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NEGOTIATING SITUATED ROLES IN A TRANSITIONAL HEALTH CARE SYSTEM: WORK ROLES, STRUCTURAL RELATIONSHIPS, AND THE EMERGING PROFESSIONALIZATION OF NURSING IN HONG KONG

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A DISSERTATION

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degree of

DOCTOR OF PHILOSOPHY

By

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TRANSITIONAL HEALTH CARE SYSTEM:

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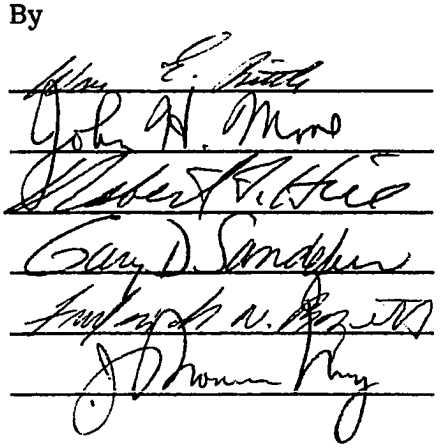
APPROVED FOR THE DEPARTMENT OF ANTHROPOLOGY

By



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PREFACE

This study of the work and identity of Hong Kong nurses grew out of an initial interest in the work roles of women in developing societies, and those of minority women in developed societies. For some time before preparation for my dissertation began, I was concerned with the relationship between work and family roles, and with examining the nature of the structural determinants and perceptual correlates of these roles from a comparative perspective. The opportunity to explore these factors as they related to job satisfaction and aspirations of women in a developing society arose when I accompanied my husband to Hong Kong for his doctoral research in sociology. From 1976-1978, while his study of the changing urban system and the interaction between governmental reform efforts and increasing bureaucratization, and negotiations by various groups and agencies, was developing, I became more familiar with the Hong Kong setting. As the local market placed more value on English teachers than anthropologists, I became a full-time lecturer in English to both college and evening-school Chinese students. The majority of these were either working or diligently searching for the best "prospect" - their term for "career opportunity" - they could achieve. Their enrollment in a private school struggling to upgrade its status by gaining increased recognition from the government brought into focus the competitive aspects of education as preparation for careers in Hong Kong.

The choice of nurses as an occupational group to investigate was influenced by the involvement of the Hong Kong health-care system in the movement toward

administrative reform in the British colony, with its ties to similar movements in the United Kingdom. Our initial study of nurses was designed to compare those in several hospitals, both private and government-sponsored, to determine the effects of specific organizational environments on attitudes toward work roles and perceptions of identity. The position of each hospital in the changing health-care system, which was undergoing integration, was to be a significant environmental determinant. With the help of sociology students at the school where my husband and I taught, a questionnaire was constructed, translated into Chinese, and given to nurses in these hospitals. From these, the sample of nurses in the hospital participating in the Kwun Tong Health Project (community health care) was selected for my dissertation analysis. This project had attracted the interest of local health professionals and the Hong Kong government, as well as that of Western social scientists. Its experimental nature gave the nursing personnel involved a community-health orientation rather unusual in Hong Kong, and brought new opportunities in nursing to their awareness.

Thus, by selecting nurses from a particular hospital as the sample of workers whose perceptions would form the basis of my dissertation, I came to focus on a specific professionalizing group. My original concern with women's work per se shifted to one with intra-occupational differences in attitudes of workers trying to achieve professional identity. This was partly a result of my growing understanding of the hierarchical structure of nursing itself through study of the field, and of the related perceptions of nurses reflected in the data. My knowledge of what professionalization meant to nurses in different positions and with varying educational backgrounds was later amplified by my association from 1979-1980 with Registered Nurses, Licensed Practical Nurses, nurses aides, and phlebotomists who had taken nurses aide training, through my work in admissions

and inservice education in an Oklahoma City hospital.

The shift in perspective from the macroscopic level of the sexual division of labor and corresponding roles, to specific work roles and positions within particular occupational settings, was also influenced by the Chinese women in other occupations whom I met in Hong Kong. Those with whom I talked informally occupied the roles of student, teacher, social worker, factory worker, secretary, pharmacist, accountant, immigration official, air-traffic controller, lawyer, conductor of a Chinese cooking school and television personality, bakery manager, and housewife and mother. I also observed women working as market vendors, trash collectors, night-club singers, construction workers, hawkers, salesgirls, waitresses, dim-sum (Chinese snack) sellers in tea houses, amahs (maids), and vegetable cultivators. Although I could not converse with these women in their native Cantonese or other Chinese languages or dialects, the variety of their occupational roles contributed to an impressionistic background against which to place the nurses I was studying. Also, for most of the women I met, feminism was not an issue. Several female students assured me that, "Here in Hong Kong, men and women are equal", with respect to job prospects.

All of this is not to deny that many jobs in Hong Kong and elsewhere are sex-typed, or to minimize the significance of the fact that the international field of nursing today is predominantly female, with the exception of some Moslem, African, and Asian countries (Glaser, 1970). Undeniably, Marxist and feminist anthropological and sociological perspectives of the relationship between capitalism and change in sexual division of labor are relevant to the field of nursing. Certainly, the society in which my respondents live and work - Hong Kong - is one whose capitalism has drawn the praise of conservative economists (such as Milton Friedman), although the division of labor along sexual lines in

Hong Kong differs from that in the Unived States or the United Kingdom. Yet my primary concern has been to reveal the internal structure of an occupational group, and the ways in which this is related to perceptual differences of work roles and professional commitment.

In my research and analysis, theory and methodology have been fitted to problem, using an interdisciplinary approach to both concepts and techniques. My perspective is that of extending the broad vision of anthropology to in-depth analysis of structural and perceptual differences within a social group. This group, although part of a unique culture, is more similar to than different from groups in other nations with which it forms a professionalizing occupation. I have drawn on both sociology and psychology, and other fields such as organizational studies, as needed, rather than considering them irrelevant, as did the Hong Kong student who referred to sociology as "some simple words from the 19th century".

It is informative to consider the reactions of both nurses and anthropologists in the United States to this dissertation. The latter have often responded by asking if I am a nurse, indicating an assumption that nurses are usually studied by members of their own occupation. Those in the nursing profession have shown interest in the results of the survey of Hong Kong nurses, with nurses in the positions of educators stressing the importance of framing the research in terms of defining nursing as a profession. The latter reflect professional rhetoric, a result of concern over autonomy of nurses - a theme of many editorials in nursing journals and an influence on selection of topics for research by nurses. British and Hong Kong nurses also express concern over the best means of upgrading their occupation, in debates over issues such as whether nurses should ally themselves with certain unions, as well as in topics of articles published.

Research by nurses has provided valuable insights into their occupation;

anthropologists can complement these by comparing nurses in different positions, work settings, and health-care systems, as Foster and Anderson have suggested (1978). Thus the reason for applying the anthropological perspective is related both to scientific objectivity and anthropological inquiry. In comparing workers in various situations and societies, our understanding of the meaning of work and professionalization is heightened, and our vision of our field made wider.

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CHAPTER I - INTRODUCTION

The Research Problem and Perspective

Introduction

This dissertation is an exploration of the meaning of work and occupational identity to members of an international "profession", nursing, employed in a bureaucratic organization (hospital) within an increasingly bureaucratized society and health-care system - that of Hong Kong. The central problem is the explication of the ways in which the nurses' varying occupational roles, positions, and power, and their perceptions of their occupational environment and professional identity, determine their satisfaction with their work roles and situation. I have related their own perceptions of the values and status assigned by their colleagues and society, and their professional commitment, to their satisfaction with their work environment, relationships, rewards, and opportunities.

In context, the general problem is to examine individuals' attitudes toward their occupation, in an organization and society undergoing social change. This change encompases processes of development and modernization as well as programs for political and administrative change, with attendant consequences for the health care system and its employees.

The purpose of obtaining data on attitudes from a different culture is twofold (Davidson and Thomson, 1980): (1) to establish boundary conditions for attitudinal models and theories, and to test and revise or improve a model or

hypothesis previously supported for another cultural group; (2) to study the effects of cultural and ecological factors on behavior. This dissertation attempts to test both the model of negotiated order and hypotheses of the effects of organizational and occupational structure and change on individuals' attitudes. It is thus an effort to establish the boundary conditions for this model, and these hypotheses, and to revise or improve them as necessary. The dissertation is also an exploration of the effects of environmental change on attitudes which are assumed to affect behavior, with emphasis on social "ecological" rather than cultural factors.

Therefore, the cross-national framework is fundamental. Hypotheses based on studies of occupations and organizations in developed societies, such as the United States and Great Britain, have been employed to collect and analyze data and determine specific ecological influences on attitudes in the Hong Kong setting. The development of the occupation of nursing in Hong Kong has similarities to its development in both the United States and Britain, but its specific characteristics and social context are unique.

Thus, while occupations and organizations vary across societies, there is sufficient commonality of structure, social processes, and individual experiences to make comparisons both possible and useful. While not adopting his modernization thesis in toto, I have assumed with Inkeles (1960), that individuals in every society undergo experiences, develop attitudes, and form values in response to the pressures of their social environment. Specifically, the occupational structure produces a particular structure of experience, attitude, and value such that occupational groups respond distinctively to their environment, according to their situation. In addition to this intra-societal patterned variation in "collective social perception and action" on the level of the

occupational group (Inkeles, 1960, p. 1), and inter-society variation of similar groups, there is also individual variation within groups. The dissertation explores the relationship between the structure of experience for occupational segments within nursing, and individual attitudes and values.

Theoretical Issues

The basic theoretical issue is that of how individuals perceive, make sense of, and negotiate their way through an ambiguous, transitional status system. Related questions are:

(1) Do individuals passively adapt to social change, or do they participate actively and selectively?

(2) Under what conditions do individuals perceive change as threatening?

(3) Under what conditions do they perceive change as offering opportunities to negotiate their structural positions and enhance their roles?

(4) What is the relationship of one's structural position in an organization and occupation to one's perception of change?

(5) What is the relationship of one's occupational and organizational position to perception of one's work roles and professional identity?

(6) What is the relationship of personal environmental factors such as family roles to perception of one's work roles and professional identity?

The underlying theoretical problem is that of how changes in structural conditions are related to individuals' awareness, perceptions, and negotiations of their roles and positions (Strauss, 1978). In reality, this relationship is reciprocal: structural changes both affect, and are affected by, the negative perceptions, dispositions to act, and deliberate actions of individuals.

From the viewpoint of the individual, the social and organizational environment is "enacted", in interdependence with the other participants in the society and organization (Weick, 1969). From the viewpoint of the organization, the concept of "structure in process" (Strauss, 1978, p. 258) succinctly denotes the reciprocal relationship of the organization and the individual. "Structure in process" describes the structure of particular institutional organizations, such as hospitals. At a broader level, society itself is actually a "structure in process", both changing and being changed by individuals and organizations.

The nature of the process here referred to involves the interaction of a number of participants with different roles and positions, acting in accordance with their various perceptions of the structure of their environment, as well as their personal goals and aspirations. The research respondents in this dissertation are also members of a society, an occupation, and an organization which are all undergoing both planned and unanticipated change. Therefore, they are in an ambiguous situation. The ways in which they perceive that situation, and the relationship of these perceptions to their occupational and organizational positions, is the focus of the dissertation.

For the sake of simplicity in analysis, the reciprocal relationship between organizational and occupational structure, and individuals' perceptions and negotiations, has been treated in a linear fashion. That is, the analysis assumes that structure affects perceptions. However, the primary focus is on the ways in which differential perceptions of structure mediate attitudes toward work roles and the work situation. Specifically, the relationship of individuals' perceptions of the status of their occupation and their commitment to it, and the meaning they attach to their work roles and situation, are analyzed.

These perceptions and meanings are interpreted as responses to ambiguity

and as reflections of the differences in role-sets and power of persons in different structural positions. In other words, response to the work situation as frustrating or threatening, or as satisfying and filled with opportunity, is to be explained in terms of the relationship between the individual's cognition and aspirations, on the one hand, and position, power, and role-set, on the other.

The dissertation examines this relationship in a developing society. The data are from a survey done in 1978 on nurses in a government-assisted hospital in the industrial town of Kwun Tong, within the British colony of Hong Kong.

The rationale for analysis of individual perceptions has been summarized recently by the social anthropologist Fredrik Barth: "Since social acts are...not simply 'caused' but 'intended', we must consider these intentions and understandings of actors if we wish to capture the essential contexts of acts" (1981, p. 3). Anthropologists should focus on the "...subjective and goal-pursuing individual actor" (p. 2): his resources and assets, commitments and interests, significant others, and "...environmental and communicative options" (p. 12). This means considering the significance of both value and utility in accounting for variations in human behavior. Since most of the phenomena that social anthropologists study are molded by human consciousness and purpose, this perspective should be integrated into our theoretical systems, including that of structural anthropology. People's "...conceptualization of their social and physical environment seen as an opportunity situation for action..." (p. 5) differs fundamentally from their macro-level generalizations about society which structural anthropologists have abstracted as norms and systems of thought. It is not necessary to elaborate here on the different perspectives on structure taken by social anthropologists and sociologists. The significant point is that understanding individual perceptions in particular social contexts is both a valid

and an essential endeavor in anthropological research.

A similar goal is emerging in both interactional psychology and psychological anthropology: that of understanding the relationship between persons and situations, or the contextualization of behavior (Howard, 1982). This interactionist perspective is also linked to the study of intracultural diversity: culture acquires the meaning of the organization of experience around situations, whether by individuals, or groups of two or more persons. The approach assumes a dynamic formulation of personality that includes both cognitive and affective components, in order to explain the interaction between person and situation. It thus

> ...dramatizes the limitations of ignoring either psychological or ecological determinants of behavior, and challenges anthropology to develop a more genuinely holistic framework for understanding both human nature and human variation.
>
> (Howard, 1982, p. 53)

Methods of Data Collection and Analysis

Data Collection

The study was designed to obtain measures of differences in attitudes among all individuals within a specific national, occupational, and organizational setting. For this reason, and because of the need to obtain data on the Hong Kong sample which could be compared in the future with data on samples of nurses in other hospitals and national systems, the questionnaire survey was used. This technique was also most efficient for obtaining information from a large number of respondents in their native language. Closed-ended questions could be translated into Chinese, and answer choices marked, then interpreted as they corresponded to the English version of the questionnaire. The voluntary comments which some respondents added in Chinese were also translated into English.

The questionnaire was given to nurses in the United Christian Hospital in the industrial town of Kwun Tong, Hong Kong, in 1978, through the assistance of the Director of Nursing Service. A sample of 212 respondents was obtained. Husbands of married nurses were also surveyed.

Questions were designed to collect basic information on age, education, marital status, number of children, income, nursing credentials (non-licensed, Licensed, or Registered Nurse), and previous work experience. The major portion of the questionnaire solicited information on nursing unit, shift, work roles and statuses, job tasks, and attitudes toward the work situation and occupation, and the health care system. These are discussed under the section on goals of the survey.

Data Analysis

The data were analyzed by means of computer, because of the sample size, and the need to measure the strength of relationships among a number of different variables. Preliminary data analysis was carried out using the Chi-square test for statistical significance of relationships between sets of two variables, according to initial hypotheses.

After examination of these relationships as indicated in the Chi-square tables, a path model was used for regression analysis of the relationship of both objective and subjective variables to nurses' satisfaction with work conditions and relationships, and the meaning of work. For variables in the model that were measured by two or more questions, scales were constructed and tested by means of factor analysis. Using the validated scales, multiple regression analysis was carried out to test hypotheses of the relationships among objective and subjective status of nurses, professional commitment, and satisfaction with work conditions,

relationships, and meaning of work. The model and statistical techniques will be further explained in the following section and in the chapter on methods of data collection and analysis.

The Survey and Perspective of Analysis

Goals of the Survey

The specific goals of the survey were: to examine the relationship of selected aspects of the occupation of nursing in Hong Kong, and of the organization, functioning, and community health care program of the United Christian Hospital, to the attitudes of nurses toward their occupation. As related to the structure of the occupation of nursing in the hospital setting, the problem was to determine the ways and the extent to which the stratified organizational hierarchy of authority and technical skills influenced attitudes of the incumbents of different roles and positions (Inkeles, 1960).

Thus the survey was initially designed to explore nurses' attitudes in terms of structural variables of the hospital organization and its environment, the health care system, and to assess the influence of the role-set of work and family responsibilities. The nurses' satisfaction with their work conditions and relationships, the meaning of work to them, and their perceptions of their occupation and professional commitment were considered dependent on the following variables:

(1) the hospital's organization of tasks by nurses' positions, wards, work schedules (shifts), and authority and peer relations in the work setting;

(2) the relative primacy of work or family roles to nurses, as measured by their responses and those of their husbands to questions on the significance of work versus family, and marital satisfaction and division

of labor, where relevant;

(3) proposed changes in Hong Kong's health care system toward greater emphasis on medical or preventive health care, and the Kwun Tong Health Project (community health) of United Christian Hospital.

The study design placed emphasis on objective determinants of the nurses' subjective perceptions, including aspects of the health care system, the hospital organization, and the job itself. These, along with family responsibilities and the priority assigned to them, were hypothesized to be the major specific determinants of job satisfaction - or, more broadly, attachment to work.

Steps and Perspective of Analysis

Preliminary data analysis using the Chi-square test for statistical significance of the relationship between each set of two variables was done to measure the strength of the relationships between independent and dependent variables. The results indicated more variation in attitudes by nursing credentials and occupational status than by variables of the hospital's organization of tasks, wards, and work schedules, or by family variables. Variation in attitudes toward the proposed changes in the health care system and the community health care project of their hospital also appeared to be related to nursing credentials and occupational status.

At this point it was necessary to return to more basic hypotheses of the relationship between occupational status and attitudes, and of professionalization and specialization in a developing society. The structural context of nurses' attitudes toward their occupation in a situation of social change is briefly outlined here, and further described in the section on the research setting.

Professionalization of nurses is developing within the context of the

changing urban system of Hong Kong, of which its health care system is part. The urban system in general and the health care system in particular are undergoing change toward corporate management. A result of the change toward bureaucratic medicine is that hospital organizations and health care are becoming dominated by administrators as well as physicians.

A related general result of the above changes, common in the United States, is that competition tends to increase both between physicians and nurses, and among nurses with different credentials and positions - Licensed Practical and Registered Nurses, in the United States hospital organization. Within the occupation of nursing, as a consequence of the increasing trend toward professionalization to negotiate the status of nurses with respect to physicians and administrators, certain segments may attempt to supersede others. For example, Registered Nurses may attempt to secure their superior position over Licensed Practical Nurses. However, the degree of competition, and the particular forms that efforts to secure positions take, vary with the organization of each health care system and its occupations.

In the Hong Kong hospital organization, as in United States hospitals, Registered Nurses have more authority and prestige than Licensed (Enrolled) Nurses, however, the degree of task specialization is not great. All of the nurses in this sample were either Registered or Licensed (Enrolled). The following propositions are applicable to individuals within these segments:

(1) Registered Nurses tend to have higher professional commitment than Licensed Nurses.

(2) Registered Nurses tend to have a higher perception of their status than Licensed Nurses.

(3) Registered Nurses tend to have a higher general level of job

satisfaction than Licensed Nurses.

(4) Registered Nurses are more frustrated in attempts to further increase their status than are Licensed Nurses, since they have reached the point at which upward mobility is limited by the dominance of physicians. This frustration may have a negative effect on the job satisfaction of Registered Nurses.

(5) Licensed Nurses tend to have a more positive attitude toward community health care than Registered Nurses, since work in the community offers Licensed Nurses more autonomy than work in the hospital setting.

Proposition five was analyzed by means of Chi-square tests of statistical significance of the responses of Licensed and Registered Nurses to relevant questions. Since it dealt with a different set of variables from those in propositions one through four, it was not included in the causal model.

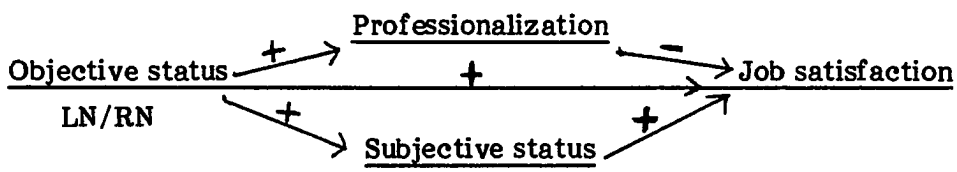
Propositions one, two, three, and four have been incorporated into hypotheses in the causal model for regression analysis. The focus of this analysis, as contrasted with the Chi-square tests, places more emphasis on the relationship between occupational status and position and perceived status, and on the significance of psychological processes in mediating the effects of both occupational and organizational structure. It is more concerned with individuals' responses to their occupation and opportunities, than with responses to the organization of tasks in the hospital. The following sets of variables, hypothesized as interrelated and depicted in the causal model, were examined in the regression analysis:

(1) Objective, structural characteristics of the occupation of nursing. These are related to a nurse's position in the hospital organization,

basically defined by nursing credentials and status (Licensed and Registered Nurses). The relationship of the two segments of nurses to one another, and to physicians, is affected by the structure of the occupation.

(2) Subjective factors, as reflected in nurses' perceptions of their jobs and the occupation of nursing. These include: perception of the professional status of nursing, as a whole; professional commitment; satisfaction with work conditions, relationships, and the meaning of work, considered as components of job satisfaction.

The relationships among these variables are summarized in the causal model, as follows:



Thus, the central problem of this dissertation is the explanation of the differential attitudes and perceptions of nurses toward their occupation. The context of these attitudes is both organizational, since the nurses carry out their work roles in relation to the hospital organization, and societal, since the development of Hong Kong society and increasing bureaucratization affect the health-care system and health professions and occupations. However, within this context, individuals respond differently to both structural position and change in their occupation and organization. It is the explanation of these differences which is the central concern of this analysis.

As a result of the regression analysis, the importance of subjective

determinants of the nurses' attitudes toward their work was strengthened. The results support the conclusion that both subjective and objective determinants must be examined. Their relative contributions are best assessed by means of multiple regression techniques, and the contribution of each is shown in the path model, discussed in the chapter on results.

Although the majority of survey research on job satisfaction has tended to focus on objective determinants, particularly job characteristics, these leave a large portion of the variance unexplained. As Gutek states (1980, p. 523):

> Social psychologists have theorized that subjective satisfaction is not only responsive to objective features of an individual's environment; it is also a function of intrapsychic mechanisms aroused in that environment.

These may include feelings of control, expectation or comparison level, and aspiration level. That is, an individual's perception of his or her current role and status relative to those of others in the occupation and work environment, as well as her amount of autonomy and potential for negotiating increased rewards and prestige, must be taken into account.

Within the hospital organization and the occupation of nursing, the positions and power of nurses in relation both to one another and to physicians constitute crucial influences on their perceptions of work roles, and occupational and professional identity. Members of each of the two status groups, or segments - Registered and Licensed Nurses - very in their attitudes toward the meaning of work and their occupational commitment and expectations. Here the "meaning of work" is conceived as composed of degree of involvement, satisfaction with work roles, and self-identity. Occupational commitment and expectations are related to professionalization. Peer and authority relations reflect individuals' perceptions of themselves and their status group with respect to members of the other status group of nurses, as well as to physicians.

In my focus on the influence of role and status differentiation on attitudes within an occupational group, I have drawn on both psychological and sociological perspectives, as have other anthropologists who have studied intracultural diversity (Thompson and Roper, 1980). My emphasis is on the significance of both objective and perceived status, and their relationship to perceptions of work roles, work relations, power and prestige within both the organization and the occupation, occupational commitment and career aspirations.

To make possible the comparison of this sample of workers with others in their occupation, I have combined concepts and theories from the sociology of work and professions (Perrow, 1965, 1967, 1972; Coser, 1958, 1979; Johnson, 1972; Larson, 1979), and from organizational analysis and the social psychology of organizations (Strauss, et al, 1963; Weick, 1969; Oldham and Hackman, 1981) both to formulate questions and interpret responses.

In conceptualizing the relationships of nurses to their occupation and organization, I have assumed that the following factors are interrelated: structural characteristics of the organization, such as the number of levels, formalization, and centralization (Oldham and Hackman, 1981), and technology and authority relations (Perrow, 1965); membership at different levels in an occupation attempting to become a profession; and individual responses of workers to their occupational positions and identity, including attempts to make sense of and negotiate change in this identity. Briefly stated, membership in an organization and a professionalizing occupation has both direct and indirect effects on work roles and status, and individual responses.

In the analysis, the emphasis on perceptual differences between two status groups of nurses in the hospital studied suggests that negotiation between groups follows a conflict model. This is also suggested by the professionalization

literature, which is reviewed briefly in the chapter on alternative perspectives. However, a more complex model is more applicable to the situation from which my data is drawn: that of concord, or "minimal bases of consensus" arrived at as a result of negotiation (Strauss, 1964, p. 14). Although my analysis deals primarily with individual attitudes as influenced by status differences, and is not a direct study of negotiation between groups, the concord model fits the organizational and occupational context of these respondents.

As Strauss has said (1964, p. 14):

> We needed a model that would permit us to focus upon both cooperative and conflicting actions; rational and non-rational actions; structured and emergent behavior; ....intra-individual action and its relation to organizational action; total and partial institutional commitment; intra-organizational and extra-organizational pressures; 'social organization' and 'social process'.

While the data and analysis in this dissertation are reflections of values and attitudes rather than actions, the concord model presented above encapsulates the context of and influences on these attitudes, which are predispositions to actions. Cooperation and conflict, structured and emergent attitudes, total and partial commitment, intra- and extra-organizational reference points and pressures are revealed in the perceptions of individuals. The extent to which their career aspirations are "rational", or related to deliberate planning, will be further discussed in the section on alternative perspectives. The anthropological assumption I have made is that their attitudes are rational from their perspective, even though they may be considered "non-rational" from the viewpoint of organizational efficiency and productivity.

Most fundamentally, the relationship of "social organization" to "social process" is crucial in understanding the relationship of the individual to the organization and occupation. The individual "enacts" his or her own environment,

and it is through the interaction of individuals that the organization, and the occupation itself, are "enacted" (Weick, 1969) - given meaning and form. In the process of enactment, the worker exercises choice, albeit under the constraints of the environment which include choices made by others. Individual choice occurs in sense-making and decision-making, and in voluntary action.

Dubin, et al (1976, p. 285) have proposed a "law" of the individual's attachment to work: "attachment is made to those parts of the social environment in which choices for personal action exist", whether in an institution, an industry, the locale, work group, or equipment. This dissertation adds the occupation or profession as a significant part of this environment. With this addition, we can then examine "linkages between persons and their work" which "center upon those aspects of the work environment...in which some voluntarism exists...." (Dubin, et al, 1976, p. 285).

The hypotheses with which my survey began assumed that individuals may, and usually do, have multiple attachments to work. The findings tend to confirm this, and to underscore the view of Dubin, et al (1976) that the working man or woman is a whole person, simultaneously economic, psychological and sociological. Therefore, attachment to work must be explained in terms of the interaction of these motives.

This approach is flexible enough to accommodate cross-cultural variation. It must be remembered, as Simonetti and Weitz have concluded in their cross-cultural study of job satisfaction (1972), that blanket application of American job satisfaction theory such as the psychological theories of Maslow (1954) and Herzberg (1959) is inappropriate. Concepts and dynamics of such theory must be modified to reflect the context of work in specific national, occupational, and organizational settings. Through viewing occupations and organizations in their

societal perspectives, those dimensions which have corollaries in other national settings can be separated from those unique to a specific locale (Child, 1981). Although my focus is on the former, both parts of the picture must be included. Hong Kong's health and medical care system must be treated as similar to, but not an exact duplicate of, other modern medical systems.

The Problem in the Research Setting

In the words of Arensberg, "...workplaces (are)...dramas of human relations, clashes of motives, adjustments of interests to larger institutional pressures and in wider economic and technical trends. They can also be considered ...stages of...dramas of contact, power and pressure, and change" (1978, p. 53), particularly in the context of development. In keeping with the anthropological imagination, the social and historical context of the workplace must be constantly borne in mind, since it sets the stage for the dramas within which workers play and negotiate their roles and positions.

To understand the context within which the roles of Hong Kong nurses are changing, it must be recognized that this is not a traditional society in the anthropological sense, but a new, rapidly transforming city-state, encompassing land leased to its colonial government by China. The population of about five million inhabits a land area of 143 square kilometers, and is continually swelled by illegal immigrants from China. The number of urban residents has undergone a recent surge due to the influx of refugees from Southeast Asia. In general, Hong Kong's government is attempting to increase its centralization, while simultaneously developing "new towns" to accommodate its overcrowded populace in suburban regions. The industrial town of Kwun Tong, situated near a former quarry area on the southeastern quadrant of the New Territories, separated by a

bay from Kowloon to the west and from Hong Kong Island to the south (Hayes, 1977), has grown to approximately 650,000 inhabitants (Paterson, 1978). This is the area most directly served by the United Christian Hospital and the Kwun Tong Health Project, whose first center opened in 1972, one year prior to the opening of the hospital (Paterson, 1978; Gray, 1974).

Within the scenario of new town development, the Hong Kong government is building up its integration of, and control over, the health and medical care system, so that some private hospitals are losing their autonomy or are under constraint to rationalize their administrations. An attempt is underway to create an integrated, hierarchical system of hospitals in which all of Hong Kong's regions are served and duplication of services is minimized. This contrasts with the previous system which was dominated by the private sector, with a minimum of government involvement - the environment in which the United Christian Hospital was established. The current program of health-care reform also parallels transformations occurring in other sectors of Hong Kong government, such as social welfare and education, as well as administrative reforms attempted in England. Although the nature of Hong Kong as a Chinese society distinguished by its colonial status under British administration is not sufficient to explain the attitudes of nurses working within it, it is necessary to consider the implications of changes in its administrative system (Lurie, G., forthcoming PhD. dissertation) for the occupation of nursing. I have viewed these changes as important background variables affecting both the positions and attitudes of nurses, and as the arena within which they are carrying out and negotiating their roles and occupational identity.

While traditional Chinese medicine exists in Hong Kong and is viable, ranging from the services of bone-setters and acupuncturists to the widespread

use of herbal medicines, it nonetheless plays a relatively minor role in the treatment of serious illness for the majority of the population. Due to the inexpensive cost and standardized quality of "Western" medicine, and its promotion through licensing of Western-trained physicians and nurses and construction of hospital and clinic facilities, virtually the entire population makes use of this system. Even though Hong Kong contains parallel medical systems, and the licensing of doctors who practice Chinese medicine is a political issue (Lee, 1975), the Western system is dominant over the Chinese in terms of government support and of utilization by patients. Although over 90% of the population is Chinese, Hong Kong's official health and medical care model is not that of China. As in economics, it is tied both to Britain and to the United States, and operates within an international arena of modern or "cosmopolitan" (Lock, 1980) medicine.

The implementation of reforms in the delivery of health care in Hong Kong has important consequences for the organization of work roles and professionalization of those who provide that care. It also affects their perceptions of these roles and career opportunities. This has been suggested by comparative anthropological, sociological, and medical research on health care systems in developing countries, but remains relatively unexplored in contrast with emphasis on the consequences of changes in health-care delivery and practitioners for patients (Taylor, 1973; Janzen, 1978, 1979; Dunn and Good, 1978; Unschuld, 1976, 1979; Ugalde, 1979; Rifkin, 1981; Lock, 1980a and b; Kleinman, 1978, 1980). However, as such comparative research makes clear, the varying roles, statuses, and attitudes of health and medical personnel cannot be completely understood apart from the social and political context by which they are shaped, and which they in turn help to form.

As members of an international professionalizing occupation, nurses in various countries are becoming increasingly aware of their professional roles and statuses. Nursing in Hong Kong is tied to its parent profession, that of British nurses, and is influenced by both Hong Kong and British governmental efforts toward reorganization of the health and medical system, and occupational mobility. Hong Kong nurses are also negotiating their own positions in relation to those of workers in other occupations and professions in Hong Kong and Britain, as evidenced by their participation in a strike in 1971 (Far Eastern Economic Review Yearbook, 1972), and subsequent attempts of the Hong Kong Nurses' Association to dissociate itself from trade unions and strikes (Iu, 1980). The context of this effort to professionalize is not limited to influences from Commonwealth countries. Comparison with the nursing profession in the United States, while largely suggestive here, is justified on the basis of both historical and contemporary connections with nursing in this country, and on the basis of similarities in the socioeconomic environments in which United States and Hong Kong nurses work.

Nursing in Hong Kong is derived from, and undergoing reorganization parallel to, that of nurses in the United Kingdom. However, it exists within a capitalistic context, and there is no Hong Kong National Health Service. In these respects the environment is similar to that of nursing in the United States, and to that of Taiwan, a capitalistic Chinese society whose parallel medical systems are also dominated by the official Western, or cosmopolitan or international scientific, model (Unschuld, in Taylor, 1973, 1979; Kleinman, 1980). Yet both Hong Kong's organization and means of delivery of health and medical services, with access afforded to the majority of patients, resemble Britain's system, in contrast with that of Taiwan which is more similar to the United States.

Nurses' training in Hong Kong is patterned after, and often supplemented directly by, British nurses' training. The majority of nurses are still trained in hospitals, rather than in colleges and junior colleges as in the United States. Licensed Nurses, Hong Kong's equivalent of England's State Enrolled Nurses, are subordinate to Registered Nurses but are relatively more numerous than the latter. This is another important difference from the United States, where Licensed Practical and Vocational Nurses are viewed as an "endangered species" (Wright, et al, in Millman, 1978). Since Licensed Nurses constitute a majority of nursing personnel in both Hong Kong and Britain, comparison of their attitudes with those of Registered Nurses is essential.

The relative position of Hong Kong nurses, as compared to that of workers in other occupations, does differ somewhat from that of British nurses. As in the United States, Hong Kong nurses are predominantly female, with the exception of a few male nurses who were formerly "barefoot doctors" in China (Topley, in Taylor, 1973). In the United Kingdom, males have a numerically minor but occupationally significant role in nursing, often advancing to administrative positions. Nurses represent a relatively cohesive subset of working women in Hong Kong society. As contrasted with recent research on Hong Kong working girls (Salaff, 1981) which emphasized their use of work to negotiate new roles and life-styles while remaining tied to their families of origin in a "centripetal" family structure, I have investigated more specifically the meaning of work to a professionalizing group of women. The perceptions by nurses of their status relative both to one another and to workers in other occupations is a problem which has emerged as a key one in my study.

In the Hong Kong research setting, an aspect of professional commitment is variation in nurses' involvement in community health care. Community health

care is sponsored by individual hospitals such as the United Christian Hospital, and by charitable organizations, with government assistance. At times it functions as an alternative to hospital admission, particularly for elderly patients with chronic illnesses or disabilities (Gray, 1974), and is important in providing follow-up care for surgical and obstetrical patients. Both the hospital nurse's position within her occupation, and her perceived role in the hospital organization, affect her involvement in and attitudes toward community health care. In turn, her orientation toward the health and medical system reflects part of her professional commitment, and her perception of work opportunities in the hospital environment.

To nurses in the United States, Hong Kong may appear to be an exotic context in which to explore attitudes toward work roles and professional identity. However, its importance lies in its illustration of the significance of social and institutional structures and processes for attitude formation. Rather than attempting to explain particular attitudes as deriving from unique, culturally-defined roles, I have conceived of them in relation to the specific organizational and occupational system in which they occur.

Use of the phrase "professionalizing occupation" in the above discussion has been made in order to avoid the issue of whether nursing in Hong Kong, or in Britain or the United States, is a profession. As discussed further in the chapter on alternative perspectives, this is matter of current debate and is related to nurses' attempts to upgrade their status and increase their autonomy with respect to physicians (Schorr, 1981; Sleicher, 1981). In the United States, this is related to the movement to dichotomize nurses by education, into "professional" (baccalaureate degreed) and "technical" (associate degreed) nurses, with assistants trained in vocational institutions (Nahm, 1981). Whether nursing possesses a

unique body of knowledge, tied to a unique theoretical base, and a unique set of skills which distinguish it from the medical and allied health professions, is being weighed in relation to its power to control and negotiate its own occupational boundaries. These questions also appear in British nursing journals, and are an inevitable influence on perceptions of Hong Kong nurses as evidenced by official formulations of their identity (Iu, 1980).

Thus, the debate over the nature of nursing as an occupation is related to its attempt to forge a solid professional status, although this is perhaps most intense in the United States and Canada (Baumgart, 1980; Larsen, 1980). However, my purpose is not to determine whether or not nursing in Hong Kong is a profession. My goal is to examine the differences in attitudes toward occupational and professional identity among nurses in different positions, and to explore the relationship of individual perceptions and aspirations to social and structural change.

Conclusion: The Problem in Broader Context

This study of nurses' attitudes is approached as a significant problem from the viewpoint of the aspirations and needs of workers. It is not immediately concerned with contributing to enhanced organizational efficiency or productivity - delivery of health services. Rather, it is part of a broader goal, to understand the attachment to work for members of specific groups. The importance of this is clear when seen in the light of current trends in occupations and organizations that pose contrasting alternatives, providing various degrees and types of choice for workers.

These alternatives have been summarized as they relate to research on changes in working life (Shimmin, in Duncan, et al 1980). They include the

following: greater automation and specialization in tasks and jobs; greater organizational control; increase in the amount of worker participation in organizations in which they are employed; increase in workers' participation in occupational and professional groups, as a result both of the expansion of education and opportunities, and of the disparity between expectations and actual work situations. A more basic recent trend which may be approaching its limits is that toward increased emphasis on consumerism and in the view of work primarily as a means of achieving more leisure and material possessions. All of these trends have effects on, and are contributed to by, nurses employed in hospitals, as well as other types of workers.

With these occupational and organizational trends, there is a concurrent need to determine whether attitudes toward work are changing - and, if so, whether such change is characteristic of all workers, in all settings, or only of members of certain groups. It is in this context that research on categories of nurses other than Registered Nurses, and cross-national research, are necessary. By delineating and contrasting the attitudes of nurses in this Hong Kong sample, I have provided a base for comparison with attitudes of workers at other times and in other places, as well as in other occupational situations.

Outline of Chapters

Following this introduction, the dissertation is organized to place the study in respect to other relevant research and the particular setting, and to explain methods and examine findings. The second chapter, on alternative perspectives, briefly reviews relevant anthropological, sociological, psychological and organizational research on work and professions and comparative health-care systems. After discussion of approaches that emphasize structural determinants

of choice, from modernization and medicalization to organizational structure, compared with social-psychological approaches and professionalization research, an eclectic perspective is presented. This suggests a synthesis of the structural/objective and individual/subjective approaches.

Chapter Three relates administrative change in Hong Kong to parallel attempts in Great Britain, and discusses similarities and differences in the occupation of nursing in Hong Kong, Britain, and the United States. The issue of professionalization is presented in relation to attempts to reorganize the occupational hierarchy of British nurses. The latter is an influence on and reference point for nurses in the study sample, as well as a relevant example of administrative change in Hong Kong's parent country.

In Chapter Four, the methods of data collection and analysis are further discussed. This includes the questionnaire survey, the sample, and the use of Chi-square tests in data analysis, in addition to the causal model and regression analysis. Primary emphasis is placed on the latter. Chapter Five presents the findings and discusses the attitudes toward work of the two groups, the Registered and Licensed Nurses. The relationship between objective and subjective variables is examined through use of the path model, in which the amount contributed by each variable in the causal model has been assessed by regression analysis.

In Chapter Six, the findings are summarized and discussed in relation to previous research. Conclusions are drawn from the findings as to the relationship between individuals' occupational and organizational positions, structural change, and perceptions of work roles and identity. The extent to which employees perceive opportunities to exercise choice is discussed as related to their attachment to work. Priorities are suggested for future research on occupations and professions, including research in the field of nursing. A subjective approach to study of attitudes is suggested for social and cultural anthropology.

CHAPTER II - ALTERNATIVE PERSPECTIVES

Introduction: Research on Work and Professions

The need for comparative studies of attitudes toward work within various occupations, professions, and societies is evident from common issues of debate and dispute in industrial and industrializing countries. These issues range from general problems of labor and management relations, productivity and employee retention, worker benefits and satisfaction, and debates over the extent to which employees should participate in decision-making, to issues of the roles and rights of women and minority workers. The relative power and prestige of particular occupations and professions within a society, the meaning of work, and occupational and professional identity are also areas of crucial concern to both employees and employers.

There is a vast multidisciplinary and international literature on these subjects, although it is based primarily on American and European research. Its recent growth has resulted from the increasing internationalization of business and economy, accompanied by labor disputes and concern for work ethics and the consequences of technological change, including the shift of large numbers of jobs from manufacturing to the service sector (Wilpert, 1978). Interest in improvement in the quality of working life for employees and in increasing organizational efficiency have developed simultaneously. Because the study of work and work organization is a problem calling for cooperation of the disciplines of psychology, medicine, industrial and organizational sociology, business

economics and labor law, political science and social philosophy (Wilpert, 1978), there is a need for greater coordination between these fields in research.

In addition, gaps exist within the literature. The study of work is based largely on industrial and organizational research, and career aspirations and job satisfaction of employees tend to be viewed from the perspective of the workplace and commitment to the organization. This contrasts with the study of professions, which has tended to emphasize autonomy and choice as distinctive of the professional. Moreover, there is a lack of congruence between theoretical models and empirical evidence in the study of the relationship between objective conditions of work and the workers' subjective level of satisfaction-dissatisfaction (Spray, Adamek, and Negandhi, 1978). Although several theoretical studies point to the linkage between job characteristics and workers' expressions of satisfaction, this is not unequivocally confirmed by empirical research (Spray, et al, 1978).

A brief survey of some theoretical and general studies on work from several disciplines reveals the range of their concerns and perspectives. The classic works on the division of labor by Parsons (1939) and Durkheim (1947), and Weber's analysis of bureaucratic rationality (1947) formed a significant theoretical base in sociology. Caplow's study of occupations and the allocation of jobs and technical skills (1954), and Gouldner's (1954) and Bendix's (1956) research on work relationships in industry were complemented by theoretical and empirical studies of organizational bureaucracy and the organization of tasks - technology, in its broad sense. These include Blau (1955), Perrow (1965, 1967, 1972), Coser (1958, 1979), Simpson (1972) and Dombush and Scott (1975). Research in industrial relations such as that by Woodward in England (1965) and Kleingartner (1967) overlaps these sociological studies, as does that in organizations and management

(March and Simon, 1958; Cyert and March, 1963; Thompson, 1967; Salanick and Pfeffer, 1977; Von Maanen and Schein, 1979). The majority of these have an organizational focus that is relatively structural, although the response of the worker is an important concern.

By comparison, sociologists such as Dubin (1956, 1976 a and b), Blauner (1964), Berger (1964), and Pavalko (1971) concentrated on the meaning of work to employees, including degree of worker alienation and satisfaction. General theories of workers' needs and desires can be traced to psychologists such as Maslow (1964) and Herzberg (1959). The organizational psychology of Argyris (1964) and Weick (1969) explored the relationship of employees' desires and perceptions to the organizational environment, and Hackman and Lawler (1971) researched the specific problem of job satisfaction.

The study of job satisfaction is an interdisciplinary area in itself. Work satisfaction theories are generally divided into those which suggest that work is the primary contributor to life satisfaction, and that there is thus a "Spillover" effect from work (Kornhauser, 1965), and those which postulate a "Compensatory" model in which either work or non-work may contribute to life satisfaction (Dubin, 1956; Argyris, 1964; Katz and Kahn, 1966). Studies by researchers in personnel and human resources management (for example, Miner, 1969) often have an applied orientation, toward increasing employee satisfaction through such means as matching characteristics of the job to those of the employee, using a basically organizational perspective to increase efficiency.

In both theoretical and empirical research on professions, sociologists have been dominant. Although a comprehensive review of this literature is beyond the scope of this section, mention is made of a few significant studies. Wilensky (1964) has analyzed the trend toward increasing professionalization of

occupations. Etzioni's comparison of professions and semi-professions (1969), the work of Johnson (1972) on the operation of professions, and Larson's historical study of the development of prototypical professions (1979) illustrate contributions in this area. With respect to health care, Friedson's Professional Dominance (1970) has been widely used to explain the position of physicians. Simpson's study of professional socialization in the field of nursing (1979) builds on Becker's earlier work on professional socialization of doctors (1961), seeking a synthesis of his viewpoint with that of Merton (1957). The latter studies reflect a common interest of sociologists in the relationship of occupational socialization to employee satisfaction and commitment, although some stress discontinuities in training and becoming a practicing professional (Becker), while others see the process as continuous and cumulative (Merton). Olesen and Whittaker (1968) have approached the process of professional socialization of nursing students from a social-psychological perspective, emphasizing the interaction among students and between them and faculty as the source of role-learning, and of role conflicts which must be integrated. A psychologist, Meyer (1960), earlier researched contrasting nursing values, captured in the phrase, "tenderness and technique"; these values are still under debate in the field of nursing.

Studies of particular professions and professionalizing occupations by social and behavioral scientists, and by members of professions, have thus contributed to contrasting perspectives. Sociological research generally attempts objective analysis of the status or construction of a profession. Social and organizational psychologists tend to concentrate on the process of becoming a professional, on role-taking and role-playing; a few sociologists have analyzed the dynamics of interprofessional interaction within organizations (Strauss, et al, 1963, 1964). The latter can be contrasted with structural analyses of the competition between

professionalizing occupations for clientele and legitimacy (Wardwell and Watson, 1979). Members of particular professions have applied both sociological and psychological approaches, often for the purpose of furthering professionalization of their own fields. Examples of this within nursing will be discussed below, following a brief review of relevant anthropological literature and discussion of the meaning of work in comparative context.

Psychological and cognitive anthropologists have attempted to delineate the perceptions of social and cultural elements and systems by their users (Johnson, 1978; Wallace, 1961). However, their goals are primarily "to discover the cultural rules of organizing principles underlying the cultural behavior of particular peoples" (Ember, 1977), and to explain cultural differences in perception and learning and in individual task performance (Laboratory of Comparative Human Cognition, 1978; Wright, 1981). Their approach contrasts with that of social psychologists, who tend to conceive of perceptions as related to experience in group interaction. Performance of tasks by members of a group is likewise conceived as carried out in the context of roles and positions which are at once the result of social structure, and of this group interaction. Moreover, the social-psychological perspective as applied to problems of attachment to work of workers in organizations assumes that, in addition to cognition, affect is a significant factor in attitudes toward work, and occupational and professional identity (Dubin, 1976).

The study of work and professions is an area still seeking legitimation within anthropology, although a few applied anthropologists pioneered in research on work and interaction in industrial and organizational settings (Chapple and Arensberg, 1940; Chapple, 1941, 1942, 1953, 1961; Arensberg, 1941, 1951, 1978; Gardner, 1945, 1978; Warner, 1947, 1962; Whyte, 1955, 1969). During the 1950's

and continuing into the 1960's, interest grew in cross-national comparisons of occupational mobility and modernization. While sociologists took the lead in much of this research (Rogoff, 1953; Kahl, 1968), anthropologists such as Manning Nash (1958) pursued questions related to the response of workers to industrialization, and the research of Inkeles (1960, with Smith, 1974) was influential in both anthropology and sociology.

Inkeles' focus on the consequences of industrialization, producing a common "structure of experience, attitude, and value which takes its form from the occupational structure" (1960, p. 4), sought to establish a framework for cross-national study of occupations and workers' attitudes. While his questionnaire survey found differences in the relative satisfaction of American and European workers at the lower end of the prestige scale, he concluded there was a common positive correlation between satisfaction and the over-all status of occupations. The element of choice was explored through questions designed to measure workers' general feelings of mastery and optimism in their lives, but it was assumed that the institutional environment shaped workers' perceptions, attitudes, and values.

Studies of modernization and development have attracted more anthropological attention than research on work and professions per se. The latter takes a secondary place in studies such as that by Harkess (in Pescatello, 1973), which attempts to survey attitudes toward work and perceptions of identity as part of social role definitions. Individual responses of women in different social classes are compared and explained on the basis of the "traditional-modern" and "rural-urban" dichotomies in attitudinal orientations. Marxist and feminist analyses have attacked the problem of development itself as one of exploitation of all workers, or particularly of females (for example, June Nash, 1977). Many

anthropologists continue to consider the sexual division of labor to be the basis for research on work roles, because of its "universal significance" (Benson, 1980, p. 308). However, occupations and professions in both developing and developed societies merit far more attention from anthropologists, both to clarify the processes of development, and to address issues of general concern to workers, be they male or female.

The "social anthropology of work" is a new, very loosely-defined field (Wallman, 1979) whose focus is still on non-industrial societies and cultural values, in keeping with the traditional field-work areas of anthropologists. "The question of work has become the stuff of political and economic debate - at least in industrial countries, and quite often in the so-called 'developing world'" (Wallman, 1979, p. v). This debate centers on the two fundamental problems of earning a living, and of personal and group identity, since "the organization, the experience, and even the classification of work are matters of moment to people in a variety of social and technological settings" (Wallman, 1979, p. v).

Still, many anthropologists are reluctant to grapple with these matters in industrial societies, and tend to relegate the study of factory, service, clerical, and professional occupations to sociologists as well as to other researchers in organizations and industry. Of those represented in The Social Anthropology of Work (Wallman, 1979), half were concerned with traditional and rural occupational groups; none dealt with any of the mainstream work activities in a modern industrialized society, whether white-collar, blue-collar, or professional. These should be included to develop a truly comparative anthropology of work. As the sociologist Berger has suggested (1964), occupations should be analyzed in terms of their three aspects: structural, socio-psychological, and ideological. This approach is complementary to the examination of the social, psychological, and

symbolic aspects of the control and evaluation of work in various social and cultural settings (Wallman, 1979).

A small but growing trend exists toward research in industrial anthropology and behavior in job environments (Mulpke, 1980). Anthropologists who have dealt directly with the organizational context of work in industrial settings have tended to apply their holistic ethnographic technique (Steel, 1980), recently adopted by organizational analysts (Child, 1981). Earlier research in industrial anthropology was done from a behavioral perspective, concentrating on observation and analysis of interaction (usually measured in terms of verbal communication and informal networks). In conjunction with social psychology, this research took a human relations approach to solving worker dissatisfaction and "alienation" (Arensberg, 1978).

More recently, concepts from cognitive anthropology have been used in the study of organizations as systems (Irving, 1980). Case studies of large-scale organizations by anthropologists are illustrated by those of Taylor (1970), on the United States hospital; Rohlen (1971), on the Japanese bank; Buehler (1980), on the Navy laboratory. Anthropological investigations of specific work units within complex organizations such as hospitals are represented by Skoner (1974), The Working World of Obstetrical Nurses, on group cohesion and intragroup interaction, and Grau and McAllister (1980), Successful Nursing in the Hospital Setting.

In some organizational studies by anthropologists, such as Rohlen's, the significance of culturally distinct values and socialization into the organization with a characteristic structure and work relationships have been underlying themes. Others have stressed the uniqueness of the particular intraorganizational environment (Taylor, 1970) or work unit with a unique task (Skoner). The majority

of these have taken the organization, rather than the occupation or profession of the workers within it, as the unit of study. In Berger's terms, they have analyzed the microsocial aspect of the organization - its structure as related to work situations - rather than the macrosocial aspect, which is the economic, social, and political configuration of occupations in relation to the larger society. Sociological research on organizations also tends to focus on intraorganizational structure and environment, and the ways in which the organization as a whole deals with the external environment. Comparison of anthropological studies with this vast literature is beyond the scope of this introduction. However, an example of different approaches is found in the treatment of The Japanese Company by the anthropologist Clark (1979), who emphasizes its historical and contemporary differences from Western companies and its place in Japanese society, contrasted with sociological studies which focus on similarities between Japanese and Western industrial organization (Cole, 1979) for the purpose of cross-national comparisons of job mobility or other aspects.

There is a need for interdisciplinary coordination in research on the changing intra- and international nature of occupations and professions, and for the full involvement of anthropologists in the study of workers' perceptions and negotiations of this change. Examination of the social and political context of occupational change is essential. However, the holistic approach of anthropologists, whether cultural, organizational, or occupational, must be refined. To obtain an accurate grasp of the conditions under which members of an occupation perceive their work as meaningful, or become disillusioned, it is necessary to analyze the perceptions of workers in different positions, within occupational systems which vary in their allocation of tasks and rewards.

The Meaning and Context of Work in Comparative Perspective

Sociological analyses of the meaning of work have often stressed the increase of alienation of workers from their jobs (for example, Blauner, 1964). This interpretation is widely viewed as related to Marxist theory, although the actual relationship of alienation theory to Marxism is still under debate (Schaff, 1980). The extent to which alienation is characteristic of workers in various positions within specific occupations needs to be further investigated, in particular social contexts.

Although the development of industrialization, specialization, and bureaucratization are commonly seen as the causes of alienation, technology and task are insufficient to explain differences in job satisfaction and professional commitment. Perceptions of relative power and prestige of workers in their occupations or professions, as well as in their work environments and organizations, must be given central consideration. The meaning of work for the individual employee is influenced by her/his structural position, and by societal rewards and values assigned to his/her job. In turn, employees' perceptions of work roles and positions are related to efforts by occupational groups to professionalize.

In American society, the trend toward "professionalization of everyone" (Wilensky, 1964) appears to be related to the "search for meaning in the private sphere" (Berger, 1964; cf. Dubin, 1956). The "wild scramble for status among a large number of occupations" may be a result of the fact that (Berger, 1964, p. 216):

> Status and identity based on work have become fluid, insecure, and subject to manipulation.
>
> ...occupational status has become a subject of one-upmanship.

> What goes on under the heading of 'professionalization' in many instances is not far away from (the)...confidence trick (of giving one's occupation a professional title).
>
> Occupations just emerging out of limbo and already aspiring to the status of 'professions', have to be even more strident in their claims to life, respect, and a healthy slice of the economic pudding.

This is linked to the perception of work by most American workers as a neutral category, between the poles of "primary self-identification and self-commitment" or fulfillment, and "indignity" or oppression due to bureaucratization and rationalization of organizations to increase efficiency and productivity (Berger, 1964, p. 216). It is important to recognize that the socio-psychological milieu of work can change fast, as a result of technological or administrative change. However, according to Blauner (1964, p. 29), "self-estranged workers are dissatisfied only when they have developed needs for control, initiative, and meaning in work".

In the United States, there are systemic reasons for rising expectations of workers in professionalizing occupations. There is a structural reason why, for example, education is one of the most important factors influencing a person's aspirations in the work process, and why: "The more education a person has received, the greater the need for control and creativity." (Blauner, 1964, p. 29). From a structural viewpoint, as Larson (1979) maintains is the case in the United States:

> The traditional legitimations of alienated labor are now in crisis, and they contradict the 'search for self'...abroad in the general culture.
>
> The growing importance of 'educated labor', in both productive role and numbers, exacerbates the crisis and the contradictions: the amount of critical information available on society as a whole to an increasingly educated labor force contrasts with the narrow definition of functions and rank in most situations.
>
> (Larson, 1979, p. 234)

This is directly applicable to nursing in the United States, where the tension between increasingly bureaucratic work settings and organizations, and the drive for professionalization and concurrent attempts to define exclusive functions in order to solidify the domain of nursing, is increasing. The extent to which this is the case for nurses and professionalizing occupations in other societies is a problem for empirical research.

Although such interpretations of contemporary feelings of alienation of workers and their loss of identity due to the secularization of work are useful in creating awareness of the effects of social and occupational change, they must be refined through analyses in specific contexts. In addition, they should be related to determinants of job satisfaction for workers in various roles and positions. More recent research on job satisfaction has pointed toward criticism of the basic concept of alienation as an explanation for presence or absence of job satisfaction. Indeed, according to Dubin (1976), there is evidence that dissatisfaction and alienation are not the same phenomenon.

From an organizational perspective, support for this interpretation has come from comparative analyses of work organizations by institutional economists and students of business organizations (for example, Harbison and Myers, 1959), and from more recent research on the quality of working life, defined by Suttle (1977) as interaction between the worker and the organization. In conjunction with these studies, research on different styles of organizational structure and worker participation in decision-making (Negandhi and Wilpert, 1978) has explored the relationship of these variables to worker satisfaction. Attachment to work is viewed as a positive phenomenon by Dubin, Hedley, and Taveggia (1976) - the basis of both theories of motivation to work and analysis of work satisfaction. Their review of relevant literature and research trends includes three areas: (1)

systems of the work environment: the self, the work group, the company, the union, the craft-profession, the industry; (2) work-place objects and human conditions: technology, product, routine, autonomy, personal space and things; (3) pay-offs for working: money, perquisites, power, authority, status, and career.

Dubin, et al (1976) conclude that multiple work attachments must be examined, for individual occupations and professions, as well as social classes, minority groups, and males versus females. Their comparative studies of work attachments among industrial and clerical workers in Britain and the United States found that priority assigned to variables from the three areas listed above differed with age, length of service, sex, and country. Workers were distinguished as to whether or not their "central life interest" was in their work, or in activities and institutions outside of work. Those who fell into the latter category had work attachments which, although "negative", constituted strong linkages to work. Thus they were not considered alienated, even though the overall image presented was one of being concerned with limiting self-investment, and seeking routinized work with payoffs of several types - an instrumental orientation.

Katz and Van Maanen (1977) have arrived at a multidimensional model of work satisfaction, based on aspects of the workplace. They distinguish three loci of satisfaction: job properties, interactional features, and organizational policy variables. The loci correspond respectively to the three basic approaches to job redesign for increasing work satisfaction: the human resources, human relations, and human rewards approaches used by organizational analysts. According to Katz and Van Maanen, since work satisfaction is usually treated as unidimensional, support can be found for any single framework - psychological, demographic, or other - in terms of overall satisfaction. However, the three loci of satisfaction are theoretically distinct, and their relative significance varies

with the situational characteristics of the workplace. Therefore, change programs must consider each of these areas, depending on the organization. For example, in public sector jobs, which Katz and Van Maanen studied - including city, county and state levels, and administrative, technical, professional, clerical, and unskilled employees - job properties and interaction may be more easily changed than organizational policies. The relationship between various organizational characteristics and perceptions and responses of employees is further examined in the research reviewed below.

When an attempt is made to relate workers' attitudes to the operation of the national economy and work organization, comparative studies are illuminating. The dynamics of the ways in which changing structural features of the economy, allocation of labor, technological innovation, and rising education levels interact to affect industrial workers' satisfaction and "consciousness" have been analyzed for the Soviet Union (Jones, 1981). The extent to which workers value social factors extrinsic to the workplace, such as housing and wages (in this context), as contrasted with internal job characteristics such as work group relations, job content, and degree of participation in decision-making, is shown to vary with changes in the above structural factors. Due to the system of labor allocation in the U.S.S.R., workers have job security, but turnover is high, and underemployment in the sense of placing skilled workers in unskilled jobs is not uncommon. Although techological change has led to a decrease in routine tasks and increased emphasis on evaluation and decision-making, workers have a generally instrumental orientation toward work. There is a "fairly uniform hierarchy of priorities" (Jones, 1981, p. 267): pay, working conditions, and interesting work come first; next, employment in a large organization; next, work relationships; last, job security, since this is already present. However, job

satisfaction is positively correlated with skill and the degree of decision-making required in tasks, and negatively correlated with the length of formal education for younger workers.

In recent years, much interest in Japan's employment system and workers' attitudes has been generated in the United States and Britain as a result of the growth of Japanese productivity and the apparent efficiency of industrial and business organizations in Japan. The security provided for many workers by the "permanent employment system" and the inclusion of worker participation in quality control systems have been the targets of research by social scientists as well as business and industrial analysts. Various approaches have been taken by the former. For example, Abegglen (1973) emphasizes the uniqueness of the Japanese system of lifetime employment, including its organization of personal relations and emphasis on group membership rather than individual skills. Abegglen gives the "ideal type" of the employment system (p. 25), and interprets its meaning in terms of fundamental patterns of Japanese society, as a system "involving employer and employee in a permanent and complex relationship of mutual obligation, and rewarding tenure rather than short-term performance..." (p. 25). Moreover, "the organization of the workplace parallels the organization of Japan's primary institutions", such as the family (p. 28). Clark (1979) similarly stresses Japan's unique development.

A contrasting approach is taken by those who emphasize the convergence of all industrializing societies toward common arrangements. Within this group, however, Cole (1971) sees the Japanese system as moving toward the Western model, while Dore (1974) takes the opposite view that the Japanese model will become dominant. Dore attributes the "organization orientation" of large Japanese corporations to the near-absolute job security, automatic promotions

and pay increases, and careers provided for permanent employees. This is in contrast to the labor market orientation found in other national systems such as the United States, although Dore recognizes there is a dual economy in Japan, consisting of small and large firms (Zaibatsu) which differ in the advantages given to workers. The overall trend in large firms is away from hierarchical, authoritarian structure and status envy among workers, and toward welfare corporatism. A contrasting picture is presented by Cole's study of medium-to large-sized firms which were subcontractors to the Zaibatsu (1971). Cole found lines of cleavage and conflict within the company, and hostility to employers, as well as unity and cooperation, and worker solidarity. However, he also stressed organizational features which contribute to stability:

> The prospect of continuous predictable rewards, a feature of careers, creates willingness in workers to train, to achieve, and to adopt a long view and defer immediate gratification for the later pay-off...
>
> (Cole, 1971, p. 103)

Negatively, workers fear being forced out of a job, with the pressures of late marriage and child-rearing, and the practice of extending company benefits to those over age thirty. The company thus exercises constant, intense efforts to control workers, and Cole interprets the employment system as a creation of capitalism rather than a Japanese creation. He also recognizes that the so-called permanent system is primarily for males, with women usually occupying temporary and menial positions that offer little career opportunity.

Macroscopic economic and organizational research is essential to provide analysis of objective conditions which structure the relative positions of occupations and of wokers within them. It must be complemented by comparisons of employees' perceptions of their work situations and their satisfaction with, or desire to change them. The two approaches are not contradictory; taken

together, they clarify the broader environment of society, work organizations, and occupations, and workers' responses to and negotiations of their situations. Such a synthetic perspective has been developed in order to examine the conditions leading to action by workers to change their situations, on a group basis (Low-Beer, 1981).

Organizational Research

Organizational analysts have generally approached the problem of worker satisfaction from the goal, whether implicit or explicit, of improving organizational effectiveness. Empirical studies have attempted to find employee behavioral correlates of organizational control (Angle and Perry, 1981; Price and Mueller, 1981). However, the relationship between psychological variables such as commitment and behavior influencing organizational effectiveness has been found to be complex.

A focus of a number of studies has been to determine whether job satisfaction is primarily caused by attraction and selection of employees whose personal attributes are suited to particular work settings, or by modifying structural characteristics of the organization such as size, hierarchy, formalization, and centralization. In a study of approximately 3000 employees in 428 jobs, within 36 organizations, Oldham and Hackman (1981) found that, taken singly, the job-modification framework offered a better explanation of the relationship between organizational structure and employee reactions than the attraction-selection framework. However, they concluded that a combination of the attraction-selection and job-modification frameworks was most effective, particularly in explaining the relationship between organizational structure and internal motivation, general satisfaction, social satisfaction and security

satisfaction. The interpretation was that structural properties of an organization affect employee reactions both by attracting individuals who are predisposed to react to the work in particular ways, and also by influencing the characteristics of employees' jobs. This was supported by subsequent multiple-regression analysis (Oldham and Hackman, 1981).

Research on the entrance of employees into organizations has taken two alternative perspectives: that of the causes and means of reducing turnover; and that of organizational socialization (Louis, 1980). Recent research on turnover in organizations has focused on the unrealistic and/or unmet expectations of new employees. These may be related to the recruiting practices of organizations as well as to the previous experiences of newcomers. A general assumption of rationality is made by the majority of researchers on turnover; that newcomers enter with preformed job expectations and, if these are not met, they will leave the organization. Although Louis states that this assumption is not well-supported by research, it is implicit in empirical studies such as those reviewed below.

Among lower-level employees in a United States organization providing bus services, organizational commitment was found to be associated with organizational adaptability, tardiness rate, and turnover, but not with organizational operating costs or absenteeism. Although two measures of value commitment and commitment to stay in the organization were used, little difference was found between the two (Angle and Perry, 1981). A recent study of several types of United States hospitals attempted to explain the relatively high rate of turnover of nurses as compared with teachers and social workers, since all three are predominantly female professions (Price and Mueller, 1981). The perspective of the researchers is revealed in their statement that although not all such turnover is detrimental to hospital effectiveness, it "strikes at the heart of

organizational control" (Price and Mueller, 1981, p. 5).

The above study uses a causal model which relates turnover to job satisfaction, intent to stay, and eleven other variables, using multiple regression and path analysis: opportunity for alternative jobs, routinization, participation, instrumental communication, integration, pay, distributive justice, promotional opportunity, professionalism, general training, and kinship responsibility. The findings indicate that intent to stay is the most important direct determinant of turnover, and alternative opportunity and general training have a strong negative correlation with turnover. Price and Mueller's recommendations for reducing turnover include creating an alternate career structure for staff nurses based on "professional" rather than administrative positions, and recruiting more diploma nurses as contrasted with those with baccalaureate and graduate degrees. These suggestions are consonant with the goal of increasing organizational retention, and thus control, of employees.

Research on the quality of working life within organizations has also been carried out with the purpose of improving morale and employee retention, hence enhancing organizational effectiveness. In their study of Welsh nurses and hospital organizational change, Wallis and Cope (1980) sought to identify the sources of nurses' dissatisfaction and reduce high turnover and low morale. Comparison of the quality of working life and job satisfaction at two hospitals led to the conclusion that certain characteristics of the working environment, as well as individual differences in values and expectations, may be equally important in producing satisfaction. Wallis and Cope noted that prescriptions for organizational change to improve morale and reduce turnover are generally based on studies of work in industry, especially of jobs that are low in skill and responsibility; therefore, job design principles such as job enrichment may not be

generalizable to service occupations. They also stressed the significance of employees' perceptions of their jobs, and noted that although nurses might have ample opportunity for psychological growth, they could be quite dissatisfied. Thus, job satisfaction was interpreted as a relative phenomenon.

Organizational socialization research, as contrasted with the quantitative empirical orientation of turnover research, has emphasized interactionism and phenomenology (Louis, 1980). However, it has also assumed rationality, or conscious expectations of new employees, and a more processual approach is needed to explain the means that newcomers use to cope with expectations and interpret and respond in, and to, unfamiliar organizational settings (Louis, 1980). Organizational socialization research has included study of the characteristics, stages, content, and practices of organizational socialization. The process itself has been analyzed along six structural dimensions: collective or individual socialization; formal or informal; sequential or variable; fixed or variable; serial or disjunctive; and investing (enhancing individual identity) or divesting. The combinations of these dimensions occurring in particular situations of organizational socialization are related to the likelihood that new employees will carry out innovation in content or roles, or exhibit "custodial" responses that serve to maintain the organization as it is (Van Maanen and Schein, 1979).

From the viewpoint of the individual, "reality shock" may occur (Hughes, 1958) in the initial stage of organizational socialization, when newcomers enter unfamiliar settings. This is the subject of a recent book on the causes of nurses' leaving their occupation (Kramer, 1974) and is an important focal point in the debate over requiring baccalaureate training for Registered Nurses in the United States. The nature of "anticipatory socialization" (Merton, 1957) is related to the degree of reality shock and the ease with which employees enter new roles, or

leave old ones (Becker and Strauss, 1956). Learning the organizational "culture" (Van Maanen, 1977) has been studied by anthropologists such as Rohlen (1971). This forms the context within which organizational members enact their roles and environment (Weick, 1979).

A model of the process by which newcomers "...detect, diagnose, interpret, and select" responses to features of the new organizational setting has been developed by Louis (1980, p. 234). This includes change and contrast with the old setting, dealing with surprise in the new environment, and applying conscious thought in "sense-making" which is identified as a recurring cycle or continuous process of reinterpretation, revision of assumptions, and integration of experiences. Comparisons of one's own and others' interpretations are significant in the attachment of meaning to organizational events. Further research is needed on the underlying psychological processes involved in sense-making and on the causes of individual variations in response to new situations.

Within the organizational envirionment, the problem of uncertainty has been explored as it affects both the organization (Crozier, 1964; Thompson, 1967) and the individual employee. Kahn, et al (1964) stress the effect of high levels of conflict or ambiguity in role definitions as leading to tension and stress for both the organization and the individual member. While such a negative approach to ambiguity and uncertainty is common, some organizational analysts have viewed this aspect of environment more positively as offering increased opportunities (for example, Weick, 1969).

Different approaches have been taken to organizational structure and process, and the relation of organizations to environment. One approach takes the view that it is the variation in information about the environment as perceived by organizational members that is the major factor in accounting for

variations in organizational structure (Weick, 1969 and Robert Duncan, 1972). A second approach sees the environmental level of resources and their availability to organizations as the critical factor (Aldrich and Pfeffer, 1972; Aiken and Hage, 1968; Blau, 1964; Aldrich and Mindlin, 1978).

Current contingency theories hold that organizational structure and process vary with the environment or situation, and this is related to organizational effectiveness (Argyris, 1964; Lawrence and Lorsch, 1967). When used in cross-national studies, this perspective is sometimes in contrast with theories that seek explanations of organizational variations in terms of cultural differences, or in the common effects of capitalism (Child, 1981).

In attempting to examine the causes of uncertainty in organizational environments, Duncan (1972) found that the static-dynamic dimension of the environment was more important than the simple-complex dimension. In a study of decision-making work groups in manufacturing and research and development organizations, Duncan (1973) found that work group structure varied with the task, or type of decision to be made, and with members' perceptions of the amount of influence they had over environmental factors.

The issue of the distribution of power has been a focus of sociological analysis of intraorganizational systems (Weber, 1947; Michels, 1949; Gouldner, 1954; Lipset, 1956; Crozier, 1964). Several recent studies have attempted to delineate objective characteristics of organizations as determining variations in power distribution. These reveal three perspectives as to the determinants of dispersion of power: (1) structural constraints, such as organizational size and complexity (Blau and Schenherr, 1971); (2) degree of uncertainty of roles, and capacity of members to cope with uncertainty (Crozier, 1964; Perrow, 1967); and (3) communication through networks (Duncan, 1972).

While most comparative research on power in organizations has dealt with the degree of centralization of authority in the organization as a whole, a focus on influence processes as differentially perceived by various organizational groups leads to recognition of the variations in power of these subgroups (Bacharch and Aiken, 1976). The study of variations in organizational influence and work processes by status subgroups can thus lead to "conceptualization of the organization as a political system composed of various status groups whose participation in decision-making is differentially constrained by processes and structures" (Bacharach and Aiken, 1976, p. 641).

The level of status-subgroup is an important link between the individual and the organization, for the evaluation of the extent to which the individual actually exercises influence over his work. However, the concept of organizational status-subgroup should be integrated with the notion of occupational or professional power; this overlaps and contributes to variations in power within the work organization. There is thus a need for integrating both organizational and occupational characteristics in understanding the context of individual perceptions of work roles and opportunities. Occupational power will be related to research on professions in the following section.

The interactionist perspective has been developed by sociologists and psychologists (Blumer, 1969; Mead, 1934) as an alternative to the structural perspective for organizational analysis (Day and Day, 1977; Driggers, 1977). This perspective places emphasis on the processual aspect of organizations, in which employees , interact both as individuals and as members of subgroups. Interactionists have seen their approach as a corrective to the static, apolitical interpretations of structuralists, although they have been criticized for abandoning the "hard realities of power and politics and the influence they exert

upon negotiative processes" (Day and Day, 1977, p. 134). There is a need to examine "those activities which have been and continue to be non-negotiable historically and why this is the case"; specific patterns of negotiation must also be conceived as mere "social products of...broader, more powerfully entrenched structural arrangements" (Day and Day, 1977, p. 139).

Driggers (1977) recommends "intertheory shifts" between the structural and interactive perspectives, and indicates that employees themselves may switch from one perspective to another, using a structural view to coordinate and delegate tasks in the work setting, and an interactionist view in task performance, with bargaining or deference in particular situations. As discussed in the previous chapter, Strauss' (1964) model of concord, built on minimal bases of consensus arrived at through the process of negotiation among members of an organization such as a hospital, reveals that both cooperation and conflict and structural and interactive influences are involved in organizational functioning.

Individual and group negotiation are general processes which occur within the context of, and are constrained by, organizational structure. Reciprocally, they also determine structure to some extent, since these are the processes by which an organizational environment is enacted, in Weick's terminology (1979). The influence of the organizational and occupational hierarchy is not primarily negative, as depicted by Goffman (1961). While subordinate employees may cope with their positions through such means as deference and creating role distance (Goffman, 1956), they also insert their own interpretations, and assert their own interests, in the general process of interaction. This may be related to the attempts of status sub-groups to define occupational roles for themselves (Mechanic, 1962).

Strauss, et al (1964) have analyzed negotiation by members of various

professional groups within a psychiatric hospital organization. In patient treatment teams on certain wards, the professionals whose training and functions overlapped most (physicians, psychologists, social workers) were in more direct competition than were other professionals (nurses, occupational therapists). Strauss, et al concluded that many clinical and administrative arrangements must be continually initiated and renegotiated, and that the choice of allies depended both on the problem to be solved and on the history of relationships as well as on established procedures. For these reasons, they found that:

> While the general pattern of negotiation is recurrent and can be observed and analyzed, many precise outcomes are relatively unpredictable.
>
> (1964, p. 310)

In addition, the most important dimension of negotiations is temporal:

> Negotiation has many dimensions...overt or covert, periodic or extraordinary, standardized or novel, general or specific in scope. But....whether negotiations result in 'agreement', 'understanding', 'contract', 'compact', or some other form, it is for a limited period, whether or not the period is specifically defined by the contracting parties.
>
> (1964, p. 311)

For this reason, any changes that impinge on the social order of the organization at any time necessitate renegotiation, and reconstitution of the organizational order.

Hall (1972) underscores the value of Strauss' use of the negotiated order concept both in the hospital setting and as a model of complex organization and society in general, and asserts the need to link the concept of power to the interaction perspective. This is necessary in order to explain how a particular bargain is made in the negotiation process, why certain groups are successful, how a situation is defined, and why certain norms emerge. To understand the outcomes of negotiated interactions, power must be analyzed and distinguished

from authority, as Buckley has done (quoted in Hall, 1972, p. 47). Hall's summary of the elements of the political process includes some activities which also occur in organizations: the defining of alternatives; "...the allocation of resources and personnel, the execution of actions, and the evaluation and adjudication of 'problems'..." (Hall, 1972, p. 49). These elements emerge through the process of negotiation.

The organization itself is thus not completely predictable, and uncertainty and ambiguity are common. However, members of the organization tend to act in accordance with what they perceive to be both their expected roles and their own interests, both as individuals and as members of sub-groups. These sub-groups are delineated and given meaning in relation to their functions and statuses both in the organization and in the occupational order; they also change through individual action.

The "action approach' to the explanation of worker behavior holds that this must be understood as the joint outcome of prior orientations or values of workers, and situational or social-structural factors (Low-Beer, 1981). It is the interaction between these factors, as opposed to the alternative approaches of cultural or technological determinism, which is crucial in understanding the behavior of the "new working class" (Low-Beer, 1981). The action approach also emphasizes actors' (workers') own rational definitions of situations, as leading to responses; this contrasts with the passive, "oversocialized" view of individuals as members of society.

Silverman (1970) has outlined three areas of interest to the organizational sociologist using an action approach: the orientations to work that employees bring with them; their strategies for obtaining goals; and the relatively stable patterns of interaction of workers. This differs from the "neo-rationalist"

approach which explains organizational strategies in terms of the resources available to each actor, and workers' common goals of maximizing monetary rewards, power and autonomy, security and status. As Low-Beer (1981) reports, Goldthorpe, Lockwood, et al carried out research on the affluent British industrial worker which drew on the action approach to explain the instrumental orientation of workers in terms of rational choice related to prior orientations. However they concluded that these orientations were homogeneous for various skill levels and occupations, and deemphasized both situational factors and the fact that work orientations are continually being redefined.

The bulk of research on job satisfaction and the meaning of work is primarily focused on the worker's response to various aspects of the workplace and organization, and is grounded in industrial settings. Much more attention needs to be paid to the ways in which occupations and professions themselves are developing, and to the reciprocal relationship of this development with job characteristics and work performance. Moreover, a balance needs to be found between structural and social-psychological approaches to the study of work.

As Kerckhoff (1976) suggests, employees' expectations of their work roles are affected by the structural constraints in society that they have observed, and these constraints mediate the effects of primary and occupational socialization. If this insight is integrated with the notion that perception of differential opportunities complements perception of constraints, it offers a useful perspective for exploration of workers' attitudes within particular occupations. Socialization into occupational roles provides only a partial basis for formation of attitudes toward work. Realization of one's relative position within both the occupation and organization, and the extent to which upward mobility is actually possible, are also significant. Both the relative advantages of various occupations

in society, and the efforts of occupational groups to increase these advantages through professionalization and negotiation with other groups, must be taken into account.

Occupational Power and Professionalization

The extent to which the individual worker perceives the necessity and/or likelihood of being able to negotiate improvement in his/her position is related to the relative power of occupations within the social system. Occupational power has been defined as the ability of an occupation to obtain and maintain an advantage in income allocation, or to defend itself against "incursions" of other occupations (Form and Huber, 1976). To secure such an advantage, an occupation must draw on material or organizational resources, including the ability to control a necessary function by a monopoly over a skill or its practice. This is also one of the characteristics of occupations which are labelled professions, but is not limited to them. In addition, professions generally have a specific code of ethics, and legal right to an occupational title, as well as particular educational requirements, usually entailing a university degree. However, competition for occupational power has led to threats to established professions by aspiring ones, as have the increase in educational levels, the rise of business professions, and the growth of bureaucracies (Alford, 1975; Form and Huber, 1976).

In the process of establishing and maintaining legitimacy of control, occupations need allies, which may range from other occupational groups, to business concerns, to government. According to Form and Huber (1976), the social context of conflict for occupational power varies, and labor, management, and professional societies bargain intermittently. However, at the broadest level, occupational power must be understood in terms of economic theories which

explain wage differences, types of occupational markets, and the ways in which differences among occupations are structured by national political economies.

An economic theory which has been used to explain differences in occupational power in the United States is the theory of the dual labor market (Piore, 1971, 1973; Doeringer and Piore, 1971; Gordon, 1972). This has been useful in revealing the way in which United States occupations are structured into exclusive sectors so that certain groups of workers, such as women and minorities, cannot easily move from one into another. Also, occupational segregation is maintained by various means, both formal and informal. While it cannot be assumed that this theory adequately explains differences among occupations in other national systems, comparative studies have shown that income inequality is common and persists in both capitalistic and socialistic systems (Jones, 1981).

To the extent that rewards are allocated unequally to, or obtained unequally by, various occupational groups, their members must compete to gain advantages. Occupational competition can take the form of either unionization or professionalization, depending on the available resources and allies, and the goals and choices of workers and occupational associations. While nurses in the United States have occasionally participated in strikes and engaged in collective bargaining, they have generally opted for the professionalization route. Their sisters in Hong Kong and Britain are now weighing the advantages of this also (Iu, 1980; Brown, 1980). Of course, this choice is partially determined by the power and influence of other occupations and professions. For example, in the United States, both physicians and hospital administrators have discouraged unionization by nurses.

Before continuing to compare approaches to the study of professions, it is useful to consider a general resource-management approach to the analysis of the

processes of occupational change and organization. Turner and Hodge (1970) advocate analysis of the strategies used by occupational organizations to develop, transmit, regulate, and expand their resources, which include skills, equipment, technology, theory, and research. This assumes a processual perspective on occupational and professional development, and inter-occupational competition.

The definition and increasing importance of the professions themselves have been of major interest to sociologists, who have noted their growing power in the occupational structure of the United States and Europe, with increasing reliance on technical expertise and specialization. From the viewpoint of Parsons (1968):

> ...the development and increasing importance of professions probably constitute the most important change that has occurred in the occupational system of modern societies.
>
> (p. 536)

Parsons held that professions are self-governing collegial associations and thus reduce the importance of the market as well as bureaucratic organization, in the development of modern societies. His perspective differs somewhat from that of Wilensky (1964), who viewed the "professionalization of everyone" less positively.

Sociological definitions of "profession" generally fall into three types, based on the factors considered crucial to distinguishing a profession. These are: (1) the nature of the work itself; (2) the status and honor, or social recognition, that become attached to a profession, effectively constituting a license to control a certain area of work; and (3) control over a political-economic domain, with sociologists emphasizing control over a market position (Johnson, 1972). According to Larson's analysis of the development of professions, based on historical research in England and the United States, professions have only the illusion of autonomy; they have status, but not power. While critics of professions usually stress their clients' lack of power, Larson focuses on the subordination of

"technobureaucratic" professions such as engineering to corporations (Larson, 1979).

The ways in which the general ideology of professionalism affects the professions themselves are Larson's central concern, and she views autonomy as an ideology. Professionals thus resist unionization and are attracted to professional associations because the latter promise individual attention and autonomy. The promise of these rewards likewise stimulates the process of professionalization. A more political approach is taken by some social scientists such as Johnson (1972), who sees the attempt to understand professional occupations in terms of their power relations in society as central. Because of inconsistencies in interpretations of the social role of professions, Johnson explains, sociologists have focused on the process of professionalization. For example, as Hughes states,

> ...the significant question to ask about occupations is not whether or not they are professions but to what extent they exhibit characteristics of professionalization.
>
> (In Jackson, 1970, p. 5)

However, according to Johnson, study of professionalization should involve examining the sources of power and authority of, and their uses by, professions. Also, there is no uniform process of professionalization; variations in the roles of associations and government, and in the clientele of the professions, affect the forms their activities take. Claims made for professional status must be examined to evaluate the extent of occupational upgrading and the deliberate expansion of professionalism through such means as ideology (Johnson, 1972). In this vein,

> If the notion that professions are oriented to service can be a shield for self-interest, it can also be a weapon in the hands of some professional segments for reform of a profession....
>
> (Schudson, 1980, p. 227)

The efforts of medical researchers to reform the medical profession within the French university hospital system constitute a case in point for the study of occupational and professional change through internal factionalization (Jamous and Peloille, 1970). Within this system, the dominant segment of the medical profession, the practitioners, used their professional ideology to legitimate and protect their position against the challenge of basic medical researchers. From this example, Jamous and Peloille argue that all occupations with loosely-defined work activities contain an internal tension, causing conflict between those members who want to routinize and rationalize their core activities, and those who see this as a threat to their monopoly of the knowledge base and to the occupation's control of its boundaries. This may lead to formation of factions and segmentation within the occupation. Again, a processual approach is taken in this research, emphasizing social and historical processes and analysis of current activities as related to ideology, and the role of internal as well as external pressures in professional change.

Inter-occupational competition is perhaps most developed in the United States, where competition among professionalizing service occupations is keen, as illustrated by the escalating rivalry among psychologists, psychiatrists, and counsellors with various types of training for treatment of clients with emotional and mental problems. This competition is related to the characteristic of professions noted by Denzin (in Jackson, 1970, p. 5): "...professions are like social movements", in proselytizing and recruitment, and in socialization of members. Both recruitment in the context of inter-occupational competition, and intra-professional change, are exemplified by the professionalizing occupation of osteopathy (New, 1958; Wardwell, 1979). The efforts of "marginal" professions such as chiropractic to gain legitimacy have met with some success, particularly

in certain regions and among certain social groups (Wardwell, 1958, 1979). Osteopaths and chiropractors claim medical functions and base their relationships with patients on a medical model, although to differing extents. In addition, "limited" practitioners, such as dentists, podiatrists, optometrists, and speech pathologists and audiologists, assert claims to particular health-care functions and attempt to recruit members, while pharmacists are expanding their provinces and redefining their profession (Wardwell, 1979).

Professionalization of Nursing

The ways in which nursing is a professionalizing occupation in an international context are clarified by comparison of professional rhetoric and debates, as well as by analysis of employees' attitudes. In the United States, Registered Nurses tend to consider themselves the only professionals in the occupation, and this distinction is used to enhance their status as opposed to other occupational segments, Licensed Vocational or Practical Nurses and nursing assistants. The drive to establish baccalaureate education as the minimal qualification defining the professional nurse, and to categorize those who receive junior college training as "technical nurses", illustrates efforts by the dominant segment and professional association to legitimate their position. The related proposal to eliminate training of Licensed Practical Nurses in some states is a further ramification of this trend, also related to the broader social context which awards higher status to employees with college and junior college training than to vocational school graduates.

This intra-occupational segmentation is increasing in the context of competition among nurses, physicians, hospital administrators, and allied health professionals such as respiratory and physical therapists as well as occupational

and recreational therapists, and social workers, in the United States. Professionalization of nursing as a whole has been most commonly analyzed in relation to the professional status of physicians. The role and status of nurses vis-a-vis those of physicians is a research problem of cross-national interest (for example, Oomen, 1978, on India) and a major one in the United States, both in social science and in nursing. A range of approaches, from interaction and negotiation of order (Strauss, et al, 1964; Mauksch, 1957, 1972), to functional differentiation within hospitals (Taylor, 1970; Heydebrand, 1973) have been used in medical sociology and anthropology.

Friedson's analysis of the United States health-care system as one dominated by physicians (1970) applies the concept of professional dominance by one occupation. Friedson asserts that health services, in contrast to industry and business, are organized around professional authority, and that the dominance of physicians contributes to the inadequacy of health-care delivery. In this analysis, the nurse is subordinate, and attempts of nursing schools to achieve professionalization make her "sensitive to her status" as a "would-be" professional (Friedson, 1970, p. 21; Corwin, 1972). Similarly, Krause (1977) analyzes the American health-care system as dominated by the medical-industrial complex, with physicians superior to other health-care workers. Nurses' "struggle against the hierarchy" (p. 48) is related to their increasing emphasis on collegiate training, and the tracking of middle- and working-class recruits into college or junior college programs, with the poor only able to afford minimal training as Licensed Practical Nurses or nurses' aides.

The research on professional dominance by the medical profession has stimulated critiques such as that by Alford (1975), who analyzes the health-care system in the United States in terms of the differential power of interest groups

and rationalizers attempting to centralize health-care services. The escalating role of health insurers and the introduction of health maintenance organizations add to this trend. Alford's perspective is somewhat comparable to that of Fielding and Portwood on the British health-care system (1980), which stresses the bureaucratic and governmental organization of health-care professions. They consider hospital nursing a "public, bureaucratic" profession, in contrast to the more "private, bureaucratic" profession of physicians - both operating within a formal working relationship with the state. Although Simpson has concluded that, in the United States, "The ceiling of nursing is still the floor of medicine" (1979, p. 27), and considers nursing a semi-profession as did Etzioni (1969), Fielding and Portwood "question the utility and even the validity of such concepts as semi-profession and deprofessionalization" (1980, p. 48). The latter term has been used to describe physicians brought under state control.

In her research on the development of professions in the United States, Larson (1979) excludes nursing. Although she sees physicians as being replaced by engineers as the prototypical American profession, she accepts the notion of professional dominance of the medical and health care field by doctors.

> ...with the possible exception of the military, no profession except medicine controls a complex organization such as the modern hospital, which by virtue of its advanced bureaucratic and technological base continuously spawns new and highly skilled specializations.
>
> (p. 38)

In her search for the current typical profession on which to model the characteristics of professions in general, Larson differs from Fielding and Portwood, who state that one should not "assume...that there is a progression toward ideal-typical professions since these are always changing" (1980, p. 48).

The socialization and occupational mobility of nurses as professionals has been of dominant concern to nurses in the United States, as reflected in research

in Bucher and Strauss (1961), Bullough and Bullough (1971), and Davis (1966). Several analyses have interpreted the subordination of nurses to both doctors and hospital administrators as a result of deliberate planning, based on the history of British and American nursing, and American hospital development (for example, Ashley, 1976). While these issues appear to be less urgent to Hong Kong nurses, comparison of their attitudes with those expressed in British and American nursing literature can enhance insight into the processes involved in development of professional identity for nurses, as can comparative study of professionalization (McCloskey, 1981).

Among studies of professional socialization of nurses, Olesen and Whittaker (1968) have stressed the active part played by nursing students in shaping their own education through selection of alternatives and organizing strategies. Based on participant observation research, the professional socialization process is interpreted as being multidimensional, with information about nursing coming from clients, family, and friends, as well as nursing faculty. Both new perceptions of self-identity and role behaviors are acquired at the same time. Simpson's study (1979) emphasizes the relationship of nursing students' expectations to their responses to the process of professional socialization.

Previous research on professional autonomy of nurses, or their lack of autonomy, has suggested that it has been enhanced by collegiate training systems such as those in the United States. However, the degree of autonomy is less than American baccalaureate nurses desire, and Simpson has shown the relationship between other factors such as finding a marital partner and college attendance as related to turnover of college-trained nurses (1979). Yet it is evident that baccalaureate training is related to efforts to further professionalization, and research by nurses in graduate programs on nursing education and socialization

(Knopf, 1972; Lurie, E., 1980) and on clinical topics (Notter, 1974; Watson, 1981) has contributed to these efforts.

In historical and societal perspective, Wagner (1980) has interpreted the development of the American nursing profession as a process of proletarianization, comparable to that in the industrialization of Britain which was accomplished by driving peasants off the land and into factory employment. In this view, professionalization was the result of proletarianization: economic depression and thegrowth of American hospitals after World War II, and declining opportunities in private duty nursing, led to regimentation of nurses' work. Nursing leadership contributed to this process by endorsing the hospital hierarchy and Tayloristic principles of management; the American Nursing Association opposed attempts by nurses to form unions (Wagner, 1980). Thus nursing leadership sought to ally itself with physicians and hospital administrators, and promoted hospital nursing. Ashley (1976) and Brown (1975) see the increasing control of hospitals over nurses in the United States from a feminist perspective as leading to general subordination of nurses, while Wagner sees a split between nursing leaders and the rank and file workers.

Most research on nurses in the hospital work environment, including ethnographic research, has tended to focus on "...that fascinating triangle - physician, patient, nurse...." (Taylor, 1970, p. 108; Mauksch, 1966). Field work on nurses in various work environments has revealed differences in interrelationship of such factors as aspects of hospital organization, inter-professional interaction between nurses, physicians, and other health-care personnel, and the effects of the type of illness and specific needs of patients (Davis, Kramer, and Strauss, 1975). Based on participant observation by nurses in areas including an intensive care unit, a pediatric ward, and emergency room, in addition to nursing care in

the patient's home, and public health nursing, the above set of studies examines the degree to which conflicting role demands occur in each setting. Nurses must carry out "hotel", "system maintenance", and managerial functions as well as care functions (Davis, et al, 1975). Both the demands of the work setting or hospital organization and the nurse's own perception of her primary function determine the nature of her work. Also, the relationship between factors which foster or deter nurses' autonomy, and those determining interprofessional control and collaboration, is a significant theme in these studies, as in Simpson (1972).

Obstacles to professionalization of nurses include lack of clarity in task organization and specialization, linked to the assumption by hospitals that nurses in general are interchangeable as workers (Mechanic, 1978). This situation contrasts with that of physicians and allied health personnel, in terms of specialization. Although the nurse may attempt to specialize, she is still a generalist to a great degree, and "...must negotiate among her roles as a technician, counselor, and educator...." (Mechanic, 1978, p. 363). Yet, the "situational location" of the nurse, with continuous responsibility for patient care, is ideal to build the role of overall coordinator of care.

A major difficulty for both nursing leaders and hospital administrators, in the United States and Britain, is sustaining occupational commitment of nurses in terms of continuous employment (Simpson, 1979; Price and Mueller, 1981; Wallis and Cope, 1980). It has even been suggested that job satisfaction and good working relationships within a hospital setting are inversely related to college-training of nurses, in the United States (Corwin, 1972; Price and Mueller, 1981; Simpson, 1979). British nurses, although trained in a diploma system which places less emphasis on upgrading the occupation through education than do American colleges of nursing, are nonetheless becoming increasingly vocal in their

dissatisfaction with salaries (editorial, "Where Do We Go From Here?", 1981). This is coupled with their attitudes toward their work roles, expressed in the editorial, "Why Sisters Are Sour" (1981), which contrasts the job satisfaction of Nursing Officers with the dissatisfaction of their subordinates, Ward Sisters (both Registered Nurses):

> If the role clarity within the sister's working situation is high, then sister is a well-satisfied and reasonably-fulfilled person - and most do like their jobs and give high quality care. But there are some sisters wilting under the burden of poorly defined roles, poor pay, poor status images and bad staff management.
>
> (p. 1)

Or, as expressed by a State Enrolled Nurse:

> ...as an S.E.N. on the wards, you just end up being a dogsbody.
>
> When there is no staff around, that is the time you are allowed to do everything... But when they are around, you are just nobody.
>
> ("Should the S.E.N. Be Abolished?", 1981, p. 8.)

It is evident that the organization of nursing staff into different positions is an important determinant of work attitudes as well as of the perceived solutions to upgrading positions. As the previous reference indicates, there is now developing a movement to eliminate the position of State Enrolled Nurse in Britain. The various efforts at reform of the British nursing hierarchy will be further discussed in the following chapter.

Much has been written about the movement of American Registered Nurses away from direct patient care and into the realm of management, a move which doctors and hospital administrators regard as problematic (Hall, 1978; Fourcher and Howard, 1981). Although American nurses also differ among themselves as to the consequences of changing their roles in this way, there is a common view that

it is a necessary step in the process of professionalization. Nurses' occupational mobility is also under debate in Britain, in the context of the current reorganization of the National Health Service (Bowman, 1981).

At the same time as American Registered Nurses have advanced to administrative positions, patient care has been increasingly relegated to those lower in the hierarchy, and in training and skills. Efforts have been made to integrate various types of nursing, medical, para-medical and allied health personnel, using a team approach for patient care. However, status characteristics of their positions do influence job performance by team members; conversely, members attempt to negotiate their own positions through interaction in the process of task performance (Bloom, 1980). For contrasting theoretical perspectives on the ways in which subordinate employees cope with their positions, see Goffman, 1956, and Strauss, 1964. A recent trend toward "primary nursing", assigning each patient to a Registered Nurse who then assumes primary responsibility for assessing, planning and coordinating his care (Shukla, 1981) has been promoted by nurses as being preferable to team nursing, in the United States. Under the primary nursing arrangement of tasks, the patient load per Registered Nurse is reduced and a closer relationship between nurse and patient can develop. Evaluations of the efficacy of primary nursing are inconclusive (Shukla, 1981), but this trend appears related to professionalization efforts of nurses.

The "...clash between the broadening reach of nurse professionalism and the tightening grasp of administrative control in hospitals..." is the context of the current movements toward nurse management and primary nursing (Fourcher and Howard, 1981, p. 299). These movements tend to increase both personal or individual rationality, and organizational rationality - means of organization of

work, which determine professional work experience. With the current thrust toward greater professional autonomy for nurses, conflict with dominant hospital administrative levels is accelerating. Mills' concept of the "managerial demiurge", concurrent bureaucratization and polarization of power between the top and bottom levels of the hierarchy, fits the hospital work force in general and nursing in particular (Fourcher and Howard, 1981).

Nurses' attempts to control nursing practice through self-management, and to reassert personal rationality through instituting primary nursing, are seen as two strategies designed to increase their autonomy. However, according to the above study, these have been accompanied by polarization of a minority of professional nurses from a majority of technical nurses and aides, since the tasks of the latter have become segmented and subordinated to organizational rationality. On the other hand, the role of the professional nurse is undergoing a process of "mystification", both in the use of the computer technology for storing records, planning services, therapy, and evaluation, and in the application of behavioral science theory to nursing practice (Fourcher and Howard, 1981).

A recent nursing journal article seeks to depict the actual working relationships between Registered and Licensed Practical Nurses (Byrne and Spatz, 1980). Based on a questionnaire given to fifteen nurses in each category in three New York hospitals, the authors conclude that relationships fall in between the extremes of lack of cooperation and complete subordination of Licensed Practical to Registered Nurses in various positions. The majority felt relations were cooperative, but one-third reported they were "indifferent", and some practical nurses expressed feelings of competition, jealousy, and frustration with the lack of clinical experience of new Registered Nurses. Staff pointed to the need for giving students practice on a nursing team in the work setting. A questionnaire

given to thirty-eight practical nursing students revealed both positive and negative perceptions of relationships with Registered Nurses, and a pattern of mutual avoidance with Registered Nursing students.

An earlier and much more comprehensive research project by Habenstein and Christ (1963) analyzed the complex set of work relationships of the general duty hospital nurse, and social and occupational characteristics of "professional and non-professional" nursing personnel. The perspective of occupational role change of nurses toward administration, supervision, management, professionality, and specialization was explored through interviews given to staff in fifty-one non-metropolitan Missouri hospitals. From the responses, three types of nurse orientation were constructed: the "traditionalizer", dedicated to the ideals of Florence Nightingale and defending past experience in serving the individual patient; the "professionalizer", who bases her work on the application of knowledge in order to improve health for society; and the "utilizer", whose commitment to her work is limited to performance of assigned tasks on her shift. In general, the professionalizers in the sample tended to accommodate the traditionalizers (both, Registered Nurses) and to "slough off" low-status tasks to both them and the utilizers (usually, practical nurses and auxilliary workers). The latter were set apart by differences in routinely-assigned tasks, dress, meetings (only for Registered Nurses), and eating facilities.

> Intra-service relationships between the registered nurse and her auxilliary subordinates are not especially difficult. Chiefly, the professional nurse complains that the auxilliary does not 'keep her place'. Yet, she is not unwilling to subrogate professional tasks to these 'second class' persons when it suits her convenience or is considered expedient from the standpoint of hospital 'policy'. For her part, the auxilliary, beginning to see herself more distinctly in an occupational category in the process of 'becoming' feels entitled to define her peers, colleagues, universe of discourse, and, most importantly, her privacy.
>
> (Habenstein and Christ, 1963, p. 161)

This analysis of professional - non-professional nurse relationships in the hospital has much relevance in the United States today, although its implication that the "auxilliary" or practical nurse is in a position to move up in the hierarchy has not been borne out. Meanwhile, college-trained Registered Nurses and nursing leaders have continued their efforts to secure and expand their professional roles (Bullough, 1980; Celentano and Anderson, 1980).

In a recent theoretical analysis of the occupation of nursing by a British sociologist (Davies, 1979), an argument is made for a "division of labor", as opposed to a "politics of occupations", approach to the comparative study of occupational roles in health care (see Lurie, S., and G. Lurie, 1981). Davies contrasts the internal control of nursing in Britain and the United States, the differences in development and organization of health services, and the division of roles among various types of health workers. The latter includes allocation of tasks to volunteers, Health Visitors, and Midwives in Britain, and Physicians' Assistants and Nurse Practitioners in the United States. The conclusion is drawn that comparative study of occupational roles of health-care personnel must be "embedded in a theoretical position concerning the nature of health-care work and the dynamic of the division of labor within it" (Davies, 1979, p. 515). While a "division of labor" perspective may be better suited to the British system with its centrally-organized health service, the "politics of occupations" approach clarifies the relationships among nursing and other health and medical professionals in the United States.

Comparative Health Systems

Comparative studies of health-care systems by medical anthropologists, as well as economists, political scientists, sociologists, historians, physicians,

psychiatrists, nurses, and public health specialists (Bibeau, 1981) have revealed the crucial importance of placing research on health-care personnel in its relevant social and temporal contexts (Lurie, S., and G. Lurie, 1981). Professionalization of personnel is proceeding with the process of "medicalization" of health care (Conrad and Schneider, 1980; Navarro, 1976) as contrasted with preventive and self-care techniques, as well as traditional practices. Comprehensive research on these areas requires interdisciplinary cooperation.

The growing trend, perhaps still emergent in medical anthropology, toward awareness of political factors in changing medical systems, and the need to evaluate the consequences of such change for societies, is evident in comparative research by various types of social scientists. Some of these are: Pearce, on Nigeria (1980); Crozier (1976) and New and New (1977), on China; Unschuld, on Taiwan (1976); Ugalde, on Columbia (1979); Lock, on Japan (1980 a and b); Frankenberg and Leeson, on Zambia, Zaire, and China (1973), and on Zambia (1976); Leslie, on India and China (1977); Lee (1974) and Rifkin (1981), on Hong Kong. These have been oriented toward supporting the viability of alternatives to "Western" medical systems, and toward examining conditions leading to competition among various types of medical systems and practitioners, and health-care providers.

Comparative and historical studies of the roles of medical and health workers are essential to reveal the vital parts they play in changing patterns of health and medical services. Olesen (1975) has suggested that medical anthropology and sociology coordinate their efforts in the following areas: socialization in health-care professions, especially nursing and medicine; the place of medical systems in systems of social control; and social policies and planning in health care. Foster (1975) contrasted the general tendency of anthropologists to

identify with patients and health workers "near the bottom of the medical hierarchy" (p. 427), and to be consumer advocates who "see the barriers to improving health care as rooted in medical personnel and bureaucratic systems" (p. 427), with the tendency of medical sociologists to "identify with...the point of view of the medical establishment" (p. 429).

While the former tendency still prevails in medical anthropology, medical sociologists have become increasingly concerned with health-care personnel at various levels (Simpson, 1979; Mechanic, 1978; Wardwell, 1979; Friedson, 1970; Strauss, et al, 1963; Mauksch, 1972), and with the changing nature of health-care systems (Alford, 1975) and the consequences of such change in developing societies (Taylor, 1973; Rifkin, 1981). The study of professions, complex social organizations, dominance, and negotiation among medical and health-care personnel have been the province of medical sociology; however, concern with the nursing profession has grown more rapidly in medical anthropology (Olesen, 1975; Foster and Anderson, 1978). In particular, Foster and Anderson (1978) stress the research opportunities for anthropologists in the field of nursing, and advocate study of nursing as a sociocultural system, including aspects of professional socialization, role interactions, efforts to increase autonomy and status, and women's liberation as related to professionalization of nurses.

In 1974, Colson and Selby designated the study of health care institutions, personnel, and programs as one of the central concerns of medical anthropologists. They also noted that the traditional focus on health care systems undergoing change, across cultural boundaries, is shifting toward concern with health care in the United States and Western European countries. The more recent trend toward anthropological research on parallel and pluralistic medical systems in developing societies (Janzen, 1978) and toward conceptualizing

changing health-care systems in terms of "political economy" (Elling, 1981) is in the direction of truly comparative research, applying general theoretical frameworks. However, American medical anthropologists are becoming increasingly concerned with their own health-care system (Foster and Anderson, 1978). British social anthropologists have been reluctant to become involved in the kind of exchange of theories and methods and interdisciplinary relationships in which American medical anthropologists are engaged (Kaufert and Kaufert, 1978).

The focus of medical anthropology is still on the healing process and on healers and patients; research paradigms include the traditional ethnomedicine (Fabrega, 1972), the "making social of sickness" (Frankenberg, 1980), and psychotherapeutic models (Kleinman, 1978). Yet the importance of understanding how different groups and categories of personnel influence the delivery of health care is emerging in the awareness of anthropologists, and leading to research on the functioning of medical bureaucracies. The relevance of anthropology to nursing practice is increasingly recognized by nursing educators and researchers (Leininger, 1970 and 1976; Aamodt, 1978; Alvarado, 1978; Kay, 1978), particularly in dealing with ethnic differences in health beliefs and practices, and in the treatment of the "whole person", involving awareness of psychological and social factors. Still, the majority of anthropological research on the roles of nurses and their occupational status has been done in the United States (Devereux and Weiner, 1962; Foster and Anderson, 1978), as has that of sociologists reviewed above. There is a need for comparative research on the professionalization of nursing in relation to medicine and allied health occupations, and on attitudes of nurses in various work settings. Professionalization of nursing in Britain and Hong Kong will be discussed in the following chapter.

Conclusion

In view of the occupational, organizational, nursing, and health care system research reviewed above, this dissertation is an effort to explore the extent to which occupational and professional attitudes are dynamic and represent intentionality on the part of employees. It focuses on attitudes as responses to, and influences on, interaction in occupations and organizations, rather than considering them merely as results of socialization processes. In particular, an effort is made to draw together the social structural and psychological determinants of occupational and organizational attitudes. This is done by relating objective influences on work satisfaction, such as occupational status, to intervening subjective factors such as perception of one's own status, and professional commitment.

This perspective is also extended to the process of professionalization, as a dynamic process in which workers are attempting to enact or create new roles, in social interaction with one another, both individually and as members of intra-occupational and intra-organizational segments. Moreover, the process of professionalization is clarified by contrasting professional attitudes of members of such segments.

Finally, this research represents an effort to interpret the context and nature of occupational attitudes, and the process of professionalization, as areas of theoretical concern in social anthropology. The focus of this concern is the integration of social structural and psychological perspectives, as a means of refining comparative approaches which have generally relied on more macroscopic cultural comparisons, or on structural analyses exclusive of social interaction and attitudinal variations.

CHAPTER III - THE RESEARCH SETTING: HONG KONG - ADMINISTRATIVE REFORM, THE HEALTH CARE SYSTEM, AND PROFESSIONALIZATION OF NURSING

Introduction

Anthropological studies of attitudes in particular cultural settings should consider the social and political context in which these attitudes are formed. Also, while it is hard to measure precisely the degree to which ideas and policies diffuse from one society to another, the process of diffusion occurs, and involves deliberate adoption of some practices, and modification or rejection of others, by various actors in the receiving society. Recognition of this is essential in research on Hong Kong, a society of Chinese residents whose relationship to Great Britain is broadly comparable to the system of federal-state relations in the United States.

Thus the research setting of Hong Kong should first be viewed in terms of its external environment. The current change in the international economy toward financial capitalism, and Hong Kong's intermediate, shifting position with respect to center-periphery relations among world regions (Wallerstein, 1979), form the context within which it functions as a "world city" (Friedmann and Wolff, 1982). Moreover, the application of managerial planning and rationalization policies to Hong Kong's government is both a local characteristic and a reflection of an international trend.

> ...the character of the urbanizing processes - economic, social, and spatial - which define life in these 'cities' reflect, to a considerable extent, the mode of their integration into the world economy.
>
> ...what is happening in world cities is in large measure brought about by forces that lie beyond the normal range of political- and policy-control.
>
> (Friedmann and Wolff, 1982, p. 309)

These forces include changes in multinational corporations and services such as banks, law firms, and accounting firms, which have contributed to a hierarchy of world cities (Cohen, 1981).

Regardless of the political uncertainty now increasing in its relationship to the Peoples' Republic of China, Hong Kong is the epitome of the capitalist city and "free market" capitalism, as well as a vital source of foreign capital for China. It also illustrates the qualifications which should be placed on the theory that world regions are integrated into a single economic hierarchy. A closer analysis reveals a loosely-coupled system (Weick, 1976) in which both nations and cities occupy multiple roles. Thus, the British colony of Hong Kong functions as a core economic center with respect to nations such as Ghana, in which it has set up factories, and as a semi-peripheral entity in economic relations with Japan, Europe, China, Britain, and the United States - as is Singapore. Discussion of world systems as loosely-coupled systems is found in Lurie, G. (manuscript in progress).

More specific external influences on the administration of Hong Kong must also be understood, particularly those of British foreign policy and the use of corporate planning by British government. Various organizations and local government sectors within Hong Kong are trying to fit into models imported into the colony (Wong, 1979) but the relationship is more complex than simple copying

or adoption of innovations. Interaction, role testing, and role creation are involved, since the external mandate for change is ambiguous, and acts as an enabling opportunity (Lurie, G., Chapter 3). This is the case in areas such as health service, influenced by both Britain and the United States (Alford, 1975, and Roemer, 1971), and among professional organizations (Johnson, T., 1972).

After a brief overview of the development of Hong Kong, change in its administration and health care system will be compared and contrasted with parallel change in the United Kingdom. The professionalization of nursing will also be related to the transitional systems in both settings.

Development of Hong Kong

Although the existence of Hong Kong preceded European expansion, as evidenced by archeological remains on Lamma Island (Meachum, 1978), Hong Kong developed both as a result of colonization and in relation to political upheaval in China. It was Chinese territory until it came under British control following a series of wars beginning in 1842, when Hong Kong Island and the Kowloon Peninsula became British. China deeded Britain a 99-year lease on the New Territories, due to expire in 1997. The least is now being renegotiated, and its future status has not yet been decided, although China announced in November, 1982, that it was planning to resume control.

In the late nineteenth century, Hong Kong became a treaty port for the Chinese market, and center for "compradores" - Chinese capitalists. Its trade and import function was predominant through the end of World War II. After the Chinese Revolution in 1949 and with the rise of the Peoples' Republic of China, Chinese refugees - including Shanghai capitalists, cotton industrialists, and others - flooded into the British colony, bringing industrial and managerial skills

as well as capital. The refugees also furnished laborers, who lived primarily in squatter settlements. Production and export of textiles expanded, and electronics developed as an industry, with the entrance of the transnational corporations in the late 1960's. Hong Kong became an "industrial colony" (Boxer, 1961). Labor, which was cheap and non-unionized, was sought by these corporations, and although Chinese capitalists remain in control of Hong Kong factories, the colony is totally dependent on the capitalist world market.

With the growth of the Peoples' Republic, and Hong Kong's relationship both to it and to the world economy, the need to stabilize and control workers and to rationalize land use arose. This led to the initiation of social policies by the government, as evidenced by the construction of public housing estates; they were poor and inadequate, but safer from fires, mudslides, and crime than the squatter settlements. Beginning with resettlement estates such as Sek Kip Mei and Tai Wan San, public housing was expanded, into the 1970's.

The role of the government in both social welfare and administrative control began to grow in the late 1950's, and the 1960's; however, the private sector was still primarily responsible for public assistance and health care. Missionary charities, and Chinese voluntary associations such as the Po Leung Kuk and "kaifong" associations, and the Tung Wah hospital association, provided the major portion of public assistance and health care until the late 1960's. Until that time, there was little government direction or control over social services. Well-known missionary charities included the Baptist Hospital, Aberdeen Floating Clinic for boat dwellers, Gee Hip (Church of Christ in China) Technical School, Lutheran Church World Service Kwun Tong Industrial Training Centre (Salaff, 1981, p. 24), and Caritas (Roman Catholic charities).

By the 1970's, almost half of the population was factory workers, and of

these, more than half were women. Workers have been constrained by law from forming large unions across trades, but are allowed to form small unions within their industries. At the end of 1976, there were 311 employees' unions registered in Hong Kong, with a total membership of 362,600 (Gill and Leinbach, 1983). The Hong Kong Federation of Trade Unions is politically aligned with China, but endorses the Hong Kong industrial system; the Trade Union Congress is pro-Taiwan. Unemployment insurance has never been initiated; neither are medical care, old age or maternity benefits provided by industry (Salaff, 1981). A critical analysis of industrial relations in Hong Kong in the early 1970's has been made by England (1971), and Gill and Leinbach's recent study of 850 businesses in Hong Kong found that corporate social responsibility in Hong Kong "...will likely not receive more than lip service because it is a mere side issue in the struggle between different political views" (Gill and Leinbach, 1983, p. 119); laissez-faire government, to be continued under Britain, and Chinese intervention to alleviate inequalities.

In the political sphere, the late 1960's and early 1970's were a time of expansion of government involvement and administrative control, at the same time that Hong Kong's economy was shifting from industrial to financial capitalism (Jao, 1979). It was this shift which necessitated the application of corporate planning, with proposals for regulation of social and health services. This will be discussed in the following section. A critical view of Hong Kong's political structure and process at this time has been presented by Rear (1971), and England and Rear (1975); the administrative absorption of politics was analyzed by Ambrose King (1981b). An overview of the political process is found in Harris (1979), while Wong (1979) has provided an analysis of administrative change in the colony as a whole.

The expansion of government control over the New Territories (Chiu, 1979; Wong, 1979), and political transformation of the rural sector (Lurie, G., Chapter 7) have been the subject of studies by both local administrators and anthropologists. These include Austin Coates' case studies of villagers' interactions with British officials in the 1950's (Coates, 1976), Maurice Freedman's overview report in 1963 (Freedman, 1976), and James Watson's work on emigration and change in the village of San Tin from the late 1950's to 1971 (Watson, 1975). In addition, Jack Potter's research on social and economic change in the village of Ping Shan in the early 1960's (Potter, 1968), Hugh Baker's contemporary study of the lineage village of Sheung Shui (1968), Graham Johnson's study of Tsuen Wan (1971), and Fred Blake's analysis of interethnic relations in Sai Kung from 1971-73 (Blake, 1975) add to the ethnographic literature. These reflect the process of extension of the colonial administration into areas formerly controlled by Chinese lineages and associations (Scott, I., 1979). However, the development of new towns within Hong Kong, and concurrent administrative centralization and bureaucratization, is the change which forms the context of the research setting for this study - Kwun Tong (Hayes, 1977).

Kwun Tong is a classic example of regional development of an industrial new town in Hong Kong. With its concentration of population close to factories, this area became an early model of new town planning, in terms of population distribution, land use, and industrial development. However, planning in Kwun Tong was ad hoc, haphazard, and ineffectual, since the area had been treated mainly as a spill-over for urban population in Kowloon. Only in recent years was innovation in community health care in the area assisted by government, with the establishment of United Christian Hospital and the Kwun Tong Health Project. Yet the development of this region foreshadowed future new town planning in

Hong Kong (Riches, 1973; Chan, 1981).

> Although official attitudes towards further urban developments along the lines of Kwun Tong were for a time restrictive, in as much as it was thought that the rural atmosphere of the New Territories was worthy and capable of preservation, the rapid urbanization of this area is now regarded as inevitable.
>
> (Dwyer, 1971, pp. 5-6)

Kwun Tong was needed mainly to provide additional industrial land to make up for the shortage in the urban areas of Hong Kong. This "industrial satellite" of about 300 acres, within about three miles of Kowloon, now includes over 650,000 people and 3000 factories (Paterson, 1978, p. 85), most of them small (King and Man, 1979). Cotton yarn, and piecegoods, cosmetics, pharmaceutical products, furniture, garments, electrical equipment, paint and lacquer, plastics, paper and metal products, printed materials, precision instruments, machine parts, and rattanware are produced here (Dwyer, 1971, p. 53). There are also a few large factories, including that which produces alligator shirts, and Fairchild Electronics. In 1977, New Kowloon, including Kwun Tong and Ngau Tau Kok, comprised 62% of Hong Kong's industrial employed (Salaff, 1981, p. 15).

The majority of Kwun Tong's residents are middle- or lower-income, and live in public housing estates, most in single-room units. Family life in Hong Kong's public housing estates has been portrayed by Salaff (1981), in her study of working daughters. The complex image - both positive and negative - of the resettlement estate, as found among residents of the Kwun Tong Resettlement Estate, has been presented as an ethnographic model by Myers (1981). This housing complex, known as the "Kaai Liu" - "Chicken Coop" - is one of the oldest in Hong Kong, and the responses of residents to their situation vary with their generation; younger residents are internalizing more attitudes of the larger Hong Kong society.

In his study of the political culture of Kwun Tong as a Hong Kong

community, Ambrose King has analyzed the particular distribution of patterns of orientation toward political objects among members of the political system (King, 1981b). This research was part of the Kwun Tong Industrial Community Research Programme, carried out under the Social Research Centre at Chinese University in the New Territories, between 1970 and 1974. Both leaders, and "ordinary men" -the latter were mostly women - were given structured questionnaires and intensive interviews on their cognitive, affective, and evaluative orientations toward the political system, its inputs and outputs, and the self as actor in the system. Findings revealed parochialism and apolitical orientations of half the population of Kwun Tong, although half were interested. Economic and religious leaders were much more concerned about politics and showed a higher sense of citizen cuty, but had "an extremely unfavourable expectation of the responsiveness of government officials, should they try to explain their point of view to them" (King, 1981b, p. 163). Both leaders and non-leaders tended to think that government rather than the citizens should be responsible for improving living conditions, and their sense of political efficacy was rather low, although a trend was developing toward more participation.

This survey gives insight into the response of one community - the research setting for the dissertation - to Hong Kong's social and political system. The overall political process is based on bureaucratic administration by district officers at various levels. Citizens do not vote directly on policies or government officials. However, they can select Unofficial Representatives to the Urban Council, one of the decision-making bodies in the colony; the others include the Legislative Council, on which leading local businessmen serve as Unofficial members; and the Executive Council, government advisory committees, and ad-hoc committees, all created by and affiliated with the government (Miners, 1975).

The system functions to select both entry into, and exit from, the decision-making structures so that political opponents are excluded, and opportunity of access to the polity is low (Tang, 1973). Political participation on the local level is carried out primarily by leaders in community and voluntary organizations, and these may become affiliated with "government-institutionalized status hierarchies through the appointment of the Unofficial Justice of the Peace and the conference of honours such as OBE, CBE and Knighthood." (Tang, 1973, p. 26). This means of strengthening the government's control over voluntary associations has been particularly applied to the Po Leung Kuk and Tung Wah charity associations.

As part of the process of political integration and administrative absorption of politics in Hong Kong (King, 1981a), the government established Mutual Aid Committees in public and private housing in 1973. These were originally set up to aid in protection against crime and improve community interaction, and communication between the residents and Hong Kong government (Scott, 1980). They have also provided a means of expanding administrative control (Lurie, G.).

Systemic change in the administrative functioning of Hong Kong is the result of a deliberate effort by government at introducing the British and American model of corporate planning. The meaning of this model, its application in Britain and Hong Kong, and its relation to the health care system will be discussed in the following section.

Although the consequences of attempts at governmental reform and the manipulation of these efforts by various local groups for their own interests are not the focus of this dissertation, it should be remembered that change involves actions by both reformers and their target groups. It is in this sense that March and Olsen have employed the notion of the "garbage can model" (March and Olsen, 1976; Lurie, G.) to characterize organizational change. Borrowing this model and

applying it to urban reform, Hong Kong - which, translated, means "fragrant harbor" - may truly be said to be the "garbage can" of Asia (Lurie, G., forthcoming dissertation).

Corporate Planning in Britain and Hong Kong

Professionalization of nursing in Hong Kong is developing in the context of the reorganization of health care toward a centrally-controlled system of regional hospitals and clinics, and government nurses have been brought into the salary scale for civil servants (Hong Kong Nursing Journal editorial, 1978). These efforts at rationalizing the health-care system are related to concurrent changes toward governmental management of education, housing, and social welfare services, occurring along with the development of new towns and planned dispersion of the urban population. In general, the model of corporate management used in British governmental reform has been imported into Hong Kong (Lurie, G., forthcoming PhD. dissertation).

The development of the welfare state in Britain since the postwar period, beginning in the mid-1940's, involved experiments in reform of local government, including those related to attempts to redistribute urban populations (Smallwood, 1965; Rodwin, 1970). These experiments accelerated and became subjects for the application of the corporate management model in the 1960's, stressing rational planning in local government (Stewart, 1973; Greenwood and Stewart, 1974; Eddison, 1973). An alternative perspective which takes the view that attempts at corporate planning were part of a deliberate, organized plan for increased social control is the Marxist interpretation, represented by such studies as Bridges (1975), Dearlove (1979) and Cockburn (1977). Still another view, that the "urban programme" of reform in Britain was characterized by evolutionary growth

through incremental changes resulting from the process of bureaucratic politics, rather than from organized planning, is represented by Edwards and Batley (1978). At any rate, the model of corporate management has become a rationale for administrative reform in both Britain and Hong Kong.

Ironically, although "one of the most important recent developments in public sector management in Britain in the recent past has been the growth of the corporate approach to organizational management and planning" (Gray, C., 1982), this approach has met with limited success. It was already being reevaluated and modified at the time it was introduced into Hong Kong government (Lurie, G., forthcoming PhD. dissertation). The corporate management approach, developed in American business in the 1950's and adopted by Britain for planning in the public sector in the 1960's, has been characterized as emphasizing the need for coordinated action in an organization, with attention to both the environment and to organizational structure and processes. Planning processes are central; these focus on analysis of needs and problems, definition of goals, setting of priorities, development of appropriate resources and programs, and evaluation of results (Gray, C., 1982).

These are general characteristics of the managerial models which were employed in restructuring of the various British public services in the late 1960's and early 1970's. Both the Brunel Health Services Organizational Research Unit and the American management consultants, McKinsey and Company, Incorporated, advised British health agencies, social service departments, and local and central governments (Alaszewski, et al, 1981). The size of administrative units was increased, and service coordination, community involvement, and use of professionals in a hierarchical management structure were stressed. Reports by Salmon (1966), Godber (1967), and Howard (1967)

applied management principles to increase hospitals' effectiveness.

However, criticisms of corporate planning developed as difficulties in implementation emerged. Some objections centered on the complexity of bureaucratic structures that were established, and on the problems involved in achieving increased rationality of management, in terms of reducing expenditures and making allocation of resources more efficient. On the one hand, the departmentalism in British local government was said to decrease the efficacy of corporate management; on the other, the introduction of corporate management was held to have had the effect of centralizing power and excluding those below the top level from decision-making (Gray, C., 1982). An alternate view has also been advanced: that corporate planning attempted to simplify administration more than was practical to deal with the complexity of problems, which were interrelated, and that it increased too much the number of persons participating in decision-making (Haynes, 1980).

Although problems of implementation are also evident in Hong Kong, corporate management is the official model for urban planning by the British colonial government there, as Hong Kong changes from industrial to financial capitalism (Jao, 1979 and 1980). The logic of financial capitalism is based on corporate management. In the 1970's, reforms in local government tended toward centralization and bureaucratization of services, and regional administrative units became responsible for implementing policies in the developing new town areas.

Review of political events just prior to the McKinsey study of Hong Kong government in 1972 gives insight into the environment in which recommendations for change were made. In 1971, the members of the Urban Council, the only Hong Kong body with elected members which had executive powers, sought an increase in their authority over education, medical services, and social welfare. However,

the colonial government held them to involvement in environmental health, recreational and cultural facilities, and minimal authority over public housing (Far Eastern Economic Review Yearbook, 1972, p. 159). Criticism of official policies had grown following the "riots" of 1967, in which some Communist extremists were imprisoned, and the Financial Secretary and British colonial governor, both experienced and influential, retired. A new immigration bill in 1971, proposing that the Hong Kong government severely restrict immigration, was criticized by China as an attempt to create an independent state (Far Eastern Economic Review Yearbook, 1972, p. 160), and Hong Kong sought support from Britain.

Reforms in 1971 included those establishing free, compulsory primary education, and extension of public assistance to allow for cash payments to needy persons. The changing relationship between voluntary charitable organizations and government was shown by response to a strike of blind workers at a factory run by the Council for the Blind: the Council of Social Service announced plans to study longterm needs of handicapped persons. In the same year, nurses and teachers protested the new salary scale for government workers, which had been introduced paralleling civil service reform in Britain (Chapman and Greenaway, 1980; Fry, 1981). A nurses' strike was called to protest nurses' initial exclusion from the plan to make pay for female civil servants equal to that of males by 1975, and their subsequent inclusion at a rate lower than that for male nurses. This was followed by introduction of a single salary scale raising beginning wages of nurses from US$72 to US$219 per month (Far Eastern Economic Review Yearbook, 1972, p. 162). The Hong Kong nurses' strike will be compared to actions of nurses in the British National Health Service in the next section.

Following these events, and paralleling similar studies in Britain, a study by McKinsey and Company, Incorporated of the "machinery of government" in Hong

Kong attempted to diagnose problems and make recommendations for improved effectiveness in the processes of planning, development of proposals for innovations, and decision-making and implementation. The goal was to determine "...how current methods of management affected performance, and what improved managerial approaches would encourage change from within, in response to the demands of the growing and more complex range of Government business" (McKinsey and Company, 1973, p. i). Recommendations were made for changes in the Medical and Health, Education, Police, Urban Services, and Public Works Departments. The overall problem was stated to be maximum use of scarce resources, including skilled and experienced staff, in the expansion of government services. Among problems of organization in the central government, it was noted that diffusion of responsibility for programs involved more than one policy branch, leading to lack of sufficient planning and coordination. For example:

> ...the provision of the Medical and Health service depends on the University training the doctors, various subvented and private institutions providing medical services, the Public Works Department designing and constructing hospitals and clinics, the Fire Services Department providing ambulances, the Medical and Health Department recruiting and training nurses, running hospitals, etc.
>
> (McKinsey and Company, Incorporated, 1973, p. 14)

Related problems were stated to be the large span of control of the central government body (Secretariat) and lack of balance between policy and resource branches. Among changes recommended were the delegation of more administrative work to various departments, and regrouping policy branches to match program areas, including placing medical and health services under the Social Services branch. A rationale was also presented for developing "programme plans" to analyze the needs and means of reaching the goals of a service, as a means of facilitating management by decision-makers.

The McKinsey report on Hong Kong government represents a direct application of the corporate management model. Although it was drafted after the consultants had spent more than a year in Hong Kong, it received criticism because of its overly close similarity to analyses and recommendations for urban areas in England, regardless of differences in local situations. Moreover, in Hong Kong, as in England, the process of actual implementation was not simple. Given the level of generality- or vagueness- of many of the recommendations, those who put them into practice were left to interpret them in terms of their own experience, environment, and interests. In the transition toward corporate planning, ambiguities arose around the process of implementation, leaving opportunities for both individuals and groups to negotiate their own positions.

Before turning to nurses in the changing health-care system of Hong Kong, a brief discussion of the British National Health Service will illustrate both the problems of corporate planning, and of professionalization of nurses, who have attempted to negotiate their roles and positions in the system.

The National Health Service and Professionalization of Nursing

Recent attempts at reorganization of the British National Health Service reveal both the trend toward rational, corporate planning in the public sector in the 1960's and 1970's, and the subsequent swing back toward incremental decision-making. The National Health Service provides most of the health care in Britain, and employs the majority of physicians, nurses, and other health professionals. In 1974, the system was reorganized to replace the three administrative branches - regional hospital boards, hospital management committees, and boards of governors - which had existed since the National Health Service was established in 1948 (Brown, 1979). These were replaced by one bureaucracy, centered in Area

Health Authorities (Alaszewski, et al, 1981), designed to increase efficiency and reduce cost of providing health care through integration of administration. The school health service, health education, health visiting and home nursing were also brought under the National Health Service (Brown, 1978), administered by the Secretary of State for Health and Social Service (Klein, 1980 a and b).

Five years later, the new centralized organization, which had been criticized as too expensive, complex and inefficient for decision-making, was again reorganized by the new Conservative government. The 1979 reorganization was carried out to reinforce both local autonomy, and "political-incremental" decision-making - the opposite of rational, corporate planning (Alaszewski, et al, 1981).

Analyses of the National Health Service have varied in interpretations of the degree to which it achieved coordination among groups involved in provision of health and medical services. Eckstein (1960) stressed pressure group politics in the National Health Service, using a perspective similar to that of Alford (1972) who emphasized the interaction of interest groups in medical care in the United States:

> ...both the expansion of the health care industry and the apparent absence of change are due to a struggle between different major interest groups operating within the context of a market society - professional monopolists controlling the major health resources, corporate rationalizers challenging their power, and the community population seeking better health care.
>
> (Alford, 1972, p. 128)

Klein's review of the British National Health Service in 1974 modified this perspective. He stated that "...the National Health Service has been a game reserve for political scientists interested in analyzing the role of pressure groups" (p. 1). His view was that to focus on issues in which doctors have been in conflict

with the government was to ignore the fact that the power of pressure groups varies with the nature of the issue, the setting, and commitments of participants. Reorganization of the National Health Service was in the interest both of central administrators and of general practitioners, who had been isolated from hospitals where the prestigious specialized work was done. However, a "bargain" was struck between the medical profession and the government in terms of control of resources and services. The 1974 reorganization was intended to establish rational-managerial decision-making and redistribute power, but failed to do so, according to Alaszewski, et al (1981); Navarro (1978); and was followed by the swing back toward political-incremental decision-making in 1979. Klein (1982) has recently analyzed the National Health Service as an organization characterized by a high degree of uncertainty as to the relationship of planning and results, by diversity of goals and activities, and by ambiguity of information; thus, it is difficult to evaluate.

Because of the opportunities for administrative positions in the bureaucracy of the National Health Service, nursing has attracted males, although they are concentrated in mental hospitals. Clinical job ladders within hospitals have been suggested, but not developed, and management is still the primary route for advancement for nurses on the hospital level. However, the service ideal still dominates nursing education, and the profession as a whole in Britain (McCloskey, 1981). Since most nurses are trained in apprenticeship programs in hospitals, student nurses provide a major portion of patient care. Nursing education will be outlined below.

Since 1979, the National Health Service has been administered by a hierarchy of central government departments, regional health authorities, area health authorities, and districts. Teams of four persons, including a physician, a

nurse, an administrator, and a finance officer, have managed district health authorities. A government proposal to further increase autonomy of local districts, to be implemented by April of 1983, would expand these teams from four to sixteen members, in order to eliminate the area health authorities. This proposal resulted in confusion about requirements for the new nurse director jobs that would be created, and received criticism from such organizations as the Royal College of Nursing, and the National Union of Public Employees, which has attempted to negotiate staff salaries and working conditions (Nursing Times editorial, 1980, p. 1330).

The overall organization of British medical and nursing personnel has influenced the professional status of nurses. Because physicians are divided into two status groups, specialists and general practitioners, and the latter do not practice in hospitals while nurses do, nurses compare more favorably with physicians in general than do American nurses. An American nursing educator working in a London hospital found nurses made most decisions on patient care, performed many tasks done in the United States by interns, and that ward sisters and staff nurses were often asked by physicians for their opinions on patient care (Sulco, 1976). As McCloskey (1981) states, the problem of professionalization is a different one in each country, and it is necessary to understand a society's values, beliefs, and constraints in order to determine who is a professional. In Britain, university education is less of a social or professional necessity for nurses or for other occupations than in the United States.

While interest in baccalaureate education for British nurses is growing, the majority receive diplomas from hospital programs; the length of training is three years for the State Registered Nurse, a position comparable to the American registered nurse, and two years for the State Enrolled Nurse, a position

comparable to the American practical nurse. These periods include a combination of theoretical and clinical training, based on syllabi outlined by the General Nursing Council. Students who desire to specialize can enter a hospital with a particular specialty for training; for example, study in a mental hospital leads to the certificate of Registered Mental Nurse. Many graduate nurses continue their education in one-year midwifery programs, or intensive care, renal dialysis, orthopedic, or coronary care nursing; meanwhile, they receive their National Health Service salaries (Sulco, 1976).

Comparison of nurses' professional associations in Britain and the United States reveals the long-term effects of the movement toward corporate planning in health care in Britain:

> At the very moment when the American Nurses' Association was unveiling a new argument about the complexity of nursing work and the long-term need for all professional nurses to have a baccalaureate preparation, the Royal College of Nursing in Britain was advancing a plan to restructure the managerial work of the nurse.... It received official endorsement in the extended nursing officer hierarchy of the Salmon Report. British nursing thus developed a hierarchical structure which is strikingly different from the American pattern.
>
> (Davies, 1979, p. 517)

In the 1950's and 1960's, the nursing matron of the largest hospital in each British district took precedence over nursing staff in local hospitals, and specialization of nursing functions in wards within each hospital increased so that the role of the ward sister was diminished. The Salmon Report led to a graded nursing hierarchy within the hospital, based on managerial decision-making functions, and involved nurses at the top level in planning, but not those in lower positions (Bellaby and Oribabor, 1980).

In their efforts to advance their positions, British nurses have been alternately drawn to professionalism or unionism. This has been interpreted from

a broad Marxist perspective as related to the "...changing mode of control and delivery of health care and nurses' contradictory position within the social relations that constitute that mode" (Bellaby and Oribabor, 1980, p. 291). Also, since 1950, there has been an increase in both demand for and supply of nurses, and a shift toward more part-time and State Enrolled Nurses (MacKenzie, 1979), compared with State Registered Nurses. There has also been a steady increase in the number of overseas-born nurses working in the National Health Service, with training schools recruiting students from the Commonwealth (Bellaby and Oribabor, 1980, p. 299). The Royal College of Nursing has recently amalgamated with the Nursing Auxilliaries Association and registered as a trade union, in order to compete with both the National Union of Public Employees and the Confederation of Hospital Service Employees, as the sole bargaining agent for nurses in Britain.

The issue of whether nurses should strike to achieve their goals has arisen among the various unions. Nurses who have been members of the Confederation of Hospital Service Employees or the National Union of Public Employees have taken "limited industrial action" (Brown, A., 1980, p. 15), and in 1978 some members of the Royal College of Nursing working in one hospital threatened to close a portion of the beds if their demands for additional nursing staff were not met. However, in 1979 the Royal College of Nursing decided against allowing nurses to strike, and the General Nursing Council for England and Wales warned all registered and enrolled nurses about the consequences of striking, following a hospital walkout. British nurses have lobbied for pay increases during the last decade. In 1978 a new salary scale gave a 10% increase in base pay to grades ranging upward from three levels of student nurses, auxilliaries, enrolled nurses, staff nurses, midwives, and nursing sisters, to health visitors, district nurses,

nursing officers, and nursing teachers and tutors. This scale was attacked by the National Union of Public Employees as not giving enough to lower-paid nurses, but it was accepted by the Confederation of Hospital Service Employees and the Royal College of Nursing (Nursing Times editorial, 1978, p. 648).

The roles of nurses both in patient care and as professionals in the British health care system continue to be a matter of concern to those in various positions. In some areas, such as London, there is an increasing shortage of nurses in the National Health Service below the level of nursing officer, since many are leaving to work in private hospitals. Although nursing grades make up almost half of the employees in the National Health Service, there are few criteria for manpower planning, so trained staff can be replaced by auxilliary personnel to save money (Kirwin, 1981). Review of professional training for nurses is an ongoing process. The Briggs report in 1972 recommended a central body to determine professional standards, education and discipline, as well as the establishment of several hundred independent nursing and midwifery colleges offering two levels of training. This educational system has not been implemented, due partly to funding requirements (MacKenzie, 1979). While interest in American nursing education is growing, there is much support among nurses for the orientation of the British system toward clinical training to be retained.

In patient care, the difficulties of implementing the American concept of the "nursing process", involving use of nursing histories and care plans, have also received attention from British nursing educators (Kirwin, 1980, p. 36). In addition, they are attempting to weigh the advantages of proposed changes in positions and responsibilities of various staff. These include the proposal to strengthen the authority of ward sisters, and place them under a director of

nursing services, as contrasted with the current bureaucracy of nursing officers. The Royal College of Nursing has also suggested absorbing enrolled nurses into the higher grade of registered nurse, by supplementing the training of the former, and eventually raising their training requirements; this has been met with discussion and argument among staff.

The most recent reorganization plan for the National Health Service will tend to further separate community health services and personnel, including general practitioners, from hospital services, and has been criticized by nursing officers for concentrating on curing illnesses rather than on health and preventive care. One nursing officer has advocated nurses' contributions to health planning, and has supported a plan for community units to be given responsibility for all community and child health nursing, within each district (Gillett, 1981). Support has also been given to expansion of the role of community liaison nurse, who provides a link between hospital and community services for discharged patients, and acts as a liaison between other medical, health, and social service workers (Wells and Snee, 1981).

The development of nursing as a profession in Hong Kong has paralleled that in Britain in some respects, but must be considered in relation to expansion and bureaucratization of the Hong Kong health care system. Training for nurses in Hong Kong follows the British pattern of general nurse education and midwifery: three years for registered general nurses, two years for enrolled (licensed) nurses, and one year for midwifery. All nursing education occurs in hospitals and nursing schools. In 1977, Community Health courses were the only post-basic ones available, and nurses had to leave Hong Kong to specialize as nurse tutors, or in other areas. Many chose Australia or the United States because the cost of travel was less than to the United Kingdom (Mellish, 1977). The hospital hierarchy of

nurses in Hong Kong is similar to that in Britain, but nurses do not hold district administrative positions in Hong Kong, since there is no National Health Service. Although community health care is a recent innovation in Hong Kong, this is carried out primarily by nurses, rather than by health visitors. The relationship of community health care and professionalization of nursing to regional organization of health care in Hong Kong is discussed in the following sections.

Expansion of Health Care in Hong Kong and Growth of Community Nursing

The concept of corporate planning has been applied to health care in Hong Kong to develop a centralized system of hospitals and clinics, organized into a hierarchy according to service functions. This deliberate effort at rationalizing organization and services has also tended to accelerate the trend toward specialization of professionals, including physicians, nurses, and allied health workers. The modern medical sector in Hong Kong, which coexists with classical Chinese, folk, and religious medical practices, includes general and psychiatric hospitals, outpatient clinics, maternity and child health care, nursing homes, rehabilitation centers, immunization services, and medical laboratories. These facilities are staffed by both general practitioners and specialists, as well as dentists, pharmacists, midwives, general and psychiatric nurses, medical social workers, and technicians, among others (Lee, R., 1975). Residents of Kwun Tong utilize both traditional and modern practitioners.

This proliferation of health care professionals and development of modern medical services based on the "Western" model has taken place along with a pattern of change in health problems often seen in developing societies: decline of infectious diseases and of infant and maternal mortality, and increasing prominence of chronic diseases such as cancer and heart disease. Also, since

World War II, water supply and sanitation have been greatly improved.

Since Hong Kong has no national health scheme, private practice forms the core of physician services, although the government employs one-fourth of all the "modern-trained" physicians - those trained in Western medicine. No Chinese-trained practitioners are employed by the government, or have access to hospital beds for their patients. Medical practice is supervised by the Medical Council of Hong Kong, and only physicians holding diplomas recognized by the General Medical Council of the United Kingdom are considered legally qualified. There are now two medical schools, including that at the British-run Hong Kong University, and a new medical school which opened in 1981 at Chinese University, located in Shatin, New Territories.

In 1975, of the more than 10,000 hospital beds in Hong Kong, only about 40% were provided by government hospitals; the rest were in missionary and voluntary hospitals (Lee, 1975, p. 54). The regionalization scheme to organize and expand health services was introduced in 1978 (Lee, 1982), and the government's policy is to provide low-cost medical care, particularly for the economically disadvantaged. In 1978, the cost of a full medical consultation at a government outpatient clinic, including medicines, was only US 20 cents per visit, and the cost of staying in a government hospital was US $1 per day. Fifty-one outpatient clinics and twelve government hospitals served both urban and rural populations, in addition to the voluntary hospitals and private practitioners (Australasian Nurses Journal, 1978, p. 20).

The expansion of health services was based on recommendations of a Medical Development Advisory Committee appointed in 1973, the same year the Hong Kong McKinsey Report was issued. The task of this committee was to make recommendations for the provision of hospital beds, physicians, and nurses for the

next ten years. In response to the committee's report, the Executive Committee of the Hong Kong Nurses Association also submitted recommendations on priorities to be given to major projects required to achieve proposed standards for improvement and expansion of health services and provision of facilities and personnel (International Nursing Review, 1974).

The 1974 proposal for regional organization of services called for new facilities in keeping with the regional program to redistribute population from the urban areas and develop new towns such as those in the New Territories at Shatin and Tuen Mun. Medical and health divisions of the government department were to be more integrated, and planning was to be based on the needs of each region. The proposal outlined the building of three new hospitals, six new polyclinics, and six general clinics, in addition to the new medical school at Chinese University, a third nurses' training school, a dental school to be established at Hong Kong University, and a school dental service. Also, the government was to expand family planning services, and medical treatment for drug addiction.

In 1978, there were four major regional hospitals in Hong Kong, with general clinics and specialized polyclinics: Queen Mary Hospital on Hong Kong Island; Kwong Wah Hospital in West Kowloon; Queen Elizabeth Hospital, serving East Kowloon and East New Territories; and a new hospital, Princess Margaret, West New Territories. A fifth region was being planned to serve anticipated population movement to East New Territories, and a hospital-clinic complex scheduled to open at Shatin in 1982-83, with an additional hospital and clinic at Tuen Mun in West New Territories. Elsewhere in the New Territories and East Kowloon, four additional clinics, a polyclinic, and a health center were planned to be completed by 1984. Also, a second mental hospital was scheduled to be opened in 1980, and three additional medical rehabilitation centers were proposed under a separate

plan for development of rehabilitation services (Australasian Nurses Journal, 1978, p. 21).

The United Christian Hospital in Kwun Tong was opened for restricted service in 1973, just prior to the 1974 government proposal for regional organization of health facilities for urban and new town areas. It had been planned by the United Christian Hospital Committee in 1968, to supplement the local government primary care clinic in the community and serve the rapidly increasing population. At the same time, a community nursing service was planned to take "hospital quality" nursing care to residents of high rise housing estates, squatter shacks, and fishing boats. A training program for nurses was tested and community work begun a year before the hospital opened, and a community health project was also planned to provide preventive care and health education and promote community responsibility for health care, as well as improve health on the "caring-curing" level (Paterson, 1978, p. 85). Provision of government funding for the hospital made this program possible, and a grant from the Protestant Central Agency of West Germany from 1976-79 led to development of Infant Health and Adult Health Maintenance Programs. The Medical Superintendent of United Christian outlined both the rationale and role of each segment of the Kwun Tong health care program, beginning with the hospital:

> The hospital itself is a miniature community, and should be a demonstration model of a healthy community for all to see. This implied care for the health of the entire staff, health education for all, an atmosphere of mutual care, concern, and responsibility, freedom from 'status' attitudes and an understanding of the meaning of the larger 'healthy community'.
>
> (Paterson, 1978, p. 88)

In addition to the hospital, which is the headquarters of the Community Health Project and provides outpatient clinic and emergency care as well as surgery and inpatient care, health centers with clinics, community health and

health education programs are located in the Sau Mau Ping, Yau Tong, and Lam Tin housing estates in Kwun Tong. An occupational health center was established in the business area of Kwun Tong outside the industrial zone by 1978, although attempts were underway to find a site closer to the factories. At this time, factory managers had not yet accepted a comprehensive, prepaid, preventive Occupational Health Programme including annual health screenings, but asked for sickness and injury care with payment for each service.

The need for home health care in Hong Kong is filled by a small number of community nurses, while health visitors mainly work in clinics and deal with health education. Physicians do not make home visits. The history of community nursing in Hong Kong reveals the interaction of charities and missionary organizations with government support on a limited level. In 1967, the Methodist Medical Committee began a small-scale, pilot home nursing program, later transferred to the Yang Social Service Centre. This was followed by plans for the Kwun Tong community nursing service. In 1970, the government recruited a planning director for community nursing from the Queen's Nursing Institute; she advocated the expansion of community nursing, presenting its success in dealing with various health problems and providing low-cost care and assistance to families (Gray, 1974). New projects began to be developed and attached to different hospitals, such as Maryknoll Hospital in Kowloon and Nethersole Hospital on Hong Kong Island.

In 1977, the government officially recognized community nursing, and granted funding to the program in operation under Caritas (Catholic charities), one of the largest and oldest social welfare agencies in the colony, which had begun community nursing in the densely populated area of Shum Shui Po in Kowloon and established a three-month training program for nurses (Philpot,

1981). Ten community nursing centers had been put into operation by 1976: two under Caritas, two from the United Christian Hospital, and one at Rennies Mill in Junk Bay off Kwun Tong. These employed a total of twelve registered and eight enrolled nurses, both male and female (Queen's Nursing Journal, 1977). During the year of 1976, between eight and eleven community nurses made a total of 20,000 home visits in Kwun Tong alone, mostly for follow-up care for patients discharged from the hospital (Paterson, 1978, p. 86).

In Hong Kong, due to Chinese household and family patterns, the community nurse spends more time on socio-psychological aspects of care, and less on bedside care for the chronically ill, than does the district nurse in British urban areas. Nurses assist maternity patients, the elderly and the chronically ill, post-surgical, handicapped, and psychiatric and mentally-retarded patients; they give instructions in medications, and refer patients to hospitals. In addition, these nurses act as liaisons with physicians, social workers, physiotherapists, and clinical psychologists. Practical problems they encounter include lack of privacy for patient care in crowded housing, poor sanitation in squatter settlements, and the amount of time required for travelling to patients' homes.

The training of community nurses employs a comprehensive approach and emphasizes the necessity of using initiative in decision-making and planning, and sensitivity to family situations. In 1972, the first post-graduate community nursing course, based on a syllabus from the United Kingdom, was held (Gray, 1974). A course sponsored by the Hong Kong Nurses Association and the Hong Kong Council of Social Service for ten registered and ten enrolled nurses, from December, 1975, to May, 1976, included field visits to institutions and organizations, with two weeks of placement in practical work and a combined written and practical examination. Lecturers from medical, health, nursing, and

allied professions were combined to train participants (Fung, 1977). Such courses supplement training received by student nurses.

Professionalization of Nursing in Hong Kong: the Organizational Context

Efforts by Hong Kong nurses' organizations to increase professional status of nurses have taken alternate paths: increasing education and training and applying pressure for better working conditions and remuneration through professional groups, or alliances with civil servants in actions to protest salaries and conditions of service. The Hong Kong Nurses Association has followed the former route to professionalization. In 1974, the Lamb report to the government on the training of Hong Kong nurses for registration with the Nursing Board commended the Hong Kong Nurses Association, founded in 1964, for its contribution to continuing education for nurses. The same year, the Association conducted twenty-one courses, on the topics of: ward administration and clinical instruction, microbiology, applied anatomy and physiology, pathology, therapeutic drugs, internal medicine, sociology, and psychology (International Nursing Review, 1974). Courses on the training of trainers, and the art of examining, were added in 1975, and a series of lectures were presented on internal medicine, and management by nurses (International Nursing Review, 1975). A course for nurse teachers was also set up by the Association at the Extra-Mural Department of Chinese University (Nursing Times Supplement, 1975).

An address by the President of the Hong Kong Nurses' Association on International Nurses' Day summarized these educational programs and set forth the International Code of Ethics for Nurses, as a statement both of nurses' responsibility to patients, and as a guideline for professional performance and participation in society (Iu, 1974). This was also the year in which the Nursing

Board announced that Hong Kong qualified nurses who desired registration with the General Nursing Council for England and Wales could no longer expect to be accepted on a "reciprocal" basis. Their applications would have to be reviewed individually, a policy change which was also being applied to Hong Kong residents wishing to enter the United Kingdom for other reasons. Knowledge of the English language was considered important for meeting British standards (Iu, 1975).

In 1975, an alliance between the professions of nursing and social work was advocated by the Director of the Hong Kong Council of Social Service (Hui, 1975). He focused on the role of the nurse as a member of a team of medical and health care professionals, and social workers, and noted the importance of unity among nurses in striving to improve salaries and nurse-patient ratios. This was also an effort to consolidate the goals of nurses with those of social workers, as groups attempting to raise their professional positions in Hong Kong society.

The Hong Kong Nurses' Association continued expansion of its educational activities, opening a centrally-located Nursing Centre in 1976 (International Nursing Review, 1976) and adding clinical courses and seminars on such topics as counselling and transactional analysis. In 1977, the president, Sheila Iu, presented a contemporary view of the nurse's role, stating that if it is accepted that patient care is nurses' primary responsibility and domain, they must "fight for adequate means with which to provide it" (International Nursing Review, 1977, p. 187). Again, in 1978, she used the occasion of the celebration of the birthday of Florence Nightingale and International Nurses' Day to present the management role of nurses, with the need to reduce patient loads, and the essential contribution of continuing education to professional development of nurses (Iu, 1978).

Contemporary actions of nurses to obtain higher salaries employed more

direct techniques. These included token sit-ins by the Government Nursing Staff Association, and efforts of the Nurses' Unit of the Chinese Civil Servants' Association to obtain benefits and reorganization of the nursing structure. The former group was protesting the failure of the government to raise the range of nurses' salaries to a maximum level consistent with salaries of Radiographers, with whom they had been previously classified (Hong Kong Nursing Journal Editorial, 1978). In response to mounting unrest among civil servants in various categories, a Review Board was set up to examine salaries and working conditions, and the Medical and Health Department promised to submit a report on payscales and grade structure of nurses to the government nurses' unions.

However, in 1980, the Hong Kong Nurses' Association was warned by its president about involvement in "industrial action", such as striking or working to rule, she cautioned nurses not to damage their profession by succumbing to "the cult of opportunism and militancy" - thereby placing their status in jeopardy. While conceding that working conditions and remuneration for nurses had been slow to improve, Iu held that: "Such action demeans the nobility of the profession of nursing and could well be counter-productive" (International Nursing Review, 1980, p. 139). The better alternative was to maintain public esteem and bring pressure through the Hong Kong Nurses' Association.

These alternate strategies to improving professional standing of nurses in Hong Kong society mirror those used in other national settings - in particular, the United Kingdom and the United States. The rhetoric of the Hong Kong Nurses Association President reflects both the viewpoint expressed by the British Royal College of Nursing in 1979 and that of a large number of American nurses. On the other hand, nurses in particular hospital settings in both countries have selected the more immediate means of demanding improvements in salaries, benefits, and

working conditions.

In Hong Kong, the transitional system of governmental administration, the changing health care system, and the publically stated views of nurses' organizations both reflect and influence the attitudes of nurses toward their occupation, and their image of themselves as professionals. These influences are necessary conditions in the professionalization of Hong Kong nurses; however, they are not sufficient to explain variations in attitudes among individuals or status groups, especially when such variations are found within a single hospital setting. The determinants of attitudinal diversity are explored by means of data analysis on the sample of nurses in United Christian Hospital, in the following chapters.

CHAPTER IV - METHODS OF DATA COLLECTION AND ANALYSIS

The Data: Sample Selection, Collection, and Characteristics

The original survey was designed to contrast work settings and job satisfaction in three types of hospital organizations: government, subsidized, and private hospitals. Questionnaires were distributed to a sample of nurses in each of eleven Hong Kong hospitals which had agreed to participate, following receipt of a letter from the researcher and initial contacts by interviewers, in 1978.

The interviewers were nine Chinese sociology students at Hong Kong Baptist College, both male and female, who had contributed to the design of the questionnaire and translated it into Chinese. The questionnaire was gone over and put into its final form with the aid of a paid Chinese research coordinator/assistant. Validation of the questionnaire was based on its construction from previously validated questionnaires, and on factor analysis, discussed below.

Initial results revealed the number of respondents in each of the original eleven hospitals to be minimal, with no one hospital contributing a sample sufficiently large for statistical analysis of the data. Consequently, a second survey was concentrated in one of the subsidized hospitals, United Christian Hospital. This site was chosen because it was the only one of the eleven hospitals to respond positively to a letter from the Department of Sociology at Hong Kong Baptist College, asking permission to survey all the nurses employed in the

hospital.

The reasons for this positive response included the familiarity of the hospital administration and American director with social research, and their desire to enhance the hospital's image through good public relations. The location of United Christian Hospital in Kwun Tong, an area in which numerous social and medical research projects had been done or were underway, was a key factor also. Concurrent research in this area of "new town" planning included that conducted in connection with the Kwun Tong community health project (dissertation in process, Kathleen Grandpierre, 1976-1978) and survey research on the practice and utilization of Chinese and western medicine, by Rance Lee (1975, a and b).

It is also significant that United Christian was a hospital striving for upward mobility, in the process of bureaucratic reorganization of Hong Kong hospitals into an integrated service hierarchy. In contrast, both those hospitals at the tops of the hierarchy, such as Queen Elizabeth II, and those hospitals which were downwardly mobile in relative position, such as Baptist Hospital, responded negatively to full-scale participation in the survey.

This points to an important methodological consideration: its is not only the researcher who seeks access to research populations and istitutions. They themselves may, and often do, actively seek contracts and participation, for their own ends. Thus, United Christian Hospital enthusiastically responded to a request for access by the researchers, because the hospital interpreted this not only as acceptable, but also as advantageous.

As additional factor which facilitated data collection at United Christian was the existence of extensive social networks between the interviewers and the nurses employed in the hospital. This both predisposed the interviewers toward data collection, and increased the likelihood of securing a large number of

respondents and a high proportion of completed interviews in the sample.

With the assistance of the United Christian nursing director, questionnaires were distributed to the entire nursing staff, and a total of 212 repondents was obtained. One interview was given to each nurse, and married nurses were asked to have their husbands fill out the husbands' questionnaire at home. The latter was a replication of that section of the nurses' questionnaire which covered household tasks, division of labor and decision-making in the home, and marital satisfaction. For the dissertation, only the responses of the nurses were analyzed, with the exception of the husbands' responses to the question on their occcupation, in order to focus on occupational and professional characteristics of the nurses. All nurses in the sample were female.

General characteristics of the sample, based on frequencies of responses to questionnaire items, are given in the following tables. Code numbers for questions refer to the nurses' questionnaire, except where otherwise indicated. Some categories, with no responses, have been omitted; others, with few responses, are grouped together.

TABLE 4.1 - Sample Characteristics

Characteristic (Questionnaire item)	Code Number	Category	Response Frequency	Percent
1. Nursing credentials:	2101	Licensed	139	67
		Registered	64	31
		No answer	5	2
2. Age*:	1013	15-20 years	0	0
		21-25	61	29
		26-30	83	40
		31-35	13	6
		36-40	3	1
		41-45	1	.4
		over 45	0	0
		No answer	44	21
3. Marital status:	1014	Married	69	33
		Single	134	64
		No answer	7	3
4. Number of children:	1019	None	53	25
		One	23	10
		Two	10	5
		Three-Five	6	3
		Six-Eight	1	.4
		No answer, not apply	117	55
5. Educational level:	1015	Secondary school	191	91
		Post-secondary school	10	5
		No answer	9	4
6. Working hours:	1016	Shift	162	77
		Non-shift	30	14
		No answer	19	9
7. Shift worked most:	1017	Morning	22	11
		Evening	8	4
		Night	1	.5
		Alternate	133	64
		No answer, not apply	43	20
8. Income level (wages per month, H.K. $)	1018	$1000-1500	17	8
		$1500-2000	46	22
		$2000-2500	54	26

(TABLE 4.1 - continued)

Characteristic (Questionnaire item)	Code Number	Category	Response Frequency	Percent
		$2500-3000	58	27
		$3000+	32	15
		No answer	4	2

*Age: high percent of "no answers" among nurses was also reflected in the servey of husbands of married nurses, several of whom merely answered "adult". This may indicate a sociocultural perception of age as a "private" item. Traver (1976, p.336) found Hong Kong residents objected more to revealing their addresses, telephone numbers, income, and financial assets than their occupation, education, religious or political views. The former items, like age, appear to be considered more personal.

In the following table, catagories of husbands' occupations are based on responses to the open-ended question on occupation in the husbands' questionnaire. Since these were tabulated and grouped by hand, no code number was assigned to the item.

TABLE 4.2 - Married Nurses: Husband's Occupation
(Items from Husband's Questionnaire)

Category	Frequency	Percent
Business	5	9
Business administration	1	2
Purchasing	1	2
Accounting	4	7
Industrialist	1	2
Textile Industry	1	2
Administration	2	4
(Subtotal =	15	28)
Teacher	9	17
Architect	1	2
Doctor	1	2
Social worker	1	2
Official	9	17
Minister (preacher)	3	5.5
Journalist	2	4
Engineer	3	5.5
Electrical engineer	1	2
(Subtotal =	30	56)
Electrician	1	2
Fireman	1	2
Policeman	1	2
Machine operator	1	2
Clerk	2	4
(Subtotal)	6	12)
No answer	3	5.5
TOTAL =	54	

Note: 15 of the husband's questionnaires were incomplete.

Methods of Data Analysis

Chi-Square

As indicated in the introduction, the chi-square test for statistical significance of relationships between various sets of two variables was used in the preliminary data analysis. The chi-square test is a general one used to evaluate "...whether or not frequencies which have been empirically obtained differ significantly from those which would be expected under a set of theoretical assumptions" (Blalock, 1960, p.212).

Chi-square (X^2) is commonly used to determine the interrelationship between two nominal-scale variables. The procedure for obtaining chi-square includes the following steps: taking the square of the difference between the observed and expected frequencies in each cell of the table; dividing this result by the expected number of cases in each cell; and obtaining the sum of these quantities for all cells. The larger the differences that are found between the observed and expected frequencies, the larger the value of X^2. The size of the total sample must be sufficiently large so that the chi-square technique can be applied (Blalock, 1960).

It is necessary to determine the degrees of freedom for each contingency problem in order to use the chi-square table for statistical significance. In the 2 x 2 table, if a value is filled in for any one cell, the other values are determined, since expected frequencies must have the same marginal totals as observed frequencies. Therefore, there is one degree of freedom.

The primary use of the chi-square technique in analysis of this data was in indicating which relationships should be further examined, and in revealing patterned differences between the two status groups, Licensed and Registered Nurses. For example, the relationship of the variables, "nursing credentials" and

"income satisfaction", was tested by chi-square and summarized in the following 2 x 2 contingency table, with observed frequencies indicated:

TABLE 4.3 - Nursing Credentials and Income Satisfaction

Income sat. (2040):	More than enough, enough	Barely enough, not fair	N
Nursing credentials (2101):			
Licensed nurse	57 43%	76 57%	133 100%
Registered nurse	11 19%	47 81%	58 100%

$$X^2 = 10.055$$

$$df = 1$$

$$prob. = 0.0015$$

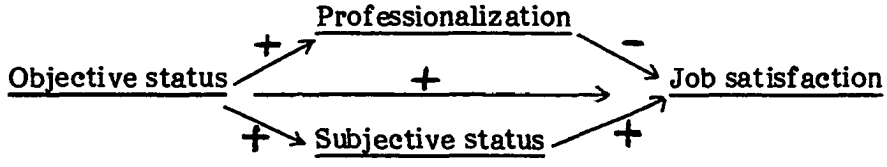
In the example given above, with one degree of freedon, the X^2 of 10.055 was found to correspond with the 0.0015 significance level. The null hypothesis of no difference between Licensed and Registerd Nurses in degree of income satisfaction is rejected, because the value of X^2 was larger than expected by chance. The probability that the frequencies obtained would have occurred by chance is 0.0015, and the relationship is statistically significant.

A summary of the relationships between objective status, as measured by nursing credentials, and variables related to subjective status, professionalization, attitudes toward the health-care system, and job satisfaction - based on chi-square tests - is given in the following chapter, Chapter V.

In the next section, the techniques of multiple regression and path analysis are discussed in relation to anthropological research and the causal model for this study. The use of factor analysis to contruct scale items in measuring study variables is then demonstrated.

Multiple Regression and Path Analysis

Following preliminary analysis by chi-square technique, multiple regression analysis was used to determine the relative effects of several independent variables on a particular dependent variable. Multiple regression is used for statistical analysis of the relationship between a single dependent variable and a set of independent or predictor variables (Kim and Kahout, 1975a; Blalock, 1960). This technique was applied to interpret the relationship among variables in the casual, or path model depicted here and in the introduction:



As a descriptive tool, multiple regression is important for evaluating prediction accuracy of a linear prediction equation, for controlling other factors to evaluate the contribution of a set of variables, and for finding structural relations and explanations for complex multivariate relationships (Kim and Kahout, 1975a). Specific application of multiple regression technique in conjunction with causal theory is best known through path analysis (Kim and Kahout, 1975a and b). Statistical inferences about a research population can also be drawn from regression analysis of sample data.

Path analysis has been used extensively in sociology (Duncan, 1966), and Hadden and DeWalt (1974) have presented the advantages for path analysis to anthropology. Path analysis is "a procedure whereby the relative importance of several independent variables on one or more dependent variables may be evaluated" (Hadden and DeWalt, 1974, p. 105). It is thus similiar to, but more flexible than, multiple regression analysis, since it permits analysis of intervening variables within a causal model.

Multiple regression analysis forms the basis of path analysis; the difference lies in the additional step in path analysis of introducing a residual variable for every intervening or dependent variable in the casual, or path, model. This is done so that the unexplained portion of the variance can be accounted for. Both assumptions about the causal model and those about residual variables can be evaluated empirically.

The advantages of path analysis to anthropological research include the general ones of making causal structures more explicit, and facilitating criticism, replication, and cumulative research. These same advantages accrue from multiple regression analysis. Specific contributions of path analysis include estimation of the effects implied by a causal model, and evaluation of the effects of particular forms of error, such as those due to bias resulting from ethnographic techniques (Hadden and DeWalt, 1974).

For this dissertation, the regression analysis of variables in the model presented above will be discussed in the following chapter. The statistical technique of multiple regression analysis in briefly summarized here.

By means of computer analysis, both unstandardized and standardized regression coefficients were obtained. The unstandardized coefficient, β, indicates the expected change in Y with a change in one unit in X. The standardized coefficient is computed on standardized X and Y values; that is, the standard deviations of both X and Y are equal to 1.

The significance of β (the unstandardized coefficient) was further tested by evaluating the F ratio. In this test, the null hypothesis is rejected if the computed F value is larger than the value for a given significance level in the statistical table (Kim and KaHout, 1975a).

The values for the regression coefficients for variables in the casual model

are given and interpreted in the following chapter. For each of the variables in the causal model, a measure based on nurses' responses to a specific question, or set of questions, was used in the computer analysis. For those variables measured by a set of questions, it was necessary to test the relationship among the questions in each set by constructing a scale and applying the statistical technique of factor analysis.

Measures

Factor Analysis

One of the three most common applications of factor analysis is as measuring device, for the construction of indices to be used as new variables in later analysis (Kim, 1975). It is this application, rather than the other common ones - exploratory detection of the patterning of variables, or testing hypeses about the number and weights of significant factors within variables - which was carried out on the Hong Kong data. Factor analysis was used to show that each question in a set actually measured a single underlying concept, or variable. This justified the use of composite indices, or scales, as measures.

Through the technique of factor analysis, if the composite scale is measuring a single concept, a one-factor solution with fairly high loadings on that single factor is revealed. The scale's reliablity can also be estimated using Cronbach's alpha statistic.

For each scale used as a measure, correlations among questionnaire items and eigenvalues for each value were computed. The size of the eigenvalue reflects the significance of a factor in the reproduction of the correlation matrix. The means and variances of scale items, their correlations, and eigenvalues are reported below.

The factor analysis performed on the computer included computation of the following statistics (Kim 1975, pages 506-507):

(1) means and standard deviations of the variables, with the number of valid cases for each variable;

(2) correlation matrix for all variables in the factor analysis;

(3) eigenvalues associated with initial unrotated and rotated factors;

(4) proportion of total variance accounted for by initial factors, and initial and final communalities;

(5) initial factor matrix;

(6) rotated-factor matrix and transformation matrix;

(7) factor-score coefficient matrix, commonly used to construct composite variables based on the rotated-factor solution.

Following examination of these results, it was possible to construct composite indices for variables in the causal, or path, model. Factor analysis thus served a practical function as a criterion for estimating the degree to which the separate items within each index, or scale, reflected a single factor.

Each variable for which an attempt was made to use composite measures is discussed below. The questionnaire items originally included in each scale are listed, and an indication is given of those retained in the final scales. The mean responses, correlations, and eigenvalues for each item are given in tabular form. Questionnaire items in tables are listed in shortened form; the complete questionnaire is included in the appendix.

Dependent Variables: Job Satisfation

For the dependent variabl, job satisfaction, an attempt was made to construct several scales to use as alternative measures in the regression analysis.

These were:

(1) work role satisfaction;

(2) work conditions satisfaction;

(3) meaning of work satisfaction;

(4) work relationships satisfaction.

Each scale, or composite measure, is discussed below, in turn. Code numbers are listed beside each questionnaire item.

(1) The scale, work role satisfaction, included the following items:

(a) public's perception of nurses' status (1025);

(b) doctors's perception of nurses' status (1029);

(c) own perception of nurses' status (1030).

The alpha reliability of the scale was found to be low, .42, due to the low correlation of item (a) with items (b) and (c).

For this reason, item (a) was dropped from the final scale; only items (b) and (c) were retained. The mean responses, correlations, and eigenvalues of the three items are given in Tables 4.3, 4.4, and 4.5.

TABLE 4.3
Means of Items for Work-Role Satisfaction Scale

Item Label	Mean Responses
a	0.9717
b	1.3679
c	0.6557

TABLE 4.4
Correlations of Items for Work-Role Satisfaction Scale

Item Label	a	b	c
a	—	0.174	0.159
b	0.174	—	0.250
c	0.159	0.250	—

TABLE 4.5
Eignevalues for Three Factors Extracted from Matrix of Corrlations Among Work Role Satisfaction Items

Factor Number	Eigenvalue
1	1.39232
2	0.85893
3	0.74874

Thus, although the eignevalue indicated one factor, the low correlations and low reliability factor (alpha) confirmed that item (a) should be dropped from the scale.

(2) The scale, work conditions satisfaction, included the following questionnaire items:

(a) income satisfaction ("income is fair" - 2040);

(b) work is dirty and noisy (1033);

(c) work easiness (1032);

(d) working hours are too long (1103).

Again, a low alpha coefficient was obtained, .19, due both to item (a), which was found to be unrelated to the other items, and item (d), which had a low relationship.

Therefore, items (a) and (d) were dropped from the final scale; only items (b) and (c) were retained. The mean responses, correlations, and eigenvalues for the four items are given in Tables 4.6, 4.7, and 4.8.

TABLE 4.6
Means of Items for Work-Conditions Satisfaction Scale

Item Label	Mean Responses
a	2.9811
b	3.0660
c	1.0613
d	0.9623

TABLE 4.7
Correlations of Items for Work-Conditions Satisfaction Scale

Item Label	a	b	c	d
a	—	0.070	-0.008	0.031
b	0.070	—	0.222	0.008
c	-0.008	0.222	—	0.004
d	0.032	0.008	0.004	—

TABLE 4.8
Eigenvalues for Four Factors Extracted From Matrix of Correlations Among Work Condition Satisfaction Items

Factor Number	Eigenvalue
1	1.23167
2	1.03109
3	0.97270
4	0.76445

Since item (a), "income satisfaction", was not correlated with the other items, this was run separately as an additional measure of job satisfaction in the regression analysis.

(3) The scale, meaning of work satisfaction, included the following questionnaire items:

(a) work gives personal satisfaction (1105);

(b) like job very much (1107);

(c) can use full abilities (1110).

These items were found to be unrelated, so the scale was not used as a measure in the regression analysis. The alpha relaibility was .37. The mean responses, correlations, and eigenvalues of the three items are given in tables 4.9, 4.10, and 4.11.

TABLE 4.9
Means of Items for Meaning of Working Satisfaction Scale

Item Label	Mean Response
a	1.5943
b	1.0943
c	1.5896

TABLE 4.10
Correlations of Items for Meaning of Work Satisfaction Scale

Item Label	a	b	c
a	—	0.159	0.112
b	0.159	—	0.227
c	0.112	0.227	—

TABLE 4.11
Eigenvalues for Three Factors Extracted from Matrix of Correlations Among Meaning of Work Satisfaction Items

Factor Number	Eigenvalue
1	1.33668
2	0.89713
3	0.76619

(4) The scale, work relationships satisfaction, included the following items:

(a) relations with supervisor (2032);

(b) relations with colleagues (2033);

(c) close friendships at work (2034).

These items were found to be well-correlated, and the alpha reliability was .68. It was concluded that all three items were measuring the same factor, and all were retained in the final scale. The mean responses, correlations, and eigenvalues of the items are given in tables 4.12, 4.13, and 4.14.

TABLE 4.12
Means of Items for Work Relationships Satisfation Scale

Item Label	Mean Response
a	1.7217
b	1.3632
c	1.9623

TABLE 4.13
Correlations of Items for Work Relationships Satisfaction Scale

Item Label	a	b	c
a	—	0.488	0.374
b	0.488	—	0.373
c	0.374	0.373	—

TABLE 4.14
Eigenvalues for Three Factors Extracted From Matrix of Correlations Among Work Relationships Satisfaction Items

Factor Number	Eigenvalue
1	1.82598
2	0.66228
3	0.51173

The measures actually employed for the dependent variable, job satisfaction, are summarized here. For measures for which it was possible to construct scales, the constituent questionnaire items are listed. Only those measures which were used in the regression analysis are included below.

(1) Work role satisfaction - scale, including items:

#1029 - doctors' perception of nurses' status;

#1030 - own perception of nurses' status.

(2) Work conditions satisfaction - scale, including items:

#1032 - work easiness;

#1033 - work is dirty and noisy.

(3) Income satisfaction - single item:

#2040 - income is fair/not fair.

(4) Work relationships satisfaction - scale, including items:

#2032 - relations with supervisor;

#2033 - relations with colleagues;

#2034 - close friendships at work.

An additional set of eight measures for job satisfaction, grouped under the category authority-peer relations satisfaction, was added to the regression analysis. This set of measures was obtained from responses to the following questionnaire items:

(a) professional relations with doctors (#1051+#1052+#1053);

(b) personal relations with doctors (#1054+#1055+#1056);

(c) doctors teach nurses (#1057+#1058+#1059);

(d) doctors act as nurses' colleagues (#1060+#1005+#1006);

(e) doctors form hierarchy with nurses(#1061+#1062+#1063);

(f) nurses teach other nurses (#1064+#1065+#1066);

(g) nurses cooperate with other nurses (#1070+#1071+#1072);

(h) nurses form hierarchy (#1067+#1068+#1069).

In the questionnaire, each of the above items had been repeated three times for the three work shifts: morning, evening, and night. This had been done to test the original hypotheses on variations in authority and peer relations during different shifts. For this reason, three code numbers are indicated for each item.

However, since preliminary data analysis revealed that the majority of nurses in the sample rotated among the different shifts, responses to a question for each of the three shifts were combined in the regression analysis.

It was not necessary to carry out factor analysis on the eight items listed above, since each of the eight constituted a single measure of authority-peer relations satisfaction.

Dependent Variables: Family Importance

One additional variable, family importance, was added to the regression analysis. It was measured by a single questionnaire item (#2057) asked of married nurses only, which contrasted the importance of a wife's career to that of her husband and children. Again, factor analysis was unnecessary.

Family importance was added to the causal model as a variable directly dependent on job satisfaction, professionalization, and subjective status, and indirectly dependent of objective status. For the rationale for considering family importance as a dependent variable in relation to work roles and professional status of nurses, see David Mechanic, 1978.

Independent and Intervening Variables

The effects of the following independent and intervening variables on the dependent variables in the causal model were examined through multiple regression analysis:

(1) objective status;

(2) professionalization;

(3) subjective status.

The measures used for each of these variables are summarized below.

The independent variable, objective status, was measured by responses to a single questionnaire item on "nursing credentials" (#2101): "Licensed" or "Registered" nurse. The frequencies of each response are reported in Table 4.1.

The intervening variable, professionalization, was measured by a composite index. An attempt was made to construct a scale, using the following questionnaire items:

(a) regret taking occupation of nurse (#1104);

(b) wish to remain nurse (#1108);

(c) profession is worthwhile and important (#1109);

(d) proud of profession and work (#1111).

As a result of factor analysis, item (a) was found to be uncorrelated with items (b), (c), and (d); (a) was dropped from the scale. The alpha reliability was .53. Items (b), (c), and (d) were combined into a scale, professional commitment, based on their correlations with one another. Mean responses, correlations, and eigenvalues of the four items are given below.

TABLE 4.15
Means of Items for Professional Commitment Scale

Item Label	Mean Response
a	2.9340
b	1.5472
c	1.0000
d	1.6462

TABLE 4.16
Correlations of Items for Professional Commitment Scale

Item Label	a	b	c	d
a	—	0.092	0.130	0.219
b	0.092	—	0.317	0.222
c	0.130	0.317	—	0.321
d	0.219	0.222	0.321	—

TABLE 4.17
Eigenvalues for Four Factors Extracted from Matrix of Correlations Among Professional Commitment Items

Factor Number	Eigenvalue
1	1.67274
2	0.94769
3	0.73848
4	0.64108

The intervening variable, subjective status, was measured by responses to a single questionnaire item, "own perception of nurses' status" (#1030): "increasing," "remaining the same", or "decreasing". Factor analysis was

unnecessary.

The independent and intervening variables and their measures used in the regression analysis are summarized here. For measures for which scales were used, the items included are listed. It should be noted that only one measures was used for each variable.

(1) Objective status - single item:

#2101 - nursing credentials.

(2) Professional commitment - scale including items:

#1108 - wish to remain nurse'

#1109 - profession is worthwhile and important;

#1111 - proud of profession and work.

(3) Subjective status - single item:

#1030 - own perception of nurses' status.

The results of the regression analysis run on the independent, intervening, and dependent variables in the causal model are discussed in the following chapter. The findings on determinants of job satisfaction and authority-peer relations satisfaction are then related to the two status groups of nurses (Licensed and Registered) in the sample, and the characteristics of these two groups as reflected in their responses to the questionnaire survey.

CHAPTER V - RESULTS OF DATA ANALYSIS: COMPARISON OF LICENSED AND REGISTERED NURSES, AND ANALYSIS OF RELATIVE EFFECTS OF INDEPENDENT VARIABLES ON JOB SATISFACTION

Introduction

The results of data analysis reveal patterned differences between the two occupational segments of nurses in United Christian Hospital, in: perceptions of occupational status; professional commitment, and issues related to professionalization; and attitudes toward work and occupational-organizational relationships. Following a brief summary of demographic characteristics of the two groups, the above differences will be described on the basis of the chi-square analysis. The relationships among the variables in the causal model will then be discussed, based on the regression analysis.

As discussed in Chapter 4, inconsistent questionaire items were eliminated from scales used to measure variables in the regression analysis. This was done by factor analysis, which thus simplified the data by increasing the consistency of items used to measure particular variables. This made it possible to determine the relative effects of variables in the model, including that of objective status, measured by nursing credentials - Licensed or Registered.

However, some apparent inconsistencies in responses of L.N.'s and R.N.'s were sociologically important. For example, varying patterns of response to questions designed to measure attitudes toward professionalization revealed

different dimensions of these attitudes. It is for this reason that the brief examination of chi-square results includes some items which were later eliminated from the regression analysis.

Taken together, the chi-square and regression results present a more complete comparison of the two status groups of nurses, than either taken singly. They complement each other, and the chi-squares suggest a depth and nuance lost in the necessary homogenization of the regression modelling. The chi-square tables below report final test results, following preliminary analysis which revealed that some categories contained too few responses to make use of the chi-square statistic reliable. For some items, closely-related response categories were combined; for others, certain categories were eliminated so that chi-square could be applied. Therefore, the number of types of reported categories varies somewhat across items, and tables were used to report pertinent final results.

Demographic Characteristics of Licensed and Registered Nurses

There were a total of 139 Licensed and 64 Registered Nurses in the United Christian Hospital sample, or 64% and 32%, respectively. Table 4.1, Chapter 4, reports characteristics of the total sample. The relationship between age and objective status (nursing credentials) was statistically significant, when tested by chi-square, based on those responding. The results are reported in the following 2 x 2 table.

TABLE 5.1 - Nursing Credentials and Age

	Age					
L.N.	21-25	26-30	31-40	Total	No Answer	N
	35	48	15	108	31	139
	32%	54%	14%			
R.N.	25	24	1	50	14	64
	50%	48%	2%			
Total	60	82	16	158	45	203

$X^2 = 7.770$

df = 2

prob. = 0.02

Licensed Nurses were relatively older than Registered Nurses, with a similar proportion in each group declining to report their ages. The proportion not answering is suprising, and may reflect a cultural reluctance to reveal information considered personal (see Traver, 1976).

The two groups of nurses were relatively similar in marital status: 34% of Licensed and 39% of Registered Nurses reported they were married, and 66% and 61%, respectively, single, although approximately 10% of each group declined to answer. The two groups were also similar in family size, with 59% of married Licensed and 56% of married Registered Nurses reporting no children, and 24% and 30%, respectively, one child. 17% of married L.N.'s and 15% of married R.N.'s had two or more children. When the two categories of married nurses with children were combined, the total percentages for each group were very close: 41% for Licensed and 43% for Registered Nurses who were married had children.

In education, the majority of both groups had received secondary-school training: 87% of Licensed and 97% of Registered Nurses. However, 7% of the

Licensed group said they had received post-secondary school education (6% did not answer). This may be partially a function of the relative difference in age range between the two groups. The majority of both groups of nurses were continuing their education in courses sponsored by the Hong Kong Nurses' Association.

With respect to working hours, the two groups were fairly similar in proportion engaged in shift work (question number 1016), 78% of Licensed and 73% of Registered Nurses. 12% and 19%, respectively, were employed on a non-shift basis. Concerning the shift they worked most (question number 1017), 19% of Licensed and 20% of Registered Nurses were on a stable shift; 19% and 22%, respectively, were on moderate rotation, and 61% of Licensed and 57% of Registered Nurses were on total rotation of shifts.

The two groups showed marked differences in monthly income range. Although the numbers in several categories were so small that the validity of the chi-square was in doubt, the result indicated a definite divergence in wages per month for Licensed and Registered Nurses:

TABLE 5.2 - Nursing Credentials and Monthly Income

	Income (HK $. $5 HK = $1 US)							
	$1000-$1500	$1500-$2000	$2000-$2500	$2500-$3000	$3000+	Total	Answer	N
L.N.	1	3	48	54	32	138	1	139
	.7%	2%	35%	39%	23%			
R.N.	15	41	3	1	0	60	4	64
	25%	68%	5%	2%	0%			
Total	16	44	51	55	32	198	5	203

$X^2 = 162.3$

df = 4

(prob. = 0.0001)

The majority of Licensed Nurses were earning between HK $2000 and $3000 or more per month, while most Registered Nurses were earning HK $1000 - $2000. This result was quite surprising, since it had been expected that Registered Nurses would be earning higher wages, in keeping with their superior credentials. The explanation probably lies in the difference in age and seniority of the two groups. Licensed Nurses tended to be somewhat older, based on the responses of about four-fifths of each group, as reported above (Table 5.1). Overall response to the questions on amount and type of previous nursing experience was too slight to yield information useful in verifying this explanation, and it remains untested. Verification would require a multivariate analysis controlling for age.

Attitudes of Licensed and Registered Nurses Toward Work and Professionalization: Results of Chi-Square Tests

The Work Setting: Tasks

As indicated above, the majority of all nurses in the sample, and a similar proportion in each group, were assigned to rotating shifts. Also, ward assignments in the work setting were relatively undifferentiated. A majority of the total sample, approximately two-thirds, rotated among several different wards in the hospital. Only a total of 69 nurses, including 47 Licensed and 22 Registered Nurses, reported that they were assigned primarily to one ward: outpatient department, emergency room, men's surgery, women's surgery, intensive care, operating room, obstetrics and gynecology, maternity ward, psychiatric ward, men's medical, women's medical, geriatrics, pediatrics, community nursing, or the nursing school. When a comparison was made of Licensed and Registered Nurses assigned to routine and non-routine wards, all relative proportion in each group did not differ significantly. Most nurses were floating rather than stationary. Therefore, most did not respond to the question on ranking the status of the various wards (questions 2021-2026).

Subjective Status

Objective status was hypothesized to have a positive effect on subjective status. However, the two groups of nurses were similar in responses to the question chosen to measure subjective perception of status (question 1030). Among Licensed Nurses responding, 68% felt their status was increasing, 22% that it was remaining the same, and 11% that it was decreasing. Among Registered Nurses responding, 53% felt their status was increasing, 30% that it was

remaining the same, and 17% that it was decreasing. This question was also used in the scale employed as measure of work role satisfaction, as discussed in Chapter 4; the results of the analysis of attitudes measured by this scale will be reported below.

Professionalization

It was also hypothesized that objective status would positively affect professionalization. Yet the responses of Licensed and Registered Nurses to questions eliciting attitudes toward their occupation as a profession, and their professional commitment, were varied. The two groups were somewhat similar in their initial reasons for becoming a nurse. Although the results were not statistically significant, responses to questions numbered 1008-1010 revealed that the majority of both groups had selected their occupation in order to "learn skills". Gaining job security and "prospects", increasing status, and helping others were relatively less important goals. It is also interesting that over half of each group had either friends or relatives in nursing (question 1024). The two groups also tended to value the respect of friends and family over that of other nurses, or doctors (question 1027).

However, they differed significantly in the percent of friends who were nurses, as indicated by the following chi-square result on responses to question 2030.

TABLE 5.3 - Nursing Credentials and Percent of Friends who are Nurses

	Percent of friends who are nurses: 100% - 50%	25%	10%-0	Total	No Answer	N
L.N.	43	31	52	126	13	139
	34%	25%	41%			
R.N.	16	8	37	61	3	64
	26%	13%	61%			
Total	59	39	89	187	16	203

$X^2 = 6.7$

df = 2

prob. = .0358

More than half the Licensed Nurses reported that between one-fourth and all of their friends were nurses, while over half of Registered Nurses reported between 10% and none of their friends were in nursing.

The pattern of responses to questions on the nature of nursing as a profession varied with the orientation of the question. In general, both groups interpreted the term "professional" as meaning "similar skills": 80% of Licensed and 89% of Registered Nurses who responded (question 1028) chose this meaning over "common values". Each group was divided approximately in half over whether they considered the occupation of nursing "highly" or "semi-" professional (question 1031): 52% of L.N.'s and 49% of R.N.'s responding answered "highly professional"; 48% of L.N.'s and 51% of R.N.'s answered "semi-professional".

When asked to characterize their perception of nursing (question 1037) as a "professional" or "service" occupation, 71% of Licensed and 60% of Registered Nurses responding answered "service" as contrasted with 29% and 31%, respectively. The majority of both groups thus espoused the service ideal of

nursing as an occupation, although aproximately half of each group had indicated they thought of nursing as highly professional. These contrasting results seem to point toward the existence of different dimensions of the concept of professionalization, and related variations in attitudes.

A statistically significant difference among Licensed and Registered Nurses which seems to indicate varying professional images is found in their responses to the question on whether or not they felt they had adequate knowledge of their job (question 2035).

TABLE 5.4 - Nursing Credentials and Knowledge for Job

	Knowledge is adequate: Yes	Not enough; no	Total	No Answer	N
L.N.	68	65	133	1	134
	51%	49%			
R.N.	16	47	63	6	69
	25%	75%			
Total	84	112	196	7	203
		$X^2 = 11.56$			
		df = 1			
		prob. = 0.0007			

While the Licensed Nurses were almost evenly divided on the question, three-fourths of the Registered Nurses felt their knowledge was inadequate. This may indicate greater status-consciousness of Registered Nurses and their relatively greater desire for upward mobility through obtaining more professional training.

However, the significantly differing responses of Licensed and Registered Nurses to question 2036, on whether they were currently taking further courses, must be taken into consideration:

TABLE 5.5 - Nursing Credentials and Continuing Education

	Taking further course: Yes	No	Total	No Answer	N
L.N.	92	8	100	39	139
	92%	8%			
R.N.	30	19	49	15	64
	61%	30%			
Total	122	27	149	54	203

$X^2 = 20.99$

df = 1

prob. = 0.0001

The majority of all those who answered affirmatively further reported that they were taking a medical or nursing course sponsored by the Hong Kong Nursing Association, undoubtedly related to training requirements. Since a much greater proportion of Licensed than Registered Nurses were continuing their training, a smaller proporation tended to feel their current knowledge was inadequate. It is possible that the Registered Nurses who were not currently taking courses tended to feel they should be doing so in order to maintain their positions.

It may be remembered that four items were tested by factor analysis in order to construct a scale of professionalization. Of these, the first, "regret taking occupation of nurse" (question 1104) was uncorrelated with the other three. There was no significant difference in responses of Licensed and Registered Nurses to this question; neither did they differ significantly on "wish to remain nurse" (question 1108) or on "profession is worthwhile and important" (question 1109).

However, on the fourth scale item, "proud of profession and work" (question 1111), the difference in their responses was statistically significant:

TABLE 5.6 - Nursing Credentials and Pride in Profession

	Proud of Profession: Very + proud	Not proud	Total	No Answer	N
L.N.	73	58	131	8	139
	56%	44%			
R.N.	21	40	61	3	64
	34%	66%			
Total	94	98	192	11	203

$X^2 = 7.556$

df = 1

prob. = 0.0006

This result was interesting in revealing that Licensed Nurses were relatively prouder of their profession than Registered Nurses, thus lending support to the hypothesis that Registered Nurses tend to be more frustrated in their desire for upward mobility. Again, the age difference of the two groups may have contributed to this result. A related interpretation is that the Registered Nurses have undergone greater, and/or more recent, "reality shock" in adjusting to their jobs (Kramer, 1974) because of their higher positions and younger age, although the disparity between aspirations and actual jobs in probably less in a system of hospital training for nurses such as Hong Kong's than for college-trained Registered Nurses.

The attitudes of Licensed and Registered Nurses toward the control of nurses by doctors, and the role of the nursing association, also point to the divergences between the two groups of nurses. Although some response categories were chosen by so few that the validity of X^2 was in doubt, the two groups differed significantly in whether or not nurses should be under stricter

control by doctors. Only 10% of Licensed as contrasted with 25% of Registered Nurses answered affirmatively. 84% of Licensed and 71% of Registered Nurses thought nurses should have more opportunity to make decisions. This can be interpreted as reflecting Licensed Nurses' desire for increased autonomy, since they are below both Registered Nurses and doctors in status. It also reflects some decrease in desire for autonomy with increase in professionalization, for Registered Nurses. However, this does appear to contrast with the result reported in the above table (5.6), on pride in profession.

Both groups of nurses favored an apolitical nursing association: over three-quarters of each group preferred a "professional association", as contrasted with either a "trade union" or a "pressure group" (question 2103). However, they differed in the urgency with which they felt the nursing association needed to be strengthened. The majority of both groups answered affirmatively; but, within this category, 28% of Licensed and only 9% of Registered Nurses were strongly in favor; 67% of Licensed and 78% of Registered nurses were in favor. Again, this points to the somewhat greater desire for autonomy and professionalization on the part of Licensed Nurses - or, more specifically, to their greater interest in change and willingness to become actively involved in achieving this goal.

Attitudes Toward Health-Care System

An initial hypothesis was made that Licensed Nurses tended to view community health care and related innoviations in the health-care system more positively than Registered Nurses. These attitudes, as indicated by chi-square results, are summarized here because they show a pattern similar to that discussed above. The two groups were similar in response to question 1035 on whether or not the health-care system was adequate: approximately one-third on

each group answered affirmatively, and two-thirds of each considered it inadequate. However, they differed significantly in the degree to which they felt the system needed improvement (question 1036), although virtually the entire sample was in favor of some improvement.

TABLE 5.7 - Nursing Credential and Need for Improvement in Health-Care System

	Health-Care system needs improvement: Strongly agree	Agree	Total	No Answer	N
L.N.	35	99	134	5	139
	26%	74%			
R.N.	7	50	57	7	64
	12%	88%			
Total	42	140	191	12	203

$X^2 = 4.5$

df = 1

prob. = 0.03

A significantly higher proportion of L.N.'s "strongly agreed" that the system was in need of improvement.

When asked if they considered industrial medicine more important than community health care, both Licensed and Registered Nurses tended to favor community health care, in which their hospital was involved (question 2105). However, on the question of the type of improvement necessary in mental health care (question 2107), they differed significantly. About one-third of Licensed as contrasted with one-fourth of Registered Nurses favored a mental health hospital; one-third of Licensed and one-fifth of Registered Nurses favored community mental health care; and slightly over one-third of Licensed, but one-half of Registered Nurses did not respond.

On the question of evaluation of the Kwun Tong Health Project (question 2112), the community health project in which their hospital was involved, Licensed Nurses were significantly more positive in their opinions, as predicted in the inital hypotheses:

TABLE 5.8 - Nursing Credentials and Evaluation of Kwun Tong Health Project

	Evaluation of Kwun Tong Health Project: Very effective	Effective	Average, less than average	Total	No Answer	N
L.N.	33	56	22	111	26	137
	24%	41%	16%		19%	
R.N.	16	15	5	36	27	63
	25%	24%	8%		43%	
Total	49	71	27	147	53	200

$X^2 = 14.965$

df = 3

prob. = .002

In the area of community health care, Licensed Nurses responded with consistently greater interest in change and enthusiasm for new projects than did Registered Nurses. This was consistent with Licensed Nurses positive attitudes toward improvement of the health care system, and points toward a general tendency on their part to favor change, as contrasted with less interest in change on the part of Registered Nurses.

Job Satisfaction

It was hypothesized that objective status positively affected job satisfaction. In Chapter IV, several measures were used to indicate job

satisfaction. These basically included the following scales: work role satisfaction; work conditions satisfaction; and work relationships satisfaction. In addition, income satisfaction was tested. Eight measures of authority-peer relations satisfaction were also used in the regression analysis.

In "work role satisfaction", the two groups of nurses were fairly similar: 82% of Licensed and 71% of Registered Nurses thought the public's perception of nurses' status (question 1025) was "medium"; 82% of Licensed and 88% of Registered thought doctors considered nurses high or medium in status (question 1029). The two groups were also similar in their own perception of nurses' status, although 68% of Licensed as compared with 53% of Registered Nurses felt this status was increasing (question 1030), as discussed above under "subjective status".

There was significant difference among Licensed and Registered Nurses in "income satisfaction". Consistent with the higher salaries of Licensed Nurses, they expressed much less dissatisfaction (question 2040).

TABLE 5.8 - Nursing Credential and Income Satisfaction

	Income fair				
	More than fair; enough	Barely; not fair	Total	No Answer	N
L.N.	57	76	133	6	139
	43%	57%			
R.N.	11	47%	58	6	64
	19%	81%			
Total	68	123	191	12	203

$X^2 = 10.005$

df = 1

prob. = .0015

However, in "work conditions satisfaction", Licensed and Registered Nurses were similar in attitudes as to whether their work was easy (question 1032) or "dirty and noisy" (question 1033), or their working hours were too long (question 1103). Most felt their jobs were somewhat, but not highly, "laborious", and average both in cleanliness and noisiness, and in length of working hours. An interesting and statistically significant difference was found in their attitudes toward shift work, an additional question related to working conditions (question 1046):

TABLE 5.9 - Nursing Credential and Attitudes to Shift Work

	Like Shift Work: Yes	No	Total	No Answer	N
L.N.	47	65	112	27	139
	42%	58%			
R.N.	11	36	47	17	64
	23%	77%			
Total	58	101	159	44	203

$X^2 = 4.922$

df = 1

prob. = 0.03

Licensed Nurses expressed less dissatisfaction with shift work, although approximately three-fourths of each group were actually working on a shift basis.

Although the "meaning of work" responses were eliminated from the regression analysis because the three scale items were found to be uncorrelated, Licensed and Registered Nurses did differ significantly in the degree to which they felt could use their abilities (question 1110), as shown by the following chi-square table:

TABLE 5.10 - Nursing Credential and Use of Abilities

	Can Use Abilities: Strongly agree and agree	Do not agree	Total	No Answer	N
L.N.	81	54	135	4	139
	60%	40%			
R.N.	27	37	64	0	64
	42%	58%			
Total	108	91	199	4	203

$X^2 = 5.551$

df = 1

prob. = 0.02

Again, Licensed Nurses expressed greater satisfaction in their work: the proportion of those who felt they could use their abilities were approximately the same as that of Registered Nurses who felt they could not. This also lends support to the intital hypothesis that Registered Nurses are more frustrated in their positions because they have reached the point at which advancement is blocked by the superior status of physicians.

There was no significant difference between Licensed and Registered Nurses on the "work relationships satisfaction" scale items (questions 2032-2034). Two-thirds of Licensed and three-fourths of Registered Nurses considered their relationship with their immediate supervisor (question 2032) "fair", while the remainder in each group thought is was "good" or "very good". Also, a majority of both thought they had a "good" or "very good" relationship with their colleagues (question 2033). However, 82% of Licensed and 91% of Registered Nurses said they had only "a few" close friends at work (question 2034), as opposed to "most" or "many". This result contrasted with their responses to a more general question

on the percent of their friends who were nurses, reported above in Table 5.3.

The attitudes of the two groups of nurses concerning "authority-peer" work relationships are summarized here, since they reveal a pattern with implications for both job satisfaction of professionalization. The differences in responses of Licensed and Registered Nurses were generally greater with respect to their perceptions of nurse-nurse, as contrasted with doctor-nurse, relationships, on all three shifts. It should be remembered that the majority of both Licensed and Registered Nurses worked on rotating shifts, so that most were personally familiar with the above working relationships on each shift.

The majority of both groups on all shifts thought their professional relationships with doctors were "average". However, on the evening shift, the difference between Licensed and Registered Nurses was significant, with 27% of Licensed as opposed to 13% of Registered Nurses responding reporting a "close" professional relationship, and 73% of Licensed, but 87% of Registered, Nurses reporting this as "average", on all shifts, and the majority of both groups reported that doctors "sometimes" taught nurses and "sometimes" ordered them to do things (all shifts). The above responses were to questions 1051 through 1059, and 1061 through 1053.

An interesting difference was found in the extent to which Licensed and Registered Nurses thought doctors acted as their colleagues. When describing work on the morning and evening shifts (questions 1060 and 1006), a higher proportion of Licensed Nurses felt doctors frequently acted as colleagues, and a lower proportion said they seldom or never did so. The difference between the two groups when describing the afternoon shift (question 1005) was in the same direction, although not satistically significant.

TABLE 5.11 - Nursing Credentials and Doctors as Colleagues - (morning shift)

	Doctors act as colleagues: Frequently, often	Sometimes	Seldom, never	Total	No Answer	N
L.N.	61	37	11	109	30	139
	56%	34%	10%			
R.N.	22	14	12	48	16	64
	46%	29%	25%			
Total	83	51	23	157	46	203

$X^2 = 5.937$

df = 2

prob. = 0.051

TABLE 5.12 - Nursing Credential and Doctors as Colleagues - (evening shift)

	Doctors act as colleagues: Frequently, often	Sometimes	Seldom, never	Total	No Answer	N
L.N.	58	35	14	107	32	139
	54%	33%	13%			
R.N.	18	14	13	45	19	64
	40%	31%	29%			
Total	76	49	27	152	51	203

$X^2 = 5.758$

df = 2

prob. = 0.056

On the working relationships among nurses, on all shifts, there were consistent differences between Licensed and Registered Nurses. A greater proportion of Licensed than of Registered Nurses felt that nurses taught each

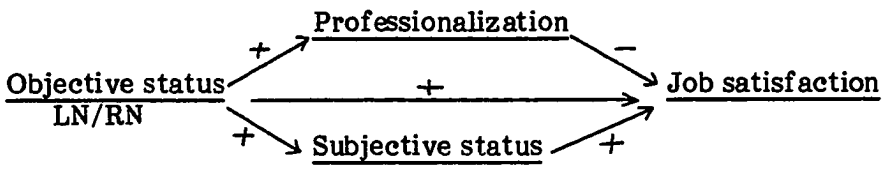
other "frequently" and "often" (questions 1064-1066), although the numbers of some response categories were too small for chi-square to be reliable. There was no significant difference in the frequency with which they thought nurses had a strict hierarchy-about one-third of each group "frequently" or "often". However, they did differ significantly in their views on friendliness and cooperation between nurses. Licensed Nurses were much more positive in their attitudes toward nurse-nurse cooperation on all shifts: 91% - 92% said that nurses were "frequently" or "often" cooperative, as contrasted with 69% - 77% of Registered Nurses; only 8% - 9% of Licensed, as contrasted with 23% - 31% of Registered, Nurses felt that nurses were "sometimes" friendly and cooperative. These percentages are based on those nurses responding to questions 1070 through 1072.

In review, Licensed Nurses were more satisfied with their work roles, conditions, and relationships than Registered Nurses in several respects. They were more optimistic in their perception of nurses' status as increasing, and more satisfied with shift work, and with their income. Licensed Nurses were also more positive in the extent to which they felt could use their abilities in their work. They were slightly more likely to have many close friends in the work setting, and were definitely more inclined to feel that nurses were friendly and cooperative and acted as teachers for one another. Further, Licensed Nurses tended to feel that doctors acted as colleagues to nurses, and they perceived a closer professional relationship with doctors than did Registered Nurses, on the evening shift. They were thus generally more positive in their attitudes toward organizational and occupational relationships.

Relative Effects of Objective and Subjective Status, and Professionalization, on Job Satisfaction: Regression Results

The above discussion of chi-square results focused on the effects of objective status on subjective status, professionalization, and job satisfaction. Objective status, as indicated by nursing credentials, was thus the single independent variable on which the other variables were considered to depend. The chi-square tests contrasted the two groups, Licensed and Registered Nurses, with respect to their responses on the dependent variables.

However, as discussed in the introduction, it was through multiple regression analysis that the relative importance of the effects of objective status, professionalization, and subjective status on various aspects or components of job satisfaction were measured and compared. The causal model, given below, shows both direct and indirect influences on job satisfaction, and mulitple regression allows for an assessment of the net influence of each variable relative to the others, using standardized net coefficients. It also allows for determination of whether particular relationships among variables are positive or negative.



In the casual model, objective status is hypothesized to have both direct and indirect effects on job satisfaction, and professionalization and subjective status are intervening variables with direct effects.

The regression results confirm that objective status as measured by nursing credentials is a strong predictor of professional commitment. The relationship between these variables is linear. When the independent variables - objective status, professionalization, and subjective status - are compared as to predictive

value with various measures of the dependent variable, job satisfaction, objective status may be less predictive than the other two independent variables. The relative strength of each of the three independent variables is discussed for each of the following aspects or measures of job satisfaction:

(1) income satisfaction;

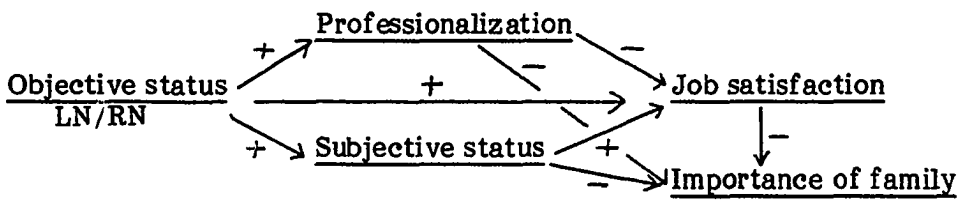
(2) work conditions satisfaction, as measured by "work easiness";

(3) work relations satisfaction;

(4) authority-peer relations satisfaction, including measures of attitudes toward both doctor-nurse and nurse-nurse relationships.

In addition, the dependent variable, family importance, was also regressed on the independent variables. In this regression, job satisfaction as indicated by work conditions ("work easiness") and work relations satisfaction was added as an independent variable affecting family importance.

The following hypothesis were tested by means of mulitple regression analysis, as depicted in the causal model:



Hypotheses:

1. Objective status has a positive effect on professionalization.
2. Objective status has a positive effect on subjective status.
3. Objective status has a positive effect on job satisfaction.
4. Objective status has no direct effect on importance of family.
5. Subjective status has a positive effect on job satisfaction.
6. Subjective status has a negative effect on importance of family.
7. Professionalizaton has a negative effect on job satisfaction.

8. Professionalization has a negative effect on importance of family.
9. Job satisfaction has a negative effect on importance of family.

The regression analysis results are reported below, in terms of R^2, the unstandardized coefficient, the standardized coefficient or beta weight, and the F-test of statistical significance. The R^2 is the overall test of accuracy of the regression equation, indicating the proportion of variance explained by the variables included in the equation (Kim and Kabout, 1975). The unstandarized regression coefficient indicates the expected change in the dependent variable with a change in an independent variable, when the other independent variables are either held constant or controlled for. Standardized coefficients or beta weights make it possible to simplify the linear regression equation, and provide a means of comparing the relative effect on the dependent variable of each independent variable when the latter have been measured on different units. The F-ratio is a convenient technique for testing the significance of the unstandardized coefficient: if the computed F-value is larger than the statistical table's critical value for a given level of significance, the null hypothesis that the unstandardized coefficient is equal to zero would be rejected (Kim and Kahout, 1975).

Tests of Hypotheses

The first hypothesis was tested by regressing the variable professionalization, as measured by the scale "professional commitment" (questions 1108, 1109, and 1111), on the independent variable, objective status, measured by "nursing credentials" (question 2101). The results were significant at the .01 level,** confirming objective status as a strong predictor of professionalization.

TABLE 5.13 - Regression Results for Professionalization

	Professional Commitment:			
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.031	99.149	0.176	6.750**

The second hypothesis was tested by regressing the variable of subjective status, measured by the question on "own perception of nurses' status" (question 1030), on objective status ("nursing credentials" 2101). The results were statistically significant at the .05 level, *confirming objective status as a strong predictor of subjective status.

TABLE 5.14 - Regression Results for Subjective Status

	Own Perception of Nurses' Status:			
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.022	.198	0.147	4.652*

The third, fifth, and seventh hypotheses were tested by regressing the variable of job satisfaction on the three variables, objective status, professionalization, and subjective status. Job satisfaction was measured by three primary indicators: "income satisfaction" (question 2040), the scale for "work conditions satisfaction" ("work easiness"), and the scale for "work relations satisfaction". In addition, it was also measured by eight indicators of "authority-peer relations satisfaction", including measures of attitudes toward doctor-nurse

and nurse-nurse relationships (questions 1005 and 1006; 1051 - 1072). The results will be presented separately for each measure of job satisfaction.

The results for "income satisfaction" were not statistically significant, indicating that the three independent variables were not strong predictors of income statisfaction. However, the effect of professionalization ("professional commitment") was negative, as hypothesized: higher professionalization was related to lower income satisfaction.

TABLE 5.15 - Regression Results for Job Satisfaction: Income

	Income Satisfaction:			
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.012	.148	0.106	2.309
Professional commitment	.016	-.182	-0.073	1.103
Own perception, nurses' status	.029	.120	0.116	2.799

The results for work conditions satisfaction were statistically significant only for the variable subjective status ("own perception"), at the .05 level*, indicating this was a stronger predictor of work conditions satisfaction than either objective status or professionalization. The results were in the direction hypothesized for subjective status alone: this variable had a positive effect on work conditions satisfaction. However, in contradiction to hypotheses 3 and 7, respectively, objective status had a negative effect, and professionalization had a positive effect. Thus higher subjective status and professionalization were related to greater satisfaction with work conditions, but higher objective status was related to lower satisfaction.

TABLE 5.16 - Regression Results for Job Satisfaction: Work Conditions

Work Conditions Satisfaction (work easiness):				
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.000	-.212	-0.015	0.046
Professional commitment	.000	.469	0.002	0.001
Own perception, nurses' status	.020	.148	0.141	4.102*

The results for "work relations satisfaction" were not statistically significant, indicating the three independent variables were not strong predictors. Only one of these variables, subjective status, had an effect in the expected direction: it showed a positive relationship to work relations satisfaction. The effect of objective status was negative, in contradiction to hypothesis #3, indicating that Licensed Nurses were actually more satisfied with work relations than were Registered Nurses. The effect of professionalization ("professional commitment") was positive, in contradiction to hypothesis #7, indicating that higher professional commitment was related to higher work relations satisfaction. This was in contrast to the negative relationship of professional commitment to income and work conditions satisfaction, discussed above.

TABLE 5.17 - Regression Results for Job Satisfaction: Work Relations

	Work Relations Satisfaction:			
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.001	-2.603	-0.005	0.005
Professional commitment	.017	.115	0.116	2.775
Own perception, nurses' status	.029	45.429	0.111	2.534*

Figure 5.1- Relative Effects of Objective Status, Professionalization, and Subjective Status on Income Satisfaction

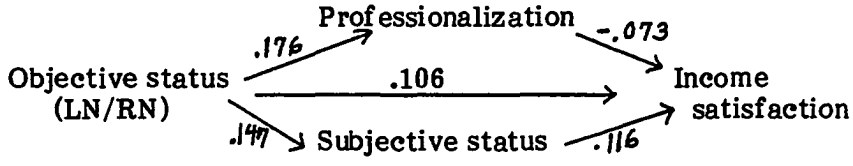


Figure 5.2- Relative Effects of Objective Status, Professionalization, and Subjective Status on Work Conditions Satisfaction

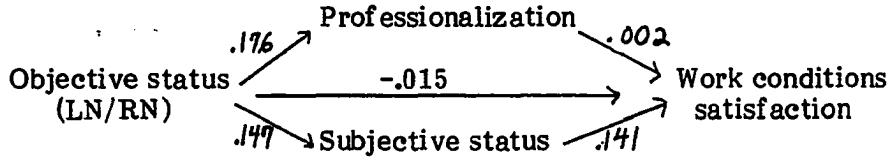
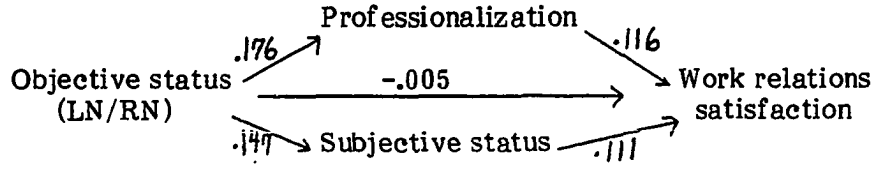


Figure 5.3- Relative Effects of Objective Status, Professionalization, and Subjective Status on Work Relations Satisfaction



The following additional measures of job satisfaction, on authority-peer relations, were regressed on the independent variables:

(a) professional relations with doctors (questions 1051-1053);

(b) personal relations with doctors (questions 1054-1056);

(c) doctors teach nurses (questions 1057-1059);

(d) doctors act as nurses' colleagues (questions 1060; 1005-1006);

(e) doctors form hierarchy with nurses (questions 1061-1063);

(f) nurses teach other nurses (questions 1064-1066);

(g) nurses form hierarchy with other nurses (questions 1067-1069);

(h) nurses cooperate with other nurses (questions 1070-1072);

Results for the measures of attitudes toward doctor-nurse relationships were not statistically significant. However, the directions of the relationships - positive or negative - lent support to some hypotheses and contradicted others. The relationships are presented in the following tables, for each of the five dependent variables measuring satisfaction with doctor-nurse relations.

While objective status (nursing credentials) had a positive effect on attitudes toward professional relations with doctors, both professional commitment and subjective status had a negative effect. This tended to confirm hypotheses #3 and #7, but contradicted hypothesis #5 on subjective status. Thus, higher professional commitment and higher subjective status were associated with nurses' greater dissatisfaction with their professional relations with doctors.

TABLE 5.18 - Regression Results for Job Satisfaction: Authority-Peer Relations Satisfaction:

(a) Professional Relations with Doctors -				
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.005	.557	0.007	1.189
Professional commitment:	.005	-.127	-.010	0.020
Subjective status	.006	-.123	-.023	0.106

The effects of nursing credentials and subjective status on nurses' personal relations with doctors were positive, confirming hypotheses #3 and #5. Professional commitment had a negative effect, confirming hypothesis #7 and showing the relationship of nurses' higher professional commitment to greater dissatisfaction with their personal relations with physicians.

TABLE 5.19 - Regression Results for Job Satisfaction: Authority-Peer Relations Satisfaction:

(b) Personal Relations with Doctors -				
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.004	.487	0.069	0.944
Professional commitment	.005	-.187	-0.015	0.044
Subjective status	.005	.113	0.002	0.001

Results for nurses' attitudes toward doctos as teachers were similar: both objective and subjective status had positive effects, supporting hypotheses #3 and #5, while professional commitment had a negative effect, as predicted by hypothesis #7. The latter result again revealed the association of higher professional commitment with greater dissatisfaction with doctors in teaching them new things on the job.

TABLE 5.20 - Regression Results for Job Satisfaction: Authority-Peer Relations Satisfaction:

	(c) Doctors Teach Nurses -			
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.005	.510	0.080	1.280
Professional commitment	.009	-.713	-0.062	0.791
Subjective status	.010	.140	0.030	0.176

Nurses' attitudes toward doctors as colleagues were positively affected by all three independent variables. This supported hypotheses #3 and #5, but tended to contradict hpothesis #7, which had predicted that professional commitment would have a negative effect.

TABLE 5.21 - Regression Results for Job Satisfaction: Authority-Peer Peer Relations Satisfaction:

(d) Doctors Act as Nurses' Colleagues -				
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.005	.241	0.034	0.234
Professional commitment	.025	.169	0.133	3.660
Subjective status	.035	.537	0.101	2.131

The extent to which nurses felt that doctors formed a hierarchy with them was also affected positively by all three variables, again supporting hypotheses #3 and #5, and contradicting hypothesis #7, which had predicted a negative effect of professional commitment.

TABLE 5.22 - Regression Results for Job Satisfaction: Authority-Peer Relations Satisfaction:

(e) Doctors form Hierarchy with Nurses -				
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.001	.850	0.012	0.029
Professional commitment	.006	.907	0.072	1.036
Subjective status	.007	.111	0.021	0.089

In sum, the effect of objective status, as measured by nursing credentials, of nurses' attitudes toward relations with doctors was consistently positive, while that of subjective status was positive except for attitudes toward professional relations with doctors. However, professional commitment had a positive effect on only two measures of attitudes toward relations with doctors - doctors act as nurses' colleagues, and doctors form hierarchy with nurses. On the three other measures - professional and personal relations with doctors, and doctors teach nurses - professional commitment had a negative effect.

Figure 5.4- Relative Effects of Objective Status, Professionalization, and Subjective Status on Professional Relations with Doctors

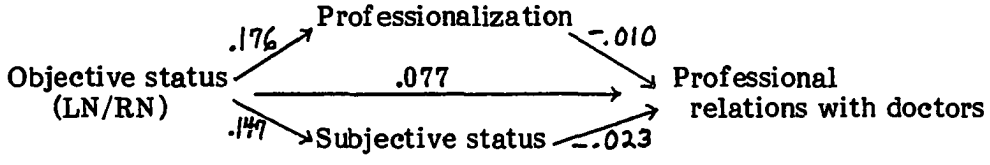


Figure 5.5- Relative Effects of Objective Status, Professionalization, and Subjective Status on Professional Relations with Doctors

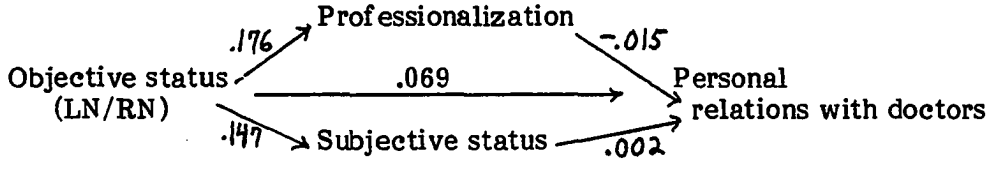


Figure 5.6- Relative Effects of Objective Status, Professionalization, and Subjective Status on Professional Relations with Doctors

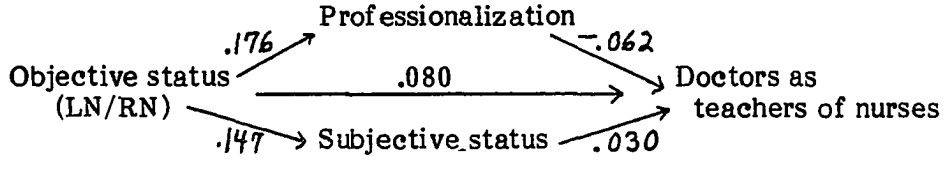


Figure 5.7- Relative Effects of Objective Status, Professionalization, and Subjective Status on Attitudes Toward Doctors as Colleagues of Nurses

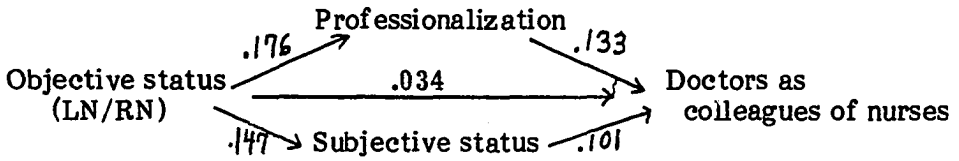
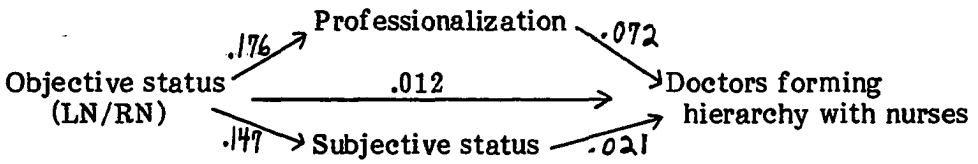


Figure 5.8- Relative Effects of Objective Status, Professionalization, and Subjective Status on Attitudes Toward Doctors' Forming Hierarchy with Nurses



The results for the measures of attitudes toward nurse-nurse relations revealed that objective status was the strongest predictor, since it alone was statistically significant, lending support to hypothesis #3. However, it was significant only for attitudes toward nurses as teachers, and nurse-nurse cooperation, and not for perception of nurses as forming a hierarchy. In other words, Licensed and Registered Nurses had similar views of the extent to which nurses formed a hierarchy, but differed significantly in their attitudes toward nurse-nurse cooperation, and the extent to which nurses acted as teachers for one another.

The direction of the effects of objective status, subjective status, and professional commitment is discussed with the tables below. Only objective status had a positive effect on attitudes toward nurses as teachers; it was significant at the .05 level*, tending to confirm hypothesis #3. Subjective status

had a negative effect, contradicting hypothesis #5. The effect of professional commitment was also negative, but this lent to hypothesis #7.

TABLE 5.23 - Regression Results for Job Satisfaction: Authority-Peer Relations Satisfaction:

(f) Nurses Teach Other Nurses -				
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.018	1.292	0.160	5.229*
Professional commitment	.026	-.118	-0.082	1.372
Subjective status	.030	-.404	-0.067	0.939

With respect to the extent to which they felt nurses formed a hierarchy, objective status (nursing credentials) had a positive but insignificant effect, again lending suport to hypthesis #3. Subjective status also had a positive effect, supporting hypothesis #5; the effect of professional commitment was negative, as predicated by hypothesis #7, indicating higher professional commitment was associated with the perception of nurses as not forming a strict hierarchy.

TABLE 5.24 - Regression Results for Job Satisfaction: Authority-Peer Relations Satisfaction:

(g) Nurses Form Hierarchy with Other Nurses -				
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.004	.469	0.060	0.714
Professional commitment	.004	-.486	-0.035	0.244
Subjective status	.006	.233	0.040	0.323

As previously indicated, the effect of objective status (nursing credentials) on attitudes toward nurses' cooperation with one another supported hypothesis #3: it was positive, and significant at the .05 level*. However, the effects of subjective status and professional commitment tended to contradict hypotheses #5 and #7, respectively: subjective status had a negative effect, and professional commitment had a positive effect. This indicated that higher subjective status was associated with greater dissatisfaction with nurses' cooperation, but higher professional commitment was related to greater satisfaction.

TABLE 5.25 - Regression Results for Job Satisfaction: Authority-Peer Relations Satisfaction:

	(h) Nurses Cooperate with Other Nurses -			
	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.017	1.192	0.140	3.943*
Professional commitment	.017	.145	0.010	0.018
Subjective status	.022	-.460	-0.072	1.076

In sum, the effect of objective status on nurse-nurse relations was consistently positive, while those of professional commitment and subjective status varied. Subjective status had a negative effect on attitudes toward nurses as teachers, and on nurses' cooperation, but a positive effect on perception of nurses as forming a hierarchy.

Figure 5.9- Relative Effects on Objective Status, Professionalization, and Subjective Status on Attitudes Toward Nurses as Teachers of Nurses

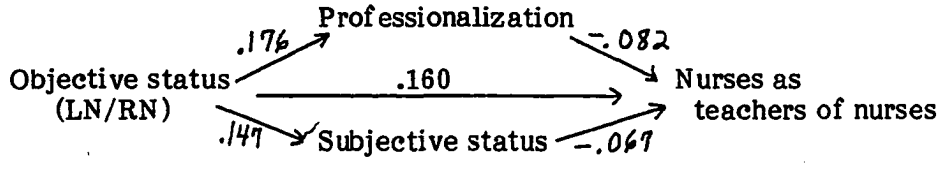


Figure 5.10- Relative Effects of Objective Status, Professionalization, and Subjective Status on Attitudes Toward Nurses' Forming Hierarchy with Nurses

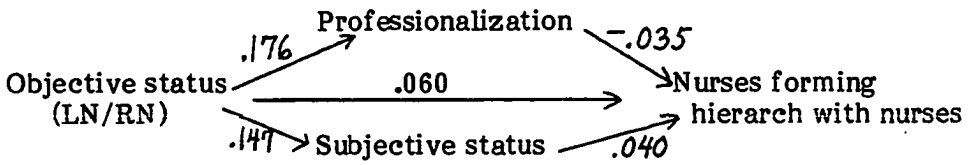
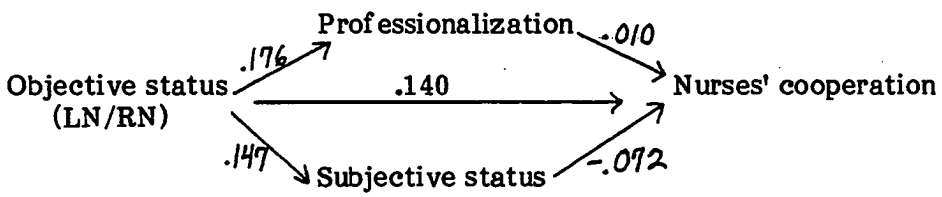


Figure 5.11- Relative Effects of Objective Status, Professionalization, and Subjective Status on Attitudes Toward Nurses' Cooperation



Professional commitment had a negative effect on perception of nurses as teachers for one another, and of nurses as forming a hierarchy, but a positive effect on attitudes toward nurses' cooperation.

For married nurses, a set of regressions was run for the dependent variable family importance. Hypotheses #4, #6, #8, and #9 were tested by regressing family importance (question 2057) on the following variables: objective status, professional commitment, subjective status, and work relations satisfaction. The results were not statistically significant. However, the effects of both professional commitment and subjective status were negative as predicated in hypotheses #6 and #8, respectively. This indicated that high professional commitment and high subjective status were related to relatively low family importance. Objective status had been hypothesized (#4) to have a direct effect

on family importance, and the results were compatible with this. Although job satisfaction had been hypothesized to have a negative effect (#9), work relations satisfaction was revealed to have a very low positive effect, while work conditions satisfaction did have a negative effect.

TABLE 5.26 - Regressions Results for Family Importance - #1:

	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.002	.638	0.061	0.738
Professional commitment	.015	-.171	-0.092	1.687
Subjective status	.016	-.274	-0.035	0.244
Work condition satisfaction	.006	-.478	-0.064	0.840

Thus, married nurses with relatively high satisfaction with their working considered their family roles less important; those with relatively high satisfaction with their work relations also tended to view their family roles as imporant.

TABLE 5.27 - Regression Results for Family Imporatance - #2:

	R^2	Unstandardized coefficient	Standardized coefficient	F
Nursing credentials: LN/RN	.002	.650	0.062	0.763
Professional commitment	.011	-.177	-0.095	1.780
Subjective status	.013	-.368	-0.047	0.442
Work relations satisfaction	.002	.515	0.027	0.150

Figure 5.12- Relative Effects of Objective Status, Professionalization, Subjective Status, and Work Conditions Satisfaction on Family Importance

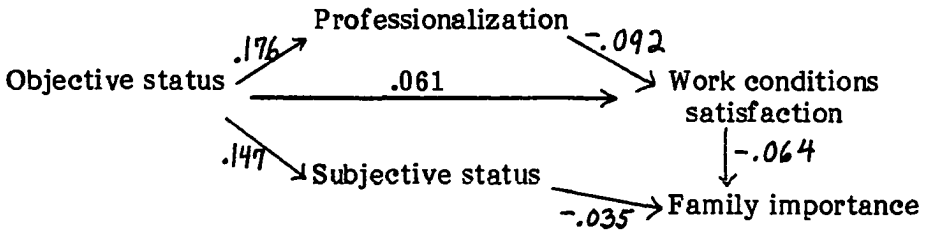
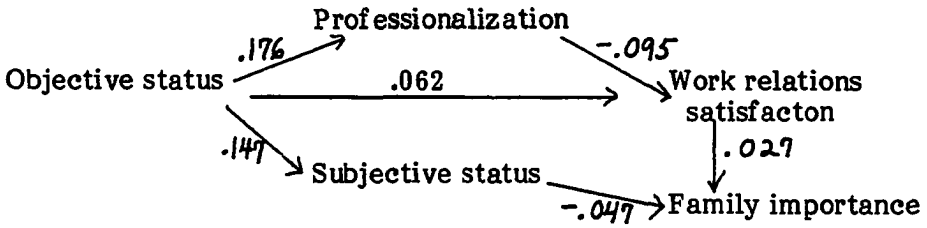


Figure 5.13- Relative Effects of Objective Status, Professionaliztion, Subjective Status, and Work Relations Satisfaction on Family Importance



Conclusion

Overall, the regression results revealed the complementary effects of both objective and subjective determinants of nurses' attitudes toward their occupation. Objective status, as indicated by "nursing credentials", was a strong, positive predictor of both professionalization, or "professional commitment", and subjective status. This signified that, in general, the higher the status of nurses - Registered, versus Licensed - the higher both their professional commitment and their subjective perception of their status.

However, subjective status itself was found to exert a stronger effect on job satisfaction as measured by satisfaction with work conditions, than either objective status or professionalization exerted. The effect of subjective status on

both work conditions satisfaction and work relations satisfaction, as well as on income satisfaction, was also positive, supporting the view that the higher the nurse's own perception of her status, the greater would be her general job satisfaction.

While objective status had a slight positive effect on income satisfaction, it affected other measures of job satisfaction negatively: Registered Nurses were less satisfied with both work conditions and work relations than were Licensed Nurses. The effect of professionalization was also varied: nurses with high professional commitment were relatively more satisfied with work relations, but less satisfied with both income and work conditions, than nurses with lower commitment.

The relationship among the independent variables and job satisfaction measures became somewhat more complex when the attitudes of nurses working on all three shifts toward specific authority-peer relations were regressed. Objective status was the strongest of the three variables affecting attitudes toward nurse-nurse relations, and was consistently positive in these regressions. When considered singly, it had a significant effect on satisfaction with both nurses' cooperation and nurses as teachers for one another. However, when the intervening effect of subjective status was taken into account, nurses with higher perception of their own status were more dissatisfied with nurses' cooperation and their roles as teachers. They also tended to feel that nurses formed a hierarchy with one another. When the intervening effects of professionalization were considered, nurses with higher professional commitment were also less satisfied with nurses' cooperation and roles as teachers, but were less likely to see nurses as forming a hierarchy, than were those with lower commitment.

In attitudes toward doctor-nurse relations, objective status again had a

consistently positive, although insignificant, effect, when considered singly. The intervening effect of subjective status was in the same direction, with the interesting exception of attitudes toward professional relations with doctors: nurses with higher perception of their own status tended to be less satisfied with professional relations. The intervening effect of professionalization was more often negative, however. Nurses with higher professional commitment were less satisfied with professional, personal, and teacher-student relations with doctors than were those with lower commitment. They also tended to feel that doctors formed a hierarchy with nurses, but were relatively more satisfied with doctors' acting as their colleagues. This latter effect appears inconsistent, unless interpreted as an idealized attitude - that is, more highly-commited nurses perhaps perceived doctors acting as colleagues since they wanted to participate in such a relationship, and felt they could do so.

Finally, analysis of the determinants of family importance for married nurses revealed the differential effects of work relations satisfaction and work conditions satisfaction: positive and negative, respectively. Since both subjective status and professionalization also had negative effects, these combined with work conditions satisfaction to decrease the importance married nurses attached to their family roles. This importance was thus shown to depend on nurses' own perceptions of their status, their professional commitment, and their job satisfaction.

The following chapter will consider the implications of the results based on the data analysis, both in terms of initial hypotheses and of questions raised by the findings. Discussion will include those areas in which further research is needed to resolve contradictions, in addition to suggestions for future research on comparative professionalization of nursing.

CHAPTER VI - FINDINGS AND SUGGESTIONS FOR FUTURE RESEARCH

Introduction: Health Care Systems and Attitudes of Personnel

The original conception of the goal of this research as understanding responses to the changing health-care system in a developing area, Hong Kong, was discussed in the Introduction and Chapter III. While no longitudinal objective measures were made of changes occurring in the health-care system, particularly the trend toward increasing bureaucratization, nurses' attitudes toward their positions and work roles were considered to be responses to such changes. Responses to specific changes were most closely reflected in the chi-square comparisons of Licensed and Registered Nurses' attitudes toward specific innovations in medical care in Hong Kong, and toward the roles of the nursing association, and the Kwun Tong Health Project. As hypothesized, Licensed Nurses were generally more positive toware innovations, including community health care. They were also in favor of strengthening the nursing association, although all nurses tended to feel that this should function as a professional association, rather than a trade union.

To clarify the consequences of increasing administrative control of hospitals and specialization of personnel, future research should include study of nurses' attitudes toward administrators as well as physicians. Further study should also be focused on the specific attitudes of Licensed and Registered Nurses toward one another, as occupants of different positions, and on the extent to which each category feels the other carries out similiar tasks, and receives a degree of

prestige that is either equivalent to or different from that which it receives. The need for this extension of the research was suggested by the regression analysis result showing a definite effect of nurses' objective status on their attitudes toward one another. Specifically, direct examination of the attitudes of the two categories of nursess toward one another in their organizational and occupational roles is necessary to complete the study of work relationships satisfaction begun here.

Further research in developing and developed countries on the attitudes of nurses and other health-care personnel with different levels of training toward one another offers an opportunity for comparative research that could make broad contributions to our understanding of the process of change in health care systems. Such research would complement the macroscopic approach often taken by social scientists engaged in comparative studies on the political economy of health care (Janzen, 1978; Baer, 1982), and would extend the scope of the anthropology of work (Wallman, 1979). It is necessary to outline the process of professionalization, particularly in health-related occupations, and to elucidate the interaction between societal and occupational structuring of this process and the contributions of individual workers.

The international medicalization of health care (Navarro, 1976) and trend toward bureaucratic organization of health and medical personnel has certainly structured new roles for these workers. However, the nature of the change in specific health care systems is often vague and ambiguous in itself. For example, the Hong Kong health care system has been and is continuing to be influenced by a mixture of British and American attempts at health care reform which must be worked out in the local context. To this amalgam is added the increasing ambiguity of Hong Kong's political situation, with the decision by China in 1982 to

resume control over the New Territories by 1997 - including Kwun Tong, the location of the United Christian Hospital and the Kwun Tong Health Project. Yet the future form of administration of this area remains uncertain; it could become semi-autonomous, depending on the directon of Chinese politics.

The consequences of the general trends toward centralization of Hong Kong's health care services, and professionalization of its nursing staff, are far from clearly spelled out. These trends have both stimulated interest in and required participations in professionalization, and have set the stage for increases in specialization of work roles and inter-segmental competition among health-care personnel. In particular, nurses have been affected by, and responded to, the emerging "institutional" values and goals (Meyer, 1980) which are pressing for the legitimation of nursing as a profession. These values and goals extend beyond the organization to affect nurses in work settings in various locations. However, the responses of various categories of nursing and other personnel are problematic. These responses are not mechanical and cannot be completely predicted merely from the knowledge that medicalization and bureaucratization are increasing.

Objective and Subjective Determinants of Occuptional Attitudes

As discussed in the introduction, transitional situations must be interpreted by actors involved in them. Employees must make sense of their roles in an ambiguous system. They may respond to the situation as threatening, or as an opportunity for advancement of their own aspirations. Further, individual interpertations of organizational situations and innovations vary, as Weiner (1976), Peterson (1976), and Sproull (1981) have found.

> Because participants' goals are ambiguous, it is impossible to apply straightforward priority orderings to all the potential responses. . . . Rather, each participant attends to a variety of ongoing streams of problems, solutions,

demands for action, and new work flows.

(Sproull, 1981, p. 465)

Priorities in responses to occupational and organizational change are also influenced by subjective perceptions and personal commitments.

This disseration has explored the relationship between objective determinants of nurses' attitudes toward their occupation, from the changing health care system of which they are part to the actual positions they occupy, and their own views of themselves considered as determinants of these attitudes. Explanations of nurses' responses of their occupational positions and work situations has been in terms both of their actual status, and of their perceptions of and commitment to their occupation. Their professional aspirations and the meaning they attach to their work roles and situations have been found to be as crucial as the nurses' actual positions and power in their occupation and organization, or hospital setting.

As discussed in the introduction to the dissertation, the individual's attachment to work (Dubin, et al, 1976) or satisfaction with work roles, relationships, and conditions, has been shown to be related to occupational or professional commitement and own perception of status, as well as to objective status. The findings of this study tend to confirm the necessity of both studying and interpreting workers' attitudes in terms of the "social definitionist" perspective in organizational theory - "Bringing Mind Back In" (Pondy and Boje, 1980) - in conjunction with the "social facts" and "social behavior" approaches. The use of all three perspectives offers the advantages of enhancing understanding of the worker within, and as a creator of, her organization and occupation. These perspectives should be integrated in future research.

The significance of nurses' subjective perception of status and professional

commitment as determinants of their attitudes can be understood in the context of the "social definition" paradigm (Pondy and Boje, 1980, pages 85-86):

> Social definitionists, according to Ritzer, treat man as an' active creator of his own social reality' and thus do not assign a status of objective materiality to social facts. What goes on in the minds of people, particularly their 'definition of the situation', is the focus of interest in this paradigm.

As predicted in the introduction, subjective factors, including nurses' perceptions of the occupation of nursing and their professional commitment, interacted with objective characteristics - position in the hospital organization, as determined by nursing credentials and status - to determine attitudes toward work.

Subjective perception complements objective structural determinants of attitudes as the social definitionist perspective complments those of social facts (analysis of inter - and intraorganizational structure - Lawerence and Lorsch, 1967; Perrow, 1972; Duncan, 1972-1973) and social worker (organizational psychology - Hackman, 1971). Although objective factors such as actual status and task assisgnments of workers affect attitudes, the individual can choose to become a productive member of his organization, and this choice is exercised within his own definition of the situation (March and Simon, 1958). The situation, in the case of nurses and other workers who belong to professionalizing occupations, is tied to the occupation as well as the organization.

Theorists using approaches related to the social definitionist perspective have confirmed the effect of subjective perception on work-related attitudes. These include symbolic interactionism (Strauss, 1963, 1978), research on sense-making by the individual in organizational contexts (Weick, 1974), and action theory (Silverman, 1970). The latter stresses "...the meaning that an actor assigns to his enacted surroundings and to the expected outcome of his actions" (Pondy

and Boje, 1980, p.89).

This disseration has presented additional evidence that the "...intentions and understandings" of "subjective and goal-pursuing actor(s)" (Barth, 1981, pp.2-3) must be taken into account in the study of attitudes. It is important for anthropologists to take seriously the range of individual variation in perceptions, commitments, and priorities, as well as the contextualization of behavior - interaction between the individual and the situation (Howard, 1982). This suggests the need for integration of social and psychological anthropology, using an interactionist or social definitionist perspective which could complement structural approaches in anthropology. It also points to the significance of anthropological research on the social and psychological aspects of the evaluation of work by individuals, as well as study of the control of work in various settings (Wallman, 1979).

In order to coordinate interactionist and structural perspectives, appropriate research techniques should be used in combination, rather than as exclusive alternatives. Ideally, questionnaires should be coordinated with observational and other types of techniques. However, as discussed in Chapter I and IV, the use of a questionnaire survey in this dissertation did increase consistency in comparing individual attitudes, and made possible quantitative analysis of the relative importance of several independent variables.

The relative importance of the overall effects of nurses' objective and subjective status and professionalization on their satisfaction with various aspects of their work was demonstrated in the regression analysis. As concluded in the previous chapter, while nurses' objective status was a strong, positive predictor of both subjective status and professional commitment, subjective status has a strong, positive effect on work satisfaction, particularly as related to work

conditions. It also intervened to affect the degree to which nurses were satisfied with relations with one another and with doctors, although its effects were generally positive in the latter case, and negative in the former. The intervening effect of nurses' professional commitment on these attitudes was primarily negative: higher commitment led to lower satisfaction.

Thus, both structural (objective) and personal (subjective) influences, including professinal commitment, were shown to be related to Licensed and Registered Nurses' satisfaction with their work situations. The variation in relative amount of influence of these two types of factors on nurses' perceptions of work relationships with other nurses, and with doctors, underscores the salience of both as complementary independent variables.

The results of the regression analysis presented in the previous chapter included evidence either supporting or contradictory to the nine hypotheses tested. In general, five hypotheses were supported: the three predicting a positive effect of objective status on professional commitment, subjective status, and family importance, and the two predicting a negative effect of professional commitment and subjective status on family importance. Inconclusive evidence was obtained for the four hypotheses dealing with job satisfaction, varying with the specific indicators use to measure satisfaction. These four hypotheses tested the effects of objective status, subjective status, and professional commitment on job satisfaction indicators, and the effect of the latter on family importance. Because of the variable results obtained with different measures of job satisfaction, this should be treated as a multidimensional variable in future research on professionalization of nurses.

The various components of job satisfaction for workers in different types of occupations need to be further explored, to clarify their relationship to causal

factors. As Gutek has stated, this is an area which merits research in its own right, as evidenced by the more than 3000 studies thus far. Regardless of the general lack of success in demonstrating a "consistent, positive link" between job satisfaction and worker productivity (Gutek, 1980, p.522), it is of primary concern to employers and employees alike.

Much American research has considered job satisfaction merely a combination of goodness or badness of aspects of the job; some has characterized it as a unidimensional variable, determined by attitudes toward objective characteristics of the organization in which workers are employed. For example, Price and Mueller (1981) have assessed the relative contributions of routinization of work, participation, instrumental communication, integration of workers, pay, distributive justice (relation of rewards and punishments to job performance), and promotional opportunity to job satisfaction, itself considered a major indirect causal variable in turnover of nurses (see Chapter II of dissertation).

However, when the focus is on explaining variations in job satisfaction among workers of varying status in a particular organization, it is necessary to treat this as a complex dependent variable. Also, while the dissertation did not directly investigate the effects of generalized "intrapsychic mechanisms" such as individuals' feelings of control, levels of aspiration, and comparison levels on job satisfaction as did Gutek (1980), my results on effects of perceptions suggest that the former variables should be included with subjective assessments, in research on causal factors of attitudes toward work. This would increase the depth of our understanding of workers' needs, as well as their attitudes, and would reveal certain underlying psychological factors involved in perceptions of the work situation. It could also enhance our comprehension of individuals' predispositions toward particular kinds of sense-making (Louis, 1980) and enactment (Weick,

1979) of their organizational and occupational environments.

Moreover, as the results of my research have indicated, workers' attitudes are only partially determined by the internal characteristics of the organization, or immeidate work environment. The fluid interorganizatinal environment also affects perceptions by workers of their roles and positions. This research project was originally planned to compare several different hospitals, and to relate the occupational attitudes of nurses in each to the changing status of the hospital itself relative to others in the health-care system. This was not successful at the time of the original survey, due to limitations on recruiting and training research assistants and the need for greater access to interviewing nursing personnel in certain hospitals. If these practical problems could be solved, such a comparison would be fruitful in the future, in order to assess the contribution of the interorganizational context - the changing hospital system - to workers' perceptions of their positions as well as their attitudes toward health-care innovations.

This would be especially interesting as a sequel to this dissertation, in view of the imminent political change in Hong Kong. Hospitals located in the New Territories could be compared with those on Hong Kong Island which are likely to remain under British control, to determine the effects of socio-political change on the emerging hierarchy of hospitals and on workers employed in them. Such an approach could also be extended to cross-cultural comparisons of health-care systems with similarities in basic organizational features. Cross-cultural comparisons should also be done on attitudes of workers in a single occupation, focusing on the occupation rather than on the organizational settings. Some research has been done on cross-cultural comparisons of workers in multi-national coporations: see Hofstede's study of international differences in work-related

values (1980). As discussed in Chapter II of this dissertation, it is also important to compare the views of workers in various organizational and national contexts toward a common occupation.

As the results of this research suggest, workers' attitudes are only partially determined by characteristics of their organizations. Individuals' attitudes of commitment toward, and perceptions of their positions as members of their occupation or profession are also important determinants of job satisfaction. Moreover, it has been shown that this is the case in developing areas such as Hong Kong, as well as in developed nations such as the United States and the United Kingdom. The latter has been confirmed by research such as Wallis and Cope's study of Welsh nurses (1980), and Redfern and Spurgeon's finding of British hospital sisters (1980). The changing status of an occupation itself withing a particular cultural setting is an objective influence on the perceptions and commitments of workers toward that occupation. As studies on various occupations in the United States have found (Stewart and Cantor, 1982), change in occupational status is related to cultural, societal, and organizational control factors. Cross-cultural research on variations over time in the status of one occupation relative to others in a society is necessary to establish a frame work against which to measure workers' attitudes.

Further study of intra-occupational change is also needed. Since little research has been done to date on the changing roles and status of United States Licensed Practical, or British Enrolled, Nurses, comparative study would clarify the social-structural reasons for the declining status of this position relative to that of Registered or State Registered Nurse, respectively. The causes and effects of such developments as the recent trend toward training United States Registered Nurses for management roles and assigning immediate patient care

tasks to Licensed Practical Nurse and nursing assistants, followed by the growing attempt to eliminate the latter positions and divide nursing responsibilities among Registered Nurses with different amounts of training (see Chapter II) could be illuminated by such cross-cultural research. Comparison of the attitudes of nurses in these positions to such changes with those of Registered and State Enrolled Nurses in Great Britain would be helpful in increasing understanding of the consequences of such occupational change.

Psychological Perspectives in Social and Cultural Anthropology

This dissertation has used both social structural and psychological, or subjective, factors to explain the attitudes of nurses in a transitional developing area toward their occupation and work situation. From a theoretical point of view, the problem of explaining attitudes has been used to explore the relationship between social structural and psychological factors as determinants. The above discussion has dealt alternatively with both types of factors, with the assumption that it is essential to consider both in any comprehensive study of responses of members of a social group to change.

It has been suggested that further integration of social and psychological anthropology is needed to deal with problems such as those analyzed in this research. The need for such integration has also been recognized in ethnology. Whether due to increasing competition with sociologists and psycologists for research funding, or to the recognition that "In building the mirror to man, we have found that the image of the builder himself looms therein" (Kiefer, 1977, p. 104), interest in perception, cognition, communication, identity, and the relation of symbolism to social action has grown. A different trend has been toward ecological theories of environmental causes of social choices.

More recently, human ecology has begun to place increasing emphasis on actor-based models such as that of decision-making, which locates the mechanism of ecological change in individual choices of alternative actions. While these choices are generally presumed to be made according to principles of "maximization, satisfaction, or least risk" (Hardesty, 1980, p. 111), there remain problems of relating individual decisions to adaptive strategies through intermediate social units, and of explaining the process by which different strategies are sorted or assigned priorities. Also, the presumptions that decisions are based on efficiency or constrained by scarcity of available resources have been found inadequate to deal with situations in which unpredictable changes may make goals difficult to attain.

Interest has grown in models of flexibility or resilience of social organizing principles and individual or group behavior, and in attempts to increase environmental stability by developing complex social patterns that buffer the effects of uncertainty (Hardesty, 1980). These models have obvious parallels to those used in organizational theory which attempt to posit methods of dealing with uncertainty, such as contingency theory and the adaptive model of multiple decision-making structures (Duncan, 1973). Social and cultural anthropologists, including ecologists, are becoming more aware of the need to understand the linkage between individuals and social processes.

Anthropologists are becoming ever more cognizant of the significance of "...the self-consciously purposive nature of human life" (Kiefer, 1977, p. 105). There remains the need to comprehend more thoroughly how individual members of social and cultural groups act, in ambiguous situations in which the consequences of their choices are unpredictable - and which offer opportunities for enacting personal goals, or pose threats, depending on interpretaitons.

Individual variation in perceptions and choices should be integrated with models of decision-making which depict actions as selected from among socially - and culturally - defined alternatives.

This goal is not antithetical to that of discovery of common human processes of sense-making and attempting to achieve goals, however vague they may be. Nor does it necessitate ignoring the social and cultural grounds of these processes, or the environmental - including political and economic - constraints on actions. Emphasis on attitudinal variation, or differences in predispositions to action, must be given a context by further research on intra-cultural variations - and interaction among social groups. The changing complex of occupations, emerging professions, and the aspirations, role-related attitudes, and involvement of their participants offer promising avenues for extension of the scope of contemporary anthropology in these directions.

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APPENDIX: NURSES' QUESTIONNAIRE

(Translated from Chinese)

Code Number:_____ ("No answer" category included for coding)

(1001 - 1010) = Refer to code number and blank columns for coding responses)

I. Background characteristics:

(1011) 1. Hospital/Clinic Name: _____

Kwong Wah Hospital
Queen Elizabeth Hospital
United Christian Hospital
Saint Teresa Hospital
Baptist Hospital
Queen Mary Hospital
Private clinic
Government clinic

(1012) 2. Government _____
Private _____
Subsidized _____
No answer _____

(1013) 3. Age of respondent:

15-20	_____	36-40	_____	56+	_____
21-25	_____	41-45	_____	no answer	_____
26-30	_____	46-50	_____		
31-35	_____	51-55	_____		

(1014) 4. Marital status:

Married _____
Single _____
No answer _____

(1015) 5. Educational level:

Secondary _____
Post-secondary _____
No answer _____

(1016) 6. Working hours:

Shift _____
Non-shift _____
No answer _____

(1017) 7. Which shift do you work most?

Morning _____
Afternoon _____
Night _____
Alternate morning and afternoon _____
Alternate morning, afternoon, and night _____
No answer _____
Not apply _____

(1018) 8. Wages per month:

$1000-1500 _____
$1500-2000 _____
$2000-2500 _____
$2500-3000 _____
$3000 or above _____
No answer _____
Not apply _____

(1019) 9. Number of children:

none _____
one _____
two _____
three _____
four _____
five _____
six _____
seven _____
eight+ _____
no answer _____

10. Ages of children: (0-11 mos., 1-5 yrs., 6-10 yrs., 11-15 yrs., 16-20 yrs., 21+ yrs., no answer, not apply)

(1020) a. child #1 _____
(1021) b. child #2 _____
(1022) c. child #3 _____

II. Questionnarie:

(1023) 1. What influenced you to become a nurse?

a. job security _____
b. expanding possibilities of job _____
c. satisfaction of helping others _____
d. gives me status _____
e. "good prospect" _____
f. chance to work closely with doctors _____
g. learn more skills _____
h. no answer _____

(1024) 2. Among the following people, who also took up nursing as her/their career?

a. mother _____
b. close friend _____
c. close relative _____
d. no answer _____
e. a+b _____
f. a+c _____
g. b+c _____
h. a+b+c _____
i. none _____
j. distant relative _____

(1025) 3. Being a nurse is considered by the general public as:

a. high status _____
b. moderate status _____
c. low status _____
d. no answer _____

(1026) 4. From your knowledge, what is the general perception of the public toward nurses?

a. (work is) "laborious and difficult to bear" _____
b. gentle and kind _____
c. rational (not emotional) _____
d. cold (not sympathetic) _____
e. hot tempered _____
f. no answer _____
g. a+b _____
h. a+c _____
i. a+d _____
j. a+e _____

(1027) 5. Which is most important to you as a nurse?

a. to be highly respected by my friends _____
b. to be highly respected by my family _____
c. to be highly respected by by other nurses _____
d. to be highly respected by doctors _____
e. no answer _____
f. none of these _____
g. self-respect _____
h. to be respected by patient _____
i. c+h _____
j. a,b,c,d _____

(1028) 6. What does "professional" mean to nurses?

a. common values and attitudes _____
b. similar training and skills _____
c. no answer _____

(1029) 7. Being a nurse is considered by doctors as:

a. high status _____
b. median status _____
c. low status _____
d. no answer _____
e. don't know _____

(1030) 8. What is your perception towards the nursing profession?

a. increasing status in recent years _____
b. about the same status as before _____
c. declining status from a few years ago _____
d. no answer _____

(1031) 9. Your perception towards the job of nurses is:

a. highly professional _____
b. semi-professional _____
c. non-professional _____
d. no answer _____

(1032) 10. Is your work laborious or not?

a. highly laborious _____
b. laborious _____
c. moderate _____
d. not too difficult _____
e. easy _____
f. no answer _____

(1033) 11. Do you feel your work is too dirty and noisy?

a. very dirty _____
b. very noisy _____
c. very dirty and noisy _____
d. average _____
e. not dirty _____
f. not noisy _____
f. not dirty and noisy _____
h. no answer _____
i. undecided _____

(1034) 12. Do you feel your work ties you down and restricts your freedom too much?

a. (strongly) ties down and restricts freedom _____
b. ties down and restricts freedom _____
c. does not tie down or restrict freedom _____
d. (strongly) does not tie down or restrict freedom _____
e. nc answer _____

(1035) 13. Do you feel the health care system in Hong Kong is adequate?

a. very adequate _____
b. adequate _____
c. average _____
d. not adequate _____
e. very inadequate _____
f. no answer _____

(1036) 14. Do you feel that the health care system needs to be improved?

a. (strongly) needs to be _____
b. needs to be improved _____
c. average
d. does not need to to be _____
e. (strongly) does not to be _____
f. no answer _____

(1037) 15. What is your perception towards your present job?

a. professional _____
b. service/help others _____
c. difficult work _____
d. other (specify) _____
e. no answer _____
f. a+b _____

(1038) and *1039) 16. What duties are your responsible for in the hospital?_____

a. Outpatient Department
b. Emergency Ward
c. Light Care Ward
d. Men's Surgical Ward
e. Intensive Care Unit
f. Operating Room
g. OB-GYN
h. Maternity
i. Men's Medical Ward
j. Psychiatric Ward
k. Womens's Medical Ward
l. Geriatric Ward
m. Women's Surgical Ward
n. Orthopedic Ward
o. Pediatric Ward
p. Private and Children's Ward
q. Community Nursing Service
r. Nursing School
s. Holiday Relief
t. T.B. and Pulmonary
u. Opthalmology
v. "Staff Nurse"
w. "Head Nurse"
x. Administration

(Questions 17-24: for shift nurses only)

(1040) 17. In your opinion, what problems will arise from your "shifting" system?

A. For family:

a. neglect of the family _____
b. have frequent conflicts with your husband_____
c. hot-tempered wife _____
d. no problem at all_____
e. no answer _____
f. not apply _____
g. a+b _____
h. a+c _____
i. b+c _____
j. a+b+c _____

(1041) B. For non-family/friends:

a. less social activities _____
b. poorer relationship with them _____
c. no problem at all_____
d. no answer _____
e. not apply _____
f. a+b _____

(1042) 18. A. What shift would prefer it you had a choice?

a. morning shift _____
b. afternoon shift _____
c. night shift _____
d. no answer _____
e. not apply _____
f. a+b _____

(1043) B. Why?

a. more challenging duties (more interesting-learn more new things) _____
b. more time to spend with the family _____
c. husband's willingness _____
d. less work to do _____
e. other reasons specify: _____
f. no answer _____
g. not apply _____

(1044) 19. Have you adapted to the shift work?

a. yes _____
b. no _____
c. partly _____
f. no answer _____
g. not apply _____

(1045) 20. How do you solve the problem caused by shift work?

a. self-patience _____
b. compromise with husband (or relatives) _____
c. rearrange your domestic habits _____
d. ask help from others (relatives: employ "amah" or maid) _____
e. can't solve it _____
f. no answer _____
g. not apply _____

(1042) 21. Do you like shift work? (give reason:)

a. yes _____
b. no _____
c. no answer _____
d. not apply _____
e. yes, more flexible _____
f. yes, should adapt to it (necessary) _____
g. yes, somewhat _____
h. no; no "normal" family or daily life _____
i. no, unstable schedule _____
j. no, unstable and "abonormal" _____

(1047) 22. If there is conflict between your social activities and working hours, how do you solve it?

a. apply to change to another shift _____
b. apply for a special leave _____
c. give up social activities _____
d. rearrange social activities _____
e. a+b _____
f. a+b _____
g. b+c _____
h. no answer _____
i. not apply _____

(1048) 23. How would you describe the nursing work you do on each shift?
(1049)

	(A)Morning	(B)Afternoon	(C)Evening
(1050) a. like an "amah" (maid)	_____	_____	_____
b. specialized technical nursing skill	_____	_____	_____

	(A)Morning	(B)Afternoon	(C)Evening
c. professional relations with colleagues	____	____	____
d. decision-making: I	____	____	____
I decide, myself	____	____	____
decided by others	____	____	____
e. learn more new things	____	____	____
f. more interesting work	____	____	____
g. no answer	____	____	____
h. not apply	____	____	____

(1051) 24. What is the relationship between the following:
(1052)
(1053)

	(A)Morning	(B)Afternoon	(C)Evening
A. Relationship with doctors:			
(1) Professional relations			
a. very close	____	____	____
b. close	____	____	____
c. average	____	____	____
d. not close	____	____	____
e. hostile	____	____	____
f. no answer	____	____	____
g. not apply	____	____	____
(1054) (2) Personal relations			
(1055) a. very friendly	____	____	____
(1056) b. friendly	____	____	____
c. average	____	____	____
d. not friendly	____	____	____
e. hostile	____	____	____
f. no answer	____	____	____
g. not apply	____	____	____
(1057) (3) Doctors teach new knowledge			
(1058) a. frequently	____	____	____
(1059) b. often	____	____	____
c. sometimes	____	____	____
d. seldom	____	____	____
e. never	____	____	____
f. no answer	____	____	____
g. not apply	____	____	____
(1060) (4) Doctors act as colleague			
(1005) a. frequently	____	____	____
(1006) b. often	____	____	____
c. sometimes	____	____	____
d. seldom	____	____	____
e. never	____	____	____
f. no answer	____	____	____
g. not apply	____	____	____

(24. What is the relationship between the following:)

		(A)Morning	(B)Afternoon	(C)Evening
(1061)	(5) Doctors order nurses to			
(1062)	things			
(1063)	a. frequently	____	____	____
	b. often	____	____	____
	c. sometimes	____	____	____
	d. seldom	____	____	____
	e. never	____	____	____
	f. no answer	____	____	____
	g. not apply	____	____	____
(1064)	B. What is the relationship between			
(1065)	nurses and nurses:			
(1066)	(1) Do they teach each other:			
	a. frequently	____	____	____
	b. often	____	____	____
	c. sometimes	____	____	____
	d. seldom	____	____	____
	e. never	____	____	____
	f. no answer	____	____	____
	g. not apply	____	____	____
(1067)	(2) Have a very strict hierarchy:			
(1068)	a. frequently	____	____	____
(1069)	b. often	____	____	____
	c. sometimes	____	____	____
	d. seldom	____	____	____
	e. never	____	____	____
	f. no answer	____	____	____
	g. not apply	____	____	____
(1070)	(3) Are they friendly and			
(1071)	cooperative:			
(1072)	a. frequently	____	____	____
	b. often	____	____	____
	c. sometimes	____	____	____
	d. seldom	____	____	____
	e. never	____	____	____
	f. no answer	____	____	____
	g. not apply	____	____	____

25. What type of nursing practice have you worked in (Please list):

(1073-1102)	Previous type of nursing practice	Dates (years)	Reason for leaving: Money	Status of work	Prosepct	No ans.	Not ap.
	1.						
	2.						
	3.						
	4.						
	5.						

(1103) 26. Does your present job require you to work too long a time?

a. too long time _____
b. average _____
c. not long _____
d. no answer _____
e. depends on shift _____

(1104) 27. Do you regret that you have taken the occupation of nurse?

a. strongly regret _____
b. regret _____
c. not regret _____
d. (strongly) not regret _____
e. no answer _____

(1105) 28. Does your job give you more real personal statisfaction than the things you do in your spare time?

a. strongly satisfied _____
b. satisfied _____
c. strongly satisfied _____
d. no answer _____
e. somewhat satisfied _____

(1106) 29. Do you often feel that your work is monotonous and boring?

a. frequently _____
b. often _____
c. sometimes _____
d. seldom _____
e. never _____
f. no answer _____

(1107) 30. Do you like being a nurse?

a. very much _____
b. like _____
c. do not like _____
d. (strongly) do not like _____
f. no answer _____
g. "neutral" _____

(1108) 31. Do you wish to be a nurse permanently?

a. strongly wish _____
b. wish _____
c. reluctant _____
d. very reluctant _____
e. no answer _____
f. undecided _____

(1109) 32. Do you think the nursing profession is worthwhile and important?

a. (strongly worthwhile and important _____
b. worthwhile and important _____
c. not worthwhile and important _____
d. (strongly) not worthwhile or important _____
e. no answer _____
f. somewhat worthwhile _____

(1110) 33. Do you feel that (in being a nurse you) can utilize your full abilities?

a. (strongly) feel _____
b. feel _____
c. do not feel _____
d. (strongly) do not feel _____
e. no answer _____
f. somewhat _____

(1111) 34. Are you proud of your profession and the work you do?

a. (strongly) proud _____
b. proud _____
c. not proud _____
d. (strongly) not proud _____
e. no answer _____
f. sometimes (or somewhat _____

35. Please rank the following table (1 is the most, 10 the least):

(2011-2026)

Types of nursing (ward)	Greatest status-respect	Greatest skills necessary	Best job prospect	Requires most flexibility	Requires most self-initiative	Most non-routine
Outpatients						
Emergency ward						
Operating theater						
Psychiatric ward						
General medical ward						
Childrens ward						
Obstetrical delivery room						
Elderly ward						
Disinfecting room						

(2027) 36. Who is your immediate supervisor?

a. doctor _____
b. chief resident _____
c. matron _____
d. myself _____
e. other nurses of my ward _____
f. no answer _____
g. division head _____
h. academic dean _____

(2028) 37. Who is responsible for your pace (set) of work?

a. doctor _____
b. chief resident _____
c. matron _____
d. myself _____
e. other nurses of my ward _____
f. no answer _____
g. division head _____
h. academic dean _____

(2029) 38. (For shift nurses only):
Do you have more or fewer friends now than before you worked shifts?

a. more _____
b. same _____
c. less _____
d. no answer _____
e. not apply _____

(2030) 39. What percent of your friends are nurses?

a. 100% _____
b. 50% _____
c. 25% _____
d. 10% _____
e. no answer _____
f. fewer than 10% _____
g. none _____
h. many are acquaintances _____

(2031) 40. Do you prefer spending time with:

a. nurses and doctros _____
b. non-medical people _____
c. no answer _____
d. a+b _____
e. nurses only _____
f. nurses and non-medical _____
g. undecided _____

(2032) 41. What do you think about the relationship between you and your immediate supervisor (matron)?

a. very good _____
b. good _____
c. fair _____
d. bad _____
e. very bad _____
f. no answer _____
g. not apply _____

(2033) 42. Do you think there is good relationship between you and your colleagues?

a. very good _____
b. good _____
c. fair _____
d. bad _____
e. very bad _____
f. no answer _____
g. not apply _____

(2034) 43. Have you made real and close friends among your working associates?

a. most _____
b. many _____
c. a few _____
d. none _____
e. no answer _____

(2035) 44. A. Do you think that you have adequate knowledge for your present job?

a. yes (strongly) _____
b. O.K. _____
c. not enough _____
d. no (strongly) _____
e. no answer _____

(2036) B. If no, are you taking any further course?

a. yes _____
b. no _____
c. no answer _____
d. not apply _____
e. type of course _____
f. study on own _____

(2037)
(2038) C. If yes, what kind, and where?

_____

(2039) D. If yes, why did you choose this course?

a. better pay _____
b. better prospect _____
c. better status _____
d. (strongly) not low status _____
e. no answer _____
f. some are, some are not _____
g. fulfill myself _____
h. helpful to work _____

(2040) 45. Do you think that your present income is fair for the amount and kind of work you do?

a. more than enough _____
b. enough _____
c. barely enough _____
d. not fair enough _____
e. no answer _____
f. don't expect increase _____

(2041) 46. Would you encourage your children to be nurses?

a. strongly encourage _____
b. encourage _____
c. not encourage _____
d. strongly not encourage _____
e. no answer _____
f. not apply _____

(2042) 47. In comparison with the government hospital, do you think nurses who work in the clinics are of lower status?

a. (strongly)-low status _____
b. low status _____
c. not low status _____
d. some are, some are not _____
e. (strongly) not low status _____
f. no answer _____
g. unnecessary to compare _____

(2043) 48. Is there any status difference between the government hospital and a private hospital?

a. (strongly) status difference _____
b. status difference _____
c. have same status _____
d. (strongly) have same status _____
e. no answer _____

(2044) (2045) 49. (A) Which setting is most or least desirable to be a nurse in?

	I. Most desirable	II. Least desirable
a. government hospital	____	____
b. large private hospital	____	____
c. small private hospital	____	____
d. large clinic	____	____
e. small clinic	____	____
f. no answer	____	____

(B) In order to improve the medical care of Hong Kong, which type of hospital or clinic should be expanded? (Rank the significance by using 1, 2, 3, 4, 5.)

(2046-2050)

a. government hospital ____
b. large private hospital ____
c. small private hospital ____
d. large clinic ____
e. small clinic ____

(2051) 50. How much (what percent) of your income is used for the expenses of the family?

a. below 35% ____
b. 35% ____
d. above 70% ____
d. no answer ____
e. not apply ____

(2052) 51. After working hours, do you think about your work?

a. frequently ____
b. often ____
c. sometimes ____
d. seldom ____
e. never ____
f. no answer ____

<u>(#55 - #99) Married and/or with children, only):</u>

(2053) 52. Do your children help you to do household tasks?

a. frequently ____
b. sometimes ____
c. never ____
d. no answer ____
e. not apply ____

(2054) 53. Who takes care of the children?

a. other relatives ____
b. grandparents ____
c. husband ____
d. neighbors ____
e. friends ____
f. older children ____
g. hired amah(maid) ____
h. institution/center ____
i. no answer ____
j. not apply ____

(2055) 54. Do your children prepare their own breakfast and lunch?

a. frequently ____
b. sometimes ____
c. never ____
d. no answer ____
e. not apply ____

(2056) 55. Do your children go to school and go home after school by themselves?

a. frequently _____
b. sometimes _____
c. not apply _____
d. never _____
e. no answer _____

(2057) 56. Do you think a married wife:

a. sees work as main tasks _____
b. sees work and family as equal _____
c. sees family as main task _____
d. no answer _____

(2058) 57. What is more important for a wife?

a. to have a career, herself _____
b. to help her husband's career _____
c. to bring up children _____
d. no answer _____
e. b+c _____
f. a+c _____

(2059) 58. Who plans the expenditure of family income?

a. wife herself _____
b. husband _____
c. both _____
d. other (specify)_____
e. no answer _____

(2060) 59. Who decides when and what social activities (there are) for the entire family?

a. wife _____
b. husband _____
c. both _____
d. other (specify)_____
e. no answer _____

(2061) 60. Who makes a decisions about household tasks?

a. wife _____
b. husband _____
c. both _____
d. other (specify)_____
e. no answer _____

(2062) 61. Who makes decisions about child-care?

a. wife _____
b. husband _____
c. both _____
d. other (specify)_____
e. no answer _____

(2063) 62. Who is responsible for meals?

a. wife _____
b. husband _____
c. both _____
d. other (specify)_____
e. no answer _____

(2064) 63. Who is responsible for buying articles for everyday use?

a. wife _____ d. other (specify)_____
b. husband _____ e. no answer _____
c. both _____

(2065) 64. Who is responsible for cleaning the house?

a. wife _____ d. other (specify)_____
b. husband _____ e. no answer _____
c. both _____

(2066) 65. Who is responsible for food buying?

a. wife _____ d. other (specify)_____
b. husband _____ e. no answer _____
c. both _____

(2067) 66. Who sends (takes) children to school and brings them back?

a. wife _____ d. others (specify)_____
b. husband _____ e. no answer _____
c. both _____ f. not apply _____

(2068) 67. Who mostly goes out with children?

a. wife _____ d. others (specify)_____
b. husband _____ e. no answer _____
c. both _____ f. not apply _____

(2069) 68. Who reminds children to do homework and study?

a. wife _____ d. others (specify)_____
b. husband _____ e. no answer _____
c. both _____ f. not apply _____

(2070) 69. Who buys clothes and the like for children?

a. wife _____ d. others (specify)_____
b. husband _____ e. no answer _____
c. both _____ f. not apply _____

(2071) 70. Who is responsible for buying furniture or Hi-Fi set?

a. wife _____ d. others (specify)_____
b. husband _____ e. no answer _____
c. both _____

(2071) 71. Who is responsible for managing the income and expenses for the whole family?

a. wife _____ d. others (specify)_____
b. husband _____ e. no answer _____
c. both _____

(2073) 72. Who is responsible for paying the expenses such as fees, telephone bills, electricity bills, etc.?

a. wife _____
b. husband _____
c. both _____
d. other (specify)_____
e. no answer _____

(2074) 73. Does one decide how to spend the pocket mony individually? Who?

a. wife _____
b. husband _____
c. both _____
d. other (specify)_____
e. no answer _____

(2075) 74. If the family has planned to have a picnic, who is responsible for preparing food and untensils that will be needed?

a. wife _____
b. husband _____
c. both _____
d. other (specify)_____
e. no answer _____
f. not apply _____

(2076) 75. When activities need advanced booking, who is responsbile for that?

a. wife _____
b. husband _____
c. both _____
d. other (specify)_____
e. no answer _____
f. not apply _____

(2077) 76. When your family holds a party, who is responsible for the preparation?

a. wife _____
b. husband _____
c. both _____
d. other (specify)_____
e. no answer _____
f. not apply _____

(2078) 77. Whose activity will you attend, if both of you are invited to different parties of the same importance at the same time, and the couple should attend together?

a. wife _____
b. husband _____
c. both _____
d. other (specify)_____
e. no answer _____
f. not apply _____

(2079) 78. Do you talk about (discuss) your family with your husband?

a. frequently _____
b. often _____
c. sometimes _____
d. seldom _____
e. never _____
f. no answer _____
g. not apply _____

(2080) 79. Do you talk about (discuss) your job with your husband?

a. frequently _____
b. often _____
c. sometimes _____
d. seldom _____
e. never _____
f. no answer _____
g. not apply _____

(2081) 80. Do you know your husband's income?

a. sure _____
b. not sure _____
c. do not know _____
d. no answer _____
e. not apply _____

(2082) 81. Do you know how your husband spends his money?

a. all of it _____
b. majority _____
c. some of it _____
d. minority _____
e. do not know _____
f. no answer _____
g. not apply _____

(2083) 82. Do you always ask about your husband's working conditions?

a. frequently _____
b. often _____
c. sometimes _____
d. seldom _____
e. never _____
f. no answer _____
g. not apply _____

(2084) 83. Do you go out with your husband?

a. frequently _____
b. often _____
c. sometimes _____
d. seldom _____
e. never _____
f. no answer _____
g. not apply _____

(2085) 84. Do you spend holidays with your husband?

a. frequently _____
b. often _____
c. sometimes _____
d. seldom _____
e. never _____
f. no answer _____
g. not apply _____

(2086) 85. Do you like to spend leisure time with your husband?

a. strongly enjoy _____
b. enjoy _____
c. no opinion _____
d. dislike _____
e. strongly dislike _____
f. no answer _____
g. not apply _____

(2087) 86. Does your husband know all your close friends?

a. all of them _____
b. majority of them _____
c. some of them _____
d. minority of them _____
e. none _____
f. no answer _____
g. not apply _____

(2088) 87. Does your husband know all your relatives?

a. all of them _____
b. majority of them _____
c. some of them _____
d. minority of them _____
e. none _____
f. no answer _____
g. not apply _____

(2089) 88. Do you know your husband's close friends?

a. all of them _____
b. majority of them _____
c. some of them _____
d. minority of them _____
e. none _____
f. no answer _____
g. not apply _____

(2090) 89. Whom do you prefer to visit during holidays?

a. relatives _____
b. friends _____
c. neighbors _____
d. no answer _____
e. a+b _____
f. a+c _____
g. b+c _____
h. a+b+c _____
i. don't visit _____

(2091) 90. How do you feel about your relationship with your neighbors?

a. best _____
b. good _____
c. common _____
d. poor _____
e. very poor _____
f. no answer _____

(2092) 91. Do you feel your neighbors are helpful to you?

a. very helpful _____
b. quite helpful _____
c. common _____
d. little help _____
e. not helpful (totally) _____
f. no answer _____

(2093) 92. How often do you have a big "blow-out" with your husband?

a. frequently _____
b. often _____
c. sometimes _____
d. seldom _____
e. never _____
f. no answer _____
g. not apply _____

(2094) 93. How often have you quarreled with your husband?

a. frequently _____
b. often _____
c. sometimes _____
d. seldom _____
e. never _____
f. no answer _____
g. not apply _____

(2095) 94. Usually, what types of problems cause disputes between you and your husband?

a. schooling of children _____
b. social activities _____
c. finances _____
d. others _____
e. 0+1 _____
f. 1+2 _____
g. 0+2 _____
h. 2+3 _____
i. 1+3 _____
j. 0+3 _____

(2096) 95. How often do you get so angry that you refuse to talk to your husband ("cold war")?

a. frequently _____
b. often _____
c. sometimes _____
d. seldom _____
e. never _____
f. no answer _____
g. not apply _____

(2097) 96. How do you solve problems after quarreling?

a. apology _____
b. discussion _____
c. compromise _____
d. cold war _____
e. running away _____
f. no answer _____
g. not apply _____
h. husband "surrenders" _____
i. wife "surrenders" _____

(2098) 97. Are you satisfied with your marriage?

a. strongly satisfied _____
b. satisfied _____
c. opinion _____
d. unsatisfied _____
e. strongly unsatisfied _____
f. no answer _____
g. not apply _____

(2099) 98. If you could rechoose your husband, what type of husband would you prefer?

a. same as the present husband _____
b. similiar to the present husband _____
c. no opinion _____
d. not like present husband _____
e. totally opposite from present husband _____
f. no answer _____
g. not apply _____

(2100) 99. What do you think about the relationship between your husband and you?

a. very good _____
b. good _____
c. common _____
d. bad _____
e. very bad _____
f. no answer _____
g. not apply _____

(2101) 100. What kind of nurse are you?

a. licensed nurse _____
b. registered nurse _____
c. non-licensed nurse _____
d. no answer _____

(2102) 101. Should nurses be:

a. under stricter control by doctors _____
b. be given greater opportunities to make decisions for themselves _____
c. no answer _____
d. it depends on tasks _____
e. neither; each has his own job _____

(2013) 102. Should the nursing association be more like a:

a. trade union _____
b. pressure group _____
c. strictly a professional association _____
d. non-pressure group _____
e. no answer _____

(2014) 103. Should it be strengthened?

a. (strongly) yes _____
b. yes _____
c. perhaps _____
d. no _____
e. no answer _____

(2015) 104. Which is the most important health problem today in Hong Kong?

(A) a. industrial medicine _____
b. public health (community) health _____
c. no answer _____

(2016) (B) a. kidney dialysis _____
b. community medicine _____
c. no answer _____

(2107) (C) a. mental health hospital _____
b. community care for mental health problems _____
c. no answer _____

(2108) (D) a. cardiac surgical units _____
b. preventive care _____
c. no answer _____

(2109) 105. Which do you feel is the most important type of nursing today?

a. hospital nursing _____
b. community medicine _____
c. no answer _____
d. they are the same _____

(2110) 106. Which do you think will be the best way to improve the health care system?

a. let the medical profession set standards _____
b. let the hospital say how medicine should be practiced _____
c. let residents (community) have a say _____
d. no answer _____
e. a+b _____
f. a+c _____
g. b+c _____
h. a+b+c _____

(2111) 107. What is your evaluation of the Kwun Tong Health Project?

(A) a. very important _____
b. important _____
c. average _____
d. less important than average _____
e. not very important _____
f. no answer _____
g. don't know _____

(2112) (B) Is the Kwun Tong Health Project:

a. very effective _____
b. effective _____
c. average _____
d. less effective than average _____
e. not very effective _____
f. no answer _____

(2113) (C) Should it be tried elsewhere?

a. agree _____
b. neither agree nor disagree _____
c. not agree _____
d. no answer _____

(2144) (sex: male or female)