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ACKNOWLEDGMENTS

Sincere and abundant appreciation is extended to Dr. Arlene Putt, thesis committee chairman, for her patience, support and time. Gratitude is also expressed to the other members of my thesis committee, Dr. Jessie Pergrin and Miss Rose Gerber, for their invaluable assistance and guidance; and to John Gaines for his assistance with the statistical analysis.

Sincere gratitude is extended to the nurses who consented to participate in this study and thus made this study possible.

This thesis is dedicated with much love and affection to my parents, Dr. and Mrs. Floyd Weaver, for their endless love, support, encouragement, and confidence over the years. For all you have given me and enabled me to become, I extend my heartfelt thanks.
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ABSTRACT

An exploratory study was conducted to determine the stated attitudes of registered nurses regarding surgery in the elderly. The paucity of information in the nursing literature and the investigator's observations of a need to look at nurses' attitudes toward surgery in the elderly, provided impetus for this investigation.

The sample for this study consisted of 50 professional nurses who worked at a southwest hospital. The instrument used was a researcher-developed questionnaire designed to elicit demographic information, attitudes toward the elderly, and attitudes toward surgery in the elderly.

The findings revealed that nurses have positive attitudes toward the elderly, but as the age of the patient increased attitudes toward surgery in the elderly became more negative.

The Pearson coefficient of correlation was utilized to determine the inter-relationships between attitudes and the demographic data. Those registered nurses who stated they had contact with elderly patients in the work setting were found to have a more favorable attitude toward the elderly.
CHAPTER 1

INTRODUCTION

Aging paints every action grey, lies heavy on every movement, imprisons every thought. It governs each division with a ruthless and single minded perversity. To age is to learn the feeling of no longer growing, of struggling to do old tasks, to remember familiar actions... The body seems slowly to give up, randomly stopping, sometimes starting again as if to torture and tease with the memory of lost strength (Curtin 1972, p. 68).

The proportion of older people in the United States is growing. "Since 1950, the over sixty-five age group has increased 63.1 percent as compared with the under forty-five age group which has increased 30.5 percent" (Weg 1973, p. 751). Reports from the 1970 census show that the older population of 65 and over grew faster than the remaining population (Smith 1973). Approximately 21 million Americans are at least 65 years of age, one million are over 85 years of age, and about 13,000 are centarians (Weg 1973). Therefore, approximately one in ten Americans is 65 years of age or older.

There are three major developmental stages: youth, middle age, and old age; and it is the third stage of old age which is consistently said to be devalued in the American society (Collette-Pratt 1976). It is well known
that people age, so therefore the problem of growing old is not new. The problem lies not so much in the process of aging as it does in the attitude of society toward those who have grown old (Smith 1973). "Whenever a service is provided to people, such as that by nurses . . ., attitudes become tremendously important because they influence both overt and subtle behavior" (Tanner, Stamler, Klein, and Lee 1971, p. 1289). Too frequently what can occur is that attitudes, whether conscious or unconscious, are translated into behavior which may not be exactly conducive to the patient's well being.

People have definite attitudes toward the aging. Barron (1953, p. 481) stated, "Prejudiced attitudes against the aged are not uncommon." This investigator was first attracted to this problem when she encountered several negative experiences in the clinical setting. At various times while working in hospitals, this investigator has overheard nurses very disgustedly questioning among themselves as to why a particular physician was attempting surgery in someone "so old." Comments have been overheard in relation to "why put someone through surgery when they could possibly not live through surgery," "why bother, they've lived a full, normal life," and "they had better not do that to me." This investigator believes it is important for attitudes of nurses to manifest themselves
as the first step toward dealing with and understanding the problems surrounding the feelings of surgery and the aged.

Since people are living longer, it is reasonable to expect that the number of surgical procedures done on the older persons will increase. Nurses need to be aware of their attitudes and behaviors toward surgery and the aged, thus being the first step toward promotion of better nursing care for these individuals.

**Statement of the Problem**

This study will seek to answer the following question: What are the stated attitudes of registered nurses toward surgery in the aged? Another question that is dealt with but not answered is how do the stated attitudes of nurses influence the care they give?

**Statement of the Purpose**

This study is designed to determine the stated attitudes of registered nurses in regard to surgery in the patient over 75 years of age, and to assess if these attitudes have any influence on the care that is given.

The purpose of this study is to determine if registered nurses have negative attitudes toward the elderly patient and more specifically toward the elderly patient who is contemplating a surgical procedure. If
particular attitudes toward the elderly can be identified and recognized, then measures can be taken to begin to deal with and resolve these attitudes.

Significance of the Problem

Hickey and Kalish (1968, p. 218) wrote that, "the image of an old person in our society is not a pleasant one." There is a definite problem in the way that the American people view the older person. "The notion that the problem will disappear if you put someone in a hospital is an excellent example of magical thinking -- one of the most pervasive of our society" (Slater 1963, p. 314).

Very little has been written in the literature about the attitudes toward surgery in the elderly, and no studies were found in relation to the nurse's attitudes toward surgery in the elderly.

Nurses may have definite attitudes about how much should be done on the elderly, and too frequently these attitudes may be transmitted into behavior which may not be conducive to the patient's well being. The majority of nurses are young -- in their twenties -- and often tend to be more critical of the elderly due to the fact that aging is half a century away. Golde and Kogan (1959) have shown that there is a difference in young people's beliefs and attitudes toward "old people and their beliefs and
attitudes toward people in general" (Hattie 1975, p. 252).
"Attitudes of prejudice and stereotyping as well as discriminating behavior against the aged by younger adults are easily discernible" (Barron 1953, p. 478).

Surgery is often a life-saving measure, but it is not without risks. Many nurses have definite views about when an acceptable age for death is or when life starts to lose its value. As the life span of humans increases, the needed measure of surgery will occur more and more frequently. "About forty years ago the age of fifty was considered the borderline for elective surgery. Since then improvements in surgical and anesthesiologic techniques have continuously raised that limit" (Kohn, Zekert, Vormittag, and Grabner 1973, p. 100). So, therefore, due to the fact of technological advances and an increased life span, "advanced age is no longer a contraindication to surgical procedures" (Kohn et al. 1973, p. 100).

"The generally unfavorable attitudes which are held toward the aging and the elderly must be removed" (Smith 1973, p. 189). Beliefs, attitudes, and feelings are a product of culture, experience, and upbringing. Bringing attitudes to surface should assist nurses in understanding these attitudes on a conscious level, and enable them to gain insight into how these attitudes are reflected in the patient care they provide to the elderly.
Theoretical Framework

Many of the important problems in the latter third of the twentieth century concern attitudes. Many attitudes held about fellowmen need to be changed to prevent conflicts. People have attitudes because attitudes help them to understand the world around them by organizing and simplifying the environment, they enable self-esteem to be protected, allow adjustments to be made, and enable values to be expressed (Triandis 1971). The study of attitude holds a central position in the domain of social psychology. Reich and Adcock (1976) commented that people are not born with attitudes, not are they attributed to physiological maturation; thus, attitudes are learned or acquired. In other words, the experience of people determine their attitudes.

The framework of this study on the formation of attitudes was taken from Krech, Crutchfield, and Ballachey (1962). They stated that as the individual develops, his cognitions, feelings, and action tendencies with respect to the various objects in his world become disorganized into enduring systems called "attitudes." Therefore, it can be said that the cognition of an individual about an object is influenced by his feelings and action tendencies toward that object. Furthermore, a change in his cognitions about the object will tend to produce changes in his
feelings and actions toward the object (Krech et al. 1962). So, the action of the individual is regulated to a large extent by his attitudes.

The term "attitude" has more than one meaning and no single definition of attitude is acceptable to all. An attitude represents a person's general feeling of favorableness or unfavorableness toward some stimulus. Attitudes are inferred from what a person says about an attitude object, from the way one feels about it, and the way one behaves toward it (Triandis 1971). In other words, attitudes involve what people think about, feel about, and how they would like to behave about an object. People prefer those who are similar to themselves and dislike those who are dissimilar (Reich and Adcock 1976). People tend to behave favorably or unfavorably toward those people or things about which one has attitudes. For example, if one has a positive attitude toward someone, one will behave toward that person in a positive manner.

An attitude can be a system which is composed of cognitions, feelings, and action tendencies. The components of attitudes which are identified by Krech et al. (1962) are the Cognitive component which consists of beliefs of the individual about the object, the Feeling component that refers to the emotions connected with the object, and the Action tendency that includes all
behavioral readiness associated with the attitude. Therefore, if an individual has a positive attitude toward an object, he will help or support it; but, if he has a negative attitude, he tends to harm or punish it.

Krech et al. (1962, p. 181) believed that "one important factor in the formation of attitudes is want satisfaction. In other words, an individual develops attitudes to satisfy his wants. A positive attitude is held toward those who satisfy his wants, and negative attitudes are held toward those individuals who do not satisfy his wants. Also, the incidence of superstitions, delusions, and prejudices are related to the reliability of authorities one depends on, the range of experiences one is subject to, and the degree to which major wants are satisfied (Krech et al. 1962).

Attitudes are often related to a set of beliefs. Beliefs are the fundamental building blocks. Beliefs about an object provide the basis for the formation of an attitude toward the object. A person forms beliefs from observation or information received. The totality of one's beliefs serves as the informational base that determines attitudes, intentions, and behaviors (Fishbein and Ajzen 1975). As a person forms beliefs about an object, he automatically acquires an attitude toward the object (Fishbein and Ajzen 1975). Fishbein and Ajzen (1975) also
believed that at any point in time a person's attitude toward an object may be viewed as determined by his salient set of beliefs about the object; therefore, beliefs are based on prior information.

A person's attitudes also tend to reflect the beliefs, values, and norms of his groups. Many attitudes that reflect the norms of a group that is highly valued by the individual may be resistant to change (Krech et al. 1962). Attitudes are also involved in relations with other persons. How a person treats a group is determined by his beliefs about them, feelings toward them, and his dispositions to respond to them (Krech et al. 1962). The uniformity of attitudes among members of a culture group is due, in part, to the fact that the members of the group come to hold common beliefs about objects, people, events, and issues (Krech et al. 1962). So, group affiliations play a vital role in the formations of attitudes.

The degree to which the various value systems of an individual shape the development and organization of his attitudes appears to be a function of the centrality of the value systems (Krech et al. 1962). Slater (1963, p. 309) revealed that, "positive or negative attitudes toward old age and the aged do not occur randomly but are based on the social, economic, and political character of the society in which the attitude prevails." In general,
many behavioral scientists maintain that the values, attitudes, and beliefs which are internalized in childhood frequently remain in some form throughout life; so, thus, the concept of the individual is attributed to a large part to his early experiences (Hickey and Kalish 1968).

Attitudes are precursors to behavior (Reich and Adcock 1976). Behavior is the result of attitudes but also norms, habits and expectations about reinforcement (Triandis 1971). One can generally assume that if one likes some object, he should hold favorable beliefs about the object and perform favorable behaviors toward it. It can then be assumed that a person's attitude toward an object can be used to predict his behavior with respect to the object (Fishbein and Ajzen 1975). Kiesler, Collins, and Miller (1969) felt that a correlation between attitudes and behavior rests on the stability of individual differences -- a tendency for an individual to respond somewhat consistently from one situation to another. Attitudes may not always be a sufficient cause of behavior but may be a contributing cause. Behavior can change attitudes as people develop attitudes that justify their previous behavior.

Tanner et al. (1971) gave three factors which are salient in considering attitudes. (1) They are deep-rooted and grow out of a series of developmental and
socialization phenomenon. Their influences are pervasive, persistent, and often lead to emotional responses. (2) They serve as restraining or driving forces toward the goal of providing good care. (3) They can often be changed or altered. Therefore, attitudes can be seen as either restraining or driving forces toward the goal of good patient care.

"Man's social actions -- whether the actions involve religious behavior, ways of earning a living, political activity, or buying and selling goods -- are directed by his attitudes" (Krech et al. 1962, p. 139).

Attitudes are enduring in the sense that such residues are carried over to new situations, but they change insofar as new residues are acquired through experiences in new situations (Jahoda and Warren 1966). Attitudes can be changed by changing the beliefs or introducing new beliefs. If one can change the beliefs the subject holds, there will follow a change in attitude toward the object, person, concept, or behavior (Fishbein and Ajzen 1975). In other words, any attempt to change the behavior must first be directed at the beliefs. Attitude changes are brought about by the exposure of the individual to additional information; therefore, by knowing something about people's attitudes it is possible to do something about predicting and controlling their
behavior (Krech et al. 1962). In this study, the investigator will examine the beliefs and attitudes in registered nurses toward surgery in the elderly.

Limitations

The limitations of the study included: (1) the type of questionnaire statement which will be used that requires the participant to admit to or reject inadequacies in his/her attitudes or behavior, and (2) the utilization of one setting for data collection.

Assumptions

The assumptions made in this study are:

1. The nurse's attitudes toward the elderly are reflected in the patient care she/he gives.
2. An individual's attitude is influenced by a multitude of social and cultural factors.

Definition of Terms

The following definition of terms were used for the purpose of this study:

1. **Attitude**: Predisposition to act, denotes a state of readiness in which a person reacts characteristically to certain stimuli (Tanner et al. 1971). An enduring system of three components centering about a single object: the beliefs about the object, the affect connected with the object, and
the disposition to take action with respect to the object (Krech et al. 1962).

2. **Aged/Elderly:** In this study, aged/elderly refers to any person 75 years of age or older.

3. **Surgery:** Any procedure utilizing general anesthesia in which the patient must go to the operating room and subsequently to the recovery room.
Attitudes Toward the Elderly

Who are the elderly? Smith (1973) stated that the elderly are people like us. They are educated and they are simple. They are a part of life and they are isolated. They are wealthy and they are on welfare. They are well and they are ill. They are productive and they are dependent. They give themselves to others and they hold themselves totally from the world. They are human.

Aging is a biological and physiological process. It is a process of life-long change, and it occurs at different rates with different persons. Therefore, each individual's aging is unique and personal. But, there are aspects of aging held in common, and concerns and problems which are universal. Chinn, as cited in Weg (1973, p. 751), stated:

Aging is the deterioration of a mature organism resulting from the time dependent, essential irreversible changes, intrinsic to all members of a species such that with passage of time becomes increasingly unable to cope with the stresses of the environment, thereby increasing the probability of death.

Aging can take place in a number of ways. Smith (1973) classified aging into primary aging, secondary aging,
psychological aging, and social aging. Primary aging is the state that occurs as one grows older and functions start to decline. Secondary aging occurs when diseases or injury make biological aging occur at a faster rate. Psychological aging can occur at any time. It is influenced by attitudes, events, and changes. Social age is gauged by social roles and habits such as forced retirement. Tuckmann and Lorge (1958) said that most people tend to believe that physical and mental decline are necessary concomitants of the aging process.

There is a greater proportion of aged in our society than ever before, and the aged population continues to grow. Life expectancy for the average male is 67 years of age and for the female 75 years of age. This represents a gain of close to 25 years over what the life expectancy was only 75 years ago (Woodruff and Birren 1975).

"Society in general stereotypes the aged with negative images" (Hickey and Kalish 1968, p. 215). In general, attitudes and values are developed as a result of many influences; e.g., family, groups in society, individual personalities, and these influences cause a wide variety of opinions about processes, objects, and people (Geist 1968). Differences in attitudes have been found among age groups and between sexes within an age group.
Young women tend to view older people's appearance more negatively than either young men or older men (Geist 1968). A subculture of aging is being formed arising from contempt for the inefficacy of the old which brings about rejection by the young and finally a mutual closing of ranks (Geist 1968).

Our ideas about the aged are inherited from two contradictory traditions (Slater 1963). There is the classical Greek view that aging is an unmitigated misfortune, but there is also the Middle Eastern view that old age is the summit of life. On the surface it may appear that our own orientation is derived from the Greek — we value youth and fear old age. The more strongly we hold this view, however, the more strongly we feel we should not. Slater (1963, p. 309) reported that,

We are uncomfortable with our worship of youth and our distaste for old age. . . . This conflict in attitudes tends to introduce a sharp tone of artificiality into our relations with the elderly. We assume with a pose of respect an interest we don't feel.

Old age is often seen not as a natural stage of human development, but as a terminal illness for which nothing can cure (Jenny 1972). Although the aged in modern society do not comprise a functional subgroup, they meet many of the criteria of a minority, and the aged have many of the reactions of a minority group (Barron 1953). The aged appear to be emerging as a quasi-minority group. Kogan
(1961) stated that the aged can be called quasi-minority because they do not constitute an independently functioning subgroup with a unique history, language, and culture. Not only does society in general have negative images, but it is also suggested that "the older person maintains negative self-concepts" (Slater 1963, p. 215). It could be speculated that one's view of himself is learned not only by the way others view him but also by his early and prior learning. Halsall (1967) commented that attitudes toward the elderly by the young, how the elderly perceive themselves, and how professional people regard the elderly, play a large part in determining the role the elderly have in society.

To date the most extensive research efforts in the study of attitudes toward older people have come from Tuckmann and Lorge (1953) who investigated attitudes toward old age by utilizing two questionnaires consisting of stereotypes and common misconceptions of old people. The sample consisted of 50 undergraduate students, 304 graduate students, 100 middle age persons, and 88 older age persons. Tuckmann and Lorge (1953) concluded that there is a tendency for the number of stereotypes about the elderly to decrease as the age specified for the beginning of old age increases. In other words, there is a tendency for the number of stereotypes about old people
to decrease as the difference between the respondent's own age and the age he specifies for the beginning of old age increases.

Hickey and Kalish (1968, p. 217) did a study which showed that "children of all ages do perceive age-related differences between distinctly different adult age groups." A total of 335 students representing four different age and grade levels participated in the study. The sample spanned an age range from 8 to 20 years. The instrument used was a questionnaire. This study indicated that the negative concept that old people live in an atmosphere which is not conducive to the feelings of usefulness, adequacy, or security of the older person may develop early in a child's life. Tuckmann and Lorge (1958) stated that studies on attitudes toward aging have shown that individuals differing in age, education, and life experience subscribe substantially to the misconceptions and stereotypes about old people and the older worker.

Gerontologists have given a variety of possible explanations of the negative attitudes toward old age. One view is that negative attitudes reflect basically negative feelings toward the low socioeconomic status, poor health, and loneliness often associated with old age. Death, which is also associated with old age, has likewise
been postulated to be a negative concomitant of old age and leads to negative feelings toward old age. A second explanation for the devaluation of old age is that the older person lacks the ability to reflect the American values of productivity, achievement, and independence. A third explanation for negative attitudes toward old age is that the age stratification that divides the American society may foster in younger people stereotypes and misinformation about the elderly (Collette-Pratt 1976). Halsall (1967) believed that the generations appear to be moving away from each other. Some feel that the younger generation no longer needs the older persons, others say that it is not specifically a break in relationship, but rather that present-day industrial society with its increased mobility decreases the ties by distance.

Conley and O'Rourke (1973) said that the prevailing current toward more openness makes for a climate where those whose opinions, attitudes, and behaviors were opposite to those held by society, now feel more able to voice their views. This freedom allows for an open system of influences and forces the traditionalists to defend their positions, thus giving opportunity for discussions, critical analysis, and shifts in attitudes.

The prolongation of life has created new social problems. The chronic progressive disorders are becoming
more prevalent and are creating the prospect of a medici-
cated survival for a large number of aging people (Geist
1968). This places a large burden on the nursing com-
community. Tanner et al. (1971, p. 1290) stated that
"barriers interfering with the professional's ability to
help may, in part, be due to a lack of exposure or
familiarity in the area." The first task of the nurse is
to assess her own values and attitudes toward aging.
According to Krech et al. (1962), only by knowing the
attitude of people is it possible to do something about
the prediction and control of their behavior.

**Attitudes Toward Surgery in the Elderly**

Advanced age is no longer a contraindication to
surgical procedures. About 40 years ago the age of 50 was
considered the borderline for elective surgery. However,
since then improvements in surgical and anesthesiologic
techniques have continuously raised that limit (Kohn et al.
1973). Also, at the same time, people are living longer,
and deterioration in health occurs as one grows older.
As a result of the older person living longer, more
chronic and acute diseases occur which may cause surgery.
This increase in the older population has created special
problems of preoperative and postoperative care in
geriatric surgery.
It is no longer uncommon at the present time to hospitalize patients for an operation who are over 80, 90, or even 100 years of age, and the remarkable feature is that many of these patients come through without difficulty (Rains 1973). People pass through a critical period at about 65 years of age, and at this time are often affected by coronary and cerebral arterial thrombosis. But, once through this period they may enter an era of comparative well-being until suddenly trauma, infection, degenerative or neoplastic conditions bring them to a hospital. Many of these are acute complications or exacerbations of chronic diseases which have been silent for a number of years (Rains 1973). For example, gallstones are present in approximately 20 percent of women over the age of 40, and in some cases the stones do not cause severe problems. Then, suddenly -- maybe in the 85th year -- a stone impacts in the neck of the gallbladder and an emergency operation is needed for a gangrenous bladder. If the emergency surgical situation is untreated, it will ultimately end in death.

There are discrepancies among writers in regard to surgery in the elderly. Andersen and Ostberg (1973, p. 354) said that,

While the immediate results in geriatric surgery have been the subject of numerous studies, the long term prognosis of the elderly surgical patient
is a rather neglected area. . . . Postoperative mortality indicated that it is at present well below ten percent.

They further stated that of paramount importance is the influence of coexisting diseases which to a large extent determines the immediate postoperative mortality. Weg (1973) agreed with this by stating that with increased age, the susceptibility to disease does increase, and the rate of mortality also increases.

Blichert-Toft and Hummer (1976) said that surgical treatment of the elderly involves a high rate of morbidity and mortality and the factors responsible for the increased hazards in surgery in the elderly are subject to considerable uncertainty. The risk factors remain unknown and the relationships between risk factors and the risk have not been reliably clarified. These writers further commented that when exposed to surgery, the elderly patient often runs a prolonged postoperative course characterized by sustained stress. Kohn et al. (1973) believed that morbidity from concurrent diseases and qualitative and quantitative factors of higher risks among older persons have increased postoperative complications and raised mortality rates. Such factors must be considered in determining whether an operation is indicated or justified. Older persons require careful
observation and special medical care if a surgical procedure is undertaken.

Kohn et al. (1973) evaluated the types of operations, concomitted diseases and causes of death in patients over 80 years of age. There were three groups. In group A were 388 patients over 80 who were having surgery due to trauma. Group B consisted of 211 patients over 80 who were having general surgery, and group C consisted of 6,656 patients of all ages who were having general surgery. Deaths occurred in 20.7 percent of group A, 11.8 percent of group B, and 4.9 percent of group C. Group A was considered poor risks because the trauma was usually due to heart failure and advanced cerebral vascular sclerosis. Factors responsible for the difference in mortality rates within groups A and B were pulmonary embolism and pneumonia due to the longer confinement in bed for the group A patients. By performing operations as soon as possible, mortality was reduced.

According to Cowdry (1968), elderly patients will tolerate major operations as well as young patients, primarily because the operative mortality rate of the elderly patients is no higher than it is in young people in certain operations of moderate seriousness. And, often the indication for elective surgery in the older patient is much stronger than in the young individual.
The aged patient is often fearful and needs suitable answers and explanations from both physicians and nurses. It is necessary for the staff to maintain a helpful attitude toward the aged patient's problems and doubts (Rains 1973). Rains (1973, p. 34) also stated, "anticipation of burial should never enter our thoughts." Frequently people think that nothing can be done with the elderly. Consequently, when admission does occur, the patient may have reached the stage of no return and needs long term care much sooner than if earlier admission had been arranged at a stage when active therapy would have been successful with return to the community (Halsall 1967). The realities of working with older people include being comfortable in the areas of body changes, depression and dying, sensory deficits, and reality testing. One can improve the caretaker's attitude toward older people through a better understanding of the aging process.
CHAPTER 3

METHODOLOGY OF THE STUDY

This exploratory study concentrated on the attitudes of registered nurses toward elderly patients requiring surgery. The research was exploratory in nature. A structured questionnaire developed by the researcher was utilized as the tool for data collection (see Appendix B). This chapter describes the selection of the setting and the sample, the protection of human subjects, the development of the tool to determine the attitudes regarding surgery in the elderly, the collection of data, and the data analysis plan.

The Setting

The target population for this study consisted of registered nurses with a variety of age, education, and experience backgrounds who worked at a general 300-bed parochial hospital in the southwestern part of the United States on eight general medical-surgical or geriatric units.
The Sample

The sample consisted of 50 registered nurses who voluntarily consented to participate. The criteria for the study were:

1. that the subject was a registered nurse, and
2. that the nurse worked on a general medical-surgical or geriatric unit.

Protection of Human Subjects

The design of the study was submitted to and approved by the University of Arizona Human Subjects Committee, the University of Arizona College of Nursing Research Committee, and the University of Arizona College of Nursing faculty (see Appendix A).

Only registered nurses who consented to participate in this study were used. A letter of explanation of the study was attached to the front of the questionnaire. The purpose of the study was explained to each nurse. The confidentiality of information obtained was insured by assigning each questionnaire with a number. The data obtained were used for research purposes only.

Research Tool

The research tool consisted of a researcher-developed questionnaire which consisted of three parts. The first part of the questionnaire was designed to obtain
demographic data about the sample population. The data included age, marital status, cultural background, level of education, and work experience in nursing. Data was also collected to determine if the participant had attended any workshops or classes regarding the elderly. This data was to be used as intervening variables in the analysis of the data. The range of the possible score was one through seventy. The second part of the questionnaire consisted of questions designed to elicit positive or negative responses toward elderly people. The third part of the questionnaire consisted of questions designed to elicit attitudes toward the elderly surgical patient.

**Measurement**

Part I of the questionnaire dealt with personal and professional characteristics of the individual. The second part which consisted of 14 questions was designed to elicit positive or negative attitudes toward aging. For scoring purposes, the numerals one, two, three, four, and five were assigned, respectively, to strongly disagree, slightly disagree, undecided, slightly agree, and agree. This section was adapted from a study done by Kogan (1961) and consisted of seven pairs of matched positive-negative responses. These questions were designed to reflect the degree of discomfort felt in the company of elderly people, the degree older people vary from one another, and the
nature of interpersonal relations across age generations. The third part of the questionnaire consisted of a scale developed by the researcher to measure attitudes toward surgery in the elderly. Situational type questions were used. This included five case presentations followed by five questions which were related to five ages: 76, 81, 86, 91, and 96 years. For scoring purposes, the numerals one, two, three, four, and five were respectively assigned to strongly disagree, disagree, undecided, agree, and strongly agree. For Part III, the sum of the columns and the rows were recorded on the coding sheets. The possible range of scores was from five to twenty-five.

Osgood, Suci, and Tannenbaum (1957) stated that how a person behaves in a situation depends on what that situation means or signifies to that person. Therefore, meaning can be defined as a process that involves the relationship or process of associating signs with significant objects or concepts and can be represented as an unknown space of multidimensions. "The semantic differential is essentially a combination of controlled association and scaling procedures" (Osgood et al. 1957, p. 20). These authors (p. 26) further describe semantic differentiation as the "successive allocation of a concept to a point in the multidimensional semantic space by selection from among a set of given scaled semantic alternatives."
The scale used in this study is a Likert-type attitude scale, a summated scale consisting of a series of statements which the subject is asked to react along a continuum. Rating scales such as Likert are used to make distinctions of degree rather than quality, and fine discrimination in measurement can be ascertained (Palmer 1965). The value of such a rating scale derives from the fact that a judgment can be made about some trait or attribute of an individual (Palmer 1965).

The researcher decided to utilize a five-point scale so that a greater discrimination in responses could be obtained between degrees of favorableness. Positions on the continuum are scored from one to five with the score of five indicating a highly favorable attitude.

The arbitrary method of scoring item responses treats the responses as though the distances between them were equal. The weights are uniform for all items. Palmer (1965) identified this as the method of equal-appearing intervals.

Palmer (1965), in describing the reliability and validity of a Likert scale, said that Murphy and Likert and Rundquist and Slette found negligible distortion when they compared the sigma method of scoring with the arbitrary assignment of scoring item responses. The sigma method of scoring is more difficult. McNemar (1946)
commented that this is because it involves converting the proportion of times each response was checked for each item to the corresponding sigma value on the base line of the unit normal curve. Palmer (1965) stated that Rundquist and Slette obtained correlations between +.946 to +.987, and Murphy and Likert obtained correlations of +.99. The arbitrary method of scoring is preferred to the sigma method due to the fact that it is less time-consuming and yields high reliability. Miller (1964) said that the Likert-type scale is highly reliable in regard to eliciting a particular attitude or attitude complex.

Consensus validity was gained from three faculty members who are in the geriatric and surgical fields. The questionnaire was reviewed and revised several times to assure that it was measuring the required attitudes. Content validity was gained by reviewing tools of others on aging. The reliability of the Likert-type scale has been shown to have reliable coefficients as was discussed previously.

The questionnaire was pretested by being administered to five graduate professional nurses with varying educational backgrounds and professional experiences. Participants were asked to analyze the questionnaire for clarity and make any judgments about the method of scoring.
Based on the results of the pretest, a revision was made of the directions for Part II and Part III.

**Method of Data Collection**

The researcher telephoned the nursing supervisor of the facility used and arranged for an appointment. A copy of the proposal and the questionnaire were submitted to the supervisor. Arrangements were then made for specific times for data collection.

The researcher arranged to approach the nurses at the beginning of each shift. The researcher's status as a graduate student at the University of Arizona College of Nursing and the purpose of the study were explained.

Verbal and written explanations were given which included the following information:

1. Participation was voluntary and the refusal of the nurse to participate at any time during the study would not have negative consequences.
2. The confidentiality and anonymity of responses to the questionnaire would be assured.
3. The questionnaire would be self-administered and the time commitment necessary to complete the questionnaire would be approximately 20 minutes.
4. The results from the analysis of the study would be available to anyone upon request.
5. The investigator would answer questions at any time upon request.

Following the explanations, a letter of consent (see Appendix A) and questionnaire (see Appendix B) were given to be read and completed. The nurses were instructed to place the completed questionnaire in a folder which the researcher picked up at the end of the shift.

**Data Analysis Plan**

Each completed questionnaire was reviewed and the results compiled on a raw data coding form. Numerical coding weights were assigned to each answer. Frequency distributions were done on Parts I, II, and III of the questionnaire. Factor analysis was then used for Parts II and III in search of underlying dimensions. This was used to construct one or more indices for each subject's responses to the questions. If dimensional reduction were successful, multiple regression analysis would then be used to determine the individual direct effect of any of the independent variables on each of the dependent variables while holding the other independent variables constant. The Pearson coefficient of correlation was used to determine any inter-item correlations in Parts I, II, and III. The Pearson coefficient of correlation was also used
to determine correlations between the three parts of the questionnaire. The significance level specified for this study was 0.05.
CHAPTER 4

PRESENTATION AND ANALYSIS OF DATA

This study was designed to measure the attitudes of registered nurses toward surgery in the elderly. The data from this study are presented in four sections. The first section deals with frequency distributions of the personal and professional characteristics of the participants as elicited by Part I of the questionnaire. The next two sections present frequency distributions of Parts II and III of the questionnaire dealing with attitudes toward the elderly and attitudes toward surgery in the elderly. The final section presents the description of the analyses for interrelationships on the data.

**Personal and Professional Characteristics of the Participants**

**Age of the Participants**

The age range for the total group of participants, which consisted of 50 registered nurses, was 22 to 60 years. The mean age for the group was 31.9 years, and the standard deviation was 9.2. The mode for the group was 26 years (8 nurses). Seventy-four percent of the total group was under 35 years of age.
Marital Status of the Participants

As shown in Table 1, 17 nurses (34 percent) were never married and 21 nurses (42 percent) were married. The remaining 12 nurses (24 percent) were either divorced, widowed, or "other".

Table 1. Characteristics of Sample: Distribution by Marital Status and Ethnicity

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number</th>
<th>Percent</th>
<th>Ethnicity</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never married</td>
<td>17</td>
<td>34</td>
<td>Caucasian</td>
<td>44</td>
<td>88</td>
</tr>
<tr>
<td>Married</td>
<td>21</td>
<td>42</td>
<td>Black</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Divorced</td>
<td>8</td>
<td>16</td>
<td>Mexican-American</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>4</td>
<td>Oriental</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>4</td>
<td>American Indian</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>50</td>
<td>100</td>
<td></td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

Race of the Participants

As shown in Table 1, 44 nurses (88 percent) classified themselves as Caucasian. Of the remaining six participants, one was Black, four were Mexican-American,
one was Oriental, and none were American-Indian. No participants indicated they belonged in the "other" category.

Religion of Participants

In Table 2 is presented the data on the religion of the participants. Nineteen nurses (38 percent) indicated that they were Catholic. The Protestant religion was the preference of 15 nurses (30 percent). Judaism was indicated by four nurses (8 percent). Four nurses (8 percent) indicated they have other preferences, and eight nurses (16 percent) indicated they have no religious preference.

Table 2. Characteristics of Sample: Distribution by Religion

<table>
<thead>
<tr>
<th>Religion</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>19</td>
<td>38</td>
</tr>
<tr>
<td>Protestant</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Jewish</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>None</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>
Basic Nursing Education of the Participants

In Table 3 is presented the data on the type of basic nursing education that the nurses completed. Nineteen nurses (38 percent) were graduates of associate programs, 16 nurses (32 percent) were graduates of diploma programs, and 15 nurses (30 percent) were graduates of baccalaureate programs.

The year in which the education was obtained ranged from 1940 to 1977.

Table 3. Characteristics of Sample: Distribution by Type of Basic Nursing Program and Highest Level of Education

<table>
<thead>
<tr>
<th>Basic Nursing Program</th>
<th>Number</th>
<th>Percent</th>
<th>Highest Level of Education</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Degree</td>
<td>19</td>
<td>38</td>
<td>Associate Degree</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Diploma</td>
<td>16</td>
<td>32</td>
<td>Diploma</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Bachelor of Science</td>
<td>15</td>
<td>30</td>
<td>Bachelor of Science</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Master's Degree</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>50</td>
<td>100</td>
<td></td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>
Highest Level of Education Attainment by Participants

As shown in Table 3, 16 nurses (32 percent) indicated that their highest level of education obtained was an associate degree, while 15 nurses (30 percent) indicated it to be a diploma degree. Eighteen nurses (36 percent) had a Bachelor of Science degree, and one nurse (2 percent) had a master's degree.

The years in which the highest level of education was obtained ranged from 1940 to 1978.

Number of Years in Nursing Practice

As shown in Table 4, the range of years in nursing practice ranged from less than 1 year to 38 years. The mean for the number of years of practice for the total group was 8.1 years, and the standard deviation was 8.0. The mode for the total group was 3.0 years, with 14 percent falling into this category.

Number of Months on a Medical-Surgical Unit

As indicated in Table 5, the range of months in which nurses have worked on any medical-surgical floor ranged from 1 to 99 months. The mean for the total number of months spent on a medical-surgical unit was 35.4 months and the standard deviation was 38.
Table 4. Characteristics of Sample: Frequency Distribution of Number of Years in Nursing Practice

<table>
<thead>
<tr>
<th>Years</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>16-20</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>21-24</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>25-28</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Totals</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Months</td>
<td>Total Time Spent in Medical-Surgical Units</td>
<td>Total Time Spent in This Medical-Surgical Unit</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>1 - 6</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>7 - 12</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>13 - 18</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>19 - 24</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>25 - 30</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>31 - 36</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>37 - 42</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>43 - 48</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>49 - 54</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>55 - 60</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>61 - 66</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>67 - 72</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>73 - 78</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>79 - 84</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>85 - 90</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>91 - 96</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>97-102</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Totals</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>
Number of Months on this Medical-Surgical Unit

Table 5 also presented the range of the number in which nurses have worked on the medical-surgical unit where they were approached for responding to the questionnaire. The range was from 1 to 99 months. The mean was 26.4 months, and the standard deviation was 21.3.

Contact with Elderly Patients

Data were collected to determine if nurses had contact with elderly patients 75 years of age or older who required surgery, and, if so, how often. As shown in Table 6, 46 respondents (92 percent) indicated they had contact with elderly surgical patients. Four subjects (8 percent) had not had any contact with elderly surgical patients.

The frequency of contact with elderly surgical patients is shown in Table 7. Eleven nurses (22 percent) had contact less than three days per week, 23 nurses (46 percent) had contact three to five days per week, and 10 nurses (20 percent) had contact five to seven days per week, and six nurses (12 percent) responded in the "other" category.
Table 6. Characteristics of Sample: Contact with Elderly Surgical Patients

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>46</td>
<td>92</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Totals</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7. Characteristics of Sample: Frequency of Contact with Elderly Surgical Patients

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3 days per week</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>3-5 days per week</td>
<td>23</td>
<td>46</td>
</tr>
<tr>
<td>5-7 days per week</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Totals</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

Workshops or Classes Regarding the Elderly

As shown by Table 8, 20 nurses (40 percent) had attended workshops or classes regarding the elderly, and 30 nurses (60 percent) had not.
Table 8. Characteristics of Sample: Workshops or Classes Regarding the Elderly

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>No</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Totals</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

Contact with Elderly Relatives

Data were collected to determine if respondents had close contact with elderly relatives while growing up. Table 9 shows that 30 participants (60 percent) had contact with elderly relatives and 20 (40 percent) had not had contact with elderly relatives. Of the 30 subjects who responded in the affirmative, 100 percent indicated that this person was a grandparent.

Table 9. Characteristics of Sample: Contact with Elderly Relatives

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Totals</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>
Nurses' Attitudes Regarding the Elderly

The investigator collected information to identify the attitudes of nurses toward the elderly. Thus, Part II of the questionnaire consisted of 14 statements designed to determine the attitudes of the participants regarding the elderly. The method of scoring this section of the questionnaire was discussed previously (see Chapter 3).

Table 10 indicates the participants' responses to statements regarding the elderly. As the means of Table 10 show, there is generally a more positive attitude among nurses toward the elderly. Statement 1 was a negative statement and a mean of 1.6 indicated disagreement with the statement. Statement 2 is a positive statement and a mean of 2.6 indicated neutrality. Statement 3 was a negative statement and a mean of 1.4 indicated strong disagreement with the statement. Statement 4 was a positive statement and a mean of 3.2 indicated neutrality. Statement 5 was a negative statement and a mean of 1.8 indicated disagreement with the statement. Statement 6 was a positive statement and a mean of 4.2 indicated agreement. Statement 8 was a positive statement and a mean of 2.6 indicated indicated neutrality. Statement 9 was a negative statement and a mean of 1.9 indicated disagreement. Statement 10 was a positive statement and a mean of 4.4 indicated agreement. Statement 11 was a negative statement and a mean of
### Table 10. Responses to Attitude Statements Regarding the Elderly from Part II of the Questionnaire (n = 50)

<table>
<thead>
<tr>
<th>Statement</th>
<th>(1) Strongly Disagree</th>
<th>(2) Slightly Disagree</th>
<th>(3) Undecided</th>
<th>(4) Slightly Agree</th>
<th>(5) Strongly Agree</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is something different about most old people; it's hard to figure out what makes them tick.*</td>
<td>33 66</td>
<td>10 20</td>
<td>2 4</td>
<td>5 10</td>
<td>0 0</td>
<td>1.6</td>
<td>1.0</td>
</tr>
<tr>
<td>2. One seldom hears old people complaining against the younger generation.**</td>
<td>9 18</td>
<td>22 44</td>
<td>5 10</td>
<td>6 12</td>
<td>8 16</td>
<td>2.6</td>
<td>1.4</td>
</tr>
<tr>
<td>3. Most old people make one feel ill at ease.*</td>
<td>38 76</td>
<td>9 18</td>
<td>1 2</td>
<td>1 2</td>
<td>1 2</td>
<td>1.4</td>
<td>0.8</td>
</tr>
<tr>
<td>4. It is evident that most old people are very different from one another.**</td>
<td>10 20</td>
<td>9 18</td>
<td>6 12</td>
<td>11 22</td>
<td>14 28</td>
<td>3.2</td>
<td>1.5</td>
</tr>
<tr>
<td>5. Most old people bore others by insistence on talking about the &quot;good old days&quot;.*</td>
<td>25 50</td>
<td>16 32</td>
<td>4 8</td>
<td>4 8</td>
<td>1 2</td>
<td>1.8</td>
<td>1.0</td>
</tr>
<tr>
<td>6. When you think about it, old people have the same faults as anyone else.**</td>
<td>1 2</td>
<td>2 4</td>
<td>6 12</td>
<td>16 32</td>
<td>25 50</td>
<td>4.2</td>
<td>1.0</td>
</tr>
<tr>
<td>7. Most old people spend too much time prying into the affairs of others and giving unsought advice.*</td>
<td>30 60</td>
<td>12 24</td>
<td>4 8</td>
<td>3 6</td>
<td>1 2</td>
<td>1.7</td>
<td>1.0</td>
</tr>
<tr>
<td>8. Most old people tend to keep to themselves and give advice only when asked.**</td>
<td>9 18</td>
<td>16 32</td>
<td>13 26</td>
<td>9 18</td>
<td>3 6</td>
<td>2.6</td>
<td>1.2</td>
</tr>
<tr>
<td>9. If old people expect to be liked, their first step is to get rid of irritating faults.*</td>
<td>22 44</td>
<td>16 32</td>
<td>8 16</td>
<td>2 4</td>
<td>2 4</td>
<td>1.9</td>
<td>1.1</td>
</tr>
<tr>
<td>10. One of the most interesting and entertaining qualities of most old people is their account of past experiences.**</td>
<td>1 2</td>
<td>0 0</td>
<td>5 10</td>
<td>16 32</td>
<td>28 56</td>
<td>4.4</td>
<td>0.8</td>
</tr>
<tr>
<td>11. There are a few exceptions, but in general most old people are pretty much alike.*</td>
<td>31 62</td>
<td>9 18</td>
<td>6 12</td>
<td>4 8</td>
<td>0 0</td>
<td>1.7</td>
<td>1.0</td>
</tr>
<tr>
<td>12. Most old people are very relaxing to be with.**</td>
<td>1 2</td>
<td>7 14</td>
<td>13 26</td>
<td>18 36</td>
<td>11 22</td>
<td>3.6</td>
<td>1.0</td>
</tr>
<tr>
<td>13. Most old people are constantly complaining about the behavior of the younger generation.*</td>
<td>19 38</td>
<td>17 34</td>
<td>4 8</td>
<td>10 20</td>
<td>0 0</td>
<td>2.1</td>
<td>1.1</td>
</tr>
<tr>
<td>14. Most old people are really no different from anybody else; they're as easy to understand as younger people.**</td>
<td>3 6</td>
<td>2 4</td>
<td>3 9</td>
<td>16 32</td>
<td>20 40</td>
<td>4.0</td>
<td>1.1</td>
</tr>
</tbody>
</table>

*Negative statement

**Positive statement
1.7 indicated disagreement. Statement 12 was a positive statement and a mean of 3.6 indicated slight agreement. Statement 13 was a negative statement and a mean of 2.1 indicated disagreement. Statement 14 was a positive statement and a mean of 4.0 indicated agreement.

Factor analysis revealed no significant correlations among the items which prohibit construction of summary indices. In sequel, therefore, the subjects' responses shall be treated as separate variables.

Nurses' Attitudes Regarding Surgery in the Elderly

The investigator collected information to identify the level of nurses' attitudes toward surgery in the elderly. Five situational examples were used. The diseases reflected in the cases were as follows: Case I -- adenocarcinoma; Case II -- orthopedic limitation; Case III -- impending cerebral vascular accident; Case IV -- undiagnosed gastrointestinal obstruction; and Case V -- chronic diabetes with a life-threatening condition. The same five questions were asked of each situation. These dealt with the constructs of age, diagnosis, quality of life, support feelings, and self-choice by the registered nurses. The respondent was to relate each question and situation to five different patient ages (76, 81, 86, 91, and 96 years). Scoring for this section is indicated in
Chapter 3. The total score possible had a range from 5 to 25 with a higher score indicating a more negative attitude toward surgery in the elderly. For purposes of clarity, the mean and standard deviation were utilized in describing the results. These results can be seen in Table 11.

As can be seen from Table 11, there was a consistent increase in scores as the age of the patient increased. Factor analysis revealed that participants responded to all dimensions for Cases I through IV in a similar fashion. However, Case V was responded to differently. There was a more negative response to the statements of Case V as indicated by the substantial increase in the mean. For example, for the age of 76 years, the means of Cases I through IV range from 10.8 to 11.2, but for Case V the mean was 16.8. This pattern was consistent for all ages. In other words, all dimensions of the first four cases correlated with each other, but Case V did not correlate with the first four cases. Thus, two summary scores were derived to do further analysis between the two indices of Part III and the other study variables.

Description of Analysis

A researcher-developed questionnaire was utilized to determine the stated attitudes of registered nurses toward surgery in the elderly. In analyzing the data,
Table 11. Means and Standard Deviations of Registered Nurses' Responses to Statements Concerning Their Attitudes toward Surgery in the Elderly According to Sample Cases

<table>
<thead>
<tr>
<th></th>
<th>Case I</th>
<th></th>
<th>Case II</th>
<th></th>
<th>Case III</th>
<th></th>
<th>Case IV</th>
<th></th>
<th>Case V</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.*</td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Sum for Ages</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>10.9</td>
<td>5.4</td>
<td>10.8</td>
<td>4.7</td>
<td>11.2</td>
<td>5.7</td>
<td>11.0</td>
<td>5.2</td>
<td>16.8</td>
<td>5.9</td>
</tr>
<tr>
<td>81</td>
<td>13.8</td>
<td>6.4</td>
<td>13.3</td>
<td>6.2</td>
<td>14.1</td>
<td>6.7</td>
<td>13.0</td>
<td>6.0</td>
<td>18.3</td>
<td>5.5</td>
</tr>
<tr>
<td>86</td>
<td>15.3</td>
<td>5.8</td>
<td>14.3</td>
<td>6.8</td>
<td>15.7</td>
<td>6.7</td>
<td>14.8</td>
<td>6.7</td>
<td>19.1</td>
<td>5.0</td>
</tr>
<tr>
<td>91</td>
<td>17.6</td>
<td>5.4</td>
<td>15.8</td>
<td>6.6</td>
<td>17.6</td>
<td>6.0</td>
<td>16.4</td>
<td>6.6</td>
<td>20.0</td>
<td>4.6</td>
</tr>
<tr>
<td>96</td>
<td>17.9</td>
<td>5.3</td>
<td>16.4</td>
<td>7.0</td>
<td>18.0</td>
<td>6.2</td>
<td>16.9</td>
<td>6.8</td>
<td>20.3</td>
<td>4.6</td>
</tr>
<tr>
<td>Sum for Statements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>15.4</td>
<td>5.4</td>
<td>13.9</td>
<td>6.0</td>
<td>15.2</td>
<td>6.1</td>
<td>14.2</td>
<td>5.9</td>
<td>17.7</td>
<td>5.3</td>
</tr>
<tr>
<td>Condition</td>
<td>13.4</td>
<td>6.2</td>
<td>14.3</td>
<td>6.2</td>
<td>15.1</td>
<td>6.0</td>
<td>14.2</td>
<td>6.1</td>
<td>19.2</td>
<td>5.0</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>15.4</td>
<td>6.1</td>
<td>13.8</td>
<td>6.2</td>
<td>15.5</td>
<td>6.0</td>
<td>14.2</td>
<td>5.8</td>
<td>18.1</td>
<td>6.0</td>
</tr>
<tr>
<td>Support Feelings</td>
<td>15.8</td>
<td>5.8</td>
<td>13.9</td>
<td>6.3</td>
<td>15.4</td>
<td>6.1</td>
<td>14.4</td>
<td>5.6</td>
<td>19.1</td>
<td>5.2</td>
</tr>
<tr>
<td>Self Choice</td>
<td>17.4</td>
<td>6.3</td>
<td>15.1</td>
<td>6.9</td>
<td>16.8</td>
<td>6.3</td>
<td>15.2</td>
<td>6.4</td>
<td>20.6</td>
<td>5.0</td>
</tr>
</tbody>
</table>

*S.D. = standard deviation

Possible range of means: 5 to 25
two or more summary measures needed to be developed. Part II, which dealt with attitudes toward the elderly, did not lend itself to construction of summary measures as no significant intercorrelations among questions could be found. Two strong dimensions could be found in Part III. In utilizing the Pearson coefficient of correlation, it was found that the items in Cases I through IV correlated strongly with each other, but the items of Case V correlated weakly with the items of the first four cases, thus, indicating construction of two summary indices.

To look further at Part III, the means given in Table 11 were converted back to the original one-through-five scale by dividing by five. This was to facilitate analysis. Table 12 gives the means and standard deviation for the summary scores of Cases I through IV and Case V.

<table>
<thead>
<tr>
<th>Case</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, II, III, IV</td>
<td>3.0</td>
<td>1.0</td>
</tr>
<tr>
<td>V</td>
<td>3.8</td>
<td>0.9</td>
</tr>
</tbody>
</table>
As can be seen by Table 12, mean responses to the statement of the first four cases showed neutrality. Mean responses to the statements of Case V, which dealt with a life-threatening situation indicated a tendency to agree with the statements, thereby showing a more negative attitude toward surgery in the elderly in this particular situation.

The inter-correlations of the individual demographic variables showed no surprising relationships.

In looking at Table 13 it can be expected that the program in which one received their basic nursing program would correlate with the highest degree \((r = .80)\) as many nurses do not further their education. The type of basic nursing program correlated with the frequency of contact with elderly surgical patients \((r = .30)\). The year in which one receives the degree from their basic nursing program as expected correlated with the year in which the highest degree was achieved \((r = .95)\), years in practice \((r = .94)\), the months spend on a medical-surgical unit \((r = .47)\), and on their particular medical-surgical unit \((r = .50)\), workshops attended \((r = .35)\), and their age \((r = .82)\). Basically, the same correlations hold true for the year in which the highest degree was achieved. This, again, is because the year in which the degree was obtained from the basic nursing program and
Table 13. Demographic Variables: Correlations (x 100)
Significant beyond 0.05 Level

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Highest Degree Year</th>
<th>Years Practice</th>
<th>Months on Medical-Surgical Unit</th>
<th>Months on this Medical-Surgical Unit</th>
<th>Contact with Elderly Surgical Patients Frequency of Contact</th>
<th>Workshop Attendance</th>
<th>Contact with Elderly Relatives</th>
<th>Age of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>80</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>30</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>100</td>
<td>95</td>
<td>94</td>
<td>47</td>
<td>50</td>
<td>--</td>
<td>--</td>
<td>35</td>
<td>82</td>
</tr>
<tr>
<td>100</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>100</td>
<td>91</td>
<td>37</td>
<td>51</td>
<td>--</td>
<td>33</td>
<td>--</td>
<td>83</td>
<td>--</td>
</tr>
<tr>
<td>100</td>
<td>46</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>34</td>
<td>--</td>
<td>81</td>
<td>--</td>
</tr>
<tr>
<td>100</td>
<td>68</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>100</td>
<td>--</td>
<td>--</td>
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<td>--</td>
<td>--</td>
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<td>--</td>
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</tr>
<tr>
<td>100</td>
<td>--</td>
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<td>--</td>
<td>--</td>
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<td>--</td>
<td>--</td>
</tr>
<tr>
<td>100</td>
<td>--</td>
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<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>100</td>
<td>--</td>
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<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>100</td>
<td>--</td>
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<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>100</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>
year in which the highest degree was obtained showed a correlation indicating many nurses did not go beyond their basic nursing program. The number of years in practice correlated with the months spent on a medical-surgical unit and months spent on this medical-surgical unit \(r = .46\). Years in practice correlated with workshop attendance \(r = .34\). There was a correlation between years in practice and age of the participant \(r = .81\). The months spent on a medical-surgical unit correlated with the months spent on the particular unit in which the nurse was working when she answered the questionnaire \(r = .68\). Months spent on the particular medical-surgical unit correlated with age of the participants \(r = .34\). Workshop attendance correlated with contact with elderly relatives \(r = .34\) and age of the participant \(r = .41\).

**Correlation of Part II with Part III**

The Pearson coefficient of correlation was utilized to check for any relationships between the two summary indices of Part III and the 14 statements of Part II. No significant correlations were found among the attitude statements of Part II and summary indices of Part III. This is related to the fact that the items of Part II did not correlate with each other, indicating
a problem with the construction of the statements of Part II.

Correlation of Demographic Variables with Parts II and III

Table 14 shows the correlations which are significant beyond the 0.05 level for the two summary indices of Part III and the 14 statements of Part II with the demographic data.

As can be seen from Table 14, Case V of Part III is statistically significant with the frequency of contact with elderly surgical patients ($r = .29$), however, this finding may be of questionable clinical value.

There was a correlation between workshop attendance and statement 1: "There is something about most old people; it is hard to figure out what makes them tick" ($r = .36$); statement 5: "Most people bore others by their insistence on talking about the good old age" ($r = .32$); and statement 7: "Most old people spend too much time prying into the affairs of others and giving unsought advice" ($r = .28$). A correlation was indicated between contact with elderly surgical patients and statement 3: "Most old people make one feel ill at ease" ($r = .64$). A correlation was shown between contact with elderly surgical patients and statement 4: "It is evident that most old people are very different from each
Table 14. Correlations (x 100) between Attitude Statements of Parts II and III with Demographic Data Significant Beyond 0.05 Level

<table>
<thead>
<tr>
<th></th>
<th>Years in Practice</th>
<th>Contact with Elderly Surgical Patients</th>
<th>Frequency of Contact with Elderly Surgical Patients</th>
<th>Workshop Attendance</th>
<th>Contact with Elderly Relations</th>
<th>Age</th>
</tr>
</thead>
</table>

**Part III**

**Cases I, II, III, IV**

- -- -- -- -- -- --

**Case V**

- -- -- 29 -- -- --

**Part II**

**Statement 1**

- -- -- -- 36 -- --

3

- -- 64 -- -- -- --

4

- -- 37 -- -- -- --

5

- -- -- -- 32 -- --

6

- -- -- -- -- 29 28

7

- -- -- -- 28 -- --

8

29 -- -- -- -- --

10

- -- 47 -- -- -- --

14

- -- 28 -- -- -- --
other" (r = .37), and statement 10: "One of the most interesting and entertaining qualities of most old people is their account of past experiences (r = .47). A correlation was found between contact with elderly surgical patients and statement 14: "Most old people are really no different from anybody else; they are as easy to understand as younger people" (r = .28). A correlation was also indicated between contact with the elderly (r = .29) and the age of the participant (r = .20) with statement 6: "When you think about it, old people have the same faults as anyone else." There was a correlation (r = .29) between the number of years in practice and statement 8: "Most old people tend to keep to themselves and give advice only when asked."

Analysis of variance was done to find relationships between marital status, ethnicity, and religion with items of Part I, Part II, and Part III. However, there was no strong relationship indicated between these items.

In summary, factor analysis showed a relationship between Cases I through IV of Part III. In combination, the mean of the four cases showed neutrality to the statements about surgery in the elderly. Case V of Part III showed a more negative attitude toward surgery in the elderly. The Pearson coefficient of correlation showed
significant correlations of inter-items of the demographic data. The Pearson coefficient of correlation also indicated some relationships between Parts II and III with the demographic data.
CHAPTER 5

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

This chapter presents the discussion of the findings, conclusions, and recommendations. This study investigated the attitudes of registered nurses toward the elderly surgical patient. Data for analysis were collected from an investigator-designed, three-part questionnaire.

Relationship of Findings to Tool Development

A correlational analysis computed on Part II of the tool demonstrated a low degree of internal consistency. An inter-item correlation of .40 is required to achieve a moderate degree of correlation between items. The items demonstrated essential independence of each other, i.e., neither the inter-item correlations nor the correlation of Part II and Part III achieved a criterion of 0.40. There was a little consistency in the answer between individuals and from one question to another for a given individual. Correlations between Part II and the demographic data met the criterion with two correlations greater than 0.40.
A correlational analysis was also computed on Part III of the tool. This demonstrated a high degree of internal consistency with the first four cases. However, a high degree of independence was found between the responses to Case V and the response to the first four cases. Correlations between Part III and the demographic data showed no correlations greater than the 0.40 criterion. The low levels of relationship among items make inference difficult.

Relationship of Findings to Attitudes

The frequency distributions from Part II of this study indicated registered nurses in general have a more favorable attitude toward the elderly. One explanation for this finding is that the statements were straightforward, making it easy for the respondent to know what the expected or positive responses should be. Individuals have a tendency to be idealistic rather than realistic; therefore, it is possible that the responses were more positive than they may be in reality because of a tendency of individuals to minimize their individual inadequacies. Of the 14 items, there were no significant correlations above the 0.5 level. Therefore, this indicates that internal consistency needs to be improved before the test is used.
The frequency distribution of Part III of this study indicated that as patient's age increased registered nurses had a more negative response to surgery. Correlational analysis done on Part III showed that the first four cases were responded to in a similar fashion. These cases dealt with cancer, minor orthopedic limitation, impending cerebral vascular accident, and undiagnosed gastrointestinal obstruction. However, Case V, which dealt with a life-threatening complication of diabetes, was responded to differently. The cumulative means of Cases I - V indicated 3.0, or neutrality, but the mean of Case V was 3.8 which indicated a stronger negative response to surgery in the elderly patient with the particular condition stated.

Again, there were no significant correlations between attitudes toward the elderly and attitudes toward surgery in the elderly which is probably due to the need of a better tool construction for Part II. In looking at the correlations of the demographic variables with Parts II and III, the two highest correlations found were between questions three \((r = .64)\) and ten \((r = .47)\) of Part II and contact with elderly surgical patients. These two response items will be discussed individually.

Question three reflected the degree to which vague feelings of discomfort and tension are experienced
in the company of old people. The frequency distribution indicated that the respondents strongly disagreed with this negative statement, thereby portraying a more positive feeling of comfort in the company of older people. The correlation of .64 indicated that nurses who were comfortable with elderly patients were those who have had increased contact with elderly surgical patients.

Question ten dealt with the nature of interpersonal tensions across age generations. The frequency distribution showed that there was a strongly favorable response to this positive question indicating an absence of tension across the age generations. The correlation of .47 means that nurses who do not feel tension when working with the older generation have had an increased contact with the elderly surgical patient. The remaining questions of Part II demonstrated levels of correlations as illustrated in the range of .28 to .37. The highest correlation in Part III was a .29 between Case V and the frequency of contact with elderly surgical patients.

Relationship of Findings to Theoretical Framework

The original assumption of this study was that the action or behavior of an individual is regulated to a great extent by one's attitudes. This was the basis of the theoretical framework. The goal of this study was
not to prove this assumption, but rather to develop a tool that would measure the attitudes of registered nurses toward surgery in the elderly.

The theoretical framework of this study contains elements of Krech, Crutchfield, and Ballache'y's (1962) attitude theory which represented the investigator's definition of attitude, Fishbein and Ajzan's (1975) theory concerning beliefs to explain the correlation of attitudes and beliefs, and Kiesler, Collins, and Miller's (1969) idea of the relationship of attitude to behavior.

Conclusions

On the basis of the findings of this study, it can be concluded that registered nurses in this study had a positive attitude toward the elderly. These same registered nurses had a more negative attitude toward surgery in the elderly as the patient's age increased. However, great caution is required in drawing conclusions about the attitudes of nurses toward the elderly surgical patient because of the limited sample size and the selection of items. The investigator can only say that as elicited by the questionnaire, registered nurses in this study tend to have unfavorable feelings regarding surgery in the patient over 80 years of age. As also elicited by the questionnaire, the more chronic the condition which
requires surgery, the less favorable the attitude for surgery.

Because the life span of humans is increasing, it is obvious that older people will require surgery. It is necessary that nurses recognize their attitudes and behavior regarding the need of surgery in elderly patients.

This study is exploratory in nature. Broader sampling and more items should improve the questionnaire. However, the results suggest probable areas of significance for further research.

**Recommendations**

Based on the findings and conclusions of this study, the following recommendations are made:

1. A larger study using a random sample should be carried out to verify the findings.
2. Reconstruction of the general attitude section (Part II) of the tool.
3. Information should be gathered about nursing behavior toward the elderly by observation of nurses in the clinical setting.
4. The information gathered about the personal characteristics of the nurses should be expanded by using a personality inventory instrument.
5. Curricula should be planned so that there is implementation of content concerning both
knowledge and attitudes regarding surgery in the elderly.

6. Specific content concerning both knowledge and attitudes regarding surgery in the elderly should be included in inservice and continuing education programs.

The above recommendations for further investigation would promote a better understanding of nurses' attitudes, knowledge, and behavior regarding surgery in the elderly patient.
CHAPTER 6

SUMMARY

The purpose of this study was to determine the attitudes of registered nurses toward surgery in the elderly patient who was 75 years of age or older. The problem is significant due to longer life spans of humans and increased medical technology resulting in more surgical procedures being performed at an older age. This causes increased chances that nurses will work elderly patients requiring surgery, and it is pertinent that attitudes be analyzed.

Attitude theories provided the basis for the framework of the study. Attitudes are precursors to behavior. Thus, attitudes are important whenever a service such as nursing is provided to the people.

The review of the literature revealed little information directly related to attitudes toward surgery in the elderly from a nursing viewpoint. Therefore, literature was reviewed in relation to attitudes toward the elderly and attitudes toward surgery in the elderly.

The study was designed to assess attitudes of registered nurses toward the elderly and to assess attitudes of registered nurses toward surgery in the elderly.
The instrument used was a three-part questionnaire which was constructed by the researcher, pretested, revised, and administered to a sample of 50 professional nurses in a hospital in the southwestern part of the United States. Part I of the questionnaire was designed to obtain demographic information about personal and professional characteristics of the respondent to be used as intervening variables in the analysis of the data. Part II consisted of 14 statements to elicit attitudes toward the elderly. Part III consisted of situational type questions designed to determine attitudes toward surgery in the elderly patient.

Information gathered from the 50 returned questionnaires was analyzed for statistical relationships. The Pearson coefficient of correlation was utilized to determine interrelationships between the parts. There were significant correlations found among the demographic variables at the 0.05 level. Significant correlations were also found between demographic variables and the items of Part II and III at the 0.05 level.

Factor analysis of Part II showed a more positive attitude of registered nurses toward the elderly. Factor analysis of Cases I through IV indicated a neutral response to surgery in the elderly, however, factor
analysis of Case V showed a negative response to surgery in the elderly in a life-threatening situation.

Findings from this study should be helpful to nurses who work with elderly patients who require surgery and to nursing educators who are responsible for the education of other nurses. Specific teaching regarding the elderly should be planned and implemented in nursing education, inservice, and continuing education programs. Other recommendations based on this study are: a larger sample, reconstruction of Part II of the questionnaire, observation of nurses' behavior, and increased information of personal and professional characteristics.

These recommendations followed because this specific research was important not only because investigations of nurses' attitudes regarding the elderly surgical patient have been limited in the past, but also because results of this study and those that follow may promote advancement and improvement of nursing care to the elderly.

The researcher recommends additional studies using a larger representative sample and a revised questionnaire.
APPENDIX A

SUBJECT'S CONSENT FORM
I am requesting your voluntary participation in the completion of this questionnaire. The purpose of this study is to determine what the existing attitudes are in regard to surgery in the older person.

This study involves completing a questionnaire which contains biographical information concerning yourself, and completing a number of short statements concerning your attitudes toward surgery in the elderly. Your participation will require approximately twenty minutes of on-duty time.

There will be no physical or mental risks involved in your participation of the study. Participation will in no way affect your status as an employee at this health care facility.

The information which is obtained during this study will be treated as privileged and confidential and in no way will your name or address be used.

If you decide to participate, please answer as many of the questions as you are able to answer with confidence. You do not have to answer all of the questions. Completion of this questionnaire will indicate your consent as a willing participant in this study.
APPENDIX B

QUESTIONNAIRE UTILIZED IN THE SURVEY
QUESTIONNAIRE ON ATTITUDES REGARDING
SURGERY IN THE ELDERLY

PART 1:
This first section deals with personal professional characteristics. Please fill in or check (v) the answer as appropriate. Remember the information from these questions will be used for statistical purposes only.

1. In what type of program did you receive your basic nursing education?
   ______ Associate Degree
   ______ Diploma
   ______ Baccalaureate

2. In what year was this obtained? ______ (year)

3. What is the highest level of education or degree obtained?

4. In what year was this obtained? ______ (year)

5. How many years have you been in nursing practice? ________ years.

6. How many months have you worked on a medical-surgical floor?
   _______ (months)

7. How many months have you worked on this medical-surgical floor?
   _______ (months)

8. In your work experience, do you have contact with elderly patients 75 years or older requiring surgery?
   ______ Yes       ______ No

9. If yes, how often?
   ______ less than 3 days per week
   ______ 3-5 days per week
   ______ 5-7 days per week
   ____________ other
10. Have you ever attended any workshops or classes regarding the elderly?
   ____ Yes   ____ No

11. If yes, when
    ______ (Date) _____________________________ (Topic)
    ______ (Date) _____________________________ (Topic)
    ______ (Date) _____________________________ (Topic)

12. Did you have close contact with elderly relatives while growing up?
   ____ Yes   ____ No

13. Who was this person(s)?

14. How old were you on your last birthday? ______ years

15. What is your marital status?
   _____ Never married   _____ Widowed
   _____ Married         _____ Other
   _____ Divorced

16. What is your race?
   _____ Caucasian       _____ Oriental
   _____ Black           _____ American Indian
   _____ Mexican-American _____ Other

17. What is your religion?
   _____ Catholic        _____ Other
   _____ Protestant      _____ None
   _____ Jewish
PART II:

This section deals with your attitudes toward patients who are 75 years of age or older. Please place a checkmark (✓) in the column at the right that comes closest to expressing your opinion about the statement.

1. There is something different about most old people; it's hard to figure out what makes them tick.

2. One seldom hears old people complaining against the younger generation.

3. Most old people make one feel ill at ease.

4. It is evident that most old people are very different from one another.

5. Most old people bore others by insistence on talking about the "good old days".

6. When you think about it, old people have the same faults as anyone else.

7. Most old people spend too much time prying into the affairs of others and giving unsought advice.

8. Most old people tend to keep to themselves and give advice only when asked.

9. If old people expect to be liked, their first step is to get rid of irritating faults.

10. One of the most interesting and entertaining qualities of most old people is their account of past experiences.

11. There are a few exceptions, but in general most old people are pretty much alike.
12. Most old people are very relaxing to be with.

13. Most old people are constantly complaining about the behavior of the younger generation.

14. Most old people are really no different from anybody else; they're as easy to understand as younger people.
PART III:

This section is concerned with your attitudes toward surgery in the patient 75 years of age or older. Five (5) cases will be given. For each case there will be five (5) questions. Each question should be answered for all five (5) different ages given. Please place a checkmark (✓) in the column which you feel is appropriate.

Following is an example:

<table>
<thead>
<tr>
<th>AGE</th>
<th>76</th>
<th>81</th>
<th>86</th>
<th>91</th>
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<td>U</td>
<td>A</td>
<td>SA</td>
<td>A</td>
<td>U</td>
</tr>
</tbody>
</table>

1. Due to the age group of this patient, I feel surgery should not be recommended.
CASE 1:

Patient is a female. She is active and cares for herself. Recently a rectal biopsy revealed adenocarcinoma. Kidney and cardiac functions are good. Liver scan is normal.

Surgical Recommendation:

Hyperalimentation and resection of the tumor by abdominal perineal resection with a permanent colostomy.

1. Due to the age of this patient, I feel surgery shouldn't be recommended.
2. Due to the condition of the patient, I feel surgery shouldn't be attempted.
3. Because this patient has lived a long, fruitful life and surgery is hazardous, surgery should not be attempted.
4. I would feel uncomfortable supporting surgery in this patient.
5. If the same condition occurred in myself, I would not want surgery done. (Relate to the five different age groups.)

CODE:

SD = Strongly Disagree
D = Disagree
U = Undecided
A = Agree
SA = Strongly Agree
CASE II:

Patient is a male with Dupuytren’s contrac­tures bilaterally.* He is slightly obese and has fair pulmonary function and good kidney function. He has mild angina which is con­trolled with nitroglycerine.

Surgical Recommendation:

Bilateral radical palmer fasiectomy in stages.

1. Due to the age of this patient, I feel surgery shouldn't be recommended.

2. Due to the condition of this patient, I feel that surgery shouldn't be attempted.

3. Because this patient has lived a long, fruitful life and surgery is hazardous, surgery should not be attempted.

4. I would feel uncomfortable supporting surgery in this patient.

5. If the same condition occurred in myself, I would not want any surgery done. (Relate to the five different age groups.)

*Flexion deformity of fingers.
CASE III:

Patient is a female. She lives in a nursing home, has no family, and cares for herself. Patient has transient ischemic attacks during which she is unable to speak or use her right side. X-ray reveals marked narrowing of the left extra cranial carotid artery and minimal narrowing of the right extra cranial carotid artery. Patient is right-handed. Pulmonary, renal, and cardiac function is adequate.

Surgical Recommendation:

Left internal carotid endarterectomy

1. Due to the age of this patient, I feel surgery shouldn't be recommended.

2. Due to the condition of the patient, I feel that surgery shouldn't be attempted.

3. Because this patient has lived a long, fruitful life and surgery is hazardous, surgery should not be attempted.

4. I would feel uncomfortable supporting surgery in this patient.

5. If the same condition occurred in myself, I would not want any surgery done. (Relate to the five different age groups.)
CASE IV:

Patient is an active male. X-ray reveals an obstruction of the splenic flexure. Liver scan is normal. EKG reveals evidence of a healed MI.

Surgical Recommendation:

Hyperalimentation and resection of splenic flexure of colon, splenectomy with end to end anastomosis.

1. Due to the age of this patient, I feel surgery shouldn't be recommended.

2. Due to the condition of the patient, I feel that surgery shouldn't be attempted.

3. Because this patient has lived a long, fruitful life and surgery is hazardous, surgery should not be attempted.

4. I would feel uncomfortable supporting surgery in this patient.

5. If the same condition occurred in myself, I would not want any surgery done. (Relate to the five different age groups.)
CASE V:

Patient is a female who lives in a nursing home. She has a history of diabetes and arteriosclerosis. No pulses were found below the femorals and there is appearance of redness and sores behind the heels. Bilateral amputation above the knees were recommended. Patient and family refused. Six weeks later patient is admitted with anorexia, weight loss, progressive ulceration of feet and ankles, and contractures of knees and hips. She is septic.

Surgical Recommendation:

Hyperalimentation and bilateral above the knee amputation.

1. Due to the age of this patient, I feel surgery shouldn't be recommended.
2. Due to the condition of the patient, I feel that surgery shouldn't be attempted.
3. Because this patient has lived a long, fruitful life and surgery is hazardous, surgery should not be attempted.
4. I would feel uncomfortable supporting surgery in this patient.
5. If the same condition occurred in myself, I would not want any surgery done. (Relate to the five different age groups.)
LIST OF REFERENCES


