NURSING PRACTICE IN A HOSPITAL CONTEXT: THE SUBJECTIVE EXPERIENCES OF FOUR FEMALE NURSES

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CONTENTS

ABSTRACT

This thesis focusses on the practice of four female registered nurses in a hospital context. It examines the degree of control these nurses feel they have over what they do and how they practise. The influence of other members of the health team on that practice is explored.

Socialist feminist theory has provided the framework and feminist research the methodology for the investigation of female nurses' perceptions of their work and the forces that shape and control the practise of nursing at present.

That the structure within which nurses work constrains their practice is demonstrated in this study. It is however the structure of the nursing profession and the relations between nurses which is seen to have the most impact on nursing practice.

PREFACE

The impetus for this study came from my own experience as a registered nurse, both in clinical practice and in nursing education, and from endless discussions with nursing colleagues. The frustrations and declarations of powerlessness by some of my female colleagues began my investigations into nursing as an occupation and profession. A frequently expressed frustration was over the domination of nurses and nursing by of some members of the medical profession. Nurses, it appeared, felt that the doctors were the biggest problem facing any reforms in nursing and in health care.

Nursing education has changed in emphasis from a biomedical model to a holistic health model. Nurses plan their care of patients taking into consideration the totality of the individual. Recent changes in schooling and society mean that new nursing graduates are likely to be more assertive and less submissive than was previously the situation of nurses. These graduates are likely to encounter some difficulties when they enter hospital employment from their nursing colleagues and from the hospital organisation. This thesis provides some insight into the practice of nursing and its relation to the organisation.

Nursing is a female dominated occupation. I believe that feminist research is the appropriate vehicle through which to examine the experience of female nurses in a male dominated organisation.

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CHAPTER ONE

INTRODUCTION

Registered nurses, no matter how well educated and skilled they may be, find that the way in which they practice is influenced not only by the setting in which they work, but also by other members of the multidisciplinary health team with whom they work. Thus any consideration of contemporary nursing practice must take into account the social forces that can affect that practice. This study focusses on the practice of four female registered nurses in a hospital context. It examines the degree of control these nurses feel they have over what they do and how they practise. The influences of other members of the health team on that practice is explored.

Nursing is a predominantly female profession, some seventy seven percent of its members work in hospitals (Fletcher & Gallon,1983:16). The history of modern nursing shows that within the hospital setting, both the education and practice of nurses has been affected and controlled by a male medical profession and male hospital administrators (Lambie, 1951; Ashley,1976; Gamarnikow,1978). Recent nurse historians have challenged the commonly held view that Nightingale substantially changed nursing in the

Victorian era and that this change was sudden and dramatic (Davies,1980; Baly,1986). Instead it is argued the reforms within nursing have been slow and painful. Baly argues that the Nightingale system was:

> ... [a] pragmatic experiment and the result of enforced compromise. The compromise between the hospital authorities who wanted the probationers as pairs of hands, the doctors who wished to keep nurses accountable to them, and the Council who wished to instigate a system of planned training with nurses accountable to trained nurses gave the twentieth century its nursing legacy.
>
> Baly,1986:4

In recent years nursing education in New Zealand has changed. Nurses no longer receive their education in a hospital-based apprenticeship type training system. They are educated at tertiary educational institutions, for example, technical institutes in programmes leading to registration (Carpenter, 1971). This change has also included the development in universities of post-registration degree programmes majoring in nursing studies (Kinross,1984). Students of nursing in technical institutes are full-time students undertaking a three academic year programme. Student nurses in hospital schools were employees of hospital boards and were released from the wards in which they worked either on a daily or weekly basis to attend lectures.

Contemporary nursing education has as its primary intent the entry into the workforce of a knowledgeable, skilled beginning practitioner who is competent to work in any area of the hospital or community. For students of nursing the emphasis has shifted from training to education, and the expected result is autonomous professionals who work as members of a multidisciplinary health team and are accountable for the care they give.

The changes in nursing education have had implications for both the nursing workforce in public hospitals and for nursing practice. Where much of the nursing care in public hospitals was previously given by student nurses, now it is more often given by registered nurses. The registered nurse, who in the past primarily supervised the work of student nurses, now enters the workforce with the intention of planning and giving patient care.

In the past, nursing care was predominantly given as a series of tasks to be completed each duty. The complexity of the task depended on the degree of training the nurse had received. In contemporary nursing registered nurses have the educational background which allows them to give total nursing care for the patients they are assigned. Such care is individualized for each patient's needs and

condition, and its effectiveness is determined through the use of quality assurance programmes.

The practice of any profession is determined by the education received and, importantly, by the structures of the society in which it is practised. Registered nurses are prepared in educational settings to use their knowledge and skills to plan and evaluate the care they give, to take cognisance of the other forms of treatment the patient is receiving, and to practise as colleagues of other members of the multidisciplinary health team. The preparation of nurses to work in this manner will only be effective if the structure in which they practise facilitates it.

Modern nursing was developed as a paid occupation for women and situated in institutions which were under the direct control of the male medical profession (Gamarnikow,1978). The history of nursing has long been allied with domestic labour and dedication to service. Diamond, in an unpublished paper, writes:

> **The mode of human service for the nurse becomes indistinguishable from that of the wife, the mother or the nun. In the case of health services, the woman's world is, once again the emotive, the man's world, the instrumental, the nursing model is feminine, the medical model is masculine.**
>
> **cited in Jaggar,1983:325.**

Nursing in its early development was a rigid hierarchy. The matron was responsible for the nursing and domestic service of the hospital. She invariably had one or two assistant matrons. The next level comprised the supervisors who were responsible for a number of wards and/or units. Beneath the supervisors in the hierarchy were the ward sisters (charge nurses) who were in charge of single wards. The nursing staff in the wards were staff sisters, staff nurses and student nurses, both in the three year and from the nineteen-sixties, eighteen-month programme. This latter training is now a one year course. The military background of nursing development is shown not only in the uniform complete in most cases with epaulets, but also in this rigid hierarchical structure.

In contemporary nursing only some elements of this hierarchical structure remain. The matron is now a principal nurse and she has one or two assistants. Nursing supervisors as a rank remain although their title is somewhat of a misnomer. They rarely actively supervise junior nursing staff. These senior members of the nursing staff have specialist areas of work, for example, as nurse specialists in infection control and as nursing personnel supervisors. The afternoon and night duty nursing supervisors act as resources for the nursing staff. They can, for example, obtain medications from the

pharmacy or equipment from the central sterilizing department outside the normal working hours of these departments.

Recent changes in nursing education mean that the nursing workforce in public hospitals contains a higher proportion of registered nurses. These nurses work within a bureaucratic organisation that can stifle individuality and rewards conformity. Nurses have divested themselves of the domestic chores of their history. Domestic cleaners have taken over the household chores, dietitians provide balanced diets which dietary staff prepare and deliver to the patients. Nurses have thus been freed to concentrate on the work they are educated for - the delivery of of nursing care.

The organisation of nursing practice affects the amount of care a nurse can give. In task-oriented nursing, each nurse performs various tasks for different patients and may never have a total perception of one patient's entire care. This form of organisation worked well when the nursing workforce comprised nurses at different levels of training. Now with a more qualified workforce nurses are more likely to work in teams, as primary nurses or in a derivative form of these two organisational processes. There remains a discrete skill hierarchy within contemporary nursing. Registered nurses are

the most skilled followed by enrolled nurses and students for enrolment. Any technical institute nursing students undertaking their clinical experience in hospital wards do not fit within the hierarchy and are likely to be supervised by their own tutors.

Bellaby & Oribor (1980) describe the mode of production in nursing care from the Nightingale era in three phases which they link to industrial revolutions. The first phase occurred with lady nurses as housekeepers. Nurses were members of a disciplined corps who worked alongside the medical professional who were emerging as individual professionals. The relationship between medicine and nursing was rooted in the class and gender relations of late Victorian England. The second phase which began between the world wars exemplified the contradictions between nursing and medical models. This phase saw the development of specialist areas in medicine and concommitantly in nursing. The result was a subordination of nursing to medicine within a technical division of labour which also saw the organisation of other occupations in health care, including X-ray and pharmacy. The third phase occurred in the nineteen-thirties with the advent of state intervention in health care and with the adoption in the nineteen-sixties of a corporate

management structure which has the effect of splitting management from the workers.

Any investigation into contemporary nursing must take cognisance of the historical factors that have shaped the development of nursing and the social forces that have shaped the position of women in society. Nursing as a female occupation demonstrates these factors and forces in a more or less discrete manner. It is therefore appropriate to examine the practice of nursing from a feminist perspective.

Early feminists alienated nurses by suggesting that in being nurses they were perpetuating their inferior status as women (Edelstein,1971). Women were instead encouraged to seek a career in medicine. In this way it was felt the discriminating effects of the male profession of medicine would be removed.
Liberal feminists further this view by advocating an equal number of men and women in medicine, this they suggest would alter the male monopoly in the upper reaches of the medical hierarchy. A counter proposition also exists for nursing:

> **...a corresponding invasion of nursing by men that would erode the artificial income and status distinctions between physicians and nurses...**
>
> **Bermosk & Porter,1979:88**

On the surface the liberal feminist view would have some merit in that equalizing of numbers will bring about changes in attitude. However, in reality there exists a quite explicit sexual division of labour within medicine. Bullough & Bullough (1977) use 1970 census data to describe differentials in status and salary in all health professions. Registered nurses were predominantly female, 97.3 per cent, compared to 2.7.per cent of males and yet the median income in dollars for males was seven thousand compared to five and a half thousand for female nurses. In a comparison of gender distribution among health care professional and health service workers these writers found a sex discrimination both in occupational groups and in salary range. Bullough & Bullough, 1977:304 state:

> **Though women enter medicine and dentistry, they usually do so on a subordinate level, continually playing the traditional role of the inferior female. ... women have been hesitant to break through this world of masculine bias because those who attempted to do so were labelled as lacking in femininity; the self-image of women in the helping professions has worked to keep the status quo that has proved disastrous to women**

In 1981 in a survey of New Zealand medical practitioners it was found of 5,037 replies that 836 were women. The two largest groups of doctors were

in general practice (38 percent) or as resident medical officers in hospitals (26 percent). The largest proportion of women were found in these two areas (Fletcher & Gallon,1983:22). In this report it was noted that nearly one-third of the women were in general practice. Fletcher and Gallon suggest possible reasons for this. General practice offers more opportunity for part-time work; it allows for flexibility in work arrangements (hours worked) and psychological factors affect the women's choice of specialty. General practice is more compatible with the traditional women's role. Young (1981) suggests that women become general practitioners because they find hospitals alienating. The relationship between the doctor and the patient is "more intimate, more trusting and more lasting and because GPs [sic] work one-to-one with their patients and are asked to meet very real demands day-to-day, whether 'trivial' or not, whether emotional, social or physical" (Young,1981:155).

Similarly New Zealand statistics related to men in nursing show that males are concentrated in specific areas of nursing, in psychiatry, in medical, surgical, orthopaedic and paediatric areas. The distribution of males in hospital administration is 4.9 percent compared with 2.1 percent females (King & Fletcher,1981:64).

Thus, although modern medicine and nursing started as gender-specific professions, inclusion of females in medicine and males in nursing has not had the effect that liberal feminists had hoped. Each gender has continued to focus on separate specialties within these fields. Males continue to hold the higher paid, more prestigious jobs.

Radical feminists see the oppressive structures existing in society as a result of patriarchy. They argue that this oppression is maintained through family socialising power. Thus the power in health care lies with the patriarch (doctor) and it is he who decides what care the patient will receive. The patient becomes a passive recipient of doctor-defined health care. Radical feminists do not agree with liberal feminists arguing that increasing the numbers of women in medicine does not remove the paternalism and authoritarianism of the medical practitioner. This behaviour is learnt and entrants to medical schools become socialised into such a role (Bermosk & Porter,1979; Young,1981).

Marxist feminism allies the sexism in health care to the sexism implicit in capitalism. Bermosk & Porter (1979:92) note:

> **Marxist feminists are concerned with the social context of health care and with who defines and**

> controls the realities of providing medical services. The people with the most power can define and enforce their view of reality, and they can create the consensus in society that it is necessary for the adoption of their perspective as the true one.

The control in this perspective lies with a coalition of Medical Association, public and private hospitals.

Gamarnikow (1978) illustrates the socialist feminist perspective in her historical analysis of nursing. She argues that the sexual division of labour within health care, that is, between male/doctor and female/nurse, is a manifestation of the patriarchal relations of the family transferred to a social (occupational) setting. Such a division, Gamarnikow argues is not biologically based but centres on an ideology of male dominance and control over women. This ideology manifests as power relations and results in the dominance of the medical profession over the nursing profession.

Nursing remains a female occupation which has a long history of performing a traditional female role in society. Ashley (1976) describes the analogy of the hospital family with the doctor as father/decision-maker, the nurse as mother/housekeeper and nurturer, and the patient as child/passive recipient of the ministrations of doctor/father and nurse/mother.

As long as structures remain which legitimize the control of a male medical profession over a female nursing profession it matters not how knowledgable and skilled nurses are, their practice will be constrained within the terms of what is acceptable to the medical profession.

Feminist theory, therefore, provides the most effective framework within which to investigate female nurses' views of their practice. Socialist feminist theory provides the framework and feminist research the methodology which structures this study of nursing practice.

Feminist research denotes a paradigm shift. It is predicated on an ideology which challenges the position of women in society. It provides a specific methodology for investigating the subjective experiences of women. Such research accepts and makes explicit both the ideology and biases. Feminist research offers potential for social change by making the position of women visible, by challenging the status quo and by making information from research projects available. Patai (1984:188) suggests:

> **Feminist research is rethinking the world and generating an immense body of new work which is transforming our sense of the possible and the desirable.**

> I think that, from the perspective of some future time, it will be clear that feminism produced the major paradigm shift of the twentieth century.

Most nursing research shows a preponderance of quantitative research methodology. Only in recent years have nurse researchers turned instead to qualitative methodology. Swanson & Chenitz (1982: 241) argue:

> The consequences of the traditional alliance between nursing research and quantitative methods are: ... the production of research that falls short of meaning for the world of practice ...

MacPherson (1983) argues that feminist methods provide a new paradigm for nursing research particularly in the field of women's health. She suggests:

> Nurses will need to utilize feminist research methods to get beyond the sex biases characterizing the existing research on women's health issues such as, for example, much of the biomedical research on menopause.
>
> MacPherson, 1983:24

Feminist research methods can equally be applied to studies of nurses and nursing.

In this study into nursing practice, socialist feminist theory has provided the framework and is described in Chapter Two. Nursing as a female occupation has rather surprisingly, only in recent years taken any consideration of feminism. Possible reasons for this are discussed in Chapter Three. Feminist research has structured the methodology of this study. Chapter Four outlines the salient features of feminist research and describes the the methodology used in this study. In Chapter Five the participants' responses to questions regarding their practice are recorded. Chapter Six contains an analysis of the research and discusses the implications resulting from this study.