with appt. desk so I called for patient the next day and to complete my discharge teaching.

Situation III

1. A reserve administrative nurse (Lt. Col.) observed my passing medications in unit dose system.
2. On the weekend, a reserve Lt. Col. asked me if she could observe me so she could compare the unit dose system in the civilian vs. military hospitals. She observed me partially & stated for me to act as if she wasn't there. However, I explained to her what I did. Few weeks later, there was an official note informing my charge nurse that hte method of passing medications was poor. She criticized every move.
3. Very upset.
4. I felt she deceived me since she did not observe me the

whole time and she didn't understand our system of passing meds. She had also lied since she did not write a comparison report.

Subject 45:

Situation I

1. I get very angry when I finish passing medications and then five minutes later, patients request pain medication.
2. I had finished passing 1000 meds. and was on my way back to the nurses' station when the assistant chief of nurses (who frequently makes rounds of the floor) approached me and informed me that two of my patients wanted something for pain.
3. I was mad!
4. I was afraid the assistant chief nurse felt as though I was neglecting my patients. I was also angry that the patients didn't voice their complaints of pain to me.

Situation II

1. I don't enjoy nursing when I don't have a chance to talk with patients to give them emotional support instead of just medical care.
2. One of my patients was going to surgery for a colostomy. I could tell she was upset and frightened about the surgery so I gave her Valium as ordered. I was so busy (due to a staffing problem) that I didn't even get a chance to talk with the patient, to let her voice anxieties about the operation, and how her life-style

would be altered after this type of surgery.

3. I felt angry at the hospital for not having adequate staffing & felt guilty because I should have made time, somehow.
4. I felt as though I should have taken time to talk with her, but knew if I did, that my whole team would fall apart and my responsibilities would not be completed.

Situation III

1. I get very angry when a Dr. leaves orders to call him if there are certain changes in one of his patient's condition, and then when you call him, he acts like you're bothering him and that the change was so insignificant.
2. I called a Dr. because one of his patient's temp. had gone above 102°F. & he said to notify him if T 101°F. On the phone he acted like it was such a trivial problem. He told me to give the patient 650 mg tylenol suppository and not to call again unless the temp is 102°.
3. I was very mad at the Dr. for making me feel like I was bothering him (though I didn't show my anger towards the Dr. on the phone).
4. I felt as though I shouldn't have bothered the Dr., at home, for that specific problem even though that's what he ordered.

Appendix X

Subjects' Responses to Personal Data Sheets

Subject 1:

- | | |
|-------------------------------------|------------------------|
| 1. surgical unit | 6. attended internship |
| 2. >12 to 18 months ex-
perience | 7. single |
| 3. 20-24 years of age | 8. general hospital |
| 4. western area | 9. female |
| 5. caucasian/white | |

Subject 2:

- | | |
|---|----------------------|
| 1. specialty unit (oper-
ating room) | 6. no internship |
| 2. >12 to 18 months ex-
perience | 7. married |
| 3. 25-29 years of age | 8. regional hospital |
| 4. western area | 9. male |
| 5. caucasian/white | |

Subject 3:

- | | |
|---|------------------------|
| 1. specialty unit (Thoracic
-Vascular Surgery) | 6. attended internship |
| 2. 6 to 12 months ex-
perience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. western area | 9. female |
| 5. mongolian/Oriental | |

Subject 4:

- | | |
|-------------------------|------------------------|
| 1. medical unit | 6. attended internship |
| 2. >12 to 18 months ex- | 7. married |

- | | |
|-----------------------|-------------------|
| 3. 20-24 years of age | 8. medical center |
| 4. western area | 9. female |
| 5. caucasian/white | |

Subject 5:

- | | |
|-----------------------------------|------------------------|
| 1. specialty unit
(oncology) | 6. attended internship |
| 2. 6 to 12 months ex-
perience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. eastern area | 9. female |
| 5. caucasian/white | |

Subject 6:

- | | |
|-----------------------------------|---------------------|
| 1. specialty unit (OB-gyn) | 6. no internship |
| 2. 6 to 12 months ex-
perience | 7. single |
| 3. 20-24 years of age | 8. general hospital |
| 4. western area | 9. female |
| 5. caucasian/white | |

Subject 7:

- | | |
|---|------------------------|
| 1. specialty unit (Thoracic
-Vascular Surgery) | 6. attended internship |
| 2. > 12 to 18 months ex-
perience | 7. married |
| 3. 20-24 years of age | 8. medical center |
| 4. central area | 9. female |
| 5. caucasian/white | |

Subject 8:

- | | |
|---------------------------|----------------------|
| 1. surgical unit | 6. no internship |
| 2. 6-12 months experience | 7. single |
| 3. 20-24 years of age | 8. regional hospital |
| 4. eastern area | 9. female |
| 5. caucasian/white | |

Subject 9:

- | | |
|-----------------------------|------------------------|
| 1. specialty unit (ICU-CCU) | 6. attended internship |
| 2. >12-18 months experience | 7. single |
| 3. 20-24 years of age | 8. general hospital |
| 4. western area | 9. female |
| 5. caucasian/white | |

Subject 10:

- | | |
|---|------------------------|
| 1. specialty unit (Ortho-
pedic Surgery) | 6. attended internship |
| 2. > 12-18 months experience | 7. married |
| 3. 25-29 years of age | 8. medical center |
| 4. central area | 9. male |
| 5. caucasian/white | |

Subject 11:

- | | |
|---------------------------------------|------------------------|
| 1. specialty unit (Operating
room) | 6. attended internship |
| 2. 6-12 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. western area | 9. female |
| 5. caucasian/white | |

Subject 12:

- | | |
|------------------------------|------------------------|
| 1. specialty unit (Oncology) | 6. attended internship |
| 2. >12-18 months experience | 7. married |
| 3. 20-24 years of age | 8. medical center |
| 4. central area | 9. female |
| 5. caucasian/white | |

Subject 13:

- | | |
|------------------------------------|------------------------|
| 1. specialty unit (Operating Room) | 6. attended internship |
| | 7. divorced |
| 2. 6-12 months experience | 8. regional hospital |
| 3. 25-29 years of age | 9. female |
| 4. western area | |
| 5. negroid/black | |

Subject 14:

- | | |
|---------------------------|------------------------|
| 1. surgical unit | 6. attended internship |
| 2. 6-12 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. central area | 9. female |
| 5. caucasian/white | |

Subject 15:

- | | |
|----------------------------|------------------------|
| 1. specialty unit(ICU-CCU) | 6. attended internship |
| 2. 6-12 months experience | 7. single |
| 3. 20-24 years of age | 8. regional hospital |
| 4. western area | 9. female |
| 5. caucasian/white | |

Subject 16:

- | | |
|---------------------------------|-------------------|
| 1. specialty unit (Orthopedics) | 6. no internship |
| 2. > 12 to 18 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. central area | 9. female |
| 5. caucasian/white | |

Subject 17:

- | | |
|---|----------------------|
| 1. specialty unit (Psychiatric/Mental Health) | 6. no internship |
| 2. > 12-18 months experience | 7. single |
| 3. 20-24 years of age | 8. regional hospital |
| 4. central area | 9. female |
| 5. negroid/black | |

Subject 18:

- | | |
|---------------------------|------------------------|
| 1. surgical unit | 6. attended internship |
| 2. 6-12 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. eastern area | 9. female |
| 5. negroid/black | |

Subject 19:

- | | |
|---------------------------------|------------------------|
| 1. specialty unit (Orthopedics) | 6. attended internship |
| 2. 6-12 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| | 9. female |

4. eastern area
5. caucasian/white

Subject 20:

- | | |
|---------------------------|------------------------|
| 1. surgical unit | 6. attended internship |
| 2. 6-12 months experience | 7. married |
| 3. 20-24 years of age | 8. medical center |
| 4. western area | 9. female |
| 5. caucasian/white | |

Subject 21:

- | | |
|--------------------------------|------------------------|
| 1. specialty unit (Pediatrics) | 6. attended internship |
| 2. >12-18 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. eastern area | 9. female |
| 5. caucasian/white | |

Subject 22:

- | | |
|---------------------------|-------------------|
| 1. surgical unit | 6. no internship |
| 2. 6-12 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. central area | 9. female |
| 5. negroid/black | |

Subject 23:

- | | |
|-----------------------------|-------------------|
| 1. surgical unit | 6. no internship |
| 2. >12-18 months experience | 7. married |
| 3. 25-29 years of age | 8. medical center |

- | | |
|--------------------|---------|
| 4. central area | 9. male |
| 5. caucasian/white | |

Subject 24:

- | | |
|-----------------------------|----------------------|
| 1. specialty unit (OB-gyn) | 6. no internship |
| 2. >12-18 months experience | 7. single |
| 3. 20-24 years of age | 8. regional hospital |
| 4. central area | 9. female |
| 5. caucasian/white | |

Subject 25:

- | | |
|--------------------------|------------------------|
| 1. surgical unit | 6. attended internship |
| 2. < 6 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. central area | 9. female |
| 5. caucasian/white | |

Subject 26:

- | | |
|---|------------------------|
| 1. specialty unit (Thoracic
-Vascular Surgery) | 6. attended internship |
| 2. 6-12 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. central area | 9. female |
| 5. negroid/black | |

Subject 27:

- | | |
|---------------------------|---------------------|
| 1. medical unit | 6. no internship |
| 2. 6-12 months experience | 7. single |
| 3. 20-24 years of age | 8. general hospital |
| 4. eastern area | 9. female |

5. caucasian/white

Subject 28:

- | | |
|---------------------------|------------------------|
| 1. medical unit | 6. attended internship |
| 2. 6-12 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. central area | 9. female |
| 5. caucasian/white | |

Subject 29:

- | | |
|---|------------------------|
| 1. specialty unit (Thoracic
-Vascular Surgery) | 6. attended internship |
| 2. 6-12 months experience | 7. single |
| 3. 25-29 years of age | 8. medical center |
| 4. western area | 9. female |
| 5. caucasian/white | |

Subject 30:

- | | |
|--|------------------------|
| 1. specialty unit (Psychi-
atric/Mental Health) | 6. attended internship |
| 2. >12-18 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. eastern area | 9. female |
| 5. caucasian/white | |

Subject 31:

- | | |
|------------------------------|-------------------|
| 1. specialty unit (oncology) | 6. no internship |
| 2. 6-12 months experience | 7. single |
| 3. 25-29 years of age | 8. medical center |
| 4. central area | |

5. caucasian/white

Subject 32:

- | | |
|---------------------------|------------------------|
| 1. surgical unit | 6. attended internship |
| 2. 6-12 months experience | 7. single |
| 3. 25-29 years of age | 8. medical center |
| 4. central area | 9. female |
| 5. caucasian/white | |

Subject 33:

- | | |
|--|-------------------|
| 1. specialty unit (Pediatrics
-Premature Nursery) | 6. no internship |
| 2. >12-18 months experience | 7. single |
| 3. 25-29 years of age | 8. medical center |
| 4. central area | 9. female |
| 5. caucasian/white | |

Subject 34:

- | | |
|-----------------------------|------------------------|
| 1. specialty unit (OB-gyn) | 6. attended internship |
| 2. >12-18 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. eastern area | 9. female |
| 5. caucasian/white | |

Subject 35:

- | | |
|--|------------------------|
| 1. specialty unit (Psychi-
atric/Mental Health) | 6. attended internship |
| 2. < 6 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. central area | 9. male |

5. caucasian/white

Subject 36:

- | | |
|----------------------------|----------------------|
| 1. medical unit | 6. no internship |
| 2. 12-18 months experience | 7. single |
| 3. 20-24 years of age | 8. regional hospital |
| 4. central area | 9. female |
| 5. caucasian/white | |

Subject 37:

- | | |
|------------------------------|------------------------|
| 1. specialty unit (ICU-CCU) | 6. attended internship |
| 2. > 12-18 months experience | 7. single |
| 3. 20-24 years of age | 8. regional hospital |
| 4. eastern area | 9. female |
| 5. caucasian/white | |

Subject 38:

- | | |
|---|-------------------|
| 1. specialty unit (Infection
surveillance) | 6. no internship |
| 2. > 12-18 months experience | 7. divorced |
| 3. 30-34 years of age | 8. medical center |
| 4. eastern area | 9. female |
| 5. caucasian/white | |

Subject 39:

- | | |
|--|------------------------|
| 1. specialty unit (C.V. &
Thoracic Surgery) | 6. attended internship |
| 2. 6-12 months experience | 7. single |
| 3. 20-24 years of age | 8. medical center |
| 4. eastern area | 9. female |

5. caucasian/white

Subject 40:

- | | |
|------------------------------|------------------------|
| 1. medical unit | 6. attended internship |
| 2. > 12-18 months experience | 7. single |
| 3. 25-29 years of age | 8. regional hospital |
| 4. eastern area | 9. female |
| 5. caucasian/white | |

Subject 41:

- | | |
|------------------------------|----------------------|
| 1. surgical unit | 6. no internship |
| 2. > 12-18 months experience | 7. single |
| 3. 20-24 years of age | 8. regional hospital |
| 4. eastern area | 9. male |
| 5. caucasian/white | |

Subject 42:

- | | |
|-------------------------------|------------------------|
| 1. specialty unit (Pediatric) | 6. attended internship |
| 2. 6-12 months experience | 7. single |
| 3. 20-24 years of age | 8. regional hospital |
| 4. western area | 9. female |
| 5. caucasian/white | |

Subject 43:

- | | |
|---|------------------------|
| 1. specialty unit (Thoracic C.V. Surgery) | 6. attended internship |
| 2. 6-12 months experience | 7. single |
| 3. 25-29 years of age | 8. regional hospital |
| 4. western area | 9. female |

5. caucasian/white

Subject 44:

- | | |
|------------------------------|------------------------|
| 1. specialty unit (ICU-CCU) | 6. attended internship |
| 2. > 12-18 months experience | 7. single |
| 3. 20-24 years of age | 8. r-gional hospital |
| 4. western area | 9. female |
| 5. mongolian/oriental | |

Subject 45:

- | | |
|--------------------------------------|------------------------|
| 1. specialty unit (ortho-
pedics) | 6. attended internship |
| 2. > 12-18 months experience | 7. single |
| 3. 20-24 years of age | 8. regional hospital |
| 4. western area | 9. female |
| 5. caucasian/white | |

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VITA AUCTORIS

Captain (Major Selectee) Alayne L. Bartlett was born in Waukegan, Illinois on 19 January 1947. She graduated from Grant Hospital of Chicago School of Nursing in Chicago in 1968 and received her Bachelor of Science degree in nursing from The Catholic University of America in Washington, D.C. in 1975. In August, 1968 she was commissioned a Second Lieutenant and in October, 1968 she entered active duty in the United States Air Force Nurse Corp. She has served in Vietnam, Europe (including the Continent, North Africa, the Near East, the Gold Coast of Africa, Scandinavia, and the British Isles), Texas, California, Missouri, Washington, D.C., and Chicago, Illinois.

Her professional experiences have included staff nurse intensive care units, staff nurse male surgical units, instructor in medical technician training, flight nurse and medical crew director; chief, aeromedical technician training; assistant chief, flight nurse training; instructor, flight nurse training; nurse recruitment officer; chief, health professions recruiting team; and staff assistant to the recruiting squadron commander.

She has had articles published in the USAFE Command Surgeons Digest pertaining to different facets of aeromedical evacuation. She is currently a member of Sigma Theta Tau, Kappa Chapter; the American Nurses' Association, the National Critical Care Institute of Education, the American Association of Critical Care Nurses,

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