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Dealing With Sexism in Nursing and Medicine

When we understand the assumptions underlying sex discrimination in nursing and women's health care we can begin to replace stereotypic thinking with enriched and differentiated approaches.

RICHARD T. HULL

A ssessing the extent and character of sexism in nursing and medicine is made difficult by virtue of subtle complexities involved in the question. Let me point out three such complexities.

Traditionally, nursing has been regarded as a field in which skilled nurturing has been the chief mode of interaction between the nurse and the patient. Indeed, from its early history, the shared view of nursing has been based on an analogy between nurse and mother. A similar analogy has been made between physician and father. Therefore, the first part of the question is theoretical: Is the view that the nurse performs skilled applications of maternal functions and that the physician performs skilled applications of paternal or masculine functions essentially correct theory or theory that is sexist?

Second, women have been regarded culturally as naturally possessing personality traits that lead to superior performance of nurturing tasks and as lacking the natural traits of decisiveness and leadership required for the tasks of physicians. Nightingale and other "originators of nursing saw nursing as a natural vocation for women second only to motherhood. Nightingale viewed women as instinctive nurses, not physicians." Thus the view arose that nursing as a vocation was more suited to women than men, since women naturally perform such actions as nurturing, caring, and education. Inherent in this view is that men lack natural aptitude in these skills and must struggle to acquire them in an imperfect and artificial manner that runs counter to their more aggressive natural traits.

Third, some will grant that the natural propensities of the good nurse may be sufficiently plastic to be acquired by both women and men. Nonetheless, there is a strong cultural bias in our society as well as most others toward cultivating nurturing traits in women and not in men. (Proponents of this view are thus able to dismiss the different sex distributions in nursing and medicine in other countries, such as Russia and China, as irrelevant to an assessment of the distribution patterns in the United States—quite possibly a subtle appeal to Americanism.) Moreover, the role of caring for the sick has been viewed as a natural extension of the woman's "responsibility to an extended family . . . to provide a home for elderly parents and other relatives." Hence, the strong statistical skew indicating women as the better source for personnel in the nursing profession and men in the medical profession is justified as being a product of our culture.

These three positions can be tendered in defense of the preponderance of women in nursing and men in medicine, and even in defense of certain attitudes towards men and women who individually seek to move
against that preponderance. At the same time, opponents of these distribution patterns may elect to disagree with any one or a combination of these positions. For example, one might agree that nursing is properly characterized by modes of behavior that are primarily nurturing, but deny that women naturally manifest nurturing character traits more than do men. Or, one may hold that while there is a cultural bias toward producing certain clusters of traits in women and others in men, such a bias is unjustly discriminatory against both men and women and requires positive redress. Or, one may hold that, however nature and culture distribute nurturing character traits among women and men, nursing is wrongly viewed as a profession requiring just that particular set of characteristics.

Answering such questions definitively within the scope of a journal article is impossible. But it may be possible to trace some of the subtle connections between these three positions and the more obvious instances of blatant sexism encountered by nurses, in order to suggest directions for further thought and action by practitioners of this "profession in transition," and ways of understanding and dealing with the more onerous types of sexism encountered in that profession.

One final, prefatory comment. Men have been criticized for engaging in efforts to contribute to the growing body of feminist literature and theory because they have not experienced the forms and types of sexist discrimination encountered by women. But I think such criticism is not valid for two reasons.

First, much of human evaluative and critical thought rests on one person's ability to empathetically assess the experiences of another. Any ethical theory that requires one engaged in moral deliberation to project consequences of various alternatives for the happiness of others (act utilitarianism) or to discriminate between competent and incompetent decisions (legitimate paternalism) or to balance competing needs within a context of limited resources (theories of justice) also requires that such deliberation be conditioned by empathy. Even the fundamental element in virtually all ethical theories, personified in the Golden Rule, would be empty of any concrete content if it did not implicitly make reference to the perceptions and needs of others. Otherwise one, like John Hinckley, Jr., could claim a moral justification for attempting the assassination of the president on the grounds that he wishes his own destruction and is simply doing unto others as he would have them do unto him. Moreover, the ability to change one's undesirable attitudes through education and "consciousness-raising" depends on one's ability to transcend the gaps in one's own experience by participating imaginatively and vicarious-ly in others' lives and to recognize analogies between one's own experience and that of others. Since humans have these abilities, it is false that a man cannot understand the discrimination suffered by a woman, a white person that by a black, a Protestant or Catholic that by a Jew.

Second, sexism is a two-edged sword; it hurts both women and men alike by excluding each from certain spheres of experience that are thought reserved for the other. Sexism in nursing and medicine is not just the problem of women nurses, women doctors, and women patients; men suffer from it as well, although in different ways.

INSTANCES OF SEXISM IN NURSING AND MEDICINE

The following illustrations of sexism in nursing and medicine are drawn from the writings of nurses about their profession.

1. "I recall a conversation with an extremely well-respected hospital administrator regarding the clinical placement of nursing students. He assured me that there would be ample opportunity for students to rotate through all of the services provided by the hospital, particularly for the male nurses to experience emergency room care and for the female students to affiliate in labor, delivery, and postpartum care. When questioned about his placement concepts, he responded that any male in nursing is a frustrated physician, and thus would enjoy the decisive atmosphere of emergency nursing, whereas women were drawn to nursing because of their innate motherly qualities. Furthermore, he stated his belief that all male nurses were homosexuals."

2. "The gynecological clinic is extremely busy this morning. There are 35 clients enrolled for clinic appointments. The three physicians are kept busy with a variety of pressing complaints. One of the physicians comes out and picks up Mary's chart. She is 13 years old and her chief complaint is 'cramps.' The physician throws her chart on the desk and tells you to give her the standing prescription and send her back to school. He adds, 'We don't have time to see hysterical women today.'"

3. "It is not uncommon to hear the complaints of nurses that female physicians are more demanding and degrading than their male colleagues. It is permissible for a male physician to excise the female nurse for her shortcomings, to try to protect and lead her through the maze of medical miracles. Such protective, paternalistic behavior on the part of a female physician would be inappropriate and might even be misread as symbolic of masculinization, with lesbian overtones...."
“Once graduated and licensed, she must choose between the role of authoritarian medical doctor with no option for paternalistic relationships with subordinate staff, or she may attempt to establish collegial relationships with female health professionals—with the attendant risk of perception as a weak sister, probably better suited to nursing, in the eyes of her male peers.”

4. “Men who do succeed in challenging and surmounting the sexist barriers confronting them when entering the career of nursing are rewarded for their gender in one way in which their female colleagues are not. A man in nursing is much more likely to be perceived as a leader or teacher, or in other authoritarian roles, than is a woman. Although men comprise less than seven percent of all registered nurses, it is estimated that they comprise fifteen percent of registered nurse administrators. When gaining entrance to the profession, they are advanced along assumptions of maleness even in the female world! Their colleagues are more likely to tolerate assertive behavior and the attributes of leadership from a man than from a female; thus, men in nursing are able to move up the supervisory ladder more rapidly than their female peers of equal education and competence.”

ANALYSIS OF THE ILLUSTRATIONS

These illustrations are but four of an increasing number of examples in the literature testifying to the belief that sexism is a major source of bias in both nursing and medicine.

The first illustration suggests that female nurses are perceived as naturally inclined toward nurturing and caring functions, understood on the basis of the motherhood model. Thus, nursing experience with labor, delivery, and postpartum care is perceived by the administrator as the ideal clinical experience for the female nursing student. There, he believes, she will achieve the integration of training and personal characteristics that will move her toward being an effective practitioner. The corollary view is that female nurses would be least happy in the emergency room where decisional and other masculine characteristics are required, traits antithetical to the female nurse’s natural inclinations. She would have to apply not only nursing knowledge and skills in that unit, but also practice characteristics that she does not naturally possess. By contrast, the male nurse, because of his being male, is perceived as having the qualities of decisiveness and emotional control that would permit a natural integration of training and personal characteristics to move him toward becoming an effective practitioner in emergency or trauma practice. Maternity services call for characteristics that are thought to be natural for the female and foreign to the male nurse. In addition, based on the unfounded assumptions that all male nurses are homosexuals and that homosexuality is rooted in a deep hostility toward women, the administrator no doubt thinks that the presence of a male in the maternity unity poses an actual threat to the patients. Childbirth is a period of great psychological vulnerability that would, by its quintessential female character, exacerbate the male homosexual’s hostility.

Analysis of this illustration uncovers several important features of sexism as it is operant in nursing. First, there is an implicit theory about personality traits that are coordinated with sex, in which traits are identified as either masculine or feminine. Second, this coordination of traits and gender is the result of natural, rather than cultural determination. Third, various nursing services can be classified as more or less feminine and more or less masculine to the extent that practice in them involves a greater preponderance of feminine or masculine traits. Thus, nursing services seem to be arrayed in the administrator’s mind along a continuum. At one end are characteristics perceived as wholly feminine, at the other end those wholly masculine. In between are mixtures of masculine and feminine characteristics, ordered according to how much utility is attached to decisiveness, empathy, diagnostic or mathematical reasoning, nurturing, or education.

The second illustration embodies an even narrower conception of feminine characteristics. Here, the physician’s reaction to menstrual problems is that they are usually psychosomatic and involve hysterical conversions of physical signs and symptoms of menstruation by neurotic women. Menstrual tension is thought to be psychogenic in origin because the physical disorder categories familiar to the physician contain no element that would account for it. The fact that this might be due to a deficiency in the physician’s knowledge or command of diagnostic categories, as opposed to a complex set of personality traits of women, would strike the physician as implausible. Both his training and his perceptions of women preclude drawing such a belief into question.

But the roots of this physician’s response go deeper. Not only is it conditioned by a set of beliefs instilled through training and other cultural influences, it is an expression of a much more common physician response: loss of perspective that the patient is a whole person and not just a set of complaints and causes. The tendency of interns and residents to convert “the patient in room C-7 with cirrhosis of the liver” to “the liver in C-7” is notorious, rooted in medicine’s preoccupation with diagnosis and treatment of organic pathologies and the fledgling physician’s sense of the power of the knowledge he or
she is struggling to master. Most physicians come through this stage showing respect to patients whose complaints are based on identifiable organic lesions; the physician is never so civil and supportive as when he can exercise his powers to the patient’s benefit and appreciation. But the patient whose complaints defy the diagnostic powers of the medical model, or whose organic complaint defies treatment, tends to challenge the limits of the physician’s knowledge. Because physicians do not learn to deal with the finitude of their powers but instead learn to practice with the heady sense of omnipotence, such patients are dismissed in some way. When viewed from the perspective of medical education and the sexist account of the female character, the behavior of the physician who dismisses menstrual cramps by saying that the patient is not really sick is not so surprising.

The third illustration gives another insight into the dynamics of sexism. Because of the dichotomies of masculine and feminine traits and identification of nursing chiefly as a feminine occupation and medicine as a masculine one, the female physician becomes enmeshed in a Catch-22 situation. Unfortunately, part of the bind is created by the perceptions and attitudes of nurses themselves. That is, just as a male nurse was perceived by the hospital administrator as a frustrated physician, so a female physician is frequently perceived by male physicians and nurses as a frustrated male. It is rather shocking to read, for instance, Florence Nightingale’s description of the few female physicians of her day, “They have only tried to be men, and they have succeeded only in being third-rate men.”

Having adopted a profession that is perceived as essentially a masculine one, a female physician (like a male nurse) is perceived as a walking contradiction, as unnatural, involved in a complex denial of her natural propensities. Unfortunately, these attitudes can be easily acquired by the female physician herself. To prove that she is as good a physician as her male colleagues, she will become (1) uncompromisingly authoritarian with respect to subordinate nursing staff, (2) possessed by the discipline and intellect of the male physician, and (3) increasingly devoid of the more feminine characteristics, whose mixture in her personality and behavior might be perceived as indicating a confusion of sex identity. It is difficult enough for a woman to enter a man’s profession; but it is perceived as inappropriate, with homosexual overtones to act like a man in that practice, just as it is for a male nurse to display maternal characteristics while practicing a woman’s profession. Women who enter the medical profession receive less subtle cues about their sexual identity in those specialties that cast them in quasimaternal support roles. Therefore, a significant number of female physicians specialize in pediatrics, family practice, and psychiatry, and not in surgery and emergency medicine.

Finally, the fourth illustration shows that the nursing profession’s internal system of advancement and rewards is perhaps marred by discriminatory attitudes and practices. One must again postulate the belief that either inherent or culturally ingrained differences between male and female nurses justifies the disproportionate advancement of male nurses to positions of administrative power. The illustration suggests how this may happen. A female nurse’s behavior that would be perceived in a man as signifying qualities of leadership and administrative skill is viewed as inappropriate in a woman. There is a kind of pejorative conjugation at work: he is persistent, aggressive, ambitious; she is stubborn, pushy, overreaching. He is on good terms with the administrator; she plays up to the administrator. He has his favorites among the subordinate staff; she is cliquish. As a result, it becomes far more difficult for a female to achieve advancement in competition with similarly qualified males...

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ETHICAL ANALYSIS OF SEXISM IN THE HEALTH PROFESSIONS

Establishing that sexism is a major ethical problem for nursing is yet a further task. Fenner sees the chief objection to sex stereotyping in nursing and medicine to be its cost. “The assumption of appropriate behavior and attributes on the basis of gender prevents health consumers and health professionals alike from realizing their true roles and contributions to and benefits from the health care system... The limitation of a person by pigeon holing according to characteristics other than capabili-

*These are characterizations that I heard while working as an employment counselor in a personnel agency, when checking applicants’ references or interviewing personnel directors to determine why positions were vacant.
ties and capacities is not only unfair; it’s wasteful.”14 Of course, the health care industry in a society of plenty has not been moved by accusations of waste. Nadelson and Norman come closer to the mark in saying, “As a result, the wide range of talents and abilities of many providers is not utilized.”15 But such waste is perceived as tolerable, since a reasonably high standard of care is maintained. Ashley argues that the systematic injustice against women in the health sciences has resulted in adverse effects on the quality of health care that is delivered.16 This observation provides a major ground for ethical criticism of sexist patterns of inclusion and exclusion.

Fenner’s point that sexism is unfair is perhaps the other most important wrong in an external critique of the situation. Sexism has robbed the public of the best possible health care by pitting professionals against one another in the “doctor-nurse game,” with the patient usually suffering the effects.17 Sexism has delayed advances in our medical understanding of problems identified wrongly as psychosomatic. Sexism violates the fundamental guarantees of a society that prides itself on its commitment to equality of opportunity. Such opportunity extends to those hardy women who survive entry into the professions, but who all too frequently become disillusioned and leave them in droves.18 The terrible impact in discovering that one’s abilities and acquired skills are devalued solely on the basis of sex, and that one possesses a kind of second-class citizenship in the world of power, despite all one’s efforts at professionalization is responsible in the eyes of one psychologist for the “well established fact that women are two to three times more prone to depression and hysteria than men.”19

The last observation suggests the major ethical wrong of sexism in terms of the values within medicine and nursing. Sexism tends to be self-confirming—that is, it is a normal tendency for people to behave as they are expected by others around them. When the dominant perceptions of women—whether patients or nurses or physicians—are sexist, a climate of expectations and interpretations is created in which the so-called feminine characteristics are rewarded and the so-called masculine characteristics are discouraged in women—the reverse being true for men. Hence, even the male nurse who knows he is heterosexual struggles with the subtle challenges to his masculinity and tends to traverse the paths where he encounters the least resistance—paths leading into those levels and divisions of nursing that are perceived as more appropriate for men. Women, who possess the drive and qualities of decisiveness and leadership to become administrators or emergency or trauma nurses, either become discouraged in those efforts by the lack of sympathetic support mechanisms or find that they must suppress the more affectionate, nurturant parts of their personalities and learn to play at “being men.” Nightingale’s unfortunate observation missed the central facts underlying her perception of women physicians. It is “inappropriate” for women to become physicians but acceptable for them to become nurses because of the way those professions are biased, not because of any inherent link between the qualities of a good physician or a good nurse and sex-dependent features of character. The tragedy of sexism in health care is that it is ultimately an iatrogenic phenomenon, self-confirming, not based on a realistic assessment of the potentials and possibilities for human growth and development that still remain unexplored promises of the free society.

The terrible irony is that medicine and nursing, with the historically persistent commitment to the Hippocratic maxim, primum non nocere—above all, do no harm—are structured in practice so as to preserve a set of assumptions that may well produce as much harm as any pathogenic agent.

DEALING WITH SEXISM IN NURSING AND MEDICINE

There are no easy prescriptions for dealing with sexism in a profession. Nevertheless, one may gain some perspective on it if one thinks about how sexism manifests itself in one’s own life, works constructively on those aspects that are amenable to change, and adopts an understanding, indirect intolerance for the rest.

One’s personal sexist attitudes and practices may be the most difficult things to perceive, and, having perceived, to change effectively. The illustrations suggest places in one’s professional practice in which sexist attitudes intrude. For instance, one might deal with one’s reactions to male nurses and female physicians by using more sensitivity and circumspection. Empathy for such individuals may provide them with deeply needed encouragement and support. A similar attitude can be taken with patients—that is, by seeking to maintain the same standards of professionalism in one’s behavior toward male and female clients, one may clarify the degree to which one’s personal attitudes have been influenced by sexist thinking. Finally, one can establish a bulwark against sexist undermining of one’s own enlightenment by good-spirited but firm resistance to being subjected to sexist patterns of discrimination by both physicians, other nurses, and even patients.

One caveat: Focusing most of one’s efforts against sexism at the personal level may invite extreme frustration, for sexism, like other forms of prejudiced thought, tends not to yield to direct confrontation. A digression into the
history of science can clarify the point.

Even in so supposedly rational an enterprise as scientific theory construction, validation, and replacement, the history of science shows that theoretical revolutions occur not through conversion of the proponents of one theory by those of another but rather through their replacement. Adherents to theories such as geocentrism or phlogiston tended to maintain their adherence to those theories despite mounting contrary evidence and the availability of promising alternatives. Theoretical change occurred mainly by the emergence of generations of younger scientists who did not accept the old views; instead, they were excited by the promise and prospects of developing alternatives that contained fewer of the old anomalies and presented a fresh set of new problems.20,21

Like some scientists, sexists generally do not change when challenged with evidence that runs contrary to their views. This occurs in part because they insulate themselves from criticism by employing tactics such as creating ad hoc criteria for the admissibility of contrary evidence. Firmness and diplomatic resistance can sometimes limit their power to enforce their sexism, but the real change comes when new generations, who have acquired views that are less oriented toward preservation of the status quo, move into positions of leadership.

It becomes important, then, to make an impact on the problems of sexism at the educational level. Actions to be taken can range from encouraging the admission of individuals into professional study who are not predisposed toward the older sexist views of the professions to restructuring educational faculties, course materials, and content so that unquestioned assumptions of previous generations can be subjected to critical scrutiny. This process gradually creates role models in both professional education and practice who have successfully resisted the biasing influences of their education, and who, by precept and example, serve as living refutations of the older sexist views of the professions. Stromberg observes, "Nursing educators need to become aware that the prevalent conforming orientation of the female precludes the acquisition of those traits which are valued by the profession. . . . the resolution of this disharmony can be facilitated by providing time within the curriculum to explore with the students the inherent conflicts of the two roles (sex role and professional role) and to provide opportunity for the students to verbalize how they can most effectively deal with this conflicted area."22 Similar counsel, of course, can be extended beyond basic preparatory programs to administrators of continuing nurse education and inservice programs.

The nurse who perceives her or his role as independent of sex-determined qualities, who openly encourages that view in others, and who supports those who run counter to the prevailing gender distributions in the professions may not see the day when sexism in nursing becomes a thing of the past. But that nurse will nonetheless have contributed to the eventual liberation of the health professions from this wasteful, harmful, and unfair bias.

REFERENCES

3. NADELSON AND NOTMAN, op.cit., p. 1716.
4. Ibid., p. 1717.
9. Ibid., p. 183.
12. Id., p. 183.
15. NADELSON AND NOTMAN, op.cit., p. 1718.

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