Nursing On The Road To Professional Growth

Surfacing in the world of medicine is a sometimes adversary relationship between doctors and nurses — particularly in hospital settings — that often goes to the roles of males and females. Following is the last of a five-part series on the subject.

By Sigrid Bathen
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"As a society, we have much to answer for in our treatment of nursing," the National Commission for the Study of Nursing and Nursing Education reported in 1973. "We have under-compensated, mis-utilized and bullied the profession for years. Hardly any proposal for improvement has not been attacked; almost none has been implemented.

"We have viewed them as a 'female occupation' with all the connotations that identity has developed in a male-dominated society. We have perceived them as 'handmaids' to the ascribed important figures in health care — the physician and the surgeon.

"The wonder in all this is that American nursing has survived as well as it has."

But change is occurring.

Nurses are increasingly refusing to settle for second-class wages, are striking over wages and working conditions in hospitals and are refusing to remain silent about physician misconduct or administrative errors.

In those hospitals and public health agencies where nursing administrators do wield real power — and their numbers are slowly increasing — nursing directors enjoy the backing of the hospital administration and at least a few physicians of some stature in the local medical community. They often carry the title "nursing services director," sometimes with the added title of a hospital assistant vice-president, assistant executive director, and the like.

Bee Photos

CAROL COX
..."doctors respect education"

DONA BURTON
...from lackey to leader

DELFI SHAKRA
..."hospitals intolerable"

They have considerable control over the budgets of their nursing departments, which constitute more than half of the average hospital's operating budget and account for at least half the facility's work force. They have successfully pushed for active nursing representation on medical committees within hospitals; sometimes they have secured voting privileges for nurses on those committees, sometimes not.

Perhaps most important, they back their staff nurses when the latter question physician judgment, and they refuse to fire or transfer nurses simply because physicians request it. Although deep splits remain between administrative and staff nurses in many hospitals — often over collective bargaining issues — nurses are increasingly recognizing the issues they face in common.

Dona Bruton was a young nursing student in 1945. She was taught to stand when doctors entered rooms, to get off an elevator if physicians were riding, unless she was specifically invited on board by the physicians. She was disciplined as a student "for being too concerned about patient care."

Dona Bruton today is an assistant administrator for nursing services at Carmichael's Eskaton-American River Health Care Center, which has been designated by the National Joint Practice Commission as one of four American hospitals to participate in a nationwide pilot project encouraging cooperation between doctors and nurses.

At American River, Dona Bruton controls the nursing budget — a fact that nursing educators say is a crucial measure of a nursing director's authority. Nurses sit on medical staff committees, although not as voting members. And nurses are encouraged to report any staff misconduct, including physicians'.

"We've worked hard to make it okay for nurses to report what they see," Ms. Bruton says. "If a nurse sees an improper dosage, for example, she has the option of calling her supervisor or the department committee chairman, and action will be taken."

Carol Cox is an assistant executive director in charge of nursing services at St. Joseph's Hospital in Stockton. She is active in state nursing politics and serves in leadership positions in several state and regional nurses' associations. One of her major concerns as a nursing administrator is the alarmingly high turnover among nurses in general and directors of nursing in particular — often by firing or forced resignation.

She has the backing of her administrator, Ed Schroeder, and of a small but respected group of Stockton physicians. She controls the nursing budget and delegates hiring and budgetary authority to the 21 nursing department heads at the 316-bed hospital. Nurses have voting membership on most hospital medical committees.

nursing director at St. Joseph's since 1970, Mrs. Cox holds a master's degree in nursing services administration from UCLA. Most of her assistant nursing directors have master's degrees — an increasingly accepted standard for nursing administrators and a standard over which former San Francisco General Hospital Nursing Director Irene Pope resigned in 1972, when the San Francisco civil service commission refused to require advanced professional training for nursing administrators.

"One of our problems in nursing is that nurses do not emphasize nursing education," says Mrs. Cox. "Doctors tend to listen if we have the education to back us up. Some physicians see it as a threat, because they're used to the traditional role of nurses doing what doctors tell them to do. But physicians are looking more and more to the nurse for collaboration.

"Hospitals have traditionally been very structured, very ritualistic, with physicians in control. But nurses are beginning to be part of the decision-making process."

Like many administrative nurses, Carol Cox has her critics. And, if 250 nurses make good on their promise to strike July 29, she will be faced with the first nurses' strike in St. Joseph's history. The issue is wages, and the California Nurses Association, which represents nurses at St. Joseph's, says nurses there are underpaid.

The lead story in a recent issue of the AMA News, the American Medical Association's weekly newspaper, was about "turmoil" in nursing. And there is: Turmoil over professional standards for registered nurses, over the role of nurses in hospitals, over advancement for licensed vocational nurses and aides, over the lack of minority representation in registered nursing, over exactly what constitutes quality patient care, over wages and the cost of health care.

"The nursing profession is in turmoil," the AMA reported, "under attack by outsiders, but even harder on itself."

Nurses complain that the "idealistic" notions of patient advocacy which are taught today in many nursing schools do not prepare nurses for the reality of work in hospitals. Nursing educators counter that education is the harbinger of change, and it just takes a while for the word to get out.

"The nursing schools have begun to emphasize the importance of an equal say for nurses in hospitals," says Ginny Cassidy-Brinn, a nurse who works for the Feminist Women's Health Center in Los Angeles. "But when you get into the hospital, it's an entirely different matter. The hospitals are set up as doctors' workshops.

"Most nurses I know have made complaints and run up against a brick wall. A lot of nurses are idealistic about providing quality patient care. I know I went into it idealistically — to help people. But that was constantly threatened by the doctor. I could make a few patients more comfortable, but I couldn't really change what the doctor did."

Many nurses confronted with the reality of work in hospitals simply leave — to go into more independent work as childbirth educators, midwives, nurse-practitioners, health counselors or educators. Some find they are able to pursue their goals of patient advocacy in a hospital setting. But they often find it rough sailing.

"There are 185,000 nurses in California and only 65 percent are working in nursing," says Delfi Mondragon Shakra, a nurse-practitioner who directs affirmative action programs for the California Nurses Association. "There is no shortage of nurses. There is a shortage of nursing, and the reason is that the hospital environment is intolerable. People go into nursing for idealistic reasons and find they are shuffling paper.

"Everything we've learned to protect the patient is lost because we're too busy protecting the institution."

Toni Propotnik is one of the new breed of nurses who find it is possible to pursue their ideals of nursing in a hospital setting. It has not been easy.

A past president of the California Nurses Association, Ms. Propotnik for eight years has been a clinical nursing specialist helping patients deal with catastrophic illness at Alta Bates Hospital in Berkeley. She works directly with patients — part of the new independent role for nurses which has met with no minor resistance from doctors.

When she began her patient coun-

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seling eight years ago, she worked with women who had undergone mastectomies. Her goal was to help the women through the trauma of losing a breast and to develop a positive image about their radically altered bodies.

"The medical staff wanted me removed because I was making their patients cry," she recalls. "I was helping women deal with it and part of that was helping them work through it."

She no longer encounters the same resistance from physicians, but says there is still physician distrust of this nurse who works independently with "their" patients.

"I get tired from time to time," she says during a late-night telephone interview. "I think about how prepared we (nurses) are to deal with people's health problems and how little we are able to do that, and how much we try. We have so much to offer, and we have been so terribly abused."

In the early days of professional nursing in the United States, nurses were trained in what have come to be known as hospital "diploma schools" which evolved into three-year programs largely devoted to on-the-job training. Nurses today say those early student nurses were exploited by hospitals as cheap labor, with the nursing "school" established primarily to serve the labor needs of the hospital.

In later years, community college and university programs were established, with two- and four-year programs to prepare registered nurses for state board exams. Some "career mobility" is possible in the California nursing education and licensing structure for licensed vocational nurses and even aides who want to move to the next level of nursing, but that mobility is limited.

Which is to say there have been many different educational roads to becoming a nurse, and patients who see a woman in a white uniform don't always know whether she is licensed to give shots or change bedpans.

With the current trend to "primary nursing care" by a single R.N. for a single patient (to oversimplify a complex and developing field), aides are being phased out in some hospitals, and the move is clearly to standardization of professional requirements for R.N.s. Experiments with primary nursing care are promising, with strong indications that patients respond better and nurses are more satisfied with their work when the nurse-patient relationship is one on one.

The American Nurses Association has recommended that all registered nurses hold a bachelor's degree — a move which has created a furor among R.N.s who graduated from diploma schools or community college programs. At the same time, the Brown administration has introduced nursing career mobility legislation which would allow "lower-level" nursing personnel to take shorter routes to the professional end.

Michael Krisman, the governor's deputy director for consumer affairs, says the bill, introduced by Sen. Diane Watson, D-Los Angeles, will also enable minority women concentrated in lower paying nursing jobs to advance into the predominantly Caucasian ranks of registered nurses. The bill is opposed by the California Nurses Association, which says nurses allowed to go the "career mobility" route through apprenticeship and on-the-job training will end up with "second-rate" R.N.s.

According to a 1977 survey by ANA, 6.2 percent of all R.N.s nationwide are minorities. In California, according to 1975 state statistics, 1.1 percent of all R.N.s are Mexican-American, 3.6 percent black, 5.2 percent Filipino, 2.3 percent Asian. Filipino nurses say the 5.2 percent figure is grossly understated, and are currently fighting what they say are racist licensing standards for foreign-born nurses, most of whom are Filipino.

The lack of Spanish-speaking nurses is a particularly serious problem in California. "It's difficult enough to do a diagnosis with a patient who speaks the same language," says the CNA's Ms. Shakra, who was raised in New Mexico and wrote her master's thesis on communication barriers between Spanish-speaking patients and English-speaking health care workers.

She points to a 1973 study of racism in nursing by a CNA task force which found widespread anti-minority bias among registered nurses.

"There is an appalling shortage of minority nurses in California," the task force said. "As a result, nursing care to minority groups is often supplied by individuals who do not speak the language, do not know or understand the beliefs and value systems, do not understand the health needs of the client . . . This lack of minority nurses has severe implications relating to the quality of care for minorities."

The ANA only opened its doors to minority nurses in 1952, according to the task force report, but black nurses still were not permitted as members of constituent associations, especially in the south. Today, for the first time in the history of the ANA, its president, Barbara Nichols, is black.

Many women entered nursing, health historians say, because they were barred from other professions, especially because they were barred from becoming doctors. Patronized by doctors and underpaid by hospitals, they looked to the people they could find "beneath" them in nursing and created a complex internal "pecking order."

Much of the dissension in nursing today is a result of that internal hierarchy, nursing activists believe. "The doctor thinks he's God; the nurse thinks she's an angel; and everyone thinks the aide is s..t," a nurse's aide told Ms. Magazine in 1975. The racial and ethnic overtones of the power struggle within nursing are obvious; the lower one goes in the levels of nursing, the larger the preponderance of minority women.

"Almost every oppressed group has turned on someone 'lower'," Kathleen McInerney, chairperson of Nurses NOW, a task force of the National Organization for Women, told health writer Gena Corea. "We've been oppressed, and we oppress others down the line."

"Hospital workers destroy each other through such divisiveness," Corea concluded. "The 'professional' nurse feels superior to the 'technical' nurse who lords it over the radiology aide who outranks the kitchen worker, so they do not join together to challenge the hospital structure which keeps them all powerless, ill-paid and underutilized."

So nursing must clean its own house, nursing activists say, before real change can occur in the health care system. And they say nurses are beginning to do that, with affirmative action programs to recruit more minority nurses and efforts to standardize educational and professional requirements for the various levels of nursing.

Nurses say their major concern is the same as doctors': quality patient care, consistently and humanely delivered. They insist quality patient care is only possible when the nurse is allowed to exercise professional judgment without fear of reprisal.

"We are in a very revolutionary era," says Dr. Bonnie Bullough, a UCLA nursing professor and president of the California Board of Registered Nursing. "The legal decisions are going against nurses who don't report physician misconduct — against nurses who have given a medication they knew was improper.

"Nurses are less protective of doctors today — and more protective of patients."