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Editor's Note

As we begin our second exciting, yet challenging year, the words of Kennedy are familiar: "Ask not what your country can do for you, but what you can do for your country." We all must remember that we became a nation because we worked together to achieve what would have been impossible for any one individual. The same can be said for us in health occupations. As Gene Bottoms stated, "Let us move forward together to improve the quality of education." With this mission in mind, let us work together to share information to improve our respective health occupations education programs through the Journal.

As stated in the Carl Perkins Act of 1984, "The broad goals of our programs include strengthening the economic base of the nation, developing human resources, and increasing productivity." Health occupations curricula address these goals, not only in preparation for a paid occupation beyond high school but also in preparation for continuing education at other levels. To meet these purposes, we must continue to evaluate, revise, and improve our programs to meet societal and individual needs.

In this issue of the Journal, authors have written about various components of instruction for consideration in our programs. Margaret Snell suggested incorporating gerontology into the curriculum with various classroom activities. She provides specific examples for discussion and role playing which could enhance understanding the problems and concerns of elderly persons and enable students to provide quality care to those they serve. Shirley Baker proposed units of instruction to prepare prospective teachers for the dual role of teacher/administrator. She stressed that administrative functions may be included in current or new courses to assist the teacher to gain the knowledge and skills necessary to assume this dual role.

A system of articulation is described by Lytle and others which illustrates a community working together to provide opportunity for career mobility through cooperation among several institutions at various levels. Even though this successful articulation program is centered on respiratory therapy, the methods may be useful for other programs in other states. In addition, Walters and others investigated a leadership opinion questionnaire dimensioned on consideration and structure for analyzing-leadership style. They suggested future research be included in various health occupations education programs to assess leadership behavior as well as to facilitate professional growth and development of emerging leaders. Also, several book reviews provide information on constructing tests, nursing care, medical laboratory techniques, and teaching your career.

According to Judy Braun, "We need to look to the past to assure ourselves that often change is needed and ok." The suggestions of these writers should give us the courage and motivation to revise our curricula. We can learn new concepts and develop new intellectual skills by successful adaptation to change. John Naisbitt has suggested that national associations should become sources of information and guidance and support systems. Our association can achieve this by sharing experiences and providing valuable information through the Journal. We can achieve excellence with our collective energies.

Norma J. Walters
Editor

STRATEGIES FOR INCORPORATING GERONTOLOGY
INTO A HEALTH OCCUPATIONS CURRICULUM

Margaret A. Snell¹

Abstract: Health occupations teachers have an opportunity to play a significant role in a major dilemma, providing care for the ever increasing number of elderly people. They can help their students improve their understanding of the problems and concerns of elderly people and they can suggest various strategies to enable their students to provide quality care to those they serve. The strategies suggested are those already utilized by some classroom teachers and involve classroom activities and role playing situations. Guidelines are provided to assist students in their interaction with elderly people and examples are given of students providing thoughtful care.

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The spectacular increase in people in the United States age 65 and over is well documented, with projections specifying an even more dramatic increase in the future. The size of the age group over 60 years old has increased seven times since the start of this century and the number of individuals over 75 years of age has increased tenfold (Tavani, 1979). The Federal Council of Aging reported in its 1975 Annual Report to the President that there will be 30.6 million individuals over age 65 by the start of the next century with those age 75 and older accounting for 44% of that number (Osterman, 1986). The U.S. Bureau of the Census (1976) projects that by 2030 A.D., 44 of every 100 people living in the United States will be over 60 years of age.

The combination of old age and chronic illness results in major changes for some older individuals. Moss and **Halamandaris** (1977), regarding the elderly in long term care facilities states: "The lees of identity, freedom and independence is a forced divestiture of human dignity and almost all aspects of self" (p. 12). **Rathbone-McCuan** and **Hashimi** (1982), specified that in elderly persons "Emotional responses such as fear, anger or grief that accompany chronic illnesses may produce withdrawal from others" (p. 13), while **Heiple** (1982) wrote: "In dealing with the elderly, attention must be given to the unique problems brought about by the emotional impact of illness and disability" (p. 153).

The Health Occupations Education (HOE) curriculum found in many high schools provides a tremendous opportunity for teachers to incorporate certain aspects of gerontology into their teaching. Students in these programs have identified an interest in pursuing a career in a health related area, and information about elderly persons in our culture may be introduced during this high school training. Indeed, some students experience meaningful interactions

with elderly persons for the first time in their lives when they start to work at a nursing home. In the book Too Old, Too Sick, Too Bad written about nursing homes, Moss and **Halamandaris** (1977) cite Margaret Mead's contention that "society's present treatment of the elderly **causes** apathy or anxiety among the younger population and . . . encourages a 'live for now' attitude. . . ." (p. 4). It is even questionable whether or not some children at all understand about the care of elderly persons in nursing homes. Moss and **Halamandaris** (1977), describe a conversation between two young children following the confidence of one child that his grandmother was in a nursing home. In response to his friend's query about what was a nursing home, the child replied, "That's where they keep dead people they ain't buried yet" (p. xiv).

Nevertheless, the needs and care of frail elderly people tend to elicit minimal interest in some teenagers. A major role of the teacher, therefore, is to create a feeling among students that they are providing a very important service for people who may be helpless, lonely, and fearful. They should encourage their students to feel that they are very special people providing an essential service to others. In essence, HOE teachers should build students' self-esteem so that they are proud of their contributions to the care of the older patient in nursing homes or other health care delivery systems.

The Florida Department of Education, The Florida Center on Aging and Florida International University sponsored a statewide workshop for health occupations educators in 1985 in which the needs and concerns of elderly persons and the concepts associated with providing quality care for elderly nursing home patients were discussed by teachers currently training students to provide such care. The **teachers** also shared with the workshop participants information about some of their successful teaching activities. Their

discussions and specific examples have been compiled into classroom activities, role playing activities, general guidelines and examples of elderly care.

Classroom Activities

Classroom activities should create an awareness of the difficulties involved in being old, should help students develop a respect for elderly persons, and should create an appreciation for what it means to be an older person.

Some typical activities are:

1. Provide guided student discussions about senior citizens.
2. Have students tell about **their** grandparents or the oldest person they know, presuming the person is over age 65.
3. Invite one or two senior citizens to visit the class to discuss their life styles with the students.
4. Ask students to talk with senior citizens in their neighborhoods and report their impressions and findings back to class. Students could have pre-determined questions, such as: (a) "What tv shows do you like?" (b) "What is your favorite food?" (c) "What physical activities **do** you enjoy?"

Students then should be taught that even though elderly persons might lose some of their independence, they deserve to be respected and treated with every kindness and consideration and that the label "senile" is often a general term, descriptive of myriad problems, some of which might be amenable to environmental or psychological intervention. Students need to know that frequently organic and functional behavioral disorders receive no distinction and people who have them are regarded as "lost causes" with a resulting dramatic decrease in their quality of life. Two activities that could develop

in students an appreciation for the dependencies of some elderly people are:

1. Have students sit on their hands and be fed a variety of foods. Foods should be different consistencies and temperatures.

2. Secure someone to a Geri Chair or put the person in a restraint. Then appear to **leave** the immediate area to give the student a feeling of abandonment, which is a feeling many elderly people have under similar circumstances.

Students also should realize that many physical changes occur as a person grows older. Some physical changes precipitate psychological changes.

Students should be made conscious of that possibility. Physical changes occurring in elderly persons can include the following:

1. Loss in muscular strength and endurance.
2. Decrease in muscular coordination.
3. Increase in fatigue and need for short naps.
4. Decrease in faculties, such as sight, hearing and smell.
5. Deterioration of skin and loss of hair.
6. Increase in sensitivity to temperature.
7. Change in weight.
8. Decrease in reaction time.
9. Impairment in cerebral function.

Among the precipitated psychological changes, also varying from one person to another are:

1. **Decrease** in memory for recent happenings and increase in memory for the past.
2. Increase in the time needed to say and do things.
3. Less willingness to change.

4. Decrease in ability to use new information along with old ideas to form a new opinion.

5. Increase in tendency to direct interest inward to concerns about self.

6. Inability to make decisions.

Role Playing Activities

Some elderly persons who experience deprivation problems have a specific type of behavior pattern. Students should be taught by role playing that they may help with inappropriate social or cultural conduct arising from situations such as the following:

1. There is hallucinating or seeing, hearing, testing or feeling things not present. Students in this situation should;

(a.) talk about concrete things people can see or hear, and

(b.) provide real activities.

2. An elderly person in exhibiting a decreased memory span, is disoriented, has slowness of thought, or daydreams. Students in this situation should ;

(a.) orient the person via clocks, newspapers, magazines or calendars, and

(b.) encourage the person to talk about something of current interest to the person, with the student doing most of the listening.

3. There is depression, irritability, loneliness or boredom. The student in this situation should;

(a.) assist the person to develop some simple goals, and

(b.) encourage and praise the person as possible.

General Guidelines

Along with orientation and information about how to provide basic care for

the elderly, students should be given some general guidelines to follow for interacting with elderly patients. Following are some guidelines that will help students in almost any situation. Students should:

1. Address by name, not a nickname or "dearie."
2. Speak slowly and distinctly while looking directly at the person.
3. Move slowly and calmly and never try to hurry an older person unnecessarily.
4. Listen attentively.
5. Use supportive touching effectively.
6. Smile whenever appropriate.
7. Establish eye contact to communicate human regard.
8. Use positive body language.
9. Attend completely to the patient's level of medical need.
10. Use language understandable to the patient.
11. Explore alternatives for serving elderly persons.
12. Observe and respect cultural/religious practices important to the patient
13. Individualize whenever possible for the person.
14. Make communications as clear as possible and check for accuracy by getting feedback from the patient.

Examples of Elderly Care

Even though students may be ready to care for elderly persons, some older individuals might object to having young **people** around. Some elderly patients do not want students to take care of them. This was an easily solved problem in one nursing home. The teacher encouraged students to make some very attractive paper flowers with fancy ribbons for each of their patients. Once

the other patients learned about the pretty corsages, they went to the head nurse. They saw no reason why students should not care for them, also. In actuality, they wanted flowers, too. They did not want to feel left out.

Sometimes students develop approaches that help or encourage particular patients. For example, one student's patient refused to leave her room because of an indwelling catheter. The patient was embarrassed by the bottle and its contents. The student recognized that the patient felt uncomfortable about going out of her room with the bottle, so she sewed a fancy-floral-pattern, drawstring covering for the bottle. The next day after giving the patient morning care the student carefully placed the patient's bottle in a plastic bag. Then she put the floral covering over it. There was no conversation about what she had done or why she felt she should do it. After completing that task the student **left** the room. Less than five minutes later the patient also left her room. Naturally, she caused an unprecedented demand for **floral** coverings among a particular population in the nursing home.

Another example involves an elderly person who developed blindness in her later years. She just sat in her chair and refused to enter into conversation or activities. Her high school student made her a "touch pillow." It was composed of different types of materials and various sewing items, such as rick rack, buttons, lace, and snaps. The patient welcomed her gift in tears and treasured it **until** it was falling **apart**.

Conclusions and Implications

Providing adequate support care for elderly persons **is** rapidly becoming a national concern. Without properly defined and executed techniques of how to care for elderly people and without interested, compassionate and trained personnel, the care of elderly people may easily become a national crisis.

High school instructors play a pivotal role in preparing their students to care for and indeed even to enhance quality of life for **older** persons. This article has discussed some of those ways.

Cultures are judged in a variety of ways. Seemingly, all **are** judged by how humanely they treat **older** people. The tendency to think that to be old is to be inferior is wrong and pernicious. **In** whatever way we impact on the lives of others, we should regard each person, regardless of age, as unique, **spec: al**, worthwhile, and irreplaceable. We can **aspire** to greatness by teaching the young how to care for and interact with the elderly citizens. **All** will benefit.

(Additional references maybe obtained from the author.)

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PREPARING HEALTH OCCUPATIONS BACCALAUREATE GRADUATES
FOR THE DUAL ROLE OF TEACHER/ADMINISTRATOR

Shirley A. Baker¹

Abstract: Baccalaureate health occupations teacher education programs may not have prepared their baccalaureate graduates for the dual role of Teacher/Administrator. Since a major portion of these graduates function at the post-secondary level, a teacher or administrative license is not required in most states. To prepare them for this role, this article proposes units of instruction such as (a) recruitment and public relations, (b) student records and documentation, (c) teachers' legal rights, (d) self-study and accreditation process, (e) certification or licensure, (f) contracts, (g) equipment purchases, (h) placement, (i) alumni chapters and advisory committees, (j) inservice or continuing education programs, (k) student organizations and (l) proposal writing. Arguments presented on the basis of observation and experience suggest many health occupations programs should maintain a staff including one or

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two teachers who also function as program administrators.

Some health occupations teacher education programs may not include separate components dealing with the administrative skills needed for the dual role of Teacher/Administrator (T/A) in undergraduate programs. However, most baccalaureate health occupations teacher education programs incorporate, in the curriculum, core courses such as history and philosophy, curriculum development, methods of teaching, and tests and measurements. These usually are standard courses for preparing teachers. But for many small health occupations vocational and technical programs, the entire program staff usually consists of two teachers--one of whom must be the director or coordinator and one the clinical coordinator or supervisor. Even though administrative duties are included among the first teaching duties, the undergraduate health occupations teachers may not be as prepared to assume their dual role as a new teacher because these topics are usually studied more in depth at the graduate level.

Adjustment in administrative responsibilities is a consequence of many changes characterizing the first half of the '80s. With the advent of Diagnosis Related Groups (DRGs), cost containment, and recertification requirements, allied health personnel have faced (a) lay-offs, (b) fund reductions, (c) development of private organizations offering contractual services, (d) purchase of hospitals by national corporations, and (e) an increase of non-certified workers. All of these together have brought about a major decrease in the employment of allied health graduates. Also impacting health occupations programs is the funding emphasis changes brought about by the Carl D. Perkins Vocational Education Act of 1984 and the Job Training

Partnership Act (JTPA) of 1982. The enlargement of responsibilities to include administrative functions appears to mandate corresponding adjustments in health occupations education programs and curricula. These may be addressed as specific units of instruction.

Units of Instruction

In order to better prepare students for their administrative roles, the following units of instruction may be considered in the curriculum:

- (a) recruitment/public relations, (b) student records and documentation,
- (c) teachers' legal rights, (d) self-study and accreditation process,
- (e) certification or licensure, (f) contracts (college catalog, clinical, consulting), (g) equipment purchases, (h) placement, (i) alumni chapters and advisory committees, (j) inservice or continuing education programs,
- (k) student organizations, and (l) proposal writing.

These units of instruction, discussed below, may be included in courses currently being taught in baccalaureate health occupations teacher education programs or may be developed into one or two new courses designed for teaching first-level administrative skills. These components, as well as more advanced courses in budgeting and staff supervision, should be included also in graduate level programs.

Unit 1: Recruitment and public relations. A unit on recruitment and public relations should be included because few education programs of any type are able to survive without an active recruitment component. Successful recruitment is often a product of successful public relations. If faculty, staff, students, and graduates are verbally supportive of the program, recruitment becomes a much easier task. In fact, public relations is sufficiently vital to the well-being of a program that a faculty member or

administrator should never pass up an opportunity to make a positive statement about the program. Public relations directly affects every aspect of the T/A's job. Obviously good rapport with the public-at-large makes that job much smoother.

The new T/A should be aware of current written materials being distributed about the program. Initially, one of the first duties should include a meeting with the recruiting officer, or person(s) responsible for past recruiting, to determine if program brochures and recruitment staff are current concerning program entrance requirements, plan-of-study, and placement. The T/A should remember that both the program and student are best served if the interests and goals of each are closely related. Otherwise, the resulting discord may erode the best of programs. Regardless of the number of individuals assisting in student recruitment, the enrollment problem seems primarily to be placed on program administrators. Therefore, the T/A should have a yearly plan for active recruitment and public relations. This plan might include some of the following: (a) radio and television interviews on public information programs; (b) newspaper **releases** about program, student, and alumni activities; (c) booths at schools' **career days**; (d) guest lectures (classes and organizations); (e) student pins, program monograms, posters, **letter-writing** campaigns; (f) industrial recruitment campaigns, (g) community services such as blood pressure screenings; and (h) wearing adopted health occupation program uniform one day each week to all classes during school day, other than the scheduled clinical days.

Unit 2: Student records and documentation. Documentation, as maintained in student records, has become an essential part of the administrator's job. Reprimands and lawsuits may be thwarted by accurate daily records. The

numerous duties of a teacher coupled with those of an administrator often push documentation to a low priority level as "something that can be done later." This concept is false. Documentation on student records should be completed while all events are current. Timeliness of a record is just as important in a hearing or court-of-law as accuracy (Valente, 1980).

The new T/A should review guidelines in effect for termination of faculty, staff, and/or student-s. If no guidelines exist, one of the T/A's first duties should be to develop these, in cooperation with upper level administrators, giving consideration to input received from affected parties. The guidelines should be three-dimensional. They should: (a) require documented counseling sessions with the individual with whom problem areas are identified, (b) require a signed and dated proposal by the T/A and the individual outlining corrective actions to be taken within a defined time frame, and (c) define clearly the consequences if these actions are not implemented (Valente, 1980).

Students should be well informed of course progress as well as program progress. One way to do this is to require each student to sign (or initial) and date each grade reviewed and each academic advisement record or change. The Buckley (1974) amendment gives rights to review and challenge student records to adult students and parents of minor students. Therefore, the T/A must be careful that each entry is signed, dated, and factual. Any entry directly affecting student progress should also have the student's signature and date of review.

Unit 3: Teachers' legal rights. Most student handbooks contain a copy of the due process procedure. Unfortunately, many times this procedure is omitted (either overtly or covertly) from the faculty handbook. As a result, teachers become aware of the required "paper trail" altogether too late. The T/A should

be responsible for making both faculty and students aware of their legal rights and responsibilities. Above all, self-control under due process should be stressed as the pivot point in many problem situations. With it, problems may be resolved uneventfully. Without it, any problem is certain to escalate (Valente, 1980).

Unit 4: Self-study and accreditation process. In health occupations, the accreditation process can enhance or destroy a program. But few program directors have appropriate training or experience prior to writing their first self-study. At times changing a single word can change the content of an entire section based on interpretation, e.g. , bimonthly means once every two months but is commonly used to mean twice a month (semimonthly). A working knowledge of the accrediting agency and process provides an adequate base for beginning any self-study procedure. In order to maintain professional accreditation, the T/A should be familiar with the program accrediting essentials, past self-studies and recommendations, and necessary fees required by the accrediting agency. Initial and ongoing accreditation fees should be budgeted as well as time for completing the process. Time lines should be established for receipt of supporting materials from other faculty, administrators, and clinical site coordinators. Any program shortcomings should be identified and corrected through this process.

Unit 5: Certification or licensure. The necessity for certification or licensure for employment should be explicitly stated in recruitment materials, college catalogs, and orientation sessions. In addition, students should be aware of the **costs of** examinations. The T/A should become a well-informed resource for current information from certifying or licensing boards, professional societies, and legislative bodies. Announcements concerning

examination review sessions or materials should become the responsibility of the T/A.

Unit 6: Contracts. Contract law is another area in which the T/A should become more proficient. College catalogs are contracts between students and colleges. A responsible T/A should carefully review and update all **applicable** areas of the college catalog on a yearly basis (e.g., admission requirements, program of study, and course descriptions). Course descriptions should reflect course content and vice versa. In addition, contracts between each college and its sites should be explicit in their treatment of (a) student dismissal by clinical site, (b) student removal by college, (c) internship hours, sick days, and holidays, (d) student on-site accidents, (e) number of students assigned to clinical site, (f) wages (if any) for clinical instruction, (g) time span of the contract, (h) clinical departments involved, and (i) other pertinent information. Potential problems at a clinical site, especially with internship students, can often be circumvented by a detailed contract which spells out the responsibilities of each party.

On occasion a faculty member will be asked to do some consulting work. If the faculty member is to receive a consulting fee, a contract will probably be required. If the contract has some unclear areas, the faculty member or T/A should ask for a review by the institution's attorney. This worthwhile service may be rendered at little or no charge (Delworth, Hanson, and Associates, 1980).

Unit 7: Equipment purchases. In order to purchase, rent, or lease equipment, the T/A should be familiar with institutional policies. Most public institutions require a list of equipment specifications devoid of brand names. At some point, an invitation for competitive bids on equipment is advertised

for a designated time. Usually, equipment is purchased from the lowest bidder on a priority basis. But the lowest bid may be refused in favor of a higher bid if justification is adequate (e.g., better quality). Institutions also may purchase expendable supplies in this manner. In addition, the T/A **should** maintain departmental equipment by engaging services of experts from within or from external organizations. Some states purchase and/or maintain equipment through state department funds while other states use local or in-house funds.

Alternative methods for obtaining equipment include consortium purchasing, fund-raising events, shared equipment usage, and donated equipment. Many public health care institutions donate equipment to local training programs. Since equipment is public property, a lot of red-tape is involved for resale. However, little more than board approval is needed usually for transfer to another public service institution. Therefore, boards of health care institutions usually prefer to donate, rather than store, equipment that is no longer in service. Any needed repair or maintenance can often be performed by the biomedical **equipment** technology or electronics departments.

Unit 8: Placement. Some states require arbitrary rates of placement for students completing the program before renewing program funding. Adequate placement records can serve as a recruitment tool as well as a defensive tool if program termination is threatened. On the other hand, if these records indicate lack of placement in the skill area, a serious review of the mission and goals of the program should be undertaken by the T/A. Professional accrediting agencies usually require a program to have an adequate student resource pool, qualified faculty, adequate facilities and clinical sites, a quality program, and available employment opportunities for its graduates. One problem faced by T/A's of rural health care programs **is** saturation of the local

job market. Solutions include decreasing enrollments of programs, changing goals of programs to meet emerging needs, increasing continuing education programs, or eliminating programs. Adequate placement records increase potential for survival of a program by forewarning of problems or indicating needs in the job market (Shingleton, 1978).

Unit 9: Alumni chapters and advisory committees. Program alumni chapters and advisory committees can be extremely helpful in curriculum development. Alumni may suggest weak points, strong points, and possible program changes. An active advisory committee may provide technical information, recruitment and placement information, and allied program support in the industrial sector. Many programs have survived because of intense support and loyalty from faculty, students, alumni, and employers (Riendeau, 1977).

Unit 10: Inservice or continuing education programs. Even if a job market area has become saturated, health occupations personnel should be concerned with their competence through continuing education. College courses or inservice workshops provide new fields of endeavor for creative faculties. Moreover, employed health care workers may be in need of upgrading their technical training. Health care financial managers may prefer to underwrite quality local continuing education since it saves on room, board, and lost work time. Just as a farmer rotates crops, a health care program T./A would be wise to establish a continuing education program in addition to the certificate/degree program area and rotate faculty assignments.

Unit 11: Student organizations. Student organizations are of two basic types: general and specific. A general organization enrolls members from broad areas of interest, e.g., health occupations or home economics. Whereas, a specific organization serves students in a specialty discipline, e.g. ,

nursing or medical technology. The type of organization developed directly **affects** potential parameters for membership, goals, and activities. Valuable opportunities in leadership, competition, and **team** work can be afforded students through these organizations. A progressive T/A should realize the positive impact an organization such as Health Occupations Students of America (HOSA) can have on student and program accomplishments. This student **organization** is an integral component of the Health Occupations Education curriculum and each prospective teacher should **recieve** instruction on the history of the organization, on the competitive events, and on how to organize and manage a HOSA chapter. The T/A responsibilities to HOSA should include **time**, effort, guidance, encouragement, and support. In addition, the T/A should be aware of and comply with institutional policies governing student organizations .

Unit 12: Proposal writing. Proposal writing is fast becoming a necessary skill of the T/A. Much funding is available for programs that qualify for JTPA or special needs groups. But, in order **to** get the funds, the T/A must write a proposal. The term "proposal" sometimes invokes ideas **of** a major writing project and of detailed long-term planning, neither of which is very exciting. If written as a joint project with other faculty or administrators, even major proposals may become manageable. The difference between programs that survive and programs that do not could well rest in proposal writing skills (Hall, 1977) .

Summary

Programs may prosper or fail based on administrative skills of personnel rather than on teaching skills. However, **if** the instructional components proposed such **as**: (a) recruitment and public relations, (b) student records

and documentation, (c) teachers' legal rights, (d) self-study and accreditation process, (e) certification or **licensure**, (f) contracts, (g) equipment purchases, (h) placement, (i) alumni chapters and advisory committees, (j) inservice or continuing education programs, (k) student organizations, and (l) proposal writing are incorporated into the undergraduate programs as separate units or are integrated into the existing curriculum, prospective teachers will have the opportunity to gain the knowledge and skills to assist them to assume the dual role of teacher-administrator.

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ARTICULATION: PROVIDING A SYSTEM OF UPWARD MOBILITY FOR
ALLIED HEALTH DISCIPLINES

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Abstract: Successful articulation programs in health related disciplines should incorporate a willingness to communicate and cooperate inter-institutionally. A system is described which illustrates a community working together to provide opportunities for individuals looking for career mobility. While this report centers on the respiratory

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therapy profession, the system and methods used may be useful for others to follow.

Articulation is defined by Webster's New World Dictionary (1966) as: "The action or manner of **interrelating**;" or in other terms, "a joint between two separable parts" (p. 84). This definition, while often used in anatomic terms to describe the coordinated movement of joints, applies equally to the opportunities given or available to students attempting to acquire career mobility. This process can provide new and varied opportunities for students in all fields including health related professions. A lack of career improvement mechanisms can result in a dead end for a promising career. The respiratory therapy educational programs in Central Florida have had considerable success in providing such mechanisms.

Historical Perspective

Problems experienced by students in the articulation process are traced to an attitude about terminal degree programs. The origin of this attitude can probably be traced to Mildred **Montag** who was partially responsible for associate degree nursing programs in community colleges. These programs were originally intended to produce graduate nurses, and were considered as terminal (cited in Miller, 1980).

Contemporary Trends

John **Naisbitt** (1982), in Megatrends, writes that learning is a lifetime process. The process of education for the foreseeable future may last an entire career, not atopping after the usual period of high school or college. To prevent career stagnation, artificial barriers to further education need to be removed to allow people to advance in their chosen endeavor. Articulation,

or some appropriate synonym, should be incorporated as a "buzzword" into the vocabularies of educators and institutions to reinforce its need. The concept of Hohenstein (1980), should be continually advanced, suggesting that junior colleges serve as colleges of the community and that senior institutions function as multiversities, not the university.

Today, articulation of programs rests with cooperation and interrelationships that exist within professions and programs. Success in articulation also is related to the willingness of personnel in institutions to actively recruit non-traditional students. The problems include providing access to non-traditional learners, developing flexible schedules, using role models and identifying specific groups. These should be approached in a dignified and creative manner for both student and institution. The following articulation problems have **been** identified by Robinson, Cones, and Gentsch (1980), for health related students: (a) loss of credit due to institutional **policy**, (b) certain upper division requirements (or specific numbers of upper division credits), (c) problems in prerequisite courses (often due to poor advisement and planning), (d) general misunderstandings, and (e) lack of planning and communication by various allied health institutions. Similarly, solutions to these problems have been proposed: (a) development of formal articulation agreements; (b) publication **of** materials, such as brochures, that outline articulation programs; (c) improvement in academic advisement; (d) greater commitment to articulation; (e) expansion of the credit by examination processes; (f) use of interdisciplinary courses; and (g) open discussion of curriculum and degree requirements between articulating institutions.

Development Strategies

According to **Galin** (cited in Galin, **Russel**, and Stewart, 1981), the success of articulation depends upon full participation by faculty and administrators in developing programs. Equally important is a communication network to keep involved persons informed about prerequisites and requirements. With time, leaders in educational organizations may perceive the transferring student as an integral part of the institution.

The respiratory therapy programs in Central Florida encompass three separate and distinct institutions: (a) a one year technician program at Seminole Community College, (b) a two year therapist program at **Valencia** Community College, (c) and a four year program in the Department of Cardiopulmonary Sciences at the University of Central Florida. A system of agreements, developed by using formal and informal lines of communication, provides an articulation network which works well. Students may start at any level in the network and progress through the system as their academic and professional development permits. In this configuration, students may begin their careers in respiratory therapy at the one year technician program and progress through the two year therapist program and complete the bachelors degree in respiratory therapy at the university. Students may progress to graduate level in a variety of programs offered at the university.

The process of articulation in Florida is represented in letters of agreement and state law. An articulation agreement between the Community Colleges and the State University System, which is enforced by state law, provides a system of common course numbering and a common calendar. The two community colleges involved are linked together by close communication ties and letters of agreement. **Valencia** Community College will award college credit for

courses completed at the one year vocational-technical level. Qualified students may then progress to the university level if they desire, receiving credit for completed courses. Graduates may look towards the future knowing that they will be able to respond to an ever changing world.

The importance of effective communication with developing programs such as those described cannot be over emphasized. Communication should include every level in each organization. Program directors should communicate with each other among institutions and with deans or vice presidents. Everyone should have confidence in the system. Advisory committees usually serve as adequate, appropriate **forums** for sharing problems **and** successes and for planning the future. In the experiences described in Central Florida, respiratory therapy programs at each level are linked to each other through advisory committees sharing common members including individuals from each college (faculty and administrators) and local industry.

When attempting to develop articulation programs, competency and performance criteria should be stressed. Removal of barriers to facilitate progression from one **level** to the next should be the primary goal. The advanced career level also can provide some incentive for additional education. **This** is obvious in well designed systems. The programmatic goal is to maximize use of all competencies or performance objectives as a foundation to develop upwardly mobile graduates.

Advantages to Articulation Programs

Well designed systems may have positive influences on enrollments. Student may be more willing to enter a program if they know that articulation is possible, a fact that should be advertised to the public. Industries may be willing to make concrete commitments knowing that educational institutions are

working with their futures in mind. Alumni may have further goals to attain.

Colleges and universities usually have a commitment to community service. Articulation programs promote community service by providing links between students, other colleges, **and** industries. People with differing educational goals and philosophies may be convinced to participate in programs if an overall benefit to the community may be visualized. Industry representatives serving as members of advisory committees seem helpful in eliminating artificial barriers.

There seems to be little to lose and much to gain in linking programs together. Recognition by the community and industry, and a source of motivated, experienced students are expected outcomes. Administration and faculty in institutions at higher levels need not worry about decreasing academic quality since students seeking further education are generally more mature and serious about their studies. Articulation between programs also provides possibilities for sharing equipment, computers, audio-visual materials, and even teaching staff.

The Process

From experience gained in Central Florida, the initial proposal for articulation should begin at the program director's level. In this case, all lecture, laboratory and clinical courses in each curriculum were compared. Once a thorough review had been completed, a proposal was drafted and presented to the next level of administration. Support from the administration is critical as is documented support from the advisory committees. Administrative leadership can provide needed guidance which should help establish details and solve problems. Administrator at each level should communicate with administrators on the same **level** at other institutions. The proposal may also

need to be presented to institutional curriculum committees. Support from administrators , faculty, and industries at this level of presentation is essential. When final approval is gained, the job of coordinating the system should be addressed. This is relatively simple but should involve the advisory committees ,

Summary

Students may be successfully articulated into advanced health related programs if leaders in the community's educational institutions will work together in a systematic fashion. Communication, understanding of perceptions and values, and a willingness to take the first step are crucial to success. The health care industry should be assertive in insisting on opportunities for qualified health care professionals.

Career mobility should be hampered only by obstacles or weaknesses within individuals, and not by conditions built into systems of higher education. The future will require society and its commerce to adjust to many changing conditions relating to recruitment, training, and retention of personnel and resources. Personnel from educational institutions and industries should work together to provide the resources necessary to power the health care systems of the future.

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MODELING LEADERSHIP DIMENSIONS OF NURSING STUDENTS:
SOME PROBLEMS OF MEASUREMENT

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Abstract: The purpose of this study was to determine if students enrolled in their last quarter of Associate Degree Nursing and Bachelor of Science in Nursing Programs **exhibit** specific patterns of leadership attributes and to determine if values of selected demographic variables account for observed differences in leadership attributes. The Leadership Opinion Questionnaire dimensioned on consideration and structure was used for analyzing leadership style. Validity of the scales was tested with factor analytic techniques. Inter-item consistency and split-half reliabilities were computed for the total questionnaire and for the two **subscales**. Measurement problems with the questionnaire were found. Factor analysis.

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revealed an ill-conditioned matrix and every reliability coefficient, both corrected and uncorrected for anchor points, was negative indicating that estimates of measurement errors in the data exceeded information. Thus the questionnaire, when coded as recommended by **Fleishman**, was unsuitable for measuring leadership opinions of nursing students. Future research focused on detailed description of the measurement properties of the Leadership Opinion Questionnaire with students enrolled in various health occupations programs is recommended.

New graduates of nursing programs leading to registered nursing **licensure** generally will be staff nurses in health care facilities and are likely to face realities of overwork, high patient acuity levels, and inadequate staffing. Furthermore, many new graduates may become subordinate to individuals not having well developed leadership abilities. Thus, ineffective supervisory leadership styles--with respect to dimensions of interpersonal relationships and organizational demands--and pressures from new employment responsibilities, may contribute to stress and burnout. A partial solution to this dilemma may arise from expanding management content within present nursing curricula by emphasizing additional material from interpersonal relationships (consideration) and organizational goal attainment (structure). In short, it is important to teach nursing students to be able to work with people to get things done for the organization. Utilizing appropriate instruments, it also is important to be able to measure attitudes of future nurses as they assume supervisory leadership roles,

Background for the Study

Developing effective leadership styles in nursing students is vitally important for alleviating complications of compounded stress and burnout. Duxbury, Armstrong, Drew, and Henly (1984) utilized the Leadership Opinion Questionnaire (LOQ) as one of three instruments for quantifying relationships among head nurse leadership styles, staff nurse burnout, and job satisfaction. That study was concerned with staff nurses in Neonatal Intensive Care Units. Head nurse structure alone was not found to be related to staff nurse burnout, except when coupled with consideration. A head nurse high in consideration could be high in structure and still operate in a positive fashion. These findings of this study supported the belief that leader structure and consideration affect behavior and attitudes of staff nurses. Leaders of management programs have also found the LOQ to be helpful as an instructional aid by providing trainees some insight into their own patterns of leadership as a feedback mechanism at an early stage in a course (Fleishman, 1969) .

Many nursing programs, the greatest majority at the baccalaureate level, offer a management course during the last quarter prior to the preceptorship. The purpose of including principles of management in undergraduate nursing programs is two fold: (a) to foster the development of leadership styles, and (b) to develop perception of self as a leader; thus, the rationale for investigating leadership attributes of student nurses in this study.

Purpose

Initially, the specific objectives for the study, formulated as research questions were:

1. Do nursing students in Associate Degree Nursing (ADN) and Bachelor of Science in Nursing (BSN) programs exhibit specific patterns of leadership

attributes ?

2. Do values of selected demographic variables account for observed differences in leadership attributes?

From these questions, a background problem arose concerning how best to measure leadership attitudes. With that problem, the purpose shifted to one of solving the measurement problem associated with use of the LOQ with nursing students

Method

Subjects

Terminal students in two nursing programs in demographically similar (adjacent) communities volunteered as subjects. There were 40 university BSN students and 13 junior college ADN students. All students signed consent forms under policy established by the educational institutions involved. Anonymity was protected through use of a numbering scheme. Demographic characteristics of the nursing sample included: (a) both male and female, (b) both married and single, (c) previously and not previously employed with job titles of nursing assistant and registered nurse, (d) age ranging between 21 and 31 years, and (e) grade point averages between 2.30 and 3.90. Only 4 students had a previous college course in either nursing management or leadership.

Instrument

The LOQ was utilized as a method for modeling leadership perceptions in nursing students. It is purported to be a valid measurement scale used for analyzing leadership style and dimensioned on structure and consideration (Fleishman and Harris, cited in Duxbury, et al., 1984). Both dimensions are relevant to managerial effectiveness. Consideration was defined as the ability to maintain mutual trust, respect, warmth, and introspect into the feelings of

subordinates. An individual with a high score on the consideration scale was presumed able to establish communication and rapport with subordinates. On the other hand, a low score was believed to indicate an impersonal manager within group settings. Structures was defined by **Fleishman** (1969) as the extent by which individuals design and define their roles and the roles of those around them. The primary drive in the structure mode was proposed to be goal attainment for organizational purposes.

DeJulio, Larsen, **Dever**, and **Paulman** (1981) suggested use of ". . . the LOQ . . . where feedback concerning personal attitudes toward leadership may be of particular benefit to persons entering into occupations requiring managerial and leadership role functions." Prospective nurses would seem to require managerial and leadership skills; therefore, it was natural to select the LOQ as an appropriate instrument for this situation.

Student responses on selected items as recommended by **Fleishman** were recoded for scaling into the two **Fleishman** scales: structure and consideration. The validity of those scales for the nursing students in this sample was tested with factor analytic techniques. Inter-item consistency and split-half (odd-even) reliabilities were computed for all 40 items and for the consideration and structure **subscales**.

Had the tests materialized as expected, additional descriptive data would have been calculated for characterizing leadership attributes of nursing students. It was intended to profile students in the sample by breakdowns on selected demographic characteristics. However, measurement problems with the LOQ interfered with pursuing that goal.

Results and Discussion

The first problem occurred in defining constructs to establish construct

validity of the LOQ subscales for nursing students, Scaled according to **Fleishman's** algorithm, the 40 items generated an ill-conditioned matrix for factor extraction using the SPSSX Factor Analysis Sub-Program. To determine the source(s) of singularity in the correlation matrix, 40 Regression analyses (by LOQ items) were performed producing R^2 's ranging between .66 and .98, with 17 higher than .90. The regressions involved, in turn, each LOQ item as a dependent variable regressed on the remaining 39 LOQ items.

Factor analysis was repeated deleting the variable with the largest R^2 , and again produced an ill-conditioned matrix due to a determinant of zero. In a second factor analysis a second LOQ item (with the second largest R^2) was deleted with similar results. This process was continued until 12 LOQ items with the largest R^2 's were deleted from the factor analytic models. Each of the 12 reduced matrices was ill-conditioned. It was obvious after 12 attempts (still with R^2 's greater than .93) that the LOQ was not functioning as expected with this sample and would **not** produce results comparable with other studies.

The inquiry shifted to an examination of reliabilities. **Fleishman's** LOQ, test-retest, and split-half (odd-even), reliability estimates for the standardizing sample of first line supervisors and Air Force NCO's ranged between .70 and .89 for the Consideration Scale and .67 and .88 for the Structure Scale (**Fleishman**, 1969). Present estimates computed for nursing students are reported in Table 1. Every reliability coefficient, uncorrected for anchor points (Wirier, 1971, p. 289) or corrected for anchor points, was a negative coefficient--a condition indicating that noise in the nursing student's data exceeds information.

The LOQ in this application was an unsuitable measure of opinions about leadership. The first line of inquiry about an instrument should focus on the

instruments reliability, for, if the instrument is unreliable, no additional inquiry should be taken.

Under acceptable conditions, the reliability of an instrument will be a number close to 1.0. Were the reliability exactly 1.0 the instrument would be providing 100% information and no noise (error). Were the reliability 0.0, the instrument would be providing no information and all noise. The reader should understand that in this context, noise implies random or chance responses to the questionnaire items.

Table 1

Reliability Data for Nursing Students on the
Leadership Opinion Questionnaire

Measures	Bet Peo MS	Within MS	Bet Mess MS	Resid MS	Reliability	
					Uncorr	Corr
40 Items Total	1.2001	1.7441	12.6717	1.5340	-.4504	-.277'3
20 Items Struct	1.3939	1.7929	12.8705	1.5799	-.2862	-.1334
20 Items Conaider	0.9276	1.7285	13.0961	1.5098	-.8634	-.6276
Odd-Even Total	24.0018	76.9245	570.9057	67.4249	-2.2049	-1.8092
Odd-Even Struct	13.9394	19.6887	68.1604	18.7565	-.4124	-.3456
Odd-Even Consider	9.2765	26.9906	244.5377	22.8070	-1.9096	-1.4586

¹Reliabilities are both uncorrected, and corrected, for anchor points.

By the mathematical nature of the reliability calculations it can be shown

for these data that the LOQ reflects dominantly noise. Not a single computed reliability exceeded 0.0, the point at which essentially no information is generated and noise predominates. But, the equation provides for computing in the numerator the amount by which information exceeds noise: mean square between people minus mean square within people, if uncorrected for anchor points; or, mean square between people minus mean square residuals, if corrected for anchor points. Both the mean square within people and the mean square residuals are estimates of error; one chooses between the two on the basis of differences observed between **the anchor** points. If anchor points are not significant, the best reliability is the uncorrected for anchor points value; if anchor points are significant, the best reliability is the corrected value.

The conceptual identity of the anchor points changes with the reliability situation. Anchor points are the items in the inter-item consistency calculations; anchor points are the odd and even totals in the split-halves reliability calculations.

Even though the LOQ has been empirically validated with managerial and supervisory personnel in a variety of environments such as industrial, business, and hospital (**Fleishman**, 1973; Kerr, Schriesheim, Murphy, **Stogdill**, 1974; Korman, 1966; **Schriesheim** & Kerr, 1974, 1977), few published reports exist concerning its validation for student-leader populations. Nevertheless, **Fleishman's** LOQ manual presents college norms.

Two studies by **Capelle** and **Florestano** cited in Duxbury et al. , 1984) were concerned with performance on the LOQ of student leaders and non-leaders from "Who's Who Among Students in American Colleges" and Omicron Delta Kappa (an honorary male leadership fraternity). **Capelle** found significant

differences between male college leaders and non-leaders on both the consideration and structure scales. On the other hand, **Florestano** reported the structure scale differentiated former college leaders from non-leaders, but the consideration scale did not differentiate. Although both studies suggested that the LOQ showed promise for possible use with male college students, reliabilities of the LOQ with the research samples were not reported.

DeJulio, et al., (1984) analyzed **concurrent validity data concerning the use of the LOQ with male and female, college level, student leaders and non-leaders** . Of particular interest to them was whether the LOQ was sensitive to the more usual kinds of leadership observed on a university campus, such as leadership in resident advising, student government, dormitory **council**, and sorority and fraternity office. They stated that discrimination between such university student leaders and an unselected group of university students would greatly enhance the potential use of the LOQ in selecting paraprofessional student counselors. The results revealed that consideration was as influential as structure for distinguishing among the leader, non-leader groups. Accordingly, the LOQ was claimed to measure general leadership capacity in contexts other than business and industry. But, reliability data were not reported for use of the LOQ with the student groups.

Conclusions and Recommendations

Reports on the use of the LOQ for study of leadership styles of student nurses are limited. Nevertheless , the LOQ was used in the present study in an attempt to measure structure and consideration dimensions of leadership style of student nurses in their closing quarter of BSN and ADN Programs. This application was based on reports of successful use of the instrument in a variety of different organizational contexts: business, industry, educational

(leadership), hospital, nursing, research and development, military and governmental. There are also reports of successful use with female groups at the college level (Adams & Hicks, 1978; DeJulio, et al., 1981).

Even though the LOQ has been applied to a number of research situations, the literature leaves open the possibility that there were problems with its application in some studies. Without explanation some researchers either modified (Duxbury, et al. , 1984) the items or used only a sample of the items on the two scales (Tucker, 1983) . Some authors (Baker, 1975; DeJulio, et al., 1981) did not report internal consistency reliabilities for the LOQ determined for their samples, perhaps because they assumed that the **Fleishman** reliabilities generalized to the populations studied, or because the reliabilities determined for the focal groups were so different from those reported by **Fleishman**. On the other hand, many researchers reported assumed appropriateness of the LOQ because of its **purported self-report format, its ability to discriminate between two leadership dimensions (consideration and structure) , its acceptable Fleishman** normalized reliabilities and validities, and its extensive application to normative data (Stun, Homer, & Boal, 1981). Analyses of student nurse data in the present study do not support application of the LOQ to that population. Although **Fleishman's** algorithms for scaling and aggregating item data were followed precisely, singularity of the correlation matrix prevented meaningful validation of the LOQ for measuring leadership attitudes of nursing students. Reliability analyses produced negative values for every computed reliability suggesting the LOQ to be an unsuitable measure of opinions about leadership for this nursing student sample.

Some previous research conducted by other authors who claim the LOQ to have potential for broad application in assessment and description of college

student leaders failed to substantiate its application with reliability and validity analysis for the populations studied. Some studies have demonstrated absence of sex bias with the LOQ, others have shown it discriminates between leaders and non-leaders, and still other studies have provided some evidence of its potential use in leader selection, placement or training of students. Thus, future investigations should be continued, but there is a need to examine reliability and validity properties of the instrument thoroughly for the groups measured.

It should not be inferred that the LOQ should not be used for measuring leadership attributes of **student** nurses. Rather, when used, one of the first analyses to be undertaken should be a reliability analysis. If reliability is acceptable, a determination of validity should follow. If both analyses are acceptable, the researcher should proceed with research plans involving the LOQ. If one or both analyses should be unacceptable, the researcher might consider beginning at the beginning, as are the present authors' plans with the present data. That means, beginning with a complete reevaluation of scaling and factor structure; perhaps even providing for a 3- or 4-factor solution.

Finally, **no** claim is being made that the LOQ would not facilitate professional growth and development of student nurses. Nor should research efforts based on the instrument be discontinued. Rather, research efforts should be continued with other student nurse groups and other student populations at secondary, postsecondary, and collegiate levels. If the measurement problems found in the present study are solved, feedback from LOQ could be utilized to assess student leadership behavior and as a training tool to assist and facilitate professional growth and development of emerging health occupations student leaders. If applied in this manner, group discussion on a

range of issues germane to successful leadership might be promoted.

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Mosby's Textbook for Nursing Assistants, Shelia S. Sorrentino. C. V. Mosby
Company, St. Louis, MO., 1987, 500 pp.

Mosby's Textbook for Nursing Assistants provides a comprehensive approach in identifying the knowledge, attitudes, and psychomotor skills required of nursing assistants functioning in a variety of settings. These settings may include acute, long-term, or home care.

The text is composed of 30 chapters. Major areas of emphasis include the work environment, body structure and function, and procedures performed by the nursing assistant, which are arranged from simple to complex. Additionally, there are chapters which extend the basic content in the areas of growth and development, rehabilitation, patients **with** hearing and visual problems, and basic emergency care. Their usefulness is inherent in providing very comprehensive content as a reference for the more advanced nursing assistant.

Strengths of the text include chapter objectives, review questions at the end of each chapter, step by step lists of procedures, and an abundance of photographs and line drawings to enhance the students' understanding of the material presented. However, some topics such as emergency care should be incorporated before laboratory or clinical experiences; skills should be included with body systems; review questions should relate to all objectives; and the soft-bound cover may not withstand repeated use. A student workbook and instructor's guide are also available to accompany the comprehensive text.

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Teaching Your Occupation to Others, Paul A. Bott. National Publishers,
Elmsford, NY, 1987, 150 pp., \$9.95.

Teaching Your Occupation to Others is a comprehensive, readable guide for beginning vocational education teachers. This book could be used also by teacher educators as a resource for pre-service education.

"A Guide to Surviving the First Year," the subtitle of this book, takes the instructor beyond survival to effective classroom performance. The book is divided into seven units with references listed for each section within the unit. The first two units give general information on a teaching career. The other five units introduce a background in educational psychology, course organization, instructional techniques, and test construction and administration.

Strengths of the book include discussion questions and exercises following five chapters which further enhance learning. The appendices include examples pertinent to course organization and test construction.

One criticism of the book may center on the publishing dates of the reference lists. These range from 1950 to 1981 with the majority published in the 70's.

Beverly Richards, R.N., Ed.D. The University of Iowa

Constructing Achievement Tests (3rd ed.), Norman E. Gronlund. Prentice-Hall, Inc., Englewood Cliffs, NJ, 1982, 148 pp.

Constructing Achievement Tests is a comprehensive, practical guide in planning and developing achievement tests for beginning vocational education teachers. The text could also be used by teacher educators as a resource for teacher preparation.

The text is divided into nine chapters and begins with an explanation of the different types of tests and their appropriate use. The author takes the reader through five specific steps for effective development of achievement tests: (a) planning the test by clearly defining the purpose of the intended learner outcomes; (2) constructing objective, essay and performance tests; (3) assembling the representative sample of test items into a well-organized and efficient form; (4) administering the test and carefully interpreting the results; and (5) using the test results to improve learning. Although four chapters describe methods for constructing **various** types of test items, the organization of the book is such that it is readily understood that writing test items is only one part of the total process **of** planning and developing tests.

Strengths of the text include clearly stated principles of test construction **with** good examples to illustrate these principles with multiple examples of interpretive exercises to **measure** higher levels of knowledge.

Joyce A. Brandt, R.N., M.A., Iowa Department of Education

Basic Medical Laboratory Techniques, Norma Walters, Barbara Estridge and Anna Reynolds. **Delmar** Publishers, Inc. Albany, NY, 1986, 412 pp.

Basic Medical Laboratory Techniques presents a competency based approach to learning the knowledge and skills needed to perform basic medical laboratory techniques. The text can be used to train prospective teachers, students at the secondary and postsecondary levels, and students in specific health care training programs such as Medical Assisting or Medical Laboratory Technician. The book also may be used as a resource in laboratories.

The book is divided into six units: Introduction to the Medical Laboratory, Basic Hematology, Advanced Hematology, Introduction to Serology, Urinalysis, and Introduction to Bacteriology. Each unit contains several lessons with a total of 42 in the book. Illustrations of equipment, diagrams of skills, tables of normal values, and worksheets are included.

The only criticism of the book is the paperback cover. The book can be used by the students in the classroom and laboratory, thus, it may not withstand the continuous handling unless placed in a hard cover binder.

Strengths of the book include: lesson objectives and glossary, student activities, student performance guides, and questions to evaluate knowledge of objectives which allows for group or individual instruction. An instructor's guide with lesson plans, tests and transparencies is also available.

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