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**Who perpetuates sex role socialization? : the changing image of the professional nurse educator from traditionalist to cycle-breaker : a qualitative interview study.**

Clara Willard Boyle  
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WHO PERPETUATES SEX ROLE SOCIALIZATION?  
THE CHANGING IMAGE OF THE PROFESSIONAL NURSE EDUCATOR  
FROM TRADITIONALIST TO CYCLE-BREAKER:  
A QUALITATIVE INTERVIEW STUDY

A Dissertation Presented

By

CLARA WILLARD BOYLE

Submitted to the Graduate School of the  
University of Massachusetts in partial fulfillment  
of the requirements for the degree of

DOCTOR OF EDUCATION

February 1990

Education

CLARA WILLARD BOYLE

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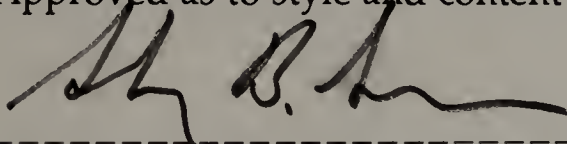
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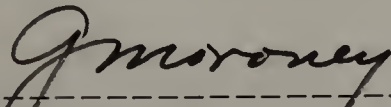
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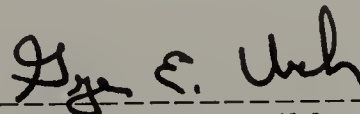
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## ABSTRACT

WHO PERPETUATES SEX ROLE SOCIALIZATION?  
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FROM TRADITIONALIST TO CYCLE-BREAKER:  
A QUALITATIVE INTERVIEW STUDY

FEBRUARY, 1990

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This dissertation explores the extent to which present day nursing education reflects its tradition-bound subservient roots. The purpose of this study was to identify behavioral phenomena which influence the perpetuation of sex-role socialization from teacher to student in the traditional milieu of nursing education. Using feminist and nursing literature as a theoretical base, the review of the literature revealed a dismal portrait of self perceived inferiority, oppression, and male domination of nurse educators in the academic environment. In contrast, the researcher found nurse educators do not succumb to environmental pressures. They do not conform to the feminine traits as defined in the review of the literature but are enthusiastic, confident, dedicated women who do not perpetuate the monastic military milieu or the rites of initiation in nursing. Nor do they socialize students into the doctor-nurse game or perpetuate the learned feminine traits of submission, passivity, conformity, and dependence.

Through in-depth interviews containing 107 open-ended questions, 42 nurse educators in Massachusetts and California described their personal experience with sex-role socialization as a woman, as a student nurse, and as a teacher. Crosstabulation contingency tables compared question responses in cell categories by 1. individual response, 2. state, 3. academic agency, 4. type of nursing program from which they graduated, and 5. type of nursing program within which they are currently teaching. Computation of means, t-tests, and Chi Square demonstrated no significant statistical difference in this nurse educator population for the five categories. The type of school they graduated from or the type of program they are currently teaching do not matter. After maturation, these 42 nurse educators present the same profile of a dynamic, competent, hard-working professional, concerned for the influence she has on students and on the nursing profession.

This study has determined that these women are positive role-models and cycle-breakers, encouraging students to be assertive, creative practitioners. This dissertation found that oppressive forces of sex-role socialization are not perpetuated by these 42 nurse educators but by others in the health care system. Implications for further research suggest that other members in the health care system be interviewed to ascertain who is responsible for perpetuating the feminine behaviors encountered in clinical agencies.



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## CHAPTER 1

### INTRODUCTION AND STATEMENT OF THE PROBLEM

Teaching is a wonderful way to influence and to guide, to help shape and mold practitioners of any kind. Sometimes I am in awe of the fact that I have some role to play in guiding and being a role model to any student. (NE # 27)

#### Nurse Educator As A Woman And A Teacher

In today's culture, the female nurse educator combines both teacher and role model into a career influencing successive generations of student nurses. The title of Nurse Educator was recently devised to describe a teacher of nursing. Prior to the development of this title, the Nurse Educator was identified and treated as a nurse, or a teacher, or a nursing teacher, or a nursing instructor. The term nurse educator has provided an identity and position description for those who teach nursing. "I am a nurse educator" is spoken proudly when credentializing the type of work.

This research examined the lives and teaching roles of nurse educators to document how they perpetuate sex-role socialization within the milieu of nursing education.

The study of women's experiences gives women a new means of understanding and coming to terms with their own personal condition. Feminist method is consciousness raising; the collective critical reconstitution of the meaning of women's experience, as women live through it . . . Knowledge should be defined, interpreted and created so as to empower different groups of people to understand (and improve) their own lives. (Maher, 1985, p.35)

The nurse educators in this study are women who were socialized in their upbringing and education to behave according to conventional feminine traits. The sex-role socialization of these women anticipated that, upon

marriage, their career would be set aside so they could assume roles as suburban wives with ruffled aprons tied behind their backs; living row by row in identical rose-covered cottages with successful husbands and 2.3 children, as typified by the television portrayals of Donna Reed, Harriet Nelson and June Cleaver.

The sex-role socialization for most of these women molded them into a traditional pattern to be passive, submissive, conforming, dependent, and nurturing. Women with this "traditional" socialization sought to fulfill a man's needs rather than their own, deriving identity and self-esteem from subservience to their male counterparts rather than from their own accomplishments because of social pre-conceptions.

A subservient service posture for the nurse educators in this study was reinforced on three fronts:

1. as women serving men;
2. as nurses serving doctors and the sick;
3. as teachers serving students in the educational bureaucracy.

### Purpose Of The Study

How does the nurse educator perpetuate sex-role socialization with her students? Through in-depth interviews with 42 nurse educators, this dissertation searched for answers to this question by examining behavioral phenomenon which influence the flow of sex-role socialization patterns from teacher to student in the traditional milieu of nursing education. During the interview, these 42 nurse educators described their personal experience with sex-role socialization as "traditional" women, as student nurses, and as teachers.



## Models Of Sex-role Socialization

Several models might apply to diagram sex-role socialization as experienced by the nurse educators in this study. One model might depict a horizontal progression along the life continuum. In this horizontal model, (Figure 1.1), the nurse educators first encountered sex-role socialization when their mothers taught them to be passive, submissive, conforming, dependent, and nurturing in preparation for their role as women in society.

Female child----> Woman----> Student nurse----> Nurse----> Nurse Educator

Figure 1.1 Horizontal developmental life continuum model

Fathers supported the socialization process, according to Grissum (1976), by assuming a protective attitude toward their daughters, thereby reinforcing a passive, dependent nature. On this horizontal life continuum, the nurse educators moved developmentally through stages from dependent female child, to conforming woman, to submissive nurse, and finally to nurturing nurse educator. In fact, they reached the ideal epitome of their generation's feminine role model. Till (1980) writes,

The popular image of nursing sounds like a reiteration of socially prescribed and sanctioned female behaviors. Nurses are envisioned as submissive, nurturing, passive, intuitive, caring, and self-sacrificing individuals (p.295).

When the women in this study entered nursing, their instructors (nurse educators) replaced mother as socializer and became teachers and role

models during the educational process. Rules for feminine behavior taught by mother were reinforced during the educational process as female students were instructed in behaviors that encouraged them to function as submissive, obedient handmaidens to doctors, thus perpetuating these traits.

The review of the literature suggested a circular pattern to diagram influential forces of sex-role socialization between the nurse educator and students. These circular forces were experienced by the nurse educators when, as students, they were guided and socialized by their own teachers into adopting the behaviors of a professional nurse. The patterns of sex-role socialization that the nurse educators experienced as students impacted their work, subsequently influencing their interaction as teachers and role models with their students.

The flow of socialization influence is circular and continuous with constant internal movement. The forces are self-referential and cyclical, but not as sealed as the literature might suggest. The circle is not totally opened nor is it completely closed. Rather, the circle opens to embrace succeeding generations of graduate nurses.

A woman may enter the circle at any point along the life continuum as a woman, as a student nurse, as a registered nurse, or as a nurse educator who has moved through all the preceding stages of child, woman, student and nurse. Thus, the circular patterns of sex-role socialization envelope child, woman, nurse, and nurse educator. Lessons of feminine behavior taught by the mother were the roots of behavior for the nurse educators in this study. The same behaviors applied as they fulfilled roles in society as female children, as women in society, as professional nurses, and finally as teachers and nurse educators. In this dissertation the effect of sex-role socialization on women, as reported in feminist and nursing literature, was the theoretical

base leading to the conceptual framework from which to analyze the effects of sex-role socialization on and dynamics of behavior in these 42 nurse educators.

### Definition Of This Study

The effects of sex-role socialization on women have been documented by Frieze and Parsons (1978), Miller (1976), and Tavris and Offir (1977). The effects of sex-role socialization on nurses were recorded by Grissum (1976) and Muff (1982). The effects of sex-role socialization on female educators were studied by Bernard (1964), Simeone (1987), and Aisenberg and Harrington (1988). As a person who combines the three roles of woman, nurse, and female educator, the nurse educator has experienced the effects of sex-role socialization in all three roles.

Societal patterns of paternalism and oppression toward women have been identified by Goldenberg (1978), Gallese (1985), and Miller (1976). According to these studies, the social system, social mores, society's expectations, and paternalism can trap a woman in a continuing circle. Because nursing has traditionally been thought of as a woman's profession, cultural parallels exist. Nursing abounds with examples of the effects of sex-role socialization in hospital and clinical practice. Ashley (1976), Cleland (1971), and Roberts (1983) explain how nurses experience the same patterns of paternalism and oppression in the service arena of hospital clinical practice and in the milieu of nursing education.

However, the arena of this dissertation was nursing education, not nursing practice; therefore the design of this study was narrowed to focus on the relationship between female nurse educators and their students. Analysis



described forces influencing these 42 nurse educators as they moved along the life continuum, progressing through the educational process to their current status as socializers of students and as women in academia.

If women's experiences are to be equally represented, then, we must locate and describe these experiences, analyze them, and give them theoretical, and conceptual frameworks. (Maher, 1985, p.33)

The purposes of this study were:

1. to add to the scant body of research on the nurse educator;
2. to identify behavioral phenomena which influence the perpetuation of sex-role socialization from teacher to student in the traditional milieu of nursing education.

Interview questions were designed to elicit information about the following issues:

1. the forces which influence transmission of sex-role socialization from nurse educator to student;
2. the manner in which sex-role socialization is exhibited in the professional behaviors of the nurse educator and her students;
3. the effects of sex-role socialization on the nurse educator as a woman in academia;
4. situations which encourage or discourage perpetuation of sex-role socialization in the traditional milieu of nursing education today.

Feminist author Adrienne Rich (1985) writes, "I would suggest that not biology, but ignorance of ourselves, has been the key to our powerlessness" (p.24). This study seeks to define and document behaviors in these 42 nurse educators which perpetuate the effects of sex-role socialization in the traditional milieu of nursing education. Documentation of the experience of these 42 nurse educators with sex-role socialization as "traditional" women,

as student nurses, and as teachers will add the nurse educator's voice to the chorus proclaiming the modern experience of women. The results of this doctoral study will begin to break through our ignorance and encourage liberation for the nurse educator and her students.

## CHAPTER 2

### REVIEW OF THE LITERATURE

In this chapter specific aspects of sex-role socialization which apply to the Nurse Educator will be explored. Content gleaned from a review of nursing and feminist literature will present the effects of sex-role socialization on the Nurse Educator. This analysis will examine how the traditional feminine behaviors developed during childhood socialization were reinforced within the professional behaviors of the Nurse Educator.

#### Mechanisms For Sex-Role Socialization

Lasky's research (1982) indicates that sex-role socialization begins on the first day of life when a child is wrapped in a pink or blue blanket. Often at the time of birth and for years later a female child is dressed in pink while a male child is dressed in blue. A female is given dolls and soft cuddly toys while a male is given footballs and trucks. These differences in dress and toys reinforce sex-role socialization, encouraging or discouraging physical, mental or emotional growth.

Vance (1979) defines socialization as "the process by which we develop an identity and expectations within that identity" (p.37). Formal and informal processes of social interaction shape behavior and define criteria for appropriate feminine and masculine behaviors. These processes lead to the acquisition of rules which govern the way of life in a society or culture. Boys and girls are taught separate sets of behaviors. For example, boys are encouraged to play baseball, girls are not. Girls are taught sewing and embroidery, boys are not. Parents reward little girls but not little boys for

playing with dolls. Boys are punished for hitting girls. It is cute when girls can play dress up in Mommy's clothes, but not when boys do. (Tavris & Offir, 1977)

Frieze and Parsons (1978) reviewed studies reporting sex-role differences between male and female subjects. These studies compared aggression, dependency, social orientation, empathy, emotionality, self-concept, self-esteem, intellectual ability, verbal and mathematical skills, memory, and cognitive styles. In summary of their research, Frieze and Parsons concluded that there is little, if any, evidence suggesting biological or inborn personality response differences between male and female test subjects. Based on these results, "it appears that socialization rather than biology is responsible for the bulk of sex differences" (Frieze & Parsons, 1978, p.96). When summarizing the results of her 1974 research study of 2000 publications for her book Psychology of Sex Differences, Eleanor Maccoby said,

When people do research where they are studying both boys and girls, if they find a difference they publish it; and if they don't find a difference they leave it out of the article and say other things about the behavior. (Maccoby, 1989)

Reporting on the current status of sex-role socialization, Maccoby (1989) says,

In societies like Sweden where they have done everything in their power to move toward gender equality, the patterns of gender segregation are just as strong as they are with us.

Socialization as defined by Grissum (1976) "refers to the pressures--rewarding, punishing, ignoring and anticipating--that push a child toward evoking acceptable responses" (p.7). Weitzman (1982) reports that for the female child "sex-appropriate responses are consistently rewarded and reinforced--and sex-inappropriate behavior consistently discouraged or



punished in the young girl until she comes to learn and internalize the feminine role" (p.43).

Grissum (1976) reminds us that all people develop within a prescribed social setting. In each setting a person learns to behave according to rules that meet the norms of the group. Three theoretical approaches attempt to explain the process responsible for the acquisition of behaviors associated with sex-role socialization in children. These three approaches are behavioral, psycho-analytical, and cognitive-developmental.

In spite of debate, theoretical differences and psychological definitions, in summary, it does not matter whether one subscribes to behavioral, to psycho-analytical, or to cognitive-developmental theories to explain the process of sex-role socialization in children. All three approaches include the same three elements: (a) imitation of role models; (b) reinforcement and repetition of positive behaviors; and (c) motivation to perform accepted behaviors.

The child strives to be like a powerful parent. Through identification with the powerful parent, the child copies actions, values, mannerisms, personality, and ambitions. Children are socialized as they imitate the behaviors of parents and other nurturing, powerful persons in their lives, or actors in the media. Children learn behaviors through imitation and in response to overt, covert, verbal, nonverbal, or paraverbal cues. The child longs to reproduce the feelings experienced while receiving love and attention from these powerful persons, their role models. This movement toward security and conformity is a foundation of sex-role socialization.

Meleis (1975) defines role modeling as occurring "when the significant other is observed enacting and playing a certain role so that an individual is able to understand and emulate the intricacies of behaviors in that role"

(p.268). He further states that expectations and previous experience influence the identification of roles. Role learning may be motivated by certain rewards: positive, negative, or threatening. A child learns to be masculine or feminine by reward or punishment resulting from consequences of behavior. An act followed by a reward or positive re-enforcer tends to occur again. An act which is ignored or punished is extinguished as a behavior.

This section has explained the mechanisms of sex-role socialization. Rules and teachings of parents, imitation of role models, and reinforcement of behaviors are primary motivators responsible for the acquisition of sex-role behaviors.

### Sex-Role Socialization Of Female Children

Vance (1979) defines feminine traits which characterize the feminine role as compliant, accepting, dependent, passive and emotional. Hiede (1973) adds the traits of caring, tenderness, intuitiveness, compassion, submission, and nurturing. Frieze and Parsons (1978) characterize the stereotypical woman as passive, dependent, quiet, gentle, empathetic, unintelligent and inferior to the average male. Pinch (1981) makes women responsible for the caring functions of humankind. According to Pinch, women are expected to alleviate trouble and discomfort, express tender feelings, demonstrate tact, and gentleness, and always maintain awareness for the feelings of others. The whole concept of sex-role socialization takes a set of stereotypical traits and universalizes them. In that, there is a danger. The researcher recognizes the uniqueness and the individuality of women; however, this study has used the phrase "feminine traits" to summarize the stereotypical feminine figure presented in the literature and taught to everyone by social

mechanisms. This study contrasts the world into which women were initially socialized and the world in which they now exist.

Lasky (1982) proposes that American society encourages two main images for females. One is the ideal girl: a passive, submissive, attractive creature who receives praise for pleasing her brothers and father. The second image embodies this girl as woman: the angelic, all-giving mother who is always happy to put her children's and husband's needs before her own. Again, a submissive, masochistic, self sacrificing image emerges" (Lasky, 1982, p.49).

Eisenstein (1982) contends that subordination is a crucial damaging element in the sex-role stereotype of women. "Femaleness has been linked to second class status with the willingness to be less powerful than and placed under the authority of a man" (p.102). Eisenstein also claims that subordination has been a major obstacle to the achievement and growth of women as professionals. She continues:

The sense of subordination . . . is not necessarily attached to a real life situation of subordination within a marriage and/or work situation. It is something that many women psychologically carry along with them into successful careers and must spend much time and energy combatting within themselves. (Eisenstein, 1982, p.102)

Frieze and Parsons (1978), Tavris and Offir (1977), and Weitzman (1982) report that the goal of sex-role socialization for a female is to become a wife and mother. As a result of this sex-role socialization, most girls come to believe that marriage will be their permanent full-time job.

One could summarize the three clear lessons that a well-socialized American girl had learned. With regard to her personality, she had learned to be nurturing, cooperative, sweet, expressive, not too intelligent, and passive. With regard to her capability, she had learned she would always be less capable and less important than most men.



With regard to her future, she had learned she would be a wife and mother. (Weitzman, 1982, p.36)

Weitzman (1982) suggests that the educational system reinforces sex-role stereotypes.

One of the first messages communicated to girls in school is that they are less important than boys. Girls' impressions that they are not very important are reinforced by the portrait of the few women who do appear in the texts. (Weitzman, 1982, p.33)

Women are shown in textbooks, according to Weitzman, as timid, inactive, unambitious, uncreative and inferior to males. "If, as much research indicates, young women internalize this devaluation and 'attribution' pattern of the larger society, they are likely to be especially prone to doubt their own competence and abilities" (Hall & Sandler, 1982, p.4).

The current system of socialization has two negative consequences for women: females grow up thinking that they are not quite as good as males, or maybe that they are not worth very much at all; and they suppress or deflect the motivation to strive and succeed. (Tavris & Offir, 1977, p.187)

### Sex-Role Socialization Of Women

In their book, Tavris and Offir (1977) demonstrate how childhood socialization is responsible for women holding low-ranking jobs. They suggest women have acquired certain traits, such as fear of success, dependence, sociability, and noncompetitiveness through socialization, and these traits limit their aspirations and abilities. Horner (1969) offers supporting evidence for this contention with the results of her achievement testing of women. Vance (1979) concludes:

As a result of socialization with its concomitant sex-role expectations and values, women are still encouraged to seek approval, affection, conciliation and to be "other directed". They do this to the extent that

they are concerned that their femininity is incompatible with being ambitious, powerful, competent, and successful. (p.38)

The psychological basis for adult female behaviors is the self-abnegation of a woman who follows the example set by her mother. Early role-model experience is crucial to the image of what it means to be a woman. Goldenberg (1978), Miller (1976), and Tavis and Offir (1977) agree that the conforming, giving woman cannot allow herself to admit that she resents the constant pressure of having to do for everyone else. She has been socialized since childhood to believe that she should WANT to respond at ALL times and in ALL ways to ALL demands ALL people place on her. She hesitates to limit or stop responding to the demands. She cannot say "No."

Miller (1976) describes how a woman fears being called selfish. The mother of childhood seemed to be an endless fount of giving. Mother seldom said, "No." Because it is emotionally impossible to give forever without sacrifice, internal turmoil can result in many psychological and somatic symptoms. Miller (1976) states, "Such symptoms are often indirect ways of saying, 'I can't give anymore, but I don't feel allowed to stop'" (p.50). Albright (1988), Goldenberg (1978), and Tavis and Offir (1977) concur with this opinion.

Seigel (1984) tells us that women are traditionally socialized to accept their lot. Marriage and the family are the marks of a successful woman. Women progress from following the orders of their fathers and brothers to obeying husbands and employers. Seigel continues, "Those who did not fit the traditional mode were usually considered outcasts to be pitied" (1984, p.114). The writings of feminine psychologists Greenspan (1983), Gilligan (1977), Miller (1976), and Tavis and Offir (1977), agree that this is a part of the socialization process for women.

Goldenberg (1978), Grissum (1976), Miller (1976), Parsons and Frieze (1978), Tavris and Offir (1977), and Torres (1981) support the thesis that if a woman tries to meet her own needs and establish her own identity, she becomes a deviant of society. The search for her own identity may lead to discomfort, anxiety, and conflict with spouse, family or friends. The woman may feel weak, vulnerable, helpless, needy, angry or depressed, these feeling regularly becoming manifest in physical or psychological illness. A "deviant" woman must endure psychological burdens placed on her. Miller (1976) states, "the woman is not encouraged to take her own needs seriously to explore them. Instead the woman is encouraged to concentrate on the needs and development of man" (p.18).

Gilligan (1982), Goldenberg (1978), and Miller (1976) describe how stress-induced illness occurs in women as a result of their sex-role socialization. The control, discipline, and giving which a women performs leads to stress-induced illness manifested as stomach ulcers, digestive problems, migraine headaches, chronic back pain, depression, hypertension, obesity and problems with weight control.

### Sex-Role Socialization Of The Student Nurse

The nurse educator population addressed in this study entered the nursing profession when women's career choices were limited to nurse, teacher, secretary, and wife. Gunther (1969) researched the attitudes of Baccalaureate nursing students toward nursing as a career and found that the first response of these Baccalaureate nursing students was: "I always wanted to be a nurse." Gunther found that one in four of these nursing students had decided to enter nursing by the age of ten. Two out of three had decided by



the age of fifteen. Till (1980) suggests, "many persons select nursing because it is a vocation congruent with their acceptance of the traditional feminine ideology" (p.295).

Research by Muhlenkamp and Parson (1972) revealed that nurses in 1960 were characterized as being submissive, dependent, possessing high religious values, and interested in choosing a helping role. Adding to the research regarding attitudes of nurses during the 1960's Pankratz and Pankratz (1967) interviewed nurses who offered the following reasons for choosing nursing as a career.

1. Nursing involves contact with people and working for the welfare of others.
  2. It seems to be God's will for my life.
  3. Nursing offers an intellectual challenge and insight.
  4. Nursing is excellent preparation for being a housewife.
  5. Jobs are available anywhere and with a variety of schedules.
  6. There is economic security in nursing.
  7. I planned to be a nurse from an early age.
  8. I want insight and understanding of myself.
  9. There is prestige in medicine and nurses are respected for their dedication.
  10. I knew someone who was a nurse or spoke highly of nursing.
- (Pankratz & Pankratz, 1967, p.170)

Tobin's research (1987) that surveyed nurses who graduated during the 1960's adds the following reasons why these women might enter nursing:

1. Becoming a nurse fulfilled a childhood dream.
2. Nursing created an opportunity to help other people.
3. A diploma school of nursing, which cost only a few hundred dollars, was the only pathway to education because their parents could not afford college tuition.
4. Some women followed the advice of a counselor who said, "You're good in science, you should be a nurse."
5. Or "a nurse, teacher, or secretary are always financially secure, each of these can always get a job, and you'll be more financially secure if your husband leaves you." (Tobin, 1987, p.42)



The traits revealed by Muhlenkamp and Parson (1972) and the reasons given by Pankratz and Pankratz (1967) and Tobin (1987) would appear to parallel the female traits of submission, conformity, passivity, dependence, and nurturing taught by mother during sex-role socialization. Nursing was considered an extension of the mothering role. Nursing meant caring for and helping others, and preparation for being a housewife. The traits of submission, conformity, passivity, and nurturing parallel the sex-role socialization of women and also epitomize the traditional stereotype of a bedside nurse during the 1960's.

However, a closer inspection of the research by Pankratz and Pankratz (1967) and Tobin (1987) suggests that nursing offered intellectual challenge, economic security, financial independence in the event of a failed marriage, prestige and respect as a career for the research subjects. So while the stereotype image of the nurse is a handmaiden, the reasons given for choosing nursing as a career permitted a woman to move out of the submissive dependent role.

Twenty five of the nurse educators in this study graduated during the 1960's, 10 graduated during 1950's. Their reasons for entering nursing and their reasons for moving into a teaching career will be discussed in Chapter 4.

Diploma schools of nursing were the most accessible type of program during the years 1950-1960. The educational milieu in a Diploma school of nursing was often a combination of self-abnegation, service, obedience, and military rules. In these Diploma schools, student nurses were responsible for hospital wards during the evening and night shifts. In addition, the students also had to attend classes during the day. Students received 1 or 1.5 days off per week. All students lived in dormitories supervised by housemothers who enforced study rules, made sure everyone signed in before curfew, and turned the lights out at night. Marriage was forbidden. A student desiring marriage was required to leave nursing school. Students were taught to stand

up when doctors entered the room, to give doctors their chairs, to fetch and carry charts during patient rounds. The student, following the example of the other nurses, anticipated the doctor's every need. They functioned as subservient handmaidens. They did not question a doctor but merely obeyed his orders.

Nursing faculty, both then and now, tend to exert power over students by placing them in submissive roles and by applying manipulative strategies to maintain authority Fain (1987). One way to maintain authority is to conduct classes in a lecture format. According to Moran (1987), Murry (1982), and Schuster (1987) lecture continues to be the primary teaching method in nursing education. Freire (1982) compares a lecture to the banking concept of education which treats students as receptacles to be passively filled with the teacher's knowledge. This educational environment, Freire asserts, keeps the students passive, manageable, and dependent.

During sex-role socialization, the mother instills in the female child a self-monitoring evaluation system. Early criticism from parents and teachers provides the foundation from which the nurse educator evaluates herself and her students. The nurse educator as sex-role socializer, like the mother, demands perfection in all areas of performance.

The educational process in nursing is measured against specific behaviors defined by evaluation criteria. Course objectives with evaluation criteria are given to each student at the beginning of a class. The student nurse is taught to employ self-evaluation techniques to judge her own performance. She compares herself to defined professional nurse behaviors. She is scrutinized and criticized for her performance. The student is encouraged by the nurse educator to study, achieve high grades, and work toward perfection.

Evidence is accumulating that what a person does and who he believes himself to be will in general be a function of what people around him expect him to be, and what the overall situation in which he is acting implies that he is. (Wiesstein, 1971, p.135)

The final result of these expectations in nursing education is described by Hammer and Tufts (1985):

Student submission to nursing authority was an accepted fact in nursing education for many years and remnants of this attitude persist today. Subtle displays by faculty of authoritarianism, intellectual elitism, and a general lack of respect for and belief in the student act in concert to promulgate low student self-esteem and self-image. (p. 281)

Many nursing authors, for example Ashley (1976), Downs (1988), Grissum (1976), Group and Roberts (1974), Hammer and Tufts (1985), Meissner (1986), and Palmer (1983), admonish that it is inappropriate to continue the subservient and authoritarian approach to nursing education. These authors agree that program content and methods of teaching are important means of preparing the student for her future role. They conclude that nursing education today still resembles a military organization where orders are given and dutifully carried out. Meissner (1986) contends that perpetuation of these military traditions occur in nursing education because the nurse educator had a similar experience in her own educational program.

Kjervik (1979) claims "nurses have been re-enforced for passive and self-abnegating behaviors which have been necessary for our survival . . . in our sexist society" (p.34). Palmer (1982) writes, "lack of positive role models is the socialization process of the nurse. Feeling powerless themselves, both teachers and practicing nurses communicate powerlessness to the student. In fact, the student is rewarded not for challenging but for conforming" (p. 195). A parallel milieu exists in modern military organizations which promote similar response in its members.



The feelings of inferiority generated in her from the critical evaluation process in nursing school controls the behavior of the nurse educator in future academic and clinical situations. These feelings are perpetuated in the circular flow pattern for sex-role socialization from nurse educator to student.

A study conducted at Fairleigh Dickenson University by Cohen and Jarret (1988) found that the further students advance in a nursing program, the more closely their responses and behaviors correlate with those of their instructors. Cohen and Jarret describe professional socialization as occurring in three phases. It begins with the student changing from a focus on broad social goals to one of professional goals. Next, the student finds role models. In the final phase the student takes on values, attitudes and behaviors associated with members of their profession.

Griffith and Bakanauskas (1983) assert that students may view faculty members as the opposition. Students fear faculty reprisal or retaliation through criticism or failing grades. Therefore students, like hostages, learn to acquiesce to their instructor's expectations in order to survive in the educational system. Students demonstrate a brain-washed response, "I'll do anything you say to get out." "Most nursing students have acquired the attitude that they must competently demonstrate their knowledge and clinical skills without any margin for error. This attitude, propagated by the instructors, invokes fear and anxiety in students" (Griffith & Bakanauskas, 1983, p.105). Palmer (1982) contends "students become so preoccupied with implementing nursing care correctly and safely there is little time and energy, will or desire for creativity" (p.192). Grissum (1976) predicts "the student learns to play the game properly with her instructors to get through the program. Students who are overly inquisitive or who challenge their instructors are soon labeled troublemakers or poorly suited for nursing"



(p.192). These "troublemakers" are counselled out of nursing programs and into other careers.

In summary, Grissum (1976) describes a woman's transition into the traditional milieu of nursing education.

When a young woman enters the world of nursing, she begins her initial socialization into the profession through an established educational program. In numerous ways, her education reinforces the socialization process she has experienced from early childhood. The meek will graduate and function as professionals in the stereotypic image of the majority of women in other walks of life. They will be submissive and conforming. They will be dependent and lack real autonomy. They will probably provide adequate nurturing care to their patients. They will never be in the vanguard, however, when overdue constructive changes are brought about in the nursing profession. Many of our schools have perpetuated society's myths about the attributes and roles of women. (Grissum, 1976, p.29)

#### Perpetuation Of Sex-Role Socialization In Nurses

Pinch (1981) warns that the cumulative effect of socialization of women makes it very difficult to separate the traditional female role from the role of the nurse. Sex-role socialization influences a woman's personality toward passivity, dependence, and nurturance, as she assumes the coping mechanisms of submission and conformity. Sex-role socialization influences life style by identifying as the prime aspiration of the women, the goal of being wife and mother.

Church and Porrier (1986) describe how nursing extends the mothering role into a more public arena. Elms (1977) admonishes that nursing has traditionally been underpaid and undervalued because it is a woman's profession. Eisenstein (1982), Gallese (1985), Grissum (1976), and Tavis and Offir (1977) agree that a student nurse may be spared the negative censure

from society and parents other professional women must endure because nursing is accepted and viewed as an "extension of what women should do--care for others" (Grissum, 1976, p.24).

Pinch (1981) describes the structure of nursing:

Not only did the role of nursing evolve from the mother's role in the family, but the family itself served as a model for care in the hospital. Nurses, who were women, were to provide efficient, economical care to patients, to be loyal to the institution, and function in the role of the mother, attending to the household chores and meeting the needs of the physician. (p.596)

Adding to the idea of Eisenstein (1982) that subordination is a critical element in sex-role socialization, Wynd (1985) alleges that the effect of socialization produces subservience in nurses. She also claims socialization contributes to the slow rate of progress and change. Dean (1985) advises that:

Changes in behavior often lag a full generation behind changes in attitude and are dependent on our own deep unconscious feeling learned from our parents. Unfortunately, the dilemma this places on today's woman is one of ambivalence in which she intellectually espouses the independent role of the modern woman while holding onto old images of home baked apple pie--the traditional concept of womanhood. (p.39)

The stereotypical nurse is a perfect result of the sex-role socialization process of women. Both women and, in an increased measure, nurses, are socialized to meet men's [the doctor's] needs, to be submissive, passive, dependent, conforming, and nurturing.

Women are taught that their main goal in life is to serve others--first men, and later, children. This prescription leads to enormous problems, for it is supposed to be carried out as if women did not have needs of their own, as if one could serve others without simultaneously attending to one's own interests and desires. (Miller, 1976, p.61)

Conformity is expected from the woman in any of her roles, whether it be as a woman in society, a student, a nurse, or a nurse educator.

"Nurses historically have symbolized the paradigms of servanthood, as models of selfless giving and caring" (LaChat, 1988, p.31). Nursing historian Joanne Ashley (1976) traced the course of the monastic influence in nursing from the Middle Ages to the present time. Historically, religious motives associated monastic nursing with a desire to serve God and man. Service was achieved through selflessness and backbreaking servile labor toward the sick. According to Bullough and Bullough (1984), the "Christianizing of the nurse's calling . . . Religion forced nurses then, and even now, to make a commitment with money, family, and personal freedom all being sacrificed" (P.3). Notter and Spaulding (1976) describe how obedience and total submission to one's superiors embodied the authoritarian milieu present in nursing.

Change in the educational milieu of nursing occurred when Florence Nightingale, while organizing care for wounded soldiers during the Crimean War of 1854 to 1856, added military traditions to the monastic code of obedience and service. Military traditions introduced under the Nightingale system reinforced strict rules, discipline, self-control, the self-abnegation already present in nursing. Stripes were added on caps and uniforms to designate status. "It was not until Florence Nightingale that the training of nurses took on the mantle of respectability and scientific knowledge. Even with scientific beginnings, obedience to physicians and superiors was absolute" (Seigel, 1984, p.114).

One thousand years after the peak of monasticism, when describing the nurse of the twentieth century, Ashley (1976) writes:

Nursing as an occupation or profession has been compared to a religious vocation. Referred to as a special calling, it requires selfless service to man and God. The nurse has to be zealous in dedication to work, have a selfless denial of personal comfort and unquestioning



loyalty to the physician. The essential characteristic of a good nurse was and is obedience. (p.47)

### Sex-Role Socialization Of Nurse Educators

Consistent with the sequence of the horizontal developmental life continuum model presented in Chapter 1, the subjects in this research study progressed from woman to student nurse to nurse to nurse educator.

Woman-----> Student Nurse ----->Nurse-----> Nurse Educator

Figure 2.1 Horizontal developmental life continuum

The horizontal developmental life continuum model is supported by Fain (1987) who describes nurse educators as nurses before they adopt the second profession of education. The nurse educators who entered teaching through clinical practice as described by O'Shea (1982) were excellent practitioners who worked as staff nurses in hospitals, intensive care units, or visiting nurse agencies. Their competence and skill as clinicians was recognized, and as a result they were recruited for a teaching position by being asked to be preceptors with students in a clinical work situation, or to develop a class for the hospital staff. Some were invited to present a guest lecture to students in a school of nursing. As a result of these experiences nurse educators began their teaching careers by accident with the discovery that they



enjoyed the teaching experience and so moved from active clinical practice into teaching. Some nurse educators, like Clarkson (1983) choose the educator role because of the "A-Ha!" syndrome of their students. "A-Ha!" syndrome describes the ignition of mental lightbulbs when students understand new concepts and say, "A-Ha!".

Heidgerken (1970) studied graduate students in nursing programs leading to a Master's degree, to ascertain motivating factors which influenced their choice of nursing education as a career. Heidgerken found that 12% of nurse educators in her study were offered unsought teaching positions. These graduate students felt the teaching offer demonstrated the dean's confidence in their ability.

Megel (1985) and Notter and Spaulding (1976) suggest many nurse educators make a conscious decision to teach. These nurse educators begin their academic careers by studying for a master's degree. Fain (1987) claims some nurses attempt to resolve the conflict of having professional ideals which are in opposition with bureaucratic values by doing a 'lateral academic arabesque' into graduate school and then into teaching. Heidgerken (1970) received corroborating responses from her research subjects such as:

I became disillusioned in nursing service, but I know there is more to nursing. Observation of the rigid and routine manner in which nurses practice nursing caused me to change from nursing practice to nursing education. (p.301)

These graduate students choose teaching to improve patient care by preparing practitioners, to motivate students, and to thereby change the milieu of nursing service towards more humanistic care.

Some nurse educators follow the example of, or were influenced by, a teacher who was a role model for them. Heidgerken (1970) writes:

Teachers exert strong influence either by serving as role models or by encouraging and supporting students in their interests. Nurse teachers direct students' learning experiences in actual nursing care of patients and thus serve not only as role-models of teaching but of nursing as well. (p.221)

According to Kelly (1976), Florence Nightingale believed "that nursing faculty should be of varying backgrounds suitable to what had to be taught, well-versed in their subjects, able to teach well, understanding of students, and role models for students and other nurses" (p.45). Zimmermann (1986) admonishes that students need to have a teacher who can function as a role model and who can demonstrate the skills, attitudes and values of a professional nurse that students hope to emulate. Research by Miller (1966) documented characteristics of a nurse educator as personally charming: she is a compassionate woman who exhibits warmth. Being socially perceptive to a wide range of interpersonal cues gives her the capacity for close relationships. Possessing a wide range of interests, she is an interesting, arresting, productive person who gets things done. She has a high aspiration level for herself, with insight into her own motives and behavior.

Fain (1987) says nurse educators are socialized into the teaching role through formal education and clinical experiences. Seigel (1984) claims scholars receive on-the-job training as educators. Miller (1977) describes the effects of faculty inbreeding when faculty are recruited from graduates of the school rather than being obtained from outside sources. Miller says the effect of inbreeding creates an environment of increased loyalty, decreased salaries, and a fatal stagnation for new theories, ideas, techniques and creativity.

The Elay Group (1988) described rites of passage for socialization into academic nursing which senior faculty members exercise over new faculty. These rites include sharing knowledge and skills in a protegee role, committee assignments, and collaboration on research projects to benefit

senior faculty members. Fear of change and desire to maintain the status quo become issues of conflict between senior and junior faculty members. The Elay Group found senior faculty members react with emotion, personalizing criticism of the system. They assume that criticism implies that something is wrong with the work they have done.

In the transition from woman to nurse, Ahmuadi (1987) claims that nursing curricula and faculty induct students so completely into the professional role that their learned behavior is retained and transposed to other life situations. This transition is supported by Bauder (1982) who says, "Schools of nursing demand heavy workloads and nurse educators accept them" (p.42). According to Bauder nurse educators have been socialized to be accountable, responsible and cooperative. The nurse educators "meet their schools' demands and serve organizational needs rather than their own. Moreover as educators try to improve their sexual and professional statuses, they take on even heavier workloads in an effort to demonstrate their equal worth in their university milieu" (p.42).

Nurse educators largely because of their traditional socialization as women and as nurses, and their current attempts to improve both statuses, meet these demands by accepting remarkable heavy workloads. The acceptance of such heavy workloads is not without personal cost (Bauder, 1982, p. 35 )

Thus the nurse educator embodies the culmination of all three roles of woman, nurse, and female nurse educator. The need to demonstrate the equal worth of nursing as an academic discipline in the university milieu will be discussed in the next section.



## Sex-Role Socialization Affects The History Of The Nurse Educator In The United States

Fear of change and rites of passage have had an historically stiffling effect on the entire field of nursing education, thus perpetuating the effects of sex-role socialization. Nursing was introduced as an academic discipline in a university in America in 1899 when Isabel Hampton Robb and a five member delegation from the American Society of Superintendents of Training Schools achieved an agreement with Dean James Russell of Teachers College, Columbia University to establish a post-graduate school of nursing at Teacher's College there. According to this agreement, if the Superintendents' Society could not guarantee an enrollment of twelve students per year, then each of the five members from the Superintendents group would pay \$1,000.00 per year to cover the administrative costs of the nursing program. In addition, the University's Board of Directors asked the women who were conducting the nursing course to teach without salary. Thus members of the society screened and admitted students, contributed \$1,000.00, and taught the course without reimbursement. A similar payment policy continued until a private donor contributed all funding for the program in 1909.

Decisions from this agreement, according to Bullough and Bullough (1981) and Pinch (1981), continue to influence nursing education to this day. Nursing is often considered a vocational rather than an academic discipline on the college campus and is treated accordingly. Historically, nursing has not been able to depend on college funds for financial support. Private endowments, scholarships, and federal monies have been primary sources of funding for nursing education.



Since the introduction of nursing on the college campus, nurse educators have been required to prove the worth of nursing as an academic discipline. The process of repeatedly having to prove oneself to a skeptical audience has left its mark. As a result, nurse educators lack confidence, maintain low self-worth and over-compensate to prove themselves and their profession. As a defense, they adopted a rigid stance with regard to academic standards and have maintained the previously successful curriculums.

### The Nurse Educator In The Modern Academic Community

In academia, inferiority for the nurse educator continues to be actualized in many ways. Barge (1986), Selmanoff (1968), and Stein (1968) claim that the nurse educators feel academically unequal to physicians. Palmer (1982) describes the sense of intellectual worthlessness felt by the nurse educator when, no matter how many years she has been in school or how many degrees she holds, she is still viewed as inferior to the physician. If a nurse educator, who has earned a doctorate degree and holds the title of Doctor, calls a physician to report on a client's condition, the nurse educator will usually refer to herself as nurse, Miss or Mrs and not as Doctor \_\_\_\_\_. Seigel (1984) explains how the nurse educator compares herself to members in other academic disciplines:

Faculty rate themselves low in prestige and status especially when comparing themselves to nonclinical disciplines in the university settings. However, studies have shown that the public rates them consistently high. Some of this inconsistency in perception can be related to societal views of women. Women often feel that they must be better than men to succeed. Being just as good is not enough. (Seigel, 1984, p.116)

## Salaries Of The Nurse Educator

Barge (1986), Eisenstein (1982), Kruger and Washburn (1987), Marriner (1981), and Wang and Watson (1976) corroborate the situation as described by Seigel (1984). Seigel (1984) provides this insight into the status of the nurse educator in higher education: "the combination of women, nursing and higher education resulted in a self-perpetuating cycle of low status, low pay and no professionalism" (p.114). In 1971 Cleland wrote:

Many universities, rank for rank, pay nurse faculty less than they pay faculty members in other colleges of the university. It is becoming public knowledge that within the same discipline, men may be paid ten to thirty percent more than women of the same rank in the same department. (p. 1546)

Duplicating the study of Bernard (1964), Simeone (1987) studied 321 female faculty members at public community colleges. Simeone concludes:

The research of the past two decades indicates clearly that those forces which dominated the careers of academic women in 1964 are still present today. While there has certainly been some improvement in the conditions they face, the overall picture remains basically unchanged. (p.141)

Simeone found that these community college educators had lower salaries, lower rank, fewer tenure positions, fewer positive role-models and women mentors. The community college educators were excluded from the institutional network and had less power and influence within their departments. In the 88 universities researched by Dienemann (1983) nursing schools were found to be the lowest in both salaries and rank. "Nursing faculty do not have ranks commensurate with their years of experience" (Dienemann, 1983, p.111). Seventeen years after the publications of Cleland, Langford (1987) documents:

Funding for schools of nursing, particularly faculty salaries, is seldom at desirable levels. Salaries of nursing faculty tend to compare poorly with salaries [for staff nurses] in nearby clinical agencies and are not of parity with those of other disciplines in the health science center. (p.179)

In a 1983 to 1984 study, RN magazine surveyed 312 schools and found the salaries ranged from \$19,196 for nursing instructors up to \$35,473 for doctorally prepared professors. Table 2.1 presents a comparison of nurse educator salaries with staff nurse salaries for the eight year time span of 1980 to 1988. In California nurse educators are on the high end of the salary spectrum while in Massachusetts, nurse educators are on the low end of the salary spectrum.

Maitland (1989) reports:

Women faculty tend to be grouped in the lower ranks and temporary positions and are working at less prestigious community colleges, women's colleges, and small liberal arts colleges rather than in major research institutions. When they teach, women are paid less, receive tenure at lower rates, and rise through the academic ranks at a slower pace. (p.3) Women faculty receive lower salaries for several reasons: they are less likely to be in the top ranks, they are paid lower salaries within the ranks, entry level salaries for women are oftentimes lower, and women tend to be grouped in lower paid disciplines such as education, nursing and humanities. (p.1)

Table 2.1

Comparison of salaries for staff nurses and nurse educators in California and Massachusetts 1980 to 1988.

	1980	1985	1988
nurse educators nationally	\$17,393	19,196	
California nurse educators		30,000	22,804- 44,964
Massachusetts nurse educators		21,000	26,000- 35,000
staff nurses nationally	\$18,821		20,964- 36,672
California staff nurse			28,870- 42,889
Massachusetts staff nurse			25,438- 43,638
sources:	<u>RN</u> magazine <u>ACE Reporter</u> <u>AJN</u> magazine		



It is clearly documented in the literature that nurse educators collect lower salaries, maintain lower rank, and hold fewer tenured positions than males in other departments.

In 1985, nineteen members of the nursing faculty in a community college in Massachusetts earned an average salary of \$21,000. Six nurse educators were included in an inequity study which found them to be paid much less than colleagues in other departments. After a new contract and salary adjustments the present salaries in this department range from \$26,000 to \$35,000. Maitland (1989) writes:

In 1986 at the Massachusetts State College NEA won a salary equity case on behalf of female faculty and librarians. An estimated 400 female faculty and librarians employed in the system shared in the settlement of back pay and salary increases. The First United States District Court in Boston rendered a major decision with broad implications for faculty pay equity cases. The evidence presented by the NEA was largely statistical utilizing linear regression equations to establish evidence of salary discrimination. A similar suit is pending in the 15 Massachusetts Community Colleges. (p.11)

The Ace Reporter (1988) reports that salaries in California community colleges in the San Jose area have risen 21.6% from 1985 to 1988. Salaries in these community colleges range from \$22,804 to \$44,964. Perry (1982) explains:

Faculty in schools of nursing are heavily weighted at the instructor and assistant professor levels. This is a direct result of academic preparation and scholarly productivity of those individuals. This factor helps keep the salaries of nurse faculty, primarily women, lower. (1982, p. 97)

In spite of lower salaries, academic, social, and emotional demands are higher on nurse educators than most other educators. Barge (1986), Dienemann (1983), Karuhije (1986), Marriner (1981) and O'Shea (1986) agree with Kruger and Washburn (1987) who explain the special demands of nursing as an academic discipline:

Nursing education . . . has a threefold objective: to maintain clinical competencies, to instruct students in the clinical setting, and at the same time fulfill traditional university standards. The time and energy consuming nature of clinical instruction is an ongoing problem. Increasing numbers of nursing leaders are advocating that clinical instructors maintain clinical expertise through their own practice, . . . yet tenure policies often do not reflect the value of the professional practice. The university places high value on research and publication. (p.182)

### Roles Of The Nurse Educator

O'Shea (1982) reminds us of the circle of influence of a nurse educator. Andreoli (1977), Kellmer (1988), Kirkpatrick and Thiele (1987) discuss the many roles of nurse educators as faculty members which include roles as teacher, scholar, researcher, clinical expert and community leader. Notter and Spaulding (1976) describe the many roles of the nurse educator associated with being student, teacher and mother. McClure (1987) agrees with the multiple roles assumed by female nurse educators. She provides insight into the strain endured juggling their multiple roles. The nurse educator enacts the many roles of teacher, counselor, and advisor when dealing with students. As a clinical practitioner, she must maintain clinical expertise through her own practice in order to maintain her nursing competence. In addition, she must be a published author and researcher in order to meet university requirements for promotion and tenure. The necessity of multiple requirements for role competency are not the same for members in other academic disciplines. If the discipline does not have a clinical component, then faculty have only the latter criteria of research and publication to fulfill.

Clarkson (1983) discusses faculty workload of a nurse educator by describing a typical clinical day. A clinical day begins with students in an

off-campus agency at 6:30 a.m. In the clinical agency she supervises students while as they give care to clients. A typical day is described by a nurse educator participant in this study who supervises second year Associate Degree students:

As a faculty person, I have ten students and each of them are taking [care of] two patients. One day [I had] one student giving ten units of platelets and checking vital signs every half hour; and then another patient comes back from a cardiac catheterization who also has vital signs every half hour. Plus [the other students have] four or five intravenous medications, plus baths, dressing, and walking patients. (NE #39)

Often times after she is finished at the clinical agency, at 1 o'clock or 4 o'clock, the nurse educator must return to the college for committee meetings. Clarkson (1983) says a nurse educator needs a secretary to keep track of all the meetings. In addition her evenings are spent grading nursing care plans, preparing lectures, reading chapters in books or nursing magazines to keep current.

Just as the nurse educator encourages her students to strive for perfection, she also pushes herself to strive for perfection and excel in all her roles. No matter how much she does, or how good she is, the critical self-evaluation process and low self-esteem acquired through the socialization process as women and the evaluation process in nursing education continue to influence her. The circular flow pattern of sex-role socialization acts as a constraint to make her feel never good enough. The circular flow of sex-role socialization is also evident as the nurse educator perpetuates the nurturing, all-giving, all-doing traits of the "'can't say no' mother" she internalized during her sex-role socialization as described by Miller (1976). Like a giving mother, the nurse educator also suffers with stress-induced illnesses: headaches, backaches, cancer, ulcers, and weight control problems.



Cleland (1971), Grissum (1976), Group and Roberts (1974), Palmer (1982), and Perry (1982) describe environmental conditions of many nursing departments in colleges and universities. The nursing departments are socially, and geographically isolated in crowded poorly equipped buildings located off campus. Teaching tools and equipment for the nursing arts practice laboratory may be obtained by the nurse educator from discarded and outdated hospital equipment. Laboratory space and equipment are commonly inadequate and inferior to the same facilities in medical schools and other laboratory courses within the agency. Grissum (1976) describes the department of nursing as cloistered, with the faculty and students perceived by "other faculty and students as inferior scholars in a second rate discipline" (p. 29). Perry (1982) refers to them, as "the girls down the hill" (p.97). Cleland (1971) compares the Nursing Dean when asking institutional male administrators for department funds to a housewife asking her husband for money. Quoting from The Carnegie Commission Report, Andreoli (1977) writes:

The inferiority of the position of women in higher education will not change decisively even with improved counseling, enlightened faculty attitudes, or even equal enrollment of men and women. Long before they come to college, students have shaped their lives and feelings in response to society's expectations. Thus, until differential socialization and stereotypic thinking disappear throughout society, patterns of inequality in higher education will continue. (p.53)

The position of women in higher education as described by Goldenberg (1978) also acts as a constraining force:

Females continually emerge as victims of whatever policies and practices dominate the day to day decisions of our major social institutions. Social institutions become handmaidens of the prevailing social ethos responsible for masking reality and perpetuating values that are the foundations of the society they represent. (p.69)



Thus sex-role socialization as reflected by women's place in society is transferred from home to hospital to the educational milieu. Socializing forces in nursing education perpetuate the stereotypical submissive, passive, dependent, conforming, nurturing status of women as the nurse educator accepts tremendous work loads and strives for perfection often at great personal and physical cost. Constraints in nursing education are personified by low salary and rank, difficult working conditions, low status within the academic community, and administrative domination by men. The nurse educator tries to be all-giving and all-doing at the expense of herself and her health. Kjervik (1979) writes, "women have been so busy caring for others that they have not attended to their own needs. More importantly, they have not been given permission or encouragement to do so" (p. 35). Grissum (1976) summarizes:

It would be easy merely to chastise our mothers and our nursing faculty for perpetuating and reinforcing the sexist, traditional roles by which we are hemmed in, but they are no more to blame than we are. Criticism serves no useful purpose, since we know that all of us have been programmed in much the same way. (Grissum, 1976, p.22)

As a result of this pervasive and consistent domination process, nurse educators continue to internalize and thus to teach the same model that they have been forced to fit.

### The Nurse Educator As Educator

As socializer of students, nurse educators are role-models and mentors, consciously and unconsciously demonstrating women's role, professional nurse behaviors, and teacher behaviors for their students. Kramer (1968)

predicts "The development of role models of tomorrow is dependent upon the present process of nurse education and nursing practice" (p.115).

According to Andreoli (1977), Melecca et al (1981), and Murray (1982), nurse educators perpetuate this milieu in nursing education by continuing to model the behaviors they witnessed in their own role-models. "Nursing faculty are in a class by themselves. Often separated by ivory towers and ivy-covered walls, many members wear straight jackets of tradition, conservatism and inertia" (Seigel, 1984, p.114).

The nurse educator remembers her experience when, as a student, she also feared retaliation from her instructors. She endured the same stress while performing to meet the standards of others. Striving to meet the expectations of others initiates feelings of inferiority which haunt the nurse educator in all aspects of her professional career. The nurse educator may endure pressure if she perpetuates the same interaction patterns with her students and thus endures double stress as memories are recalled from both her past student role and her present educator role.

Feelings of inferiority generated from the critical evaluation process in nursing control behavior of the nurse educator in future academic and clinical situations. These feelings are perpetuated in the circular flow pattern for sex-role socialization from nurse educator to student.

Downs (1988) offers the criticism that nurse educators are still teaching the same old tired content under a new guise. Palmer (1982) and Grissum (1976) claim that by concentrating on task-oriented courses, nursing programs fail to encourage participation in the larger community of scholars. Grissum (1976) says that nursing curricula include adequate preparation in liberal arts, sciences, and humanities but "it is the application of knowledge acquired in these areas that creates a problem for students. They feel hampered in using

this knowledge in a creative way because they are expected to conform to the ideas of their teachers" (Grissum, 1976, p.22). Palmer (1982) claims that students generally view non-nursing classes as "getting elective or extra requirements out of the way" (p.194).

From his research, Ira Goldenberg (1978) adds the sociological insight that both the learning experience and the social settings in which most formal learning takes place is "characterized by fear, the denial of individuality, and the affirmation of conformity, control, and coercion as appropriate mechanisms for shaping what is considered responsible behavior" (p.8). Having experienced control, conformity, and coercion herself, the nurse educator perpetuates this in students as evidenced by their hostage response to graduate from the nursing program.

#### Socialization Into Male-Female Patterns Of Communication Used In Nursing Education

Goldenberg (1978), Miller (1976), and Tavis and Offir (1977) describe how a mother teaches a daughter to communicate in nonverbal language between men and woman. Following the same pattern, the nurse educator teaches the student nurse to communicate and interpret subcultural messages between men and women in medicine.

Ashley (1976), Cleland (1971), Palmer (1982), Stein 1968), and Wolf (1977) provide similar insights when describing a pattern in medical education which parallels the mother-father-child triad of family life: In this triad the nurse educator is mother and the doctor is the patriarchal father. His role is similar to a father who is home only part of the time and then leaves for work. A student nurse enacts the role of the child. Tavis and Offir (1977)



write that women are socialized to be sensitive and respond to communication cues in others.

Sensitivity to the feelings of others is related to status; the underdog must be able to read signs and signals of the master's moods. If women, as well as other oppressed groups, must 'read' the expressions of others with great accuracy in order to advance or even survive, then they could become nonverbally sensitive at an early age . . . When one is powerless, one must be subtle. (Tavris & Offir, 1977, p.48)

A look at news stands demonstrates how housewife folklore in some current women's magazines instruct wives on how to read their husband's moods. For instance, New Woman, July, 1989, "How to stay (very) married: 6 secrets of happy couples." or "The most happy marriage: still cooing after all these years." or "A woman's work is never done." In the magazine Woman, August, 1989 these titles appear; "Relationships: Good Women, Bad Marriages", and "10 Ways to Push Him Into Another Woman's Arms".

### The Doctor-Nurse Game

The doctor-nurse game, described by Stein (1968), is the subcultural communication system most often used in medicine. A game is an interactive pattern between two or more people which rather than being straight forward communication contains some secondary motive, pay-off, or intent which provides satisfaction or advantage for the players. Stein (1968) defined the object of the doctor-nurse game:

The nurse is to be bold, have initiative and be responsible for making significant recommendations, while at the same time she must appear passive. This must be done in such a manner so as to make her recommendations appear to be initiated by the physician. (Stein, 1968, p.102)



The pay-off satisfaction in the doctor-nurse game is that the nurse obtains the patient orders she wants; while at the same time the doctor thinks that the recommendation was all his idea. In the doctor-nurse game, the student is taught how to request orders without threatening the doctor's ego. For example if the nurse wants a medication order she may say, "Mr Jones seems to have a temperature of 103, what would you think about ordering some tylenol?" Or "I know you would want to be told because we are not to start lasix without permission, but you will certainly want to start this medicine on this patient." Or if the nurse does not really agree with the type of care the doctor has ordered, she may say, "This is a new type of patient for me. I want to take this opportunity to understand and learn your reason for doing it this way. Will you explain that to me please?"

Elements of the doctor-nurse game reinforce stereotypic roles of male dominance and female passivity. Mother teaches the female child that she is inferior to her father and other males in her life. The student (child) is told that the doctor (father) has infinitely more knowledge than a nurse. According to Goldenberg (1978), Palmer (1982), and Torres (1981) the subordinate status in interpersonal relations can be regulated and maintained through belief that the authority accorded the physician results from his many years of study, superior knowledge, and intelligence.

Following patterns of sex-role socialization, the student is taught that the doctor must be shown the utmost respect because he is superior. Nurse educators teach students that power rests with the male doctor. The premise is "He's [the doctor is] God Almighty and your job is to wait on him" (Stein, 1968, p.105). This belief is internalized by the student nurse, and when she becomes a nurse she remains under male domination, in essence continuing to please and obey "father."

The other player in this game, the male doctor, is taught by his male medical educators to believe that lives depend on his knowledge. From this socialization, according to Stein, doctors develop a fear of making mistakes. Mistakes remind a doctor of his vulnerability and so "a substitute defense maneuver is employed. The physician develops the belief that he is omnipotent and omniscient and therefore incapable of making mistakes" (Stein, 1968 p.103). Accepting advice from non-physicians is highly threatening to his omnipotence. The solution for the physician is to receive recommendations as long as they appear to be initiated by himself.

Selmanoff (1968) claims that a nurse who acts like a subordinate of the doctor will be treated as such and not as a professional peer. He says many conflicts between nurse and doctor stem from organizational structure rather than from personalities. Wolf (1977) suggests:

The roots of the dependent stage in nursing can be observed in early male-female roles in the care of the sick. It has been pointed out that the suppression of women health workers and the rise to dominance of male professionals were not parts of a natural process resulting from . . . changes in medical science, nor was it the result of women's failure to take on healing work. It was an active takeover by male professionals. (p.65)

Torres (1981) claims male-female interactions are the dynamics responsible for dominance of nursing by medicine. She sees women in roles from nurse all the way up to Dean in a school of nursing as vulnerable, conceding control to men. Torres continues, "the thrust toward collaborating with medicine is contaminated with the reality that nurses are not generally viewed as peers or even as having a distinct profession by most physicians" (Torres, 1981, p.10).

McGriff (1976) encourages the independent practice of nursing in which a nurse works in collaborative, collegial relationships with other disciplines,

and especially with the physician. Thomstad et al (1977) describe their work environment and the resistance they encountered when trying to change the rules of the doctor-nurse game in a medical clinic.

Even though the concept of the doctor-nurse game was introduced by Stein in 1968; Collins (1988) found the same patterns of communication persist in nursing today. The handmaiden, maid-servant posture also continues to apply to nurses. In her article, "Doctors are S.O.B.s", Collins (1988) records quotations from nurses which describe doctors as spoiled, inconsiderate, lazy, and demeaning. "They don't become S.O.B's until they turn 35. Older physicians tend to think of nurses as unquestioning servants. Older MDs believe a nurse should have almost no input into a patient's care" (p.32). This she found was due to generational difference, their training, and the socialization they received in the clinical agencies from their peers.

More evidence was collected during a reader survey conducted by RN magazine. The author, Friedman (1982), received many quotations from nurses describing positive working situations between nurses and doctors. However, most of these nurses are employed in emergency rooms or intensive care units where nurses and doctors function closely as a team. The nurses working on regular medical-surgical units said that doctors often demonstrate lack of respect for nurses as people and professionals. "Male doctors treat nurses . . . as second class citizens, not as equal members of the health care team. They act as though they are gods and nurses their servants" (Friedman, 1982, p.40).

Webster (1985) interviewed medical students to ascertain their perception of a nurse. She found that "the nursing role across the four years of medical school became even broader and more diffuse in the medical students' descriptions" (Webster, 1985, p.315). This was evident in the



following quotations from medical students who claim that they learn the role of the nurse by:

just observing what nurses do. You're working right next to nurses, but you really don't even have an idea of what their role is. I mean, that's not really discussed in medical schools and certainly it's not a big emphasis. (Webster, 1985, p.315)

So while the nurse educator socializes her student nurses into the communication patterns used in medicine, the medical student is not even introduced to the role of the nurse. Thus the myth of a nurse as a subordinate, helping, handmaiden is perpetuated by the behaviors of the doctor who is taught that he is omnipotent and has no experience or education to deny the teaching because he is not oriented to the actual role of the nurse.

The nurse educator appears to be a key person in maintaining the status quo of submission, obedience and the doctor-nurse game by teaching her students the communication patterns. She thus perpetuates patterns of sex-role socialization. A part of the research for this dissertation was to discover what the nurse educators in the study population actually do teach students with regard to the doctor-nurse game and communication patterns with physicians.

The purpose of this literature review in nursing and feminist literature was to discover and to document the influence of the nurse educator. How does the nurse educator perpetuate the circle of sex-role socialization with her students? The next chapters contain information that fulfill the purpose of this study which was to identify behavioral phenomenon which influence the perpetuation of sex-role socialization from teacher to student in the traditional milieu of nursing education. Chapter 3 describes the design of this study. Chapter 4 presents the results of the interviews with 42 nurse



educators and demonstrates how sex-role socialization is perpetuated in nursing education. Chapter 5 analyzes the data by comparing the information presented in the review of the literature to the responses of the 42 nurse educators in this study. Chapter 6 proposes areas for future study.

## CHAPTER 3

### DESIGN OF THE STUDY

#### Introduction

The purpose of this study was to identify behavioral phenomenon which influence the perpetuation of sex-role socialization from teacher to student in the traditional milieu of nursing education. The target population of this research study was nurse educators who teach either in a community college or a baccalaureate academic setting in Massachusetts and California. Personal interviews were conducted with 42 nurse educators to obtain information about their experience in nursing as women, as students and as educators.

Data from this study were collated for analysis by geographic area (Massachusetts and California) and also by type of academic institution (community college or baccalaureate setting). Grouping the population by geographic areas posed no problem. However, the comparison based upon community college and baccalaureate academic environments did pose many difficulties.

A dichotomy has always existed in nursing education between Diploma and Baccalaureate programs. The dichotomy problem was increased in 1952 when, Associate Degree programs were introduced in community colleges by Mildred Montage. The advent of this new program created a situation in which there were three types of nursing programs with different formats, different philosophies, and two to four year time spans for length of program although each program prepared students to take the same licensure examination for Registered Nurse.

Over the past fifteen years, Diploma programs have been phased out, and, as a result, the rift between Associate Degree and Baccalaureate programs has increased. There is pending legislation which mandates Baccalaureate education as the minimum preparation for nursing practice, thus causing a national dispute and jeopardizing the survival of Associate Degree programs.

Based on the differences between Associate Degree and Baccalaureate programs, this researcher considered the following as possible variables to describe the nurse educator population in this study:

1. the difference in program philosophy between Associate Degree and Baccalaureate programs;
2. the difference in the academic setting of two year community college versus the four year college or university setting;
3. diverse goals for graduates from each program, Associate Degree or Baccalaureate programs;
4. educational background and attendant philosophical differences in the type of program from which each nurse educator graduated these being Diploma, Associate Degree or Baccalaureate programs;
5. educational requirements, policies for hire, tenure, and promotion in each type of employing agency whether community college or four year Baccalaureate programs.

As a result of the diversity, this researcher feared that the quantity and contrasts in all of these variables might overwhelm the study before it began. However, while searching for commonalties, this researcher found the studies by Bernard (1964), Simeone (1987), and Aisenberg and Harrington (1988) which demonstrate how women from divergent backgrounds, who taught at different types of private and public academic institutions can be united by common interests. The three research studies also cut across

academic disciplines as these women taught in diverse fields such as history, science, medicine, nursing, languages, sociology, and marketing. Even though the participants in these three studies taught in varied academic disciplines, they were unified by their work environment and gender. Applying the same unifying principle, the following variables were identified as commonalities which unify the nurse educator population in this research study:

1. all participants have at least ten years of teaching experience;
2. all are white;
3. all are female.

A quotation from a nurse educator participant serves to establish the common ground within the diversity. "All of us . . . went to different schools. We all come from different bases, but there are certain principles you never forget." (NE # 5)

### Definition and Description Of The Population

In total, 42 nurse educators were interviewed. Participants included 21 nurse educators who teach in Massachusetts: 9 in Baccalaureate programs and 12 in community college Associate Degree programs. The other half of the population are 21 nurse educators who teach in California. Consistency exists between the two baccalaureate programs; nine of the nineteen baccalaureate educators teach in Baccalaureate (BS) programs in Massachusetts; ten teach in Baccalaureate (BS) programs in California. However among the 23 community college educators, eleven teach in Associate Degree (AD) programs in Massachusetts, four teach in Associate Degree (AD) programs in



California, and seven community college educators teach in Licensed Vocational Nurse (LVN) programs in California (see Table 3.1).

Table 3.1

Distribution of nurse educators by states and type of nursing program.

MASSACHUSETTS N =	21
Baccalaureate =	9
Community College =	12
Associate degree =	12
CALIFORNIA N =	21
Baccalaureate =	10
Community College =	11
Associate degree =	4
Licensed Vocational Nurse =	7

Note N = 42

Teaching experience ranged from ten to thirty years with a mean of 17.4 years. Two of the nurse educators in Massachusetts are retired, one from an Associate Degree program, the other from a Baccalaureate program. Two educators currently teaching in a California baccalaureate program are semi-retired.

The demographic portrait represented cuts across all the variable groupings which induced the concerns described above, thereby providing richness and diversity in the population. All types of school programs are represented, yielding philosophical difference and diverse goals for graduates.

Table 3.2

Geographic distribution of basic nursing programs from which the nurse educators graduated.

MASSACHUSETTS	17
OTHER NORTHEAST STATES	6
New York, New Jersey, Maine, Connecticut,	
SOUTHEAST	3
Georgia, Alabama	
MIDWEST	3
Wisconsin, Minnesota,	
SOUTHWEST	1
Texas	
CALIFORNIA	8
NORTHWEST	3
Montana, Iowa, Oregon	
CANADA	1

Note N = 42

These 42 nurse educators also represent diverse educational backgrounds. Twenty of these nurse educators graduated from Diploma schools of nursing, two from Associate Degree programs and twenty from Baccalaureate programs. Thirty-nine hold Master's degrees, eight have Doctorate degrees, and six more are enrolled in Doctoral programs.

Participants range in age from 37 to 63 years with a mean average of 48.7 years. They graduated from their basic nursing program between the years 1946 to 1976. These nurse educators attended and graduated from undergraduate nursing programs in many different states (see Table 3.2).

Seventeen studied in Massachusetts, eight in California, six in Northeast states, three in the Southeast, three in the Midwest, one in the Southwest, and three in the Northwest (see Table 3.2). All areas of the United States are represented.

### Population Recruitment

Several approaches were employed to recruit the target population of nurse educators for this study. Nurse educators from baccalaureate programs on both coasts were recruited through announcements at faculty meetings requesting volunteers. In California the invitation was announced at a faculty meeting on August 26, 1988; and in Massachusetts on October 10, 1988.

Initial contact to secure subjects from Massachusetts community college nurse educators was made several years ago when this researcher worked at a community college in Massachusetts and solicited colleague participation in the study. August, 1988, the Massachusetts community college population was contacted by letter to reaffirm their interest in and willingness to participate in the study (see Appendix A). A self-addressed stamped postcard was included to facilitate participant reply. Follow-up telephone calls confirmed interview appointments.

California community college educators also volunteered over a two-year time span in response to personal invitation. Volunteers were contacted by telephone to establish a convenient time and location for their interviews.

## Definition of Qualitative, Descriptive Research

Polit (1987) and Burns and Grove (1987) define qualitative research as a mode of systematic inquiry concerned with understanding human beings and the nature of human transactions with themselves and their surroundings. These authors characterize qualitative research as unique, dynamic, holistic, and subjective. The focus of qualitative research is complex and broad because the theory of qualitative research is based on the premise that "knowledge about humans is not possible without describing human experience as it is lived and as it is defined by the actors themselves" (Polit, 1987, p.349).

According to Oiler (1982), designs in qualitative research consist of a very general research question. The people who live the experience are the source. In data collection, the researcher is immersed in the phenomenon. Mechanisms for recording data vary according to the data source and techniques identified in the design. The techniques selected to present that experience to others are limited only by imagination and ethics. Best (1981) proposes that findings from qualitative studies can be employed to identify relationships among variables and to lead to theory development.

Descriptive research is the description, analysis, and interpretation of existing conditions (Best, 1981). Descriptive research is designed to summarize the status of a currently existing body of phenomenon (Polit, 1987, and Burns and Grove, 1987). A descriptive study is

an accurate portrayal of characteristics of a particular individual, situation or group. These studies are a means of discovering new meaning, describing what exists, determining the frequency with which something occurs and for categorizing information. (Burns & Grove, 1987, p.38)



A descriptive study, Best (1981) continues, is concerned with

opinions that are held, processes that are going on, effects that are evident, or trends that are developing. It is primarily concerned with the present, although it often considers past events and influences as they relate to current conditions. (p.93)

Qualitative research techniques were used in this study to provide an inquiry system from which to obtain and analyze the responses of nurse educators who described their experience with sex-role socialization.

Descriptive research techniques were used to describe the influence of past and present conditions existing in nursing education. Qualitative and descriptive research techniques and the nurse educator responses were combined to identify and analyze how their experience influences the perpetuation of sex-role socialization in nursing education.

### The Interview Procedure

According to Best (1981), an interview is an oral questionnaire. He advises that preparing for the interview is critical, and that developing a clear plan for information to be solicited is crucial. The researcher "must clearly outline the best sequence of questions and stimulating comments that will systematically bring out the desired responses. A written outline, schedule, or check list provides a set plan for the interview" (Best, 1981, p.165). The interview guide keeps the questions focused and consistent so that the same information can be obtained from each participant.

In this study, a structured interview guide was used to obtain comparable data from each participant in order to limit the length of the interview and keep the interview focused (see Appendix C). Repeating an unanswered question prompted the respondent to return to the topic,

preventing mental meandering. A single repetition of the question was usually adequate for clarification.

Following Polit's advice (1987), quotations used during the interview were written on index cards. These quotations were read silently by the nurse educator rather than being read aloud by the researcher. In this manner, interviewer effect was minimized. During the early interviews, if a participant responded with "no" to a question, the follow-up question was not asked. An accidental question led to the discovery that even if a nurse educator did not experience something herself, she did have opinions about it and could give examples of it in nursing education. Therefore, in later interviews, all questions were used exactly as they appear in the interview guide.

The participants volunteered to participate in this study, therefore a spirit of cooperation, comfort, and communication already existed before the interview began. Language and norms of the nurse educator community were familiar to the interviewer, and a relationship of trust had been previously established because the researcher had worked with most of the participants. The atmosphere during the interview corresponded with that described by Polit (1987):

A primary task of the interviewer is to put respondents at ease so that they will feel comfortable in expressing their honest opinions. The interviewer should strive to appear unbiased and to create a permissive atmosphere that encourages candor. The job of the interviewer is to serve as a neutral medium of communication. (p.240)

On August 18, 1988, a pilot interview was conducted, which lasted sixty-seven minutes. The questions were asked as written in the interview guide. The nurse educator interviewed did not need any additional explanation or

repetition to answer the questions. Based on the success of the initial interview, subsequent personal interviews were conducted.

At the time of the interview, each of the 42 nurse educator participants were requested to sign a written consent form (see Appendix B). A brief verbal explanation of research methodology and the purpose of this research were delivered as an introduction before each interview. Participants were offered the opportunity to refuse to answer any questions during the interview or to withdraw from the study at any time.

Interview questions were designed to elicit information about the following issues:

1. The forces which influence transmission of sex-role socialization from nurse educator to student;
2. The manner in which sex-role socialization is brought into professional behaviors of the nurse educator and her students;
3. The effects of sex-role socialization on the nurse educator as a woman in academia;
4. Situations which encourage or discourage perpetuation of sex-role socialization in the traditional milieu of nursing education today.

### Recording The Interview

Interview sessions conducted during this study were tape-recorded which allowed the interviewer to concentrate on the subject. None of the nurse educators objected when asked for permission to record interviews. One participant asked for a copy of her taped interview because she had enjoyed the interview, felt it was a therapeutic experience, and wanted to relive the experience again by listening to the tape recording.



The taped interviews were later transcribed to typed manuscript by a professional typist. Anonymity, privacy, and confidentiality were protected by assigning each participant a code number and thereafter identifying the participant by code number as part of a population group rather than as an individual. Only this researcher had access to the tapes and transcribed text.

According to Polit (1987), having written copy allows the researcher to locate pieces of information more easily and discover recurring thematic ideas more readily. Diers and Schmidt (1968) describe how listening to tapes enables the researcher to detect nuances of tone, inflection and information missed by the transcriber. Through comparison studies, they found that 9.6 to 25.5 percent of interview material was lost during transcription typing. Much of the loss of content was due to the pitch or speed of voice, tone, inflection, competing or muffled sounds in the interview situation, and unfamiliarity of the transcriber with medical language. "In spite of the loss of data, transcripts are usually adequate in giving a comprehensive view of the interactions and the changes which occur within each one" (Diers & Schmidt, 1968, p.240).

The same conditions were found to exist with the transcription of tapes recorded in this study. After interviews were transcribed to typed manuscript, the text was audited for accuracy by simultaneously reading the hard copy of the transcript while listening to the tape recorded interviews. Approximately ten percent of the recorded material was missed during data transcription, concurring with percentages quoted by Diers and Schmidt (1968).



## Qualitative Analysis

Schatzman and Strass (1973) caution researchers that qualitative analysis does not enjoy the operational advantages of quantitative methods that are able to predict analytic processes.

Qualitative data are exceedingly complex, and not readily convertible into standard measurable units of objects seen and heard; they vary in level of abstraction, in frequency of occurrence, in relevance to central questions in the research. (Schatzman & Strass, 1973, p.108)

When analyzing the results of qualitative research interview questions, Best (1981) identifies the first problem as designating appropriate, logical, and mutually exclusive categories for the tabulation of data. Both Best (1981) and Polit (1987) warn that analysis of open-ended items is difficult and time-consuming. The normal procedure followed is to develop categories which serve as a classification index or cataloging method for subject responses. However, Polit (1987) warns that the classification process requires considerable time and skill, adding:

Open-ended questions allow for a richer and fuller perspective on the topic of interest if the respondents are verbally expressive and cooperative. Some of this richness may be lost when the researcher later tabulates answers by developing a system of classification, but excerpts taken directly from the open-ended responses can be extremely valuable in the final report in imparting the "flavor" of the replies. (p.233)

In this study, every interview was read, and responses were recorded for each individual interview question. Then these responses were sorted, organized, and divided into categories which were reworked into groups of similar responses. These groups were collated according to category or content and finally were tabulated for frequency. Tally was maintained by participant number so that information could be transferred to the coding

format required by the Statistical Program For Social Sciences (SPSS) statistical computer program. SPSS programming was employed for statistical analysis to organize data and to determine significant relationships within responses. Illustrative quotations were recorded separately and re-evaluated for inclusion in Chapter 4 of the dissertation. All data collected from each subject response were analyzed, grouped, and compared by:

1. individual response to each question;
2. creation of categories of responses for each question;
3. tabulation of the number of individuals responding in each category;
4. examination of trends within responses.

Introducing the need to acknowledge subjectivity of the researcher when interpreting data results, Best (1981) says "distilling the essence of the reaction is difficult and interviewer bias may be a hazard" (p.165). His view is supported by Diers and Schmidt (1968), Oiler (1982), and Polit (1987), who also caution against interviewer bias. A contrasting opinion acknowledging the virtue of personal involvement is presented by Oiler (1982):

Researcher's involvement is exploited in qualitative research. Because the researcher is involved, a range of modes of awareness can be used in data collection. Empathetic and intuitive awareness are deliberately and purposefully employed. (p.179)

The reliability of data codification was tested in this study by having a second reader analyze several sample questions. His results demonstrated similarities when compared to the results obtained by the original researcher.

### Statistical Analysis

In this study individual item responses of the nurse educator to each question were transcribed, categorized, tallied, and inventoried as outlined

above. Content and frequency of responses for each variable were coded in the SPSS format. The number of responses to a given question varies between 40 and 42. Forty-two nurse educators were interviewed. Demographic information was obtained in response to questions 1 through 29, and the Likert Scale grading of feminine traits from all 42 participants. However questions 30 to 107 were tabulated on N = 40 for two reasons. One tape was lost by the typist. The other untallied participant was the practice interview conducted in August, 1988. During this initial interview some of the questions were asked in a slightly different format and so not all of the information was consistent with later interviews.

The researcher computed the descriptive frequencies of categorical variables such as content categories and means of continuous variables for responses to each question. Crosstabulation 2 X 2 contingency tables were developed to facilitate visual presentation of research results. Responses were compared via the statistical test appropriate to that variable. Statistical tests employed included computation of means, t-tests, ANOVA, repeated measures of ANOVA, and Chi square. Patterns were analyzed as follows:

1. individual response;
2. state, Massachusetts and California;
3. academic agency,
  - a. Massachusetts versus California community college nurse educators;
  - b. Massachusetts versus California baccalaureate nurse educators;
  - c. community college versus baccalaureate nurse educators in the Massachusetts;

- d. community college versus baccalaureate nurse educators in California;
- 4. type of program they graduated, Diploma, Associate Degree, or Baccalaureate nursing programs;
- 5. type of nursing program they teach, Licensed Vocational Nurse, Associate Degree, or Baccalaureate nursing programs.

Interpretation of Chi Square and other statistical comparison methods demonstrated no significant difference in this nurse educator population when compared by the above criteria. Therefore the 42 nurse educators in this population will generally be addressed as a whole, although some questions will have responses presented in detail as differences to discuss points of interest. Chapter 4 will present the specific results and analysis for responses asked during the interviews with these 42 nurse educators.



## CHAPTER 4

### PRESENTATION OF DATA

#### Introduction

How does the nurse educator perpetuate sex-role socialization with her students? Through in-depth interviews with 42 nurse educators, this researcher sought answers to this question by examining behavioral phenomena which influence the flow of sex-role socialization patterns from teacher to students in the traditional milieu of nursing education. This chapter will present the results of interview with 42 nurse educators in Massachusetts and California.

In the first section, primary sex-role socialization, questions elicited information about the nurse educator's family of origin, how perceptions of sex-role socialization determined career options and educational progression. Attention was focused on how being a woman affects a career as a nurse educator.

The second section, secondary sex-role socialization presents the experience of these educators with initiation rites in their basic nursing programs, their perceptions of their nursing instructors as role-models, and how they were taught to communicate with doctors.

Finally, the focus in section three, transmission of sex-roles in nursing education, shifts to role transmission, discussing how these 42 nurse educators function in their present role as women in academia, what they teach their students with regard to rites of initiation and communication with doctors. They were asked how the feminine traits of submission,

passivity, conformity, dependence, and nurturance are perpetuated in nursing education today.

The responses to questions 1 to 29 and the Likert Scale scoring of the feminine traits were tallied on  $N = 42$ . Because one tape was lost by the typist and the initial practice interview had a slightly different format than subsequent interviews, responses for questions 30 through 107 were tallied on  $N = 40$ .

## Part I Mechanics of Sex-Role Socialization

### Socialization of the Female Child

Sex-Role socialization, discussed in Chapter 2, begins on the first day of life and continues through both formal and informal processes of social interaction. Acquisition of defined rules established by parents and society, positive reinforcement of acceptable behaviors, and imitation of role models facilitate sex-role socialization in the female child. Primary socialization generally occurs in the family where the child imitates behaviors of parents, trying to live according to the rules and the expectations of the parents. It is here that the female child learns behavior patterns that will follow her all of her life, and where she begins to answer the question "What will I be when I grow up?" Family expectations were examined to determine how these 42 nurse educators acquired sex-role socialization. The questions presented in Table 4.1 were asked to provide a framework for sex-role socialization in the family of origin. These questions were designed to obtain data about their families and their family expectations from the 42 nurse educators for comparison with stereotypical images of women and of nurses.

Table 4.1

Questions to elicit family sex-role socialization.

95. What jobs did your parents have while you were growing up?
96. What were your ambitions as a child?
97. As a child what kind of work did you want to do when you grew up?
98. What did your mother expect you to be when you grew up?
99. What did your father expect you to be when you grew up?
100. Did you expect to get married?
105. Would you describe yourself as a traditional woman?
106. Would you describe yourself as a feminist?
107. Where would you place yourself on the continuum of being a "traditional" woman at one end, or a feminist at the other end?

Table 4.2

Frequency response for parental occupations.

MOTHER		FATHER	
housewife	25	salesperson	4
nurse	5	engineer	4
factory worker	4	factory worker	6
teacher	2	postal worker	2
secretary	2	navy	2
waitress	1	farmer	2
store manager	1	barber	2
		electrician	2
		store owner	2
		policeman	3
		machinist	3
		doctor	1
		carpenter	1
		lawyer	1
		minister	1
		deceased	4

Note N = 40



## Socialization In Family Of Origin

### Occupation Of Parents

Table 4.2 presents responses to the question number 95, "What jobs did your parents have while you were growing up?" These nurse educators came from white, middle-class families. Twenty-five of the 42 mothers stayed home as housewives, other mothers were employed in traditional woman's positions. Seven fathers were employed in the professions of doctor, lawyer, minister and engineer. The other fathers represented diverse male careers. Four fathers died when their daughters were very young, therefore their careers are not included in Table 4.2.

### Distribution Of Family Of Origin

Geographic diversity provided by the cross-country representation of birth places is comparable to the geographic distribution of educational settings (see Table 4.3). Seventeen of 19 nurse educators educated in Massachusetts were born and raised there, whereas students from other parts of the country represent more mobility. Five of the 8 participants who attended school in California were born and raised in that state.

Family birth position for these nurse educators correspond to the ratios found by Heidgerken (1970). Twenty-three were eldest or single child, 8 were middle or second born, and 11 were the youngest child in their families.

Table 4.3

Geographic distribution of birth places.

MASSACHUSETTS	19
17 were born, grew up, and attended school in Massachusetts	
OTHER NORTHEAST STATES	5
New York, New Jersey, Maine, Connecticut, Rhode Island	
SOUTHEAST	3
Georgia, Alabama	
MIDWEST	5
Wisconsin, Minnesota, Michigan, Illinois, Nebraska	
SOUTHWEST	1
Texas	
NORTHWEST	4
Montana, Iowa, Oregon, Wyoming	
CALIFORNIA	5

Note TOTAL N = 42

Table 4.4

Frequency of responses regarding parental career expectations for these nurse educators.

Mother's career expectations

go to college	10
never said	8
nurse	5
teacher	4
"Whatever I want."	4
housewife	3
medical doctor	1

Father's career expectations

don't know	13
"Whatever I want."	9
agreed with mother on college attendance	8
"Be happy"	2
housewife	2
teacher	2
medical doctor	1
engineer	1

Note N = 40

### Parental Career Expectations

The career options available to these 42 nurse educators were examined in relation to their social and economic position and family expectations. Responses to question number 98, "What did your mother expect you to be when you grew up?" are presented in Table 4.4. Maternal expectations correspond with alternative careers available for the female sex-role stereotype. There was a correlation between mothers who were teachers and

the incidence of expecting daughters to attend college. Daughters of nurses made the decision to become a nurse early in life.

In response to question number 99, "What did your father expect you to be when you grew up?" responses indicated fathers often agreed with maternal expectation (see Table 4.4). As with mothers, professional fathers encouraged their daughters to go to college.

### Childhood Career Expectations

Question number 96 "What were your ambitions as a child?" obtained information about the nurse educator's own childhood ambitions. Data about work goals were elicited with question number 97, "As a child what kind of work did you want to do when you grew up?" After analysis, childhood ambitions contrasted with goals for adult employment. A comparison of ambitions and work goals is presented in Table 4.5.

The responses supported continuing choice of middle class professions, possibly due to parental work roles and career expectations for their daughters. The daughters also disclosed ambitions and work goals in predominantly female positions concurring with the limited career choices available to women with their sex-role socialization. Some interesting phrase responses included among ambitions were "to please my parents," "to get thinner," "to leave home."

Of the 22 nurse educators who wanted to be nurses, 13 decided to be a nurse so early that they could not remember when the decision was made: "I wanted to be a nurse all my life." The remaining age distribution at which these nurse educators decided to become a nurse is presented in Table 4.6. Not all participants were asked the specific question regarding time they



Table 4.5

Frequency of respondents' career ambitions and work goals.

<u>Ambitions</u>		<u>Work Goals</u>	
go to college	5		
nun	4	nun	3
missionary	3		
nurse	3	nurse	22
medical doctor	3	medical doctor	4
teacher	2	teacher	3
to please my parents	2		
to leave home	2		
airline stewardess	1	airline stewardess	2
artist	1		
telephone operator	1	telephone operator	1
journalist	1		
opera singer	1		
none	1	none	3
engineer	1	research chemist	1
		interior decorator	1
To get thinner	1	veterinarian	1

N = 40

Participants gave more than one response.

decided to be a nurse, therefore N = 28. Note that 19 (68%) of these 28 nurse educators had made the decision prior to high school.

The "all my life" to early teen years spectrum of the age for career choice corresponds with Heidgerken's research (1970) presented in chapter 2 whereby most nurses made their career choice at an early age. As one respondent said, "Nursing is within you. You are born with a little 'N' on your heart." (NE # 10)

Table 4.6

Frequencies of age when respondents decided to become a nurse.

all my life	13
age 5 to 8	3
early teens	3
high school	6
during college	3

Note N = 28

### Sex-Role Socialization Of Women

Table 4.7 presents the responses of 40 nurse educators to questions 105 "Would you describe yourself as a traditional woman?" and 106 "Would you describe yourself as a feminist?" The nurse educators split approximately down the center on response to these questions.

Table 4.7

Frequency of identification as a "traditional woman" or a feminist.

	<u>Traditional woman</u>		<u>Feminist</u>	
yes	15	37.5%	16	40%
no	21	52.5%	17	42.5%
don't know	4	10.0%	3	7.5%
somewhat			4	10.0%

Note N = 40

Responses to Question 107, "Where would you place yourself on the continuum of being a "traditional" woman at one end and a feminist at the other end?" obtained the distribution presented in Table 4.8. Again, an almost equal division occurred, with only a one person difference towards the feminist end of the continuum. Of the 16 respondents who said they were feminist in Table 4.7, only 3 declared the feminist end of the continuum presented in Table 4.8. The respondents were grouped in a middle position (17) or slightly towards feminist (18). None offered the parallel position of slightly towards "traditional woman".

Table 4.8

Distribution of respondents along the female continuum of "traditional woman" to feminist.

<u>Female Continuum</u>				
Frequency of responses				
#	2	17	18	3
-----				
%	5%	42.5%	45%	7.5%
	traditional woman	middle	toward feminist	feminist
Note N = 40				

One respondent's statement clearly summarized what many of these women said:

I'm probably a result of the feminist movement. I feel very strongly about women's abilities and the opportunity that women should have. In a lot of ways I'm traditional in my sense of commitment to my home and family and the people who are important. But I don't think one has to be sacrificed for all. I think there is a combination, and I get

upset when people think [being] feminist is being this person who is out there fighting [with] no sense of who she is and her femininity, and all these other things that go into it because a total woman is all of those parts. (NE # 35)

### Marriage

The traditional sex-role socialization of these women was that they would marry and retire from work to raise children. Did these nurse educators adhere to the marriage expectations encouraged by sex-role socialization? What of the role as suburban wife, living row by row in identical little white rose-covered cottages with husband and children? Question 100 "Did you expect to get married?" produced the following statistics. Thirty-one (77.5%) of these nurse educators expected to marry, 5 (12.5%) did not expect to marry. Three replied "I do not know," and one did not want to marry.

Did these nurse educators expect to cease work upon marriage? Distribution for duration of time these nurse educators expected to work is presented in Table 4.9.

Table 4.9

Distribution of expectations for duration of work.

All my life	22
Did not know how long	12
Work until married	4
Until age fifty	1
Until age sixty five	1

Note N = 40



From the results observed, these nurse educators planned to work after marriage. They perceived nursing as a life-long vocation rather than as a job to do until they married.

### Nurse Educators And The Feminine Traits

As discussed in the review of the literature, western society has a traditional understanding of the feminine role and educates all females into that role to a certain extent. Whether or not the nurse educators adhered to the traits defining the role, they understood the relationship between society and role expectations for women and the relationship between those role expectations and reality. To ascertain how these nurse educators view themselves in relation to the feminine traits of submission, passivity, conformity, dependence and nurturance, they were asked to grade each of these traits on a Likert Scale with 5 being extremely characteristic and 1 being extremely uncharacteristic (see Appendix, Exhibit 3). Table 4.10 depicts the means of responses scoring these feminine traits both for themselves and for other women.

Clearly these nurse educators see themselves as manifesting only the trait of nurturance. A score of 4.38 which nears the 5 end of the scale means that the trait is very characteristic. Scores for the traits of submission and passivity, graded at the 1.5 level and dependence, graded at 1.8, judged these traits as personally uncharacteristic. Conformity with a score of 2.46 predicts a middle position. Suppression of the feminine traits was supported by the expectation to work after marriage and by an early choice of nursing presenting career viability, and permitting them to support themselves and to leave home.

Table 4.10

Means of feminine traits for respondents and other women.

Feminine traits	Self	Others
submission	1.57	3.26
conformity	2.64	3.45
passivity	1.52	3.14
dependence	1.81	3.07
nurturance	4.38	3.69

1 = very uncharacteristic

5 = very characteristic

Note N = 42

These nurse educators were deviants who did not conform to stereotype sex-role expectations nor did they consider themselves submissive, passive or dependent. They did not expect to retire upon marriage and settle in a rose covered cottage with husband and children.

The nurse educators assessed the presence of the feminine traits of submission, conformity, passivity, dependence and nurturance in other women at a higher level than 3 (see Table 4.10), judging these traits as more characteristic in other women. However, many nurse educators commented about the difficulty of grading women as a group because women individually are so diverse. Verbal examples of women for whom these traits are very characteristic and of women for whom these traits are very uncharacteristic were given by most of the nurse educators while marking the Likert Scale.

## Multiple Roles And Stress Induced Illness

Chapter 2 discussed the all-giving mother who, as a result of sex-role socialization, cannot say "No" but takes on more and more. In Chapter 2, Miller (1976) described how a woman's fears of being called selfish enhance sex-role socialization because a woman believes she should want to respond at all times and in all ways to the demands people place upon her. A nurse educator also received the same sex-role socialization to be an all-giving mother from both her mother and her nursing instructors. In addition these nurse educators scored the feminine trait of nurturance at 4.38 indicating that it is a very characteristic component of themselves, adding to the desire to be the all-giving "can't say 'No'" mother. Sex-role socialization by nurturing and mothering persons in her personal life is compounded as she nurtures her students and patients in her professional life.

### Roles Of The Nurse Educator

As discussed in Chapter 2, stress-induced illness is the consequence of not saying "No" and assuming multiple roles. Table 4.11 lists questions asked in this study to elicit information related to the incidence of stress-induced illnesses and the many roles enacted by these nurse educators.

Table 4.11

Questions related to roles and stress-induced illness.

79. Tell me about (list) all the roles that you have?
80. How do you handle all your roles?
81. Do you ever have problems handling all these roles?
82. What do you do to help yourself cope?
83. You have listed some medical conditions. Do you see any correlation between these medical conditions and the many roles you juggle?
84. Is there any correlation between your medical conditions and work situations?
85. Do you think you spend too much time at work?  
Why must you put in all this time?
93. How do you view yourself in relation to juggling your professional and private lives?



Table 4.12

Frequencies of the roles of nurse educators by state and agency.

	Massachusetts		California	
	Comm College	BS	Comm college	BS
mother	10	6	7	6
wife	8	4	5	7
friend	8	5	5	4
daughter	7	5	1	1
housekeeper	5	0	4	2
teacher	11	7	9	9
counselor	9	6	9	9
clinician	8	4	7	6
committee member	7	7	5	8
role-model	6	1	3	4
member professional organizations	5	4	1	9
student	3	4	1	4
researcher	1	3	1	6
administrator	1	2	2	4
grant writer	0	3	0	2
neighborhood activities	5	5	2	5
church	4	5	2	3
business woman	3	1	2	4
handyman	3	0	2	0
gardner	1	1	1	1
vet			2	1
romantic relationship	2	0	2	0
average number of roles	8.8	8.6	7	10.4

Note N = 40

Note: Participants gave multiple responses.

Like other women who assume many roles, these nurse educators also suffer stress-induced illnesses ranging from aches and pains to weight control problems to cancer.

The weight problem . . . I don't see it as related to my roles. I just see that as overeating and that could be whatever role I was playing. The migraines certainly come mostly when I am absolutely into stress beyond belief and unable to cope or unable to express myself. (NE # 19)

In addition to her personal roles as wife, mother, family member, and friend, in her position of a woman in academia, the nurse educator has professional responsibilities as teacher, as a member of the nursing department, and as a clinical specialist in nursing. Therefore the nurse educator enacts multiple roles in her personal, professional and academic lives (see Table 4.12). The average number of roles listed by these nurse educators was 7 in California community college educators, 8.8 in Massachusetts community college educators, 10.4 in California Baccalaureate educators and 8.6 in Massachusetts Baccalaureate educators. Baccalaureate educators listed additional roles of grant writing, agency administration, and research. Massachusetts community college educators listed higher incidence of home roles as wife, mother, daughter, and friend. All four groups had equal distribution of professional roles as teacher, counselor, committee member and clinician. Community college educators were not under the same pressure of tenure and promotion policies as Baccalaureate educators and so family roles received precedence as these women waited before pursuing Doctoral degrees. The respondents did not list every role in each sphere of their lives. Some focused on professional roles while others focused on their female roles involving personal and family life. These nurse educators have even more roles than the incidence listed, but due to fatigue of participants and the length of the interview, the interviewer did not press for all roles in each sphere of their lives. Table 4.12 lists the frequencies of roles by agency and by state.

## Incidence Of Stress-induced Illness

Chapter 2 discussed the correlation between the number of roles a woman performs and the amount of stress she endures and also the incidence of stress-induced illness. Participants in this study listed self-incidence of stress-induced illnesses and were aware of a correlation of illness to their work situation. An average work situation was described by participant number 4:

I think the work situation is 95% of the stress. You eat at your desk. You get constant interruptions. You never get a break. Even if you close your door and try to get five minutes of privacy, somebody is not going to acknowledge that closed door. You always have somebody at you. (NE # 4)

Table 4.13 defines the incidence of stress-induced illness by states. The first number is the frequency of respondents who gave that medical condition as a first response. The second number is the frequency of incidence as the second response and the third number is the frequency as the third response. The fourth number after the equals sign (# = #) is the total number of respondents who listed having that medical condition. Most participants offered two or three responses of medical conditions that are considered stress-induced illnesses.

It is interesting to note relationship between the incidence of first, second, and third responses for each illness presented in Table 4.13 and the relationship of the geographic location of the nurse educator. The response of no illness occurred sooner and in larger distribution in California (33) than in Massachusetts (24). Arthritis, backaches and weight control had higher incidence in Massachusetts.

Table 4.13

Incidence of stress-induced illness by states.

	California	Massachusetts
arthritis	0-1-0 = 1	0-2-1 = 3
asthma	1-0-0 = 1	0-0-1 = 1
backaches	1-2-1 = 4	5-2-2 = 9
cancer	1-0-0 = 1	0-0-0 = 0
headaches	1-1-1 = 3	2-1-0 = 3
hypertension	0-2-1 = 3	0-1-2 = 3
ulcers	2-1-1 = 4	0-3-1 = 4
weight control	10-3-0 = 13	11-4-1 = 16
none	5-11-17 = 33	3-8-13 = 24

Note N = 42

Note: Participants gave more than one response.

### Coping Strategies Of These Nurse Educators

Table 4.11 lists questions related to stress-induced illness and the many roles of these nurse educators. The first response to the question number 82, "What do you do to help yourself cope?" from 10 of these nurse educators was "eat." The frequency of other responses are listed in Table 4.14.

Many of these nurse educators actively employed stress reduction techniques and coping strategies. For example, 18 employed various time management techniques such as making lists and schedules, then chipping away at items in order of priority. Eighteen talked with a support person who was either their husband or a peer at work. The following response is a typical coping response for many of these nurse educators:

Someone told me, 'You must really like it or you wouldn't do it.' So every time I get stressed, I remember that. I just handle a piece at a



time and try to focus on what I am doing. Once I'm here, I'm here: personal life and stuff goes somewhere else. (NE # 18)

These nurse educators may actively employ positive coping strategies for stress management because the relationship of stress to illness, role overload, and burnout are topics included in the nursing curriculum.

Table 4.14

Coping strategies of the nurse educators.

Talk with peers	18
Exercise	13
Play	12
Time management	12
Work harder	11
Eat	10
Talk with person involved	7
Set structure for students	7
Not well	6
Take one day at a time	6
Work to cut back	5
Talk with my husband	5
Take it out on my body	5
Increase pressure on myself	5
Practice stress management	5
Hobbies	5
Yell at my kids	5
Spiritual life	4
Make lists	4
Remind myself of basics	3
Budget time	3
Relaxation	3
Look forward to vacations	2
Clean house	2

Note N = 40

Note: participants gave more than one response.

Many of these nurse educators reported displacing their stress outside of work rather than directing distress at their students. Several discussed how home relationships suffer. For example, some replied, "I yell at my kids." In addition, housework and other household chores were secondary to the professional role with its associated pressure and deadlines.

I am beginning to give myself more credit for being able to do all those things. I think I just did them and expected it of myself and wondered why I was always exhausted and frustrated and unable to get things done exactly as I would like. Now I finally have begun to say, "I really have done a lot and accomplished a lot and some days are better than others." There are times when I put myself down and wonder why. My windows are still dirty, but considering all the things I have done, I have done well. (NE #27)

## Part II Sex-Role Socialization Of Nurses

Following the progression described in Chapter 1 along the horizontal developmental life continuum model

Female Child---> Woman---> Student Nurse---> Nurse---> Nurse Educator

Figure 4.1 Horizontal developmental life continuum model

the following section will focus on socialization effects of the sex-role transition from woman to nurse. This section includes motivation for career

decisions beyond childhood and the meaning of nursing for these 42 two nurse educators. Table 4.15 presents questions used to obtain information regarding the transition from woman to nurse.

Table 4.15

Questions related to transition from woman to nurse.

- 101. How does being a nurse fit with your view of being a woman?
- 104. What did nursing mean to you when you considered it as a career?
- 94. A. How do you think being a woman has influenced your career?
  - B. How do you think being a woman has influenced your career as a nurse?
  - C. How do you think being a woman has influenced your career as a nurse educator?

#### Meaning Of Nursing As A Career

Responses to question number 104, "What did nursing mean to you when you considered it as a career?" were grouped into categories summarizing care for people, hero role models, career viability potential, and career facets. Table 4.16 presents this response distribution.

Table 4.16

Frequency distribution of responses regarding the meaning of nursing as a career for the nurse educators.

category of responses	number who answered	percentage of respondents
Caring for people	21	52.5%
career viability allowing advancement	18	45%
Career facets	14	35%
Following hero role models	6	15%

Note N = 40

Note: Participants have given more than one response.

Half or 21 of the respondents provided responses embodying the altruistic motivation associated with caring for people.

We do for others, we do for . . . kids, we do for husband, and clean up after people, and that is all a part of nursing even though we have been advanced into the technical aspects. I think that you have to be a certain kind of person to be able to do that graciously. (NE # 30)

Six identified hero role model responses such as "a crusader," "Florence Nightingale, Sherry Ames, and Sue Barton." The respondents who trained during World War II had the romantic picture of "a cadet nurse marrying her soldier boy." As one respondent said, nursing meant:

All the wondrous things [involving] a submissive nurturer, the lady with the lamp, onward Christian soldiers, and all the other glorious pictures. (NE # 19)

Responses in the category career viability provided job security and potential for career advancement. Seven said nursing meant "security - never



being without employment." Nursing jobs meant power, independence and career viability potential for 18 (45%) respondents as exemplified by statements such as "I can go far, not a dead end street," "financial security, I can earn money and be independent." Other respondents said, with nursing "I can travel," "leave home," and "change my identity." To some, nursing presented an opportunity to break from the feminine traits of passivity and dependence. These responses correlated with the Likert Scale grading scores for independence and non-conformity of the nurse educators.

Fourteen respondents provided insight into the peculiar combination of demands and skills required by nursing when they said, nursing is "a life long commitment," "fascinating," a way "to understand science and people," "not going to be easy," but it will provide a "lot of internal rewards."

In response to question number 101, "How does being a nurse fit with your view of being a woman?," 37 (92.5%) participants thought there was no difference, that nursing extends woman's role. For example, one respondent said, "I can use my nurturing skills and my perceptions and my intuition." (NE # 9)

The two dove-tail a lot because we are able to be supportive and empathic, nurturing as well as being strong enough to help people help themselves. (NE # 16)

Nursing and being a woman share a lot of similar traits . . . the need for nurturing, caring, intelligence, decision-making, assertiveness . . . a lot of that. I think they mesh well. (NE # 1)

Six nurse educators saw no difference. Only one respondent kept her woman's role and nursing role separate:

I think being a nurse is important, and women do a good job with nursing. I think they need to be careful not to let those facets of womanhood, which are dependency and submissiveness to a great degree in the private sector, take over and affect their role as a nurse because it can make them less effective as a nurse. If they want to be

dependent at home, that's fine, but don't be dependent in the hospital.  
(NE # 42)

### Woman's Career Influence

When asked question number 94 A, "How do you think being a woman has influenced your career?" 26 (65%) of the responses concurred with patterns of sex-role socialization which indicated that nursing was among the few career options available for these women. The other career options listed were teacher, nun, or secretary. Eight nurse educators said being a woman had no influence on their career choice.

Question 94 B was refined in focus: "How do you think being a woman has influenced your career as a nurse?" Fifty percent of these nurse educators viewed nursing as an extension of women's role. The influence being a woman had on their careers as a nurse were typified by responses such as, "Very nicely, the nurturing side of my womanness fits into nursing."

Oh I think much the same. In a more negative way, I think being a nurse has taught me to stay in my woman role, and my being a woman has reenforced the nursing role, which is all passive and nonassertive, both victim and rescuer. (NE # 21)

Six (15%) respondents offered the negative consequences being a woman had on their career as a nurse with comments such as, "I could go further in a man's career," "Nursing was a second choice," "I had to set my sights lower than if I were a man," "[being a woman] kept me from doing a lot more in my profession than I might have." "I have to prove skills over and over again, male nurses don't." "Male nurses move up the ranks faster." "Women are not skilled in prioritizing their needs and going for it. It's a handicap."

Eight (25%) nurse educators spoke about money as a frustration. When these women began teaching, educators were among the highest nursing salaries. That is no longer true. Today new graduates may earn more than their teachers who have college degrees in addition to years of service and teaching experience.

Women traditionally have earned 60 cents to every dollar earned by men. The same is true for these nurse educators who earn less than faculty members in other departments and much less than most men. As one participant offered, "It has taken me 25 years of teaching to earn a salary that is comparable with most men who are just getting out of college."

Not all responses were negative or based on the female stereotype. Six respondents, when discussing the career potential nursing presented, said "I could go far, [nursing was] not a dead end street," and "I would not have to be submissive."

Addressing the next step along the developmental life continuum from woman to nurse to nurse educator, question 94 C asked, "How do you think being a woman has influenced your career as a nurse educator?" Twenty-two (55%) replied that a career as a nurse educator was an extension of woman's role, that nurse educators "nurture and support students and clients." In comparison to jobs traditionally limited to men, 5 (12.5%) thought being a female nurse educator limited aspirations and salary. For example, "I probably would be president of the college now if I were a man."

Woman's stereotype was not there for me when I grew up. Nursing has taught and made me aware of women's roles. When I was a faculty member, I became very tuned in to what it was like to be a woman and the whole concept of subjugation and oppression. (NE # 3)

Six (15%) respondents discussed career potential and said, "Nurse educators are top professional people." Seven (17.5%) felt being a woman had no influence on their careers as nurse educators. Responses to questions 94 A, the influence being a woman has had on their careers, 94 B influence on their career as a nurse, and 94 C influence on career as a nurse educator are presented in Table 4.17.

Table 4.17

Comparison of responses regarding the impact being a woman had on career as a nurse and as a nurse educator.

Response	<u>Impact on career</u>		
	as woman	as nurse	as nurse educator
Only option	26 - 65%	5 - 12.5%	
No influence	8 - 20%	5 - 12.5%	7 - 17.5%
Extension of women's role		20 - 50%	22 - 55%
Comparison to men	6 - 15%	4 - 10%	5 - 12.5%
Provide potential		6 - 15%	6 - 15%

Note N = 40

### Summary Of Sex-role Socialization Child To Nurse

In summary, the nurse educators in this study represented a wide geographic distribution in both birthplace and location of basic nursing school across the United States of America. There was representation from each of the three types of nursing programs: Diploma, Associate Degree, and Baccalaureate. They taught in three levels of nursing programs: Licensed



Vocational Nurse, Associate Degree, and Baccalaureate. These 42 nurse educators were raised in white middle-class families in which 63% of the mothers remained at home as housewives. Nursing was considered an extension of mother's role and woman's nurturing role.

The decision to choose nursing as a career was made so early during childhood that 13 (32.5%) of these respondents said they "always wanted to be a nurse." Corroborating sex-role socialization, 31 (77.5%) expected to marry and have children. However, these women planned to work after marriage, a deviation from traditional sex-role socialization. Also an outcome of sex-role socialization was their willingness to assume multiple roles because they had difficulty saying "No," causing them to endure the resulting stress-induced illness.

Using a Likert Scale of 1 to 5, these 42 nurse educators graded other women in a middle range with scores of 3 for personifying the feminine traits of submission, conformity, passivity, dependence, and nurturance. Using the same 1 to 5 Likert Scale, these 42 nurse educators graded themselves high in nurturing, and low in the other feminine traits of submission, conformity, passivity, and dependence, a fact corroborated by their desire to have a career and to work after marriage. Nurse educators further demonstrate their independence and nonconformity by pursuing a career transition from nurse to the select specialty of nurse educator.

## Educational Preparation As Nurse Educators

In a 1980 sample of 1,615,864 nurses licensed to practice in the United States, 45,114 (3.6%) were nurse educators. Table 4.18 presents comparison of this nurse educator population to the 1980 sample of nurses with the purpose of substantiating that the nurse educator population in this study is representative of nurse educators nationally. Statistics presented for the nurse educator population in this study reflect their status in 1980.

A difference in the two populations is that only 5% of the 1.6 million nurses held masters or doctoral degrees, one-third of which were earned in education. forty percent of nurse educators in the 1980 sample held masters or doctoral degrees (AJN, 1982, p,451) while, in comparison, 78.5% of this study's population held masters or doctorate degrees. The higher percentage of earned degrees demonstrates independence, non-conformity, motivation and achievement of these 42 nurse educators as they juggled personal, professional, students and family roles to earn advanced degrees.

Table 4.19 presents educational statistics for the 42 nurse educators in this study. In 1988, 39 (93%) of the 42 respondents held master's degrees. Eight (19%) of these 42 nurse educators have earned doctoral degrees. The typical educational journey for the nurse educators in this study was offered by this participant:

I graduated school and stated working. I thought about going back to get a baccalaureate, but at that time they [faculty in collegiate nursing programs] made it so difficult that I just took a lot of other classes. You know, things that were pertinent to my clinical specialty. When I started teaching, I had to go finish my bachelor's degree and then after

that my master's. I was working full-time and I had a new baby. My children have always seen me going to school. (NE # 35)

Building on the use of their education, Table 4.20 presents demographics of initial degree, years of teaching experience, current rank, salary, if tenured, and the highest degree earned.

Table 4.18

Comparison of this nurse educator population in 1980 to a 1980 national sample of nurses.

	US Nurses	These 42 nurse educators
total number	1,615,846	42
married	70.8%	64.3%
median age	36.3 years	40.7 years
never married	15%	16.6%
widow, divorced	14%	16.6%
nursing program graduated		
Diploma	66%	47.6%
AD	18%	5%
BS	17%	47.6%
MS OR PhD	5%	80%
nurse educators	45,114	42
nurse educators holding masters or doctorate degrees	40%	80%
respondents who teach in nursing programs		
LVN	6,513 (14%)	7 (16.6%)
AD	9,867 (21.8%)	16 (38%)
BS or higher	14,194 (31.4%)	19 (42%)

Table 4.19

Educational statistics of nurse educators in this study.

ID NUMBER	SCHOOL PROGRAM	HAVE BS	HAVE MS	HAVE PHD	GOING PHD
1	Diploma	yes	yes	no	yes
2	Diploma	yes	yes	no	no
3	BS	yes	yes	no	no
4	BS	yes	yes	no	no
5	Diploma	yes	yes	no	no
6	Diploma	yes	yes	no	yes
7	BS	yes	yes	no	no
8	Diploma	yes	yes	yes	DNS
9	Diploma	yes	yes	no	no
10	Diploma	no	no	no	no
11	Diploma	yes	no	no	no
12	Diploma	yes	yes	no	no
13	BS	yes	yes	yes	EdD
14	Diploma	yes	yes	no	no
15	BS	no	yes	no	yes
16	BS	yes	yes	no	yes
17	Diploma	yes	yes	no	no
18	BS	yes	yes	yes	DNS
19	BS	yes	yes	yes	EdD
20	Diploma	yes	yes	no	yes
21	BS	yes	yes	yes	DNS
22	Diploma	yes	yes	yes	DNS
23	Diploma	yes	yes	yes	PhD
24	Diploma	yes	yes	no	no
25	Diploma	yes	yes	no	no
26	BS	yes	yes	no	no
27	Diploma	yes	yes	no	no
28	BS	yes	yes	no	no
29	BS	yes	yes	no	no
30	BS	yes	yes	no	no
31	Diploma	yes	yes	no	no
32	BS	yes	yes	no	no
33	Diploma	yes	yes	no	no
34	BS	yes	yes	no	no
35	AD	yes	yes	no	no
36	BS	yes	yes	no	no
37	Diploma	yes	no	no	no
38	BS	yes	yes	no	no
39	BS	yes	yes	no	no
40	BS	yes	yes	no	no
41	BS	yes	yes	no	no
42	AD	yes	yes	yes	EdD



Table 4.20

Demographics of nurse educator's academic status.

ID CODE	SCHOOL PROGRAM	YEARS TEACHING EXPERIENCE	RANK	SALARY	TENURED	HIGHEST DEGREE EARNED
1	Diploma	13	Assistant	\$26-30	yes	MS
2	Diploma	10	Assistant	26-30	yes	MS
3	BS	12	Assistant	31-35	yes	MS
4	BS	30	Associate	31-35	yes	MS
5	Diploma	25	Assistant	31-35	yes	MS
6	Diploma	16	Assistant	31-35	yes	MS
7	BS	19	Assistant	31-35	yes	MS
8	Diploma	14	Associate	31-35	no	DNS
9	Diploma	15	Instructor	20-25	no	MS
10	Diploma	15	Instructor	31-35	no	BS
11	Diploma	13	Instructor	over 40	no	BS
12	Diploma	30	Professor	31-35	ret	MS
13	BS	30	Professor	31-35	re	EdD
14	Diploma	23	Professor	26-30	yes	MS
15	BS	17	Assistant	31-35	no	ABD
16	BS	12	Assistant	31-35	no	ABD
17	Diploma	30	Professor	over 40	yes	MS
18	BS	11	Associate	36-40	no	DNS
19	BS	12	Associate	over 40	yes	EdD
20	Diploma	20	Assistant	26-30	no	MS
21	BS	13	Assistant	31-35	no	DNS
22	Diploma	15	Associate	31-35	yes	DNS
23	Diploma	13	Associate	36-40	yes	PhD
24	Diploma	14	Professor	26-30	yes	MS
25	Diploma	23	Assistant	31-35	no	MS
26	BS	10	Instructor	26-30	no	MS
27	Diploma	23	Assistant	26-30	yes	MS
28	BS	24	Professor	36-40	yes	MS
29	BS	20	Professor	36-40	yes	MS
30	BS	11	Associate	31-35	yes	MS
31	Diploma	22	Assistant	31-35	no	MS
32	BS	15	Associate	31-35	yes	MS
33	Diploma	14	Associate	26-30	yes	MS
34	BS	27	Instructor	over 40	yes	MS
35	AD	18	Instructor	over 40	yes	MS
36	BS	17	Instructor	over 40	yes	MS
37	Diploma	18	Instructor	26-30	no	BS
38	BS	13	Instructor	36-40	yes	MS
39	BS	22	Professor	over 40	yes	MS
40	BS	12	Associate	over 40	yes	MS
41	BS	10	Instructor	20-25	no	MS
42	AD	10	Assistant	31-35	yes	EdD

Table 4.21 presents questions related to the career transition from nurse to nurse educator.

Table 4.21

Questions related to the career transition from nurse to nurse educator.

30. Was your entrance into teaching on purpose or accidental?

31. How did you acquire your first teaching position?

32. What were your reasons for choosing a teaching career?

For staying in a teaching career?

33. What courses or other preparation did you have before starting your teaching career?

34. What has helped you develop your teaching expertise?

### Acquiring Positions

Eighteen (45%) of these nurse educators began their teaching careers by accident; 22 (55%) decided deliberately to go into teaching. Table 4.22 presents how these nurse educators acquired their first teaching experience and how they acquired their current teaching positions. Based on skill and experience as a staff nurse many of these participants were invited by another nurse educator to accept a teaching position. This accounts for the 18 respondents who said they began their teaching careers by accident.

Table 4.22

How participants acquired a teaching position as a nurse educator.

Method of acquisition	First position	Present position
Invited by another nurse educator	18	14
Reference		4
School desperate for teachers	2	
Prepared classes for hospital staff	9	
Responded to advertisements		7
Applied for a position	13	17
Note N = 42		

The 22 participants who deliberately decided to teach applied for a teaching position. Persons with a Baccalaureate degree as their basic nursing program had a higher incidence of a deliberate decision to teach than Diploma graduates.

The replies of these nurse educators to question number 32, "What were your reasons for choosing a teaching career?" are summarized in Table 4.23.

Table 4.23

Reasons for choosing a teaching career.

Enjoyed working with students	11
Wanted the hours teaching offered	10
Reasons given: to be home with the children to have summer vacations and holidays off not required to work every other weekend	
Tired of being a staff nurse	9
Always wanted to teach	6
To make a difference in the nursing profession	4
Nursing was physically too much strain	2
More money in teaching	2
Followed a role model	2

Note N = 40

Note: Participants gave more than one response.

Responses to question 32 were divided between altruistic and practical reasons. Altruistic reasons for choosing a teaching career were:

I always wanted to teach;

I wanted to make a difference in the nursing profession;

I followed a role model.

Practical reasons for wanting a teaching career were:

I wanted to spend more time with my family;

I wanted to earn more money;

Teaching was less physical strain than bedside nursing.



A response typical for many of these nurse educators was:

I see myself as a helping person, and also one that has a great deal of patience, and I see myself as a student. I have an affinity for other learners, and I just feel that I have a gift to help them. (NE # 3)

### Preparation For And Improvement Of Teaching

Educational preparation prior to beginning the teaching career is presented in Table 4.24. In contrast the ways by which these nurse educators have improved their teaching techniques are presented in Table 4.25.

Ten (25%) of these nurse educators had no formal preparation prior to beginning their teaching careers. Formal classes at both the baccalaureate and masters level were considered by 29 (72.5%) of these respondents as significant preparation prior to beginning their teaching careers.

Table 4.24

Educational preparation prior to teaching.

Preparation	Frequency	Percent
None	10	25.0
B.S. Class	15	37.5
MS Class	14	35.0
Teaching credential	1	2.5
Total	40	100.0

Note N = 40

Table 4.25

Methods nurse educators employed to improve teaching.

Method	Frequency
Life Experience	19
Discussion with peers	14
Attend graduate courses	11
Attend workshops	11
Work with a mentor	8
Practice Self evaluation	7
Request Student feedback	7
Work as a staff nurse	1

Note = 40

Note: Participants gave more than one response.

"Working with peers" was the method employed by 14 (35%) of these nurse educators to improve teaching expertise. Eight recalled working with a mentor during their pre-teaching clinical experience. Twenty (50%) cited experience as a staff nurse and as a nurse educator as the way they developed teaching expertise. Graduate classes and workshops were considered useful by 11 (27.5 %) respondents. It is interesting to note that 7 of these educators listened attentively to student feedback and 7 others employed some form of self evaluation. See Table 4.25 for presentation of data.

## The Status Of Nursing In Academia: Why Return?

Sex-Role socialization affects the way women are treated and the way they permit themselves to be treated in the academic environment. In Chapter 2, a review of the literature presented a dismal portrait of inferiority, oppression, and male domination for nurse educators in the academic environment. According to this portrait, there should be no reason for nurse educators to continue to pursue the dual role of practitioner and educator. The salary is not a significant factor, the prestige is certainly not. Why then do these women return year after year to the academic community? The questions listed in Table 4.26 were asked to elicit the nurse educator's perspective about her position in the academic community.

When asked question 40, "What keeps you coming back each year?" the primary reasons offered were pride in their work and the excitement of seeing students learn. The challenge of a dual career role involving both clinical practice and academic stimulation provided the "best of both worlds." These nurse educators responded to the challenge of finding a new or better way. Each semester was considered a new beginning with students. Twenty-two (55%) said simply, "I like it," as their reason for returning yearly to the academic environment. "Seeing students light up and learn it, and then do it well; that's all you need." (NE #11)

In the academic arena, the rewards for these nurse educators were student growth and the "Aha" syndrome, the lightbulbs of student understanding. Also, several enjoyed receiving letters from students. In the clinical area, their rewards were seeing patients receive good care from graduates in practice.

Table 4.26

Questions related to academic environment of the nurse educator.

37. What are your rewards as a Nurse Educator?
40. What keeps you coming back each year?
43. Do you think that the nursing department is treated the same as other departments and disciplines in your college? On what do you base your opinion?
44. Is there much cross campus contact?
45. What activities do you have on campus outside of the nursing department?
46. Do you feel academically equal to faculty members in other academic disciplines within the college?
47. Are you treated equally as a person?
88. How do college deans view you and the nursing department?
89. What do faculty in other disciplines think of the nurse educators?
15. What is your rank? ☐ Instructor    ☐ Assistant Professor    ☐ Associate Professor  
☐ Professor
16. Is your rank at the same level as women in other departments who have your educational background and experience?
17. If not, how does your rank compare with other women of comparable education and experience in the college?
18. Is your rank at the same level as men in other departments who have your educational background and experience?
19. If not, how does your rank compare with male faculty members in the college who have comparable education and experience?
20. What is your salary per year?  
☐ \$20-25,000    ☐ \$26-30,000    ☐ \$31-35,000    ☐ \$36-40,000    ☐ over \$40,000
21. How does this compare with women who have comparable education and experience in other departments?
22. How does this compare with men who have comparable education and experience in other departments?



## The Status Of Nursing Within Academia

Providing insight into the status of nursing as an academic discipline, five nurse educators said, "nursing is looked at as being something different," many replied "other faculty believe nursing is a vocation and does not belong in the college." "They [non-nursing faculty] have a very old traditional view of nursing as being non-scholarly and as being task oriented and as being narrow and parochial in thinking." (NE # 21)

One nurse educator who helped establish the nursing program in which she was teaching replied, "Nursing was thought of as a waste of time and money." She continued:

I can remember when the nursing program first began; we went to a general faculty meeting and somebody in the philosophy department got up and said there really was no room at [this college] for 'pragmatic, utilitarian, non-academic disciplines.' Of course, I was sitting there in uniform. Then later [non-nursing faculty] really liked the nursing students to provide bodies for their classes. Also, nursing students got to be seen as the best students in the college. (NE # 4)

The view of non-nursing faculty that nursing was an inferior academic discipline was supported by two other nurse educators who had thirty years teaching experience recounted the struggles to gain recognition for nursing as an academic discipline. One taught in Massachusetts, the other taught in California, so geography was not an influencing factor. Another participant described the recent demise of all the nursing programs at Boston University.

## Departmental Equality

In response to question number 43, "Do you think that the nursing department is treated the same as other departments and disciplines in your college?," 31 (74%) of these 42 nurse educators said, "No."

We are the largest department on campus, we are the strongest, we are the most successful. We are building a new college and they cut the budget. They cut the nursing department out of the new building. It was the first to go. We will probably be in rented buildings again. As a large department we certainly should have some clout. (NE # 33)

In two Massachusetts colleges the response was "They take our space for other programs." Facilities of nursing departments in both colleges were converted to other uses. In one, the college president converted the only conference room in the building to a smoking room. In the other college the large, most frequently used classroom was divided into offices for part-time faculty from the business department.

The nursing department in both Massachusetts colleges suffered budget cuts. Unequal treatment in the area of financial resources was echoed by a California educator who said, "We tend to get by with a whole lot less resources."

The nursing department is one of the largest departments in the academic community on nine campuses included in this study but in spite of this, the nursing department tends to get by with less financial assistance from the academic agency. In keeping with nursing history, these nurse educators do not depend on college and state educational funds but rather, apply for external funding sources via grants and lottery monies to finance program needs, to purchase equipment, to rectify inadequate conditions by

remodeling existing structures and inferior facilities which correspond to those described in the literature.

Only two agencies out of the nine represented in this study had money and provision for substitute clinical instructors. Because there is no agency money, these nurse educators relate incidences when they must leave their own sick bed or their sick children to go to clinical agencies to supervise students. These nurse educators exist under the constant pressure of knowing that if they are not in a clinical agency then their students cannot be in the agency. Without these clinical days the students will not have the hours necessary to meet Board of Registered Nursing graduation requirements.

### Administrative Support

When asked if the nursing department received support from the college administration, 32 (76%) of these nurse educators said that their immediate deans were supportive. The immediate deans respected the nurse educators as efficient, hard-working, professional women committed to students. According to one California educator:

Our dean looks at the nursing department with great respect. We are very innovative, we are very politically aware and we raise a ruckus. So we are respected in that way. Recently we have had much more work with the other schools and the other departments across campus and so, instead of wondering who we were, they know who we are.  
(NE # 19)

Only 17 (42.5%) nurse educators thought that other deans within the college were supportive. When asked the reasons for this, five nurse educators replied, "They don't know what to do with us." "We mess up FTE with low teacher student ratios of 1 teacher per 10 students which makes us

an expensive department." Two Massachusetts nurse educators offered "The opinion of other deans is [that] we comply, we are not trouble-makers, we are tools for their use." Other nurse educators working in this same Massachusetts program were optimistic, hoping for change in dean's attitude because the new president and dean both have nursing backgrounds.

Experience caused a change in attitude in a California community college where the president of the college and every dean spend a day with a nurse educator in a clinical agency. When describing this experience, the nurse educator said:

The day begins as usual at 6 a.m. to prepare the student's assignment. The observer also begins the day at 6 a.m.. By 9 a.m. the observer is very tired and begging to go home. But he must stay the entire day through post-conference. As a result of this one day clinical observation, the nursing faculty are very respected by upper management personnel on our campus. (NE # 38)

### Non-Nursing Faculty Perceptions

"What do faculty in other disciplines think of nurse educators?" The first and most frequent response was that non-nursing faculty "Don't have any idea about nursing."

There's a cross section that runs the gamut from respect to wondering what we are doing on campus. But I think there is a lot of respect. The respect comes when we finally get out of the building and get on university committees. And also the fact that we make it mandatory that tenure and promotion only comes with the same rules and regulations as the rest of the campus. (NE # 19)

Massachusetts nurse educators thought faculty from other departments view the nurse educators as "workaholic," "doing more than what the contract calls for," "odd balls," "sick of hearing nursing is different." Four other respondents said nurse educators are "not treated as academic equals, we are



"always referred to as "The Nurses," or as "the ladies down on south campus." However another view was offered:

I think [non-nursing faculty] think highly of us. I think we have always had a good reputation and they see our students as highly motivated. They always like to have nursing students in their classes because they [nursing students] are so motivated to learn. (NE # 27)

Nurse educators are viewed as "hardworking" and "generally positive." Another said "the faculty on our campus who are aware of the nursing hours are amazed." A different view from NE # 29 states:

Some of the [non-nursing] faculty think we do real strong work, and some of them think we are suckers. They get very angry at us for the hours we work.

Another respondent replied:

I have faculty members say, 'I don't know how you do all you do. You have so much going on, you have to spend such long hours. You're up at 5 a.m. and in there at 6:30 since you start clinical by 7:00, you go until 3:30.' They just kind of shake their heads. They have no conception of how that would be. They are into their 3-5 classes, whatever that is, and they meet on that kind of schedule. They have no idea. (NE # 35)

In California colleges the image of nurse educators has undergone a change.

We are changing our image. Faculty members are on different committees. We get in there and organize them and get something accomplished, and I think that they see that as a plus. (NE # 20)

At our school we are respected. We are known to be hard workers. We are on a lot of committees and our voices are heard. (NE # 36)

Also in California several nurse educators said that non-nursing faculty thought "the nursing department had too many department meetings." Two suggested non-nursing faculty consider nurse educators as "uncooperative because we [nurse educators] spend so much time off campus." From all agencies nurse educators said, we are "not [treated] as

academic equals," non-nursing faculty from other departments "don't think professional schools are equal to other schools."

### Image of the Nursing Department

Half of these nurse educators spoke of the conflict created by clinical assignments and the problems of estrangement caused by inability to be on campus and at college meetings. The impression of non-nursing faculty is that "if we are not on campus but are in the clinical agency, they [non-nursing faculty] don't think we are working." (NE # 38)

They don't have any good perception of what clinical means. They just know that we can't attend meetings on clinical days or we are not available on the phone or for consultation or for feedback or whatever. And I think those clinical components are hard for other faculty to understand. (NE # 41)

Five educators said, "nurses work harder" than other departments.

I don't think that the college perceives the time commitment that we put in. Our workload never computes right. We put in a long day. Clinical [work], clinical preparation and then correcting all the papers, plus classes and other problems. In our type of program we have to see [and counsel] the students much more. (NE # 30)

Two replied, "Yes," the nursing department is treated well, but added qualifiers, "it [the nursing department] is [treated well] here, but not at other schools I have worked at," and:

Over the years this nursing department has gained respect. I think in a lot of ways they [other academic personnel] would like not to treat us the same, but we are out there, we are visible and active. I think we have really pretty much created our niche. It's kind of cute in a way because they'd like to put us off as had been my experience in previous institutions, but they have a hard time doing that because of the fact that our administration is female. The president and the two top deans are all women. (NE # 36)

Five could not make a comparison, and 4 thought the nursing department was treated better than other departments in the college.

Because most nurse educators are women, the issue of gender influence was raised by four participants:

It's essentially a woman's profession, and so I think that in part of it we've been "supported" by the administration, saying "Oh you are marvelous nurses. They all love nurses, but when it comes down to it, we are not recognized as equals in academia. We're getting there slowly, but it's a hard battle. (NE # 3)

### Nurse Educators Within The Academic Community

When asked question number 44, "Is there much cross campus contact?" 16 (40%) nurse educators replied "no." The reason given for not having much cross campus contact was that time was consumed by the number of committee meetings within the nursing department. Also, on campus time was limited by clinical teaching and the geographic isolation of the nursing department.

Nine replied that there is "not as much [cross campus contact] as I would like." However eight contradicted this by saying, there is "as much [contact] as you want, it depends on the individual." Some nurse educators were

heavily involved with major college committees, in fact [deans and faculty in other departments] will say if you want something done, get the nurses to do it. (NE # 35)

To discover how much cross campus contact these 42 nurse educators have each participant was asked question number 45, "What activities do you have on campus outside of the nursing department?" The responses presented in Table 4.27 demonstrate active cross-campus involvement

serving on college committees, faculty representation as teachers in continuing education classes, and other extracurricular activities. These women hold high ranking positions by serving on the Board of Directors, advising and managing extended care facilities, home care facilities and nurse-run clinical agencies. A nurse educator in Massachusetts is "the Political Action Liaison for the nursing department and the state legislature."

Table 4.27

Cross campus activities of the nurse educators.

College committees	30
No activities outside of the nursing department.	9
Writing proposals and grants	7
Teaching continuing education classes	6
Conducting Recertification CPR classes	6
Board of Directors in outside clinical agencies	4
Political liaison	1

Note N = 40

Note: Participants gave more than one response.

### Equality Within The Academic Community

When asked question number 46, "Do you feel academically equal to faculty members in other academic disciplines within the college?" 34 (85%) said, "yes," 5 (12.5%) replied, "No, because I don't have a doctorate," and 2 said they feel "equal if not better."



When asked question number 47, "Are you treated equally as a person?" 31 (77.5 %) said, "yes," and 6 (15%) said "no." Three replied "I do not know because of limited outside contact."

An example of different treatment occurred in a Massachusetts community college when bonus monies were received by the allied health division, the sum of money was divided equally among four departments. In some of these departments two members divided the same amount of money as was divided among sixteen members in the nursing department. In this same college the nurse educators who have earned doctorate degrees were not permitted to put their names with the doctor title on their door while in all other departments this practice was permitted. Another example of title inequality for a nurse educator who has a doctorate degree occurs in clinical practice when she is telephoning a doctor's office to report on a client and refers to herself as Nurse \_\_\_\_\_ not as Doctor\_\_\_\_\_.

The teachers' contract with the state of Massachusetts provides tuition waivers for employees who attend state schools. However there are no doctoral nursing programs in Massachusetts state schools so, if these nurse educators want to earn a doctorate (DNS) in nursing science, they are forced to use their own money and resources attending private colleges."

### Salaries

Most of the nurse educators echoed the observation:

Because we are women, we receive lower salaries. I started at half the salary the faculty in other departments were getting. (NE # 3)

A nurse educator teaching in a baccalaureate program in Massachusetts described salary inequity. "I never really was brought up to the same salary as

men with comparable rank and experience." (NE #4) Newly hired faculty from other departments without longevity or experience earn almost as much as this nurse educator with thirty years teaching experience.

In this institution a nurse educator can't advance to professor without a doctoral degree. All nurse educators begin as instructors and are required to earn thirty credits toward their doctorate within five years or they are automatically terminated. Then once you get to assistant professor rank, you are locked in. (NE #4)

Ten participants in this study holding the rank of Instructor had taught an average of 15.6 years, 14 Assistant Professors had taught an average of 16.8 years, ten Associate Professors had taught a mean of 14.7 years, and 8 Professors averaged 24.1 years. All participants started at the Instructor level with minimal salaries and worked their way upward through the system requirements.

Demonstrating how nurse educators start at the lowest level in rank and salary, one nurse educator in a Massachusetts community college with eighteen years teaching experience including four years prior teaching experience at the same college reapplied after six years teaching elsewhere and was rehired at the Instructor level upon her return to the college.

### Part III Transmission Of Sex-Role Socialization In Nursing Education:

#### Nurse Educators As Role-Models

Table 4.28 lists questions designed to assess the nurse educator's perceptions about the perpetuation of sex-role socialization within the traditional milieu of nursing education. This section was introduced during

Table 4.28

Questions designed to assess the nurse educator's perceptions about the perpetuation of sex-role socialization within the standard milieu of nursing education.

78. How have your nursing instructors been role-models for you?

87. This is a quotation about how students perceive faculty. Do you agree or disagree with this statement?

Students do not find enough adequate role-models among their faculty. What they see usually are powerless, non-innovative faculty members who conform to and perpetuate the feminine stereotype. They do this through their behavior and their mode of communication with students and also by educating students in outmoded, traditional curricula that do not prepare them for the real work world. With this type of traditional teaching, we prepare a trained dependency characterized by high predictability of behavior. (Grissum, 1976 p.221)

66. Do you think faculty encourage monastic military traditions in nursing education today?

67. Can you identify anything which may perpetuate the monastic military milieu (traditions) in nursing education today?

70. Do you feel that you went through a rite of initiation in your nursing school? How difficult was this? extremely difficult, slightly difficult, easy? How long did it last? What was it like?

71. Do you think the students of today experience rites of initiation? In what ways?

72. What do we do as faculty to encourage or discourage rites of initiation?

53. Which class format do you prefer: lecture, seminar, discussion? Combination?

54. Why do you think lecture method is so widely used in nursing education today?

55. PLEASE READ THIS QUOTATION.

Do you think this quotation describes the classroom milieu in nursing education today?

Students become containers or receptacles to be filled by the teacher. Students are under the control and domination of the teacher. The more completely the teacher fills the receptacles, the better teacher she is thought to be. The more readily the receptacles permit themselves to be filled, the better students they are. Education thus becomes an act of depositing. In stead of communication, the teacher issues communiques and makes deposit which the students patiently receive, memorize and repeat. (Freire, 1982, p.58)

the interview with the statement "Now I would like to ask you a few questions about nurse educators as role-models for students."

### Faculty Role Models

To question number 78, "How have your nursing instructors been role-models for you?", 11 (27.5%) of these nurse educators said, "some positive, some negative." Sixteen (40%) "respected the knowledge and expertise" of their teachers. Thirteen (32.5%) learned "how to teach" and now do similar things with their students. Fifteen (37.5%) thought their instructors "modeled professional behaviors," were patient oriented, demonstrated how to communicate with patients, and "acted like nurses." Only 2 nurse educators said that their instructors "modeled the doctor-nurse game."

Concerning faculty student interaction, 17 (42.5%) felt their instructors were "caring and attentive towards" them as students. Six (15%) said, "My instructors taught me to think for myself." Four (10%) thought their instructors "expected perfection." Two (5%) recalled instructors who "said one thing and did another."

On the negative side, nine (22.5%) said, "I don't ever want to do that to students." "That" refers to constantly requiring the student to prove herself, scenes of public humiliation, verbal lashings, and other demeaning instructor student interchanges. In addition there were rites of initiation or special rules nursing faculty imposed on students, varying from instructor to instructor.



## Reaction To The Grissum Quotation

In an effort to stimulate their thinking, these 42 nurse educators were asked to read the following quotation from Grissum (1976). The quotation was introduced with the statement: "This is a quotation about how students perceive faculty. Do you agree or disagree with this statement?" Then they were handed a five by seven inch index card on which the quotation was typed. They were requested to read the quotation and the question was repeated, "Do you agree or disagree with this quotation?"

Students do not find enough adequate role-models among their faculty. What they see usually are powerless, non-innovative faculty members who conform to and perpetuate the feminine stereotype. They do this through their behavior and their mode of communication with students and also by educating students in outmoded, traditional curricula that do not prepare them for the real work world. With this type of traditional teaching, we prepare a trained dependency characterized by high predictability of behavior. (Grissum, 1976, p.221)

Six (15%) agreed with the quotation: I don't feel I have much influence.

The students come with behaviors formed. They have been socialized their whole life [into] acting a certain way. (NE # 28)

Eight (20%) said, "Things are changing." Eight others thought the Grissum quotation might be "characteristic of some but not of all."

There are some people on our faculty that have never outgrown their own beginnings and have not been able to move. Most of our faculty are wonderful because they are out there with their own practice and they are demonstrating the nurse-run clinics and they are presenting papers. They are being colleagues with physicians. I think we have some real good role-models. (NE # 15)

The 19 (47.5%) who disagreed with the Grissum quotation were typified by the responses "I hope we are not doing that anymore." and

I disagree whole-heartedly. I think our faculty are excellent role-models. There is no-one on our faculty that is not doing something to change nursing. (NE # 20)

### Students Perceive Faculty

Response to question number 92, "How do you think students view you?" is summarized by the following:

Students can identify the non-innovative status quo faculty member and the faculty member who is current, who has the expertise, is a good clinician, does feel that he or she has power and control, (personal power and professional power) and is excited about nursing. [The students] can differentiate very clearly. The [students] value the [faculty members] who are nurturing, are caring, and are good clinicians. The [students] would like us all to be that way. (NE # 3)

Another quotation from one of these nurse educators provided insight into how students view the nurse educator in relation to her many roles:

First of all [the students view me] certainly as a teacher. I have a role as a nurse, and I don't want them to see me as anything less than that, that's really important. I think as a woman I have a role, and . . . when they look at me I want them to see someone who is knowledgeable, independent, assertive, caring, communicative. I hope that they are viewing me in all of those facets. I think that I want them to see me as far as a woman is that it's possible to achieve the kinds of things that I have achieved and also still be a woman in a sense of relating to my environment. (NE # 35)

Other nurse educators were less verbal and provided the one word responses listed in Table 4.29.

Table 4.29

Students perceptions of nurse educators.

very positively	19
supportive	17
fair	17
hard and demanding	15
approachable	11
a good teacher	11
compassionate	8
a role-model	8
students were awed by all I can do	5
a person with a family	4
a perfectionist	2

Note N = 40

Note: Participants offered more than one response.

One nurse educator described student perception of the nurse educator as "somebody between them and a grade. Someone to pull them along and try to stimulate them." (NE # 8) Adding a touch of realism, one nurse educator said students at her school view faculty "as unrealistic until [the students] get to be working graduates." (NE # 28)

#### Nurse Educators View Students

Four of the nursing programs in this study have been established within the last twenty years, and have had long waiting lists of applicants until recently. Today, like other college programs, nursing actively recruits students, therefore, the nursing department has acquired a student

population that is more homogeneous to the average college population. Previous populations of female nursing students were composed of women who were screened for their motivation, aptitude, and superior academic ability. Because of the open door admission policy in public institutions these 42 nurse educators voiced frustration with the changing student population. These educators said teaching today is much harder. The ethnic diversity of students creates problems for the educator instructing in English, which is for many students a second language. In addition to linguistic diversity and also in common with non-nursing students today, nursing students have lower study skills than previous populations.

These nurse educators voiced concern for the challenge of designing curriculum to meet the academic needs of today's student population without reducing the quality of the nursing program, while at the same time striving to meet requirements of the National League for Nursing and the State Board of Registered Nursing to maintain accreditation.

Most nurse educators said they enjoy inquisitive students who present a challenge. They do not think this student should be counseled out of nursing because she does not "fit the mold." They agreed that the ability to relate to the unique student depends on the educator's confidence.

Current students have many demands on them. They live off campus and commute to classes, simultaneously juggling student, personal, family, and professional roles while working to support families. The 42 nurse educators interviewed in this study were very cognizant of the multiple role demands on students. Because of the multiple demands these nurse educators tried to provide resources and support for students. "We teach students to look at the patient as a whole, we must look at the student as a whole." (NE # 2)



## Lecture In Nursing Education

The banking concept of education proposed by Freire (1982) discussed in Chapter 2 asserts that the lecture method of teaching is a way of molding student behavior to become more submissive, passive, conforming and dependent. To obtain the response of these 42 nurse educators to the banking concept of education, this section was introduced with the comment from the interviewer, "The next questions concern teaching style in nursing education." Participants were asked question number 53, "Which class format do you prefer, lecture, seminar, discussion or combination. Eight (20%) replied lecture, because:

[The lecture is] easiest. It covers a lot of people and you can do certain things with lecture that you can't do with others, but it has a lot of negatives. It is really not useful. The negatives are that you have a wide variety of people sitting out there and you have no way of knowing who is getting what. (NE #24)

Fourteen (35%) liked seminars and 18 (45%) preferred a combination. Reasons for preferring combination class format included, "Need dialogue to help the student understand," and "Student participation is a much more valuable way of learning."

Responses to question number 54, "Why do you think lecture method is so widely used in nursing education today?" are presented in Table 4.30.

Table 4.30

Reasons why lecture class format is so widely used in nursing education today.

Able to cover a lot of material	25
It is the way we were taught	11
It is the easiest teaching method	8
Teacher has control	8
Less expensive	7
Teachers don't know any other way	5
Requires less preparation	4
Have need to teach students everything	4
To help students learn	4

N = 40

Note: Participants gave more than one response.

Explanation why lecture is so popular include:

We all feel that we know the material better and therefore we have to lecture and get it out to the student. We tend to not think the student can get that material on their own. So we have to tell them. (NE # 31)

Feeling of being a gatekeeper . . . means that if they haven't been introduced to the material and if you didn't introduce them, then you somehow failed at meeting the requirements. (NE # 20)

Can talk more content in a lecture. I didn't say teach, I said talk more content. I think people have the idea that if I say it out loud the students will absorb and learn it. People have the idea when you have large quantities of information what you need to do is pour it into the student's head. If you ask people if they believe that, they will say "Oh no, no, no." But I think that's how we plan a lot of teaching when we have a lot of content. I don't know if faculty have experience in other ways of learning. (NE # 39)

I don't know if faculty have experience in other ways of learning. I have been observing a class where a teacher says "I never lecture, it's always student participation and discussion. You might think I was lecturing but it is really not. It is discussion." What it really is, it's her lecturing and her asking questions every once in a while of the students. But she thinks she is carrying on a discussion even while she is lecturing. I think she does that because she doesn't know how to make a discussion happen. (NE # 21)

### Response To The Freire Quotation

The next part of this exploration into teaching methods to control students in nursing education required participants to read the following quotation by Freire (1982) and respond to the question, "Do you think this quotation describes the classroom milieu in nursing education today?" Again the participants were handed the quotation on a five by seven inch index card and asked to read the quotation silently to themselves.

Students become containers or receptacles to be filled by the teacher. Students are under the control and domination of the teacher. The more completely the teacher fills the receptacles, the better teacher she is thought to be. The more readily the receptacles permit themselves to be filled, the better students they are. Education thus becomes an act of depositing. Instead of communication, the teacher issues communiques and makes deposits which the students patiently receive, memorize and repeat. (Freire, 1982, p.58)

After reading the quotation 12 (30%) said, "Yes this describes the classroom milieu in nursing education today." Nineteen (47.5%) said "No." and 14 (35%) replied, "There are people who think (do) that." Other responses included "This is a hierarchy and the teacher has a dominant position." "More mature students don't put up with that." Six (15%) said "That's not teaching." Seven replied with anger, "I don't see students as containers or receptacles." Another educator added "[Students] fill their own

container, I don't. I put it right beside them." (NE # 38) Three offered the position, "I'm not there to fill receptacles I'm there to discuss in a clearer way than some of the passages in their books." And from a realist:

I've learned over the years even though it comes out of my mouth, there is no guarantee it's going into their receptacle. And if it has, that it can be retrieved. They are forever amazing me. Which lights are on during a given day. (NE # 1)

On a positive note participants said, "Students have a tremendous amount to give, I am a facilitator." This quotation "doesn't have the teacher learning anything from students." "Teaching nursing is opening, broadening, and enlightening." "Education is changing allowing students more initiative."

We need to foster more independence. This is just the very beginning for them. They are going to have to continue to learn the process all the way along, [the student] needs to be responsible for that, has to be responsible for her own learning. I think the teacher can present and can be available to clarify but the students have to be actively involved, have to be motivated and have to do the work. (NE # 40)

So as with other facets of their lives, these nurse educators break with tradition and the historical policy of lecture as the primary class teaching method as 80% encourage student initiative, responsibility and active participation in the learning process via seminars and discussions.

### The Influence Of Monastic Military Milieu

The 42 nurse educators who participated in this study graduated from their basic nursing program between the years 1946 and 1976. A prevailing educational influence in nursing during that time span was the monastic military milieu introduced in Chapter 2. The monastic military milieu as used in this study was defined during the interview in the following way:



Nursing had its roots in monasteries where care was given to the sick. To this was added the military structure and rules set down by Florence Nightingale.

The concept of monastic military milieu may not have a focused historical reality, however, the nurse educators in this study did understand the elements and the contextual background of the concept. The term "monastic" in this context symbolizes the qualities of unconditional obedience and servanthood of the medieval nursing brother that were transferred to the role of nurse. The nurse socialized in this milieu also responded to the demands of obedience to superiors, self-abnegation, loyalty and service to the agency.

The 20 nurse educators in this study who graduated from Diploma schools of nursing and the 2 who graduated from Associate Degree programs recalled the monastic military milieu as the educational milieu in their undergraduate nursing programs. In addition, six of the 20 Baccalaureate graduates described a similar atmosphere and experience in their schools. During their basic nursing program, these nurse educators were required to remain single, live in dormitories, and devote their entire existence to nursing school. Agreeing that marriage was not allowed while in school, two nurse educators recounted their stories of having to drop out of school for marriage. Both returned years later and have progressed through the hierarchy of nursing education programs to earn doctoral degrees.

To determine if the monastic military milieu persists today in nursing education or to ascertain if there had been a transition in the philosophy of education, these 42 nurse educators were asked the questions listed in Table 4.31.

Table 4.31

Questions pertaining to the monastic military milieu in nursing education.

65. Nursing had its roots in monasteries where care was given to the sick. To this was added the military structure and rules set down by Florence Nightingale. Do you think that the monastic military tradition persists today in nursing education? Why?
66. Do you think faculty encourage monastic military traditions in nursing education today?
67. Can you identify anything which may perpetuate the monastic military milieu in nursing education today?
68. Do you think the milieu of nursing education has changed in the last ten years? In what ways?
69. What is your response to this quotation?

Nursing as an occupation or profession has been compared to a religious vocation. Referred to as a special calling, it requires selfless service to man and God. The nurse has to be zealous in dedication to work, have a selfless denial of personal comfort and unquestioning loyalty to the physician. The essential characteristic of a good nurse was and is obedience. (Ashley, 1976, P.47)

In response to question number 65, "Do you think that the monastic military tradition persists today in nursing education?," 12 (30%) nurse educators said, "Yes."

There are teachers that are very rigid and they say you have to learn this way and you have to do it this way, and there is only one right way to do it and by God you better do it. Those kinds of teachers put students through hoops. (NE # 21)

There is still organization. There is still some sense of obedience. People do give us orders that we do carry out. (NE # 30)

You have to ask me to divorce my former monastic self because this was the tradition I was trained in. (NE # 9)

Twenty replied monastic military traditions persist "less and less."

Nursing is a discipline. The kinds of things that need to be learned are so critical that I think there is a sense of discipline. Not necessarily rigidity, but that's still there. I don't know if it's quite as narrow, maybe, as it was in that period. There is certainly a more humanistic approach than there was in those days. (NE # 35)

Students must learn fundamentals correctly and be precise. It is a necessary evil. There are rules you have to follow. It's life threatening if you don't. (NE # 29)

Four agreed that, "Nursing education is getting away from this milieu, but nursing service is still functioning that way."

We have a wide range of education, a wide range of nurses who are practicing who are in administrative roles, but they have moved up through the ranks by just experience, not education, and so they still carry this [milieu] with them. I can name some people even on our faculty who I would consider to be very skill oriented, task oriented, technical nurses as opposed to professional nurses, so I think that that's still around. I think that we are moving out of it, but we still have it. (NE # 20)

Four said, "No," asserting that the monastic military milieu does not persist in nursing education today.

Response to question number 66, "Do you think faculty encourage monastic military traditions in nursing education today?," 6 said, "Yes," 7 said, "No," and 27 (67.5%) replied, "Not as much."

A lot of it depends on where your educators come from. There are people who teach on a Baccalaureate level who are still very much wedded to those kinds of traditions. Because you are educated in it doesn't mean that your professional life [hasn't] evolved, that you can't go beyond that beginning. I think that probably the change that has most broken down that connection to history was when the focus of education moved away from the hospital setting. (NE # 15)

Another view speaking in favor of monastic military milieu:

I think nursing is suffering because there has been a dilution of that monastic, military type of education which was certainly not the ideal, but it had some definite benefits. The structure was necessary; the regimentation was somewhat necessary, it instilled a certain sense of responsibility on the part of the student. I think we need more of it. I don't know that we need it quite as regimented as it was because it didn't allow any flexibility on the part of the student. But we have gone completely to the other side where there is no structure and I think nursing is suffering because of that. (NE # 11)

A comparison of frequency responses for the persistence of the monastic military milieu in nursing education and faculty encouragement of that monastic military milieu is presented in Table 4.32. The results suggest that monastic military milieu may still persist but is not pervasive in nursing education.

Table 4.32

Comparison of response frequency of the persistence and encouragement of monastic military milieu in nursing education.

	Persists	Encouraged
Yes	12	6
No	4	7
Less and less	20	27
In service	4	

Note N = 40



## Response To The Ashley Quotation

The Ashley quotation (1976), question number 69, was used as a summary description of the monastic military milieu to provide a framework from which to stimulate the memories of these 42 nurse educators about their basic nursing programs. The purpose of this quotation was to encourage comparison and description of transitions from their basic nursing school experience to present day nursing education milieu.

Nursing as an occupation or profession has been compared to a religious vocation. Referred to as a special calling, it requires selfless service to man and God. The nurse has to be zealous in dedication to work, have a selfless denial of personal comfort and unquestioning loyalty to the physician. The essential characteristic of a good nurse was and is obedience. (Ashley, 1976, P.47)

Three nurse educators agreed with the quotation, but 22 (55%) disagreed.

People that go into nursing don't think it's a religious vocation or a special calling. I think that you have to be a really people-oriented person. You have to be bright, you have to be assertive, and need to function as an advocate for somebody. This selfless sort of thing has gone by the board. Nurses are speaking out more. They are demanding higher salaries or salaries that are comparable to their worth. (NE # 1)

Six (15%) responded with statements such as "It's garbage," "hog wash," and "I am enraged." Five (12.5%) replied, "I used to believe it."

I think that's one of the reasons why nurses have been historically ambivalent about finances. Because they kind of look at it, well "Hey I'm providing a service, and I'm doing this out of the goodness of my heart; so what's money?" Now all of a sudden you hear the nurses aides are making more money than we are. [The perception of] nurses being dedicated to work and selfless denial [is] one of the major deterrents for people coming into nursing now. I think this was the way when you had the three year programs. This is what they expected of you. But this is why they are losing nurses too. (NE # 2)

Four said,

The consumer definitely sees us as this. "You [nurses] are so marvelous, you are such a caring profession." They don't see the knowledge base and the level of expertise that's required. The consumer sees us more as a calling still and doesn't see the educational rigor involved. (NE # 3)

Unfortunately society sees us as the nun role and really gets put off when we strike or do some other things. [Nursing is] still seen as a calling. So many of our students come in wanting to be missionaries. These are the people that I see often times get very disenchanted when they find out [nursing is] not part of a religious calling. (NE # 18)

Most of the educators preferred to view nursing as a profession and not as an occupation.

I don't even like the idea of vocation, a special calling. I think that we need to work at nursing, and maybe . . . the problem all these years is the fact that it's been viewed [as] this special thing, with all this dedication and caring. It is not viewed then as an occupation . . . as a job. . . . Unfortunately that is why nurses have been relegated to a lesser role and had to fight so hard because of the fact that we were supposed to break our necks because we were dedicated. (NE # 5)

Many of the nurse educators responded from the perspective of nursing service and expressed concern about the working conditions of nurses, for example:

A lot of agencies are dogmatic, they have their rules and regulations and you can't stray from them. It is still pretty autocratic. (NE # 33)

There is still organization. There is still some sense of obedience. People do give us orders that we do carry out. (NE # 30)

This is what hospital administration and people who are paying the nurse would like us to feel and believe, that we can just do [the work] and not be compensated. (NE # 40)

I believe that the doctors think that. I don't think nurses see themselves this way, so that's where the real dichotomy is, distinguishing between the two. (NE # 20)

Concern was also expressed about the quality of nursing service: "The better your working conditions, the better you are going to work," and "If nurses are not healthy and don't take care of themselves, they are not going to be very good care-givers."

Nurturing is one-sided. The nurse is giving it, and nobody is giving it back to the nurse. We nurture our patients, but we need some very positive stroking for ourselves and we don't get that. We don't get it from physicians, we don't get it from each other. (NE # 3)

Even though several of the nurse educators graduated from Catholic schools or entered nursing with the ambition to be a missionary in response to the religious implications of the Ashley quotation (1976), they have moved away from the formal religious orientation of the church to assume a posture similar to the following response.

Nursing is certainly a profession and occupation. I'd like to strike out the word religion and put in spirituality. I think spirituality is where nursing is going . . . In order to survive in nursing, nurses have to take care of themselves and not deny their own personal comfort or they won't last. I don't think a good nurse is always an obedient nurse. A good nurse is one who can think and work independently at some point and also be part of a team. (NE # 22)

The issue of obedience raised great emotional response from these nurse educators. Nine (22.5%) echoed comments such as "obedience is not an issue," "nurses are dedicated to patient care, no longer loyal to doctors." A humorous response to the Ashley quotation concerning obedience:

I don't like the word obedience. Trouble with that, I mean, the word, "obedience" [reminds me of] a dog. I don't like to see myself as someone who is going to mind. (NE # 29)

In summary, these 42 nurse educators did not agree with the quotation by Ashley (1976). To them, nursing is not a religious vocation but a profession which requires members who are assertive and have good interpersonal skills. Nurses need to take care of themselves so that they can be in a position



to care for others. Obedience is for dogs, not nurses. Nurses are members of a team working in cooperation with doctors for patient care. These 42 nurse educators have moved away from their origins in the monastic military milieu.

### Rites of Initiation

This researcher spent many years comforting students and trying to answer the question, "Why did she [another nurse educator] do that to me?" It was thought that because the nurse educator had passed through rites of initiation she felt obligated to put her students through the same ordeal.

Some faculty are busy doing things that were done to them. On a subconscious level they are doing those things to the student. It is very unhealthy, the same thing just gets perpetuated. I have been in three other education programs and it is the same. (NE # 28)

Table 4.33 lists questions which were asked to obtain information about rites of initiation in nursing education. Do nurse educators have the belief, "When I was a student, I suffered, therefore you [students] will too"?

Fifteen (37.5%) of these nurse educators said they did not have rites of initiation during their basic nursing program. Twenty-seven (67.5%) said they had experienced rites of initiation during their basic nursing program. Fifteen of the 27 found their rites of initiation difficult, three thought they were easy, and five found the rites exciting.



Table 4.33

Questions related to rites of initiation.

70. Do you feel that you went through a rite of initiation in your nursing school?

How difficult was this? extremely difficult, difficult, slightly difficult, easy? How long did it last? What was it like?

71. Do you think the students of today experience rites of initiation? In what ways?

72. What do we do as faculty to encourage or discourage rites of initiation?

Responses described rites of initiation as "uniform stripes," "keeping shoes shined," the "probation period," "capping," and the privilege of "staying on the top floor of the dorm." Five nurse educators described their rites as "having to prove yourself." "Enduring public humiliation in front of a patient by instructor criticism." "Each teacher had new rites we had to conform [to] to pass with her." One participant recalled: "I can remember the psychiatric rotation and the strategy was to tear you down and build you up the way they wanted you." Another described practice in the nursing skills laboratory when the "instructor timed on a stop watch how long it took a student to make a bed."

We went through a capping ceremony. [In addition] your shoe strings had to be white, your shoes had to be white, your hair had to be off your collar. So we had the rites of what a nurse should look like and what your uniform should look like. Then you had the rites you went through on behaviors. We went through proper etiquette. How do you approach the administrators, the doctors, and what was the proper behavior when you approached the patients. So we were indoctrinated into certain behaviors. (NE # 20)

As remembered by the nurse educators, rites of initiation lasted from six months to four years. Perhaps those who said four years were interpreting their entire school process as a rite of initiation.

When asked if students today experience rites of initiation, 13 (32.5%) nurse educators said, "No," 8 (20%) said, "Not to the same degree." Ways that perpetuate rites of initiation suggested by these nurse educators included: "making goals hard," "tedious paper work," "inconsistencies between faculty members," and "posting grades."

Eighteen nurse educators were not asked the question, "What do we do as faculty to encourage or discourage rites of initiation?" because 13 of them had previously stated that they did not think students today experience rites of initiation, five others offered only the capping ceremony as a rite of initiation. In some schools capping and pinning ceremonies have been discontinued, however their students are now requesting that these ceremonies be reinstated.

Ways in which rites of initiation are discouraged were offered by two nurse educators who said, "Teach students to take care of themselves and prevent burnout." Three thought educators could be "less punitive," and more "flexible to look at alternatives that allow students to use their experiences."

Present rites of initiation were described as "rites of growth," "learning what nursing is," "proving oneself," "capping," and "graduation." "Having to pass from year to year in both theory and clinical." Overall, however, these nurse educators did not think students today experience rites of initiation, but rather, students experience rites of passage. The student matures as a result of successfully completing rites of passage experienced

during the educational process. Many rites of passage are scholastic requirements of the nursing programs.

I think students experience them [rites of initiation] because any program has a certain structure to it, and those are rites of passage in that structure. For instance, they have to take a math test. That's a big rite of passage for them. (NE # 20)

There has been a trend at both the local and national level to establish consistency in program requirements. Rites of initiation were more individualized, differing from person to person and school to school without internal consistency. None of these nurse educators actively planned to perpetuate the old-fashioned rites, selecting those with educational and psychological merit instead.

### Perpetuating Feminine Traits In Nursing Education

As described in Chapter 2, sex-role socialization of the female child encourages the child to assume the feminine behavior traits of submission, passivity, conformity, dependence, and nurturance. According to the literature, indoctrination of these traits continues in nursing education when instructors mold students in these behaviors to become a professional nurse. The nurse stereotype into which these 42 nurse educators were originally socialized placed the nurse in a very dependent role. This stereotypical nurse was trained to follow a doctor's orders and to ask a doctor's permission before initiating any patient care. In addition, stereotypical nurses were passive women who received low salaries and accepted their working conditions without complaint. As a student, the stereotypical nurse was educated by the system molding her behavior and encouraging the adoption of the feminine traits of submission, conformity, passivity, dependence, and nurturance.

To ascertain the presence of the feminine traits in nursing students, these 42 nurse educators were asked to evaluate themselves, their classmates, students ten years ago and students today. Thus comparison of these traits in students over a thirty year time span was obtained.

The nurse educators were asked to score each trait on the same Likert Scale of 1 to 5 described earlier. A score of 1 means that the trait is very uncharacteristic and not present in the student. A score of 5 means the trait is very characteristic and is strongly present in student behavior. Table 4.34 presents the means obtained from scoring the feminine traits on a Likert Scale for the nurse educator herself and the three student populations.

Table 4.34

Means of feminine traits for herself, and other student populations.

	Self as student	Classmates students 20-30 years	Students 10 years ago	Students today ago
submission	3.42	3.52	2.76	2.21
conformity	3.59	3.69	3.02	2.57
passivity	2.81	3.00	2.59	2.35
dependence	2.97	3.07	2.81	2.61
nurturance	3.88	3.90	3.57	3.54

1 = Very uncharacteristic  
5 = very characteristic

Note N = 42

The lowest mean score for self as student compared with classmates differed by 0.2 points on passivity, by 0.1 for the traits of submission,



conformity, and dependence. Both groups, classmates and self were rated with only a 0.02 difference in nurturance representing very little significant difference between these nurse educators and their classmates. Most of the means were at a 3 level meaning that students twenty to thirty years ago were placed in the middle of the grading scale for these feminine traits.

Students ten years ago exhibited mean scores in the high 2's with approximately an 0.5 drop in scores from the earlier students. Mean scores of 2's indicate that the feminine traits were less pronounced in students ten years ago during the 1970's than in previous student populations.

Today's students of the 1980's were graded with even lower mean scores. There was almost a full one point drop in submission and conformity from students thirty years ago to students today. Passivity dropped 0.65 and dependence dropped 0.46 which indicates these four feminine traits are less characteristic in students today.

Nurturance also showed a drop of 0.36 from students twenty to thirty years ago but only 0.03 compared to students ten years ago. The trend across thirty years is that these 42 nurse educators score students as becoming less submissive, less conforming, less passive, and less dependent than previous populations. Nurturing has consistently stayed in the mid to high 3's with only a 0.36 drop in score over the thirty years. Therefore nurturing has remained quite constant as a nursing trait.

### The Methods That Perpetuate Feminine Traits

After ranking the feminine traits on the Likert Scale presented in question number 77, the nurse educators were asked to list ways these traits

are encouraged and ways the traits are discouraged in students (see Appendix Exhibit 3 page ).

Suggestions for ways in which the feminine traits of submission, passivity, conformity, and dependence are perpetuated in the traditional milieu of nursing education today and in students behavior are presented in Table 4.35. Suggestions to discourage these traits are presented in Table 4.36.

I don't think we have too many people that teach . . . the feminine stereotype, meaning the dependent female that uses the wily ways to get what she wants. The students come to us [in their] Senior year . . . a lot of their behavior is already set. I might have some influence on them, I don't feel I have major influences in the behavior of these people. They are socialized their whole life, and they are acting a certain way. (NE # 7)

The most frequently offered response was that the nurse educator act as role-models for students and to pair students with positive role-models in clinical situations. Several suggested role-playing as a method of providing opportunity for students to experience and practice scenarios safely, to discuss what might be done differently when problems arise. These nurse educators also advocated encouraging dialogue allowing expression of students opinions and including assertiveness training in the nursing curriculum. Addressing learning needs of individual students was important to help establish student identity, assist students to recognize their own self-worth, validate their accomplishments, and promote their self-esteem. One of these nursed educators added this observation:

Submission, passivity and dependence imply insecurity with self in all aspects. Security comes from thorough knowledge of self and subject. Discussion of 'who, what, why' helps discourage the above traits. (NE # 2)

Table 4.35

Suggestions of ways to encourage perpetuating the feminine traits in nursing education.

Demand conformity in student behavior.

Discourage student decision making skills.

Stifle creativity with fixed assignments.

Use the same curriculum without variation.

Place focus on grades rather than student development.

Structure course content allowing no flexibility for student experience.

Assign students to work with negative role-models in clinical agencies.

Model behaviors of the doctor-nurse game .

Condone clinical situations which provide negative learning for students.

Criticize and belittle students.

Adopt an authoritarian demeanor.

Maintain a hierarchical teacher - student relationship.

Over-structure objectives and assignments.

Regiment assignments.

Table 4.36

Suggestions of ways to discourage perpetuating the feminine traits in nursing education.

Act as a positive role-model.

Include assertiveness training in the curriculum.

Encourage student participation in curriculum planning.

Invite students to be voting members on committees.

Listen to and solicit student input for school problems.

Develop tools which enhance freedom of expression for students.

Encourage student participation in community and professional organizations.

Assign students to work with positive role-models in clinical agencies.

Reinforce positive behaviors.

Validate students and positive role-models.

Encourage student self-confidence.

Enhance student self-esteem.

Apply adult learning theory.

Teach critical thinking skills.

Help students research theory and to process the information.

Assist students to apply classroom theory to clinical situations.

Role-play situations allowing students to safely practice and receive feedback on scenarios.



Table 4.37

Suggestions for ways to encourage nurturance in nursing education.

Act as a role-model.

Encourage compassion for self and others.

Plan assignments based on world issues to force students to expand their opinions and scope.

Include service projects in curriculum development.

Avoid stressing pathophysiology as the only theoretical base for nursing practice.

Do not forget the patient by limiting focus to technology and machines.

Instruct students in ways to care.

Allocate clinical time to expose students to nurturing experiences.

Discuss positive nurse role-models.

Role-play to allow students to practice nurturing techniques.

Include comments on students evaluations.

Validate students for positive nurturing experiences.

Maintain a supportive relationship with students.

Teach assertiveness training.

Enhance student self-esteem.

## Nurturance

The feminine trait, nurturance, was addressed as a separate entity by these 42 nurse educators who said they encourage their students to be nurturing. Many thought nurturance needs to be retaught because modern students are less apt to come with this quality. People are not nurturing when they display a "me first" attitude. Nurturing is not developed when students are preoccupied with self-concern, lacking compassion for self, classmates, clients and others and so these nurse educators encourage students to reach out and help others as a way to learn to nurture. Table 4.37 presents suggestions for ways to encourage the feminine trait of nurturance in nursing education.

Nurturance may be diminished due to technical learning needs by stressing pathophysiology and machines and neglecting the consideration of the personhood of the patient. Nurturance is discouraged by not having enough time allotted for clinical practice providing student exposure to situations and experiences where they can practice nurturing techniques. Student evaluations describing the way they give nursing care provides insight into a student's ability to nurture while interacting with patients.

Faculty role-model nurturance by maintaining a supportive, collaborative relationship with students. Nurturance is encouraged when students are taught assertiveness techniques. As students are taught to care for themselves, they learn to care for and nurture others. When nurse educators encourage self-esteem and self-confidence in their students, they break the cycle and do not perpetuate the effects of sex-role socialization. Self-esteem and self-confidence breaks the cycle of sex-role socialization and

the transference of the feminine traits of submission, passivity, conformity, and dependence.

### Doctor-Nurse Interaction

Table 4.38

Questions related to the doctor-nurse game.

56. As a student, what did your nursing instructors teach you about the relationship between doctors and nurses?
57. Do you teach this to your students today?
58. How does it differ today? What do you teach your students?
59. Leonard Stein describes the doctor-nurse game. Please read the quotation written on this index card. Do you think we teach students to communicate with doctors in this manner today?

The nurse is to be bold, have initiative and be responsible for making significant recommendations, while at the same time she must appear passive. This must be done in such a manner so as to make her recommendations appear to be initiated by the physician. (Stein, 1968, p 102)

60. How do we as educators encourage or discourage this form of communication?
61. What do you think other faculty in your school teach with respect to the doctor-nurse game?
62. What do you think other faculty in America teach with respect to the doctor-nurse game?

As discussed in Chapter 2, much of primary sex-role socialization pivots around male-female communication techniques a mother teaches her daughter. These techniques include how to interpret the meaning of a man's

nonverbal body language. The male-female communication patterns taught by mother are transferred in nursing to the doctor-nurse game. The nurse educator replaces mother as socializer, teaching her students the ways to approach a doctor and the behaviors to use with doctors which are also the rules for communication patterns in the doctor-nurse game. The questions listed in Table 4.38 were designed to ascertain how these 42 nurse educators socialize their students to communicate with doctors.

The purpose of question 56, "As a student, what did your nursing instructors teach you about the relationship between doctors and nurses?" was to obtain history about the experience of the nurse educator as a student nurse and of her socialization process in communication patterns and behaviors to use with doctors. Ten (25%) nurse educators replied, "That was back in another era when doctors were gods." The "doctor was responsible for patient care, [the nurse must] clear things with him before doing them." The frequency of responses which described doctor-nurse handmaiden era behaviors in which nurses were subservient and serving to doctors are given in Table 4.39.

Table 4.39

Frequency of responses for doctor-nurse handmaiden behaviors.

Stand up	22
Respect him	15
Don't question	10
Doctors are gods	7
Fear them	6
Carry charts	5

Note: participants gave more than one response.



Four respondents said some of their instructors demonstrated a "double standard in that they talked [as if] nursing was a team with the doctors, but acted the doctor-nurse game." Nurse educators who were exposed to a more progressive position were taught that doctors and nurses form "part of a team." One jokingly said she was told, "If I get rich someday, I could socialize with them."

When asked question number 57, "Do you teach this to your students today?," 32 (80%) of the interviewed nurse educators said, "No." Three (7.5%) said, "Yes"; and six (15%) responded with "Sometimes."

Some of the faculty are still in that kind of mode. They know better intellectually, but their training prevents them from pushing forward.  
(NE # 36)

Teaching these behaviors to students depended upon the personality of the doctors with whom the nurse educator had to interface.

As a follow-up these 42 nurse educators were then asked question number 58 "What do you teach your students?" Frequency of their responses is presented in Table 4.40. These nurse educators did not socialize their students into the same subservient behaviors they had learned. Instead of the behaviors they learned as students, listed in Table 4.39, these nurse educators teach students that the [students] are part of a team and their input is valuable for patient care. Thus the cycle of sex-role socialization is interrupted on a conscious level. Two responses describe the change in education milieu.

The [doctors] are at a different level than we [nurses] are. They are professional persons and they have great expertise. But I encourage the students to go to the physicians and talk to them about questions on their patients. (NE # 30)

I give specific instruction that [the doctor-nurse game] is not what nursing is about. That [nursing] is a team effort and that [nurses] are there to supplement the doctor, not to be their handmaiden. That the

[students] have fully functioning brains and [should] use them. That's why they were in school. Doctors and nurses should complement each other. (NE # 2)

Table 4.40

Frequency of behaviors nurse educators teach students to interface with doctors.

What do you teach your students?

You are part of a team	24
Question doctors	13
Don't be afraid of doctors	13
Be prepared before talking with doctors	11
Discuss the professional independent roles of the nurse	10
Respect doctors	5
Never do anything just because the doctor tells you to do it.	4
Look at human relationships	4
Stay in the room with a doctor	3
To be intellectually capable people	3

"We all have the same rights to respect. We all have responsibilities . . . to the patient." (NE # 8)

Note: Participants gave more than one response.

### Teaching The Doctor-Nurse Game

To obtain information about what these nurse educators teach with respect to communication in the doctor-nurse game, these 42 two nurse educators were handed a five by seven index card and were asked to read the

following quotation. The quotation was introduced with the statement:

"Leonard Stein described the doctor-nurse game, please read this card. Do you think we teach students to communicate with doctors in this manner today?"

The nurse is to be bold, have initiative and be responsible for making significant recommendations, while at the same time she must appear passive. This must be done in such a manner so as to make her recommendations appear to be initiated by the physician. (Stein, 1968, p.102)

Thirty six (90%) of these nurse educators said that they do not teach the doctor-nurse game.

I don't think we teach them now. I think we teach them differently. What I think happens is similar to what Marlene Kramer wrote [Reality Shock (1974)]. When they get out there in practice, this is what is taught them, and this is what is emphasized. So I think they come to this terrible role strain about what we were teaching to be empowered and be collaborative, and then the subservience is demanded by the work place, in the acute setting. That does not happen in the community health setting. (NE # 18)

An interesting counter-view was offered:

Unfortunately, I think that we do teach nurses to do this. It's alright to be bright, but don't let anybody know this, especially a male. I think it was interesting in my experience working closely with three female physicians recently - that this also applies to female physicians. It's the doctor part, it's not the sex problem. (NE # 11)

Five said, "It depends on the situation," adding the observation, "the training of newer doctors makes them different."

I think with the older doctor it probably is true. The guys in their early forties are a pain in the neck. I think the younger guys, the ones just graduating are much more colleagues, easier to work with. You spend most of your time trying to seduce the [older] guy into thinking it's his idea. (NE # 29)

I think we are in a transition period where the older doctors are saying 'those nurses think they are hot stuff' and then you have the younger doctors who say, 'you know, those nurses are really helping me out'. I

think that medical schools are moving away from teaching doctors that we are the handmaidens. (NE # 15)

Twenty five (62.5%) nurse educators said, "you see the [doctor-nurse game] role-model in clinical situations."

I don't think there is hardly any nurse coming through school who is not exposed to at least some of that thought. I don't believe in it. There is still a lot of that cultural way in hospitals and the [students] are told sometimes point blank those words by other nurses. (NE # 41)

To counter-balance this negative influence, nurse educators talk to students about the doctor-nurse game. Twelve (30%) of these nurse educators "teach by experience" as clinical situations arise. To combat the negative model, eleven nurse educators said they "discuss the actions of the nurse" and "discuss student's actions" with focus on what might be done differently in a clinical situation.

### Perpetuating The Doctor-Nurse Game

Even though these 42 nurse educators claimed not to teach the doctor-nurse game, they had ideas on how the doctor-nurse game was perpetuated in nursing education. educators encourage or discourage this form of communication?" Ways in which communication is perpetuated in the doctor-nurse game are listed in Table 4.41. Table 4.42 lists suggestions for ways the nurse educator might discourage rather than perpetuate these behaviors.

I discourage it [the doctor-nurse game] by not doing it, thereby providing an example for others. I don't like to think anybody encourages it, other than the doctors themselves. (NE # 11)

These 42 nurse educators responded from an individual's point of view. To broaden the base of information, participants were next asked question



number 61, "What do you think other faculty in your school teach with respect to the doctor-nurse game?" Thirteen (32.5%) responded "same as me," 8 (20%) said "some teach it"; it "depends on the image of the faculty member." The other 19 (47.5%) participants gave the response, "I do not know."

If you have a clinically adept instructor, you will have more adept and more assertive students. If you have someone who is really afraid of the situation, they will enhance the doctor-nurse game. But when you are knowledgeable and competent, it doesn't happen. (NE # 17)

Table 4.41

Ways to perpetuate communication patterns in the doctor-nurse game.

Act as "role model, doing it ourselves"	22
"Not empowering the student"	10
"By not pointing out when other people do it."	5
"We give the students phony little ways of beating around the bush when asking for what you want."	4
"I have to ask the doctor"	3
There is still a lot of 'he's god' around."	2
"Students are too inexperienced to learn these behaviors."	2
"By downing a student who is too assertive."	2

Note: Participants gave more than one response.

Table 4.42

Ways to discourage the communication patterns of the doctor-nurse game.

"Include assertiveness training in the nursing curriculum."	13
"Teach the students to be assertive"	10
Discuss values and consequences of the student's responsibility and the behaviors of others."	8
Tell students their "input is important for patient care."	8
Inform students "You are a patient advocate."	5
Teach students to "be prepared before talking to the doctor, and to articulate information clearly."	5
Encourage students to "Ask for information."	3
Remind students to "refuse to do what they know is wrong."	2
Encourage student "participation in the decision making process."	2
Teach students "You are your own advocate."	1

Note: Participants gave more than one response.

I think the majority of the faculty probably admit that there is a game played by some nurses and bring it out into the open and discuss why it is not effective. (NE # 41)

### Teaching The Doctor-Nurse Game Across America

The population in this study consisted of 42 nurse educators who worked on opposite ends of the United States in Massachusetts and California. To gain insight into what might be occurring across the United

States, these 42 nurse educators were asked question number 62, "What do you think other faculty in America teach with respect to the doctor-nurse game?"

Thirteen (32.5%) thought nurse educators across America might teach "the same," 15 (37.5%) said, "I don't know." Eleven (27.5%) thought nurse educators may "still teach it" depending on the part of the country. Three thought the doctor-nurse game is "not taught in baccalaureate programs" but is taught in diploma schools of nursing and might be taught in associate degree programs.

One nurse educator who was a participant in a recent medical seminar returned with this impression:

I get the distinct impression that in the random sampling of women involved in a biomedical engineering class that this kind of thing is encouraged with the female students. The biomedical engineer was an integral part of the team; "but you young ladies that are going into [biomedical engineering], have to be careful when talking to the doctor." (NE # 11)

### Equality With Doctors?

To confirm or dispel the myth that nurse educators consider themselves inferior to doctors, these 42 nurse educators were asked question number 49, "With all your educational preparation do you feel academically equal to medical doctors?" Seven (17.5%) said, "yes"; nine (22.5%) said, "no." Nine felt equal but were "prepared in different knowledge." Eight (20%) felt equal "in my field, yes." Two said, "until it comes to money." Five replied, "equal if not better."

### Summary Doctor-Nurse Game

In summary, 36 (90%) of these 42 nurse educators said that they did not teach the doctor-nurse game. One third thought that most nurse educators in America still teach the doctor-nurse game. These nurse educators felt equal to doctors in academic preparation.

To discourage perpetuation of the doctor-nurse game, these nurse educators discuss clinical situations with students focusing on the behavior and actions of the nurses and what could be done differently. These nurse educators strive to teach their students to be assertive, questioning, responsible, and intellectually capable practitioners. They encourage students to be patient advocates and self advocates and to share their valuable information and patient insights which are helpful for patient care. These 42 nurse educators try to act as role models working in a collaborative relationship with the doctors.

### Changes In Nursing Education

In response to question number 68, "Do you think the milieu of nursing education has changed in the last ten years?" seven nurse educators said "No" and 33 replied, "Yes." The responses for the question "In what ways?" are presented in Table 4.43.



Table 4.43

Ways nursing education has changed in the last ten years.

In the classroom

- Moved from diploma into baccalaureate setting making education more unified
- Flexible curriculum
- Less task oriented
- Push for recognition as a profession
- Demanding more from students as the scope of knowledge increases
- Need to teach students everything
- Not as demanding of students as we used to be
- Increased technical skills
- Teaching more theoretical information
- Continue to stress research in teaching
- Nursing diagnosis is the foundation of curriculum

In the clinical area

- Use more research in practice as compared to what was in the past
- Less clinical hours
- More legal issues
- Fewer clinical placements available

In the student population

- Students work 36-40 hours per week and attend school
- Higher level of commitment to students
- Bend over backwards to save students
- Loose dress codes
- Students are more assertive
- Lower quality academic skills of students
- Greater ethnic diversity of students
- Students have more freedom to discuss
- Students today are not as caring with patients

The most dramatic change in the past ten years is the closing of the hospital based diploma schools of nursing. As a result, the transition to college classroom has brought less task and service orientation in nursing practice, less clinical hours in the hospital, looser dress codes, and older, more assertive students juggling family, work, and academic responsibilities.

Looking beyond the surface, three respondents echoed the thought that nursing education has not changed. "We have changed the words around, but it is still the same format." Some educators are tired of word games.

National educators still beating old dogs. Still contemplating some real old questions that I don't see any use in discussing anymore, they've been answered as far as I am concerned. (NE # 39)

Ten years ago we were worrying about things like behavioral objectives and whether or not they were worded exactly right. Today it is nursing diagnosis. We are standing on our heads trying to build A and trying to make sure every word is in place. In both instances losing the larger sense of scholarly, creative learning and also losing sight of the whole purpose of nursing and whole purpose of caring for other human beings. There is still a lot of obsessing about details that are irrelevant. (NE # 21)

The following response explains the dilemma created in nursing education by expanded knowledge and the demand for increased technical skills due to the technological explosion in medical practice.

We are demanding more and more of the students as the scope of knowledge increases. We have great difficulty in leaving anything out. I have said repeatedly to our faculty, we need to identify what is crucial content and stick with that and not feel guilty about the rest. (NE # 14)

Has nursing education changed in the last ten years? Yes, in educational setting, types of students, and level of commitment to saving students. Yes, in the amount of clinical practice time, the commitment to education rather than service. Yes, in the amount of information the student must learn due to technological advancement. Yes, in the compassion of the nurse educator, the demise of the military monastic milieu, the rites of socialization rather than initiation. Yes, in communicating with doctors in an assertive collegial fashion. Yes, in the increased amount of student-teacher interaction encouraged by these forty two nurse educators.

## CHAPTER 5

### ANALYSIS OF THE DATA

Like Christa Mc Auliffe, I believe I touch tomorrow and I think touching tomorrow in nursing is very important. I think we are in exciting times, and one of my prime goals, I believe, is motivation and stimulation. I'll always think [the students] hear one fourth of what I teach, but they might remember some of the lessons and role-modelling that I've done. (NE # 18)

#### Purpose Of The Study

A review of the literature suggests that sex-role socialization perpetuates in a circular fashion from mother to female child and later in education from teacher to student. In nursing, the nurse educator is thought to replace the mother socializing and reinforcing stereotypic feminine traits of submission, dependence, passivity, conformity and nurturance as the student nurse assumes the behaviors of a professional nurse.

In this study 42 nurse educators in California and Massachusetts were interviewed to:

1. add to the scant body of research on the nurse educator;
2. identify behavioral phenomena which influence the perpetuation of sex-role socialization from teacher to student in the traditional milieu of nursing education.

Interview questions were designed to elicit information about the following issues:

1. The forces which influence transmission of sex-role socialization from nurse educator to student;

2. The manner in which sex-role socialization is exhibited in the professional behaviors of the nurse educator and her students;
3. The effects of sex-role socialization on the nurse educator as a woman in academia;
4. Situations which encourage or discourage perpetuation of sex-role socialization in the traditional milieu of nursing education today.

Using the statistical capabilities of the Statistical Program For Social Sciences, (SPSS) computer program, the responses of nurse educators in this study were analyzed and compared by:

1. state (California and Massachusetts);
2. agency (Community College or Baccalaureate program);
3. type of nursing program they were teaching (Licensed Vocational Nurse, Associate Degree and Baccalaureate);
4. type of nursing program from which they graduated (Diploma, Associate Degree, and Baccalaureate).

#### Part I Mechanisms of Sex-Role Socialization: The Nurse Educators and the Feminine Traits

In Chapter 2 the literature characterized women as compliant, submissive, dependent, accepting, passive, unintelligent, emotional, caring, compassionate, and nurturing. The nurse educators in this study were asked to grade women in general on a Likert Scale of 1 to 5 for the feminine traits of submission, conformity, passivity, dependence and nurturing. Calculation of means provided scores in the mid-range of 3 in all five categories.

Mean scores were 1.5 to 1.8 indicating that these nurse educators did not identify themselves as personifying the three feminine traits of submission, passivity, and dependence, but they moved toward the midline



submission, passivity, and dependence, but they moved toward the midline in conformity with a mean score of 2.6. Their classmates in nursing school, like women in general, received mean scores of 3. However, compared to their classmates, these 42 nurse educators again graded themselves lower in all traits.

Mean scores for the feminine traits of other nurse educators as a group of women in academia ranged in the low 2's for submission, passivity, and dependence. Conformity received a score of 2.78 indicating that once again nurse educators seem pre-disposed toward this trait. They returned comparable scores for other women in academia, scoring them in the low 2's.

These 42 nurse educators are positive role-models who do not embody the stereotypic feminine traits of submission, passivity, conformity and dependence presented in the literature review and they do not encourage acquisition of the same in their students. They scored themselves higher on the feminine trait of nurturance than they scored other women in general and women in academia. Reflecting their concern for caring for others, the nurturing mother role described in the literature is extended as these nurse educators nurture their students and patients.

These responses indicate that the 42 nurse educators in this study do not strongly personify the feminine traits of submission, passivity, conformity, and dependence. This observation is supported by their deviation from traditional sex-role expectation of marriage and family as a primary goal in life. It is also supported by their selection of a lifetime nursing career as a nurse educator in an age when their sisters stayed home caring for husband and family and other nurses were content with working an eight hour shift at an agency. In addition to fulfilling family roles, and professional roles as nurse educators, these women assumed student roles by

continuing study towards advanced degrees. Only 4% of the nurses in the United States in 1980 had earned Master's or Doctoral degrees, however by 1980, 80% of these nurse educators held Master's degrees. Now approximating the average age of 48.8 years they continue to study towards Doctoral degrees.

When locating themselves on a continuum between a "traditional woman" at one end and a feminist on the other end, these nurse educators placed themselves in the middle or slightly towards a feminist position. While holding to the "traditional woman" values with commitment to family and home in their personal lives, the movement towards feminism is reflected in their career commitment, their lower scores on the feminine traits, and the number of roles they enact combining family, personal, and professional roles.

### The Incidence Of Stress-Induced Illness

According to Goldenberg (1978), Miller (1976), and Tavris and Offir (1977), if a woman attempts to meet her own needs and establish her own identity she becomes a deviant of society developing physical and psychological symptoms of depression and stress-induced illness. All nurse educators in this study made a correlation with the incidence of stress-induced illness and their workload and career demands. It is interesting to note the relationship between the incidence of stress-induced illness and the relationship to geographic location. Arthritis and backaches had higher incidence in Massachusetts, perhaps due to the cold, moist climate. Nurse educators in Massachusetts also offered higher incidence of being over weight and suffering weight control difficulties. Nurse educators

in California demonstrated lower incidence of stress-induced illness than nurse educators in Massachusetts.

## Part II Sex-Role Socialization As Nurses

Horner (1969), Tavis and Offir (1977), and Vance (1979) suggest women are non-competitive, fear success, and are self-abnegating, accepting low status and low ranking jobs. The results of this dissertation indicate that these characteristics do not personify the 42 women in this study.

Within their original sex-role socialization, nursing was one of the acceptable career options available to these women because nursing was considered an extension of women's nurturing role. In the literature, nursing presented intellectual challenge, hard work, economic security, and prestige (Tobin (1987), Pankrantz and Pankrantz (1968)). Many of these nurse educators received their education during the same time period as subjects of the research studies discussed in the literature review, therefore, it is not surprising that the perceptions of these 42 nurse educators are consistent with the earlier studies. These 42 educators viewed nursing as hard work, a life-long commitment, an extension of the nurturing feminine role as care-givers helping other people, and an avenue to provide economic security, and prestige. Most of the participants in this study decided on nursing as a career prior to the age of thirteen corresponding to the research of Heidgerken (1970) and their parent's career expectation.

Consistent with the literature, the nurse educators in this study were nurses prior to adopting the second profession of nurse educator. However, these 42 nurse educators never fit the stereotypic role of a passive, submissive, dependent, conforming staff nurse, but rather quickly advanced



to nursing positions in intensive care units and other high stress areas within agencies. In these units because of their leadership potential, nursing skills, and superior expertise, they were chosen to teach other members of the staff or to assume other positions of responsibility.

### Educational Preparation

Supporting Seigel (1984) these nurse educators said they learned on-the-job since 25% had no formal training or experience prior to commencing their teaching careers. Peer support, working with mentors, student feedback, and courses in graduate school were listed as ways they have gained teaching expertise.

In-breeding described by Miller (1977) was not an issue with the population in this study because each agency had a mix from many different schools. These nurse educators dispel the myth about academic inferiority as 85% said that they feel academically equal to colleagues in other departments. If a nurse educator voiced feelings of inferiority it was due to the lack of a doctoral degree. Most of the group of nurse educators desiring the doctoral degree felt the need for the credential rather than the education because they realized that they had more formal knowledge and experience in curriculum development and adult teaching techniques than many non-nursing faculty.



## Student Socialization In The Academic Milieu

Review of the literature portrays an historical tradition of a dominant autocratic environment in nursing education where students are treated as submissive receptacles in a military organization (monastic military milieu). These 42 nurse educators are very carefully trying not to perpetuate or recreate that world for their students. They denied consciously perpetuating rites of initiation, saying instead that present students experience rites of socialization that produce professional growth. Rather than placing students in submissive roles by exclusive use of the lecture method for class presentation (Freire, 1982), these nurse educators prefer discussion and seminar classes where students actively participate in the learning process.

Graduating from schools located across the United States and Canada, the educational philosophy in Diploma and Baccalaureate undergraduate nursing programs experienced by these nurse educators was consistent with the portrait of the monastic military milieu presented in the review of the literature. The monastic military milieu demanded student submission, servitude, obedience, adherence to strict rules, and self-abnegation with school as the central life focus. The school "rule" demanded that students live in dormitories, be subjected to curfews and act as nursing staff giving service on hospital wards. Marriage was not allowed while in school as testified by two participants who dropped out of school for marriage, only to return years later.

Being trained in the monastic military milieu that made impossible demands for perfection, these nurse educators continue to maintain high expectations for themselves and for students today. The evaluation system in

nursing continues to provide the discipline for self analysis and self-criticism necessary to measure excellence in performance and theory. These high standards and expectations are necessary because students must learn how to be safe practitioners.

However, nursing education no longer pivots on the premise that everything must be done perfectly to avoid expulsion. These nurse educators are more flexible than their predecessors, recognizing the needs of students who fill the multiple roles of commuter, self-supporter, single parent, spouse, and/or supporter of other family members.

### Student Socialization In The Clinical Milieu

Results of this research indicate that the 42 nurse educators in this study have moved away from the stereotypic, obedient, submissive unquestioning handmaiden to a posture where the nurse is a skilled practitioner and professional colleague of physicians. Responding to the Ashley quotation (1976), in question number 69, which compared nursing to a religious vocation, requiring obedience, dedication to work, selfless service and loyalty to the physician, these nurse educators said obedience is no longer demanded; loyalty is to the patient not to the physician. Nursing no longer has a religious foundation but does contain a spiritual dimension for patient care.

The focus of clinical practice in education has moved away from giving mere service to the agency. These nurse educators encourage students to be assertive, creative thinkers, to be a patient advocate, to administer nursing care safely, to care for themselves, and to reach out into community and professional agencies.

Therefore the mechanism responsible for maintaining the stereotypic nursing demeanor portrayed in the literature and still prevalent in the health care system must be ascribed to the other members within the system.

Because of simple economics and personnel control, administrators of hospitals and other clinical agencies prefer that workers maintain belief and behaviors congruent with the monastic military milieu. The public still thinks of the nurse as the "lady with the lamp" ministering to patients with great skill and sacrifice while being unconcerned with low wages. The doctor treats the nurse as a servant continuing to play the doctor's role in the doctor-nurse game that will be discussed later in this chapter.

In the clash between academic idealism and the clinical realities related to that monastic military milieu predominating in clinical agencies, the nurse educator must acquiesce to the constraints placed on her and her students by hospital administrations and by staff nurses in order to maintain student placement within an agency. Attempting to counteract the negative influence of these agency constraints, nurse educators discuss with students the real world of nursing, the roles and responsibilities of a staff nurse, and negative role-models encountered in clinical agencies. The nurse educators in this study perceive that graduate nurses encounter stress, frustration and burnout when caught in the dichotomy between what they were taught in school and the constraining forces they encounter in the work environment. Nurse educators attempt to prevent burnout and exodus from the nursing profession by discussing the real world of nursing with their students.

## The Doctor-Nurse Game

These nurse educators denied teaching the doctor-nurse game as defined by Stein (1968) in which the nurse carefully phrases questions so that the doctor thinks her suggestions regarding patient care are his ideas. However these nurse educators support the research of Selmanoff (1968) and Collins (1988) that the doctor-nurse game is alive and flourishing. Doctors' negative behaviors infect communication and pervade relationships between doctors and nurses in clinical agencies. Students are indoctrinated into this game by observing the behavior of clinical role-models. Responses from participants in this study indicate that the doctor-nurse game is perpetuated by organizational structure, doctors, certain nurse role-models in clinical agencies, and by other factors within the health care system, but not by nurse educators and members in the educational system.

## Perceptions Of The Doctor-Nurse Relationship

As nursing students, these 42 nurse educators were introduced to the behaviors of the stereotypical image of the nurse portrayed in the literature and by the media. This nurse was an inferior, subservient handmaiden in relationship with doctors, taught to carry charts, to stand for doctors, and to accept and implement all orders. However, over time these nurse educators have moved away from that posture. Contradicting the claims of Selmanoff (1968), Stein (1968), and Palmer (1982) that nurse educators feel academically unequal to medical doctors, 50% of the nurse educators in this study said they now consider themselves equal to if not better than medical doctors in educational preparation and patient care skills. Of the remaining 50%, 22.5%



of these nurse educators said medical doctors have different preparation in sciences; however, these nurse educators felt equal to if not better than doctors in the social sciences and interpersonal relationships. The 42 nurse educators have advanced to a higher professional level by gaining clinical experience and expertise in family practice, obstetrics, gerontology, and as nurse practitioners. Because of this clinical expertise, they now address doctors as colleagues. Like McGriff (1976), these nurse educators indicate that they teach their students to be assertive, to think before acting, to ask questions, and to work in a collaborative, collegial relationship with doctors.

### Part III Socialization As Nurse Educators

Forty-five percent of these women were recruited into teaching by another nurse educator, who recognizing their leadership ability and outstanding nursing skills, invited them to teach in a school of nursing. The other 55% made a conscious decision to teach because they followed a role-model or thought that they would like teaching. Both groups considered nurse educators professionals who, through teaching, could make a difference in the nursing profession.

These women described how the career transition from nurse to nurse educator combines the best of both worlds. They are now able to enjoy the stimulation of the academic environment and maintain their clinical nursing skills while supervising students. Another factor influencing the career transition from nursing service to nursing education was that the academic year allows these women more time to be home with their families during weekends and holidays. However, that was balanced against the time required for the mountain of paper work involved in preparing classes,

correcting nursing care plans, conducting research, and fulfilling other professional responsibilities.

In the academic community nurse educators experience the negative facets of being in a predominantly female profession. The teaching experience of these 42 nurse educators spans ten to thirty years across all types of nursing programs: Diploma, Associate Degree, Licensed Vocational Nurse, and Baccalaureate. Despite their experience, they all started at the very bottom, in rank and salary and as the literature suggests, continue to work longer hours and to be underpaid both as nurses and as nurse educators. Statistics verify Perry's stance (1982) that "faculty in schools of nursing are heavily weighted at the Instructor and Assistant Professor levels, thus "ranking lower than non-nursing faculty in other departments with similar education and experience. Sixty percent of these 42 nurse educators held these two ranks. Three of the ten Associate Professors, after 16 years of teaching at the same community college, in addition to prior teaching experience, finally attained the rank of Associate Professor last year.

In comparison to faculty members from other academic disciplines, Seigle (1984) and Bauder (1982) observe that nurse educators carry larger workloads with classroom instruction, clinical supervision, student advisement, and committee work than non-nursing faculty. In addition nurse educators must maintain competency as teachers, clinical skills as practitioners, and research and writing skills for publication. Most of the 42 nurse educators in this study hold clinical positions as consultant, staff nurse, or agency administrator in addition to college teaching responsibilities and meeting professional requirements for continuing education.

Because stress management is part of the nursing curriculum these nurse educators were very aware of the methods they use to cope with

frustrations encountered in their academic positions. The nurse educators listed the following as their primary coping methods: eating, exercise, talking with peers, demanding more of themselves, time-management by making and prioritizing lists. Agreeing with Bauder (1982), these nurse educators put household chores in abeyance during the academic year as school and teaching responsibilities take precedence.

### Nurse Educators As Role Models

In response to the question number 78, "How have your nursing instructors been role-models for you?" these 42 nurse educators said they used both the good and the bad examples learned from their instructors. On the good side, their nursing instructors were generally positive role-models, respected for their knowledge and expertise. They demonstrated professional nurse and teaching behaviors, were caring and attentive to students, teaching students to think for themselves.

Responding to bad personal experience, many of these nurse educators said they have changed their teaching style so that their students would not have to endure the same traumas and pass through the same rites of initiation that they experienced during their educational process. The nurse educators in this study have developed a more compassionate style of teaching as a result of their teacher's negative role-models.

Contrary to the Grissum quotation (1976), in question 87, which characterizes nurse educators as inadequate, powerless role-models, these nurse educators are not powerless role-models, nor do they convey powerlessness to their students. An observation that emerged from responses to the Grissum quotation is that the role-model described may have



been true previously of faculty, but now most nurse educators perceive that a change is occurring. Discussing their peers, these women thought that nurse educators today are powerful, innovative role-models. They are not the passive, conforming, submissive, feminine stereotypes of earlier times. As professionals, they occupy leadership and management positions. They teach, maintain practice in a clinical specialty, conduct research, write, and publish while continuing their education. These women are positive role-models for students demonstrating how to juggle and successfully cope with multiple roles.

Miller (1966) described characteristics of nurse educators as productive, personally charming, interesting, arresting, compassionate, warm, skilled in interpersonal cues and relationships. All of these characteristics are present in the nurse educator population of this study.

These nurse educators reported today's students perceive nurse educators as being good teachers, fair, supportive, compassionate, approachable people. Students see these 42 nurse educators as hard and demanding perfectionists, good role-models and family members. Several said students are awed by all that the nurse educator can do.

### Nurse Educators As Women In Academia

Using feminist and nursing literature as a theoretical base, review of the literature revealed a dismal portrait of inferiority, oppression, and male domination for nurse educators in the academic environment. In contrast, the researcher found nurse educators who do not succumb, but rather rise above environmental pressures.



In most colleges the immediate dean was described as supportive, respecting nurse educators as hard working professionals who are dedicated to their students. In contrast, the nurse educators said other administrators and non-nursing faculty do not understand the nurse educator's dual role with classroom and clinical teaching responsibilities.

The geographic isolation of the nursing department described in the literature holds true for three schools in this study. Nurse educators were known as the "ladies down on south campus or in \_\_\_\_\_ building." However interview responses indicate that these nurse educators were over-coming geographic isolation by becoming active in college meetings; 75% serve on college-wide committees, others accept offices as union representatives, and organize faculty in-service education programs. "If you want something done, ask the nurses." They have gained a reputation as capable, hardworking, dedicated, energetic women, busy with students, research, publishing and professional organizations. In two of the colleges, college-wide committees were beginning to explore teaching methods and policies the nursing department had implemented years ago.

Grissum's (1976) description that non-nursing faculty perceive nursing "as inferior scholars in a second rate discipline" may no longer be true. According to the findings in this study nurse educators have worked diligently to change this image. Nursing is gaining credence as an academic discipline on the college campus as nurse educators and their activities are becoming known. Nursing students are viewed as highly motivated serious students and are welcomed into non-nursing classes. Four participants did recall the continuing struggle during the last twenty years to gain recognition for nursing as an academic discipline. Historically on many campuses the nursing program was considered a vocational program rather than an

academic program. Testimony by non-nursing faculty who, while hospitalized, received care from graduates added credence and value to a nursing program in Massachusetts.

Working with students in clinical agencies away from the campus was another isolating factor because nursing faculty are unable to participate in college functions held on clinical teaching days. It is thought by non-nursing faculty that if the nurse educator is not on campus, she is not working, or that she is just being difficult by not attending faculty meetings and other faculty functions. Agreeing with Clarkson (1983), these nurse educators were very aware of the responsibility involved in clinical teaching days. A California nurse educator described the practice at her college of having an observation visit by non-nursing faculty and administrators to gain appreciation for the responsibilities of the nurse educator during a clinical teaching day.

### Models For Perpetuating Sex-roles In Nursing Education

The research of this study indicates that these nurse educator are cycle-breakers who are positive role-models. They return each year because they enjoy teaching, the rewards of seeing students learn, succeed, and graduate. They thrive on the stimulation of the dual role in clinical and academic areas. Like Clarkson (1983) these nurse educators find reward in teaching from the "Ah-ha!" syndrome of their students. These nurse educators convey enthusiasm and optimism as they describe the challenge of returning each year to a new beginning with new students. In addition their lives have purpose, they make a contribution, and they have influence on the nursing profession. Their reward is to see their graduates influencing other

students as positive role-models while working in nursing positions giving good care to patients in clinical agencies.

The cycle of sex-role socialization is not circular as suggested by the literature but upon further examination of existing social patterns and after the research for this dissertation was complete the model for socialization assumed the shape of an infinity loop. The infinity loop enlarges to embrace succeeding generations of students and graduates in a regenerating interactive exchange of nurturance, role-modeling and positive transformation thus assuming the shape of a DNA spiral. The DNA-like spiral maintains its configuration as the nurse educator influences students who become registered nurses and who in turn, replicating learned behavior patterns influence the behaviors of the next generation of students who replicate the behaviors. The nurse educator assumes a central position as an influence on students, graduates, and staff nurses.

Just as a woman may enter the circle at any stage along the life continuum, she also may enter the spiral at any point, whether as a woman, as a student nurse, or as a nurse. The internal forces of the spiral model are self-referential growing wider in their arc to envelope succeeding generations of students and nurses.

It is clear from the comments and teaching practices of the 42 nurse educators that the effects of sex-role socialization as presented in the literature review are not perpetuated by the participants in this study. They do not mold and encourage students to assume the stereotypical feminine nurse behaviors of submission, passivity, conformity, and dependence. Results of this study indicate we must look elsewhere in the medical system, perhaps within the administration or within the belief structures and behavioral

patterns of physicians or staff nurse role-models to determine responsibility for perpetuating these stereotypic nursing behaviors.



## CHAPTER 6

### SUMMARY AND IMPLICATIONS FOR FUTURE STUDY

Oiler (1982) tells us a more comprehensive sense of understanding comes from qualitative descriptions.

Common sense knowledge and a sense of reality grow from qualitative descriptions about a given phenomenon. A task of qualitative research is to locate appropriate sources boldly and creatively. (p 170)

#### Adding The Nurse Educator's Voice

Twenty-one nurse educators in Massachusetts and 21 nurse educators in California were interviewed for this study, that is only 42 out of 45,000 nurse educators in the United States. Therefore an area for future research may be interviewing nurse educators in other geographic locations to add a broader knowledge base by analyzing and comparing their responses to the responses obtained during these interviews. The research questions are implicit, i.e., will similar results be obtained in the Midwest or the southern areas of the United States? Other populations to compare with these 42 nurse educators are

1. younger nurse educators with less experience than the ten years required for participation in this study;
2. male nurse educators;
3. nurse educators who represent ethnic and cultural diversity.

## Perpetuation Of Sex-Role Socialization

Responses from the 42 nurse educators in this study indicate that they are cycle-breakers who have moved away from the stereotypically feminine nurse behaviors of passivity, submission, dependence and conformity. A suggestion for future study to help identify behaviors that perpetuate sex-role socialization from teacher to student in the nursing education milieu is to conduct generational studies of nurse educators. Interview the teachers of the nurse educators who participated in this study. What are their teachers' perceptions about the effects of sex-role socialization? How do their responses compare with the perceptions of their students?

To gain further comparison, interview the students of these 42 nurse educators. What are their perceptions about the effects of sex-role socialization? How do their perceptions compare with the perceptions of their teachers? What is the comparison of sex-role socialization between three generations of teachers and students?

## Forces Which Influence Transmission Of The Feminine Nurse Stereotype

These nurse educators have moved beyond the milieu they experienced during their basic nursing program with its required obedience, servitude, self-abnegation, strict rules and rites of initiation. Research responses in this study indicate that the nursing education milieu is now more flexible, considering and responding to individual student needs. Students are not socialized into the stereotypically obedient handmaiden

nurse who enacts the feminine traits of submission, passivity, conformity and dependence. Rather students are encouraged to follow faculty role-models to be professional, independent, assertive, thinking practitioners. If these 42 nurse educators break the cycle and do not perpetuate sex-role socialization, a significant contribution to this genre of research may result from asking the question, "Who in the health care system is responsible for perpetuating the feminine behaviors that students and graduates encounter in clinical agencies?" In the clash between education and service the system may be blamed as the cause of perpetuating the problems associated with sex-role socialization. However, the system is composed of individuals who contribute to dysfunction. Additional suggestions for areas of future study significant to this research may be:

1. interviewing doctors, administrators, and nurses to obtain their perceptions about the effects of sex-role socialization and to identify where responsibility lies for perpetuating the stereotype submissive, dependent, conforming handmaiden nurse.
2. analyzing the dichotomy between education and service to identify factors that stifle graduates and encourage transmission of sex-role socialization.
3. identifying changes in the health care system that could break the cycle perpetuating the effects of sex-role socialization.

### Implications For Other Disciplines

The researcher asked a high school teacher the questions from the interview guide and received similar responses about the effects of sex-role

socialization. Therefore the questions in this dissertation could be adapted to identify the effects of sex-role socialization on women

1. in other academic disciplines;
2. teaching in all levels of education from kindergarten through postgraduate.

In retrospect as a result of these interviews the researcher gained greater understanding of colleagues, their background, and insight into dynamics of their stance upon certain positions. The same process might apply of women in other disciplines. The suggestion is to compose a similar questionnaire and to use it for building departmental relationships.

On a personal level the questionnaire maybe a resource for personal growth as expressed by this participant:

I want to thank you for the opportunity to participate in your research. It was very meaningful to me to be able to do a "life review" of my career and to be able to express my ideas and values about nursing. Your interview was a very growing experience for me!

### Recognizing Nursing As An Academic Discipline

To counteract the oppressive negative forces that refuse to recognize nursing as an academic discipline, areas for future study might include:

1. looking at the power of those forces in individual schools and agencies to determine situations which encourage or discourage perpetuation of sex-role socialization in nursing education today;
2. analyzing the potential power of nurse educators who unite and use their numbers to initiate and influence change within the educational system;



3. identifying ways to ensure continued recognition of nursing education as a power within the academic community and a valued academic discipline.

Suggestions to increase recognition of nursing as an academic discipline include:

1. developing educational programs to increase understanding of non-nursing faculty about the uniqueness of nursing education;
2. inviting non-nursing faculty to observe a day in a clinical agency;
3. documenting work effort in calculated numbers and hours to provide a statistical base from which to influence promotion and tenure policies;
4. analyzing the effect of accepting leadership roles while serving on college committees;
5. spreading the sphere of influence by publishing in non-nursing journals to inform others what nurse educators are doing.

This study has cited examples of the action and the attitudes of the 42 nurse educator participants; therefore, this dissertation may be used as a starting point in future research from which to reinforce positive aspects of nursing education, to validate the nurse educator's success, and to add the nurse educator's voice to the chorus proclaiming the modern experience of women.

## APPENDICES

APPENDIX A  
INVITATION LETTER

September 19, 1988

Dear

The hour is at hand! The dissertation is finally in progress for finishing next year, 1989.

Would you still like to be a part of the study? I will be in Boston November 10 through 17. Could we schedule two hours for hello's, hugs, and the interview?

During the interview I will be asking questions about your experiences as a nurse educator working with students in the community college setting. Easy, non-threatening questions to answer.

This project continues to delight as I read and learn more about us as women and as nurse educators. What special people we are. I look forward to sharing this with you during the interview.

Please write back using the enclosed postcard. Please let me know if you are interested and suggest a possible time for the interview. Or let me know if you are not able to be interviewed.

Looking forward to hearing from you and seeing you in November.

Love,

Clara

APPENDIX B  
CONSENT FORM

I, \_\_\_\_\_,  
agree to participate in the dissertation research project  
conducted by Clara Willard Boyle. I understand that during an  
interview with Clara I will be asked to answer questions about  
my experience as a student nurse, and as a nurse educator.

All responses will be guarded with anonymity and  
confidentiality. In none of the data reported will responses be  
identified as individuals. Participants are free to withdraw  
and discontinue participation in the research procedure at any  
time.



APPENDIX C  
QUESTIONNAIRE

STATISTICAL BACKGROUND

1. Are you married? ☐ yes      ☐ no
2. How many children do you have?      Ages?
3. What is your age?
4. What is your place in your family birth order?
5. In what state were you raised?
6. In what state did you go to school?
7. Name of nursing school from which you graduated?
8. Year of graduation?    19\_\_\_\_\_
9. Type of nursing program.  
☐ Diploma      ☐ Associate Degree      ☐ Baccalaureate
10. Would you encourage student nurses to enter this same type of program?  
☐ Yes      ☐ No    Why?
11. Name of institution where you are now working?
12. Years of teaching experience?
13. Number of years you have taught at this institution?
14. How did you acquire this position?
15. What is your rank?  
☐ Instructor    ☐ Assistant Professor    ☐ Associate Professor  
☐ Professor
16. Is your rank at the same level as women in other departments who have your educational background and experience ?
17. If not, how does your rank compare with other women of comparable education and experience in the college?

18. Is your rank at the same level as men in other departments who have your educational background and experience?
19. If not, how does your rank compare with male faculty members in the college who have comparable education and experience?
20. What is your salary per year?  
[ ] \$20-25,000 [ ] \$26-30,000 [ ] \$31-35,000 [ ] \$36-40,000  
[ ] over \$40,000
21. How does this compare with women in other departments who have comparable education and experience?
22. How does this compare with men on other departments who have comparable education and experience?
23. Are you eligible for promotion? [ ] Yes [ ] No
24. Are you tenured? [ ] Yes [ ] No
25. Are you eligible for tenure? [ ] Yes [ ] No
26. What progression of schooling have you followed? Diploma or AD or BS to MS to Doctorate
27. Did you work while pursuing degrees? [ ] Yes [ ] No
28. Do you need to earn a Doctorate degree for professional advancement?  
[ ] Yes [ ] No Why?
29. Do you have a medical history of migraine headaches, ulcers, Hypertension, weight control problems, back aches or any other conditions? Please list conditions.

THE FOLLOWING QUESTIONS CONCERN YOUR PROFESSIONAL STATUS AS A NURSE EDUCATOR. PLEASE ANSWER THEM VERBALLY

30. Was your entrance into teaching on purpose or accidental?
31. How did you acquire your first teaching position?
32. What were your reasons for choosing a teaching career?  
For staying in a teaching career?

33. What courses or other preparation did you have before starting your teaching career?
34. What has helped you develop your teaching expertise?
35. Does your educational journey influence the way in which you teach students today?
36. Does your educational journey influence the way in which you deal with students today?
37. What are your rewards as a nurse educator?
38. What are your frustrations as a nurse educator?
39. How do you cope with the frustrations of being a nurse educator?
40. What keeps you coming back each year?
41. Who or what helped you make the transition to become a professional nurse?
42. How do you help your students make the transition to become a professional nurse?
43. Do you think that the nursing department is treated the same as other departments and disciplines in your college?  
On what do you base your opinion?
44. Is there much cross campus contact?
45. What activities do you have on campus outside of the nursing department?
46. Do you feel academically equal to faculty members in other academic disciplines within the college?
47. Are you treated equally as a person?
48. Is your department treated equally? (not asked see question 43)
49. With all your educational preparation do you feel academically equal to medical doctors?
50. Has anything restrained you from earning a doctorate degree?  
If yes, what?

51. What has your agency done to encourage or to aid you in pursuing education?

52. In what discipline is your doctorate degree?

THE NEXT QUESTIONS CONCERN TEACHING STYLE IN NURSING EDUCATION.

53. Which class format do you prefer lecture, seminar, discussion, combination?

54. Why do you think lecture method is so widely used in nursing education today?

55. PLEASE READ THIS QUOTATION.

Do you think this quotation describes the classroom milieu in nursing education today?

Students become containers or receptacles to be filled by the teacher. Students are under the control and domination of the teacher. The more completely the teacher fills the receptacles, the better teacher she is thought to be. The more readily the receptacles permit themselves to be filled, the better students they are. Education thus becomes an act of depositing. Instead of communication, the teacher issues communiques and makes deposits which the students patiently receive, memorize and repeat. (Freire, 1982, p.58)

THESE NEXT QUESTIONS CONCERN DOCTOR NURSE INTERACTIONS.  
YOU ARE DOING VERY WELL WITH ALL THESE QUESTIONS.  
THANK YOU FOR DOING THIS INTERVIEW.

56. As a student, what did your nursing instructors teach you about the relationship between doctors and nurses?

57. Do you teach this to your students today?

58. How does it differ today?  
What do you teach your students?

59. Leonard Stein describes the doctor-nurse game.



PLEASE READ THE QUOTATION WRITTEN ON THIS INDEX CARD.

Do you think we teach students to communicate with doctors in this manner today?

The nurse is to be bold, have initiative and be responsible for making significant recommendations, while at the same time she must appear passive. This must be done in such a manner so as to make her recommendations appear to be initiated by the physician. (Stein, 1968, p.102)

60. How do we as educators encourage or discourage this form of communication?
61. What do you think other faculty in your school teach with respect to the doctor-nurse game?
62. What do you think other faculty in America teach with respect to the doctor-nurse game?
63. PLEASE READ THE QUOTATION AGAIN.  
In your private life do you think you communicate in this way?  
Towards whom?
64. How often do you behave like this? very frequently, frequently, sometimes, never?

#### NOW, A LITTLE NURSING HISTORY

65. Nursing had its roots in monasteries where care was given to the sick. To this was added the military structure and rules set down by Florence Nightingale.  
  
Do you think that the monastic military tradition persists today in nursing education?  
Why?
66. Do you think faculty encourage monastic military traditions in nursing education today?
67. Can you identify anything which may perpetuate the monastic military milieu (traditions) in nursing education today?
68. Do you think the milieu of nursing education has changed in the last ten years?  
In what ways?

68A. I am interviewing women our age with at least ten years teaching experience. Do you think younger teachers with less experience have the same attitudes as more experienced nurse educators?

69. WHAT IS YOUR RESPONSE TO THIS QUOTATION?

Nursing as an occupation or profession has been compared to a religious vocation. Referred to as a special calling, it requires selfless service to man and God. The nurse has to be zealous in dedication to work, have a selfless denial of personal comfort and unquestioning loyalty to the physician. The essential characteristic of a good nurse was and is obedience. (Ashley, 1976, P.47)

70. Do you feel that you went through a rite of initiation in your nursing school?

How difficult was this? extremely difficult, difficult, slightly difficult, easy?

How long did it last? What was it like?

71. Do you think the students of today experience rites of initiation?  
In what ways?

72. What do we do as faculty to encourage or discourage rites of initiation?

73. How is a student who is inquisitive and free spirited treated in nursing education today?

74. Is that different from the way a free spirited student might be treated in other academic disciplines?

75. Do you encourage students to continue on and pursue a higher education level?

76. What do you do to encourage career advancement in your students?

77. WILL YOU PLEASE FILL OUT THIS SURVEY?

HOW MUCH DO THE FOLLOWING TRAITS DESCRIBE YOU ?

FOR EACH QUESTION WRITE A NUMBER FROM THE FOLLOWING SCALE TO SHOW HOW MUCH THE TRAIT IS CHARACTERISTIC OR UNCHARACTERISTIC OF YOU.

EXTREMELY  
CHARACTERISTIC

EXTREMELY  
UNCHARACTERISTIC

1

2

3

4

5

Would you describe yourself as

\_\_\_\_\_ submissive?  
\_\_\_\_\_ conforming?  
\_\_\_\_\_ passive?  
\_\_\_\_\_ dependent?  
\_\_\_\_\_ nurturing?

Think about nurses as a whole, how much do these traits describe them?  
Where would you rate nurses using this scale?

\_\_\_\_\_ submissive?  
\_\_\_\_\_ conforming?  
\_\_\_\_\_ passive?  
\_\_\_\_\_ dependent?  
\_\_\_\_\_ nurturing?

Consider other women in academe. Where would you place them for these traits using the same scale?

\_\_\_\_\_ submissive?  
\_\_\_\_\_ conforming?  
\_\_\_\_\_ passive?  
\_\_\_\_\_ dependent?  
\_\_\_\_\_ nurturing?

Consider other nurse educators, how much do these traits describe them?

\_\_\_\_\_ submissive?  
\_\_\_\_\_ conforming?  
\_\_\_\_\_ passive?  
\_\_\_\_\_ dependent?  
\_\_\_\_\_ nurturing?

Consider women in general as a group, Where would you place them for these traits using the same scale?

\_\_\_\_\_ submissive?  
\_\_\_\_\_ conforming?  
\_\_\_\_\_ passive?  
\_\_\_\_\_ dependent?  
\_\_\_\_\_ nurturing?

#### USING THE SAME SCALE

How would you rate yourself when you were a student?

\_\_\_\_\_ submissive?  
\_\_\_\_\_ conforming?  
\_\_\_\_\_ passive?  
\_\_\_\_\_ dependent?  
\_\_\_\_\_ nurturing?

How would you rate other students when you were in school?

\_\_\_\_\_ submissive?  
\_\_\_\_\_ conforming?  
\_\_\_\_\_ passive?  
\_\_\_\_\_ dependent?  
\_\_\_\_\_ nurturing?

How would you rate the students you taught 10 years ago?

\_\_\_\_\_ submissive?  
\_\_\_\_\_ conforming?  
\_\_\_\_\_ passive?  
\_\_\_\_\_ dependent?  
\_\_\_\_\_ nurturing?

How would you rate students of today?

\_\_\_\_\_ submissive?  
\_\_\_\_\_ conforming?  
\_\_\_\_\_ passive?  
\_\_\_\_\_ dependent?  
\_\_\_\_\_ nurturing?



How desirable is it to teach or encourage these traits in your students today?

- \_\_\_\_\_ submissive?
- \_\_\_\_\_ conforming?
- \_\_\_\_\_ passive?
- \_\_\_\_\_ dependent?
- \_\_\_\_\_ nurturing?

LIST WAYS THESE TRAITS  
ARE ENCOURAGED  
IN STUDENTS

LIST WAYS THESE TRAITS  
ARE DISCOURAGED  
IN STUDENTS

NOW I WOULD LIKE TO ASK YOU A FEW QUESTIONS ABOUT NURSE  
EDUCATORS AS ROLE MODELS FOR STUDENTS.

78. How have your Nursing Instructors been role models for you?  
Please explain.
79. Tell me about (list) all the roles that you have.
80. How do you handle all your roles?
81. Do you ever have problems handling all these roles?
82. What do you do to help yourself cope?
83. You have listed some medical conditions. Do you see any correlation  
between these conditions and the many roles you juggle?
84. Is there any correlation between your medical conditions and work  
situations?
85. Do you think you spend too much time at work? Why must you put in  
all this time?
86. What outside activities do you have?  
professional  
personal  
family  
groups  
play

87. THIS IS A QUOTATION ABOUT HOW STUDENTS PERCEIVE FACULTY.

Do you agree or disagree with this statement?

Students do not find enough adequate role models among their faculty. What they see usually are powerless, noninnovative faculty members who conform to and perpetuate the feminine stereotype. They do this through their behavior and their mode of communication with students and also by educating students in outmoded, traditional curricula that do not prepare them for the real work world. With this type of traditional teaching, we prepare a trained dependency characterized by high predictability of behavior. (Grissum, 1976, p.221)

Why do you agree or disagree with the quotation?

88. How do College Deans view you and the nursing department?
89. What do faculty in other disciplines think of the nurse educators?
90. Can you give a one or two line summary of how your children might describe you?
91. Does your husband think you devote too much time to work?
92. How do you think students view you?
93. How do you view yourself in relation to juggling your professional and private lives?
94. A. How do you think being a woman has influenced your career?  
B. How do you think being a woman has influenced your career as a nurse?  
C. How do you think being a woman has influenced your career as a nurse educator?

NOW TO FINISH UP, JUST A FEW QUICK QUESTIONS ABOUT YOUR CHILDHOOD. You are doing great!

95. What jobs did your parents have while you were growing up?
96. What were your ambitions as a child?
97. As a child what kind of work did you want to do when you grew up?

98. What did your mother expect you to be when you grew up?
99. What did your father expect you to be when you grew up?
100. Did you expect to get married?
101. How does being a nurse fit with your view of being a woman?
102. How long did you think you might work as a nurse?
103. Would you encourage your daughter to be a nurse?
104. What did nursing mean to you when you considered it as a career?
105. Would you describe yourself as a traditional woman?
106. Would you describe yourself as a feminist?
107. Where would you place yourself on the continuum of being a traditional woman at one end or a feminist at the other end?

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