The impact of gender on nursing knowledge development in the perioperative setting

Name: Kerry-Ann Adlam

Supervisor: Malcolm Anderson

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Supervisors signature:..... **Date:**.....

Examiners signature:..... **Date:**.....

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Abstract

This treatise explored the history of nursing within a radical feminist framework, encompassing the facets of women's history, the sex/gender system, men's and women's nature, women's language and the system of patriarchy. Through this framework the literature suggested that there was an impact on knowledge development in nursing settings, especially in the perioperative setting, because nursing was a female dominated profession in a patriarchal society. The literature shows that women as healers in history, were marginalised by the modern medical profession. Modern nursing, because of its female domination and the values of culture at the time of its inception, is based on the supposed feminine attributes of caring, nurturing and self sacrifice, and this makes it subject and subordinate to men, and in particular, male medicine. Women's perceived place in western society and the lack of women centred history have all impacted on knowledge development. In order to gain knowledge that would make it more powerful; nursing has emulated the empirical knowledge of medicine, as opposed to the aesthetic and personal knowledge that makes nursing the caring and patient centred profession it should be. To further examine the knowledge that nurses, and in particular perioperative nurses have developed, a qualitative historical approach is suggested. An historical design may be a useful approach to study the history and knowledge development of nurses from premises that are based on feminist values. This would include historical research based in women's language, with an emphasis on the impact of women's place in society, giving a rich, more complete and meaningful history of nursing and nursing knowledge in the perioperative realm.

Chapter One

Introduction

The knowledge that nursing, in recent years, has laboured to develop has been very empirically based, and some authors suggest this is to the detriment of other types of knowledge that are as important as scientific knowledge in nursing (Chinn & Kramer, 1995, p. 2). Why has this occurred? This study explores this phenomenon, within the framework of aspects that have impacted on nursing as a 'gendered' profession.

In all societies there is a code of behaviour assigned to either sex because of the perceived differences in them. Western society has assigned a code of behaviour for the sexes that embraces male supremacy (Passau-Buck & Magruder Jones, 1994, p. 1). Male supremacy, whether it is a myth or not, must be taken seriously, because as Passau-Buck and Magruder Jones (1994, p. 2) write, it shapes and colours the way the world is seen now, in the future and most importantly, the way that history is viewed and has been written.

These factors and their impact on nursing, as a female dominated profession, form the basis of this treatise. The purpose of this study is to examine the impact that gender has had on nursing knowledge development in the perioperative speciality, through an examination of nursing history. There are, however, inherent difficulties in this, as, even in histories of women, nursing has been given little or no mention, or it has been written by men, from the perspective that

medicine has given the history worth recording, whilst nursing has merely been sidelined as the 'helper' of medicine (Symonds, 1990, p. 2).

Coupled with this, within the profession of nursing, perioperative nursing has been considered a technical branch that has little of the caring component so apparent in most other fields of nursing. This study aims to determine why this is so, through an examination of the history of perioperative nursing and knowledge development, within the wider setting of general nursing history.

To examine this nursing history and the impact of gender on knowledge development a framework of radical feminism is proposed, in an attempt to clarify and enlarge upon those issues that have impacted on women's knowledge development. These issues include, women's history, women's own language, the sex/gender system, men's and women's nature, and the system of patriarchy. This framework will then focus the literature review on those factors considered to impact upon nurses, and more specifically perioperative nurses, and their knowledge development historically. Radical feminism promotes this because its main focus is to describe the situation of women living and working in western society.

Finally, as perioperative nursing continues on its pathway to better recognition of the knowledge that it deems as important, it is vital to gather and understand those factors that have impacted on this knowledge development. It is only after

understanding these factors that questions can be asked as to the agendas behind advocating some forms of knowledge having higher value than others. In order to do this, it is proposed that further examination of how perioperative nurses view their knowledge development is necessary, to gain a full picture of the multifaceted environment perioperative nurses work and learn in.

Chapter Two

Conceptual Framework

"the master's tools will never dismantle the master's house"
(Lorde 1984 in Davies, 1995, p. X)

Culture, sociology and gender combined with centuries-old history of both women and pre-modern nursing have contributed to the birth of modern nursing. A proposed map through the complex concepts and issues of gender, social structure, nursing history and the development of nursing knowledge is a framework based on the theory of radical feminism.

Radical feminism is a useful tool for understanding both nursing history and knowledge development of women in western society. It illuminates aspects of Nursing's long history and knowledge by focusing attention on the gender dimension of nursing. Lynaugh and Reverby (1986, p. 4) state that the historical subordination of nurses must be examined and interpreted accounting for factors such as gender, male oppression and the system of patriarchy. Radical feminist theory provides the capacity to examine and explore knowledge development in nursing from its modern inception to the current situation. It can uncover the meaning embedded in the history of nursing as a woman's profession, it achieves this because one of its central purposes is to uncover the mechanisms that surround and impact upon women's lives in western societies.

Coming to terms with nursing as 'women's work' was one perspective Davies (1995, p. IX) proposed to examine nursing, she felt there needs to be a feminist analysis of nursing as women's work, because it is a gendered profession, to find what this means in terms of the professionalisation and regulation of nursing practice. This valuing of nurses and devaluing them because they are women lies at the root of any discussion or examination of nursing.

Radical feminism had its beginnings through the 1950's, 1960's and 1970's, during the civil rights and social change movements of these times (Saulnier, 1996, p. 29). However Saulnier (1996, p. 29) believed it started much earlier with authors such as Mary Wollstonecraft in 1769, Maria Stewart during the 1830's and Elizabeth Cady Stanton in the 1880's. These women promoted and wrote about ideas that questioned the ways in which women were oppressed as a group rather than as individuals. They felt that sexual repression was the fundamental cause of poverty amongst women, "argued against male sexual rights to women and attacked the religious justification of women's oppression" (Saulnier, 1996, p. 29).

Radical as a term pertains to the 'root' (McLeod, 1986, p. 697) and radical feminism is concerned with the root of women's oppression (Rowland & Klein, 1996, p. 9). The dominant concept in radical feminism is the belief that the sex/gender system is the fundamental cause of women's oppression (Tong, 1996, p. 46). Rowland & Klein (1996, p. 11) further this by stating that as a social

group, women, are oppressed by men as a social group. They believe that this oppression is at the root of women's problems and is the primary oppression which women are under. Rowland & Klein (1996, p. 11) state that the structure of this oppression, of women by men, is through patriarchy. Radical feminism aims to make this structure of patriarchy visible so that it can be seen that it operates in every sphere of women's lives, both public and private, because it is only through making it visible that women will be aware of it, and take steps to eliminate it (Rowland & Klein, 1996, p. 11).

Robin Morgan describes radical feminism thus,

> ...it wasn't...a wing or arm or toe of the Left – or Right - or any other male defined, male controlled group. It was something quite Else, something in itself, a whole new politics, an entirely different and astoundingly radical way of perceiving society, sentient matter, life itself, the universe. It was a philosophy. It was immense. It was also most decidedly a real autonomous Movement, this feminism, with all the strengths that implied. And with all the evils too – the familiar internecine squabbles.
>
> (Morgan 1978 cited in Rowland & Klein, 1996, p. 11).

The most important aspect of this definition is that radical feminism grew solely out of women's ideas, therefore it was owned by women only, Rowland & Klein (1996, p. 11) state "it is created by women for women" and therefore contains none of the patriarchal structure so detrimental to women.

Differing from other feminisms, radical feminism does not strive for 'emancipation' or 'equality' with or from men, radical feminists feel that is not enough. There needs to be, rather, an entire revolution of existing social structure and through this an elimination of patriarchal processes (Rowland & Klein, 1996, p. 12).

From this promising beginning little was done until the mid- 20th century when feminists began getting involved in anti-war and civil rights organisations. Many women of that time believed they could achieve gender equality through reforming and eliminating discrimination in education, legal and economic policies. Their paramount goal was equal rights with men, this was, and is, called liberal feminism (Tong, 1998, p. 45). Among these women, however, there was a group that saw themselves not as reformers but revolutionaries. They did not want to preserve the status quo and bring about change incrementally, but made bold statements about their views of the cause of women's oppression, the sex/gender system (Saulnier, 1996, p. 30; Tong, 1996, pp. 45 - 46).

This idea was not new, Stanton nearly a century before had felt that western society was based on patriarchal ideals, because women were made after, for, and subject to, men (Tong, 1996, p. 46). Women from the mid 20th century borrowed ideas from the 'new left' and civil rights movements and from these movements it was postulated that the problems of women and the

powerlessness they experienced had political origins and this meant radical action was necessary in order to achieve personal power and the liberation of women as a whole (Saulnier, 1996, p. 30).

Tong (1996, p. 46) states, even with these types of definitions it is often hard to draw a definitive line between liberal and radical feminist ideology, and within radical feminism it is even more difficult to differentiate the various types of feminism or clarify a definitive 'theory' of radical feminism. The reasons, say Rowland & Klein (1996, p. 9), are that "radical feminism has concentrated on creating its theory in the writing of women's lives and through political analysis of women's oppression", rather than defining and redefining radical feminist 'theory'. Radical feminists state that other forms of feminism have had convenient existing theoretical structures in which to work and develop their theory e.g. socialist and post modernist feminism, whereas radical feminism has striven to "create an original political and social theory of women's oppression, and strategies for ending that oppression which come from women's lived experiences" (Rowland & Klein, 1996, p. 9).

Because of this approach, some have argued that radical feminism does not have a theory. Radical feminists support this claim to a degree, in that they admit radical feminist theory has not been written down. However, their theory has always been embodied in practice and in the way a woman acts politically. They believe this practice and the resultant actions should be taken just as

seriously as a statement of theory written down in a book that no one reads (Rowland & Klein, 1996, p. 13).

From this comes the concept that radical feminism is not "an objective exercise, disengaged from women themselves" (Rowland & Klein, 1996, p. 13). Rather it sees women at the centre of an oppressive society and names this oppression as the system of patriarchy. A holistic view of the world women live in is required by analysing and probing all facets of the existence of these women, women and their experiences are the centre of experience (Rowland & Klein, 1996, p. 13). "It should not be, and radical feminism is not, a laundry list of women's issues, rather it provides a basis of understanding every area of our lives...politically, culturally, economically and spiritually" (Rowland & Klein, 1996, p. 13).

The theory of radical feminism tries to understand women and their lives from four interrelated concepts. It describes the reality of women's existence, it provides analysis on why this reality exists, where this oppression of women originated, and strategies on how to change this reality and "determine a vision for the future" (Rowland & Klein, 1996, p. 14). The first two concepts will be described to make up this framework in the areas of; women's language, the sex/gender system and men's and women's nature, history and the system of patriarchy.

HISTORY

An understanding of many subjects starts with a viewing of its history. History making and writing began in ancient Mesopotamia, selected events were recorded and interpreted so their meaning and significance was understood (Lerner, 1986, p. 4). Within a feminist framework, from the onset, difficulties are inherent with the very concept of history. This is because, to look at a history of nursing is to look at women's history, and the relationship of women to history is full of conflict and problems.

Versluysen (1980, p. 176) writes that history is a look into the past, it is "an intellectual operation which reconstructs the past through the interpretation of fragmentary written residues". However, there are factors that profoundly influence it. Initially, the historian is limited to available resources, these sources are normally written by individuals who are long dead, about issues they deemed as relevant or important, from this it can be seen there is already a bias (Versluysen, 1986, p. 176). Secondly, the selection of relevant events and interpretation is then done by the historian and their social values are a part of this selection and interpretation (Versluysen, 1980, p. 176). Because of the implicit values, history can never be an "atheoretical neutral collection of facts", since 'facts' only become history via the intervention of individual historians (Versluysen, 1980, p. 176).

The third, and for radical feminists, very important aspect of history is the belief that thus far history has been very highly selective to the point of being one dimensional (Versluysen, 1980, p. 176). It has done this by addressing most history from a male perspective with masculine interests, values and concerns, "our legacy is a literature in which vast tracts of the past seem to have been populated exclusively by men" (Versluysen, 1980, p. 176). Women's accomplishments and experiences have been left unrecorded and not interpreted, history has seen women marginalised when accounting for the making of civilisation (Lerner, 1986, p. 4). Lerner (1986, p. 4) goes on to say that as a result of this marginalisation, the past of half of humankind has been omitted, and therefore distorted, as the remaining half is from the male viewpoint only.

Women's history has not been valued, or their contribution has been trivialised with the end result that it is very difficult to perform a sustained systematic study of women's past (Versluysen, 1980, p. 176-177). Feminist historians are starting to rectify this, but history, like many other academic arenas, has been dominated by men and their value systems,

> If history has failed to study women as it has studied men and has treated the sexes unequally, it has simply reflected the principal values and social arrangements of a sexually unequal society. Our society has evolved an elaborate set of beliefs to justify its consistent ranking and rewarding of male interests and activities. This belief system has usually informed historical investigation and explanation
>
> (Versluysen, 1980, p. 177).

Lerner (1986, p. 5) states that women are both essential and central in creating society, they have made history and yet the problem lies with their not knowing, and therefore not interpreting, their own history. Women's historical experience has differed significantly from men's, and the study of their history is intriguing for radical feminists and may hold the answers to questions they have been asking for decades, such as, women's complicity in upholding the patriarchal structure (Lerner, 1986, p. 6). History, and the study of it, is vital to understanding women, and therefore nursing, as a predominately female occupation.

A view of nursing history as described above will be laden with the values, culture and beliefs of those writing it and yet these biases provide invaluable clues as to what has shaped nursing through the years until the present day. It allows individuals to examine those aspects that have impacted on nursing and made it what it is today, both negative and positive.

Radical feminists believe history needs to be reviewed and re-examined where women have a central role. Versluysen (1980, p. 175) feels very strongly that the examination of the history of nursing needs to look even further back than its 19th century modern beginning. It is paramount that sexual divisions, women's position in society and society's values be examined also within this history, it is

only through this interpretation and viewing of women's history that nursing can and should be understood.

WOMEN'S OWN LANGUAGE

Radical feminist writing often combines creative writing within their theory (Rowland & Klein, 1996, p. 9). Radical feminism is not just based on rational intellect but also on emotional aspects, and creative writing is an invaluable tool to illustrate this. This concept is evident in the writing of women such as Mary Daly. Daly is a radical feminist and describes the oppression of women as patriarchy, "a prevailing religion of the entire planet with its essential message of necrophilia",

> radical feminism means that mothers do not
> demand Self-sacrifice of daughters, and that daughters
> do not demand this of their mothers, as do sons in patriarchy.
> What both demand of each other is courageous moving
> which is mythic in its depths, which is spell-breaking
> and myth-making process. The 'sacrifice' that is required
> is not mutilation by men, but the discipline needed for
> acting/creating together on a planet which is under the Reign of
> Terror, the reign of the fathers and sons. Women moving
> in this way are in the tradition of the Great Hags.
>
> (Daly, 1990, pp. 39-40).

This type of writing is not the accepted and 'normal' type of theory and yet radical feminism embraces it and base much radical feminist theory on it. It is about women living both on a real and emotional plane, and radical feminists believe

this is how women as an oppressed social group can understand and be understood by other women.

SEX/GENDER SYSTEM – MEN'S AND WOMEN'S NATURE

Another fundamental concept of radical feminism is the belief that men's and women's nature is influenced by culture in which they dwell. As a culmination of this nurses and nursing is firmly associated with the female sex in the mind of society. Because of this nursing is the most sex segregated of occupations (Davies, 1995, p. 2). Radical feminists state that although it is believed that women's nature is kind, loving and nurturing, this idea has come from what the patriarchal structure has forced on women rather than their true nature (Rowland & Klein, 1996, p. 12). Davies (1995, p. IX) felt that these gender assumptions were a fundamental aspect of social life and part of the 'codes of masculinity' which all individuals in western society are exposed.

Ideas from the Greek philosophers have determined and shaped western science and philosophy, and therefore culture and values (Lerner, 1986, p. 206). Aristotle's work on the origin of human life took these ideas from a myth to a science by defining four factors, three of which could be attributed to the male's contribution and the fourth (and incidentally lowest) to the female. Throughout this very convoluted 'scientific theory' he discussed the male as active and the female as passive (Lerner, 1986, p. 206). Through further explanation he finally defined women as 'mutilated males', devoid of the principal of the soul and these

ideas permeate much of Aristotle's work, both biological and philosophical (Lerner, 1986, p. 206). He continued this, reasoning, that if women were biologically inferior to men, all other faculties would also be inferior (Lerner, 1986, p. 207).

Slavery as an institution in his time was much debated, Aristotle used in his writings the metaphor of the marital relationship, male over female, to justify the master's dominance over the slaves. Because the former was 'natural' it made the latter acceptable (Lerner, 1986, p. 209). From the active male, passive female concept, he extrapolated and stated "males were rational, strong, endowed with the capacity for procreation, equipped with soul and fit to rule", the female conversely was "passionate and unable to control her appetites, weak, providing only low matter for the process of procreation, devoid of soul and designed to be ruled" (Lerner, 1986, p. 209).

This 'naturalness' of male dominance over females, Aristotle gave to their life roles. Men should be involved in politics, philosophy and rational discourse (being of greater value), women should minister to the needs of life (Lerner, 1986, p. 209). Aristotle's philosophy "encompassed and transcended most of the knowledge then available in his society" and therefore ensured that not only was the inferior status of women incorporated into this patriarchal structure, it did so in a manner that was invisible, through the management of the state, individual house holds, body politics and the patriarchal family (Lerner, 1986, p. 210).

Much of Aristotle's philosophy has been debated through the centuries, however male supremacy and dominance was elevated to the power of natural laws, quite a feat says Lerner (1986, p. 210). Aristotle's science and philosophy would, for many, be considered ancient history, with no impact on 19th and 20th century nursing. Lerner (1986, p. 211) states however, the heritage of Aristotle's science and philosophy has been used by Western civilisation for many centuries and continues to be an influence on its science, philosophy and gender doctrines.

The modern beginning of nursing was during the late 1800's. During that time early social science has its beginnings. Pure scientific knowledge such as mathematics, physics, astronomy and biology were seen as the gold standard of knowledge development and it was upon this that the early sociologists developed their knowledge (Conway, 1973, p. 140). Assumptions were made by early sociologists, lacking clear understanding of reproduction, whereby it was thought females had not developed on the evolutionary scale as far as men because of the need to conserve energy for reproduction. This conservation of energy meant women did not have the psychic and intellectual growth of men or the capacity for abstract reason and abstract justice, signs of a highly evolved life (Conway, 1973, p. 141).

Sociologists following in Darwin's footsteps of inheriting 'acquired characteristics', could explain the existing stereotypes of female character on the basis of

females living under male domination since the beginning of time, therefore scientific views of women as intuitive and irrational were accepted as fact (Conway, 1973, p. 142).

These concepts were promulgated by other social scientists of the time who saw sex differences as arising from a basic difference in cell metabolism. At its most basic level male cells were seen to have a tendency to dissipate energy, females to store and build up energy (Conway, 1973, p. 143). What this meant was male and female sex roles were clear and decided at the most basic form of life, the cell, and therefore nothing could change these immutable facts of nature (Conway, 1973, p. 144). Further to this, the position of women in society and their subjection to men was a mere reflection of what had been ordained in the cells (Conway, 1973, p. 146). The results of these cellular findings of social scientists defined males as of higher intelligence than females, men were more independent and courageous than women and could expend and sustain energy bursts in physical and cerebral activity (Conway, 1973, p. 146-147). Women conversely, possessed "social talents based on their cellular activity, they were considered superior to men in constancy of affection and sympathetic imagination, they were patient because of their passivity and the need to store energy" (Conway, 1973, pp. 146-147). Feminists claim that this patience practised by women then and now is one of the qualities of the oppressed.

These sociological concepts were considered 'proof' of the roles and relationships among the sexes, it was 'provable' because it was in the cells and therefore no guilt should be felt by either sex about female inferiority. Cellular function, after all, was governed by natural laws (laws of nature) and these operated outside of human societal control (Conway, 1973, p. 147).

Society, values and culture are based around these types of beliefs. The persistence of belief in these type of sexual stereotypes Conway (1973, p. 154) says has been ingrained and accepted by society for well over a century now (Aristotelian beliefs, many centuries), with little serious thought on the subject. Men are the providers, aggressors and logical beings, whereas women are caring, nurturing and illogical. The essentialism and association of these characteristics with the sexes means that the real reasons behind these supposed gender characteristics are overlooked. The main cause is socialisation according to radical feminists. Instead 'biology' is given as the reason behind our social structure.

Davies (1995, p. 2) finds proof in these ideas by citing an example, where the qualities of warmth, nurturing, caring and emotional contact are so believed to be inherently female, that women nursing is unremarkable, however a man in the same job is very rarely described as a 'nurse' but as a 'male' nurse.

This has not always been so, certainly men have been nurses in the past, especially under the influence of Christianity. History shows that their care was based on the principles of kindness and nurturing and humanitarian endeavours (Dolan, 1978, p. 45), according to early sociologists traits only females possessed. It may therefore be possible to extrapolate that this division between the sexes and their apparent caring traits would appear to be based on something other than the true nature of men and women.

Lerner (1986, p. 6) states that men and women are biologically different but the values associated with the differences mentioned above, and the implications that are derived from those values, are not based on biology but the culture and society lived in i.e. socialisation. The structure that makes up these values and culture was created by men, so that male power and female subordination could be sustained. This structure is named by radical feminists as 'patriarchy'.

PATRIARCHY

A radical feminist concept is described by Kate Millett when she states that "sex is a status category with political implications" (Rowland & Klein, 1996, p. 12). Millett (Spender, 1985, p. 31) proposed the hypothesis that there is a power dimension in the relationship between the sexes, and this makes up a major part of radical feminist belief, that women are a group which can be likened to a social

class. Radical feminists have felt that this class, male/female system, is the first and most fundamental example of female oppression, upon which "all other oppressive systems are built upon" (Rowland & Klein, 1996, p. 12). This is further emphasised, as mentioned above, when men as a social group oppress women as a social group. It is power rather than difference which determines the relationship between men and women (Rowland & Klein, 1996, p. 13). The system through which men do this to women is named as patriarchy.

Patriarchy is defined in the dictionary as a "form of social organisation or society governed by such a system in which a male is the head of the family and descent, kinship and title are traced through the male line" (McLeod, 1986, p. 618). However, to radical feminists this definition only tells part of the truth. Patriarchy, as described by Saulnier (1996, p. 34) means family systems organised by male lines, but also, and most importantly, a society with a construct which proportions the share of power mainly to men. Indeed this 'male supremacy' ideology is described by radical feminists as the oldest type of political division and it is upon this model that all other systems of domination are based (Saulnier, 1996, p. 34). Patriarchy as a universal value system can manifest itself in different forms based on culture and history, but its main precepts still consist of a,

> ...system that privileges men through the complex political manipulation of individual identity, social interactions, and structural systems of power. It is not only legal systems that create and reinforce the sexual hierarchy,

> but all human interactions perpetuate and are permeated by male privilege
>
> (Saulnier, 1996, p. 34).

A definition by Bleier illuminates further,

> By patriarchy I mean the historic system of male dominance, a system committed to the maintenance and reinforcement of male hegemony in all aspects of life – personal and private privilege and power as well as public privilege and power. Its institutions direct and protect the distribution of power and privilege to those who are male, apportioned, however, according to social and economic class and race. Patriarchy takes different forms and develops specific supporting institutions and ideologies during different historical periods and political economies
>
> (Bleier 1984 cited in Rowland & Klein, 1996, pp. 14-15).

Underlying patriarchy, as described above, is the assumption that men are the providers, aggressors and logical beings, whereas women are caring, nurturing and illogical. The structure that makes up these values and culture was created by men so that male power and female subordination could be sustained. This structure includes institutions such as the law, religion, and the nuclear family. Indeed, any of the ideologies that support the 'naturally' inferior position of women, and socialisation processes in which behaviour and belief systems are taught and perpetuated among men and women, making men powerful and women less powerful are considered part of the system of patriarchy (Rowland & Klein, 1996, p. 16).

Knowledge, and the control of it is very important to continuing patriarchy. Men have controlled knowledge to such an extent that women are almost invisible in many spheres of culture (Rowland & Klein, 1996, p. 16). From a position of power it is obvious that it is in the best interests of men to maintain the patriarchal system as it now stands. This is achieved through pay inequality and the sex segregated work world, and there are very few jobs as sex segregated as nursing in the modern world (Rowland & Klein, 1996, p. 17). This system has worked against females even within nursing. In New Zealand male nurses received higher pay than their female colleagues in a parallel position. Until 1964, male nurses in New Zealand received £200 more a year than women (O'Connor, 1993, p. 16).

Patriarchy, then, can be seen as the culmination of all the before mentioned ideas. History and the sex/gender system are the support structure of patriarchy and have a profound effect on the lives of women in both the public and private spheres.

A summary of the major concepts of radical feminism would include a framework where, women are viewed historically as the first oppressed social group and history has been skewed because of this. History therefore, must be reviewed where women are a central component for accuracy and determination, but already existing history can be viewed to see its impact on women currently and through time. Women's oppression is widespread and exists in virtually every

known society. The oppressors are named as men, as a social group, and at the root of this oppression is the structure of patriarchy. This structure is visible and manifest in all facets of western society including law, religion, family and employment. Although biologically different it is the values and culture of society that teaches men and women the aggressive, powerful, provider, and caring, less powerful, nurturing roles. Control, specifically of knowledge, is the domain of the powerful group (men), through pay inequality and sex segregated work. This control comes from power, and it is power, rather than difference between men and women that determine the relationship between the sexes (Rowland & Klein, 1996, pp. 11-17; Saulnier, 1996, p. 32 and Tong, 1996, pp. 46-47).

A radical feminist theory framework provides a basis for understanding areas of women's lives including, political, cultural, economical and spiritual. It allows a description of what exists by being able to name and analyse the reality of women's existence. It also names the origins of women's oppression and strategies on how to change that reality and determine a vision for the future.

Finally, it is only through allowing women to look at their lives and explain it in their own language that women will be able to grow and become more powerful. Examining nursing and nursing knowledge development within a framework of the concepts of male oppression and the structure of patriarchy, provides a means to view the history of women and the female dominated profession of nursing, from a generally unexplored perspective.

Chapter Three

Literature Review

Nurses bring knowledge from many sources to their everyday practice. This knowledge can come from life experiences influenced by society and social upbringing, and structured education with its inherent professional nuances (Chinn & Kramer, 1995, p. 2). Carper (1978, p. 14) examined nursing literature and described four patterns of knowing that nurses have valued and used in practice. Ethics, the component of moral knowledge in nursing, aesthetics, the art of nursing, personal knowing in nursing and empirical, the science of nursing. Each component contributes an essential part to the practice of nursing (Chinn & Kramer, 1995, p. 4).

However traditional science (empirical knowing) has acquired a superior status as a means for nursing to develop knowledge (Chinn & Kramer, 1995, p. 2). In order to appreciate why empirical knowledge is valued over the other ways of knowing, gender, in relation to the history of nursing, and the roots of nursing knowledge need to be examined. This will be examined within a framework of radical feminism, from the perspective of history, women's own language, the sex/gender system and men's and women's nature and the patriarchal system. Although patriarchy will be discussed within this literature review as a single concept, it is possible to see its thread weaving throughout the literature review.

History

Versluysen (1980, p. 175) says that history shows women have been the healers in the past. This healing role has assumed many roles including first aid, midwifery, apothecary and the general care of the sick and dying. The interesting point however, is the description of the vast range of roles has been more or less absent from history, and Versluysen (1980, p. 175) states this is because of the biases against women in a male dominated history. Versluysen (1980, p. 175) states it is important to view medicine and nursing, not from how historians paint these two jobs, i.e. professional and non professional, orthodox and unorthodox, these facets are of less value historically than the pivotal fact, that from the mid 19th century, medicine was male dominated and nursing, female. It is on this basis that Versluysen (1980, p. 176) states nursing has been mainly ignored in history. Further to this Versluysen (1980, p. 177) says history has portrayed and interpreted medicine in a positive and superior manner, whereas nursing has been marginalised and portrayed in a subordinate manner, and therefore as having less value.

The focus of health care history as Versluysen (1980, p. 177) states, has been extremely narrow and almost solely from a medical perspective. 'Great men' of medicine, however did not make history alone and the development of the modern health care system has not been solely as a result of them. As Versluysen (1980, pp. 177-178) points out again and again, history has tended to concentrate on these 'great men' and their influence has been seen as

paramount in medicine and medical knowledge development, all other providers of health care have been marginalised and given names such as 'quacks' and 'old wives'. From this, any ideas or knowledge from these other marginalised groups was dismissed by medical men as having little or no consequence, this Versluysen (1980, p. 178) says has been accepted by historians and should be seen for what it was and is, "a sexually selective and extremely partial view of the past".

Nursing is older than medicine and was often associated with the church and military and delivered by both women and men (Bunting & Campbell, 1990, p. 16). In the 13th century women distinguished themselves in the nursing role, alongside men and wielded considerable power and wealth (Bunting & Campbell, 1990, p. 16). Hospitals long ago had no physicians, only nurses that provided care (Bunting & Campbell, 1990, p. 16). Coupled with this, women's health, and especially midwifery, was considered for many centuries the domain of women healers. The Beguines are an example of this. They established a nursing order for women outside the control of the church. These women had control over their own lives, nursing and nursing scholarship in medieval times. However, along with many other 'healers' of the time, Beguines were aligned with, and part of, the peasant classes and their power was derived from support from this class who had faith in them, a class, it must be noted, that wielded little or no power in society (Bunting & Campbell, 1990, p. 17).

Some history points to the fact that women have always been healers and were often the only ones offering healing to women and the poor (Ehrenreich & English, 1973, p. 4). What happened to these 'healing' women? Ehrenreich & English (1973, p. 7) single out the witch craze which began in the 14th century and lasted to the 17th century. The 'renaissance', or as stated by Bunting & Campbell (1990, p. 21), the rebirth of absolute patriarchy was characterised by a "ruling class campaign of terror directed against the female peasant population" or the healers of these times. To those in control, such as the protestant and catholic churches, these women represented a political, religious and sexual threat (Ehrenreich & English, 1973, p. 7), because of the power they wielded through the peasant class. Physicians conversely were under the patronage of the ruling class and wanted full control and power of healing (Bunting & Campbell, 1990, p. 17). Bunting & Campbell (1990, p. 17) point to the reformation or Protestantism as being a dark age for nursing and the religious nursing institutions and hospitals. Men left this healing profession and there was a general decline in nursing care.

From the early 19th century there were major societal changes especially in the area of population shift. This brought large amounts of people into the cities of Britain with the inherent problems associated with health and care of the sick. As a result of this there were many social and humanitarian problems, not the least of which was caring for the sick (Jolley, 1993, p. 10).

Into this setting Florence Nightingale began her campaign that changed the face of nursing. Nursing, Nightingale felt, was giving women, especially unmarried women, a means to support themselves and "a respectable way to contribute to society" (Bunting & Campbell, 1990, p. 21). Indeed, it allowed them a place in society, respectability and protection (Lumby, 1991, p. 4).

Nightingale was raised in an aristocratic family, Palmer (1983, p. 231) saw this as influencing her outlook towards nurses, so that she saw them as being similar to servants, and thus belonging to the same class and being treated in a similar manner. This outlook and the events during the Crimean war also affected how nursing was seen, then and now. Nightingale recognised the power and influence of the medical men in the Crimea and not wishing to raise their opposition and feeling the need to supervise and control the women she took with her, established a system and organisational structure where the nurses were subservient to the physicians (Palmer, 1983, p. 230).

Faced as she was with the situation in Crimea where the support of the physicians was vital for the continuation of nursing as she perceived it, Nightingale promoted the circumstance where Nursing's worthiness was equated with their 'helpfulness' to the physicians. Keddy, Gillis, Jacobs, Burton & Rogers (1986, p. 746) felt this situation was closely linked with the marriage situation of

the time, with the wife being considered a helpmate and appendage of the husband.

As a result of this, medicine had a lot of control over nursing and this continued into the 20th century with doctors being moderators over what nurses learned, who passed the examinations and who was allowed to register. This process empowered medicine and meant that nursing did not have the means to control their own work environment and learning (Keddy et al. 1986, p. 747). Nightingale was a party to this, even if unwittingly. Breen (1986, p. 16) felt that Nightingale believed nursing knowledge was distinct from medical knowledge because her schools of nursing were autonomous in administration and decision making. However, Lumby (1991, p. 5) states, although autonomous practice was Nightingale's aim and idea, Nightingale destroyed this autonomous practice herself by insisting that doctors provide the orders for nurses to follow.

Breen (1986, p. 16) points to the rapid and extensive medical technology expansion in the late 19th century, from this nurses were seen as a support to medicine and because of their lack of formal educational preparation, this again lead to control by the medical profession. However, Lovell (1981, p. 37) points to a more sinister cause of medicine's interest in the teaching of nurses. Namely, prior to 1910, medicine came to the realisation that not only was nursing an applied science, but also, that it had the potential to become as 'important' as medicine. Therefore, physicians attempted to 'lure' nursing toward medicine thus

establishing control over nursing. Medicine achieved this by 'assisting' with nursing education reform and in doing so, disempowered nursing and ownership of nursing, by nurses, was lost.

In 1976 Jo Ann Ashley wrote a groundbreaking work that examined the whole concept of medicine's control over nursing knowledge and its attempts to try and prevent nursing from gaining more power, control and prestige than medicine. She quotes many medical speakers from the turn of the 20th century for example,

> Every attempt at initiative on the part of nurses...
> should be reproved by the physician and by the
> hospital administration. The programs of nursing schools
> and the manuals employed should be limited strictly to the
> indispensable matters of instruction for those in their
> position, without going extensively into purely
> medical matters which given them a false
> notion as to their duties and lead them
> to substitute themselves for the physician.
> The professional instruction of...nurses
> should be entrusted exclusively to the physician,
> who only can judge what is necessary for
> them to know.... These maxims should certainly
> be borne in mind by the physician who has
> dealings with the nurse, as a matter
> of simple justice to her that she be not
> encouraged to take steps that are not in her province.
>
> (Dorland, 1906 cited in Ashley, 1976, p. 78)

In these early days of nursing, a nurse's worth was most often not described in nursing care, but rather in the proficiency with which she carried out the physicians orders. Patient outcomes were seen as unimportant so long as the nurse was regarded as 'good' by the physician (Keddy et al. 1986, p. 748).

Nurses had to show respect for a doctor because of his abilities, knowledge and devotion to the community's health, nurses must not disagree with a doctors judgement as the doctors image in the eyes of the patient must be upheld (Keddy et al. 1986, p. 748-749).

Clark (1993/1994, p. 27) a New Zealand nurse who started her training in the 1930's describes the power that doctors had over nurses. The doctors 'rounds' meant the "sister, with the charts ready to produce at a moment's notice" was expected to walk deferentially behind the doctor, staff nurses followed with "hands meekly behind their backs" and it was preferable that the junior nurses be in the sluice room and not visible at all.

From this brief historical overview it can be seen that medicine emerged and developed and became associated with high social status and prestige, whereas nursing languished far behind. One reason Versluysen (1980, p. 179) states, is history shows medical writers were often derogatory about nurses especially in the years when doctors and nurses competed for the same patients, and it would be wrong to suggest that history has ignored nursing entirely. Instead, Versluysen (1980, p. 179) says it has been far more subtle, with stereotyping of women by exaggerating certain characteristics, especially feminine ones. These stereotypes include "illiterate old wives, exceptional wives, exceptional heroines or saintly ministering angles whose mystical aura contrasts starkly with the apparent rationality of male medicine". These factors all show that history

making has been influenced by social norms rather than reporting from an unbiased or factual perspective. Another important factor in this equation was the sex of both these groups.

Sex/gender system – Men's and Women's nature

The history that is portrayed of nursing has lent power to the belief that nursing is the 'helper' of medicine (Versluysen, 1980, p. 182). This 'helper' role has been perceived to be part of women's makeup, their "natural biological functions" (Versluysen, 1980, p. 182) that is germane to the care of the sick.

Some historical accounts have shown that it was not until the 19th century, during Victorian times, that gender became defined into 'curing' and 'caring' functions, these being designated to male doctors and female nurses respectively (Versluysen, 1980, p. 188)

Jolley (1993, p. 1) also states that nursing as we know it today had it roots in the second half of the nineteenth century and that professions reflect those norms, attitudes, beliefs and values that are held at the time of the professions inception. Because of this, nursing began in a world that was male-oriented, where women and their activities were always measured against and in relation to men, certainly not independently, and where the role of women was to serve men's needs and convenience (Lovell, 1981, p. 35).

The Victorian world, as in most cultures that have been influenced by Judeo-Christian beliefs, saw women as the vehicle for the "continuation of the patriarchal lineage" (Perry, 1994, p. 482). Any education for women was done with the ultimate aim of preparing them for marriage and motherhood (Jolley, 1993, p. 7). Education was given to encourage women's 'natural' submission to men and authority and they were not expected to develop personal opinions except in trivial matters (Jolley, 1993, p. 7). With regard the concept of nursing, it was felt in those Victorian times, that for women there could be no greater mission in life than caring for "God's poor, in doing so a woman may not reach the ideals of her soul; fall short of the ideals of her head, but she will satiate those longings in her heart from which no women can escape" (Lovell, 1981, p. 36).

Women had no rights to property, her children or indeed her existence in common law apart from her husband, and once married her life consisted of continuous child bearing and raising large families (Jolley, 1993, p. 8). Conversely an unmarried women was seen as a failure and often had financial and psycho-social difficulties resulting from not fulfilling her God ordained role of marrying and child rearing (Jolley, 1993, p. 7).

Because of the culture at its modern inception, nursing is a gendered occupation (Robinson, 1991, p. 29). For much of recent history, medicine has been associated with men and nursing with women, this translates into male

dominated medicine being characterised by dominance, aggression and exploitation whilst the female dominated nursing characterised by subordination and submission (Keddy et al. 1986, p. 750). Breen (1986, p. 16) continues in this vein by stating that Nursing's fundamental problem is that nurses are women in a women dominated profession within a male dominated culture and they are controlled by male systems in medicine and hospital administration.

Sadly, however nurses themselves have, at times, promoted these ideals. Isabel Stewart, a prominent nursing leader, in 1921 noted that nurses and nursing in supporting physicians,

> [supported the] age-old tradition that men are naturally superior to women, that women exist mainly to serve the comforts and purposes of men, and that men know best what is good for women, whether in politics or education or domestic life.
>
> (Stewart, 1921 cited in Ashley, 1976, p. 76).

Robinson (1991, p. 29) goes on to say that the health system from the beginning of modern nursing has capitalised on the qualities that make a woman, because nursing has always and in many ways continues to be seen as 'women's work'. Those qualities that make a good nurse also make a good woman and nursing has always been seen as an acceptable job for women since it merely extends their domestic role into the public domain (Rafferty, 1995, p. 141).

Robinson (1991, p. 30) felt that in all the jobs in the world that were dominated by sex-role stereotyping, nursing was the most handicapped because they are

made to doubly follow the subservient role both in the patriarchal society in which they live, and also in their submission to the medical profession. When women are subordinated in a patriarchal society their growth and learning is limited and distorted (Lovell, 1981, p. 25). "Nursing was to be, therefore, a woman's duty not her job. Obligation and love, not the need of work, were to bind the nurse to her patient. Caring was to be an unpaid labour of love" (Reverby, 1987, p. 6). Robinson (1991, p. 30) states this type of thinking 'de-professionalised' nursing, especially the relations between nursing and medicine, and within the patriarchal structure which is western society, meant subordination of nursing to medicine.

Patriarchy

Patriarchy, as outlined in chapter two, causes the relationship between the dominant and submissive group to follow a pattern whereby the dominant defines the acceptable roles for the subordinate. These roles generally provide services that the dominant group does not want to perform, and are not those that are highly regarded by the particular culture (Lovell, 1981, pp. 25-26). Lovell (1981, p. 26) points out that modern medicine would have been severely impeded if it were not for the subordinate group of nurses to provide the commodities that were required by the medical profession, but which they did not want to perform. Lovell (1981, p. 27) also goes on to state that medicine has a vested interest in that which may affect its profits, and the medical professions habit of protecting its assets or scope of practice has brought patriarchal practice to the fore in the

means it has used to limit Nursing's full potential. This is a direct result of doctor's fear of losing control of that which they have dominated for nearly two centuries. Ruether, an historical theologian gives an accurate portrayal of the position of nurses (and other women) in a patriarchal society,

> Socially, women form a caste within every class, meaning that they share a common oppression as women, but they find it hard to unite across class and racial lines because they are divided by the class and race oppression exercised by the ruling class.... As women they serve as the domestic servants of society, freeing the male for the work day by bearing all the auxiliary and supportive chores. When let into the work world they are generally structured into the same kind of domestic services and auxiliary support systems of male executive roles – as nurses, secretaries....
>
> (Ruether, 1976, cited in Lovell, 1981, p. 27).

Because the nursing workforce was a female dominated one, altruism, sacrifice and submission were expected, encouraged and demanded (Reverby, 1987, p. 7). Today this legacy still lives on, because, as Reverby (1987, p. 8) states, nursing has never been able to unite this altruism and sacrifice model with the autonomy that nursing so desperately needs. Keddy (et al. 1986, p. 745) felt that this history of submission to the medical profession had also been inadvertently perpetuated by nursing itself, by not recognising the power that nursing has and by imitating their knowledge base in the hopes of attaining their status and power.

Historically, individual nurses have perpetuated this medical control because doctors had 'favourites'. Being a doctor's preferred nurse meant you were a 'good' nurse with a special status within nursing. For nurses it was a matter of pride and honour, however it also allowed for more competitiveness among nurses and did not allow them to become a unified, and therefore, a powerful group (Keddy et al. 1986, p. 747).

Breen (1986, p. 16) and McLoughlin (1997, p. 111) state that when nursing is analysed it has all the hallmarks of an oppressed group exhibited by symptoms including, nurses' dislike of other nurses, divisiveness, lack of cohesion and believing the 'myths' of the oppressors. This is known as horizontal violence, and comes about, Breen (1986, p. 16) continues, because nurses can not revolt 'against the master' and because nurses, thinking they are powerless have internalised the attitudes of subordination. Sohier (1992, p. 66) states these feelings of distrust for each other are a true legacy of patriarchal rule.

Through recent feminist examination of nursing and its history Breen (1986, p. 16) contends that nursing has begun to be aware of its own culture, and through this awareness, it has become obvious that nursing has become infiltrated with the mechanistic, empirical model of medicine. McLoughlin (1994, p. 111) gives the example of how midwifery embraced the technology and empirical knowledge of the 1970's which they saw as an extension of their skills rather than how it eroded them.

Finally in the arena of gender and its impact on nursing, Reverby (1987, p. 10) states that the problems of nursing are tied up with society's broader problems of gender and class, so inextricably linked are they that one occupational group such as nursing can not possibly make the impact required to reverse these problems. Nursing because of its female nature, instead, reflects all those problems that being a female in a male dominated patriarchal society causes. Jones (1987, p. 59) contends that it isn't individual attitudes that need to change to enhance nursing, rather it is the tradition and historical nature of the nurse-doctor relationship that requires changing.

Women's own language

The concept of women's own language is germane to nursing. Davies (1995, p. IIX) studied nursing as part of the Project 2000 in Britain, and found in her two and a half years that she still had much to learn about the language of nursing. It was certainly made up of specialist and clinical terms, expressions and dialogue but she also saw something more fundamental,

> When those in the nursing world spoke of how they saw the nature of nursing work, of their ideals, of what they needed in the way of educational and other resources to deliver optimal care, above all when they spoke of holistic care and of commitment, their words sounded out of place. They were accused of being 'unrealistic', 'sentimental', or 'muddleheaded', they were said to be 'pretentious' in their borrowing from social science jargon, 'elitist' in their aspirations, and in particular, 'defensive' and 'hard to help'. Above all, it seemed, they were a frustration and a puzzle to their colleagues in the health field
>
> (Davies, 1995, p. IIX).

From this brief, but illuminating research, Davies felt there seemed to be problems with the language spoken. One reason nursing communication may be seen as 'sentimental' and 'muddleheaded' is because it is not considered mainstream, normal or proper by other health professionals. It is not how other health professionals 'talk', it is not understood by them and therefore negative descriptive words are given to it, rather than allowing nurses to develop their own language further.

Yet nurses have a way of discussing and relating to one another about their failures, problems and (rarely) their successes, and it is upon this that they learn and communicate with one another. Nurses have not kept records of their clinical knowledge and learning (Benner, 1984, p. 1). Because of this lack of record keeping Benner (1984, p. 2) feels nursing has been deprived of the "uniqueness and richness of the knowledge embedded in expert clinical practice." It may well be that this uniqueness and richness has been lacking in nursing writing and language as a result of medical male domination over the nursing profession. Indeed Antrobus (1997, p. 833) puts it most succinctly when she points out that "the limited kudos and job satisfaction available to nurses can be gained quickly and more easily if nurses align themselves with the language, knowledge and assumptions of the more powerful profession of medicine". It is no small wonder that nurses do not feel compelled to use their own language more and this is a facet of nursing that requires far more investigation.

Knowledge development

Changes in the mid 19th century meant medical doctors were gaining formal education at universities. Added to this, western culture had undergone a change in thinking from 'divine right' to a world view that was "mechanistic, individualistic and based on observable phenomena" (Hagell, 1988, p.228). This in turn meant that medical practitioners espoused the empirical method of science as the best and only legitimate one, and it was on this they based their medical practice.

However within this change, the position of men in patriarchal society and the rise of power and prestige of the medical profession meant other healthcare provider numbers, mainly consisting of women in the form of healers and midwives declined, "their knowledge was not considered legitimate because it was not scientific" (Hagell, 1988, p. 229). Further, western society has historically viewed health as the presence or absence of disease, therefore 'curing' the disease is the major aim. It stands to reason then, that because of this impetus, 'curing' or medical knowledge has been seen as the most prestigious (Jones, 1987, p. 59).

Since the turn of the century however, nurses have been attempting to improve their social and professional position and one of the ways that has been used has been an attempt to imitate medicine and its use of science (Hagell, 1988, p.

229). The development of nursing knowledge has been very dependent on the empirico-analytic view of science as espoused by medicine (Hagell, 1988, p. 230). Through its modern history the problem with nursing has been its intangibility, it has always been difficult to explain what nurses do (Radcliffe, 2000, p. 26). Radcliffe (2000, p. 26) states that it is therefore not surprising that nurses have attempted to mimic the medical knowledge structure through the academic world of post graduate, evidence based practice. Nursing roles have expanded and often taken over junior doctor's roles. Radcliffe felt that doctors were only too happy to relinquish these "crumbs from the table of medicine", tasks that are deemed less meaningful to them (Radcliffe, 2000, p. 26).

Why did nurses follow this pattern of thought? Lovell (1981, p. 28) states as a result of the internalised oppression of nursing as a class, women who were nurses, could find some semblance of self-worth by imitating medicine. Certainly because of the society that nurses were raised in, they were socialised to think of, not only themselves but also their work, as not valuable and inferior, especially their theoretical writings (Chinn, 1998, p. 80). Women's ideas have been trivialised, ridiculed and discounted for centuries and none more so than nursing ideas (Chinn, 1998, p. 81). So what better way to improve this situation than by imitating medicine's use of science? (Hagell, 1988, p. 229).

The esteem with which science has been held by nurses is illustrated by its prevalence in nursing writing, many theorists and educators have attempted to

illustrate the scientific nature of nursing (Hagell, 1988, p. 226). However as Hagell (1988, p. 226) goes on to state, the real problem lies with the fact that nursing has a "distinct knowledge base which is not grounded in empirico-analytic science and its methodology, but which stems from the lived experiences of nurses as women and as nurses involved in caring relationships with their clients."

Knowledge that is seen as true and important has been based around the patriarchal ideology, and science has been considered the legitimate, important knowledge because of powerful groups in society e.g. medicine (Hagell, 1988, p. 227). On the other hand, nursing knowledge, based on the position of women in a patriarchal society, within a specific gender-defined occupation, has been given very little value by society. Society has and continues to value the empirical knowledge which is linked with men, but in doing so has marginalised any of the other means of knowledge development, namely those associated with women (Krieger, 1991, p. 31). Although recent changes in nursing knowledge has attempted to define what 'nursing' is, it still receives very little attention, is ill defined and nurses and nursing faculty when speaking about nursing care, are more often than not, referring to medical care instead (Hagell, 1988, p. 230).

What are the problems with imitating science, the science used by medicine? Connors (1980, cited in Hagell, 1988, p. 230) states that it "fosters fragmentation, processing sickness into raw material for institutional enterprise and promotes

the interests of science over the needs of society." However the most damning statement of Nursing's reliance on the medical model and science comes from Ashley (1980, cited in Hagell, 1988, p. 230),

> In maintaining a close and long standing relationship to medicine and many other male dominated groups in the health field, which are based on the non-capacity to care, nursing has done great damage to itself, destroying its potential for power, prostituting the practice of nursing and killing the moral consciousness of nurses.

Obviously science in nursing is essential, much of what nursing does, relies upon scientific models and biomedical knowledge, unfortunately to the exclusion of other forms of knowledge essential to carry out patient care (Liaschenko & Fisher, 1999, p. 32). As pointed out by Hagell (1988, p. 231), nursing has relied upon and allowed scientific knowledge to assume too great an importance to the detriment of developing nursing knowledge. Nursing knowledge includes anatomy, physiology, pathophysiology and so on, however Liaschenko & Fisher (1999, p. 32) point out nurses also know how to move patients through the health care system and the resources to tap, in essence how to get things done. This knowledge is not scientific but nonetheless is absolutely essential for patient care.

Changes in nursing especially in the 1950's, with increased technology and the information explosion in medical science, meant that nurses had to increase their knowledge and skills to provide adequate care. Unfortunately whilst increasing

knowledge in these scientific areas, nurses' thinking and research mimicked academic standards and conditions which did not truly reflect their practice, rather, once again they reflected scientific models (Lumby, 1991, p. 5).

Nursing literature defines health as 'wholeness', holism is supposedly central to nursing care (Antrobus, 1997, p. 832). So why does nursing continue to emulate a profession where illness is central, as in medicine? (Sohier, 1992, p. 63). Sohier (1992, p. 64) felt that there should be a valuing of nursing knowledge. Nurses should show the importance of an experiential and intuitive knowledge base because it is supported, most ironically, by a growing body of empirical information in the form of nursing research, which states the different forms of knowing are essential in nursing care (Sohier, 1992, p. 64).

The knowledge that nurses use in day to day work was the subject of a study by Greenwood and King (1995, cited in Antrobus, 1997, p. 832). This study found that in both inexperienced and experienced nurses alike, reasoning was based on the medical model of care. Indeed, even oral communication between nurses was dominated by the medical paradigm, nursing and nursing care was virtually invisible. Antrobus (1997, p. 832) continues by stating that, nursing has drawn its knowledge base from a preoccupation with disease, and nursing care is still dominated by a view of illness as the starting point. Nursing as a whole is operating within an illness and disease oriented paradigm. The reason for this is a difficulty in articulating a distinct nursing knowledge base for nursing care, it is

therefore easier to use the visible and already articulated language of science and medicine (Antrobus, 1997, p. 832).

Krieger (1991, p. 31) points out that nurses need to be taught Carper's ways of knowing (as mentioned earlier), to realise that while empirical knowledge is important, so too are the other ways of knowing, because nurses must use their intuitive and nurturing abilities to develop meaningful relationships with their patients. Although changes have recently been underway to address this problem it is no small wonder that nurses feel an inability to speak about their knowledge when constrained by medicine's dominating practice within the healthcare setting.

One of the ways in which nursing has most tried to incorporate this empirico-analytic way of knowing into their practice, is their attempt to gain recognition as a 'profession' in their own right. Wuest (1994, p. 360) gives a long history of the concept of professions. In short, however, a sociologist by the name of Abraham Flexner, prepared a report from 1904-1905, which stated those requirements that were essential in order to be recognised as a profession and gain all the benefits that society offered to that group,

> Professions involve essentially intellectual operations; they derive raw materials from science and learning; this material they work up into a practical and definite end; they possess an educationally communicable technique; they tend to self-organisation; they are becoming

increasingly altruistic in motivation.

(Flexner, 1915, cited in Wuest, 1994, p. 360).

Wuest (1994, p. 360) states this view has never been challenged and is alive and well today because it stresses rationalism, science, objectivity, indeed everything masculine. This paper by Flexner also suggested that occupations could become a profession by developing the traits that were lacking in it. It is perhaps easy to see now, why nursing has developed the knowledge it has. To become a profession, was nursing going to develop women's knowledge, that intuitive caring knowledge so essential to nursing? In the male dominated culture of a university this type of knowledge would have been very suspect, when intellectual scientific achievements were seen as the highest source of knowledge (Wuest, 1994, p. 361). Instead research became the means in which nurses were going to establish a scientific knowledge base, and by doing so be accorded the same professional respect as other professions.

History, as pointed out by Wuest (1994, p. 361), was against them however, as it suggests that professional status does not evolve passively through recognition of scholarly discipline. Indeed as stated by Baer (1987, cited in Wuest, 1994, p. 361) "Nursing's major goal in fostering research was to achieve recognition of its professional status...it was an end, a criterion of professionalism they yearned to attain." So whilst it often has been used to improve nursing practice, it was seen as a means by nursing to show they could do research, rather than using it as a

tool to improve nursing knowledge. Cash (1997, p. 139) agreed with this notion by stating that professions are characterised by the power they have, the power structures that maintain them, but certainly not by "...the more internal definitions of professions that stress the special nature of their knowledge base." Thus nursing could strive for the most scientific knowledge base possible, but ultimately they do not, and have never had, the power structures in place to elevate them to the level they yearned for.

Further problems within nursing exist with the perceived gap between nursing theory and practice. Nursing theory has most often been developed by the elite and well educated in nursing. Unfortunately most often these have not been the nurses giving the 'care' which is purportedly Nursing's main work. Instead nursing scholars have become part of the problem through developing nursing knowledge which endorses the existing patriarchal structure, this has lead, as Wuest (1994, p. 363) states, to the situation where nursing knowledge reflects the wants of the dominant culture rather than the lived experience of nurses at the bedside.

The ways in which nurses 'know' and how they develop this knowledge is very topical at the beginning of a new century as shown in New Zealand recently with the establishment of a new nursing department in Auckland University's Faculty of Medicine and Health Studies. Nursing tutors spoke out against this move stating it "brings plans and nursing decisions related to nursing education under

the authoritative gaze of the medical profession [again]" (Jones, McKean, Smythe, Baker, Gunn & Giddings, 1999, p. 3). They felt nursing in New Zealand had attained a "strong nursing voice within the inter-professional health arena, gaining a status of its own due to nursing programmes that remained outside the medical school environment and in the hands of nurses" (Jones et al. 1999, p. 3). In reply to this the head of the medicine faculty of Auckland University stated, that apart from this faculty being the most sophisticated health training facility in New Zealand, equally important was the fact that it is the largest health and medical research facility available and he exhorts nurses to turn their attention more to research issues of relevance (Gluckman, 1999, p.4). Many nurses have come out in support of this by saying that they believe that "knowledge gained by nurses [in this research/empiric based arena] can only serve to increase the profession's standing..." (Mellars, 1999, p. 4). Empirical knowledge once again being seen, both from within nursing and medicine, as the standard to be attained.

Perioperative nursing

The imitation of medicine and its use of science is especially evident in the perioperative setting. This nursing speciality began in the late 1800's and throughout most of its development has been considered a technically based field designed to closely assist the 'important' work of the surgeon or anaesthetist, with very little patient contact, and therefore lacking the 'caring' component of nursing (Gilette, 1996, pp. 262-263). There was no mention of

assistance during surgery until the late 1800's (Groah, 1983, p. 4). In the 1880's Lister's discovery of the need for antisepsis during surgery made it necessary for someone (and who more appropriate than nurses?), to be trained in the prevention of infection through asepsis (Groah, 1983, p. 5). From there the operating room nurse speciality was born, becoming Nursing's first speciality.

Those early operating room nurses cleaned, polished, dusted, made gauze sponges, sterilised instruments and were responsible for every detail of the preparation and clean up required for a surgical procedure, obviously an extension of their role in the home (Groah, 1983, p. 6). About the patient, very little was noted or written about.

Operating room nurse shortages in the ensuing years meant that ancillary staff were often used to fill in where once registered nurses used to work, and the term operating room 'technician' was created. In the ensuing years the number of technicians increased and began to perform tasks that were formerly identified as nursing responsibilities (Groah, 1983, pp. 10-11). Up until the 1960's, increasingly, the operating room was seen as a technical field, so why use personnel, nurses, who were trained in the bedside care of the sick? With this came the thinking by nurse educators that because of its technical nature, the operating room was not necessary as a part of nursing students learning rotations (Groah, 1983, p. 12).

To counter the perception of 'technician', in the 1960's and 1970's the perioperative role was established. From this model it was envisaged that nurses would care for patients pre, intra and postoperatively, assessing patients needs and care, which supposedly would now became a major part of the job (Groah, 1983, pp. 14-16). However it can still be argued that nursing in the operating theatre is most often considered a purely technically based offshoot of nursing. Nowhere in the hospital setting, too, is the medical profession likely to have as much power as in the operating theatre, where all personnel are there with the common goal of 'helping' the surgeon. Walby, Greenwell, Mackay & Soothill (1994, p. 38) talk about nurses being spectators in the operating room, especially with regards staffing, theatre allocation, patient care and resourcing, where surgeons, because of their perceived dominant role, preponderate over all other members of the team.

With the establishment of the perioperative role, advanced education is now available for perioperative nurses. But how do nurses feel about this advancement of knowledge, have ideals changed and do nurses want to embrace this knowledge? Kate Nightingale, speaking to a perioperative nurses' annual congress, had this to say about knowledge development in the perioperative setting,

> Now, with a longer perspective, we may be able to agree that we never did need a caring workforce entirely made up of highly educated, degree level nurses; and that it is wise to have a vocationally trained body of carers, well prepared to work directly with patients and

> whose aspirations are to do that well, not to move on elsewhere to meet more challenges. *We have always needed more caring hands than professional nursing brains. (emphasis added)*
>
> (Nightingale, 2000, p. 360).

A person might be forgiven for thinking they were listening to a physician at the turn of the 20th century instead of a nurse at the turn of the 21st; that individuals are 'born nurses' and "womanly qualities on the part of the nurses [are] valued more than knowledge" (Ashley, 1976, p. 76). Have we come so far in time, yet progressed so little?

Traditional science (empirical knowledge) has acquired a superior status as a means for nursing to develop knowledge (Chinn & Kramer, 1995, p. 2) in all areas of nursing, but especially in the operating room. Nursing history, gender and knowledge development are all inextricably linked to nursing practice. However there is a dearth of literature on knowledge development within the perioperative setting as practised today. Therefore a research study on the impact of gender on nursing knowledge development in the perioperative context might be pursued.

Chapter Four

Summary, Conclusions and Recommendations

When the concepts of gender, patriarchy and women's history are viewed through a framework of radical feminism, it is possible to see that these facets have melded together to have a major impact on nursing knowledge development.

The history of nursing, skewed as it is by male domination through the medical profession and the social values of historians, shows nursing is older than medicine but its history is often unseen. The system of patriarchy with its inherent social, cultural and political values of male supremacy have caused this history and nursing knowledge to be not only invisible, but denigrated and marginalised if it has been brought to the fore. This is especially evident in the speciality of perioperative nursing, with recent developments to evolve its own nursing knowledge and role.

The perioperative role in nursing has been seen as a mere extension of the 'housekeeping' role women have in the household. The perioperative, like all nursing roles, has been seen as the sole domain of women, not only because of this extension, but also because caring has been seen as a part of women's 'feminine' nature. These factors, women's subservient position and living in a patriarchal society, have meant that all of nursing has been considered as having a low status and given no voice within the healthcare sphere.

There is a dearth of literature written in women's own language, what there is, is often seen as 'unrealistic' and 'muddleheaded' (Davies, 1995, p. IIX), and therefore considered unimportant and given very little priority. This is evident in the perioperative setting, where, what little is written is framed almost wholly in technical, and it could be argued, male based terms. The culmination of all these factors has meant that the perioperative role, like all nursing, as a women's profession, has been seen as unimportant in the health care sector and dominated by male medicine.

Attempting to rectify this situation, gain a 'voice' and be seen as an educated group with an important contribution to health care, nurses have actively worked to be seen as professional. The imitation of medicine has been seen as the means to do this and nursing has developed theories and gained knowledge through empirical means, holding it aloft, to show that nursing has the empirical knowledge that 'professions' should have. However, it may be argued that this approach is to the detriment of nursing, as described by Chinn & Kramer (1995, p. 2), although empirical knowledge does give nursing an excellent knowledge base to work from, and is completely necessary to keep nursing current and safe, it is the other forms of knowing and knowledge development that makes nursing a caring and patient centred occupation.

Nowhere is this affinity for empirics and lack of the personal and aesthetic ways of knowing more evident than in the perioperative setting. Within the nursing

field, perioperative nursing has long been considered a technical role without the 'caring' aspect prevalent in other areas of nursing (Gilette, 1996, pp. 262-263). Perioperative nursing in the 1960's and 1970's attempted to rectify their image of a 'technical' role that was being usurped more and more by non nursing staff, by developing the perioperative role, but what type of knowledge did they strive to gain? Because of the lack of literature on this subject, this is an area that requires more research to understand why nursing knowledge has developed as it has in the perioperative setting, and through this, to also understand the impact that gender has had on this knowledge development.

The history of perioperative nursing needs to be re-examined, as does, how the existing knowledge base of perioperative nursing developed since its inception over 100 years ago. To re-examine these issues, the impact of being a woman in a female dominated profession, that has been and is so subservient to the male dominated profession of medicine within a patriarchal society, is essential. Versluysen (1980, p. 189) writes that it is possible to construct a different kind of history about healthcare from women's perspective, but the historian must work from a different set of values and premises. These premises and values must include; viewing history with women as central in the role of perioperative nursing, valuing caring as highly as curing within the perioperative setting, recognising women's oppression and the impact that this has had on the perioperative nursing role, and valuing women's own language in the rewriting

and re-examination of perioperative nursing history, work and knowledge development.

A means to examine and develop this new type of history is a qualitative approach through historical research. An examination of historical documents and an interview of a sample of perioperative nurses, to examine their experiences and knowledge development as nurses living and working as women in western society and the nursing profession, is a suggestion for a useful starting point. Using an historical research method to explore primary and secondary sources of information, where the experiences of nurses in the perioperative field, living as women in a patriarchal society, and how those factors that have impacted on knowledge development related to gender, would be examined.

Historical research is 'the systematic collection and critical evaluation of data relating to past occurrences (Polit and Hungler 1999, p. 248). It allows questions to be answered of causes and trends and in doing this may illuminate current behaviours and practices (Polit and Hungler 1999, 248). Firby (1993, p. 32) states historical research allows information gathering which is of immense value, when the area of research is considering the nursing profession and the role of women in society. It provides knowledge and understanding both of

individuals and groups of nurses, and what they have contributed to development of the profession as a whole.

Firby (1993, p. 33) points to historical research as important in gaining insights into nursing and its development – its value lies especially in showing how society has functioned in the past, and in this case, presents a female perspective of history to counteract the male dominated one normally proffered.

This method of research would allow the re-examination of perioperative nursing knowledge development and the impact that gender has had on this knowledge development by allowing women to speak out, both in oral and written history, about those factors that have impacted on their knowledge development. It allows for examination of social, economic, cultural, political and philosophical issues, and by using women's own language, a 'new' history of perioperative nursing and knowledge development may become evident.

Gender and its impact on perioperative nursing knowledge development would be best explored in this manner because it is about women, and should thus be described by women, about their lives and that which has impacted on them and their knowledge development within this clinical setting. Apart from enabling a view of nursing that is female based, the historical approach allows women the opportunity of using their own language to describe their history, their

experiences of being women in a female dominated profession, and living in a patriarchal society.

The literature suggests that perioperative nursing has undergone many changes from its inception over 100 years ago. How nurses feel this and their knowledge have developed because of their gender and occupation would be the next step in examining knowledge development in the perioperative setting.

REFERENCES

Antrobus, S. (1997). Developing the nurse as a knowledge worker in health – learning the artistry of practice. Journal of Advanced Nursing, 25,(4),829-835.

Ashley, J. (1976). Hospitals, Paternalism, and the Role of the Nurse. Columbia University: Teachers College.

Benner, P. (1984). From Novice to Expert Excellence and Power in Clinical Practice. California: Addison-Wesley Publishing Company.

Breen, S. (1986). Feminism and Nursing. The New Zealand Nursing Journal, 79,(7),16.

Bunting, S. and Campbell, J.C. (1990). Feminism and nursing: Historical perspectives. Advances In Nursing Science, 14,(4),11-24.

Carper, B.A. (1978). Fundamental patterns of knowing in nursing. Advanced Nursing Science,1,(1),13-23.

Cash, K. (1997). Social epistemology, gender and nursing theory. International Journal of Nursing Students, 34,(2),137-143.

Chinn, P.L. (1998). Response to "Revisions in Knowledge Development". Scholarly Inquiry for Nursing Practice, 12,(1),79-82.

Chinn, P.L. and Kramer, M.K. (1995). Theory and Nursing a systematic approach. (4th ed.) St Louis: Mosby.

Clark, M. (1993/1994). Looking Back. The New Zealand Nursing Journal,26-27.

Conway, J. (1973). Stereotypes of femininity in a theory of sexual evolution. In M. Vicinus (Ed.),Suffer and be still Women in the Victorian Age (pp. 140-154). Bloomington: Indiana University Press.

Daly, M. (1990). Gyn/Ecology The Metaethics of Radical Feminism. Boston: Beacon Press.

Davies, C. (1995). Gender and the Professional Predicament of Nursing. Buckingham: Open University Press.

Dolan, J.A. (1978). Nursing in Society an Historical Perspective. (4th ed.). Philadelphia: W.B. Saunders Company.

Ehrenreich, B. and English, D. (1973). Witches, Midwives, and Nurses. A history of women healers. New York: The Feminist Press.

Firby, P. (1993). Learning from the past. Nursing Times,89,(46),32-33.

Gilette, V. (1996). Applying Nursing Theory to Perioperative Nursing Practice. AORN, 64,(2),261-267.

Gluckman, P. (1999). Equal status for nursing and medicine. Kai Tiaki Nursing New Zealand,5,(4),4.

Groah, L.K. (1983). Operating Room Nursing The Perioperative Role. Virginia: Reston Publishing Company Inc.

Hagell, E.I. (1988). Nursing Knowledge: women's knowledge. A sociological perspective. Journal of Advanced Nursing,14,(3),226-233.

Jolley, M. and Bryckczynska, G. (eds.)(1993). Nursing its hidden agendas. London: Edward Arnold.

Jones, C. (1987). Handmaiden Mentality. Nursing Times, 83,(40),59.

Jones, M., McKean, B., Smythe, L., Baker, H., Gunn, I. And Giddings, L. (1999). Valuing diversity in nurse education. Kai Tiaki Nursing New Zealand, 5,(3),3.

Keddy, B., Gillis, M.J., Jacobs, P., Burton, H. and Rogers, M. (1986). The doctor-nurse relationship: an historical perspective. Journal of Advanced Nursing, 11,(6),745-753.

Krieger, S.K. (1991). Nursing.ed and feminism. The Canadian Nurse, 87,(8),30-32.

Lerner, G. (1986). The Creation of Patriarchy. New York: Oxford University Press.

Liaschenko, J. and Fisher, A. (1999). Theorising the Knowledge That Nurses Use in The Conduct of Their Work. Scholarly Inquiry for Nursing Practice, 13,(1),29-41.

Lovell, M.C. (1981). Silent But Perfect 'Partners': Medicine's use and abuse of women. ANS Advances in Nursing Science, 3,(8),25-40.

Lumby, J. (1991). Nursing: Reflecting on an Evolving Practice. Victoria: Deakin University.

Lynaugh, J. & Reverby, S. (1987). Thoughts on the Nature of History. Nursing Research,36,(1),4-11.

McLeod, W.T. (Ed.)(1986). The Collins Paperback English Dictionary. London: Collins.

McLoughlin, A. (1997). The "F" factor: feminism forsaken? Nurse Education Today, 17,(2),111-114.

Mellars, C.J. (1999). Nurses must have confidence in own profession. Kai Tiaki Nursing New Zealand, 5,(4),4.

Nightingale, K. (2000). The past as prologue to the future. British Journal of Perioperative Nursing, 10,(7),354-363

O'Connor, T. (1993). Down the Decades. New Zealand Nursing Journal, 86,(2),16-17.

Palmer, I.S. (1983). Nightingale Revisited. Nursing Outlook, 31,(4),229-233.

Passau-Buck, S. & Magruder Jones, E. (1994). Male Ordered Health Care: The Iniquities of Women. New York: Power Publications.

Perry, P.A. (1994). Feminist empiricism as a method for inquiry in nursing. Western Journal Of Nursing Research, 16,(5),480-494.

Polit, D. F. and Hungler, B. P. (1999). Essentials of Nursing Research: principles and methods. (6th ed.) Philadelphia: Lippincott.

Radcliffe, M. (2000). Doctors and Nurses How come we're losing if we scored the equaliser? Nursing Times, 96,(15),26.

Rafferty, A.M. (1995). Art, science and social science in nursing: occupational origins and disciplinary identity. Nursing Inquiry, 2,(3),141-148.

Reverby, S. (1987). A caring dilemma: womanhood and nursing in historical perspective. Nursing Research, 36,(1),5-11.

Robinson, J. (1991). Working with doctors Educational Conditioning. Nursing Times, 87, (10),28-31.

Rowland, R. & Klein, R. (1996). Radical Feminism: History, Politics, Action. In D. Bell & R. Klein (Eds.), Radically Speaking: Feminism Reclaimed (pp. 9-36). North Melbourne: Spinifex Press.

Saulnier, C.F. (1996). Feminist Theories and Social Work Approaches and Applications. New York: The Haworth Press.

Sohier, R. (1992). Feminism and Nursing Knowledge: The Power of the Weak. Nursing Outlook, 40,(2),62-66,93.

Spender, D. (1985). For the Record The making and meaning of feminist knowledge. London: The Women's Press Limited.

Symonds, J.M. (1990). Searching for a paradigm: historical development of nursing and the women's movement during 1870-1920 and 1970-1990. Unpublished doctoral thesis, Vanderbilt University, Tennesee.

Tong, R.P. (1998). Feminist Thought. (2nd ed.). St Leonards NSW: Allen & Unwin.

Versluysen, M.C. (1980). Old Wives Tales? Women Healers in English History. In C. Davies (Ed.), Rewriting Nursing History (pp. 175-199). London: Groom Helm.

Walby, S., Greenwell, J., Mackay, L. and Soothill, K. (1994). Medicine and Nursing Professions in a changing health service. London: Sage Publications Ltd.

Wuest, J. (1994). Professionalism and the Evolution of Nursing as a Discipline: A Feminist Perspective. Journal of Professional Nursing, 10,(6),357-367.

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