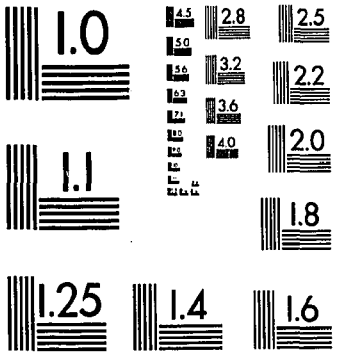

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by

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ABSTRACT

PROFESSIONALIZATION OF NURSING: A HISTORICAL ANALYSIS OF AN EXAMINATION OF THE SEGMENTATION OF THE NURSE PRACTITIONERS

by

Susan B. Del Bene, R.N., M.S.

Advisor: Professor Paul Montagna

An examination of a representative sample of nurse practitioners who exemplify the vanguard for professionalization in nursing, is conducted to test the generalization of Larson (1977) that the standardization and codification of professional knowledge is the basis on which a profession as a "commodity" can be distinct and recognizable to a potential market for its services. Specifically, it is found that the lack of standardization of knowledge in educational preparation leads to excessive stratification and indeterminism in nursing and the consequential inability of the members to generate a consensual identify. Further evidence indicates that standardization of knowledge and market control will have a significant positive effect on professionalization and professional autonomy, as perceived by nurse practitioners in the occupation of nursing; that preparation of college graduates in post-baccalaureate programs for nurse practitioners will lead into diverse non-traditional professional settings rather than into bureaucratic institutions; that standardization of educational processes for the nurse practitioner will tend to lead to a collaborative oriented career path with the physician rather than a traditional role career path; and that those nurse practitioners who have substantial control in their role formulation and implementation perceive

high status consistency and high professional satisfaction and conversely that those nurse practitioners who do not have substantial control in their role formulation and role implementation perceive low status consistency and low professional satisfaction.

From a regionally stratified systematic random sample of 215 nurse practitioners from the total population (N = 1244) of nurse practitioners certified by the American Nurses' Association, the accrediting board for nurse practitioners in the United States, 176 usable questionnaires were elicited. Hypotheses were tested using bivariate and multivariate analysis answers to open-ended questions and historical data.

The study concludes that: (1) standardization and codification of theoretical and clinical knowledge in a post-baccalaureate program for nursing have a significant effect on professionalization and professional autonomy as perceived by nurse practitioners; (2) this standardization will lead to professional career paths that are entrepreneurial rather than physician-surrogate; and (3) the contextual setting for practice will be significantly greater in non-traditional health care settings rather than in the bureaucratic institution of the hospital. The factors that have been shown by the historical and empirical data to be of significance in determining professionalization and status within the occupation of nursing are role autonomy, attitude toward work, high status consistency, and high professional satisfaction. The study recommends increased standardization and codification of knowledge in nursing education commensurate with actual work.

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This dissertation owes its existence to Dr. Paul Montagna, Dr. William Kornblum, and my late husband Joseph Del Bene. Dr. Montagna for his sustained support, Dr. Kornblum for his belief in my capabilities, and Joseph Del Bene for his love.

I am most grateful that I had the opportunity to share in their knowledge and compassion.

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CHAPTER I

PROFESSION, PROFESSIONALIZATION, PROFESSIONALISM

A good point to embark on this analysis of nursing is to examine its professionalism historically. Nursing is an occupation which from a "socio-evolutionary" perspective, is still developing its professional identify. That is, it is continuing to define its parameters of practice and to delimit these parameters vis-a-vis other health professionals. Thus, it seems appropriate, even necessary, to examine how nursing has proceeded in its pursuit of recognition as a fully qualified profession. This study analyzes how the members of the occupation of nursing have engaged in an ideological struggle for autonomy, professional identity, and increased socio-political power. In its broadest sense, the purpose of this study is to examine first, how nurses have historically been unable to control their practice settings, and second how the indeterminism and lack of codification of knowledge led one segment of the occupation -- nurse practitioners -- to disengage from the established paradigm of the "care" model, and to form a new paradigm of "care and cure" model to implement its role.

Nursing has historically been unable to utilize a specialized body of knowledge with the "care" paradigm, because this paradigm is very task oriented, follows along traditional lines, and is usually hospital-based with no functional autonomy. The ideas, beliefs, values and techniques in the nursing community that made up this "care" paradigm resulted in placing

the nurse into a dependent role of carrying out the physician's orders, which required a minimum of knowledge. While this paradigm provides nurses with direct patient care and emphasizes "hands on" practice, it is even more of a block to professionalization and is analogous to the position of technocrat or semi-professional.[1] With a task approach and apprenticeship type "training," there is little opportunity for intellectual development despite the recent emphasis on increased education for nurses. Their feelings of a subordinate role to the physician perpetuates a gulf where nurses are forced to work more closely with aides than with physicians. The result of the "care" paradigm is marginal autonomy and limited decision-making for what is supposed to be a profession.

Kuhn argues that science should be scrutinized more in terms of conflicts of knowledge rather than in accumulation of knowledge. He further states that a science may contain one or more paradigms. That paradigm is composed of ideas, beliefs and values in a community or subcommunity within a discipline, and provides models for problems and solutions for the practitioners.[2] The "care" model did not provide for the expanded role of the nurse practitioner and led to dissatisfaction, role conflict, environmental deprivation and role confusion.

With the utilization of a new paradigm that had been historically developed by the physicians in the public health sector, the expanded role of the nurse practitioner changed the occupation of nursing and has attracted a new group of practitioners away from the "care" paradigm that encompassed the traditional idea, beliefs, values and techniques of the nursing community. This phenomenon is analyzed by using the "process approach" to professionalism developed by Bucher and Strauss. The authors state:

> A process approach to professions focuses upon diversity and conflict of interests within a profession and their implications for change. The model posits the existence of a number of groups, called segments within a profession, which tend to take on the character of social movements.[3]

Nurse practitioners, one segment of the community of the occupation of nursing, developed distinctive identifies, a sense of the past, and goals for the future. They organized their work activities in order to secure an institutional position and have attempted to implement their distinctive missions. The nurse practitioner, a segment of nursing, has taken on the character of a new social movement, as Bucher and Strauss describe, in their attempt to change the role of the occupation. Specifically, the nurse practitioner has tried to change nursing by expanding the role of nursing to include theoretical and practice components that were conventionally under the rubric of the medical profession. The assessment and diagnostic skills were not nursing functions until the nurse practitioner incorporated their skills into their practice. Prior to the 1960s and the nurse practitioner, nurses' roles were more of a surrogate to the physician roles and could not initiate care. The "shift" as described by Bucher and Strauss, consisted of role behaviors and responsibilities for patients that were new to the occupation.

Historically, the post-baccalaureate nurse in the health care delivery system has been largely unrecognized and unrewarded. In the health care system, nursing is one of the least prestigious, lowest paid, and most stratified as to educational preparation. Physicians and hospital organizations have never given nurses separate professional status nor differentiated the post-baccalaureate nurse from less educated nurses. Sociologists have viewed all nurses as semi- professional and technical workers.[4,5] This classification of the occupation by ascriptive

characteristics fails to recognize nursing's potential for professionalization in terms of employment outside institutions, third party reimbursement for services, and greater autonomy over care and treatment.

I will investigate how the role of the nurse practitioner in the occupation of nursing leads to different levels of professional status within the nursing profession. This analysis will permit a determination of whether post-baccaluareate education for nurses allows the nurse practitioner more professional autonomy, job satisfaction, collaborative practice with physicians, and work in non-traditional settings outside the bureaucratic institutions for their practice settings.

Nurses have retained a sense of history in their educational institutions and processes attempting to keep the best of the old, while adapting to current and future health care needs. Nurses have changed roles, repertoire of skills, attitudes, and attire so completely over the years that today they bear faint resemblance to their predecessors.

Schools that have opened nursing programs for college graduates represent a wave of future innovation if indeed the profession is concerned with building a professional degree program on a liberal arts and sciences foundation. These schools focus upon acquisition of clinical skills in a variety of autonomous practice roles. Graduates of these schools are supposed to be capable of giving skilled and knowledgeable nursing care in an "expanded role" in a specific setting of their choice. They are research-oriented scholars who should be capable of engaging in research studies and capable of being responsible nursing administrators.

Despite the confusion and arguments which have ensued within the ranks of the profession since the addition of the word "practitioner" to the

title "nurse," little disagreement exists regarding the failure of nurse educational institutions, licensing boards, and credentialling bodies to develop a central dimension of educational preparation. The lack of this central dimension leads to status incongruency for its members and to the inability of the occupation to occupy a particular status configuration in the health care delivery system. This study therefore, is a critical analysis of the occupation of nursing which investigates professionalization as a conflictual ideology and a process. The task is to identify the core dimensions of characteristics of the adult nurse practitioner, the graduate of the post-baccalaureate program, and how the role of post-baccalaureate nurse practitioners contribute to the differentiation of nursing as an occupation from nursing as a profession.

Sociologists have viewed nursing as a marginal profession or a semi-profession.[6,7,8] Katz describes nurses as non-scientific, as a semi-profession, delivering nuturant care that has no clear place in the medical textbooks.[9] Prior to the 1960s, the literature on the occupation of nursing had a historical viewpoint and did not encompass the expanded role of the nurse outside of the bureaucratic institutions and the domain of medicine. The movement to differentiate practice and education has been an ongoing process from the time hospital schools opened. At that time lectures came under the category of "privileges" like hours off duty, to be granted when hospital duties permitted.

At present, there are over one thousand programs of study for nurses in institutions of higher learning. The varied educational programs that are available to nursing today are in part a result of the increased demand for nurses. To meet this demand, the number of pathways into nursing at different educational levels were increased. As the variety of programs

increased, so, too, did the debate as to the wisdom of the multiplicity of avenues for the preparation of professional nurses. This debate is not dissimilar to that which occurred in medicine, which was brought to a conclusion by Abraham Flexner's 1910 report and the subsequent standardization of medical schools.[10] At that time, nurses did not embrace the organizational changes that medicine accomplished in order to facilitate professionalization and market control of their services. Nursing, historically has been fraught with conflict both from internal and external forces.

Today, conflict and the stratification of the occupation of nursing has arisen because of the struggle between the professionalizers, who want to update educational standards and the traditionalizers, who do not want change. The traditionalizers view the professionalizers as deviants who neglect their mission in the "calling" -- the care of the patient. The conflict is reflected in the bitter controversies among nurses following the publication of two important documents affecting nursing education. The two documents are the American Nurses' Association 1965 Position Paper on Education and the American Nurses' Association Board of Directors' recent statement on graduates of hospital-based diploma programs. The first document placed primary emphasis on education as a criterion for professionalism. The second stresses the importance of service contributed by nurses, in this case graduates of hospital-based diploma schools. There continues to be ambivalence and controversy between those whose status membership gives rise to conflicting values and expectations and who are likely to experience greater strain and tension, and those nurses whose status sets are consistent and crystallized.[11]

The external forces of polarization and conflict in nursing can be

traced to the surrogate role of the nurse to the physician. The dichotomy of the two most prominent members in the health care system exists because there are an almost infinite number of polarities by which one can differentiate between nursing and medicine. Medicine, when forced to choose, tends to give preferences to territorial rights over personal rights, technological requirements over human needs, competition over cooperation, the producer over the consumer, striving over gratification, market control over social reform. Nursing takes the position opposite of medicine.

Nursing represents the recent history of the professions whereby social and technological changes have produced conditions for new occupations to challenge the hegemony of the old; where existing professions have been subject to continuous differentiation; where changing client demands have reinforced trends toward differentiation; and where new sources of external authority have arisen to challenge those of the professional community.[12] The changes in the health care system, the consumer demand for increased participation in decision-making matters of health, the high cost of the health care system, and the continued disillusionment of the public with the practice of medicine, have all challenged the hegemony of the professional community of medicine.

In chapters two, three, and four, I will consider in some detail the characteristic situation of the occupation of nursing as it emerged as a semi-profession providing menial work for their members. I will analyze the status ambiguity in nursing from a framework of women in the labor market and the proletarianization of women and work. Nursing is an integral part of women's work because 97percent of nurses are women. Nursing has been referred to as both a profession and a semi- or para-profession. A

significant part of the status ambiguity in nursing stems from the difficulty other health care providers and the public have in differentiating between the many career paths in nursing, the diploma, associate degrees, and the post-baccalaureate degree nurses.

Chapters four and five focus on the macrolevel, or global issues in professionalism that confront nursing and the emergence of segmentation by the nurse practitioners. The nurse practitioners in their quest for professionalism, have increased specialization within the occupation. Increased professionalism accompanies not this increased specialization, but also increased skill development, non-traditional practice settings, and transferability of skills. Nurse practitioners, desiring to gain professional status, have also tried to convince their colleagues as well as the public that they have appropriate qualifications for higher status and, thereby, deserve the designation.

Definitions and Hypotheses

For the purposes of this study the interactionist approach is utilized to view a profession as a set of role relationships between expert and client. The expert provides esoteric skill in a service given to the client. The client gives trust and payment of an equitable fee.[13] Hughes defines a profession as a type of social role defined by the nature of the relationship between the professional and the client. The key factors, as defined by Hughes are: (1) autonomy of the professional in the work setting (i.e., autonomy, or freedom from control over one's work), and (2) trust of the client that the professional is working in the best interest of the client.[14]

Professionalization represents a process, a dynamic state of career sequences in which workers develop significant professional identify,

autonomy, market productivity.[15]

First professional degree graduates who learn to function as generalists in health care settings such as hospitals, clinics, communities and social groups. Second professional degree education in nursing provides advanced nursing knowledge, skills and expertise in a specialized area and prepares graduates for leadership roles in nursing practice, education and administration in diverse traditional and non-traditional settings. The graduate is expected to synthesize biological, psychological, socio-cultural and nursing knowledge to enhance the delivery of nursing care to individuals, families and communities.

The hypotheses tested in this study are, first:

A survey of nurse practitioners will indicate that nurses employed in hospitals are less satisfied with their occupation than nurses employed in other less traditional work settings;

and second:

A survey of nurse practitioners will indicate that occupational satisfaction is positively correlated with nurses' perceptions of the mental challenge in their positions.

Hypotheses I and II examine job satisfaction among nurse practitioners. Hospital nurses have more than three times the turnover rate of teachers and one-and-one-half times the turnover rate of social workers.[16,17] Although some turnover is unavoidable, researchers have reported that 64 to 75 percent of the turnover is not associated with involuntary causes.[18]

Employee turnover is of interest to many disciplines and has been widely studied. The literature in this area has demonstrated that absenteeism and turnover are dependent upon job satisfaction.[19,20] The

Herzberg Motivation-Hygiene Theory has been shown to have validity and usefulness for the study of employee satisfaction and dissatisfaction. This theory has been widely tested in industrial settings and has been used in a limited number of studies of nursing.

Hypotheses I and II are based on the Herzberg theory to investigate the correlation of job satisfaction and practice setting. Herzberg postulated the theory to be the result of two different sets of needs of man. One set of needs arises from the animal nature -- that is, the drive to avoid pain and the drive to meet one's basic biological needs. The other set of needs relates to what is uniquely human, that is, the ability to achieve and thus to experience psychological growth.[21] The latter aspect, psychological growth, is the theoretical framework that the hypothesis addresses. The needs that are not met and are associated with dissatisfaction include company policy and administration, supervision, interpersonal relationships, work conditions, salary, personal life, status, and security. The motivations associated with satisfaction include achievement, recognition, work, mental challenge, responsibility, advancement, and growth.

Nursing 77, a Journal for practicing nurses, conducted a survey in 1978 in which nearly 17,000 nurses responded to a questionnaire about job satisfaction. The most important consideration when nurses looked for a job was opportunity for professional growth.[22]

In a more recent and extensive study, Wandelt, Pierce, and Widdowsan (1981) questioned 3,500 RNs in Texas to identify factors associated with nurse dissatisfaction and unemployment. They reported data from interviews that reinforced the conclusion that dissatisfaction stems from the work setting rather than nursing practice.[23] In numerous other studies of job

dissatisfaction, there is a strong correlation between job satisfaction and hospital nursing.[24,25]

Work itself, responsibility, mental challenge, and professional growth are related to job satisfaction, the corollary is why nurses are dissatisfied. Chapter three specifically addresses the issue of hospital nurses and elaborates on the probable causes of dissatisfaction among nurses in this practice setting. Historically, hospital nursing offers little potential for mental challenge and professional growth. Proletarianization of hospital nurses and its effect on choice of practice settings are topics of chapter three.

The third hypothesis deals with work settings of nurse practitioners:

The profile of strengths and weaknesses affecting the implementation of professional responsibilities and role development reported by nurse practitioners employed in hospitals will significantly differ from those reported by nurse practitioners employed in less traditional settings.

The nurse practitioner enters the practice setting at a considerable advantage in prestige, a circumstance that, it is thought, will further egalitarian relations with physicians. Physician advocates of the nurse practitioner role, have generally stressed the functions of the nurse practitioner in the work setting. These functions, although different in content from traditional nursing, do not affect the traditional structure of nursing and medical practice. In essence, physician advocates have taken the Becker-Freidson position:

> Situational or structural conditions in the work setting determine the nature of the role.[26]

From this perspective, nurse practitioners are desirable to physicians because they extend their medical functions, relieve them of role strain

caused by taking care of the well when the physician is oriented toward the acutely or gravely ill, and at the same time do not challenge medical authority and independence. This is, in general, the case for employment of nurse practitioners in hospital settings.

The concept of autonomy incorporates a philosophy that differentiates it from other forms of professional interaction. In their article on nurse practitioner and autonomy, Fagin and Lamberton define a professional, autonomous practice as:

> (A) a relationship in which there is no hierarchy or boss, in which participants from two different but related health professional work together, bringing distinct and different talents and abilities to the situation, in which the unique skills of each are used on behalf of the patient and family, and in which the participants take from and give to each other, also on behalf of the patient and the family. The crucial element of professional collaboration . . . is the development of a strong relationship built on sharing of knowledge, confidence, and, most important, trust.[27]

In autonomous, collaborative practices, nurse practitioners and physicians often see patients with the same kinds of medical problems. Coulehan and Sheddy (1973) propose that the role of the adult nurse practitioner includes diagnosis and treatment of general medical conditions falling under the headings of "wellness care," "stable chronic disease," and "acute self-limited conditions."[28] Indeed, in busy practices, there may be a growing tendency for nurse practitioners to emphasize their clinical assessment and diagnostic skills more than their involvement in wellness care, such as lifestyle counseling regarding exercise and nutrition, or in more time-consuming psychosocial problems.

Methodology

From a regionally stratified systematic random sample of 215 nurse practitioners from the total population (N = 1244) of nurse practitioners,

certified by the American Nurses' Association, the accrediting board for nurse practitioners in the United States, 176 usable questionnaires were elicited. Focused interviews were also conducted with six graduates from hospital training schools prior to the 1950s.

Data as to type of practice, setting for practice, mental challenge of the occupation, work satisfaction, attitudes toward nursing and nursing practice, and the perceived influence of the physician on the role of the nurse practitioner, was used for analysis. (Appendix B: The Questionnaire).

Hypothesis One uses an independent t-test comparing the mean satisfaction of hospital nurses to non-hospital nurses. The following items were combined from the questionnaire to measure occupational satisfaction:

Item #

2 Taking all aspects into consideration how satisfied are you with your occupation?

3 Suppose you choose a career all over again would you choose nursing?

7e Self-perceptions of a nurse--I am happy in the profession of nursing.

To further examine the data on occupational satisfaction, the nurse practitioners were classified according to age. The specific purpose for selecting age as an indicator for occupational satisfaction in nursing was to focus on new graduates' attrition rate and the relationship between occupational satisfaction and dissatisfaction.

To determine the relationship between age of the respondents and job satisfaction, a Chi Square analysis of nurse practitioners' age and occupational satisfaction was used to ascertain if age of the respondents was more predictive of variance in occupational satisfaction than the more

global category of traditional and non-traditional practice setting.

Hypothesis Two involves a Pearson-Product-Moment correlation coefficient analysis where occupational satisfaction of nurses was correlated with a measure of mental challenge. The following items from the questionnaire were combined to create a measure of mental challenges.

1a My position encompasses use of my skills_____

1b My position allows for professional autonomy_____

1c My position is interesting and provides for professional growth_____

Further analyses of the data, mental challenge, and occupational satisfaction was conducted to explore the micro-level of the interactive relation between occupational satisfaction and nurse practitioners' perception of mental challenge. Seven Pearson Product-Moment correlations were computed to determine the relationship between occupational satisfaction and mental challenge in the specific practice settings of the nurse practitioner respondents in the survey.

Hypothesis Three is tested by performing an analysis of variance to see if a significant difference existed in the profile of the two groups, (hospital nurse practitioners -- non hospital employed nurse practitioners.) Second, a discriminant analysis was used to determine the nature of the significant difference uncovered in the analysis of variance.

Additional analysis of data factors (barriers) influencing the utilization of the nurse practitioner in the specific practice setting were examined. The barriers identified by the nurse practitioners for their impact on role implementation in the specific practice settings were 1) time allotment for seeing patients as inadequate, 2) legal restrictions, 3) resistance to role implementation by physicians, 4) resistance to role

implementation by other nurses, 5) resistance to role implementation by consumers, 6) personal lack of confidence, 7) too many work responsibilities, 8) resistance by work setting. Analysis of variance was the statistical procedure used to analyze the impact of the barriers as perceived by the nurse practitioners in the specific practice setting; the hospital, the hospital clinic, the hospital emergency room, community health department, health maintenance organization, collaborative practice, and solo practice (analyses of the data are discussed in Chapters six and seven).

Theory

Professional status is granted an occupation when society is confident that members of that occupation possess specialized knowledge and place service to the community above self-interest. Because of the esoteric nature of the knowledge, only members of the profession are recognized as competent to define what tasks and practice are necessary and safe.[29] Nursing has five different educational preparations for entry into the practice setting at this time. The associate degree, the diploma degree, two baccalaureate degree programs and a generic master's program, all with different philosophies, conceptual frameworks, theoretical applications and terminal objectives for competency. This lack of standardized educational preparation leads to an inability of the occupation to generate a consensual identify or market control for its services.

Before the twentieth century, there were no legal requirements for nurses with regard to formal education, state examination, or state license. States have passed statutes that require a person to take the state licensure examination in order to practice nursing. The examination given for licensure is a national one, thereby allowing the practitioner to

practice in the fifty states of the United States. The use of uniform examinations have helped equalize standards and facilitate reciprocal licensure. However, there is no standardization of educational preparation for the occupation.

The lack of consensual identity can be directly attributed to the many and diversified career paths available to nurses. Nurses have been moving into the academic establishment in a most confusing, self-defeating manner. At the present time, consider these current levels of preparation and credential for entry into the nursing field:

- Nursing assistant: short-term, on-the-job training, institutional certificate.
- Practical/vocational nurse: post secondary education of two to three years under hospital auspices; hospital diploma; practical/vocational license.
- Registered nurse: post secondary education of two to three years under hospital auspices; hospital diploma; "professional" license.
- Registered nurse: post secondary education of two years usually under community college auspices; associate degree in nursing; "professional" licensure.
- Registered nurse: post secondary education of four years under college or university auspices; baccalaureate degree in nursing; "professional" license.
- Registered nurse: post-baccalaureate education of one and one-half to three years under university auspices; master's degree in nursing; "professional" license.

The necessity of rationalization and standardization in a profession

and of production is both revealed and maximized by orientation to a market of services.[30] While in the aggregate nurses subscribe to a number of values and goal aspirations in common, nursing as a discipline fails to be a community in the sense that Goode (1957) has described it.[31] Rather than being a unified community of like-minded professionals, nurses comprise a segmented work group.

The real issue of professionalization is not whether the occupation objectively has an abstract theoretical knowledge base (and therefore, one mark towards professional status), but rather what the social conditions are that allow a particular occupational group first to claim, and then perpetuate their claim to holding special expertise. Thus, the issue of professional knowledge emerges as a social question as well as a "scientific" or technical one. The theoretical position that this thesis takes is both a class conflict and interactionist approach; it explores the processes that one segment or group of nurses are undertaking in order to professionalize the occupation.

To some extent every profession can be viewed as more or less continuously in process of professionalization or deprofessionalization, since the interaction between practitioner and clients bring about alterations in practice and/or public posture. Larson, a conflict theorist, views professionalization as the process by which producers of special services seek to constitute and control the market for their expertise. Professionalization appears also as a collective assertion of special social status and as a collective process of upward mobility. Professionalization represents the effects of role conflict and the ability of some members of an occupation to control and to monopolize their work.[33] Professionals' belief in their autonomy will determine the actions they

will take in order to professionalize.

Sociologists have approached the study of professions from a number of different paradigms. Some have defined; some have described; some have classified; others have critiqued. The concern of this section is to identify the core dimensions and attributes of work that differentiate professionals from other occupations. In doing this I will, in effect use concepts of professionalization in a historical approach to the study of professions.

Theoretical Models of Professionalism

In examining theoretical models of professionalism one must first review the various paradigms developed by sociologists of different persuasions and then discuss the specific paradigms that are important to my analysis of nursing.

Theoretical models of professionalism utilize three broad paradigms; functionalist or trait, symbolic interaction, and conflict.

Functionalist/Trait Model. With its roots in the organicism of the early 19th century, functionalism is the oldest, and, until recently, has been the dominant conceptual perspective in sociology. The organicism of Comte and later, Spencer, clearly influenced the first functional anthropologists.[33] Durkeim's analysis helped shape the more modern functional perspectives. Coupled with Weber's emphasis on social taxonomies -- or ideal types -- of both subjective meaning and social structure, a strategy for studying the properties of the "social organism" similarly began to shape contemporary functionalism.[34]

The functional or trait approach used in defining professions focuses on central dimensions or attributes designed to differentiate professions from nonprofessions. One early trait approach widely used in the literature

is by Goode (1957) who defines a profession as having:

(1) a basis in systematic theory;

(2) authority recognized by clientele;

(3) broader community sanction and approval of that authority;

(4) an ethical code regulating relations with clients and colleagues;

(5) a professional culture sustained by professional associations.[35]

Wilensky, continuing in the "list makers" tradition, has a shorter list consisting of two criteria: the job of the professional is technical, based on systematic knowledge acquired through long training and the professional adheres to professional norms.[36] Goode (1969) depicts a community of professionals with one dominant factor, trust, since he argues that the job of professionals is such that the client or society could be harmed by unethical or incompetent work by the practitioner.[37]

The functionalist approach arranges occupations along a continuum of professionalism according to the degree to which they are characterized by the trait or dimensions that they possess that distinguish them from a nonprofession. This taxonomic approach generates problems of value orientation and assumes that because an occupation involves such characteristics as trust, ethical codes, and a service ideal, the occupation is worthy of the higher status of a profession.[38]

Functionalism views a profession largely as a relatively homogeneous community whose members share identity, values, definitions of role, and interests.

A profession is often defined as a "calling"; i.e., an occupation that requires specialized knowledge and often long and intensive academic preparation. The concept "calling" is provocative in that it embraces in ideology of a divine value system with a heavy influence on intrinsic

altruistic connotations. The concept profession is derived from the Latin: (professio) and its translation, meaning affirmation or avowal. Professions then were bound with the faith they professed and with the value system of their mission in the pursuit of universalistic achievements. Thus, medicine professed health, law professed justice, education professed knowledge, the clergy professed salvation. Professions are occupations with special power and prestige. Society grants these rewards because professions have special competence in esoteric bodies of knowledge linked to central needs and values of the social system, and because professions are devoted to the service of the public, above and beyond material incentives.[39] From their pre-industrial days the learned professions' associations and social standing were equivalent to the elites of the state.[40]

A 1953 paradigm developed by Morris Cogan, an educator, from a thorough study of the many definitions of profession serves well as a conceptual framework for the functionalistic paradigm:

> A profession is a vocation whose practice is founded upon an understanding of the theoretical structure of some department of learning of science 'a discipline,' and upon the abilities accompanying such understanding. This understanding and these abilities are applied to the vital practical affairs of man. The practices of the profession are modified by knowledge of a generalized nature and by the accumulated wisdom and errors of specialism. The professions, serving the vital needs of man considers its first ethical imperative to be altruistic service to the client.[41]

Cogan's conceptualization of a profession emphasizes the universality of the discipline as it is applied to the vital practical affairs of man. He further advocates his belief in the collective orientation of an altruistic ethical practice of service and accumulated wisdom of the profession whose main mission is to serve his fellow man. From this framework of a profession evolves the functionalist emphasis on elitism and

prestige of the profession. From the profession contributions of service to the vital needs of mankind are the rewards gained from superior qualities according to what is intrinsically valuable to the larger society. The physician will receive higher income, more prestige and power, and greater autonomy than the nurse. The sociologist, Becker, provides a less orthodox and cynical touch; he defines the term "profession" to be primarily a symbol. In his view, professions can only be defined as those occupations which have been fortunate enough in the political arena of the marketplace to gain and maintain possession of that honorific title.[42]

Conceptualization of latter day entrants into the field of professionalization have been relatively consistent, with some variation on the same themes. Goode, in the context of dealing with the professions, identified the profession as a community, and identified the characteristics of priority as essential characteristics of professionalism, "a prolonged specialized training in a body of abstract knowledge and a collective of service orientation," and an additional ten characteristics that are derivates of that core:

1. The profession determines its own standards of education and training.
2. The student professional goes through a more far reaching adult socialization than the learner in other occupations.
3. Professional practice is often legally recognized by some form of licensure.
4. Licensing and admission boards are manned by members of the profession.
5. Most legislation concerned with the profession is shaped by that profession.

6. The occupation gains in income, power and prestige ranking, and can command higher caliber students.
7. The practitioner is relatively free of lay evaluation and control.
8. The norms of practice enforced by the professions are more stringent than legal controls.
9. Members are more strongly identified and affiliated with the professions than are members of other occupations with theirs.
10. The profession is more likely to be a terminal occupation. Members do not care to leave it, and a higher portion assert that if they had to do it over again, they would again choose that type of work.[43]

Johnson's argument is that professionalism is an example of social power and an ongoing struggle to maintain the status in the work place. He states:

> .....the trait approach to theorizing about professionalization, despite attempts to suggest a process and a chronology, is then ahistorical to the extent that it ignores variations in the historical conditions under which variant institutionalized forms of occupational activities develop.[44]

This is a fundamental criticism of both trait and functionalist models of professionalism. They "are not definitions of occupations at all, but impose upon us -- as does the very concept of professionalization -- a unilineal view of the development of selected occupations." "This confusion between essential characteristics of occupations and the characteristics of a historically specific institutionalized form of control is the most fundamental inadequacy of both "trait and functionalist" approaches to the study of the professions."[45]

As David Lockwood argued in 1956, functional theory had created a fictionalized conception of the social world in continually assuming for analytical purposes a system of equilibrium. From this world of fantasy, as

Lockwood phrased the matter, it is inevitable that analysis emphasizes mechanisms that maintain social order rather than those that systematically generate disorder and change. Furthermore, by assuming order and equilibrium, the ubiquitious phenomena of instability, disorder and conflict are too easily viewed as deviant, abnormal and pathological.[46]

Becker, the iconoclast in the field, acknowledges the contents of the many lists of characteristics and concludes that the problem of characterization, as well as definition, is the blending of a technical, scientific, value-free use of the term "profession", with the popular, eulogistic, moral valuation usage. In his opinion, it represents consensus in a society about what certain kinds of work group ought to be like. In his opinion, the symbol functions to legitimate claims to autonomy -- the sole differentiating characteristics of a profession.[47]

Indeed, autonomy is viewed by many as the significant variable of professionalization. Nursing, as an occupation, is now contemplating increasing its autonomy and is slowly evolving in that direction, much to the concern of medicine. Dachelet and Sullivan, in writing about the role of the nurse practitioner, remind us that autonomy, as a central concept in professional practice, must be recognized as having two aspects: job content and job context. In their opinion, it is the former, relating to the technical or scientific aspect of the practice itself, rather than its organizational milieu, which is essential to professionalization.[48]

In sum, the application of the "trait" model adduced as a checklist for the measuring of the degree to which an occupation is professionalized, is itself fundamentally ahistorical and presents a unilineal view. But perhaps most fundamental to the argument is that these models are not definitions of occupations at all, but specify the characteristics of

peculiar institutionalized forms of occupational control. This is the most fundamental inadequacy of both 'trait' and 'functionalist' approaches to the study of the professions.[49]

Symbolic Interactionism

The second approach to the study of the professions was led by Everett C. Hughes, utilizing symbolic interactionism as the theoretical emphasis for examining occupations.[50] Hughes conceptualized the professions as a social role defined by the nature of the relationship between the client and the professional. Self-interests and internal conflict are integral parts of the situational environment in this theoretical approach. Professionalization is viewed as a process, a dynamic state of career paths or sequences in which the worker develops significant professional identity, autonomy, and market productivity.[51] A profession encompasses the social role of the worker and professionalization the social status of the role.

Hughes further states that the concept of professionalization and its end-state, professionalism, are based upon models which are an abstraction from the core dimensions which are fully exhibited by the "older" professions of law, medicine and the clergy.[52] However, when either of these processes is identified with a profession, it remains incumbent upon the analyst to state unequivocally what the nature of the process is. What is being claimed? What are the claimants striving for? What are the socio-political conditions inherent in this claim? What sources of power are available to this occupation's group making such claims, is a question of crucial significance. "To achieve an understanding we must make a clear distinction between the characteristics of occupational activities (which may change over time) and historically variant forms of the institutional

control of such activities which are a product of definite social conditions," states Johnson.[53] No profession or occupation is static and unchanging. There are major tensions within such a system that are constantly threatening its stability. An example of the tension and conflict that Johnson describes is within the health care system and the federal government. The health care system rejects cost containment and intervention by the federal government. The health professionals respond to societal needs and demands for heroic measures, sustaining life, artificial mechanical organs, and costly research; the federal government regulates, set fees for Medicare and Medicaid, controls government monies for research and development, and advocates general cost containment.

In sum, the emphasis of the symbolic interactionist approach is on internal conflicts and competition.[54] Theoretical issues as to the nature of humans are conceptualized within a framework of symbols and uniqueness. Humans see themselves as objects in social situations. The social situation is constructed by humans (or actors in the symbolic interactionist terminology) adjusting their responses to each other. The social structure is subject to constant realignment as actors' definitions and behaviors change, forcing new adjustments from others.[56]

At best, the theory can offer general, and tentative, descriptions and interpretations of behaviors and patterns of interaction.[56]

Conflict Theorists. Conflict theorists analyze the professions in terms of their relationship to capitalist production.[57] Marx included in this classification state officials, military people, priests, doctors, judges, artists, lawyers-all professionals whose functions "had hitherto been surrounded with a halo and had enjoyed superstitious veneration."[58] Marx saw the "professional" classes as making themselves necessary, i.e.,

becoming doctors because of physical infirmities of the population. The doctors create their own market for consumer consumption. An example is in the proliferation of medical specialties within the last two decades; the oncologist to treat cancer patients, the internal medicine practitioner, the obstetrician, i.e., all specialities that were formally under the rubric of the general family practitioner. Specifically, Marx has made a number of points long before the processes I just described in the medical profession existed. First, the professional classes are seen as having power. They are able to "impose" their services. Secondly, they are able to "appropriate" material wealth because their "services" have a use value and lastly, they created their own market based on ideology and technical superiority. While Marx did not single out physicians as the technocrats of his time because he dismisses them as ineffective, he did describe them as ideologically useful to capitalists in that era.[59]

Taking a Marxist position, Larson, a contemporary theorist, skillfully uses a historical perspective to examine the development of law and medicine in England and the United States in the 19th century. She traces their development in their attempt "to trade one order of scarce resources -- special knowledge and skills -- into another -- social and economic rewards."[60]

Larson's argument for the structure of professionalization specifically addresses two processes necessary to solidify an occupation into a profession. The first process is standardization or codification of professional knowledge.[61] She states that cognitive standardization allows a measure of uniformity and homogeneity in the "production of producers,"

In her words,

> "Cognitive commoduality, however minimal, is indispensable if professionals are to coalesce into an effective group. This enables connection of the profession with superior cognitive rationality and appears to establish the superiority of one professional commodity."[62]

The second process Larson describes is the establishing and securing market control. She lists the following measures that the profession employs to gain a market for their services: (1) the lower the visibility of the services, the more favorable the situation is for high marketability; (2) the more unorganized the clientele, the more favorable the situation for the profession; (3) the increase in institutionalized educational processes and control of admission; (4) the elimination of incompetent or less competent professionals; (5) the creation of a dominant ideology, i.e., the right to services for the client.[63]

In sum, the conflict theorists define production as the creation of products in that the "professional" creates the market for their services and defines the production or their producers. The expertise or codification of their knowledge is the bases of professional power, according to the conflict theorists.

Summary

In the following chapters I will consider in detail a historical analysis of nursing and an examination of the segmentation of nurse practitioners and their striving for unification. Chapters two, three and four required an extensive review of appropriate periodicals and books for a specific time period, 1950-1960. The rationale for selecting this time period was that 90% of nurses were trained in hospital diploma schools prior to 1960. This supports the relationship between the semi-profession perspective in the literature and the occupation of nursing.

Prior to the 1960s 87 percent of all programs of nursing were hospital based. Chapter three specifically will examine this occurrence and the detrimental effect this had on professionalization. The hospital based schools trained nurses for apprenticeship with minimum or no apparent theoretical basis. Larson describes the direct relevance of the university to the success of professionalization. In Larson's analysis of the professions, she states that as the codification of theoretical knowledge advances, apprenticeship is superseded -- "standardization allowed by a common and clearly defined basis of theoretical knowledge and training is far more important for unification of a profession." Larson further states that the standardization or codification of knowledge is the basis on which a professional "commodity" can be made distinct and recognizable to the potential public.[64] That the occupation has control of their educational institutions and content of their abstract knowledge and clerical skills is inherent in Larson's argument.

As was stated in the introduction and will be addressed in the proceeding chapters, nursing with minimum or no control of its educational institutions, limited autonomy in its practice setting, produced a surrogate role to physicians, and has been viewed by the social scientists and the public as a semi-profession.

In recent years, writers from a variety of disciplines have examined the impact of social change on the health care delivery system in general and nursing in particular in terms of the social issues that are contributing to crises and change within the system. Chapters four and five examine the present forces from both within and without nursing that have influenced changing role relationships, consumerism, and the drive to professionalization. The concept of role expansion and the resulting

controversy that has emerged since its inception in the 1960s, is addressed. This concept has been operationalized into the development of the nurse practitioner. The data compiled for this dissertation, demonstrates that the nurse practitioner works in collaboration with the physician in devising treatment and health maintenance plans that have both a medical and nursing component. This role places the nurse practitioner into non-traditional practice settings; hence they may function as the direct and primary resource of those who seek entry into the health care system.

This has helped to sharpen the drive to professionalism and has been viewed in the literature as a creative response to a need for innovation in health provider roles and in turn has helped to change the "label" of semi-professional.

This analysis will lay the ground for a view of the elements which can increase one segment of an occupation, nurse practitioners, to gain professional status and market control for their services. The studies done by Bucher and Strauss, 1961 indicate what may actually be occurring in the occupation is a process of social change whereby new segments arise from within the group (occupation) and have an impact on the core group. Bucher and Strauss indicate that the assumption that there is a relatively homogeneity within a professional group is contraindicated by the multiplicity of segments within it, each with an independent identity.[65] The nurse practitioner group may simply represent a segment in nursing striving not to deny nursing, but rather to assert an individual or additional identity within it. The attention is on internal and external dynamics of professionalism, market control, and institutional forces and arrangements of power.

CHAPTER I

Footnotes

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CHAPTER II

HISTORICAL PERSPECTIVES: THE SOCIAL ORIGINS OF THE OCCUPATION OF NURSING 1873-1933

Throughout its history, nursing has struggled with definitional terms and issues. Embedded firmly in traditional women's role patterning, it has been difficult for nursing to make a transition into the professional and scientific realms. Caught up in multiple systems (educational, health and societal), the struggles for the occupational identify and definition has been carried forward for over a century in the United States.

In studying the historical perspective of nursing and the dimensions of the occupation as a community, we need to explore the processes that allowed the occupation to take on its particular dimensions and attributes of that community. That would involve abandoning the view of the occupation as an isolated entity, but rather explore what are the means by which the occupational status became verified and expanded into wider social and political significance,[1] thus clarifying the process of occupational patterning within the professions.

Nurses and the Social Structure in Mid-nineteenth Century America

Before the 1870s, hospital nurses were virtually unknown in America. The few women who did work in the hospitals were considered to be of the lower classes, those who did menial work. Many were conscripted from the penitentiary or the almshouse. The hospitals were viewed as houses of death. Both patients and physicians had reasons to be leary of hospitals.

Cross-infection was rampant and the death rate at times exceeded 40 percent.[2] The movement for reform originated, not with doctors but among upper-class women who had taken on the role of managing the new hygiene order. While the germ theory had not yet been formulated, news spread to the United States of the work of Florence Nightingale, who through improved hygiene had greatly reduced the death rate in the British military hospitals. She advocated airing the bed linen, daily baths for the patients, clean dressings for the wounds. At this time the hospitals were constructed in long wards of fifty or sixty beds two feet apart, and the windows were always nailed shut, for this was the age of the fear of fresh air. The well-to-do, when sick, arranged care in their own homes, but those who came to the hospitals were from the poor tenements. The beds were dirty; a new patient was put between the same sheets used by the last patient.[3]

In New York the impetus for change came from women in the State Charities Aid Association, who in 1872 formed a committee to oversee the hospitals and almshouses. It was from these societal roots that the origin of nursing came to being.

The first nursing schools were established along the eastern seacoast. In 1861 Women's Hospital of Philadelphia was founded, because women physicians were not permitted to practice in the established hospitals. Dr. Ann Presten interested ten Quakers in forming a board of managers to provide a hospital with a three-fold purpose: to provide a hospital and dispensary for women and children, to advance the careers of women physicians, and to establish a school of nursing.[4]

Because of war conditions the school did not flourish. In 1872 it was reorganized on principles which most schools did not recognize for half a

century. It was to be maintained for the benefit of the student and was endowed to make this possible -- the first endowed school in the United States. A nursing school committee was appointed by the board of managers, and the first diet kitchen for instruction of nurses was equipped.[5]

The New England Hospital for Women and Children was founded in 1863 by Dr. Marie Zekrzewski; her primary purpose for establishing the hospital was to provide facilities for women physicians in Boston. Dr. Zekrzewski had studied medicine in Berlin and had spent some time at Kaiswersworth, Germany where she was greatly impressed by the nursing school. Although the school of nursing was not open at the New England Hospital for Women and Children until 1872, plans for the school were included in the original hospital charter in 1862.[6]

At first a six month nursing course was given at the New England Hospital for Women and children; later the length of the course was extended to one year. Within ten years Dr. Zekrzewski trained thirty-two nurses. The training for the most part, consisted of clinical work. It was from this school that Linda Richards, America's first trained nurse was graduated.[7] Nutting and Dock in A History of Nursing take the reader on a tour of duty with Miss Richards.

> Our days were not eight hours; they were twice eight. We arose at 5:30AM and left the wards at 9:00PM to go to our beds, which were in little rooms between the wards. Each nurse took care of her ward of six patients both day and night. Many a time I got up nine times in the night; often I did not get to sleep before the next call came . . . . Every second week we were off duty one afternoon from two to five o'clock. We had no evenings out, no hours for study or recreation, and no regular leave on Sunday. Only twice during the year was I given the opportunity to go to church. We were supposed to understand and act. Great care was taken that we should not know the names of the medicine given. All bottles were numbered, but not labeled. We had no text.[8]

Nursing as it was established in 1871, was as an adjunct to the

medical profession with no clear identity, defined role and educational preparation. This was the age of the "gospel of hard work." In America, an agricultural nation, the day was long. As industry increased the same pattern was taken for granted. Nurses carried a double burden. Nursing was considered a dedicated, selfless type of work, and the American tradition of hard work meant twenty-four hour nursing in the beginning. Later, night nurses were introduced, but both day duty and night duty continued as twelve-hour periods until the turn of the century. Hospital boards and physicians argued against the practice of night duty nurses. They wanted the nurse to be on twenty-four hour duty, not to disturb the patient with changes of nurses.[9]

Apprenticeship and the Hospital

Nursing in the mid-nineteenth century represented the philosophy of the times, that work was valued as an end in itself. As Weber emphasized in the Protestant Ethic, a person's "duty in a calling (for occupation) is what is most characteristic of the social ethics of capitalist culture, and is in a sense the fundamental basis of it."[10] The hospital at this time could be compared to a capitalist structure. The nurse provided the labor as a student in training and the hospital existed as an inherently proper and even righteous state of being.

The role of women nurses was very early conceived as that of caring for the "hospital family". Their purpose was to provide efficient economical production in the form of patient care: they were to be loyal to the institution, the physician, and devoted to preserving their occupation.[11] The nurses resided in dormitories on the grounds of the hospital and had to obtain permission for a few hours off the premises, usually once a week. Through service and self-sacrifice, they were to work

continuously to keep the family happy. All the departments of the hospital, from the kitchen and supply rooms to the operating rooms and all patient care units, dependent on the continuous presence of the nurse. In the mid-nineteenth century the nurse assigned to these areas was usually a student. This practice continued to the mid-twentieth century and continues in the United States today in many hospitals.[12]

Since the beginning of the early nursing schools in the 1870s, the content of formal classes and bedside teaching had been decided by the individual school. Each school planned its own curriculum and published its program of classes and lectures, although formal program was not necessarily earned yet. The Board of Trustees and the attending physicians controlled the schools as to curriculum, budget and staffing lectures. In most instances, they physician was the lecturer, a graduate nurse administered the examination and corrected the papers. Class time was arranged around duties on the ward. The classes were scheduled in the early afternoon when ward duties were light. The student was assigned to the unit at six in the morning, did all the baths, bedmaking, cleaning of the unit, feeding of the patient, attended class after lunch, and then would return to the unit for afternoon and evening assignments.*

In 1906, a hospital administrator wrote of the nursing school and its dominant position in the hospital:

> That the training school has become an essential feature of the modern hospital cannot be questioned. To attempt to conduct a hospital at the present day without it, would be like attempting to conduct business on methods which prevailed two or three decades ago. The nursing of the patient is almost, if not quite as important as medical care.[13]

By 1900 the number of hospital training schools had increased to 432.

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*Author's Personal Experiences, 1950, Bridgeport, Connecticut.

By 1910 the United States Board of Education reported the existence of 1,129 training schools. This was an era of unprecedented growth both for apprentice programs for women and for institutions caring for the sick. The hospitals and the physician viewed nursing as a form of "cheap labor" and offered the young women an opportunity to prepare for an occupation, while exploiting her services during the period of training. It is to be noted that many of the early members of the occupation were young women from immigrant families mainly of Irish heritage. Also, black women were not allowed to enroll in many of these schools. For example, the first black student permitted to enter a training school in Bridgeport, Connecticut was in 1948. The student was not assigned a roommate, even though all freshmen in the class did have a roommate to share her quarters. This student did not complete the program and was dismissed prior to graduation. (The school stated that it was for academic reasons.)[14]

Nursing education enforced dependency in many instances. Rules were against student marriages, and living away from the hospital complex; strictly enforced hours were for study and certain behaviors were not considered appropriate or worthy of the "Nightingale Ideal." The student nurse was aware that attempts to question, clarify, or disagree with instructors were regarded as a sign of clinically unsafe behavior for a nurse, even if the student was unusually good.[15] With students in a powerless class status, they could not bring about change. Hospitals made little effort for the betterment of their training departments until mid-century. In the mid-thirties, almost thirty percent of the faculty of the training schools had not even finished high school. Only twenty percent of the total number of training school staff members across the country had one full year of college.[16]

Ambiguity of an Identify

Nursing in the mid-nineteenth century and early twentieth century in sum, then, viewed these values -- the goodness of work, success as personal rectitude, the use of reason to guide one's life, and delayed gratification -- as reflecting some of the important cultural values in the West.

The educational preparation of nurses was in a crisis because the power of the social structure was in the domain of the discipline of medicine and the hospital. The mid-twentieth century processes of nurse "training" led to fragmentation of education with little control of the content of the curriculum or the practice setting.

During the 1890s hospitals were opened as profitable business enterprises; many-room mansions were bought and equipped as a hospital. A graduate nurse was placed in charge and students were recruited. By the second year the students were assigned to patients as special nurses in the hospital and also in their homes; the salary for their services was collected by the hospital.

Nurses scrubbed floors and boiled instruments and did endless other chores in addition to patient care, and stood up when the doctor came in the room. Two longtime nurses shared these thoughts during a recent interview, as the Bridgeport, Connecticut Hospital School of Nursing prepared to celebrate its 100th anniversary.[17] They were Annie Hoffman, who graduated in 1935 and Judy R. Acine, a 1939 graduate, talked about the rules in those day, "You stood up when the doctor entered the room," Hoffman said, "and you let him go ahead of you in the elevator. There were a lot of rules like that, but I didn't mind a bit. They represented what a nurse was, and I am proud of that."

Because the hospital depended so heavily on student labor, the student carried heavy responsibilities. Hoffman said it was routine for a student, after only four months training, to take care of 30 patients alone. The women mentioned moral character as the prime qualifying characteristic for a "good" nurse. The nurses often worked in the home of the patient. In discussing the medical records, the women stated the records included words and phrases like "temperate," "correct," "dissolute," "cured," "died," and "eloped," the last meaning he had not payed his bill.

No married student was permitted in the school or in a hospital job, and "if a student was pregnant, she was immediately out," she stated. The prohibition against married students was a sign of the times. Racine said, in the early days, when a woman married, she was expected to stay at home. Society considered it wrong for her to take a job away from a man. Yet there were no men in hospital nursing at this time.

An interesting observation from the focused interviews in the literature, is that the description of the occupation is phrased as "nurse training." The word education seldom is mentioned. This further validates the occupational patterning of apprenticeship and surrogacy, as well as, the ascribed role of women in the early nineteenth century and well into the mid-twentieth. The word train or training school is defined as that which gives vocational and technical instruction. The early schools of nursing prepared women for a vocation, a technical occupation and a life of servitude.

The apprenticeship had no standard content. Occupational socialization did not exist and graduate nurses were not allowed to work in hospitals. The hospital was staffed by students. The process was difficult for these women who found work in homes, and the social and economic rewards were

minimal. The stresses and insecurities were particularly acute, the nurses were totally powerless to the bureaucratic organization of the hospitals and the physicians were the sovereign profession.

Federal Government Involvement in Public Health Service

In the 1790s, practically the entire population of the United States resided on the Eastern seaboard or closely adjacent to it, and transportation was by water. Because a well-developed merchant marine was essential to prompt economic development for the new nation, it was mandatory to provide for the medical care of the seaman who became sick and injured in the vigors of crossing the Atlantic. Actually, the idea was adopted from the British with the establishment of a hospital in Greenwich and later in Liverpool for the merchant seamen.[18]

Many factors led to the development of a medical care system in America for the merchant seaman. The mortality rate was high for them. Many times, sick or injured sailors were left at the ports where they died in the streets or in some cases were taken in by families.[19]

The federal government soon took action. On February 28, 1978, Robert Livingston, a representative from New York, reported a bill from the Committee on Commerce and Manufacturers for the relief of the sick and injured seamen. The report addressed the issues with the following opening remarks:

> The committee finds the number of seamen, as well as foreigners and natives, arrive at the different ports of the United States in such a disabled situation that they either become a great burden to the public hospitals, where any such are established, or are left to perish for want of proper attention.[20]

A petition for legislature for a relief fund was set in motion and after a great deal of debate the bill passed the House of Representatives and on July 14, 1798, the Senate signed the legislature into law. This was

the beginning of the Public Health Service. Although the name has evolved from many other titles, this was the genesis of the P.H.S. known today.

During the first 120 years of the Public Health Service (PHS) nurses were used in only a limited way. World War I changed this, making the first extensive deployment of nurses by the PHS. When special zones were established around military camps to safeguard the health of the adjacent civilian population, more than 120 nurses were assigned to carry out the sanitary measures designed by the PHS.

Development of Federal Nursing Education Policy

Following the First World War, the initial federal stimuli to public health nursing at the state level came with the Maternity and Infancy Act of 1921 (Sheppard-Towner Act), which allocated more than $1 million annually to those states that would establish agencies to improve the health protection of mothers and babies. The public health expenditures of the 1920s proved that public health-nursing has helped to lower the mortality rate, to increase life expectancy, and to reduce significantly the morbidity rate from tuberculosis, typhoid fever, smallpox, malaria, and most infant diseases.[21]

The advent of Franklin Roosevelt's New Deal in 1933 produced an unprecedented expansion of federal involvement in social welfare of the American people, and nursing was not neglected. In 1933, with one quarter of the labor force out of work, Congress created the Federal Emergency Relief Administration (FERA) to aid the states in alleviating the hardships of the Great Depression. Under FERA, relief funds were available for nursing service. Shortly thereafter, the Civil Works Administration hired over 10,000 unemployed nurses in various health institutions, public health programs, and other services. The Works Progress Administration (WPA),

helped the states to support various health projects.

The first Roosevelt administration embarked upon many other health initiatives, the most significant of which was the Social Security Act of 1935, which provided for old-age. A new era began with a functional specificity for the occupation and a repatterning of the role for nurses. But federal funding for nurses remained on a small scale until the nursing shortage of the Second World War threatened the war effort. And even then, the full-scale commitment was slow in coming.

The structure of the occupation of nursing in the 1930s did not exhibit the process of organization for a market of services, nor the process of collective mobility for the members to generate role status and social standing. The educational system was not institutionalized nor standardized. Power within a profession lies in controlling education and career facilities. Nursing had neither. In the United States training standards were abysmally low, there was no structural means to incorporate and regulate individual ambition into a career. Nursing in this area had marginal cognitive proficiency and the members of the occupation could not demonstrate a consensual ideological basis.

Age of Endowments for Nursing Education and Nursing Surveys

To make a study of ways and means of providing well qualified public health nurses, the Rockefeller Foundation called a special conference in December, 1918. Approximately fifty health leaders including doctors, nurses and representatives of hospitals and health agencies met, and, after much discussion, reached an opinion that the usual three year course was inadequate for nurse graduates to take employment in public health work.[22] To gain more information the delegates named a Committee for the Study of Nursing Education, whose efforts were to be financed by the Rockefeller

Foundation.

At a second meeting called by the Rockefeller Foundation, a year later, the entire field of nursing was discussed, and the Committee requested to investigate all phases of nurse activity. Josephine Goldmark, well known in the field of social research, was made secretary of the group. The results of the survey, together with some definite conclusions, were published in 1923 in the volume, "Nursing and Nursing Education in the United States." The survey was referred to as the "Goldmark Report."[23]

A study of nursing schools brought to light the fact that courses of instruction had received meager attention during the period of rapid expansion. Senior students were often used as head nurses, or were kept on night duty for long periods. They were sent out on private cases, and the financial return made to the hospital. Full time instructors were little known. Lecture rooms, demonstration rooms, laboratories and libraries were generally inadequate. Courses were often based on ward needs, and frequently modified to comply with pressure of work in the hospital. As a means of remedying deficiencies of all three phases of nursing studied, the following recommendations of the Goldmark Report are of significance:

1. That as soon as practicable, all agencies, public or private, employing public health nurses, should require as a pre-requisite for employment the basic hospital training, followed by a post graduate course including both class work and field work in public health nursing.

2. That steps should be taken through state legislature for the definition and licensure of a subsidiary grade of nursing service, the subsidiary type of worker to serve under the physician in the care of mild and chronic illness.

3. That the development of nursing services adequate for the care of the sick and for the conduct of the modern public health campaign demands as an absolute prerequisite the securing of funds for the endowment of nursing education of all types; and that its primary importance, in this connection, is to provide reasonably generous endowment for university schools of nursing.

The Goldmark Report solidified nursing as a surrogate occupation in the wording of the occupation as a "subsidiary type of worker" serving under the physician. One important historical ramification that did evolve from this report was the recommendation that nursing schools be independent of hospitals and on a college level. As an immediate answer to the recommendations of the Goldmark Report, two endowed universities for nursing education were developed, one in connection with Yale University, New Haven, Connecticut, and the other with Western Reserve University, Cleveland, Ohio. The Yale School of Nursing was financed by the Rockefeller Foundation as an experiment to prove the feasibility of planning both classroom instruction and ward practice in accordance with the educational needs of students. Patients of a type and number suitable for teaching were to be selected for care during the course in each special subject, and emphasis was to be placed on the social and health aspects of nursing.[25]

Annie W. Goodrich became so successful as the Dean of the Yale School of Nursing, the school received a large endowment by the Rockefeller Foundation.[26] The School at Western Reserve University was made independent by endowment from Frances Payne Bolton. This school proved successful and is still in existence today. Financial endowment of nursing schools with University affiliations became more and more available as the large capitalist financiers sought altruistic endeavors as well as tax shelters for their mass fortunes. Many nursing schools in the United States today are endowed by these foundations.

A study financed by the Carnegie Foundation was made to determine by whom professional schools should be organized, administered, and financed. Esther Lucille Brown, a social scientist experienced in social research, working with a lay advisory committee, served as director.[27] The objective

nature of this project is indicated by an early decision of the group to "view nursing services and nursing education in terms of what is best for society -- not what is best for nursing as a possibly 'vested interest'."[28]

Dr. Brown visited about fifty selected schools conducted by both voluntary and public hospitals over a cross-section of the country. Findings were evaluated as being both better and worse than had been expected. In addition, individual interviews were carried on with those responsible for nursing education and three regional conferences conducted for their special benefit. The conclusions reached, with recommendations for improvement, were published in 1948 in the volume, "Nursing for the Future," by Esther Lucille Brown.

The report recommended that "effort be made toward building basic schools of nursing in universities and colleges . . . that are sound in organizational and financial structure, adequate in facilities and faculty, and well-distributed to serve the needs of the entire Country."[29] The feasibility of a combined general and professional university course, shortened to four years, was set forth, but the necessity for continuing hospital nursing far into the future was acknowledged. That this continuation of hospital based nurse training continues into the 1980s was not forseeable to this committee in the 1940s.

Another foundation endowment that would have ramifications for the occupation of nursing was the project financed by the Kellogg Foundation to Milfred Montag, an educator at Columbia University in the early 1950s.[30] She hypothesized that nursing education could be placed in the community college curriculum as a two year didactic course of study. A pilot study was initiated in five states of the United States. Along with the growth of the Community Colleges in the 1960s, so too did the associate degree nurse

proliferate with the consequence of the nursing having many pathways to a career in the occupation concurrent with continuation of conflict and polarization of vested interests in the occupation. As a consequence of this "technical nurse," the occupation has moved further away from professionalization and closer to deprofessionalization. It is of significance that the greatest growth in the occupation has occurred in this segment of nursing (the technical nurse).

The occupation of nursing did not standardize the body of knowledge offered in its curriculum, nor was there standardization in clinical training. Each hospital specified the clinical assignment for the student. The clinical assignment was made to fulfill staff deficits and not models for learning and meeting the students' needs. In most cases there was no integration of theory to practice. To be specific, the student may be learning about surgical nursing in the classroom and be placed on an obstetrical unit in the hospital. Therefore, nursing had little standardization of knowledge nor standardization of clinical skills. Returning to Larson, she states:

> . . . the crucial means for unification (professional), and therefore the concrete core of the professions' organizational task, was systematic training -- or, in my terms, the standardization and centralized production of professional producers.[31]

The occupation of nursing did not determine the standardization of the content of knowledge for the occupation nor the implementation of systematic training for its practitioners, as did the physician, the lawyer, and the clergy. As a consequence, the occupation did not gain market control of its services and failed to obtain social power.

The occupation of nursing was spawned by altruistic values and rationalization of women and women's work. The occupation's claim to

altruistic service distinguished it from ordinary male occupations. Nursing was not merely a profession but a vocation. As one nurse stated: "Nursing is not merely a profession - but a ministry." A ministry for women.

This conception pressed the notion of service beyond professional responsibility to an ideal of religious abnegation. Nursing, at this historical time, prior to the 1960s, was distinguished by the sentimental conception of womanly service and female domestic ideology.

During the rapid expansion of nursing between 1890 and 1920, the surveys and analyses made by nursing leaders reflected a continuing lack of control over nursing education and practice. Each school represented a coherent ideology of its own that offered a powerful alternative, and sometimes a direct challenge, to the values of professional ideology. There was the wide variation in the schools programs, no uniform requirements for admission, no standardization of curriculum to generate standardized theoretical knowledge, and the programs weighted toward clinical experience rather than academic education. In the professional associations, leaders called for control of accrediting nursing schools. A commitment to autonomy was advocated by the nursing associations. They sought to separate nursing education from hospital ward service. Throughout, the nursing leaders stressed the value of a "professional" education -- that is, a program oriented to standardized theoretical knowledge, didactic clinical practice, and the end to apprenticeship training as the major component of nursing's craft tradition. The leaders recognized the paternalistic discipline of the hospital as greatly impeding the quest for educational control.

Summary

This chapter inverts the familiar history of progress in nursing education. The ideology and culture of the schools stood at the center of nursing history: the hospital programs provided a common experience shared by the practitioners. The nurses were lost in the organizational context and the bureaucratic institution represented a sign of career immobility for the occupation of nursing. That the apprenticeship training stood as the main career path for nurses can be apparent in the statistics of the graduates of nursing programs. Until 1971, the diploma school graduated more nurses than associate and baccalaureate programs combined; even as late as 1974, 76 percent of all active nurses held diplomas from hospital schools.[32]

The apprenticeship training with no control of the nurses' education system resulted in a surrogate role to the physician. Nurses were perceived as loyal public servants. An example of these beliefs was illustrated in the Ginsberg Report, a sociological study of nursing published in 1948. This report reflected the postwar philosophy of "life adjustment" education and showed its conservative implications:

> It is not sound educational and personnel practice to train people to a degree beyond opportunities in their work. Nursing cannot offer sufficient opportunities for all its members to make fairly constant use of advanced knowledge and specialized skills.[33]

The literature viewed the limited possibilities for nurses' opportunities. This greatly aided the cause of the American Medical Association when they lobbied against bills that brought federal money into nursing programs.[34] To argue that nurses did not "need" college education was to confirm their secondary status as women and as workers.

CHAPTER II

Footnotes

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CHAPTER III

BUREAUCRACY AND THE RATIONALIZATION OF HOSPITAL NURSING

The purpose of this chapter is twofold: to examine the nature and type of practice setting where nurses historically have been employed within the health care system and to characterize the proletarianization and rationalization of hospital nursing. By 'proletarianization," I mean that nurses, by the nature of the labor process in which they have been involved, have historically become more and more comparable to that of the traditional industrial proletariat. Like the latter, they have experienced blocked mobility, skill obsolescence, and erosion of their market value of labor.

Prior to the 1960s, the setting for practice for the nurse was the bureaucratic institution. This setting incorporated the altruistic and surrogate traditions of nursing together with the symbolic linking to female role images that have contributed to the structure and function of rationalization and proletarianization of hospital nursing. The proletarianization of hospital nursing was the contributing factor that led the nurse practitioner to seek career mobility outside the institution in a non-traditional health care setting. In order to lay the ground for the exodus by the nurse practitioner, I will examine historically the proletarianization of hospital nurses.

Proletarianization of Nurses

The term "proletarianization" is used to denote the process in which an occupational category is divested of control over certain perrogatives

relating to the location, content, and essentiality of its activities. McKinley (1982, p. 38) states:

> . . . perrogatives lost or curtailed through proletarianization are all variously associated with the relative power of an occupation and usually involve loss of control over the criteria for entrance, the content of training, autonomy regarding the terms and content of work, the objects of labor (commodities produced) the tools of labor, the means of labor, and the amount and rate of remuneration for labor.[1]

Nursing has been historically a proletarian segment in the labor market subject to the rationalization of work in the hospital. Nurses have had little control regrading the content of their work, the objects of their labor (the clients served), the location of labor (the organizational bureaucracy), and the amount and rate of remuneration for labor.

Throughout the history of nursing the occupation was divested of control over its educational preparation, occupational location, content of course preparation, and essentiality of its work activities. This resulted in the subordination of the occupation to broader requirements of production under advanced capitalism in the industrial complex of the bureaucratic institution of the hospital. In the hospital, as the primary setting for nursing practice, nursing had little autonomy regarding the terms and content of work, the setting of practice, the educational preparation, all important to the ability to generate a professional role. Nurses were and still are confronted with the difficulty of transforming service work into autonomous marketable skills by the hospital's unwillingness to use more skilled and expensive labor. The hospital's concept of efficiency meant the use of as inexpensive a worker as possible. Nurses have traditionally found themselves (despite legal regulations to the contrary) doing the same work as aides or licensed practical nurses and trying to define and justify what the differences were between the skills.[2]

Aiken and Blendon (1981) also addressed the interchangeability among nursing personnel, noting that the shift in the proportion of nurses in hospital nursing services during the past 10 years. They reported that between 1968 and 1979 the percentage of nurses in hospital nursing service personnel increased from 33 to 46 percent. The percentage of licensed practical nurses remained at about 10 percent of the total, while untrained nurses' aides declined from 51 to 35 percent. The authors conclude that there has been a direct substitution of nurses for nurses' aides. They state that this substitution is possible largely because the salary differential between nurses and nurses' aides is so small that it is advantageous to the hospitals to have nurses perform all jobs rather than only those requiring special training.[3]

Nurses have been proletarianized through the use of a variety of tactics at the disposal of powerful self-interest groups, the physicians and the hospitals. This proletarianization has been forced upon them by the bureaucratization of their practice setting. Nurses are expected to exercise technical skills and theoretical intelligence, but only in limited functions.

Aronowitz (1973) has shown that the proletarianization of the professions resulted in white-collar occupations of technically trained workers having limited authority in the hierarchy of labor, and furthermore, these workers have no control over their own labor nor that of the organization. They have been highly trained in skill acquisition, but their expectations and job satisfactions are low. Their responsibilities and power base are limited, resulting in the proletarianization of labor, and the transformation of technical labor from independence to dependence.[4]

Historical Perspectives of Proletarianization of Hospital Nursing

The important changes that took place in hospital nursing began in 1873 when the first nurses' training schools were opened. Prior to this time patients were expected to care for each other. The women employed in the hospitals were mostly unskilled and comparable to domestic servants. Many were inhabitants of almshouses.[5] The training schools were organized and controlled by the hospitals. The students were used as non-wage labor and they were the major employees of the hospitals until the 1930s. The students dispensed the medicines, (pharmacists did not appear in the hospitals until mid-twentieth century) staffed the kitchens, scrubbed the floors, and coordinated the central supply units (from sterilizing bed pans to preparing surgical supplies).

The growth of hospitals was tied to the growth of training schools. In 1873, when the first nursing schools were founded, there were 178 hospitals in the United States. By 1923 there were 6,830 hospitals and every fourth one included a nursing school.[6]

The late Joann Ashley (1977) documented the practice early in this century of hospitals establishing nurse-training programs in order to gain a ready supply of persons to give the nursing care in hospitals.

> Many of the hospitals were small, private "doctors" hospitals, which were financially remunerative to the physicians who operated them because of the free labor of student nurses. Reliable statistics for the year 1905 indicate that more than half of these private profit- making hospitals had "schools" for women. Thought the "hospital" may have been limited to 40 beds, it established a so-called "school" for nurses in order to obtain nursing services at the least possible cost.[7]

A common practice was to sent student nurses into patients' homes to deliver patient care, with the hospital receiving reimbursement.

It was apparent that this form of labor greatly enhanced the

proliferation of the capitalistic institution, the hospital. Student nurses upon graduation, were not employed in the hospital. The only graduate nurses were the superintendents and nurse administrator. The graduate nurse found employment in upper class homes as private duty nurses. Even though the nurse worked for small wages in the home, they did have control of their work setting. The trained nurses were as Aronowitz (1973) noted, technically trained with some independence and control over their own labor.

With the societal changes of industrialization, urbanization and specialization, the role of the hospitals took on a new focus. Prior to this time, the hospital was largerly an undifferentiated welfare institution. Vogel states:

> The patients were socially marginal, overwhelmingly poor, and often without roots in the community. In cities with substantial immigrant populations, the patients were likely to be foreign born. There was strong cultural bias against hospitalization.[8]

Hospital administrators became more aware of the need to change the image of the hospital as a welfare state and to market their services. This lead to the statement in 1908 of the superintendent of St. Luke's Hospital in Chicago to declare at a convention:

> If we can make our hospitals sufficiently attractive to induce patients to remain during convalescence, to come for diagnosis instead of going to hotels and visiting the doctor at his office and to come in for treatment of more or less chronic forms of disease, we will not only increase the number of chronic forms of disease and the number of patrons, but the prolonged stay will mean added work and further the average profit per patient will be greater.[9]

As health care in the hospitals began to become a commodity to be marketed to an increasingly high class of patients, the administrators and physicians became more and more concerned with their labor force. "Hospital care may have become a commodity, but it still was being produced, despite

the rhetoric, in a workplace by a largely undifferentiated work force."[10]

Graduate nurses were offered duties in the hospitals. In many instances, these graduates lived in hospital residences, did not marry, and became a loyal "core" to the hospital family. As one administrator pointed out "training will imbue them with essential characteristics of loyalty to the institution."[11] For most instances the hospital was staffed by the students of their training schools and the graduates of this school. It was rare to find an "outside" graduate in the hospital prior to World War II and if they were an "outside" graduate, the nurse remained marginal within the hospital "family".[12]

Additional factors which may account for the proletarianization in the occupation of nursing are their seemingly less privileged social position, and personal disgruntlement over their treatment by the bureaucratic institutions and the physician. As examined in Chapter I and II, they have contributed through a variety of tactics at their disposal to their proletarianization and have placed themselves into a position from which they have obstructed social change. Also, it is to be noted that many nurses have protected their own vested interests.

Rationalization of hospital nursing

A distinguishing characteristic of bureaucracy is rationality. A rational act can be regarded as one that occurs when the organization or the individual defines the goal, outlines the possible strategies to obtain the goal, and proceeds to make decision and interventions necessary concerning the efficient and productive means to obtain the goal. Historically, under the capitalist bureaucratic institutions the most efficient means for solving large-scale problems involves some specialization of tasks or divisions of labor. Mannheim (1940) defines

"functional rationality" as task specialization: that is, large numbers of people organized rationally with each performing specific functions which contribute to some end.[13] From this it is possible to argue that the bureaucratic structure of the hospital is functionally rational in that labor in the institution is task oriented and task delegated. Mannheim also has argued that this specialization and apparent efficiency, termed "functional rationality," sometimes has negative consequences.

Nurses, inside the bureaucratic setting, are required to devote themselves to two main ends; the dedication to the status and control of the managerial hierarchy (physicians and hospital administrators) and to perform in a variety of roles ranging from housekeeper, caregiver, and house manager. Nurses are responsible for doing bits of care for large numbers of people and for acting as messengers and coordinators for other workers in the hospital. The result is that nurses have little time to give the individualized patient care they have been taught to value as students.

Hospital nursing has historically been task-oriented learned through constant repetition and adhered to each hospital's "one right way" and not the "best way", of performance. A nurse wrote of her early experience in nurse training school.

> . . . Good care of patients . . . is not made to depend on the individual nurse any more than is absolutely necessary. It is more a matter of a routine being established whose proper working will prevent mistakes on the part of a worker.[14]

Hospital nurses have no control over their content of work. Many hospitals must use "functional nursing" because of their low level of staff. "Functional nursing" is designed for task oriented delivery of care, that is one staff nurse administers all medications to the patients on that particular unit. Another nurse is responsible for all vital signs of the

patients (temperature, pulse, and blood pressures), a third nurse is assigned all procedures (ie., dressing changes, rounds with the physicians and interns.) This delegation of patient care, this functional rationality, is fragmented and in many instances hazardous to the patient. The nurse is not aware of the patient as a total human being and in many instances is not aware of changes in the health and illness of the patient. It is not uncommon in hospital jargon to have the nursing staff refer to a patient as the "cholecystectomy in room 702", for in many instances the staff is unaware of the individual patient's name. Most hospital units of 35-50 patients will have three registered nurses on day duty, two registered nurses on evening duty, and one registered nurse to care for the patients at night. It is impossible for the hospital nurse to give holistic care to the patients and as a result hospital nursing is fragmented and the nurse is further proletarianized in the organizational institution.

Rationalization and Time Management

The hospital complex, turning to scientific management in the 1920s to help alleviate rising budgets and using new techniques of cost control further reduced the nurses potential for occupational control and increased rationalization in the occupation. Based on Fredrick Winslow Taylor's methods for efficiency in hospital management, the movement was for simplification of production by reducing each task to its smallest components.

Taylor is considered to be the father of scientific management. His school of thought was developed in the ;1920s when he and his followers were concerned with rationalizing the flow of work. A rationalized work flow would maintain the highest level of work efficiency through pay incentives, which Taylor and his followers believed would encourage the

greatest amount of productivity on the part of the worker. The Taylor economic school gave rise as well to the nation of rationalizing decision-making to time-and-motion studies, to issues and models related to spans of control, and to an emphasis on the formal structure of organizations.[15] That the hospitals accepted this ideology was significant to further rationalization of nursing work. Although the hospital did not give nurses pay increases for increased production.

Analyzing the minute components of the work, "efficiency experts" pared away at wasted notions and substituted the simplest methods. According to Milash (1982), "the resulting standardization of work disrupted the traditional craft process in many industries, often stripping workers of their skills and their control over production." Once analyzed into separate components, the work process could be divided into a number of workers. Each assigned to a few repetitive tasks. Taylorization lent the materials and the rationale for increasing elaborate division of labor.[16] Hospital management invoked the principles of rationalization onto nursing, in standardization of nursing procedures and placing a premium on speed, which encroached on traditional craft practices in nursing.

Medical Dominance in Hospital Nursing

Hospital nursing has historically been dominated by the medical profession. Returning to Freidson in his analysis of the medical profession, and their dominance in the practice of medicine, hospital nursing continues to be dominated by the physician on the one hand and hospital administrators on the other. To the extent that nurses have moved away from hospital settings, they have had more success in achieving control over their work separate from the physician domination and administrative supervision. Nurses believe that in the acute care hospitals

the physician and administrative control over nurses' work remains firm and pervasive.

A somewhat paradoxical issue related to who benefits economically from nurses' work is how the costs of nursing services are treated in hospitals. The primary reasons why patients are hospitalized are (1) to enable the physician to carry out sophisticated diagnostic or treatment procedures unavailable in the physician's office and (2) to receive highly skilled nursing care, also not available in the physician's office. In the first case--diagnostic treatments and procedures--the services are treated as revenue generating, with hospitals highly valuing these as a source of income. In the second case--provision of skilled nursing care--the service is treated as a cost liability.[18]

The organizational setting has proved to be an important determinant of both the nature and the pace of the evolutionary process which an occupation undergoes. Setting, more specifically the organizational position of the employee, has important consequences for the status of the individual worker. In general, although not always, those individuals who are self-employed tend to enjoy higher status than those who are employed in organizations. Nurses not only were produced in the organization by apprenticeship but also were employed in the same organizations after graduation. The process of identification with the larger community of nurses was practically impossible because the graduate continued within the ideology of that organizational structure. The crucial means for unification and ultimate professionalism is the control of standardization and centralization of product by its producers. Nurses did not have this unification nor did they share in cognitive elusiveness in their theoretical knowledge base.

Summary

In summary, the student entering a hospital training school entered into a very consuming system of relationships and learning. It was a system that took over the entire person for the sake of producing a specific end product. The hospital training school emphasized regimentation, obedience, conformity, and appearance. Priorities focused on mastery of firmly established technical skills and on avoidance of mistakes and uncertainty.

The literature reflects the authors' view of nursing prior to 1960. May Agres Burgess, an influential author of a 1928 study that was nursing's equivalent to medicine's Flexner Report, warned both nursing leaders and hospital administrators that the problem was class; nursing was drawing from a social group that was not professional.[19]

Many of the studies done prior to the 1960s focused on hospital management, and nurses were viewed as technical laborers within the institution.[20,21,22] The hospital was a family and the nurses contributed to the success of that family. The students were cut off from other systems of evaluation and were dependent on the nursing school for a sense of identity and self worth. Several students, in a study done by Sonn, spoke of their convent-like training of how they learned to be good nurses and nothing else.[23]

This chapter has examined the hospital training schools and supports the relationship between the apprenticeship surrogate role of the nurse and the detrimental effect it had on professionalization.

CHAPTER III

Footnotes

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CHAPTER IV

WOMEN IN THE LABOR MARKET

The occupation of nursing has always been embedded firmly in traditional women's roles. Most nurses are women. They comprise 96 to 98 percent of all nurses. Therefore, the occupation is an integral component of the societal and political arena of women in the labor market. The way to analyze the relationships of the occupation, its practice setting and its practitioners to other aspects of the social and functional structure of the milieu that contribute to its composition is to focus on the societal framework of women in the labor market. The history of nursing is an episode in the history of women and women in the work force. As one author states:

> The nurse is the mirror in which is reflected the position of women through the ages.[1]

Women and Work Outside the Home

Women have always worked in their homes and the homes of others, in fields, factories, shops, stores, and offices. The kind of work has varied for women of different classes, races, ethnic groups, and geographic locations. The nature of women's work has changed over time with urbanization and industrialization. What remains the same is that the ways in which women have worked involve a constant tension between two areas of women's lives: the home and the marketplace.

Historically women's lives were bordered by their homes. Even when they were part of the labor market, their wages were considered family

income, and their primary roles were wife and mother. This notion of women's proper role greatly limited work force options, severely regulated the lives of women who worked outside the home and diminished the influence they might have had. While middle class men were out earning a living, middle class women made their homes havens for morality and religion. To legitimize this role middle and upper class women were described as frail and dependent creatures, physically and emotionally in need of the man's protection, but spiritually closer to God and keeper of morality and virtue.[2]

In the labor market of the early twentieth century, most women who needed to earn money went "out to service" doing domestic work in other people's homes. This perpetuated the role of the woman as caregiver and house person. A woman who worked as a domestic was described by Harris:

> A domestic was expected to clean the entire house and iron and mend. She might also launder all the clothes and prepare, serve, and clean up three meals a day. To this would often be added such tasks as baking bread, watching children, shopping, and attending to sick members of the household.[3]

All this when many households still had coal-fired stoves that needed cleaning biweekly; when irons were heavy instruments that calloused the hands; when vacuum cleaners were nonexistent; and many times the mistresses demanded personal services. This was the pattern of work for women in the labor market prior to the third decade of the twentieth century.

Resistance of women to the lack of independence and their insistence on better working conditions contributed to a change in the domestic role of women. What had before been a "sleep in" occupation slowly transformed itself to one where women were more and more hired by the day. One woman described what it was like to be on the "slave" market.

> "Every morning, rain or shine, groups of women with brown paper bags or cheap suitcases stand on street corners in the Bronx and Brooklyn waiting for a chance to get some work. Sometimes there are fifteen, sometimes thirty, some are old, many are young and most are Negro women waiting for employers to come to the street corner auction blocks to bargain for their labor."[4]

Domestics were excluded from social security benefits until 1952 and from Federal minimum wage provisions until 1974; they often labored at the lowest possible pay.[5] They continued to be recruited from the newest and least skilled immigrant groups and black women.[6]

Nurses also were not included in minimum wage provisions until after World War II. Through the 1930s, hospital nursing meant a return to the paternalistic regimen of the hospital training schools. On the ward, superintendents tried to apply the same strict discipline to graduate staff nurses and students. Most hospital administrators expected their nurses to live in hospital residences. A 1936 survey showed that 84 percent of hospitals included room, board, and laundry as part of the nurse's wages. Even when institutional policy did not require nurses to live in hospital quarter, few administrators adjusted the salaries of those who wished to "live out." The uniformly low wages compelled many to use institutional residences. Nurses frequently complained about this arrangement, wanting to reject the curfews and social restrictions but in most instances not being able to afford to live outside the residences.[7]

Urbanization and industrialization did not offer women who worked much better conditions in industry prior to World War II. In cities like Philadelphia, Boston, Chicago, and New York, the large majority of those in industry earned their living sewing. They worked under detrimental conditions. Poor working conditions were typical. Carrol Wright, then chief of the Massachusetts Bureau of Labor Statistics, found that long hours,

inadequate toilet facilities, lack of ventilation and fire hazards were the normal milieu of the wage-earning woman's life. There were no laws prior to 1935 for minimum wages, child labor or length of employment hours, and many women worked a twelve hour day.[8] Without any interruption whatever for sickness, or attention to their families, they could earn seven dollars a week. The expanding urbanization and industrialization of the United States brought the corporation structure and retail stores. Women sales clerks were recruited. The work required long hours and women had to stand to look busy. To avoid unionization, stores like Filene's in Boston and Bloomingdale's in New York set up rudimentary programs of goodwill such as distributing turkeys at Thanksgiving and welfare funds to make loans to their employees.[9] Although, salesclerks earned less than domestics and factory workers, their jobs were considered more desirable for women even in the 1980s, even though career ladders were male dominated.

The pattern of sexual segregation and stratification has never disappeared from the labor market. Women worked as domestics, sewing machine operators, in sales and in offices. The upwardly mobile daughters of immigrants were destined to become teachers, nurses, and social workers, a reflection of the ascribed role for women as moral missionaries and caregivers.

Hughes states:

> "An individual's work is one of the most important parts of his social identity, of his self; indeed, of his fate in the one life he has to live, for there is something almost as irrevocable about choice of occupation as there is about choice of a mate."[10]

Women's social identify in the labor market long reflected a system of low status and rewards and limited social mobility.

Montagna comments that women have a stronger bond to their family

roles and thus do not have the time to develop the strong colleague relations needed for career paths to develop.[11] Historically, this has been true, but it is also true that women have been placed in low status positions by a male-dominated labor market and in many instances by other women. Veben claims that most men's jobs "exploit", and most women's jobs are "drudgery."[12] Etzioni comments further that if the majority of semi-professional occupations were male-dominated, many of the relationships between professionals and semi-professionals might not be possible - for example, between nurses and doctors, school teachers and superintendents, social workers and supervisors.[13]

Women's subordination in the workplace and their designation as secondary wage earners in their family results in limited power and limited autonomy. It its effects on an individual woman's self-concept, this pattern has been a major obstacle to achievement and growth in professional work.[14] The ideology of femininity has had a powerful impact on the kinds of jobs that were considered suitable for women who worked outside the home. Prior to World War II, women in the marketplace were derrogated. A woman was thought to work because of financial deprivation, not by choice. This view prevailed in the mores of underprivileged immigrants as well as in the middle and upper class. Education was seen, not a means of a vocation, but as an avocation for women.

Nursing and Capitalist Patriarchy

Beginning in the 1930s, nurses initiated the first programs to establish control over their education and to wrest from physicians control of their work. That this change was slow in evolving and conflictual in nature relates to the change in the women's labor market in a capitalist patriarchal society. Division of tasks by sex appears to be a widespread

and universal characteristic of human society, and the continued sexual division of labor has been a dominant characteristic of "advanced" Western industrial society.

Piore develops a "dual labor market" theory claiming that the labor market is composed of two sectors - primary and secondary. The primary sector offers jobs with relatively high wages, good working conditions, chances of advancement, and employment stability. In the secondary sector, jobs tend to be low-paying, with poorer working conditions, little chance of advancement, high turnover among the labor force, and with considerable instability in jobs.[15] The stratification of the labor market by sex and race overlaps the dual labor market. In the primary sector, where white males dominate, the occupations maintain a generalized theoretical basis for practice and career mobility is most prominent. In the secondary sector where women and minority groups are predominant, the basic learning process is of specific skills, training is mostly thorough apprenticeships, and job performance is generally automatic and repetitive. Women have historically been part of the lower tier of the primary market as salespersons, clerical workers, and significantly represented in the secondary sector as semiskilled workers and service labor. Women in the secondary labor market lack social integration, grievance channels, and do not generate unifying cultural symbols, such as values and beliefs in a shared ideology of work. Furthermore, they were viewed as financially deprived or as deviant. If they were not financially needy, they were thought to be depriving a male of livelihood unless they worked in a female-dominated occupation. The development of nursing as a female-dominated occupation, which dates from the mid-nineteenth century, is intimately connected with the Victorian ideology of what "benefits" a woman. By the twentieth century, this

ideology was codified in the literature on nursing, which claimed:

> Nursing is distinctly women's work. Women are peculiarly fitted for the onerous task of patiently and skillfully caring for the patient in faithful obedience to the physician's orders. Ability to care for the helpless is women's distinctive nature. Nursing is mothering. Grown-up folks when very sick are all babies.[16]

This ideology prevailed until the social and political change of the 1960s. Prior to this time, female social mobility was downplayed because achievement was considered a male rather than a female characteristic.[17] Epstein argues that women are not supposed to acquire valued things independently but rather are to be "vicarious achievers".[18] Women are expected to share in the husbands' achievements and serve on the periphery of their husbands' careers. Similarly, the nurse was expected to function as a surrogate to the physician and to bask in reflected glory when a patient got well. For those women and those nurses who were ambitious, the prevailing view that women are not achievers generates role conflict between the feminine role and the occupational role.

Levinson's concept of role is useful in analyzing this conflict and the dichotomy it presents to the process of professionalization in nursing. She defines a role not as a unitary concept but as a process involving three components related to a person in a given social position:

1. Structurally given demands: norms, expectations, and pressure from others for role behavior.
2. Personal role conception: the individual's personal definition of what someone in his/her social position should think and do.
3. Role behavior: the way a person acts in accord with or in violation of norms and expectations.[19]

Women in nursing occupy a social position that contains conflicting structural role demands between those stemming from the female sex role and

those stemming from a professional role. Their socialization for the role of adult female dictates one set of attributes and dimensions, whereas their socialization for the role of a professional dictates their opposites.

The Status of Women in the Health Care System

Women in the United States are the majority of patients in the health care industry, and at all but the top level, the majority of providers. The system is thus dependent on women for the consumption of products and services and for their work, both paid and unpaid.

As consumers of the services of health care, women are hospitalized more often than men, particularly as they get older. Women receive about 65 percent of all surgical operations; women 15 to 44 years of age experience surgery at about 2.5 times the rate of men the same age. Women consumer more drugs than men, particularly the psychotropics. They are also institutionalized more often than men in mental health institutions and extended care facilities.[20]

As providers, women comprise 80 percent of all health care workers and nearly 100 percent of extra-market caretakers - unpaid workers in the home caring for sick family members. In most instances, if two siblings in a family are employed (male and female) and one of the parents becomes ill, the female sibling is the designated care-taker. Historically, for many women, particularly the unskilled, health care is an available avenue for paid work. The health care industry's dependence on women and women's dependence on the health care industry is a mutual pattern. Although sociological opinion varies as to the causes of this mutual relationship and the desirability of medicine's control of women's bodies, women continue to use the health care system as the principle caretaker for their

physiological and emotional needs. Their willingness to become patients arises from legislative mandates as well as social values. Legislative mandates define who can treat the ill, what is illness, and in many cases, how episodic the illness is. Pregnancy is an example of a medically defined illness. Women, in many instances, take a specific time period from their occupations to have a baby. Legislative mandates determine what salary compensation the individual will receive for her time of employment. Also, medicare and medicaid eligibility determines who is ill, how episodic the illness is, and what financial compensation is to be reimbursed to the individual for the illness.

Parsons defines the "sick" role, it well describes women's position as consumers of health care.

> It is not only that the patient has a need to be helped, but that this need is institutionally categorized, and the nature and implications of this need are socially recognized, and the kind of help, the appropriate general pattern of action is relation to the source of help, are defined. The fact that others than the patient himself often define that he is sick or sick enough for certain measures to be taken, is significant.[21]

Although the sick role applies to men as well as women, women are more likely to adapt the sick role, or to be urged to define themselves as sick, than men are. Women did not learn to look to the male physician and his "science" for medical intervention until after their own skills had been cast aside, and the "side healers" who were mostly women and had practiced these skills, had been silenced.[22]

This segment of the chapter is not intended to examine women's role as consumers of health care in depth but to relate the expanded role of the nurse practitioners as providers of health care, specifically, as providers of women's health care. As it was stated earlier, the history of nursing reflects the history of women in the labor market. The history of health

care is also an integral and interrelated component in the history of nursing.

Women as health care consumers

The growth of the medical profession at the turn of the century and its growing respectability following the Flexner Report of 1910[23] encouraged an increasing number of women to seek medical services. The upper classes, particularly because they could afford their fees, turned to organized medicine. The lower classes continued to rely on themselves and home remedies, midwives, and local healers.

The development of physician-managed health care, government programs providing prenatal care, the advent of third-party payment, and the tremendous growth of the medical complex with its promotion of cures for female symptoms all were factors that contributed to rising rates of female morbidity, and to women turning to the medicalized sector of the health care system in increasing numbers.

In the nineteenth century, particularly, when the "cult of female invalidism" was very much in vogue among middle and upper-class women, femaleness and sickness were synonymous. As Ehrenreich and English point out, the image of women as sickly did not expand to poor women who were forced to labor in sweat shops, factories, mines, and basement kitchens in order to eat. The wealthy woman could be sick at home, and working woman was considered the carrier of disease to others.[24] Women were divided into two compact and easily described groups which uphold the ideology of women as sick.

There have been many explanations for the sex differences in utilization of health care services in the twentieth century. Women are said to report more illnesses than men because it is more culturally

acceptable to do so. Another proposition is that women's social role is more compatible with adopting the sick role. Still another is that women actually are sicker than men because their assigned roles are more stressful.[26,26] Other speculations are that women experience a greater sense of personal failure and use illness to justify this;[27] that women are more anxious[28] and somatize their feelings so the sex differences in rates of illness are the result of mild forms of physical illness which "can be primarily attributed to women confronting more nuturant role demands and generally being in poorer mental health.[29] The "captive population" thesis, which states that women's needs for contraceptives, prepartum and postpartum care, and relief of menopausal symptoms, (all of which women are encouraged to seek medical care), also contributes to women's greater utilization of health services.

Women as health care providers

Women have always worked to provide health care. Although assisting in childbirth was a natural task for women, their role in the health care delivery system in the United States has been limited in this function. When pregnancy, labor, and child birth became designated as an "illness" and no longer as a natural function, the medical profession took control of this area of health care delivery, and midwives were stripped of their functions by regulations and licensing laws.[30]

Women have been surgeons, nurses, public health workers, dentists, herbalists and lay healers. The exact number of women involved in all these occupations in unknown. Many social and economic forces influence women's participation in the medical care system. Contemporary issues of licensure, access to university education, shortage of men in the health care system during eras of national crises of wars and epidemics, church influence on

medical care, stratification of labor and delegation of tasks and privileges, maldistribution of health personnel, and economic motivation all have shaped women's role in the medical labor market. Various types of women practitioners, for example, empirics (apprentices to university-trained physicians) and physicians, midwives, and nurses and registered nurses and licensed practical nurses have competed against each other in struggles for professional recognition and status.[31]

Women as physicians

In spite of early attempts at licensure of physicians, the concept was not firmly established until the 1880s. Although several states had licensure laws by the 1830s, these were soon repealed during the 1840s and the 1850s under the influence of the Popular Health Movement. The Popular Health Movement, formed by a coalition of feminists and working-class activists, sought a redefinition of health care.[32] Various sects within the Popular Health Movement, such as hydropathy, herbalism, and homeopathy, had individual theorists. The movement drew support from the elements in society that were becoming increasingly disenchanted with the physicians' arrogance and noticeable lack of curative success. Members of the Popular Health Movement viewed the body and mind not as separate entities but as a holistic being more than the sum of its parts. Balance of the holistic being had to be achieved for health.[33] Eventually the conflictual theories for practice, ie., hydropathy, herbalism, and homeopathy, contributed to the Popular Health Movement's decline, but several significant changes occurred. One was the formation of Ladies Physiological Reform Societies. These societies offered lectures on general hygiene, sex, diet, contraception, anatomy, and sensible dress (no corsets).[38] The societies' main purpose was to combat growing female invalidism, weakness and

sickliness - the fashion of middle and upper-class women.[34]

The Ladies' Physiological Reform Societies helped to establish female sectarian medical colleges. The efforts to open the health professions to women faced strong opposition from the American Medical Association (AMA). The AMA, formed in 1847 as the professional organization of one sect, the allopaths, maintained a male, white orientation for admission to the profession.[35]

The AMA's opposition was served by the Flexner Report of 1910, which, in establishing standards for medical education, effectively produced the decline of all marginal and proprietary medical schools. Women had been disproportionally concentrated in these schools. Only one school, the Woman's Medical College of Pennsylvania, founded in 1850, remained open for women. Now called the Medical College of Pennsylvania, it admitted its first male medical students in 1970.

By 1881, 470 women were known to have taken medical degrees.[36] Many of these women had been educated at the Women's Medical College of Pennsylvania. Others were educated at the University of Michigan (open to women 1879 - help separate classes for women) and Syracuse University (incorporated 1870 - did not hold separate classes for women). Columbian College in Washington, D.C. (later George Washington University) admitted women in 1882, but 10 years later refused to admit them.[37]

The following decades, from 1930 to 1960, witnessed social and economic forces that were to alter and diminish the medical school slots open for women. As the number of women physicians decreased, the opportunities for marginal health care laborers increased. There was a greater need for the semi-professional, the technicians, nurses, and other health care workers.

As opportunities for women in the general labor market opened beginning in 1900 and continuing to the present, the percentage of female medical students rose from 4 percent to 13 percent. By 1975 and with the use of affirmative action, an estimated 22.2 percent of first-year medical students were women (18 percent of total medical school enrollment) and approximately 11 percent of the graduates were women.[38] In the 1980s, most medical schools have leveled off with about 25 percent to 30 percent of students being women, resulting today in 87.8 percent male physicians and 12.2 percent female.

Today health care work can still be characterized as women's work. From the historical development outlined of nurses and women physicians has come a legacy of underrepresentation of women in the higher echelons of health care delivery and of overrepresentation in the bottom layers. The power in the health care delivery system is concentrated at the top among the approximately half million (usually male) physicians, hospital administrators, medical school educators, health insurance and pharmaceutical company executives.[39]

Women as Nurses

Today's nursing work force is clearly stratified along the lines suggested in the 1880s. Today there are baccalaureate registered nurses (RNS), diploma school RNs, associate program RNs, licensed practical nurses (LPNs) or licensed vocational nurses (LVNs, in California and Texas), and nurses aides, who are usually trained on the job. Nurse practitioners are master's degree RNs with additional specialty training in, for example, pediatrics, women's health, obstetrics, and family health. They have more status than baccalaureate RNs, who in turn have more status than RNs from 2 year programs. At the top of the hierarchy are the nurse-educators and

nurse administrators. The nurse educators' salary is usually one-half to one-fourth of the nurse administrators' salary.

It has been reported that in the Greater New York area, nurse administrators' salary are from $75,000-$200,000. Nurse educators on University faculties are reported to earn from $18,000-$40,000 depending upon University rank, credentials, and length of employment.

The quest for a professional identity has led nursing to push for college degrees for all RNs. Nursing is trying to codify and standardize the theoretical and clinical components of their educational pathways. The end-result of this policy is debatable as the RN is moving away from direct, hands-on care, and patient care tasks are delegated to lower-cost health care providers. Furthermore, if the quest for professionalism succeeds, there will be limited access to nursing careers; the medical profession's elitism and exclusivity will be emulated by nurses. Most of the college-degree granting institutions require Graduate Record Examination scores that are quite high (1000 combined score) and an undergraduate grade point of B to B+ for entrance. Also, the cost for a graduate degree has escalated at most of the private universities, resulting in the unattainability of the degree for most middle-class and minority students.

The Nurse Practitioner and the Contemporary Women's Health Movement

Today women's health activism focuses on issues of qualitative health care and the empathetic organization and delivery of health services to women. In the hierarchial male-dominated health care system, women are the largest segment of the consumer population seeking health care services. The societal revolution of the 1960s brought alternative methods for health care delivery to the fore, and many women began questioning their former

medical compliance. One of the goals of the women's health movement is to attempt a redefinition of what comprises quality care. Other goals raised by the women's health movement are equitable access to health care, an end to class and sex biases in the health system, and the right to quality health care.

The first women's health center was founded in Los Angeles. Similar self-help groups continue to explore issues and problems effecting women and health.[40] Some of the services the clinics offer are routine gynecological care, pregnancy screening, routine primary care with appropriate physician referrals. Most clinics also provide psychological counseling and situational crisis intervention. Programs offered for the community are suicide prevention, substance abuse, help for victims of rape and other violence, and advocacy of occupational health programs. A few clinics such as Somerville Women's Health Project in Massachusetts,[41] and the Femont Women's Clinic in Washington, provide primary health care. Sometimes clinics have a home-birth service.

Women's clinics are in many instances affiliated with universities that offer nurse practitioner graduate programs. Yale University in New Haven, Connecticut, provides pre-natal care, birthing services, and post-partum care by their nurse practitioners', students and faculty. The population served is mainly in the poor minority sections of New Haven. Pace University in Pleasantville, New York, has a practice center endowed by the Robert Wood Johnson Foundation and staffed by nurse practitioners who hold joint appointments as faculty at the university. The population served is the local community, as well as students and faculty.

In these clinics, nurse practitioners are rendering services that women leaders rendered centuries ago. The technology has expanded, but the

conflicts are the same. Issues of licensure, of appropriate task delegation of hierarchy among health providers (nurse/practitioner/physician - nurse practitioner/nurse) of the ownership of knowledge about health care and healing, the costs of health care, the rights of the consumer, and of the need for more women in the higher hierarchy of health care providers all have had their counterparts in the historical sage of women in the medical labor market.

Summary

Patriarchy has been a strong and vital threat in the intricately woven mantle of women in the labor market. Nurses have historically worked in the labor market. Nurses have historically worked in the labor market for low wages, low status, and little if any thought for career mobility. In most instances, nursing was a stop-gap between marriage and motherhood. With the changing societal and political views of the 1960s, there was a change in focus from a surrogate role for the nurse to increased professionalism and prestige. Nursing education moved from the hospital training school into the colleges and universities. Education was viewed by nursing as an instrument for social change. The boundaries of nursing knowledge expanded. The changes of the 1960s reflected in the nursing literature in such terms as "emerging profession," "marginal profession," "semi-profession," "professionalizing occupation," and so on. The literature increasingly discusses the process by which the nurse acquires the identity of a professional in terms of three criteria: specialized education, service orientation, and autonomy. Attributes the nurse may have acquired previously, such as obedience, were deemphasized. Along with the educational change, nursing reflected the women's movement's emphasis on self-awareness. Directed at all levels of nursing, it was aimed at

apprising the nurse of the efficacy of consciousness-raising, not only for herself as a nurse, but also for herself as a woman.

The following chapters will examine the role of one segment in the occupation, the nurse practitioner. This segment of the occupation questions the status quo in nursing and introduces a new paradigm for nurses based on the concept of holistic care for clients of the health care system.

CHAPTER IV

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CHAPTER V

NURSE PRACTITIONERS: THE SOCIAL CONTEXT OF PROFESSIONALIZATION

> . . . in my own studies I passed from the false question "Is this occupation a profession?" to the more fundamental one, "What are the circumstances in which people in an occupation attempt to turn it into a profession, and themselves into professional people?
>
> Everett C. Hughes

Between 1960 and 1970 a gap in the health care system of America became apparent. On one side of the gap was a better educated public receiving impersonal, fragmented service at a high cost; on the other side were a few doctors not always available offering expensive services.[1] Out of this gap arose a new health provider, the nurse practitioner.

Gaps are also now apparent between two health care providers: the nurse practitioner on one side; the physician on the other side. Specifically, the concerns are (1) the continued crises in the health care system, (2) the relationship with the physician and whether the expanded role of the nurse practitioner is that of an independent practitioner or a physician assistant, (3) whether the nurse practitioner is practicing outside the institution where the roadblocks to implementation are minimal,[1] (4) whether the providers are satisfied with their career choice and remain a nurse practitioner.

The purpose of this chapter is to discuss four concerns as issues confronting nurse practitioners and how they have led to professionalization. The focus for each of the issues is: (1) the crisis in the health care system that had a direct relationship to the implementation

of the nurse practitioner role, (2) professional role development of the nurse practitioner, (3) physician/nurse practitioner role conflict and the consequences of this conflict, (4) job satisfaction and mental challenge of the practitioner role as perceived by the nurse practitioner.

(1) Health Care System in Crisis

The early 1960s were turbulent times of tremendous social unrest with growing demands for rights, equality in access to health care, equal opportunity for minorities and accountability for professionals. The consumer demanded increased participation in decision-making in matters of health and illness. The federal government, the consumer and the physicians assumed that biomedical research was paramount to conquering disease and disability. The focus was on disease as a state of non-health rather than prevention and wellness. From these assumptions national concerns for the availability and use of health manpower grew and resulted in the multiplicity of training programs for many members of different types of health care providers, many of whom supported the "medicalization" of health care and its biomedical orientation.[2]

The "medicalization" of health care has evolved into a disease-oriented, capitalistic enterprise that has made physicians dominant and wealthy. It has created high-technology medicine, a specialized system which is in the throes of spiraling inflation and consumer distrust. Most Americans readily admit to dissatisfaction with their own personal care and that of the system.

The statistics of health care in America tell some of the story. Americans average four physician visits a year and 14 percent of the population is hospitalized each year, amounting to more than 230 million days of hospital care for over 29 million people.[3] These figures suggest

the magnitude of the health care industry.

Size itself is a problem. All aspects of the health arena have experienced astronomical growth in the past ten years. The health labor force has more than doubled. At the same time, it has expanded horizontally into hundreds of professions whose services conform to the emphasis on specialization and high technology. Hospitals are the largest part of the system, employing 75 percent of the work force. The amount of money spent on hospital care increased from $50 per person in 1960 to $500 in 1983 due to inflation.[4] Much of this cost relates to the tremendous growth in technology witnessed in the past decade, including sophisticated electronic heart monitors and CAT head and body scanners, as well as the "medicalization" of the individual. Medicalization as defined, is disease care and not health promotion.

Illich argues that rising irreparable damage accompanies expansion and the medicalization of health care produced iatrogenesis.[5] Iatrogenesis can be direct, when pain, sickness, and death result from medical care; or it can be indirect, when health policies reinforce an industrial organization which generates ill health. Illich describes the health care system as a medical technostructure and that in several nations, the public is ready for a review of its health care system. He states "in rich and poor countries the demand for reform of national health care is dominated by demands for equitable access to the wares of the guild, professional expansion and subprofessionalization, and for more truth in the advertising of progress and lay-control of the temple of Tantalus."[6]

Health care in the United States is fragmented and has been described as "chaotic, uncoordinated, overlapping, unplanned, and wasteful of precious personal and financial resources.[7] There is multiplicity of health

care systems (or sub-systems) in the United States. The middle-class, middle America has a private practice physician fee for service system. The poor, inner-city, minority America has local government health care and is faced with an endless stream of health professionals who treat one specific episode of an illness and then are replaced by someone else for the next episode. While the middle-class system of health care is able to establish at least some thread of continuity by the continued presence of a family physician, the poor family is not able to maintain any thread of continuity. When the poor inner-city family's newborn needs its vaccinations, that family goes to the district health center of the health department, not to the private physician. The private physician usually demands an immediate fee for service. When a low-income woman needs a Papanicolau smear for cervical cancer testing or when a teenager from a low income family needs a blood test for syphilis, it is most likely that the local health department will give the tests. One can visit any local health department and community health nurses' department and find poor minority families waiting hours to be seen by the nurse practitioner.

The emergency room of all the inner city hospitals also serve the poor as the entry point to the health care system. The poor obtain much of their ambulatory services in the out-patient clinics of the city/county hospitals. The poor income patient often is cared for in two or three specialty clinics, each of which may handle one particular set of problems but none of which will take responsibility for coordinating all the care the patient is receiving. The long-term care situation of middle income people is generally inadequate, the long-term care of the poor can only be described as terrible.

William Glazier, a professor of community health at the Albert

Einstein College of Medicine, New York City, argues for a community-based system that would address today's needs for health education, maintenance, and management of chronic illness. Comparing the nature of illness today with that in 1900, he argues that the fee-for-service system is incompatible with current needs.[8] Glazier states that the medical system of the United States is able to meet with high efficiency the kind of medical problem that was dominant until about 40 years ago, namely infectious disease. It also deals effectively with episodes of acute illness and with accidents that call for advanced, hospital-based biomedical knowledge and technology. This system, Glazier argues, is much less effective in delivering the kind of care needed today: primary (first-contact) care and the kind of care needed at a time when chronic illnesses predominate. Technology and medical procedures available for coping with the diseases that affect the population have been expanded and improved, but the structure of the system that deploys the technology and resources have tended to remain fixed in a mold determined by medical and social circumstances that are quite different from those that exist today. Glazier's answer to the mismatch of technology and delivery is for medicine to orient itself toward a more interventionist approach. The interventionist approach would have members of the health care delivery system prepared to take the initiative in delivering medical care, rather than leaving the initiative to the patient. The system should perform the functions of: reaching out to people seeking out those who for genetic reasons or because of their work or way of life may have a predisposition to a disease; carrying on health education among those at risk; reaching out to the poor for better nutrition; and maintaining an open health care delivery system focusing on health teaching and health promotion.[9]

The demand in the decades of the sixties and seventies for more personal, accessible, and less expensive primary health care led to the development of "midlevel practitioners." In the 1960s an absolute shortage and maldistribution of physicians in the United States initiated a public outcry for more primary care services. These needs were felt most acutely by rural and inner-city areas.[10] The major causes of this shortage and maldistribution were threefold:

1. The shift in medical education and practice from the general practitioner to the specialist.
2. The tendency of specialists to congregate in the larger towns, and, in the case of major cities, in the suburbs.
3. Increased expectations on the part of the ocnsumer on wellness and health promotion rather than illness and disease.

The nurse practitioner programs developed from this mandate for change for improved service and for an expansion of health and life style programs. Nurses became more skilled and increasingly assumed more and more roles and responsibilities in areas previously considered "medical practice". Even such a simple act as the taking of a patient's blood pressure was once considered a "medical act." As nurses became more skilled and physicians were increasingly consumed by more complex tasks, a wide variety of such tasks were defacto delegated to nurses. Nurses accelerated this process by assuming responsibilities of more complex and varied procedures, such as administration of intravenous medications, diagnosis and management of arrhythmias in coronary care units, and service as triage officers in emergency rooms. The curriculums of the educational institutions for nurses were offering courses in physical assessment, primary nursing, and wellness. The focus was on health promotion and no

longer on a medical model of illness and disease. In public health and occupational health, nurses expanded their skills and practice in the provision of primary medical care services in both rural and urban communities. The role of the midlevel practitioner evolved throughout the nursing profession before and coincidental with the demand for more primary care providers.

In some, the maldistribution of the health work force is a major barrier to the delivery of needed health care. Inequitable access and quality of care are caused partially by the shortage of physicians in rural and inner-city areas and by the increase in specialization and consequent shortage of primary care practitioners. It has been argued for the use of midlevel practitioners as one solution to maldistribution of physicians and the inadequate health care delivered to the low income inner-city family and individual. Today there are about a million registered nurses in the United States, making an average salary of $12,000 yearly. There are 20,000 nurse practitioners and 1,244 masters prepared nurse practitioners in the United States. Organized medicine opposes the use of nurses to intervene in the health care crisis. For example, obstetricians are doctors who deliver babies and nurse mid-wives are nurses who deliver babies. The obstetrician trains seven years, the nurse midwives considerably less, and as a result the obstetricians think that nurse-midwives don't know what they are doing. But at one California hospital, when two nurse midwives came in, the infant mortality dropped from 29.9 to 10.3 per thousand. When the doctors succeeded in getting rid of the nurse-midwives, the rate went up to 32.1 per thousand.[11] Similarly, lab technicians and pathologists often do the same work; so do x-ray technicians and radiologists. Nurse practitioners are running inner city clinics, and prescribing some drugs.

Factors in the Health Care System Contributing to the Utilization of Nurse Practitioners

Nursing in the mid-1980s is involved in the concept of role expansion, a claim for esoteric and identifiable skills specific for nurses and changing physician nurse relationships. The quest is for social recognition and higher status visability in the health care system.

Definitions of these practitioners have varied, but they have come to be known as nurses who have physical assessment and clinical management skills in addition to a solid nursing orientation. They are educated in a standardized graduate program with a strong codification of knowledge relevant for the specific role of expansion. They work in collaboration with the physician in devising treatment and health maintenance plans that have both a medical and nursing component. The newer role frequently involves placing nurses into positions where they have primary contact with patient; hence they may function as the direct and primary resource of those who seek entry into the health care system. The emphasis of the nurse practitioner in primary care is on prevention, not only treatment.

The emphasis of health care service provision in the medical model is on treatment, not prevention. Because insurance programs tend to reimburse medical costs for treatment but not for primary prevention, people tend to wait until they are very sick before they seek medical intervention. In the long run, this of course, results in higher costs in terms of hospitalizations, insurance costs, etc. Insurance or Major Medical will not pay for primary prevention programs, e.g. immunizations, but they will cover patients if they contract the disease. This is not cost-effective in terms of overall health care costs. This wasteful and inefficient emphasis on treatment rather than prevention leads to increased

costs and inflated insurance premiums.

There are other numerous factors influencing the crisis in the health care system, as well as arguments for the utilization of the nurse practitioner. They are most efficiently exemplified in the following:

By the end of 1940, the physician-per-thousand-population rate was less than half of what it was when Flexner wrote his report on the state of medical education (1910), and even today it is substantially less. Consequently, all this money vastly increased the earnings of doctors. From 1970 to 1977, the consumer price index for doctors' fees nearly tripled. Each citizen spent, on the average $17.52 on doctor bills in 1950., $30.57 in 1960, and $145.84 in 1977. Between 1960 and 1976, the average income of doctors more than doubled.[12] More and more doctors coming into practice were choosing specialties over general practice and the cities over small towns and rural areas, particularly because they are better paid. In 1965, 22 percent of American doctors were in general practice; in 1975, 12 percent. Today there are about 350,000 doctors averaging $100,000 a year, which makes them the highest paid occupational group in the country.[13]

Poverty has an effect on the crisis of the health care system. Thirty-four million people in the U.S. fall below poverty guidelines. Poverty increases illness and premature death due to stressful life style, inadequate nutrition, increased exposure to accident, crime and illness cycle. Poor families are twice as sick as the rest of the population; spent twice as many days ill. There is also a higher rate of heart disease, cirrhosis, homicide, and crime among low-income groups.

The life style of Americans, which includes overnutrition, increased alcohol consumption, cigarette smoking and sedentary activities, leads to the development of chronic conditions which are today's major health

problems: cancer, coronary disease, diabetes, degenerative joint disease and mental illness. These people become clients in the health care system. In addition, the profit motive is inherent in medical providers and the institutions which lobby for them. For example, the AMA lobbies to keep costs up for physicians, the AHA resists any government attempt to contain costs; it insists on voluntary efforts or self-regulation.[14]

All of these factors which cause health costs to rise have an impact on our own expectations and utilization of the health care system. Because there is no definitive health policy in this country and there constantly arises the debate of whether access to health care is a right or a privilege, it is assumed that the present health care crisis in costs will continue. The issues in the health care system raise the controversial question for the consumer, i.e., how we can make competence, rather than professional status, the basis for determining who should treat a patient, and for what fee.

(2) Nurse Practitioner: Professional Role Development

The assumption about the need for additional manpower was not the only impetus for the introduction of the nurse practitioner concept. The shortage of the physicians involved in primary care did exacerbate the need in the health care system for additional paraprofessionals to meet the need for primary care providers. Early in the 1960s, the American Medical Association proposed the role of the physician assistant to nursing. Nurses reacted strongly against these proposals, cognizant of the fact that they would once again take on the role of the physician extender. As a consequence, nurses themselves initiated the nurse practitioner role. This individual would take on the curing and caring aspects of health care, with strong emphasis on physical assessment, diagnosis, and treatment of the

patient.

The emergence of eighteen years ago of the practitioner was lauded as a possible solution to economic, political and personnel problems in the health care delivery system. Extensive literature exists attesting to the nurse practitioners' ability to function successfully as a primary care giver. However, some physicians, health care providers and nurse themselves have been skeptical about the role and its feasibility, acceptability, and ultimate contributions to the provision of health care. The fear appears to be the substitution of one provider (nurse practitioner) for another (physician) in primary health care.

The nurse specialty of primary care provider has developed during the 1970s and 1980s most fully in defining a model for care, the provider process and patient outcomes. Reforms in health care will not come simply by changing bodies. Changes must include invention of new forms of care which can be tested for their improvement over existing ones. The agent of care is but one consideration. Specialization may be one appropriate response for nurse practitioners to take.

Precedents in the Nurse Practitioner Movement. The nurse practitioner movement started out as an opportunity to test an expanded scope of practice for professional nurses in the care of well children in ambulatory settings, traditionally a major concern and responsibility of the public health nurse.

At this same time, the field of nursing was undergoing many other changes which included:

- graduate education in nursing was redirecting its focus from functional roles of teaching and administration to clinical specialty majors.

- nursing programs were moving out of the hospitals and into the academic setting.
- nurses began to have input on utilization review committees of hospitals, with an emphasis on improving the quality of health care and reducing costs.
- nursing doctorates emerged.
- nursing research aimed towards an examination of the delivery of health care services to improve nursing care of patients.

This change in the role of the nurse occurred in the context of a physician manpower shortage which provided opportunities for nurses to experiment with new clinical specialties.

The first nurse practitioner program emphasized pediatrics and was initiated in 1965 at the University of Colorado. According to the program orchestrators, Ford and Silver, the ideal nursing candidate was one who held a master's degree in public health nursing.[15]

The social times of the 1960s were ripe for innovations in health care provision and social services. People were demanding their rights to good health care, institutions were under pressure to be responsive to society, health care personnel were relatively scarce and humanistic values were in vogue.

Ford and Silver were both from nursing academia. They started the program at Colorado in 1965 as a demonstration project in a continuing education format of 2 academic semesters, 4 months of clinical experience at a medical center, 4-5 months community field work and 1 year of practicum as a nurse practitioner. Funds for the program came from private foundations and later from the federal government. The first title for the graduates was "pediatric public health nurse practitioner" which was later

shortened to Pediatric Nurse Practitioner for simplicity sake.[16]

Ford describes resistance to the concept and training of nurse practitioners as coming from nursing colleagues, pediatric nursing faculty and federal health agencies. However, there was much support that came from national health visionaries in both nursing and medicine. They developed plans for promoting the concept via publication in nursing and medical journals and general medial exposure. Research studies were undertaken to collect data, establish a data base and evaluate the nurse practitioners in terms of preparation, performance, development and acceptance by patients, physicians and other nurses and agencies.[17] From this point on the field expanded from pediatrics to include specialities in family nurse practitioners, adult, school, obstetrics, geriatric and perinatal nurse practitioners.

Much has been written, studied and documented on the changed role of the nurse practitioner. Edmunds sees the field as progressing through 3 developmental stages:

1963-69: Primary stage - included communication, planning and implementation of new program.

1970-74: Role definition and legitimization.

1975-present: Role consolidation and maturation.[18]

Le Roy further states that:

> .....Findings indicate that where nps are employed, more patient education, counseling, home care, other health promotional activities, and a greater range of services are available to patients; they assume roles primarily concerned with health maintenance, health assessment, and the management of minor acute illnesses and stable chronic condi- tions; they may function as part of a health care team to implement or coordinate all health action for patients on the basis of a continuing nurse-patient relationship; they can assume responsibility for a significant portion of the patient care load; and, they spend about 50% more time in clinical activities and 50% less time in clerical/ routine administration tasks than the traditional nurse.[19]

Major barriers to the profession include reimbursement, legal constraints, little educational support and underuse in practice settings. Complicating the issue is the predicted glut of physicians in the market by 1990 leading to increased competition in the health care industry, limited federal support for health services, education and research, and funding for clinics and health programs operating in underserved areas. Barriers may also be imposed by professional groups feeling threatened by the role of the nurse practitioner, from physicians, to physician assistants to the nursing profession itself.

In reference to the issues raised by Aiken, the central issues seem to be "will the nurse practitioner survive?" She is most concerned with the soon to be surplus of physicians in the market. She argues that those groups of nurse practitioners will survive who (1) provide services to the structurally underserved (ie., those persons physicians are unwilling or unable to serve); and (2) develop truly complementary practices in collaboration with those physicians who are primarily concerned with their patients.[20]

(3) Physician/Nurse Practitioner Role Conflict

Historically, medicine and nursing have been recognized as the dominant members of the basic health team. Sociologists have documented the hierarchial status system in the medical establishment and the one most acutely aware of the status disparity is the nurse. The nursing profession is challenging physicians for a higher rung in the status hierarchy, for a collaborative role with the physician rather than the surrogate role and increased market control in the health care system.

There are some interdisciplinary issues of territoriality critical to the physician/nurse relationship, i.e., discrepancies between the

socialization process of physicians and nurses in their educational environments and the question of responsibility for the patient. Interdisciplinary conflict is also indicated by the lack of social mobility for nurses.

The Socialization Process of Nurses. The socialization process, which begins very early in nursing students' educational experience, has served to stifle the initiative, creativity and academic potential of the human resources of the profession. A comparison of the products of medical education and nursing education is instructive. First, for example, there is John H. Knowles, M.D.'s description of a medical graduate:

> At the end of four years, he is a highly individualistic person, cloaked with the charismatic roles of the profession, trained to take immediate action with the individual patient and to expect immediate rewards with his knowledge firmly grounded in science.[21]

Second, Riba de Tornay (1971) describes the nursing education process:

> We have socialized nursing students to the submissive role. We have helped students to be tactful and diplomatic to the point of obscuring their collaborative role. We have so filled nursing students with the fear of making a mistake that they are low risk takers. Along with fostering this fear of making mistakes, we socialize our students to depend on physicians and to be reluctant to accept responsibility and accountability for their own actions.[22]

Many authors have recognized the implication of this socialization process on the nurse. The nurse educated little more than a decade ago lives not only with a sense of dependence and subservience on the physician, but was taught the act of communicating recommendations to the physician in such a way as to disguise the fact that she was actually contributing something intelligent to the management of patient care. Indeed, she was a participant in the too familiar doctor/nurse game described by Stein.[23]

The formal education process that has been traditional to nursing since Florence Nightingale has impeded the profession. One can draw a comparison between medical education and nursing education. The academic rigors, demanding scholarship, and scientific inquiry that have typified post-Flexner medical education were absent from nursing education. It has been most detrimental to nursing to have an educational process that focuses on learning how to do rather than learning how to know. To the extent that the nursing education process is technique oriented, hospital based, and of relatively short duration, the profession will be hampered in its bid for increased recognition. The wide range in educational background (unlike the physician), occupational commitment, and skill level represented by approximately 1.5 million "nurses" is largely responsible for the lack of consensus on professionalization for nurses.

Occupational Territoriality: An Introduction. Historically, the concept of health care in America was synonymous with medical care. Legally, the Medical Practice Act gave physicians control of the domain of health care. Gradually other professions claimed portions of health care as their domain. Simultaneously, nurses began to expand their role to encompass functions traditionally performed by physicians. The rise of the physician's assistants stimulated the need for clarification of the role of nursing in its identify, accountability, and scope of practice. Boundary demarcation as achieved by the nursing profession through its professional associations, legislation, and education have been influential in changing the traditional boundaries between the nursing and medical profession.

Some behavioral scientists have borrowed ideas of territoriality from animal behavior and have adapted this concept to human behavior. Ardrey, one of the major authorities in this field has proposed that humans, like

other animals, have an inherent need to acquire and defend space. Ardrey also extends the idea of territory to a human space-time continuum which an individual or a cohesive group defends as an exclusive preserve. He viewed motivation for territory as psychological, not physiological, claiming that it arises from twin needs for security and stimulation and that it is satisfied by the territorial heartland and the territorial periphery.[24] He adds a third need called identify-which-territory-satisfied; that is, identification with a unique fragment of something larger and more permanent than the individual per se, a place whether social or geographical which belongs to that individual alone. Identity, stimulation, and security are seen by Ardrey as opposites to anonymity, boredom and anxiety. A few years later, Altman (1970) and Joiner also recognized that territoriality provided the individual with security and identity.[25]

The anthropoligist Edward T. Hall describes territoriality as a basic evolutionary instinctual behavioral system characteristic of living organisms, including humans. Hall sees territoriality as a "primary message system which is a nonlinguistic form of the communication process." According to Hall, territoriality meshes with cultural concepts in many different ways. Status, for example, is indicated by the amount of space, type of space or territoriality possessed.[26] In humans, territoriality becomes highly elaborated, as well as very greatly differentiated from culture to culture.

Since ideas of territoriality are helpful in understanding human behavior, these ideas can be further extended to encompass the behavior of groups within a profession.According to Hediger "in order to occupy and defend a territory, or circumscribed region, it is necessary to render it recognizable by marking its borders."[27] Professional territoriality, then,

can be conceptualized as an area of work in which boundaries have been set through jurisdictional limitations and educational control by the profession and the professional association. As professions have evolved, they have set up mechanisms for the establishment of boundaries and methods of protection of this territory from invasion by others outside their profession. Boundary demarcation, or professional monopoly has been achieved in three ways: professional associations, legislation, and education. The analoguous territorial components of the professional taken together are self-regulation, licensure, and areas of authorized practice.

Likewise, the professions have certain characteristics, one or more of which are frequently discussed by many authors including the following: autonomy, altruism, colleague review, accountability, belief in public service, identity, body of knowledge, and belief in self-regulation.[28]

Another characteristic, conflict, also has appeared important in the study of professional territoriality. Professions experience a definite sense of conflict in the defense of their boundaries from other occupations, in restraining the unqualified (by the profession's standards) from areas of authorized practice, and in changing the territoriality through legislature. Autonomy, accountability, and identity have been identified as specific characteristics of professional territoriality. Autonomy is seen as self-regulation by professional associations and by the individual; accountability has roots in licensure through legislation; and identity is developed within areas of authorized practice as socialization occurs during the educational process.

In his study of evolution of professions, Carr-Saunders observed that as soon as a profession emerges, the practitioners are moved by recognition of common interests to form a professional association and mutually

guarantee competence of qualified members as well as their honor. In his view another motive leading to formation of a professional association is the desire to obtain proper recognition of its status in the larger society and a rise in the levels of remuneration.[29] That the American Medical Association was established in 1847 and the American Nurses' Association was founded in 1911 proves to be most significant.

Analysis of Conflict. Historically, the behavior pattern of the physician has been one of dominance and authoritarianism toward the nurse. The physician has the opportunity to function independently, the nurses were freely expendable, and functioned under the orders of the physician. The physician has little difficulty asking for advice from other physicians, but the thought of openly consulting a nurse seems incongrous. Kalish states, "as a partial explanation for this phenomenon, several writers attribute this reluctance to the fact that they are not completely independent and totally in control of all health care situations."[30] This high degree of individualism and desire for independence among many physicians seems to preclude or limit their capacity for being integrated into multidisciplinary teams for developing interdependent relationships with other health care workers.

Physicians view themselves as omnipotent. This feeling of omnipotence appears in the early socialization process of the medical student in preparation for the world in which he will be confronted with heavy and awesome responsibilities. The nurse, on the other hand, has assumed the behavior of deference to the physician. She has fulfilled a role of deference to the physician and other authority figures. The physician's self-concept of omnipotence is also found in the highly authoritarian physician/patient relationship. Most physicians dominate patients and

exercise a potent and unusual authority over them. Parsons describes and defines the sick role as helplessness, technical imcompetence, and emotional involvement.[31] He further elaborates on the role of the physician as a pattern of affective neutrality, functional specificity and universalism. These elements or achieved characteristics further add to the aura of omnipotence and beyond reproach from the layman as well as other health care providers. Patients and nurses view the physician as someone who is endowed with almost mystical healing powers. It is within the past decade, that consumers have questioned this authority and requested a second opinion.

Let us explore this behavioral characteristic of deference. Why do nurses exhibit deference? A number of factors contribute to the primarily autocratic relationship. One of the reasons is that most physicians are male and most nurses are female (98 percent female nurses). Men, and thus physicians, in Western societies are expected to be dominant and women exhibit deference.

Another contributing factor is due to the level of education of the nurse and physician. Until 1960, 87 percent of nursing education was in the hospital diploma schools with no institution of higher learning affiliation. Unlike physicians, who mandated the highest level of education for the practice of medicine and for the medical researcher, nurses have only recently begun to see the value of higher education but still maintain and accredit five different career paths for licensure. The educational career gap has severly hindered the development of mutual respect.

Nurses exhibit deference because as a group they come from lower socioeconomic class than physicians. Historically, the ranks of nurses in the large industrial cities were made up of daughters of immigrants. The

young women could receive an inexpensive "training" in one of the many religious hospitals in the inner cities. Forty years ago the physician earned $4,695 and the average nurse earned $1,220 yearly. Physicians capitalized on the skyrocketing demand for health care by indirectly limiting the supply of doctors under the guise of standards and today the salaries of physicians are from sixty to one hundred thousand dollars, the average income for nurses being $15,000.[32]

Fear of territorial overlapping and usurpation of responsibility between medicine and nursing is large. The rise of the nurse practitioner has been especially alarming to physicians who fear that their responsibility will be usurped. The American Academy of Pediatrics, originally subscribed to an AAP-ANA liaison committee statement that pediatric nurse practitioners should be able to function both independently and cooperatively with pediatricians and that the nursing profession would be in charge of training and certification. Thinking about this further, the AAP, apparently fearing too much independent action and competition for patients by nursing, decided to withdraw its support and develop its own certification test moving away from collaboration.[33]

(4) The Concept of Job Satisfaction and Mental Challenge

Earlier in this study, it was postulated that standardization and codification of professional knowledge is the basis on which a profession as a "commodity" can be distinct and recognizable to a potential market for its services.[34] Historically, from a sociological standpoint of professions, nursing represented a fragmented occupation with diverse and confusing career paths, few mental challenges, low occupational satisfactions, and a technocrat orientation to work and occupations. Based on these assumptions, Hypotheses I, II and III focused on job

satisfactions, mental challenge and strengths and weaknesses in the practice setting. This section will address these characteristic predictors for professionalization.

Historical Overview. While systematic attempts to study the nature and causes of job satisfaction as such did not begin until the 1930s, the important role played by a worker's mental challenge and attitude toward the job situation was recognized long before.[35] Taylor, for example, recognized attitude and mental challenge or in his words "mental revolution" in 1912.

> . . . it is not a new scheme of paying men . . . it is not time study . . . it is not motion study . . . in its essence, scientific management involves a complete mental revolution on the part of the working man engaged in any particular establishment or industry . . .
>
> The great revolution that takes place in the mental attitude of the two parties under scientific management (the worker and management.)*[36]

By "attitude" Taylor meant much more than just feelings; he meant the worker's philosophy concerning cooperation and satisfaction with management and the workers own view of their own self-interest.[37] Taylor implicitly assumed that a worker who accepted the scientific management philosophy and who received the highest possible earning with the least amount of fatigue would be satisfied and productive.

In 1935 Happock published the first intensive study of job satisfaction. He used samples which included a correlation study. The study examined employed adults in one small town who held varied jobs and compared them to 500 schoolteachers from several dozen communities. Happock's orientation was not toward any particular management philosophy;

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*The italics are mine.

rather his results and interpretations emphasized the multiplicity of factors that could affect job satisfaction, including both factors that had been studied previously (fatigue, monotony, working conditions, supervision) and those which were only to be emphasized later (achievement).[38]

The Hawthorne studies which Mayo and his colleagues initiated in the late 1920s would shape the trend of research in job satisfaction for the next two decades and produce leaders in the study of industrial sociology.[39] The Hawthorne studies began as a study of the effects of such factors as rest pauses and incentives on productivity. But the emphasis soon shifted to the study of attitudes when the employees failed to react in a mechanistic manner to these changes. In short, the Hawthorne researchers discovered what Taylor had observed decades before: that workers had minds, and that the appraisals they make of the work situation affect their reaction to it.[40]

Research stimulated by the needs of the arm forced in World War II, was the "Human Relations" movement. The Human Relations movement signaled a new trend which suggested that real satisfaction with the job could only be provided by allowing individuals enough responsibility and discretion to enable them to grow mentally.[41] The method of improving employee morale and performance through redesign of the work itself has gained rapidly in popularity in the last decade.

Job Satisfaction of Nurse Practitioners. For the purpose of this dissertation job satisfaction may be defined as a pleasurable or positive emotional state resulting from the appraisal on one's job or job experiences. Locke states: "Job satisfaction results from the perception that one's job fulfills or allows the fulfillment of one's important job

values, providing and to the degree that those values are congruent with one's needs."[42] It can be argued that it is not necessarily what a man needs but what he values most strongly that dominates his thoughts and actions. The Human Relation movement initiated the potential for personal growth, mental challenge and humanistic values as integral components of man and his work. Combining the defensible aspects of the theories discussed, we can expand the definition of job satisfaction to include mental challenge resulting in mental growth made possible mainly by the nature of the work itself.[43] An individual's perception of a profession, as measured by his job satisfaction and opportunity for mental challenge, may have important effects relative to his behavior in the profession and the further development of the profession itself.

Bullough compared the job satisfaction of nurse practitioners to that of registered nurses and found that nurse practitioners reported greater intrinsic job satisfaction than non-nurse practitioners. The nurse practitioners cited increased creativity, greater use of skills, and more responsibility than did the traditional nurses. The nurse practitioners perceived the opportunities for mental challenge in their choice of a career.[44]

Dachelet and Sullivan (1979) cite the importance of nurse practitioner job satisfaction to the greater health care system. They point out that "as nurse practitioners realize greater job satisfaction, they are less likely to drop out of the work force due to job dissatisfaction, frustration and lack of a sense of independence and responsibility in their work."[45]

Sultz in his longitudinal study of nurse practitioners, reported that two-thirds of the nurse practitioners who had graduated from certificate programs and one-half of the nurse practitioners who had graduated from

master's programs were very satisfied in the role of nurse practitioner.[46] Six percent of the total group of 1101, or 61 nurse practitioners, were dissatisfied in the role of nurse practitioner. They cited administrative climate, pay and benefits, and time spent on non-professional tasks as reasons for their dissatisfaction. Prior nursing preparation and the length of the educational program attended proved to have no bearing on employer satisfaction.

Zammuto, et al explored the effect of clinical setting on utilization and satisfaction of nurse practitioners. They found a significantly greater proportion of nurse practitioners left settings which were slowest for formalize the role of nurse practitioners. Large institutions with well-developed administrative systems were better able to formalize the role, thereby promoting implementation of nurse practitioners.[47]

Sullivan et al, on the other hand, found that nurse practitioners working in hospitals faced more problems of acceptance from providers than did nurse practitioners in other settings. The authors also found significantly more resistance from other providers in the practice when the nurse practitioner was not the first practitioner to work in that practice setting.[48]

The job satisfaction of nurses in traditional roles has been repeatedly measured, but there are few studies which address the job satisfaction of nurse practitioners. Those few studies compare nurse practitioners to nurses in traditional roles or discuss the impact of role adjustment, barriers to practice and personal characteristics of the practitioner in relation to job satisfaction. To date, no literature is available which examines either the relationship between the length of time in practice and job satisfaction, or between collaborative practice and job

satisfaction among nurse practitioners.

Summary and Conclusions

Eighteen years have elapsed since the first nurse practitioner program began in the United States (1967). In this period the nurse practitioner group has developed training programs, increased numbers, found employment in a variety of settings, achieved acceptance by patients and health providers, established professional groups, and moved toward achieving an acceptable legal status. Nurse practitioners are the only members of the occupation of nursing who have standardized their knowledge and codified their clinical skills. While nurses in general are struggling for unification and professionalization, the nurse practitioner movement has disengaged from the occupation and implemented a new paradigm of the care and cure model. They have standardized their curriculum, have a credentialling mechanism for members, and standardized licensure for practice.

Medical and nursing literature written early in the nurse practitioner movement emphasize the role conflict between nurses who assume practitioner responsibilities and the physicians with whom they work. The familiar sex role stereotype and nurse/physician dichotomies of care versus cure, subordinate versus superordinate, and compliance versus authoritarianism are underscored as obstacles to the nurse's willingness to assume more independent function and the physician's willingness to grant more responsibility to the nurse. These stereotypes are acknowledged as especially critical in determining the way in which the nurse practitioner is able to function. The tendency of physicians to assign traditional nursing activities (teaching, supporting, and counseling patients) to nurse practitioners rather than more traditional medical responsibilities (physical assessment, management of common illnesses) has been documented in the literature. It

has been suggested that physician receptivity to the nurse practitioner is less than that to the physician assistant because the nurse practitioner role is seen by physicians as role-threatening rather than role-elevating.

The issues of how the nurse practitioner group identifies with and relates to nursing as a whole has been of concern since the beginning of the nurse practitioner movement. One concern is related to the potential identification of nurse practitioners with medicine rather than with nursing. Some nurses fear that nurse practitioners will practice medicine while including their traditional nursing skills, thereby performing only an expanded set of delegated medical tasks. Research does not support a trend toward exclusive identity with the practice of medicine. More than one third of the nurse practitioners queried in one study saw themselves as a bridge between nursing and medicine, practicing aspects of both professions.[49] These studies hypothesize that what actually may be occurring is a natural process of social change within an occupation whereby new segments arise from within the group and have an impact on the care group. Bucher and Strauss indicate that the assumption that there is a relative homogeneity within a professional group is contradicted by the multiplicity of segments within it, each with an indepentent identity.[50] The nurse practitioner group may simply represent a segment in nursing striving to assert an individual or additional identity within nursing - perhaps an identity of putting aside the stereotyped role of nursing as a subordinate to medicine. The nurse practitioner movement has made a contribution to our knowledge and understanding of the nature of job satisfaction. This contribution stems from the practitioners' stress on the importance of psychological growth as a precondition of job satisfaction and their nurse practitioner showing that such growth stems from the work itself.

TABLE 5-1

CURRICULUM OUTLINE FOR PROGRAM

NURSE PRACTITIONER

University of Illinois - Family Nurse Practitioner

Epidemiology

Biostatistics

Community Assessment Methods and Practicum

Advanced Physiology

Primary Care Health Assessment

Lecture and Practicum

Primary Health Care - Child Lecture and Practicum

Primary Health Care - Adult Lecture and Practicum

Family Counseling

Source: University of Illinois
College of Nursing
Requirements for Family Nurse Practitioner - 1978

CHAPTER V

Footnotes

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CHAPTER VI

SURVEY RESULTS: STATISTICAL ANALYSES RELEVANT TO HYPOTHESES

Subjects

A survey of 176 nurse practitioners was conducted and analyzed. Table 6-1 depicts the various settings in which the nurses were employed. As can be seen, 34 percent of the nurses worked in a hospital setting while 66 percent worked in less traditional settings. Most of the respondents were recent graduates of a generic master's program in nursing. Approximately 60 percent of the respondents graduated between 1980-1984 while 36.4 percent graduated between 1975-1979. Only 3.5 percent graduated in 1974 or prior to 1974. Table 6-2 presents data on the age distribution of respondents. As can be seen, their age ranged from 21 to over 50 with a median age category of 31-35 years. Ninety-six percent of the respondents were female.

Scale Derivation

Two scale scores were derived from the survey: an occupational satisfaction score and a mental challenge of occupation score. The satisfaction score was calculated by adding together responses on question 2, question 3, and question 7e. The mental challenge score was calculated by adding together responses on question 1a, question 1b, question 1c, question 7f, question 7g, question 7h, question 7i, and question 7j.

The internal consistency of these two scales was assessed by calculating coefficient alpha. Coefficient alpha sets an upper limit to the

reliability of scales. When it is low, either the scale is too short or the items have very little in common. In this case, no other estimates of reliability are necessary as they will prove to be even lower than alpha. When coefficient alpha is high it indicates that the items have something in common and other measures of reliability can be potentially high. Coefficient alpha is a function of the average correlation among items in the scale and the number of items.[1]

Alpha was .73 and .66 for the satisfaction scale and mental challenge scale, respectively. These coefficients suggest that the scales have a moderate level of internal consistency. Total scores based on these scales should reflect the underlying dimensions of satisfaction and mental challenge.

Total scores in the mental challenge scale could range from 8 to 37. The average score on the scale was 33.02 with a standard deviation of 3.46. Clearly, many nurses felt their jobs possessed mental challenge. Total scores on the satisfaction scale could range from 3 to 13. The average score on the scale was 10.88 with a standard deviation of 2.07. In an absolute sense, it seems that most nurses were satisfied with their work. In fact, 24 percent of the nurses received the maximum score of 13 on the scale.

Hypothesis I: A survey of nurse practitioners will indicate that nurses employed in hospitals are less satisfied with their occupation than nurses employed in less traditional work settings.

An independent t-test comparing the mean score of these two groups on the satisfaction scale was calculated to determine if this hypothesis was supported. The hypothesis was not supported. The mean satisfaction of

nurses in a hospital setting was 10.78 while the mean of those working in non-traditional settings was 10.93 ($t = .45$, $df = 174$; $p > .05$).

In addition, there was no significant difference in the variability of satisfaction scores from these groups. The standard deviation was 2.00 and 2.11 for nurses in hospital settings and and non-traditional settings, respectively ($F - 1.11$; $p > .05$). Given the very high level of satisfaction present in both groups, this outcome is not surprising. It is difficult to find differences in satisfaction when so many respondents are satisfied.

Occupational Satisfaction and Age of the Nurse Practitioner

To further examine the data on occupational satisfaction, the nurse practitioners were classified according to age. Table 6-1 presents the age representation of the respondents from this survey. The specific purpose for selecting age as an indicator for occupational satisfaction in nursing can be documented in the literature; the largest attrition rate is in the first year after graduation. [2,3] Authors focusing on new graduates' attrition rate have looked at the emotional and attitudenal conflicts correlating with leaving; those investigating attrition of licensed practitioners have focused on the conflicts between the bureaucratic and the professional ideologies - or how the system drives practitioners first hostile and then out of the field.

One problem mentioned by many of these authors[4,5,6] but not studied as a core dynamic is nursing's adult socialization into the profession. The authoritarian tradition that nursing has historically followed and the effect this has had on the occupational satisfaction of the new graduates in the occupation needs to be addressed. In this section, I explore the relationship between age and the satisfaction in the profession.

TABLE 6-1

WORK SETTING OF NURSE PRACTITIONERS RESPONDING TO SURVEY

Setting	Frequency	Percentage
Hospital	13	7.4
Hospital Clinic	30	17.0
Hospital Emergency Department	17	9.7
Community Health Department	26	14.8
HMO	42	23.9
Solo Medical Practice	9	5.1
Collaborative Practice	22	12.5
Other	17	9.7

TABLE 6-2

AGE DISTRIBUTION OF NURSE PRACTITIONERS RESPONDING TO SURVEY

Age Category	Frequency	Percentage
21-25 Years	4	2.3
26-30 Years	51	29.0
31-35 Years	64	36.0
36-40 Years	35	19.9
41-45 Years	18	10.2
46-50 Years	1	.6
Over 50 Years	3	1.7

Question 2 in the Questionnnaire, Generic Master's Program Questionnaire (Appendix B) stated:

> Taking all aspects in consideration, how satisfied are you with your occupation?

Category (1) very satisfied, and category (4) very dissatisfied were examined to determine the relationship between occupational satisfaction and age of the respondents. In response to question 2, concerning overall job satisfaction, 37 nurse practitioners 30 years old and under responded very satisfied, while 15 responded very dissatisfied. Of those respondents over 30 years of age, 67 responded very satisfied and 4 responded very dissatisfied (Table 6-3 n = 123).

To determine the relationship between age of the respondents and job satisfaction, a Chi square analysis of nurse practitioners' age and occupation satisfaction was used to ascertain if age of the respondents was more predictive of variance in occupational satisfaction than the more global category of traditional and non-traditional practice setting.

TABLE 6-3

CHI SQUARE ANALYSIS OF NURSE PRACTITIONER UNDER 30 YEARS OLD AND OVER 31 YEARS OLD AND OCCUPATIONAL SATISFACTION AND DISSATISFACTION

	Very Satisfied	Very Dissatisfied	Total
Age < 30	37	15	52
Age > 31	67	4	71
	104	19	n=123

Note: 7.32 with 2d.f that is significant at the .05 level

A Chi-square analysis of nurse practitioners' age and occupational satisfaction (Table 6-3) showed a relationship between the two variables at a .05 level. The Chi-square statistic was 7.32 which is significant at the .05 level with 2d.f. There is a relationship between occupational satisfaction and the nurse practitioner's age with the nurse practitioner over 31 years old significantly more satisfied in their occupation than the younger practitioner.

The researcher then performed a Z-test for difference of means, comparing the mean satisfaction scores for nurse practitioners over 31 years old and nurse practitioners under 30 years old

$H_a - M_1 \quad M_2$

$H_0 - M_1 = M_2$ where M_1 is the mean satisfaction score of nurse practitioners over 31 years old

M_2 is the mean satisfaction score of nurse practitioners under 30 years old

the Z statistic was calculated at 2.0981, which is significant at the .05 level. (At the .05 level, H_0 with no significant difference would be rejected if $Z > 1.643$). This further supports the data that nurse practitioners over 31 years old are more satisfied with their occupation than nurse practitioners under 30 years old. While the data did not determine a relationship between nurse practitioners in traditional practice settings and nurse practitioners in non-traditional practice settings and occupational satisfaction, the data did support a significant relationships between occupational satisfaction and age. On this point, it is important to note that age of the respondent may lead to greater job satisfaction and one of the consequences of age is that the potential is greater for both satisfaction and dissatisfaction.

The data in the dissertation support the relationship between job satisfaction and age, and notably sustain the findings in the Cronin-Subbs study of 30 new graduate nurses. The new graduate nurses in that study stated that they had been given too much responsibility too soon and felt overwhelmed.[7] Kramer, who has done extensive work with the new graduate, also reports job dissatisfaction to be related to "reality shock" experienced by the new graduate in the practice setting.[8] On the other hand, it may be that those who are dissatisfied with nursing drop out of the occupation early in their career.

Hypothesis II: A survey of nurse practitioners will indicate that occupational satisfaction is positively correlated with nurses' perception of the mental challenge of their position.

A Pearson Product-Moment correlation coefficient was calculated between total scores on the satisfaction scale and the mental challenge scale to determine if this hypothesis was supported. Moderate support for the hypothesis was obtained. The correlation between the two scores was .374 ($p > .001$).

While the cause of this relationship cannot be assured, it seems unlikely that satisfaction could cause a perception of mental challenge where none existed. It seems more likely that mental challenge has a bearing on nurse satisfaction. Moreover, these results conform to other findings regarding the relationship between mental challenge and occupational satisfaction.

Interestingly, nurses working in hospital settings did not feel their jobs possessed less mental challenge than nurses working in non-traditional settings. The mean for nurses in hospital settings was 33.35 while the mean

for nurses in non-traditional settings was 32.85. An independent t-test comparing these scores showed no significant difference between the groups ($t = .91$, $df = 174$; $p > .05$). (See Table 6-4).

In addition, there was no significant difference in the variability of mental challenge scores obtained from the groups. The standard deviation was 3.01 and 3.67 for nurses in hospital settings and non-traditional settings, respectively ($F = 1.48$; $p > .05$).

While mental challenge is not related to the traditional or non-traditional nature of work settings in nursing, it may be distributed as a function of specific practice settings.

This may account for the lack of support for hypothesis 1. If mental challenge fosters satisfaction and mental challenge is not significantly different in hospital and non-traditional settings, a theoretical rationale for a difference in the satisfaction uncovered in the two settings may not exist. Further research on the satisfaction of nurses as it relates to mental challenge should focus on specific factors in the practice setting.

Mental Challenge and Occupational Satisfaction in Specific Practice Settings

The data were examined to explore the micro level of the interactive relation between occupational satisfaction and nurse practitioners' perception of mental challenge in their position in different practice settings. Seven Pearson correlations were computed to determine the relationship between occupational satisfaction in the specific practice settings. As indicated in Table 6-4, strong significance for mental challenge was obtained in the specific setting, collaborative practice, and needs to be addressed (0.842 $p > 0.974$).

TABLE 6-4

PEARSON CORRELATION OF MENTAL CHALLENGE AND OCCUPATIONAL SATISFACTION FOR SPECIFIC PRACTICE SETTINGS

	Mean and S.D. Mental Challenge	Mean and S.D. Occupational Satisfaction	Variation	Significance
H.	33.9231	10.0000		
n = 13	2.5968	2.7689	5.4167	0.7533
			p	0.003
H.C.	33.333	10.4828		
n = 30	2.9517	1.7242	3.1490	0.6081
			p	0.010
H.E.R.	32.9412	11.8824	1.8051	
n = 17	3.4905	1.2690		0.4075
			p	0.104
C.H.	31.2692	10.4615	7.3108	
n = 26	5.2578	2.6718		0.5204
			p	0.006
H.M.O.	33.2143	11.6667	0.0752	
n = 42	2.4449	1.4595		0.513
			p	0.636
C.P.	34.3500	11.0526	0.0351	
n = 22	2.1343	2.0131		0.842
			p	0.974
S.P.	33.33	11.222	0.9118	
n = 9	4.1833	2.1082		0.705
			p	0.871

Hospital (H.)
Hospital Clinic (H.C.)
Hospital Emergency Room (H.E.R.)
Community Health Department (C.H.)

Heath Maintenance Organization (H.M.O.)
Collaborative Practice (C.P.)
Solo Practice (S.P.)

The collaborative practice model offers a satisfying role to the nurse practitioner, as noted in the comments from the respondents in this study. Bullough, a nurse historian, theorized that nurse practitioners would experience greater job satisfaction and mental challenge in their role of collaboration with the physician than would traditional nurses. Bullough stated that "collaborative practice offered the nurse practitioners more creativity, greater use of skills and more responsibility than traditional nursing."[9] The greater use of skills is an important factor in occupational satisfaction because the work attributes that have been found to be related to work interest and satisfaction include: opportunity to use one's skills and abilities; opportunity for new learning; creativity; variety; control over work methods; job enrichment (which involves increasing responsibility and control); and complexity.[10,11,12,13,14]

Hypothesis III: The profile of strengths and weaknesses affecting the implementation of professional responsibilities and role development reported by nurses employed in hospitals will significantly differ from those reported by nurses employed in less traditional settings.

Barriers to role implementation. A review of the literature revealed nine major barriers to the implementation of the role of nurse practitioner within the health care system. These were:

- time allotment for seeing patients inadequate
- legal restrictions
- resistance to role implementation by physician
- resistance to role implementation by other nurses
- resistance to role implementation by consumers
- personal lack of confidence

- too many work responsibilities
- resistance by work setting
- other barriers

The survey asked nurse practitioners to rate the impact of these nine different barriers to the implementation of their perceived roles. Hypothesis III suggested that the profile of nurses on these nine barriers would significantly differ since hospital environments differ from non-traditional environments.

The independent variable in this multivariate analysis was nursing setting (ie. hospital versus non-traditional) while the dependent variables consisted of the ratings made by nurses on the nine barriers listed in the survey.

First, an analysis of variance was performed to see if a significant difference existed in the barrier profile of the two groups. Second, a discriminant analysis was used to determine the nature of the significant difference uncovered in the analysis of variance. Discriminant analysis is often used after analysis of variance so that the overall effect uncovered in the analysis of variance can be better understood and interpreted.[15] In short, analysis of variance was used to confirm that a significant difference existed in the barrier profile of the two groups while discriminant analysis was used to uncover the significance of the relationship among variables.

The results of the analysis of variance (see Table 6-5) supported hypothesis III. The two groups perceived the barriers in their jobs differently (Wilk's lambda = .894, $F = 2.20$; (9.166); $p > .05$).

Discriminant analysis was used to uncover the nature of this significant difference. A linear discriminant function was calculated that

maximized the difference between the two groups of nurses on the nine response variables. The mean score on this discriminant function for nurses in hospitals was .478 while the mean score for nurses in non-traditional settings was -.247.

In order to better understand the nature of this discriminant function, the relationship of each barrier to the discriminant function was examined. The results of this examination are presented in Table 6-5 where the barriers are listed in the order of their correlation with the linear discriminant function. When this correlation is high it suggests that the barrier will yield discrimination comparable to the optimal linear composite of the variables. It also provides insight into the nature of any dimension underlying the function. If a variable has a high correlation with the discriminant function, it has something in common with the dimension.

The F-to-remove value, with all of the barriers entered into the discriminant analysis, is also provided in Table 6-5. A large F to remove value implies that removal of the variable will decrease group separation substantially. Thus, barriers with large F-to-remove values are important for distinguishing the environments of nurses in hospitals from nurses in non- traditional settings. F-to-remove values do not necessarily parallel the discriminant function but do not have any discriminating potential in the analysis because they are highly correlated with other variables that have more discriminating potential.

An examination of Table 6-6 indicates that the most discriminating variables involve resistance to the role implementation by nurses. This resistance seems to come mainly from other nurses and from the work setting itself. Resistance by the physician and legal restrictions are also factors

but their removal would not hurt the discriminating ability of the function since these two barriers are related to the most discriminating barriers. The relatively large F-to-remove value for "too many work responsibilities" suggests that it may add to the function because it moderates the effects of the resistance variables.[16] It does not characterize the underlying dimension of the discriminant function.

As such, it is clear that resistance to role implementation by nurses describes the general nature of the discriminant function quite well. Nurses in hospitals scored significantly higher on this "resistance" function than nurses in non-traditional settings. Table 6-6 further clarifies the impact of the barriers comprising the discriminant function where it can be seen that nurses in hospitals scored higher than nurses in non-traditional settings on all barriers except the "other barriers" item. In sum, resistance to role implementation is a primary dimension distinguishing the work environments of nurses in hospitals from nurses in non-traditional settings. Nurses in hospitals experience more resistance than nurses in non-traditional settings. Future research should focus on the reasons for these resistance differences.

TABLE 6.5

DISCRIMINANT ANALYSIS RESULTS FOR BARRIERS TO NURSES' ROLE IMPLEMENTATION

n = 176

Rank	Barrier	Correlation With Discriminant Function	F to Remove Value
1	Resistance to role implementation by other nurses	.748	8.95
2	Resistance by work setting	.518	4.90
3	Resistance to role implementation by physician	.361	.03
4	Legal restrictions	.358	.61
5	Other barriers	-.168	.43
6	Resistance to role implementation by consumers	.145	.00
7	Time allotment for seeing patients is inadequate	.074	.00
8	Personal lack of confidence	.039	1.28
9	Too many work responsibilities	.017	1.94

TABLE 6.6

MEANS AND STANDARD DEVIATIONS ON BARRIERS FOR NURSES IN HOSPITALS AND NON-TRADITIONAL SETTINGS

Barrier	Hospitals n = 60 Mean	Hospitals n = 60 S.D.	Non-Traditional Settings n = 116 Mean	Non-Traditional Settings n = 116 S.D.
Resistance to role implementation by other nurses	3.33	1.69	2.43	1.65
Resistance by work setting	2.32	1.61	1.79	1.27
Resistance to role implementation by physician	3.08	1.69	2.64	1.71
Legal restrictions	2.47	1.70	2.07	1.44
Other barriers	1.12	.49	1.20	.75
Resistance to role implementation by consumers	1.90	1.40	1.76	1.32
Time allotment for seeing patients is inadequate	3.02	1.86	2.92	1.71
Personal lack of confidence	1.73	1.22	1.70	1.23
Too many work responsibilities	2.65	1.75	2.63	1.68

Additional Analysis of Data Factors Influencing the Utilization of the Nurse Practitioner in the Practice Setting

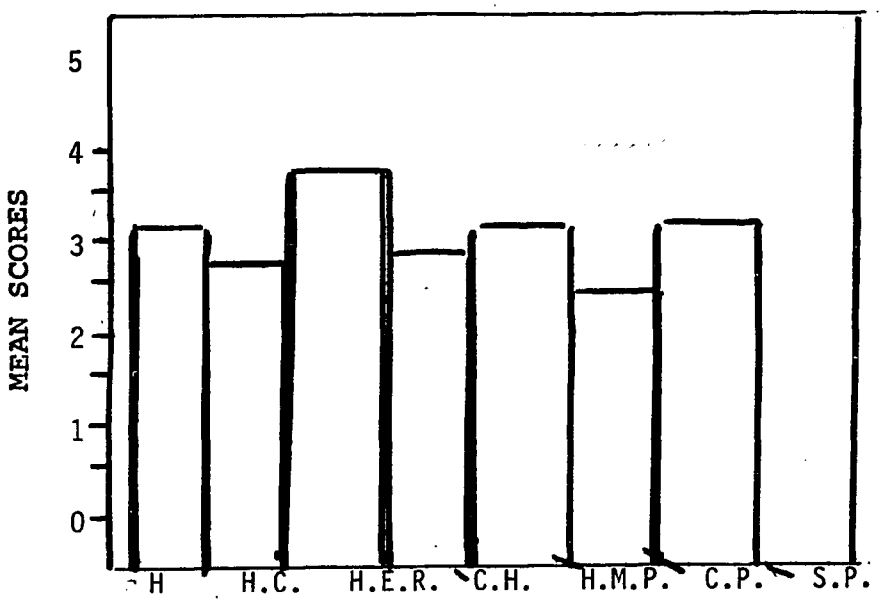
Additional analysis of the data are presented in this section. Each of the nine barriers are examined individually for the practice setting: hospital, emergency department, hospital clinic, health maintenance organization, community health department, collaborative practice, and solo practice.

Although the nine barriers are analyzed individually for their potential impact on role implementation in the specific practice setting, it should be noted that the barriers are not mutually exclusive; in any given situation there will likely be considerable interaction among them. For example, physician resistance to role implementation might be a function of the legal risk he perceives, his fears of patient response, or his concern over how to bill for services provided by another professional. This interaction should be kept in mind as these barriers are examined for their impact in the traditional practice setting and the non-traditional practice setting.

TABLE 6.7

ANOVA COMPARING MEAN SCORES FOR BARRIERS ENCOUNTERED BY NURSE PRACTITIONERS IN SEVEN PRACTICE SETTINGS

BARRIER VIII: Time Allotment for Seeing Patients



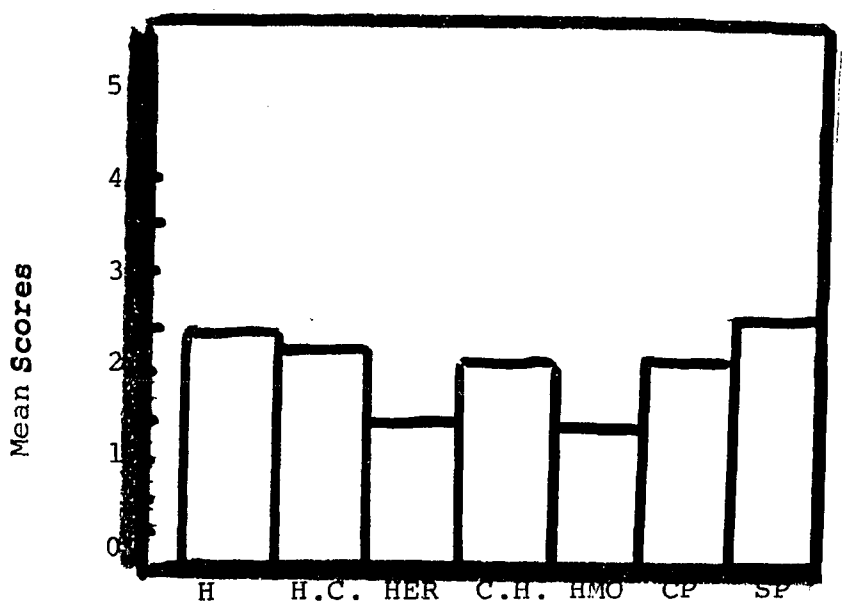
Practice Setting

		Mean	S.D.	Variance
H	Hospital	3.077	0.500	3.244
H.C.	Hospital Clinic	2.600	0.338	3.421
H.E.R.	Hospital Emergency Room	3.706	0.444	3.346
C.H.	Community Health	2.885	0.339	2.986
H.M.O.	Health Maintenance Organization	3.262	0.264	2.930
C.P.	Collaborative Practice	2.455	0.365	2.922
S.P.	Solo Practice	3.111	0.588	3.111

TABLE 6.8

ANOVA COMPARING MEAN SCORES FOR BARRIERS ENCOUNTERED BY NURSE PRACTITIONERS IN SEVEN PRACTICE SETTINGS

Barrier V: Legal restrictions

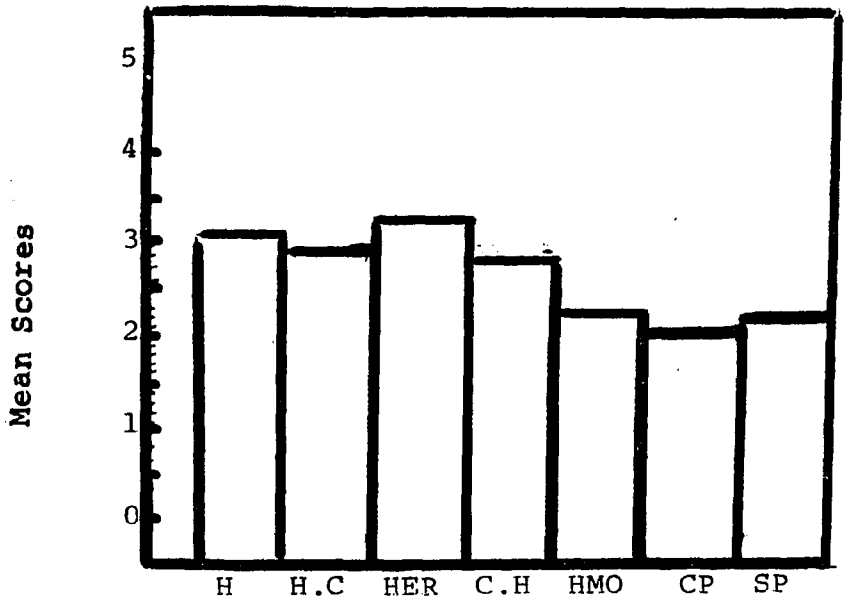


		Mean	S.D.	Variance
H	Hospital	2.846	0.451	2.641
H.C.	Hospital Clinic	2.667	0.323	3.126
H.E.R.	Hospital Emergency Room	1.824	0.376	2.404
C.H.	Community Health	2.077	0.282	2.074
H.M.O.	Health Maintenance Organization	1.714	0.264	2.930
		1.714	0.188	1.477
C.P.	Collaborative Practice	2.364	0.352	2.719
S.P.	Solo Practice	2.556	0.580	3.028

TABLE 6.9

ANOVA COMPARING MEAN SCORES FOR BARRIERS ENCOUNTERED BY NURSE PRACTITIONERS IN SEVEN PRACTICE SETTINGS

Barrier II: Resistance to Role Implementation by Physician

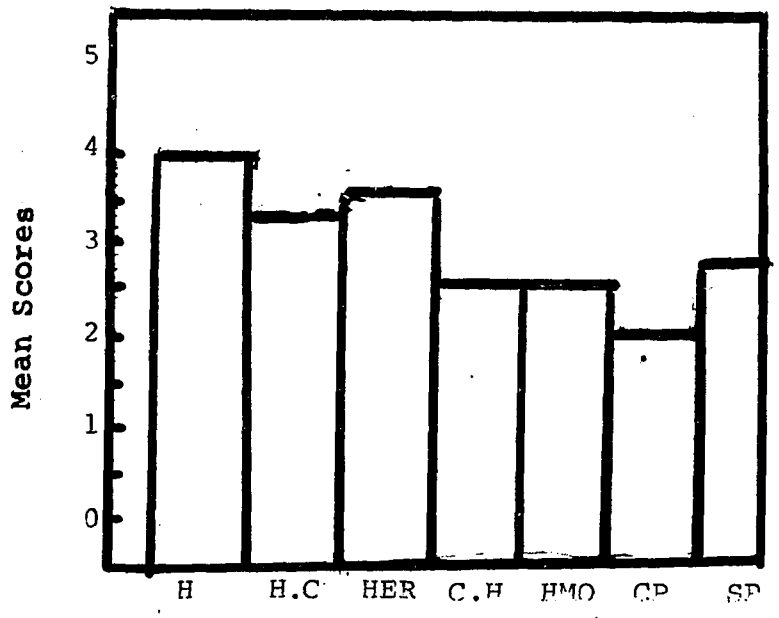


		Mean	S.D.	Variance
H	Hospital	3.077	0.383	1.910
H.C.	Hospital Clinic	2.800	0.319	3.062
H.E.R.	Hospital Emergency Room	3.588	0.429	3.132
C.H.	Community Health	2.731	0.344	3.085
H.M.O.	Health Maintenance Organization	2.333	0.261	2.862
C.P.	Collaborative Practice	3.045	0.386	3.284
S.P.	Solo Practice	3.333	0.601	3.250

TABLE 6.10

ANOVA COMPARING MEAN SCORES FOR BARRIERS ENCOUNTERED BY NURSE PRACTITIONERS IN SEVEN PRACTICE SETTINGS

Barrier I: Resistance by Other Nurses

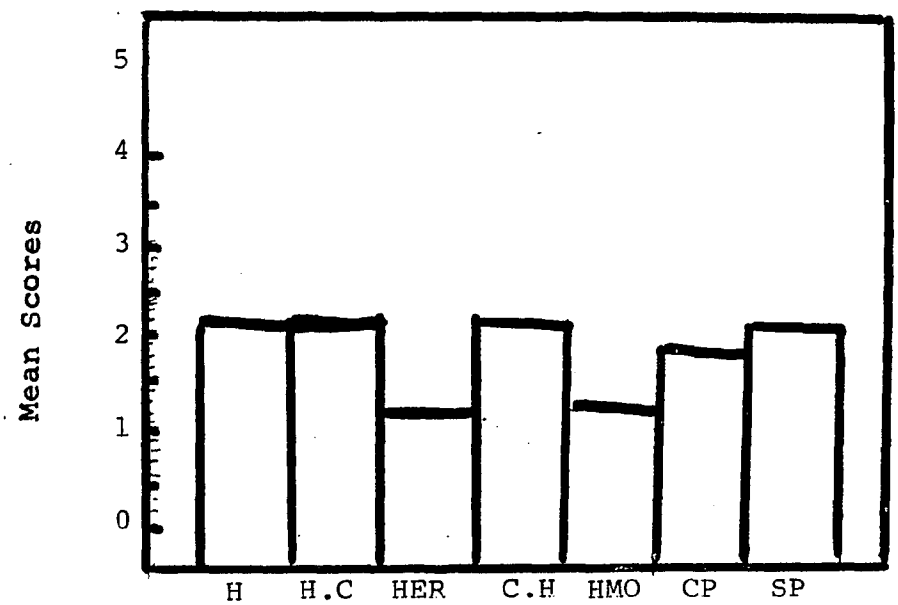


		Mean	S.D.	Variance
H	Hospital	3.862	0.369	1.769
H.C.	Hospital Clinic	3.300	0.322	3.114
H.E.R.	Hospital Emergency Room	3.588	0.429	3.132
C.H.	Community Health	2.538	0.343	3.058
H.M.O.	Health Maintenance Organization	2.500	0.273	3.134
C.P.	Collaborative Practice	2.091	0.308	2.087
S.P.	Solo Practice	2.778	0.596	3.194

TABLE 6.11

ANOVA COMPARING MEAN SCORES FOR BARRIERS ENCOUNTERED BY NURSE PRACTITIONERS IN SEVEN PRACTICE SETTINGS

Barrier IV: Resistance to Role Implementation by Consumer

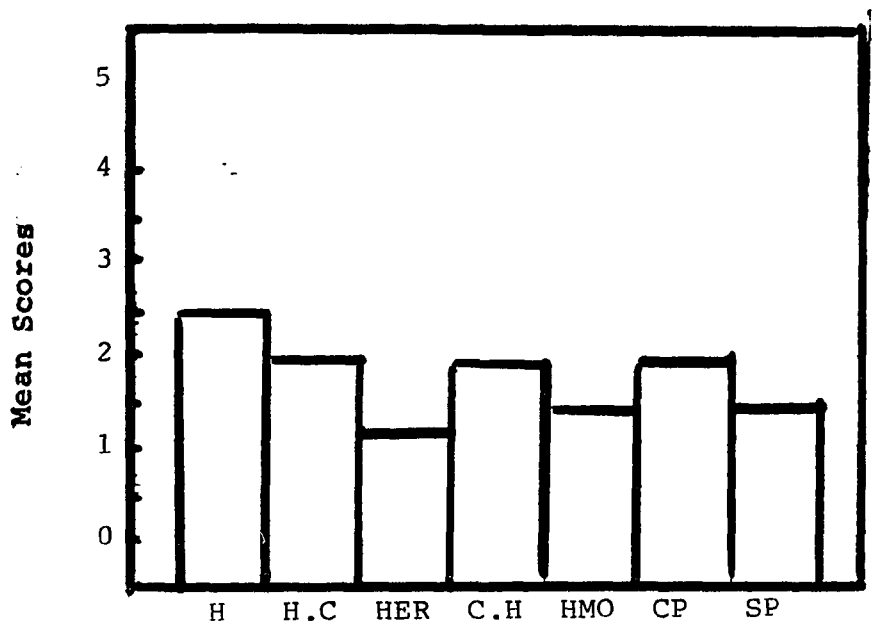


		Mean	S.D.	Variance
H	Hospital	2.154	0.406	2.154
H.C.	Hospital Clinic	2.100	0.289	2.507
H.E.R.	Hospital Emergency Room	1.353	0.191	0.618
C.H.	Community Health	2.231	0.325	2.745
H.M.O.	Health Maintenance Organization	1.310	0.512	0.110
C.P.	Collaborative Practice	1.818	0.260	1.489
S.P.	Solo Practice	2.111	0.564	2.861

TABLE 6.12

ANOVA COMPARING MEAN SCORES FOR BARRIERS ENCOUNTERED BY NURSE PRACTITIONERS IN SEVEN PRACTICE SETTINGS

Barrier VI: Personal Lack of Confidence

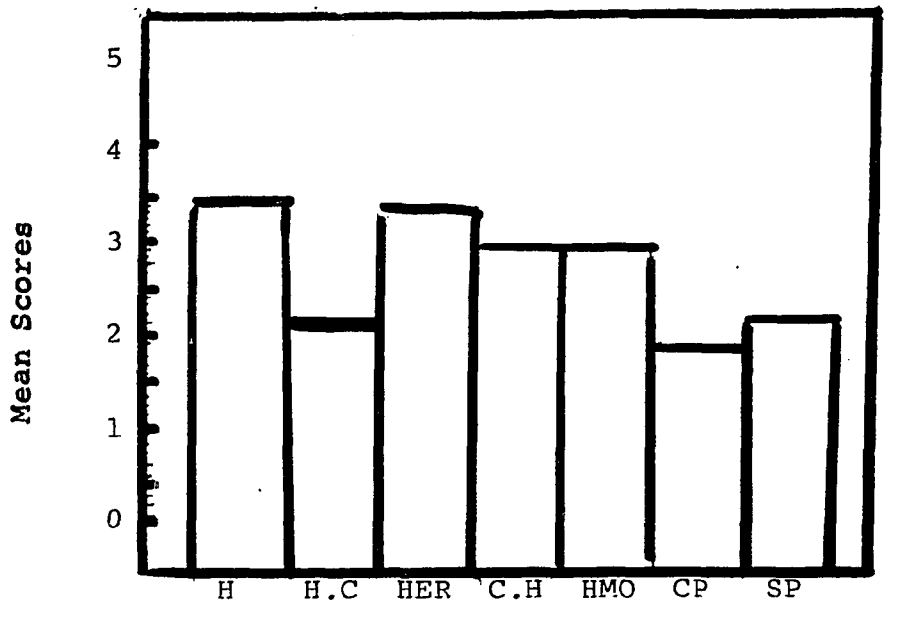


		Mean	S.D.	Variance
H	Hospital	2.462	0.447	2.603
H.C.	Hospital Clinic	1.900	0.255	1.955
H.E.R.	Hospital Emergency Room	1.235	0.106	0.191
C.H.	Community Health	1.808	0.266	1.842
H.M.O.	Health Maintenance Organization	1.429	0.157	1.031
C.P.	Collaborative Practice	1.818	0.260	1.489
S.P.	Solo Practice	1.556	0.377	1.278

TABLE 6.13

ANOVA COMPARING MEAN SCORES FOR BARRIERS ENCOUNTERED BY NURSE PRACTITIONERS IN SEVEN PRACTICE SETTINGS

Barrier VII: Too Many Work Responsibilities

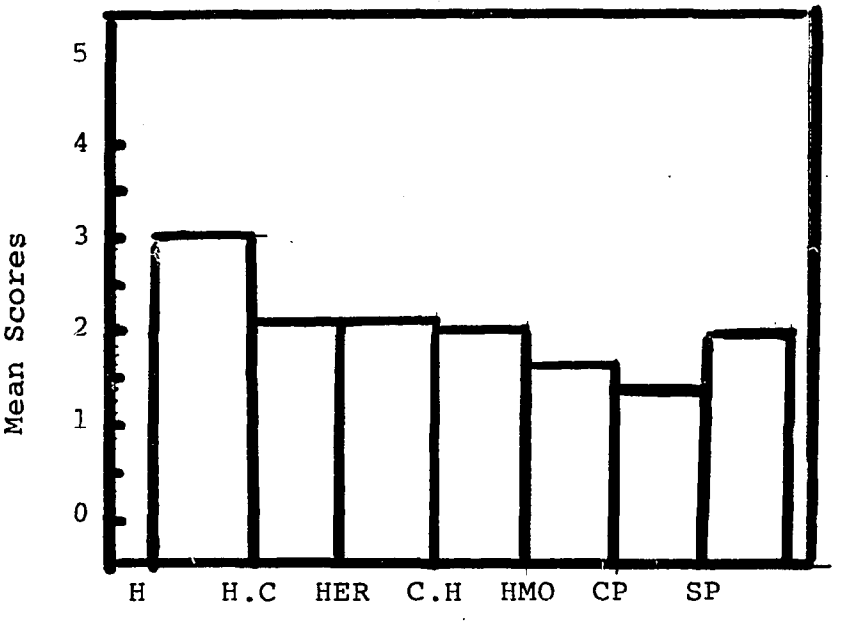


		Mean	S.D.	Variance
H	Hospital	3.462	0.447	2.603
H.C.	Hospital Clinic	2.167	0.275	2.351
H.E.R.	Hospital Emergency Room	3.941	0.424	3.059
C.H.	Community Health	2.846	0.322	2.695
H.M.O.	Health Maintenance Organization	2.833	0.163	1.461
C.P.	Collaborative Practice	1.773	0.263	1.517
S.P.	Solo Practice	2.222	0.521	2.444

TABLE 6.14

ANOVA COMPARING MEAN SCORES FOR BARRIERS ENCOUNTERED BY NURSE PRACTITIONERS IN SEVEN PRACTICE SETTINGS

Barrier III: Resistance by Work Setting



		Mean	S.D.	Variance
H	Hospital	3.231	0.359	0.166
H.C.	Hospital Clinic	2.271	2.271	0.275
H.E.R.	Hospital Emergency Room	2.294	0.452	3.471
C.H.	Community Health	2.000	0.038	1.920
H.M.O.	Health Maintenance Organization	1.619	0.187	1.461
C.P.	Collaborative Practice	1.409	0.157	0.539
S.P.	Solo Practice	2.000	0.500	2.250

The Barriers as Ranked by the Nurse Practitioners

I. Resistance to role implementation by other nurses. Table 6-10 shows that the nurse practitioners in this survey rank the resistance to role implementation by other nurses in the practice setting to be the greatest barrier to their practice. Nurses in traditional settings experienced this barrier more frequently than nurses in the non-traditional setting. Table 6-10 indicates that nurse practitioners in the Health Maintenance Organizations did not find this barrier to be of significance to their role development or role implementation.

One concern in the traditional setting is related to the potential identification of nurse practitioners with medicine rather than with nursing. Some nurses fear that nurse practitioners will practice medicine to the exclusion of their nursing skills, thereby performing only an expanded role set of delegated medical tasks.[17,18] Some nurses studied in the literature also believe that nurse practitioners do not have identification with nurses, although these same nurses believe that nurse practitioners should have this identification. More than one-third of the nurse practitioners in this study saw themselves as a bridge between nursing and medicine, practicing both aspects. The nurse practitioners in Health Maintenance Organizations, solo practice and collaborative practice do not work in a setting with other non-nurse practitioners, which is no doubt why the respondents in those settings did not find that other nurses were significant barriers for their role implementation.

II. Physician-nurse practitioner role conflict. The barrier that identified the physician as a potential factor contributing to role development in this dissertation had a mean of 3.08 p .053 by the nurse practitioners in the traditional hospital, 2.800 p .041 by nurse practitioners in the hospital clinic, and p .001 in the health maintenance organization. These were significant relationships, with the nurse practitioner in the traditional setting perceiving the resistance from the physician to be greater than the resistance encountered by the nurse practitioner in the non-traditional setting (Table 6-9).

Many of the respondents cited the familiar sex role stereotypes and nurse-physician dichotomies of care versus cure, subordinate versus superordinate, and compliance versus authoritarianism as obstacles to the nurse's willingness to assume more independent functions and the physician's willingness to grant more responsibility to the nurse practitioner. (Additional comments from the respondents appear in Chapter VII.) While these stereotypes influenced the attitudes of both the nurse practitioner and physician, the physicians' attitudes were acknowledged by the nurse practitioners in this study as especially critical in determining the way in which the nurse practitioner is able to function. The tendency of physicians to assign traditional nursing activities (teaching, supporting, and counseling patients) to nurse practitioners rather than more traditional medical responsibilities (physical assessment, management of common illness) have been documented in this study and others.[14] It has been hypothesized that physician receptivity to the nurse practitioner is less than that to the physician assistant because the nurse practitioner role is seen by the physician as role-threatening rather than role-elevating.[20]

III. Resistance by work setting. Impact of the practice setting was identified by hospital nurses as a highly ranked barrier for role implementation (Table 6-14). All of the specific practice settings with the exclusion of the health maintenance organization, the community health department, and solo practice were significant barriers in the nurse practitioner's role implementation.

Williams (1974) analyzed the influence of the practice setting in her evaluation of the family nurse practitioner program at the University of North Carolina and stated that areas of specialization (that is, pediatrics, adult medicine, and others) need to be correlated with a variety of work settings in order to completely understand the influence of the setting on the development of the role.[21]

The findings in this study suggest that the specific practice setting of the health maintenance organization may be the most conducive setting for role development for the nurse practitioner. Carlin and Freidson talk of "situation adjustment", which occurs as a resocialization process for practitioners in their attempt to negotiate expectations and reward systems.[22,23] The practice setting of the health maintenance organization, as indicated in this study, supports the nurse practitioner role development because the nurse practitioner is treated as an integral part of the health care team. The health maintenance organization differs significantly in philosophy, policy and hierarchy from the hospital out-patient clinic or emergency room with a rotating physician staff that has added nurse practitioners to ensure continuity of care. Although nurse practitioners in the out-patient clinic or emergency room have a crucial role, they are not integrated into the work the way nurse practitioners in the health maintenance organization are. Therefore, after collaborative practice, the HMO is the least resistant practice setting to the nurse practitioner role.

IV. Resistance to role implementation by consumer. The present survey of nurse practitioners supports the acceptance of the nurse practitioner by the consumer (Table 6-11). An analysis by geographic location showed that slightly more patient resistance was reported by nurse practitioners from the Northeast (3.7 percent); slightly less patient resistance was reported by nurse practitioners in the South (1.6 percent).

Nurse practitioners reported moderate resistance from other barriers as time allotment for seeing patients as inadequate. Of the specific barriers identified, resistance from consumers in and outside the practice ranked sixth and seventh respectively, in order of frequency cited. Nurse practitioners in inner-city practice more frequently cited resistance from other providers in the practice (34.9 percent) and less frequently noted resistance from providers outside the practice (26.4 percent). In rural areas, about 21 percent of the nurse practitioners reported resistance from other providers in the practice setting, and about 14 percent reported resistance from other providers outside.

V. Legal restrictions. As shown in Table 6-13 one of the specific barriers checked frequently was "legal restrictions". In all geographic areas of the country, over 50 percent of the nurse practitioners identified legal restrictions as a barrier. In relation to other variables, it was found that nurse practitioners in suburban and rural practice locations cited this barrier more frequently than did nurse practitioners in inner-city locations. It was noteworthy that nurse practitioners in mid-wifery, the oldest specialty group, and pediatric nurse practitioners, the next oldest specialty checked legal barriers significantly less frequently (p 0.01).

VI. Personal lack of confidence. Perhaps the most important psychological barrier the nurse practitioner has had to deal with is the insecurity that accompanies a major role change. Only 11.3 percent of the nurse practitioners identified "lack of confidence" as a barrier to role development (Table 6-12). The reasons most frequently cited by these nurse practitioners for choosing their current positions reflected a desire to maximize the potential of the new role: "the practice offered the opportunity for role autonomy and an opportunity to participate in a new approach to health care delivery".*

VII. Too many work responsibilities and time allotment for seeing patients is inadequate. As shown in Tables 6-7 and 6-13, the barriers identified with the actual content of work was not a significant factor for role development. However, the data did show that 40 percent of the nurse practitioners under 35 years of age and 28 percent of those nurse practitioners under 35 years of age reported this barrier to be significant in their practice setting (p 0.05). This was not unexpected, given the findings of higher employment satisfaction in those nurse practitioners over 31 years than those nurse practitioners under 30 years old.

Discussion

The data indicated that collaborative practice, solo practice, and the health maintenance organization offered the least resistance for practice by the nurse practitioner. Nurse practitioners in traditional settings encountered resistance by other nurses, as well as by physicians. The settings that offered greater autonomy and independence were sites not overrun with physicians and traditional nurses. Solo practice allowed the nurse practitioner to offer services directly to the clients rather than through physicians. In this way nurse practitioners were able to establish

professional autonomy. The nurse practitioners in this study moved beyond traditional settings toward new clinical sites where barriers for practice offered the least resistance.

I believe that the survey from which these data were derived provides a benchmark for potential future research on nurse practitioner roles. Had its primary objective been to identify and seek explanations for barriers to role development and implementation, more detailed, refined questions focusing on specific aspects for practice would have been incorporated in the questionnaire. Nevertheless, it is important to identify the barriers that exist in a profession and to recognize that the barriers encountered in the specific settings add to a theoretical knowledge base for studying professionalization as a process.

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* Comments from one respondent. Additional comments appear in Chapter VII.

CHAPTER VI

Footnotes

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CHAPTER VII

DISCUSSION AND IMPLICATIONS OF FINDINGS

In this chapter, the findings are discussed and implications for professionalization are examined. The purpose of this study was to examine the process of professionalization in nursing historically and then to examine a segment of the profession - nurse practitioners - in a variety of practice settings. Role implementation for professionalization was defined as a combination of occupational satisfaction, mental challenge, and lack of perceived barriers in the practice setting.

The theoretical framework used argues that the professions create a social control system through their own ideology and mystique.[1,2] The emphasis in this dissertation, was on social processes and change. As such, it is partly an interactionist view; the profession is viewed as a set of role relationships. The profession is also the setting for the actors to develop and to perceive an occupational culture arising from their role performance and role relationship.[3] From this theoretical standpoint of nurse practitioners' perceptions of role performance, role relationships were examined. Occupational satisfaction and mental challenge of the work were chosen as the two relatively stable indicators that demonstrate career passage for professionalization.

It was hypothesized that nurse practitioners in non-traditional practice settings, ie., HMO and ambulatory clinics, would significantly differ in occupational satisfaction and mental challenge in their work, and would perceive and actually experience barriers to role implementation

differently from nurse practitioners in a traditional setting, ie., bureaucratic hospitals. Hypothesis I predicted that nurses employed in a hospital setting would be less satisfied with their occupations than nurses employed in less traditional settings. This hypothesis was not confirmed at the macro-level of traditional and non-traditional practice settings. This finding is consistent with the interactionists' conceptualization of occupational culture as arising from role performance and role relationships and not from organizational or regulatory mechanisms of social control.[4] As Becker and others describe their study of the socialization processes in medical education,[5] individuals experience new situations and those that are constantly changing. The individuals or actors in the environment adjust their role performance and role relationships as they perceive the occupational culture. The profession, then, is seen "as a basic activity through which knowledge of an occupation is detected and displayed."[6] The profession is not a structure but a state of mind, a social mind. It is this state that gives the profession its social reality. By standardizing educational pathways, nurse practitioners have created a system of shared beliefs and values, and so occupational satisfaction is a shared collective claim, no matter what the practice setting.

It is also of significance that the role of the nurse practitioner is not the traditional role of the non-nurse practitioner. The repertoire of skills and working arrangements differ from those of the traditional nurse.[7] Nurse practitioners in the primary sector of the labor market of the occupation have better paying jobs, good working conditions, more chances for advancement, more equity and due process in the administration of work rules, and greater employment stability[8] than nurses, who are

largely in the secondary sector.

Occupational satisfaction was also examined in the micro-level by determining the relationship between occupational satisfaction and the age of the practitioner. The data in this study indicated that younger nurse practitioners (30 years old and under) were significantly less satisfied with the occupation than older nurse practitioners. The frustration of new graduates in trying to act independently and creatively has been described by Marlene Kramer in her studies of professional- bureaucratic role conflict. Kramer has described the exodus of baccalaureate graduates from nursing as a result of their not being able to use the knowledge that they gained while in their education programs. Feeling frustrated and thwarted in their attempts to improve patient care, 20 percent of these nurses drop out of nursing completely. Others move from job to job looking for some place where they can behave somewhat independently with regard to patient care. Many of the new graduates lack the knowledge and experience that is needed to function effectively as professionals in organizations and bureaucracies.[9]

Mental Challenge and Occupational Satisfaction. Hypothesis II predicted that there would be a positive correlation between occupational satisfaction and nurses perception of the mental challenge of their positions. Data analysis revealed moderate support for the hypothesis. Since the correlations lacked significance with the two-item inventory (i.e., traditional and non-traditional practice settings), it was decided to report the correlations between occupational satisfaction and the perception of mental challenge of the specific practice setting. The purpose was to assess whether different types of settings contributed to

occupational satisfaction and the perception of mental challenge. These two variables were strongly correlated in three practice settings: the health maintenance organization, collaborative practice, and solo practice. Role satisfaction and perception of mental challenge are affected by the degree to which physicians influence or control practice setting operations. Thus, there is an inverse relationship between occupational satisfaction and the perception of mental challenge in the practice setting and the scope of influence exerted by physicians in the agencies' management. In the health maintenance organizations and the collaborative practice settings, physicians function as a partner in health delivery and so occupational satisfaction and perception of mental challenge are frequently reported by nurse practitioners working in these settings.

Discussion of the Questionnaire and Occupational Satisfaction. In trying to justify the components used in the questionnaire (Appendix B), problems of previous research were confronted, ie. which components are most important to job satisfaction and mental challenge, as well as the practical questions of whether these components can be measured, and whether management in the practice setting has the ability to make changes in these areas. For example, the Maslow model of hierarchy of needs suggests that self-actualization is the most important need for many people,[10] yet the work situation is such that many jobs fulfill neither this nor lower-level needs. The Herzberg theory suggests that certain factors offer more satisfaction than others. However, some of the factors, (e.g., "satisfiers" such as achievement, interpersonal relations, factors in personal life, and status) are difficult for the practice setting to control or improve. Thus, while a questionnaire which measures these areas is important because it

substantiates or disapproves motivation theory, it may have less value on practical levels. For this reason, management in the practice setting, attempting to improve job satisfaction, often centers on what are considered peripherally important areas such as personnel policy, working conditions, supervision, or organizational structure, although attempts are made to change job structure.

The questionnaire should be: 1) expanded to include Maslow's full list of needs as well as more biological data; 2) analyzed by multiple regression to determine which areas are the best predictors of job satisfaction and mental challenge in order to produce a better tool as well as improve existing job satisfaction theories.

Strengths and Weaknesses in the Practice Setting As Identified In Relation to Nurse Practitioners' Role Implementation. One of the changes introduced into the health care system within the last decade is the role of the nurse practitioner. It has been responsible for discontinuity in interprofessional role alignments and changed nurse/patient role expectations. During the process of integrating this new role parts of the system have lagged behind in developing the necessary accommodative changes, thus causing resistance or barriers to the integration of the nurse practitioner in today's health care system. The third hypothesis examined the strengths and weaknesses in the practice setting experienced by the nurse practitioner and further investigated the barriers perceived by the nurse practitioner in non-traditional sites.

The results of the analysis of variance support Hypothesis III. The two groups perceived the barriers in their practice settings differently. Discriminant analysis was used to uncover the nature of this significant

difference to the nine barriers listed in the questionnaire. The findings of the data for Hypothesis III as well as discussion of additional analyses are discussed in this segment.

Descriptive data concerning the nurse practitioner role in the practice setting revealed that between 80 and 90 percent designed treatment plans for patients, made referrals when appropriate, monitored chronic illness, did short-term emotional counseling, took complete medical histories, and referred patients to other service agencies. Between 73 and 85 percent performed complete physical examinations. Nurse practitioners surveyed felt they were functioning autonomously as far as patient-focused activities were concerned. Like the physician, nurse practitioners enjoy a certain degree of clinical autonomy, although the limits are set not only by their own perceptions of competence but by formal written protocols mandating consultation in certain circumstances. Most practitioners could not diagnose illnesses.

The following comments were offered by some nurse practitioners in the survey concerning autonomy, role responsibility and type of practice:

- My agency doesn't allow direct medical referrals by PNP's but is probably the most progressive in Central and South New Jersey in its use of PNP's. It has only NP's employed. We work with MD's collaboratively.

- Nursing has been good to me as a profession, but I find the lack of cohesiveness and support as a group, a major deterrant to our profession. I enjoy and am enthusiastic about the added autonomy and responsibilities that the NP role gives me, so much so that I am looking for added responsibility by pursuing a medical career.

- Recent role change from NP to administrator. Despite responsibility, still felt as if I was treated as an inferior by medical community. Dislike the fact that I need anyone to supervise me.

One nurse practitioner from Kentucky is involved in prescribing drug therapy. She stated:

- Had I completed this a year ago, the answers would be much different, because I've only been in my current position since October 1983. I am completely autonomous in nursing management but still request a good deal of supervision with medical management- especially drug therapy.

Another nurse practitioner wrote of the legal restraints:

- Some of my dissatisfaction is being new and using alternative approaches to 'medical problems' such as an oriental approach or a nutritional approach. I am definitely limited by legal restraints and physician's distrust and desire for control.

Additional comments on autonomy and salary status were reflected in the following:

- Autonomy will be increased with third party payment in effect.

- I had the privilege of developing the Emp. Health Service in the hospital where I work. I do not provide care although often work collaboratively with an employee's primary physician. My role has been what I've made it and will always be a learning process.

- If I had it to do all over, I would major in marketing. However, I am about to begin as an occupational nurse practitioner- much more of a salary, etc.

- I use role outside office setting both with patients and others in community in providing health related workshops to encourage wellness and a healthy lifestyle. Masters preparation provides the much needed communication skills, teaching, learning skills, and professionalism needed to implement role.

Setting for Practice. There were almost no significant differences by work setting (traditional versus non-traditional) in what nurse practitioners did. The core activities were those of physical and historical assessment. In the comments on work settings by the nurse practitioners, those that were most favorable were those in which an examining room or a specific area was set aside exclusively for their use. Most practitioners also gave high occupational satisfaction to work settings in which they designed their own plan of care for patients. However, some nurse practitioners

enjoyed working in a drop-in or acute care clinic without responsibility for a case load.

Work settings varied in the extent to which they offered to practitioners traditional "support nursing" services, or "core" organizational functions. Traditional services in the hospital, in many instances, consisted of the staff nurse placing the patient in a room and then taking vital signs before the practitioner came in, and cleaning rooms afterwards. This minimal help explains the high rank order of resistance from other nurses encountered by nurse practitioners in the hospital setting.

Responses to open-ended interview questions showed that practitioners felt themselves more supported in their role by the physician with whom they worked than by other nurses in their work setting. The fact that nurse practitioners' support came from physicians in the organization and not other nurses suggests that effective constraints can be placed on their work and why non-practitioner nurses could sometimes subvert their functioning. It appears that the existing structure of the hospital (traditional) setting and the expectation of other actors in the setting (non-nurse practitioners) exerted an influence on the nurse practitioner in the traditional setting. Despite their educational credentialling and their role socialization, nurse practitioners in the traditional setting encountered barriers in the practice setting that were not congruent with their earlier socialization into the expanded role utilizing the paradigm of the care and cure model.

The nurse practitioner outside the traditional setting, which includes HMOs, birthing centers, private practice, orphanage, summer camp, city ghetto, and rural areas, responded with the following comments about the

possibilities for autonomy:

- MD's do not appreciate nurse practitioner-concerned they will lose patients.

- Have a private practice in a rural area in Vermont - most patients are gerontology.

- I work in a city ghetto. I can do pretty much as I please because it's hard to attract nurses to the area.

- I believe that being a male, I have less difficulty with role implementation and am able to be more autonomous in my work setting.

- MD in area does not accept FNP or refer patients - referrals from word of mouth - satisfied customers!

- Solo practice allows for more autonomy.

- MD's allow male nurses more autonomy in making medical decisions and planning cases.

- I am only source of care in a poor rural area and my patients respect me.

- The 'consumers' don't have many choices in health care available, but they seem satisfied with me, and I think I give competent care.

The comments were varied on the role of the nurse practitioner. One reflected on the role in the following manner:

- Not sure the role of an NP is really valid - are we becoming too medical and less nursing?

Additional comments on the role of the nurse practitioner included:

- Can't get a FNP job where I live. Work as a staff nurse and nobody there knows or cares about what I can do!

- I'm a FNP at a summer camp. There's not much illness. Lots of 'first-aid' stuff. Dull but restful for the summer while I look for another job.

- Position allows for complete autonomy.

- Private practice allows for autonomy and career satisfaction.

- Sorry I didn't go to medical school - more status, prestige.

As the data shows ~~in table I~~ nurse practitioners were employed in

Health Maintenance Organizations (HMOs). The following were comments received from the practitioners in non-traditional settings:

- The main weakness in being able to perform my role as a NP is the (lack of) ability to write prescriptions.

- I have only been in the role of an independent nurse practitioner (with phone consult) for one month; therefore, I am still evolving that role. In a year, my answers would be very different.

- I have been very successful especially with consumers. My only regret is that I am not an owner of corporations. I would strongly recommend that nurses who seek independence be owners or full partners in any joint practice arrangement.

- Financially unrewarding - RN role unrewarding - RNP role unrewarding.

- I have been in the same job for 8 years and become increasingly useful to the organization and pleased with the rewards. This is not to say that it is never an easy job.

- Upon graduation, I met much disappointment in attempting to secure a NP position. The only position I was able to find pay very poor and only offered per diem status. Hospital work was somewhat satisfying and allowed me to use my skills, but I encountered much professional jealousy. Home health offered the most mobility, opportunity and autonomy.

- Working as a nurse practitioner has provided my greatest career satisfaction. I was a nurse for 17 years before I became a practitioner. I would not choose nursing again as a career because it is a 'woman's job'. Women are not supportive of each other in general. Nursing administration is often poorly run. Pay scale is poor compared to my responsibility and education.

- Prior to working in an HMO, I worked in a family practice setting. I enjoyed this much more than straight internal medicine as in HMO.

- Work alone in this setting - treat anything comes in door. All eight OHC nurses (grade 11) work well together - define own role within our setting - very satisfying - total challenge.

- My satisfaction would be complete if the legislation regarding limited formulary RXing passed and if pay would increase in relation to the responsibility.

According to these comments, the role of the nurse practitioner is problematic in many settings, but certain types of settings are able to

utilize nurse practitioners more effectively than others. The structural characteristics of individual agencies are more important to whether a nurse practitioner can function effectively than by generic type of agency. The size of the agency, public or private ownership, demands for services, philosophy of leadership, and availability of resources are all likely to be more directly linked to effective nurse practitioner implementation than to agency type.[11] Further research is needed to assess the impact of agency characteristics on the implementation of the nurse practitioner role.

Collaborative Practice

Twenty-two of the nurse practitioners surveyed were in collaboration or a shared practice. These nurse practitioners are not in a traditional surrogate role. For example, in the visiting nurse association category, physicians have a collaborative role with the nurse practitioner. The nurse practitioner autonomously performs casefinding, initially admits the clients for services, does case management, assessment, diagnosis, planning, implementation, and evaluation, resource referral, and discharge planning. The nurse practitioner works with the physician in a collaborative role. Within this particular type of agency, a nurse administrator exercised control of the resources deemed essential for practice. In hospital out-patient departments, free-standing clinics, boards of health, and Health Maintenance Organizations, physicians are salaried employees as the nurse practitioners. Therefore, the role is collaborative and the physician exercises little administrative control.

Implications for Professionalization

Professionalization has been seen as a two-step process in which the

skills and values acquired in a standardized post-baccalaureate program for nurse practitioners must be adjusted to the work setting. The crucial factor is the relative power of the professional to choose alternatives outside the hospital. The latter is the intervening variable.

Nurse practitioners, in response to changes in the health care delivery system, and to women consumers, have separated into a specialty of health care provider that takes them away from bedside nursing care into a more specialized and perhaps more autonomous position. Now that the initial stages of development and implementation of the role have been achieved and there are indications of its acceptance and integration into the system and further clarification of the demarcation and boundaries of the nurse practitioner role are required. There particularly must be clarification of issues concerning: 1) the changes occurring in the health care system; 2) the aspects of actual practice that must be reconsidered in order to enhance the future development of the role; 3) the possibility that the nurse practitioner will replicate the medical model of elitism and power within the health care system.

Changes in the health care system/The corporate enterprise. The health care system is evolving into the formation of large-scale corporate enterprises. The voluntary non-profit hospital will not be able to compete in the marketplace with the corporate chains. Starr comments that since the passage of Medicare and Medicaid health care has become lucrative for providers.[12] Public financing has made health care exceedingly attractive to investors and the corporate profit-making sectors of the medical care industry. The shift from non-profit and government organizations to for-profit companies in health care, from single-level-of-care

organizations, such as acute-care hospitals, to organizations that offer various levels of care such as walk-in medical clinics and short-stay, free standing ambulatory centers, from the increasing concentration of ownership and control away from the community to national markets and to the diversification and corporate restructuring have a strong impact on the mid-level health care practitioner. The physician increasingly has become a salaried employee. There are no longer independent proprietary hospitals where small institutions are owned and controlled by physicians. The rise of the for-profit chains introduced managerial capitalism into American medicine. No longer will the physician appoint specialty chiefs, be involved in the selection of hospital administrators, and help make key decisions.

In the multi-hospital system, according to Starr, centralized planning, budgeting and personnel decisions will deprive physicians of much of the influence they are accustomed to exercise over institutional policy.[13] But the nurse practitioner, a highly educated and specialized laborer in the occupation of nursing, will not necessarily benefit from the rise of the corporate complex. The corporate enterprise is more segmented and stratified than the voluntary hospital and does not encourage professional autonomy and health care planning. The focus now is health care marketing. The health care center of one era is the profit center of the next. With the focus on the profit market, stratification, and segmentation, the mid-level practitioner will be replaced by the lower level technician. Corporate planning, corporate financing, and conglomerates' interests in rate of return on investments will not support specialization. With a two class system in medical care, the rich and the poor, the focus is not on health promotion and case finding or areas of

specialization for the nurse practitioner. Nurse practitioners will have to look outside this corporate structure for practice, further eroding their potential for market control. Profit-making enterprises are not interested in treating those who cannot pay. Starr states:

> The voluntary hospital may not treat the poor the same as the rich, but they do treat them and often treat them well. A system in which corporate enterprise plays a larger part is likely to be more segmented and more stratified. With cutbacks in public financing at the same time, the two-class system in medical care is likely to become only more conspicuous.[14]

The focus in the corporate complex is not on health promotion, case finding, health screening, or health care which is not revenue generating. These are the predominant areas of the nurse practitioners' specialization in the health care system. Therefore, the nurse practitioner will have to look outside the corporate complex for practice with clients who lack the financial resources to enter that system. By delivering care to the less prestigious clients who have little social or financial power, the potential for market control will further elude nurse practitioners, and will diminish their potential for power and prestige. In the capitalist society, there is a strong relationship between the power and prestige of the profession and the class rank of the clients.

The nurse practitioner will continue to serve in the less prestigious practice settings of the rural clinics, the HMOs and the inner city ghettos, thereby lessening their marketability and potential for financial and social power.

Aspects of practice. The type of education needed to become a clinical specialist nurse practitioner is a post-baccalaureate master degree

program. This practitioner has a bachelor's degree in nursing upon entry as a specialist, requires two additional years of preparation, and offers a master's degree along with a clinical specialist practitioner program. This is the only segment in the occupation of nursing which has a standardized theoretical body of knowledge taught in the curriculum and a standardized clinical component. Direct patient care provided by the nurse practitioner in the practice setting emphasizes patient education, counseling, prevention of health problems, continuity of service, and disease management. THe nurse practitioner carries a case load of patients, assesses their needs, and determines if care is in the realm of nursing since they cannot prescribe medication.

Defining the domain of nursing practice is vital to the occupation if indeed, nursing wants to be recognized as a profession. Territorial conflict between physicians and nurse practitioners will continue as long as there is overlap of functions between the two occupations. In the era of too many physicians, it seems probable that only those nurse practitioners who can do some of the things physicians cannot do or will not do will continue to be in demand. Nursing has historically been sensitive to attending to the needs of certain sub-groups of patients, notably the chronically ill, the well, mothers and children, the low income, and the aged.

Thus, those groups of nurse practitioners will survive who 1) provide services to the structurally underserved (ie. those persons physicians are unwilling or unable to serve) and 2) develop fully complementary practices in collaboration with those physicians who are primarily concerned with their patients' care, rather than the economics of their practice. None of these conditions promoting survival and lack of conflict in relations

between the health care providers seem able to lend themselves to implementation through policy.

One cannot determine what may lie ahead for the occupation of nursing by unilaterally extending present attitudes about career choices and mental challenge in the occupation. In the words of one practitioner:

> Working as a nurse practitioner has provided my greatest career satisfaction. I've had the opportunity to work in a high risk, in-hospital program, with a multi-disciplinary team. I have, however, also seen the intransigence of the political MD's with allowing the expansion of the nurse's role. We still have a long way to go in fighting legislatively for power and autonomy. It won't be an easy fight, and I think nursing may lose but it's worth the battle.

Attention has been given to the social context of practice, social status and job satisfaction in the practice setting, and changing roles for practice. This includes collaboration between disciplines, new role descriptions, addition of new roles for health professionals, and shared decision-making as the key to change. Although, all these factors are helpful for the professionalization of the occupation of nursing, they are not sufficient to alter the basic structure of the occupation. To change the occupation of nursing is a staggering structural task, akin to changing everyone's basic socialization. What the nurse practitioner has accomplished in two decades is the creation of a model for future professionalization and a total change of an ideology of what is valued, by whom, and to what end.

Potential for Elitism and Power

Florence Nightingale (the nurturant mother figure) is obsolete according to Hughes, except as a symbolic founding mother.[15] Hughes further

elaborates:

> All those occupations, (librarians, social workers and nurses) in their present form, result from new technical development, social movements and/or new social instititutions. Its basic techniques are changed.
>
> Nurses are delegating much of their former work to practical nurses, aides, while continually taking on new duties assigned to them by physicians and administrators some functions are downgraded: ie., bedmaking and bathing patients for nurses.[16]

Hughes describes the developments of separating the professional from the semi-professional. The semi-professionals, according to Hughes, are the people in the occupation who do not have the full new training. The new professional group will go through a process of studying its work and deciding what functions are really professional and what can be delegated to non-professional or less-than professional people.[17] This sorting out of functions has a double effect. It can be successful for increased autonomy and occupational satisfaction, and detrimental to those nurses who do not have the credentials of the nurse practitioner. The greatest barrier in the practice setting for role formulation by the nurse practitioner is at present the conflict or resistance manifested by other nurses.

At this point in the structure and function of the occupation of nursing, the question surfaces: who will minister to the sick patient? As medicine moved away from bedside care, so has the nurse practitioner. "In a considerable number of professions the basic techniques and intellectual skills are becoming something one learns as a condition of getting on the ladder of mobility."[18] If the line of promotion in a profession is in the direction of administration, what should the professional training be? It appears that whatever solutions are arrived at will be compromises.

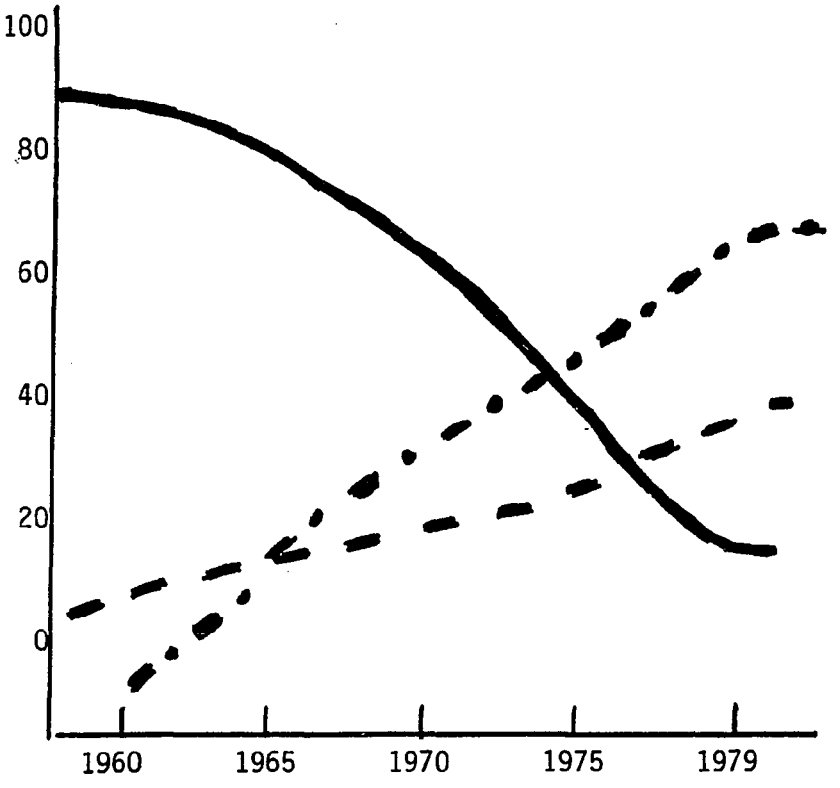
Entry into practice. The issue of entry into practice will further impede the potential for power and elitism in the occupation. The multi-pathways

for nurse education appear to continue to have the support of the National League for Nursing, the accrediting body in the occupation, which supports and encourages the varied career paths. Table 7-1 illustrates the multi and varied educational levels possible for entry into nursing. The occupation has remained fragmented and a powerless force in the health care system. Nursing has become more hierarchially stratified into primary and secondary labor markets due to the lack of standardization and codification of theoretical knowledge resulting in a primary labor market for nurse practitioners that offers jobs with more autonomy, mental challenge and greater potential for job satisfaction. The secondary market for the technician or non-degree nurse offers little chance of advancement, considerable job dissatisfaction, and a higher turnover among the labor force. The work of the nurse practitioner encourages mobility chains (career patterns), while the lower tier exhibit a work history of chronic turnover. Montagna states:

> upper tier occupations maintain a generalized and diffuse body of theoretical knowledge, whereas in the lower-tier occupations, the basic learning process is specific, training is mostly on-the-job, and skills are nothing more than an array of specific skills.[19]

The two-tier labor market in the occupation has produced a different model of occupational levels. The factors that fostered this situation are likely to continue. With an occupational hierarchy and dual labor market, there appears little potential for power and elitism in the occupation.

Table 7-1



____ Diploma

- - - Baccalaureate

- . - Associate Degree

Percent distribution of graduates of nursing programs by type of program. 1960-1979 (National League for Nursing. NLN Nursing Data Book, 1980. New York: National League for Nursing. 1981).

Summary

The purpose of this study was to view the occupation of nursing in its historical matrix and to examine a representative sample of nurse practitioners who exemplify the vanguard for professionalization in nursing. I have followed the occupation through the bureaucratic institutions, the women's labor market, the health care system, and the system of higher education.

I have tried to explore in this dissertation the structural foundations of the diverse professional attributes of occupational satisfaction, mental challenge, and potential barriers for role implementation. My central concerns have been these: the processes for professionalization, the occupational satisfaction that will help generate professionalism, the mental challenge inherent in the role, and the potential barriers to professional role development.

It was hypothesized that nurse practitioners employed in traditional hospital settings are less satisfied with their occupation than nurse practitioners employed in less traditional settings. Statistical analyses of the data did not support the positive relationship between occupational satisfaction and the non-traditional practice setting. However, the data did support the positive relationship between occupational satisfaction and the age of the respondents, with the older nurse practitioner (31 years and older) perceiving greater occupational satisfaction than the younger practitioner.

It was hypothesized that occupational satisfaction is positively correlated with the nurses' perception of the mental challenge in their position. There was support for the relationship between nurses' occupational satisfaction and mental challenge in their positions. Further

analysis of the data supported a strong and significant correlation between occupational satisfaction and two practice settings, the collaborative and solo practice. The traditional hospital setting has historically offered minimum mental challenge to the nurse, while solo practice is a new and challenging practice setting for nurse practitioners.

Lastly, it was hypothesized that barriers affecting the implementation of professional work responsibilities and role development by nurse practitioners employed in hospitals would significantly differ from those reported by nurse practitioners employed in less traditional settings. Multivariate analysis did support the interactive relationship between factors in the work setting and factors in role development and role implementation.

One of the consequences of age is that the potential is greater for both satisfaction and dissatisfaction. The nurse practitioners in this study perceived the non-nurse practitioner nurse as a greater barrier to role development and role implementation than the physician. These findings strongly support the Bucher and Strauss discussion concerning segmentation in professions.[20] Segmentation within a profession separates a given area out of the general stream of the occupation, gives it special emphasis and a new dignity. The new group claims an area for itself and it aims to exclude others from it. This exclusion from the main "core" of the occupation can cause alienation with the other members of the occupation, in this case, the non-nurse practitioner. This study has been able to offer some preliminary data toward this segmentation of the nursing professions in process and segmentation within an occupation.

Conclusions

Reference was made in this thesis to the identification of nursing as a "semi-profession" and the suggestion by some that it is not likely to obtain full professional status, partly because of the predominance of women in the ranks. The influence on nursing of this fact cannot be overestimated. Cleveland addressed herself to the issue when she identified sex discrimination as nursing's most pervasive problem. Many of the characteristics associated with being a "good nurse", that is, warmth, obedience, willingness to serve others, passivity, and so forth, are also attributes of "good women". The sex of its practitioners should be an irrelevant consideration to how autonomous nurses can be, states the author.[21] The nature of the service provided and the amount of specialized knowledge necessary to provide that service are what should be the primary determinants of a profession. There is no doubt that the fate of women in the labor market is an integral factor in the professionalization of the occupation. What affects women in the general labor market will ultimately affect the professionalization of nurses.

In view of the present and emerging patterns of multi-disciplinary approaches to health care delivery and evidence that such patterns will increase, there seem to be clear implications for health professionals as they develop their roles. One of the major tasks facing these professionals who seek to develop and maintain their autonomy is that in applying their specialized knowledge in the interests of clients they must frame their knowledge and expertise to the rationality of the practice setting. However, this must be a reciprocal endeavor, so that the organization does not inflict alienation and ultimate power over the profession but allows space for professional growth, decision-making, and autonomous judgments.

The nurse practitioner has rejected this role and has successfully established a distinct and recognizable professional practice that has a significant effect on professionalization and satisfaction for that segment of the occupation of nursing. Nurse practitioners are a group of producers in nursing who have defined the areas of knowledge and skills that are amenable to standardization. Their place of expertise, in the practice of the vocation, has changed from a traditional to a non-traditional setting during the process of unification of the profession. Nurse practitioners did not attack the core with which the dominant group identifies, but branched out and generated their own new field or subfield within the occupation. This process may be seen as involving efforts of codification of a new area.

Utilization of the holistic approach has given the nurse practitioner a new paradigm for practice - the health-oriented primary care model. This approach has contributed to job satisfaction and has increased mental challenge for the nurse practitioner. It has also provided the impetus and challenge through which knowledge has been expanded and professionalization maximized for the occupation.

CHAPTER VII

Footnotes

[1]Everett C. Hughes, "Education for a Profession", The Library Quarterly, 31(October 1961), 336; Everett C. Hughes, "Professions", Daedalus, 92(Fall 1963), p. 657.

[2]Eliot Friedson, Profession of Medicine. (New York: Dodd, Mead & Co., 1970) pp. 79-82.

[3]Paul Montagna, Occupations and Society. (New York: John Wiley & Sons, 1977), pp. 202-203.

[4]E.A. Locke, "Satisfiers and dissatisfiers among white collar and blue collar employees" Journal of Applied Psychology (1973 58, 67-76).

[5]Howard S. Becker et al., Boys in White: Student Culture in Medical School. (Chicago: University of Chicago Press, 1961).

[6]Ibid., Montagna, p. 206.

[7]Lawrence S. Linn, "Expectation vs. Realization in the Nurse Practitioner Role", Nursing Outlook (March 1975, Vol. 23, No. 3, 166-171).

[8]Ibid., Linn.

[9]M. Kramer and Constance Baker, "The Exodus: Can We Prevent It?" Journal of Nursing Administration (May/June, 1971), pp. 15-30.

[10]Elton Mayo, The Social Problems of an Industrial Civilization. (Cambridge, Mass: Harvard University Press, Division of Research, 1945).

[11]Ibid., Linn.

[12]Paul Starr. The Social Transformation of American Medicine. (New York: Basic Books, 1982).

[13]Ibid., Starr, p. 447.

[14]Ibid., Starr, p. 448.

[15]Everett Hughes, Men and Their Work. (London: The Free Press of Glencoe, 2nd Printing, July 1964), pp. 117-130.

[16]Ibid., Hughes, pp. 133-137.

[17]Ibid., Hughes, pp. 133-147.

[18]Ibid., Hughes, p. 133.

[19]Ibid., Montagna, p. 68.

[20]R. Bucher and A. Strauss, "Professions in Process" American Journal of Sociology, (66, January 1961, pp. 325-334).

[21]Virginia Cleveland, "Role Bargaining for Working Wives", American Journal of Nursing, (1970, Vol. 70 [June]:1242-1246).

APPENDIX A

THE METHODOLOGY AND THE COLLECTION AND ANALYSIS OF DATA

Method and Sample

Sociological studies have traditionally focused on the functionalist or trait approach to study professions. Despite severe short comings of this approach, it has persisted. The alternative in this dissertation, was to explore the occupation of nursing from a historical perspective and examine the occupation as a class issue in an attempt to differentiate nurse practitioners in their social role and to be aware of the critical factors in their relationship to the wider social system.

Before my hypotheses were finalized, inquiry was made to the American Nurses Association as to the availability of the names of members that held a master's degree from post-baccalaureate programs in the United States and were certified by the American Nurses' Association to be licensed nurse practitioners. Following the initial contact with the American Nurses' Association in Kansas City, Missouri, it was strongly suggested that I submit a copy of my proposal for the research, which included a sample of my questionnaire. I sent a copy to the Association for a critical review. Within two weeks I received a favorable response with no revisions for the proposal or questionnaire suggested and I also received the names and addresses of the 1,244 nurse practitioners in the United States who held credentials as certified nurse practitioners, graduates of a post-baccalaureate program in nursing.

The first move upon acceptance was to conduct a pretest of the questionnaire, and then, after the questionnaire had been mailed, to

interview a cross section of the sample. For the pretest questionnaire I decided to obtain a cross section of nurse practitioners, who had graduated within the past three years from an accredited eastern university and who were representative of a cross-section of graduates as to age, sex, racial characteristics and place of employment. I selected 25 nurse practitioners for my pretest and my response was 20 questionnaires returned. The results were satisfactory and no changes were made on the questionnaire.

I decided that the total universe to be sampled would represent all fifty states in the United States so that there would not be bias in my data as to geographically extraneous variables. Therefore, from a regionally stratified systematic random sample of 215 nurse practitioners from the total population (N = 1244), 176 usable questionnaires were elicited.

Familiarization with regard to the peculiar language, work situation and so on, of the nurse practitioners, was not necessary since I could draw upon may twenty odd years in nursing both as a hospital staff nurse and as a nurse educator five years of which consisted of being a faculty member in a Generic graduate program for nurse practitioners at Pace University, Pleasantville, New York.

Consideration in Measuring and Interpreting the Data

On the basis of the method used in collecting the data, the extent of coverage of the universe from which the sample was chosen, and the excellent response rate from the population, a fair representation was attained. All levels of specialization as a nurse practitioner and all levels of hierarchial positions within the discipline were covered. Also, content of the questionnaire contained data that complimented and expanded on the original research proposal facilitating a broader perspective on the

expanded scope of practice.

Statistical techniques used for determining relationships between pairs of variables were correlational procedures. Correlational procedures were used with bivariate and multivariate distributions. In coding the answers to the broad, open-ended questions on the questionnaire, specific types were listed under the general categories, so that readers can interpret for themselves the general content of the category.

The nurse practitioner examined in this work is the "average" nurse practitioner, who is a graduate of a generic graduaate program in a post-bacclauareate degree granting university. Bias and possible distortion concerning the occupation and the role of the nurse practitioner were avoided by not limiting the sample to only new graduates or graduates from earlier programs. This was avoided purposely to limit the effects of "burn-out" and attrition from the occupation, as the literature strongly suggests. A nurse practitioner who is a new graduate of a program would certainly be led to false perceptions concerning the expected expanded role prior to at least a year's experience in the practice setting.

A final note: the response from the nurse practitioners was most gratifying. In most instances the replies were returned immediately. The comments extending good luch and success were most encouraging from these new practitioners in the occupation. It was here that they gained my respect and I gained their cooperation.

APPENDIX B

The Questionnaire

GENERIC NURSING MASTER'S PROGRAM

GRADUATE SURVEY

Age_____ Sex_____ Year of Graduation_____

Please read code below and check one for each statement.

Code:
Strongly Agree = SA
Agree = A
Disagree = D
Strongly Disagree = SD

		4 SA	3 A	2 D	1 SD
1a.	My position encompasses use of my skills.	___	___	___	___
1b.	My position allows for professional autonomy.	___	___	___	___
1c.	My position is interesting and provides for professional growth.	___	___	___	___

2. Taking ass aspects into consideration, how satisfied are you with your occupation?

IV (check one)
Very satisfied (4)_____ Somewhat satisfied (2)_____
Rather satisfied (3)_____ Very dissatisfied (1)_____

3. Suppose you chose a career all over again, would you choose nursing? (check one)

Probably not (2)_____ Very definitely (4)_____
III
Definitely not (1)_____ Probably (3)_____

4. Are you employed as a nurse practitioner?

Yes_____ No_____

5. In what type of setting are you employed?

III

_____(1) Hospital	Hospital
_____(2) Hospital Clinic	
_____(3) Hospital Emergency Department	
_____(4) Community Health Department	Non-traditional
_____(5) Health Maintenance Organization (HMO)	
_____(6) Solo Medical Practice	
_____(7) Collaborate Practice	
_____(8) Other (specify)_____	

6. Professional Responsibilities and Role Development
What are the barriers in the setting in which you are employed that you think influence your role development and role implementation?

(5 = strongest barrier; 4 = strong barrier; 3 = moderate barrier; 2 = small barrier; 1 = not a barrier)

6a. _____Time allotment for seeing patients as inadequate.

6b. _____Legal restrictions.

6c. _____Resistance to role implementation by physician.

6d. _____Resistance to role implementation by other nurses.

6e. _____Resistance to role implementation by consumers.

6f. _____Personal lack of confidence.

6g. _____Too many work responsibilities.

6h. _____Resistance by work setting.

6i. _____Other barriers (specify)_____

7. Self Report Items: Attitude toward professional self and others.

5 = Agree completely
4 = Agree somewhat
3 = Neither agree nor disagree
2 = Disagree somewhat
1 = Disagree Completely

7a. Attitudes toward patient care. _____I am completent in diagnosing patients condition--competent in assessing effects of illness on patients' activities of daily living.

Self Report Items (continued)

5 = Agree completely
4 = Agree somewhat
3 = Neither agree nor disagree
2 = Disagree somewhat
1 = Disagree Completely

7b.	Attitudes toward relations with others.	_____I have no problems communicating with other staff members . . staff ask me for advice.
7c.	Attitude toward relations with physicians.	_____I am not afraid to state my opinion to the physicians.
7d.	Attitude towards role implementation.	_____I like the responsibility of the practitioner's role.
7e.	Self-perceptions as a nurse.	_____I am happy in the profession of nursing.
7f.	Nurse-practitioners activities with patients.	_____I perform a complete physical examination.
7g.		_____Provide for patient's emotional needs.
7h.		_____Make judgments that are based on a thorough assessment of all available information.
7i.		_____Diagnose a broad range of illness.
7j.		_____Determine an appropriate plan of care for the patient.
7k.		_____Direct the details of the patient's health care programs.

Additional comments on autonomy, role implementation and occupational career satisfaction.

_____

_____

_____

_____

July 1, 1984

Dear Nurse Practitioner,

I am a doctoral student at the Graduate Center of the City University of New York. My dissertation is entitled Professionalization of Nursing: A Historical Analysis and an Examination of the Segmentation of the Nurse Practitioners.

The purpose of the study is to gather information about factors that contribute to professionalism in nursing.

The procedures for collecting the data consist of one questionnaire solicited from Nurse Practitioners who have graduated from a Generic Master's Program. The respondents will remain anonymous and all responses will be used by the researcher solely for purposes of this study.

I would like to thank you for your participation.

Sincerely,

Susan B. Del Bene
506 Jamestown Road
Stratford, Connecticut 06497

APPENDIX C

SALARIES FOR MALE CLASSIFICATIONS AND NURSES IN DENVER, COLORADO

The low salaries of nurses in comparison to other workers is clearly illustrated in a recent lawsuit by a group of nurses in Colorado. Lemons, the director of nursing for the municipal hospital, and her colleagues complained that they were discriminated against salaries they received because nursing is primarily a women's occupation. At every level in the classification system employed by the city and county of Denver, starting salaries for jobs requiring comparable or low qualifications and responsibilities were higher than those for nursing. Table demonstrates some of the classifications.

The judge who heard the case noted that:

> . . . We are confronted with a history which I have no hesitancy at all in finding discriminated unfairly and improperly against women . . . I think they (the nurses) have established that they by and large, receive less pay than male dominated occupations receive for comparable work . . . I accept that nurses have been discriminated against, but so have other occupational groups. The nurses don't have it as bad as the clergy.

TABLE

SALARIES FOR MALE CLASSIFICATIONS AND NURSES IN DENVER, COLORADO (1977)*

100% Male Job Classifications	Monthly Starting Salary
Sign Painter	$1,245.00
Painter	1,088.00
Tree trimmer	1,040.00
Tire Serviceman	1,017.00
Meter Repairman	994.00
Nurses Salaries 97% Women	929.00

* Lemons vs. City & Cty of Denver. Civil Action No 76-1156-Denver, CO, 1977

APPENDIX D

MILESTONES IN THE HISTORY OF NURSING

1617 Sisterhood of the Dames de Charite organized in France by St. Vincent de Paul; may have been first home health care service

1812 Sisters of Mercy established in Dublin where nuns visited the poor

1813 Ladies' Benevolent Society of Charleston, S.C., founded

1836 Modern Order of Lutheran Deaconesses created by Pastor Fliedner at Kaiserworth

1851 Florence Nightingale goes to Kaiserworth

1859 District Nursing established in Liverpool by William Rathbone

1860 Florence Nightingale Training School for Nurses established at St. Thomas Hospital in London

1867 Nursing program started at New England Hospital

1868 Training schools established at Bellevue Hospital, New Haven Hospital, and Massachusetts General Hospital

1872 Training School for Nurses started at New England Hospital for Women and Children

1873 Linda Richards becomes first nurse graduate in United States

1885 District Nursing Association in Buffalo established

1886 First visiting nursing society in Philadelphia provides home health care; instructive district nursing begins in Boston

1889 Chicago Visiting Nursing Association established

1892 School nursing first undertaken in London

1893 Visiting nursing service for the poor in New York organized by Lillian Wald and Mary Brewster; American Society of Superintendents of Training Schools for Nurses organized (became National League for Nursing Education in 1912)

1895 Industrial nursing program initiated at Vermont Marble Works

1897 Nurses' Associated Alumnae of United States and Canada organized (became ANA in 1911)

1898 Public health nurses hired by Los Angeles Health Department, Detroit Visiting Nurse Association formed

Appendix D (continued)

1899 International Council of Nurses organized; university education for nurses introduced at Teachers College, New York

1900 American Journal of Nursing begins publication

1901 58 organizations providing public health nursing (about 130 nurses)

1902 School nursing started in New York (Lina Rogers)

1903 First nurse practice acts; tuberculosis nursing in Baltimore

1905 200 organizations providing public health nursing (about 440 nurses)

1906 First post graduate course in district nursing offered by the Instructive District Nursing Association (Boston)

1907 Alabama law permitting employment of public health nurses passed

1908 Detroit Health Department hires public health nurses

1909 The Visiting Nurse Quarterly first published in Cleveland (in 1918 became a monthly, The Public Health Nurse, and in 1931 name changed to Public Health Nursing); first nursing program affiliated with a university (Minnesota) inaugurated; 566 organizations providing 1413 public health nurses; Metropolitan Life Insurance initiates offer of home nursing to its industrial policy holders

1910 Public health nursing program instituted at Teachers College, New York

1911 First state public health nursing laws passed

1912 National Organization for Public Health Nursing formed with Lillian Wald as first president; Rural Nursing Service of American Red Cross established; National League for Nursing Education started

1913 Divison of Public Health Nursing, New York State Department of Public Health, organized

1914 First undergraduate nursing education course in public health offered by Adelaide Nutting at Teachers College

1916 1922 organizations providing 5,152 public health nurses

1917 Publication of the Standard Curriculum for Nursing Schools

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