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Nursing's Gender Politics: Reformulating the Footnotes

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Abstract

Nursing's survival in the new millennium necessitates the application of a fresh lens to the manner in which nurses participate in and perpetuate the insidious nature of their oppression. This article critically explores the language and activities that annotate nursing's gender politics to expose how language and power intersect, facilitating the development of a language of social change. Self-deception is found to be a central organizing concept of professional and service delivery organizations that perpetuates professional mediocrity, limits freedom of thought and action, and preserves the borderline status of nurses. Dialogue inclusive of the internal and external systems operating to oppress nurses is suggested to transform nurses as collective social agents and reframe their sociopolitical reality.

As a woman and a nurse, I create my practice on the fringes of the health care delivery system. My attempts to enact nursing's self-defined professional responsibilities and ethical obligations remain unsupported and unacknowledged in the contemporary sociopolitical environment. The primary imposed purpose of my nursing practice is not to create affirming interpersonal relationships with patients but rather to implement the medical directives of physicians, which for the most part are inane, manual tasks.

Although not revolutionary in rhetoric, I ask the following: Where did all the previous scholarly analysis of this situation take us in destination? Do we remain ticket holders, waiting to board an agenda that will take us from this well-documented problem 1-5 to a place where there is true reformulation of the gender-class politics that emerge from gender-class identity? In the new millennium, nursing's survival necessitates the application of a fresh lens to the manner in which nurses participate in and perpetuate the insidious nature of their oppression. The foci of this new lens are the language used and the activities performed that not only generate but simultaneously preserve the situated subservience. The articulation and critical examination of historically constructed experiences expose how language and power intersect and facilitate the

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development of a language of social change.

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LANGUAGE CREATES THE MARGINS

Language is an essential communicative process that connects day-to-day lived experiences with the cultural representations of those experiences. 6 It is the primary medium through which reality, as it has come to be known, is constituted and mediated. Moreover, language is a site of social, political, and pedagogical struggle within which diverse groups compete for influence over the borders, meanings, self-definitions, and orderings that language provides. 7 The significance of language lies in the fact that it is through language that people both *name* experiences and *act* as a result of how they interpret those very experiences. 7 As the mask of cultural hegemony, language is used to both legitimize and marginalize different subject positions, each with distinct identities, desires, and needs.

Years of personal observation and participation in nursing have provided me with insight into the socially constructed position of nurse. Within a gender-class conscious society, I have observed that many nurses weave complex webs of self-deception in an effort to negotiate relationships they have with themselves, with others, and with the world at large. More significantly, nurses' use of self-deception regarding issues of class and gender is a central organizing concept of the professional and service delivery organizations and is partially responsible for their marginal existence.

A most intriguing aspect of the manner in which many nurses use self-deception and the manner in which it positions nurses is that nurses are actually convinced, albeit half-heartedly, that they want what they are forced to do. Many nurses chafe at the constraints created for them by their secondary gender-class existence, yet they actively participate in sustaining these very constraints. To make their lives more tolerable, illusions are created to distort the experiences, so nurses do not have to necessarily believe that what they experience is true. These illusions allow nurses to embrace their peripheral position, albeit grudgingly, and simultaneously offer a protective defense against the illusions created. Many nurses delude themselves that the illusions originally created to distort experiences are actually true.

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DIMENSIONS OF DECEPTION

Nursing opened as an occupation for women based on the principle of women overseeing and supervising other women. This delusion that power could actually belong to women is within the overall sphere of male dominance, in both the state and in the medical profession. 8 Nurses want to believe that they are in charge, but they sense they are not. They are bound to the authority and power of the next class and the masculine gender within the hierarchy of a gender-class conscious society.

Class and status boundaries demarcate the engendered nature of nursing as woman's work and facilitate social control within the female sphere of work. Perhaps transitional change seldom occurs within nursing because nurses themselves promote and require engendered behaviors that reinforce the accustomed and accepted lines of behavior created by their secondary gender-class identity. These engendered behaviors remain fixed into nurses' reactions and inform the gender politics of professional and service delivery organizations.

The sense of self as nurse is firmly attached to these received behaviors and becomes extremely fragile when any threat to the boundary of self is perceived. For example, a common infighting phenomenon exists among nurses, referred to as horizontal violence. 4,9 Horizontal violence is a behavior that is expressed by

oppressed groups. 10,11 Many nurses laterally express marginal behaviors of aggression and complicity to one another, and also they express vertically across status boundaries, attempting to impede coworkers, advance their individual agendas, and hopefully relieve the tensions that arise out of situated subservience. Do they not understand how self-defeating these behaviors are? How many more times must they say they are their own worst enemies before deciding to become cooperating allies?

These intraprofessional acts of complicity cut across and through collegial relationships, keeping nurses fractious and discontented in political and practice contexts. Nurses will never be able to expunge gender politics without first developing an understanding of how many use self-deception and how that action perpetuates nursing's professional mediocrity, limits freedom of thought and action, and preserves nurses' borderline status.

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HISTORICALLY LOCATING CONTEXT

During the era of consciousness raising, nurses began to realize the consequences of nursing's sex role structure as being closely allied with the ideals of woman. "Woman" as a socially constructed reality is defined by social roles that assert the secondary nature of the female personality. 12 Most of my secondary roles remain contingent on my alleged natural aptitude to care for and nurture others. I remain enslaved in secondary labor markets, both public and private, as expressions of my feminine characteristics. 13 As woman and nurse, I am frustratingly entangled within the dialectic of gender.

The dialectic of gender ordains the primacy of gender difference and keeps the borders of the marginalized intact. Within a man/woman dialectic, I am still posited as non-A to the male A in the universally exclusive dichotomy of life. 14 I am not only the "other," the negative, I am the unequal "other." 15 Ironically, despite this well-documented reality, nurses continue to embrace and perform many of the asserted, unequal proficiencies of woman in the public sphere. Such a performance is enhanced when nurses deceive themselves to the effect gender disparity could have on consciousness in nursing. As such, the dialectic of gender remains as foundational to nursing's gender politics as it was prior to the woman's revolution of the 1960s.

The gender dialectic is still so fundamental to gender politics that it permeates the traditions of nursing, such as the belief that nursing is woman's work. As a nurse, I am the physician's administrative assistant and mother to the patients. 16 I am defined by words originally intended as descriptors but have been transformed and now locate me in roles that are centered on profound life crises (birth, death, and illness). Being born female is not a unilateral mandate for admittance into secondary roles that are historically associated with women's work. In reality, nurse, wife, and mother are actually adjectives that describe roles that women could choose to perform. However, nurse, wife, and mother have been transformed into nouns that inextricably link the female gender with its sex and extend the archetype of secondary existence. Self-deceit allows nurses to eschew the dominant discourse and feign ignorance of the larger overdetermining gender-class structures that define what women's options are.

For example, nurses appear at times to have lost interest in the issues and concerns that their gender and class create for them. Anderson 17 and Cameron 18 argue that the entry educational level for nursing is already established at the diploma or associate degree level, and that any further debate is an impossibility. Moreover, Cameron 18 argues that patients "are not concerned about the level of education the nurse has [and urges] all professional nurses to let go of this old, tired debate."(p4) A stance such as this is extremely dangerous and should scare us, if, in fact, what she believes is true.

However, nothing could be further from the truth or more self-deceptive in nature. Nursing's subordinate gender-class status is only one consequence of the reality that, as a whole, they are an undereducated collective desiring professional status on parity with groups such as teachers, occupational therapists, social workers, architects, and physical therapists. These imprecise statements by nursing leaders are an illustration of how nurses use self-deception to convince themselves into believing what they might know on some level does not have to be true. The majority of nurses dismiss the influence their undereducation has, perpetuating their subordinate status by minimizing any link among level of education, class, gender, and status.

Another example of how many nurses use self-deception is their continued participation in traditional physician-nurse roles that "are instrumental in medical hegemony." 19(p205) I am appropriated into nursing in an attempt to reproduce community-based gender-class relations in the health care setting. I am exchanged as a part of a social contract among men to institutionalize the gender dialectic and maintain the dominant class interests of patriarchy. As a woman and a nurse I am a mere being who is merely being-an object whose work loses meaning in its sacrifice to the subjective meaning of the health care regime.

The health care regime is implemented by administrators and physicians who for the most part are men, or who are women who have self-confessed to becoming part of the patriarchy to survive (P Munhall, personal communication, August 24, 1998). Defined through my role to provide subjective meaning for the delivery of health care, I remain most often impotent, maneuvering the system from my peripheral position. I betray myself by going along with the masses, passively reading along, hoping to see choices that could change the nature of my existence; while simultaneously refusing to choose or act.

Self-deception is also readily apparent in the never-ending fracas over the multiple credentials for entry into nursing practice. 20,21 Recognizing the effect multiple levels of entry have on professional status, the American Nurses Association 22 issued a position paper calling for the bachelor's degree as the minimum educational preparation for professional nursing. More recently, the third report of the Pew Health Profession Commission 21,23 called for a 10% to 20% reduction in associate and diploma degree programs. Yet in today's rapidly changing health care delivery system, 32% of nurses have a bachelor's degree, 9% have a masterOs degree, and 6% have a doctorate; more than 50% of all nurses continue to have no academic degrees above the associate level. 24

This reality stands in stark contrast to the minimum graduate education and residency requirements for medical physicians to enter practice. 13 Physical therapists also mandate graduate study as the minimum requirement for professional practice. At the present time, the majority of colleges and universities are in the process of changing their bachelor's degree in physical therapy to a master's degree as the minimum academic credential to practice. 25 The American Physical Therapy Association believes that graduate-level education is necessary to prepare therapists to better meet the diverse needs of patients in our constantly changing health care system. Characteristically, nurses remain divisive and disengaged from the crucial decision of making a master's degree the minimum level for professional practice. As the majority of nurses do not want to discuss it, the issue remains dormant, and their self-deceptive logic tells them that perhaps this is the way they really want it to be.

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LOCATING A CONTEMPORARY CONTEXT

The continuing lack of a minimum, university-prepared entry standard to nursing practice locks nurses into a manual, nontheoretical, lower-class work practice. As long as nurses have different avenues of entry to practice, nursing will

continue to be publicly perceived as a confusing, poorly differentiated occupation of menial tasks. One could describe nursing as an entry-level, service-oriented, quasi-profession where one can become a nurse right out of high school. 18 It is a quasi-profession within which the majority of members have no academic degree 24 and are not entitled, nor have they been invited, to sit at the table of health care discourse.

Tangential to nurses' disparate educational experiences is the pervasive belief that clinical nurses engage in nursing actions, and nurse scholars theorize about nursing actions, perpetuating further class division within the already fractious profession. 8,19,24 The dichotomy between actual nursing practice opportunities and educational preparation is symptomatic of the zeal with which nurses perpetuate their own gender-class consciousness while adding fuel to the fires of horizontal violence.

What is indefensible in this educational battle is that many nurses with advanced academic degrees vigorously defend multiple entry-level credentials for the sake of their own job preservation. 18 Acknowledging that associate degree nurses lack upper-level courses for classroom teaching, public health, and leadership, Cameron 24 argues that the "need for a clinically trained professional remains … and [that patients merely want an] RN who is capable of meeting their needs."(p4) When they have the opportunity to introduce the concept of a higher level of academic preparation with differentiated practice, and to expand nursing's vital part in the nation's well-being, nurses flinch from the challenge and sell out the discipline for their own immediate economic security. One generation unwilling to take the ethical and courageous step paralyzes the profession.

Self-deception allows many nurses prepared in diploma and associate degree programs to ignore how they are supported by the system to remain in a lower-level work practice and co-opt nursing's potential to become a full-fledged profession. Nursing leadership's refusal to enforce a higher level of academic preparation with differentiated practice has sabotaged efforts to raise the standard of practice on par with entry-level academic credentials. I believe that the foundational knowledge needed to do professional nursing practice is acquired only in the process of obtaining a bachelor's degree in a university setting. The key word here is "foundational," as the knowledge necessary to enact a professional practice of nursing consistent with nursing values can be acquired only in graduate education. What is needed, as in other disciplines, is a master's degree in nursing as the minimum academic credential to practice.

As long as many nurses engage in marginal behaviors such as these, they perpetuate a narrow and stagnant gender-class consciousness. Nursing will continue to be publicly perceived as a nonprofession, unacknowledged and invisible for the invaluable work nurses do. Nursing's essential relational work is not invisible simply because it is unacknowledged; it is invisible because it is not seen by administrators, physicians, sometimes other nurses, and certainly the public. 26 The vital work nurses do is somewhat taken for granted.

One needs only to peruse cultural texts to see how insignificant the nursing perspective is to those who possess the power to mediate practice contexts. In its annual public opinion poll, the Gallup Organization surveyed the public on five separate occasions during 1996 and 1997 concerning the public's opinions of physicians. 27,28 The public was queried on its perceptions of physician honesty and ethical standards; participation in patient assisted suicide; sexual orientation; and the necessity of offering alternatives to abortion. Not once during the 1996 or 1997 surveys did the Gallup poll ask the public a question related to nurses or nursing.

In addition, the Woodhull Study 29 of nurses and nursing in the news media found that nurses "are essentially invisible to the media and consequently to the American people."(p8) More specifically, the Woodhull Study found:

* Nurses were cited only 4% of the time in over 2000 health-related articles culled from 16 major news publications.

* The infrequent references to nurses or nursing that did occur were only in passing.

* In many of the stories, nurses would have been more germane to the story subject matter than the references selected.

Unfortunately, these are accurate reflections of the majority of nurses' experiences in the practice of nursing. Having a place is contingent on being seen and being heard. These cultural documents provide ample evidence that nursing's place in the discourse of health care is tenuous at best. Occupying such a tenuous place is symptomatic of the extremely marginal space nurses are relegated to.

Not only are administrators, physicians, and the public unfamiliar with who nurses are and what they do, often nurses are estranged from their own sense of who and what they are. Projected as the "other" for so long, many nurses have a distorted perception of themselves and the vital significance their work has toward the health and well-being of society. All too often, most nurses shrink from the challenge of taking a firm stand because they have seen those who speak up become disenfranchised for their courage, and they are fearful. However, effective change in the political environments of our professional and service delivery organizations is far too exhausting for one person to affect. Nursing needs a wellspring of effort to disassociate nurses from the engendered behaviors of our gender-class mediocrity.

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TOWARD A POSTMODERN REFORMULATION

The postmodern existence is a paradoxical dualism, continually questioning everything in a snakelike dialectic. Postmodernism calls for return of the subject, a value on authorship, and the plurality of voices wherein opportunities abound for nurses to proactively reframe our historically reactive gender-class existence. Reflection on the past, with an awareness of the incongruity between actual events and expected results, allows nurses to actively participate in the linguistic and social construction of a perspective reality-a perceptual reality where the meaning is local and personal. 30,31

Naming experiences gives voice to our world and affirms us as active social agents with free will and purpose. 7 Critically examining the assumptions on which experiences are built transforms the meaning of those experiences and allows us to actively engage in what critical postmodernists refer to as "critical agency." 7(p30) Foundational to critical agency is learning "to negotiate, translate, resist, and transform power arrangements and interests which are legitimated by uncritically assuming particular subject positions. Subject positions ... grant us the illusion of being temporarily fixed as autonomous authors of meaning and agents of social practice. 7(p30)

The socially integrated subject position of nurse and woman is a contemporary reality with a realm of latent meanings that fulfills the covenant of biological sex through social behaviors. Women and nurses are not entities unto themselves but secondary extensions of social interaction that provide an unacknowledged, undervalued, and most often invisible service. Yet the socially constituted reality of woman and nurse is only meaningful in how it is interpreted and acted upon.

Nurses need to read their experiences not as processes of submission to an authority of discursive self-production but as the dialectical process of a "resistant subject position." 7(p37) Assuming a critical, resistant subject position provides

nurses with opportunities to understand, criticize, and transform terms in the traditional social contract and construct a new language and a new voice. Constructing a new language is a political activity that changes the meaning of the language and "amounts to intervening differently in one"s own self formation and the self formation of others." 7 (p30)

The emphasis on language and text to challenge overdetermining social practices and power relations is germane to critical postmodernism, poststructuralism, and deconstructive social theory. However, critical postmodernists articulate concern with the poststructural legacy that dismisses the viability of political work by enacting a discourse of profound skepticism. Specifically, the critique is of the poststructural

lack of a public philosophy, its lack of organic connections to a wider public sphere, its suffocating emphasis on a narrow notion of textuality, its domination by intellectuals from elite schools, and at times, its suffocating pedanticism make it less than a threat to the established configurations of power than an unwilling ally. There is a domesticating element in its practice, an elitism that threatens to suffocate its most important theoretical insights by cutting it off from those who are really oppressed, and a smugness that substitutes academic convention for real substance and action. 7(p33)

Agency is a key concept to challenge prevailing power relations. Nurses must not only choose to be; they must reframe the sociopolitical reality and give it back. Nursing has long existed as the negative of medicine, in large part arising out of what physicians did not want to do. In nurses' socially constructed roles of professional task implementer and nurturer, they are shackled in servitude, denied freedom to acknowledge the full benefit of their health and healing practices.

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STRATEGIES OUT OF THE MARGINS

A fundamental paradigmatic shift in nurses' consciousness is critical to reformulating the dilemma of their existence. For until they change their own consciousness, they cannot demand a change from others. What is needed is a shift from silent, divisive sufferers to collective, proactive risk takers engaging in what Hooks 32 refers to as "talking back." Talking back is a movement from silence to speech, a primary act of resistance that confronts the dehumanizing politics of domination that renders nurses voiceless and nameless. Talking back is a courageous, defiant act "that is the expression of our movement from object to subject-the liberated voice." 32(p9) Moving from silence to speech has potential to transform nurses as they attempt to name and understand the representations and practices that define and marginalize the social identity of nurse.

Creating a new category of woman and nurse as B, where previously there was only an indifferent non-A, is a liberating social political strategy. 13 The construction of the new language is within the dualism of the dialectic. Movement between and within the binary opposites of nurse/non-nurse, woman/man illuminates the oppositional relationships that underpin how difference is constructed. Awareness and acceptance of these relationships allow nurses to understand, critique, and transform their voices and visions of who is nurse.

Constructing the new language requires the type of dialogue long extant in the Afrocentric call-and-response tradition. 33 In this tradition, power dynamics are fluid, everyone has a voice, but everyone must listen to other voices in order to remain in the collective. I suggest a dialogue that is inclusive of the historical external forces credited with the oppressive existence and the newly identified internal damage being done today by nurses themselves. When nurses truthfully critique the internal and external forces that oppress them, dialogue emerges that encourages transcendence of their differences, cooperatively creating possibilities

for new paradigms of self-representation and practice. Language thus becomes a means to reconcile, rewrite, and renew individual struggles and foster power through creative, collective acts of resistance.

For example, race, class, and gender are the axes of oppression that characterize Black women's experiences within the overdetermining matrix of domination. 32,33 Black feminist scholars emphasize the power of self-definition and the necessity of a free mind as a sphere of freedom from which to change the matrix of domination. In a sphere of freedom, African-American women can reject the dimensions of knowledge; whether cultural, institutional, or personal; that perpetuate objectification and dehumanization. 33 Whereas Afrocentric feminist thought emphasizes individual responsibility as key for bringing about change, collective action is viewed as the only method to generate lasting social transformation of oppressive economic and political institutions. 32,33

Another disenfranchised group who proactively responded to their marginal status is New York City's gay community. The mass mobilization effort by the volunteer initiative of the Gay MenOs Health Crisis (GMHC) during the early years of the AIDS epidemic was launched to counter the institutional and socially homophobic response to AIDS victims and care partners alike. Central to advancing the GMHC's political, social, survivalist, and altruistic agenda was the establishment of a shared sense of identity as gay and the building of a sense of gay community. 34 The GMHC's initiative has had a transformative, politicizing, legitimizing, and morale building effect on people with AIDS and their care partners. 34

These groups offer nurses a solution with common imperatives for successful change-establishment of a shared sense of identity and community and collective human agency. Only through collective efforts to expand the awareness of gender and class as interlocking internal and external systems of oppression, and the manner in which nurses inadvertently reinforce these structures, can nurses learn to transform themselves as collective social agents.

When nurses survey the horizon of their current reality, there is cause for concern, but there is also reason for great hope. "Nurses have confronted death; have heard the late night secrets; have been present at birth; and have seen mutilation, pain, terror, agony and hope." 35(p40) These are the powerfully intimate and essential relationships in which nurses are engaged and wherein they create nursing. Watson 36 proposes that nurses are at a critical turning point that calls for them to transform themselves as well as to relight their own light, metaphorically and literally. The profound contribution that nurses have to offer to the nation's health and well-being will never be realized until they are willing to confront and resolve the harsh realities that their stubbornness and self-interest help perpetuate.

If nurses do not "step out of the tracks of politics, philosophy, anthropology, history, 'cultures,' to understand what is really happening," 37(pxiii) their legacy will be irresponsibility to their constituents and to their profession (P Munhall, personal communication, April 30, 1999). Nurses can and must break the mold of their thinking to create their own version of who "nurse" is and what the engendered role of nursing will be. If nurses take action and use their willfulness to socially construct their own context, taking ownership and power, they will define what is left of nursing in the next century. So, why not?

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