

## Nursing and the Political Arena

### INTRODUCTION

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What is the future of nursing as a profession? What will its role be in the health care delivery system and on the social and political stages? These questions for many a year have provided a basis for discussion. In this debate, overwhelming calls of pessimism issued by members of the profession have been heard loud and clear. In the words of one practitioner:

Is this the beginning of the end of nursing? Impossible some will say. Impossible because of the numbers of nurses and the invaluable service they render to society. Think again. Peter Drucker points out that at the turn of the century the largest populations of workers were farmers and live-in servants. Ninety years later, these groups barely exist. Although farmers and domestic servants were everywhere, as a class, they were invisible. Drucker attributes their invisibility to the fact they were not organized as a group. As a class, nurses may be more visible inasmuch as they are organized. However, they remain vulnerable. Their work remains invisible to far too many. The invisibility of nurses may lead to our profession's demise. (Gottlieb, 1996, p. 4)

These strong words present a desperate situation. Yet we all know that this knowledge-based group, being essential to the operation of the health care delivery system, will survive. The important question is: In what form will it survive? The response, in part, will be decided, like other professional issues, by the interplay of political forces and the resulting public policies. Nurse leaders are in general agreement that nursing's continuous evolution as a truly autonomous profession is inextricably bound to its ability to influence policy development and to evidence a positive public image of nursing as an essential societal service.

The concept of power and its distribution and use are concerns of many groups, including professions. It is generally acknowledged that the most important part of the professionalization process, “. . . an attempt to translate one order of scarce resources—special knowledge and skills—into another—social and economic rewards” (Larson, 1977, p. xvii), is gaining and maintaining power and control. Power is defined as the ability to influence or persuade decision makers to act in a way congruent with desired outcomes. Professional power has dual aspects. It may be sought and exerted at a local or parochial level, that is, internally, or in a national or cosmopolitan setting, that is, externally. The nursing profession has not always enjoyed access to the external, broader, societal dimension of power and, consequently, it was forced to focus most of its efforts in a narrower fashion, internally on the profession. Internal power had to compensate for external power.

In comparison to other professionals, especially physicians, little has been written on the topic of power, politics and policy related to nursing. Although the profession has engaged in the power game at the cosmopolitan level, it has been demonstrated again and again that nurses have not been adept at politics. Their political efforts, with rare exception, have been casual, nebulous, and lacking in continuity. There has been a failure to recognize their potential impact on the political arena and the significance of the nursing profession as an interest group. Cathryne A. Welch (1985), a prominent commentator on the profession, has appropriately written:

As a profession, nursing has not been a major determinant of health policy in this country.

Predominantly, nursing has been in a reactionary or responsive state versus the creative role with respect to designing health policy. Frankly . . . nursing has stood on the periphery of both power and politics for so long as a result of its inability to use its own force in the formulation of health policy. (p. 107)

This judgment is not atypical.

Being the largest of the health care professions and consisting, according to the Bureau of Health Professions, of 2.6 million registered nurses and, thus, representing a significant majority of American health care providers, and accounting for the largest noncapital portion of health care institutional budgets, nursing should have been more influential than it has been in the making of health care policy. In spite of their numbers, nurses have experienced difficulty in channeling their strength to achieve status, recognition and power. Historically, they have had limited power in the health care delivery system as well as in the political arena. They have been isolated from political, social and economic power. Never having been able to capitalize on its knowledge, skills, numerical advantage and key role in the health care delivery system for utilization of power on the political stage, the profession has often been referred to as a “sleeping giant.”

One element important to the development of political competence is faculty role modeling of the knowledge, attitudes, and behaviors associated with successfully impacting the political system. Perhaps nursing education has not demonstrated the significance of participation in policy development and nursing faculty have not served as critical role models. It may be that the profession has fallen far short of its potential impact on health care policy, in part, because of the manner in which socialization agents have functioned.

Inherent in the preparation of the professional practitioner of nursing is this concept of socialization, meaning the learning of values, attitudes, morals, knowledge and skills. One of the skills that nursing education programs, especially baccalaureate and higher-degree ones, profess to transmit to their students is the ability to influence health care policy development in general and, in particular, that related to nursing. Faculty role modeling is a significant factor in the creation of this competency. Data from the nursing literature suggests, however, that although nursing graduates, especially those with

a baccalaureate degree, value professional autonomy and leadership, many may not see change and its implementation through active participation in professional associations and policy making as part of their professional role. If such is the case, labeling these graduates “change agents” may be a misnomer with significant adverse repercussions for the profession of nursing.

The graduates’ ambivalence toward the importance of professional organizational affiliations and participation in policy development may reflect the knowledge, attitudes, and behaviors role modeled by the nursing faculty to which they are exposed. In view of this, it is imperative to examine the role modeling that nurse faculty members exhibit relative to the profession’s role in policy development. To date this has not been done. This work discusses the role of nurses in the political process. More specifically, it examines nurse educators’ attitudes toward political participation and the behavior these professionals exhibit relative to political and organizational activism. The study is based on an extensive questionnaire administered to full-time faculty members in baccalaureate and higher-degree programs in the state of New York. Research objectives were threefold: (1) to examine the nurse educators’ participation in professional, political, and other organizations; (2) to examine their knowledge of and attitudes toward select professional concerns; and (3) to examine their actual involvement in the promotion of policies and candidates supportive to nursing. All of these relate to how nursing faculty members serve as role models for their students.

Professions, however, cannot be understood in terms of the current balance of social relations. One cannot study any given profession without studying its context. Present-day behavior has its roots in various stages and facets of professional history (Tousijn, 1997) containing many forces referred to as determinants. These critical elements forming over time in a profession’s development influence the conduct of its practitioners today. Many factors have been used to explain nurses’ limited power. In addition to history and its broad social formations, these include the state and its organization, gender composition of the profession, religious and military influences, professional closure, education, the work setting, remuneration, and culture and socialization to the profession. Before pursuing the main focus of this work, I will briefly discuss each of these elements so that the reader will be able to relate the major theme to a broader perspective.

Politics is not new to nursing. Gains for the profession have been minimized, in part because throughout its history nurses have exercised power as individuals and not collectively. There have been visionary and capable nursing leaders who, exerting power externally, were consummate politicians. However, they have been few in number. Most leaders, having a restricted vision of power, have been internalists. Nursing in the course of its development as a profession has constantly been in a position of being controlled by a variety of outside forces. Thus, it has experienced a long history of dependency in major health care decisions. Politically, the profession has been recognized primarily at times of crisis. It has been essentially dismissed as a significant political actor.

Nurses themselves, leaders and otherwise, have admitted and complained that their counsel has rarely been sought in health care planning. In part, this situation resulted because, although organized nursing considers itself professional, the public has held this profession in a different regard from that of medicine or law. Thus, it has not been consulted on issues of public policy in the same manner as the other professions. In general, when there are questions concerning health care matters, the advice of physicians and hospital administrators has been sought. And if solicited, the counsel of nurses has usually not been taken as seriously as that of more influential constituencies. A recent development in the profession is increased interest in the public policy arena and greater recognition by other players. Influence, to date, however, has lagged behind enhanced interest and recognition.

#### THE STATE AND ITS ORGANIZATION

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Different types of knowledge-based groups result from diverse social and political environments, a major component of which is the nature of the nation-state and its organization. Use of the word *state* should not be confused with the subnational unit of government in the United States, that is, New York State, Maine, Wyoming, and so on. As used here, “nation-state” refers to a sovereign unit whose constitution distributes power to the various institutions and whose policies are determined by its agent, government.

The role of the nation-state has been paramount in the evolution of various professions.

[It] has granted legitimacy to the professions by, for example, licensing professional activity, and setting standards of practice to ensure public safety and protection. The state has also acted as a guarantor of professional education, not least by giving public funds for academic education and research . . . the state has extended its support for the professions by paying for the services rendered to the public by professional experts. (Hellberg, Saks, & Benoit, 1999, p. 2)

A monopoly over the provision of a particular service, the ideal of any knowledge-based group, can only be granted by the state. The role of the state and sectors within it fluctuate according to the values that dominate at a given point in history. Professional activities continually change in content and legitimation. Legitimacy is of particular importance to professions. It justifies what they do and how they do it. It denotes approval and establishes that their activities reflect cultural values and norms. Professions, having a distinctive relationship with the state, explain their professional position at any point in time as a result of their encounters with it (Abbott, 1988; Macdonald, 1995). In their pursuit of monopoly and privilege, professions cannot avoid the state. They must use it to support the basis of their professional claim.

A basic distinction between nation-states is that of the welfare state, as exemplified by countries in continental Europe, and the liberal state as in the case of the United States. In the former, the concept of governance features the promotion and maintenance of social goals such as income support, including pensions and child subsidies; housing; and health care and social services provision. Citizens are endowed with a broad array of legally guaranteed social and economic rights. Economic, physical, mental and cultural security is facilitated for the citizenry by services forthcoming from the public sector and paid for by taxation. In the liberal state as it exists today, the claims of rights of individuals are not as broad as in the welfare state and, thus, the social agenda is much more restricted. Many of the same goods and services that are forthcoming from the public sector in the welfare state are purchased in the liberal state on

the market from diverse professional practitioners by citizens as customers or clients.

Not only does this distinction between states bear consequences for the role and position of the citizen, but it also impacts on the role and development of knowledge-based groups. The professions regulate the market and are regulated by the market in the liberal state, whereas in the welfare state, professions regulate the law and are regulated by it. The allocation of social goods in the liberal state is realized by means of the supply and demand of the market, and in the welfare state by means of law. Professions have important but diverse roles in the distribution of social goods depending on the nature of the state. Moreover, they have a different kind of relationship with the state depending, again, on its type.

The driving force for the development of professions in continental Europe and especially Scandinavia was principally the demands and needs of the welfare state. Professional development was linked to the development of citizen rights. As the state expanded its public sector activities and, thus, services to the citizenry, the development of the individual professions reflected the ambitions that the state had for them. For example, in the Scandinavian nations, the state promoted expansion of the health care system. As it has grown within the confines of the welfare state, so has nursing. In this case the state has served as a significant source of legitimation. Having a critical role in its activities, nursing achieved social legitimacy. There is a relationship between professional power and citizens' rights. Furthermore, these professions have become identified with the state in such a way that they perform a moderating function between the state and its citizenry. They occupy a critical and sensitive spot. Being in service of the state and firmly implanted in the public sector, health care professions, and specifically nursing, have been assigned various responsibilities that the welfare state has toward its citizens. In exchange for carrying out these duties, the state initiated authorization for the professions to perform certain tasks and offered aid in establishing professional closure or territoriality, a demarcation of professional boundaries and responsibilities (Bertilsson, 1990; Brante, 1999; Elzinga, 1990; Hellberg, 1990). In essence, in the welfare or interventionist state, professionalization evolves "from above," that is, within the state. The state and the professions are joined in a partnership in which both pursue their own interests.

The situation varies considerably in the liberal state with its laissez-faire philosophical foundation based on the notion that the government that governs best is the one that governs least. The restricted role of the state has meant that the principal determinant of the development of the nursing profession in the United States has been private-sector enterprise and not the state, as in continental Europe. Professions, not being in service of the state, established themselves apart from it. The formation of monopolistic practitioner organizations operating on the market for services was important. These structures, lending status to individual groups, assumed the initiative and approached the state to support their power of monopolization and self-regulation over their members. Thus, the liberal state, as opposed to its welfare counterpart, is a passive recipient of stimuli from aspiring knowledge-based groups. It does not initiate, but rather reacts. Moreover, the politics of professional development and projection also differ in the two state models. In the welfare state, conflict centers on bureaucratic position and in its liberal counterpart, the struggles are for decentralized market regulation associations. Both models have affected professional identities and work conditions (Castro, 1999; Collins, 1990; Fielding & Portwood, 1980; Larson, 1990; Torstendahl, 1990). In essence, the shape of the state has had significant connotations for many facets of nursing's collective development.

## GENDER

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Throughout their history, the values of a patriarchal society have been built into the institutions and practices of the caring professions, such as nursing. Being embedded in a gendered world, in the sense that nursing is composed largely of women, that profession has been impacted negatively in its attempt to leave its mark on the public agenda and health care institutions. There is a link between gender, status and power. Structured features of the profession, regarded primarily as a female one and as an extension of domestic service, can be related to its gender composition. Caregivers, like women in general, have been defined and delimited by patriarchal custom and male authority. This, in part, accounts for the low esteem assigned to nurs-



ing. The lack of leadership in the profession has been explained by reference to nurses' social orientation as women. In fact, the role of nursing in the health field is the epitome of the female role in American society. The status of nursing at any point in time reflects the status of women. Both are manifestations of prevailing sex-role norms. For example, after valiant service in World War I, nursing's professional image declined dramatically. Most nurses were unmarried and thus lacked the prestige that marriage brought in the society of that era. Nursing problems are a part of the larger question of women's social, economic, sexual and political bondage. There are many connections between the subordinated status of women and of women in the nursing profession (Ashley, 1977; Capuzzi, 1980; James, 1985; Lewis, 1985; Roberts & Group, 1995).

Davies (1995) posits that gender divisions are basic to all social structures and gender codes of masculinity and femininity pervade organizations in such a way that they and their interrelationships are gendered. She argues: "Starting from assumptions, such as these, what appears initially as disconnected personal discontents of women as nurses gradually transmutes into the collective dilemmas of nurses as women—the dilemmas, in other words, of gender" (p. ix). In short, gender fashions the way people relate to each other and it pervades their institutions, including those of work and politics.

Not accorded full professional status, the nurse is perceived as a female who has a "job" rather than a profession or a career. This, in turn trivializing the practitioner's work and belittling those who perform it, creates doubts about the profession's leadership and its members (Davies, 1995). Hierarchical relationships within the health care system reflect this situation. Consequently, it has been extremely difficult for nurses to gain influence external to their profession. It is generally assumed that "women are a subgroup, that 'man's world' is the real world, that patriarchy is equivalent to culture and culture to patriarchy . . ." (Code, 1988, p. 20). In the patriarchal health care system, thought structures and social policies have dictated a particular and subordinate status for women in the "man's world." Given the traditional gendered nature of the health care professions, the predominantly female profession of nursing has been less privileged than those dominated by males.

The sheer number of women in the profession has placed a brake on the extent to which it could make a bid for power in the

political and professional arenas. Despite being a heavily female world, nursing is not a united world founded on gender. This fragmentation complicates the situation even more. One of the profession's many divisions is based on age. As in most professions, there is a gulf between the older and younger generations, which in the case of nursing, was congruent with a schism between nurse leaders and regular nurses. Moreover, marital status has divided the practitioners. For example, as far as leadership is concerned, until after World War II there were almost no married women influential in the internal affairs of nursing. However, some leaders had been married and widowed or divorced. Also, at one time, married women were not accepted into most nursing schools because of the conflict between having to live in the hospital and maintaining an outside home. In addition, many work sites preferred singles and some were legally restricted to unmarried women. Working conditions definitely favored single females. Eventually, barriers based on marital status disappeared and it was possible to combine marriage, family, and a career without being ostracized. Divisions such as these, in addition to severe professional ones that will be presented throughout this work, have plagued the profession, especially in its bid for power (Goodman-Draper, 1995). Nurses are perceived as having many positive qualities, but the list does not include power. It remains to be seen whether the profession's attempt to achieve increased power will materialize or not. Unfortunately, ". . . perceptions and images of nurses are processed . . . according to ingrained, gender-based, stereotyped schemata, totally opposite to images of power and influence" (Roberts & Group, 1995, p. 292).

Being essentially a female profession, and the largest group of professional women in the United States, it could be expected that nursing would have connected immediately and intimately with feminist concerns, especially the struggle for the franchise and the women's movement. However, the profession as well as its individual members were slow to embrace these elements. The two constituencies, the female and nursing worlds, had diverse foci. Nursing in the latter 1800s was primarily preoccupied with professional growth and control. It applied social feminist activism to its own professional agenda (Lewenson, 1993). It was concerned with issues specific to the profession, such as autonomy, self-control, work schedules, pay equity and professional equality. On the other hand, the women's move-

ment had broader horizons and more general concerns relating to work opportunities, education and political rights for women. Moreover, when, in 1907, the suffrage movement re-emerged with the founding of the Equality League of Self-Supporting Women, few nurses were quick to grasp its message. In addition, there were strained relations between the profession and the National Woman's Party that was active on the political stage from 1913 to 1920 and an important force in obtaining women's right to vote.

Nursing leadership, from a practical perspective, eventually became aware of the importance of the franchise to realization of professional objectives. As these leaders struggled for state licensure, their inability to vote for such a change underscored the significance of female suffrage. Perceived as a guarantor of women's rights in the home and at work, the vote symbolized personal and professional freedom. A new stance was consequently assumed by the profession at the 1915 gathering of the governing body of the American Nurses Association (ANA), the principal representative body of the profession. Previous opposition to women's suffrage was overturned. This new orientation was congruent with the spirit of the late nineteenth and early twentieth-century women's movement. It was realized that nursing and feminists had overlapping and complementary interests. Nursing organizations allied with other women's groups in their attempt to improve the social, political, and economic conditions of females. The nursing profession moved from its parochial professional concerns toward a more extensive and active role in the social reforms of the Progressive era.

If members of the profession were hesitant to endorse the franchise, they were equally hesitant to support the Equal Rights Amendment (ERA) that was placed on the public agenda in 1923, immediately after women were given the right to vote. Nursing was as divided as feminists on this issue that was supported only by a small minority. Opposition centered on the fear that implementation would result in the invalidation of all social legislation protecting women achieved as the result of fierce battles during the Progressive years. Fifty years after its introduction, the ERA was approved by Congress, but it was not ratified for lack of votes. Although nursing was heavily involved in these two controversial struggles, it was not in the vanguard of either, nor did it assert itself in a leadership capacity (Palmer, 1983).

The alliance between nursing and the women's movement has always had its uneasy moments. However, it was most fragile when feminist activities in the broader society intensified in the early 1960s (Feldman & Lewenson, 2000). Failing to acknowledge the ties between the two constituencies at the start of the last century, women's groups put down nursing. These feminists were externalists. They knew little and cared little about the internal world of the profession. Basically they disregarded it. Even though they were promoting the advancement of women in male-defined professions that systematically oppress females, they did not consider as worthy of attention the political, professional and personal potential women created in nursing. In part, the discrepancy between feminists and nursing resulted from a lack of, and incorrect, knowledge of the profession that generated many misunderstandings.

Nurses were severely chastised for their promulgation of negative female stereotypes. Feminists regarded them as the epitome of woman's servile role. Moreover, they pointed to a large body of professional literature, penned by nurses, that affirmed the male definition and domination of the profession along with the systemic oppression of its members. Nurses were thought to be the victims of a totally male-defined system, considered to be the opium of the feminists, and in essence, the professional response was labeled weak. Nursing, it was charged, had succumbed to oppressed-group behavior and was imitating what it viewed as powerful, that which is male. Not only were nurses accused of identifying with the oppressor, symbolized by physicians and administrators, but it was charged with a form of antifeminist self-aggression. This disregard for nurses is evident in the feminist and working women's literature. There is very little material focusing on the profession. The largest single group of female workers in the nation is barely mentioned in connection with politics and the women's movement (Archer & Goehner, 1982; Lewenson, 1993; Lynaugh & Brush, 1996). These accusations took their toll on nursing. Many potential students selected other occupational directions and as a reaction to the lack of respect and questioning of their worth by other professionals and society at large, many nurses deserted the profession. Within it morale dramatically declined and practitioners were generally overcome with a sense of powerlessness and lack of self-esteem, significant obstacles to assertiveness external to the profession.

In spite of the tense relationship and lack of collaboration between feminists and nurses, some practitioners believed that the women's movement could be used as an instrument for the advancement of the profession. Thus, some prime feminist nursing leaders effectively linked the liberation of women with that of nursing. This was done most capably by Wilma Scott Heide, who served as the head of the National Organization for Women. Nurse scholars have positively evaluated the impact of feminism on their profession, especially as it relates to professional development and the utilization of power and politics. In addition, the women's movement is credited with putting nursing economic issues, such as remuneration, chauvinistic treatment, and less-than-desirable working conditions, as well as the importance of self-fulfillment, on center stage. It is generally acknowledged that feminism could and did contribute more to nursing than nursing offered feminism (Lerner, 1985; Roberts & Group, 1995).

#### RELIGION AND THE MILITARY

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Professional attitudes result from specific historical situations. In the case of nursing, the environment in which the profession developed, colored at times by religion and the military, provides, in part, an explanation for its failure to realize its potential strength in the political arena. Religion has been important to the history of nursing. The profession, embedded in Judeo-Christian institutions, is a product of a long religious tradition. Given the Bible's emphasis on care and healing, it was natural for nursing to become a major responsibility of the church in the early Christian era as evidenced by the monastic care and concern for the ill. Providing training and care, many religious orders, both Catholic and Protestant, were closely associated with nursing, first abroad and then eventually in the United States. This religious orientation resulted in a confusing overlap of religious vocation or calling and intellectual and personal commitment for nurses identified with these religious institutions. The seeds of asceticism, self-abnegation, obedience to authority, and strict discipline were sowed as ideals essential to nursing practice. They became the watchwords of the profession and have continued to exert influence

until this day, although in altered form. Not only has religion impacted the personal concerns of nurses, but, in part, religious movements account for the feminization of the profession. Religious imagery has also had a part in the domination of women. There are images of female submissiveness in the New and Old Testaments and these have been employed to justify the general dominance of males over females. Thus, as far as the nursing profession is concerned, this religious sex-role imagery legitimated the professional order of female subordination to the male (Brown, Nolan, & Crawford, 2000; LaChat, 1988). These religious tendencies are not conducive to participatory and assertive behavior.

Wars have also been an important factor in the development of the nursing profession. Military nursing orders had their origins in the Crusades, the military expeditions undertaken by Christians in the eleventh through the thirteenth centuries to take the Holy Land from the Moslems. This was part of the penetration of the military into the profession. Military influence yielded results similar to the religious. The military spirit even pervaded early nursing education that, reflecting Florence Nightingale's model for the army medical service in the Crimea, emphasized dedication to duty and obedience to superiors, both qualities expected of an exemplary soldier. Military influence continued to develop in innumerable wars throughout the world and professional nursing eventually became a feature of the military establishment.

#### PROFESSIONAL CLOSURE

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Whether nursing is a profession or not has served as a source of lively and bitter debate. Some authorities consider it a profession, although a relatively young one. On the other hand, there are those who affirm that professional status remains to be obtained. In this study, 76% of the participants believed that nursing was a profession as opposed to a quasi-profession or an occupation. Although the literature concerned with professions is vast and contains much disagreement over the variables that are considered crucial in distinguishing occupations from professions, there appears to be consensus on the characteristic of autonomy. This element is perceived as

being critical to professional status. The core of any profession is control of tasks, which is determined by the culture and established by competitive claims in the political arena. The potential for autonomy varies as occupations change over time in terms of skill content and cultural significance. Thus, the concept of territoriality is important to professions.

As noted previously, gaining and maintaining power and control is an important facet of the professionalization project. Much of the sociological literature on professions stresses this struggle for power and privilege. A part of this effort is territoriality or closure, “. . . a process through which an occupation controls entry into itself . . .” (Walby & Greenwell, 1994, p. 63). It “. . . involves a set of practices whereby an occupation creates a monopoly over its skills by both controlling entry to training and membership, and by preventing others from practicing that trade who have not acquired recognized membership” (Walby & Greenwell, p. 63). A profession must establish boundaries to its knowledge and occupational area and methods of protecting its territory from attack by those persons external to it. Clearly some professions have been more successful in this endeavor than others. Nursing has been less adept than other knowledge-based groups. Various strategies and instruments are used to achieve closure, the major purpose of which is to maximize rewards by limiting access to resources and opportunities to a restricted set of eligible persons. (Ramprogus, 1995). Education, legislation and professional associations are the most common tools employed.

Education produces professional skills and the knowledge base of the profession. It puts in place a particular preparation based on a systematic body of theory allowing for the acquisition of a professional culture. Its content coincides with professional expansion, attacks, potential and real, to the material base of the profession, and demands for access to professional services from previously disenfranchised groups. Moreover, its curricula encompass and legitimate partial versions of professional work and interests (Atkinson, 1985; Dubar, 1991). Licensure, practice acts, and other legislation secure professional jurisdictional limitations. Reflecting the federalist distribution of power in the United States, these legislative measures vary from one individual state to another. For example, each features Nurse Practice Acts that result from the police power granted to it by the national government to protect the safety of its population. Al-

though they differ from state to state in terms of specifics, most define the nursing function and describe educational requirements for entry into practice, the licensure process and exemptions from it, scope of practice, composition and selection of the state board of nursing, disciplinary procedure and reciprocity. Usually the practice is discussed in such a way that it allows for the necessary freedom of interpretation of the law to account for new and innovative techniques and future conditions of practice.

Professions are part of a social system with constant interaction and competition affecting all, some for better and some for worse. Changes in the circumstances of one profession usually impact on the position of one or more of the others. All are interdependent and the basis of their identity is subject to modification. The shape of knowledge-based groups is ever changing because territoriality is a dynamic concept. It can be expanded, restricted, or withdrawn when the professional environment demands change. Consequently, professional associations are important because they allow an occupational group to promote its interests and to shield itself from competition.

All of these closure tools, being organized on a legal basis and consisting of a mosaic of constitutional clauses, legislative enactments, judicial interpretations, and agency rules, are intimately identified with politics. Closure is definitely subject to political struggle. Moreover, the existence of distinct models of closure demonstrates professionalization is a historically specific concept. In addition to politics, closure is closely affected by the profession's past, its specific activity and the workplace (Bureau, 1999; Larson, 1990; Saks 1999). Territoriality is important to a profession and motivation to achieve it is great. Status, material rewards, the legitimation of authority, prestige, power, ambition to create elitism and monopoly of service, a claim to autonomy, upward social mobility, and desire to assume more exclusive functions all provide the stimulus to pursue it.

As noted, closure has been difficult for the nursing profession. Most evident is the fact that its efforts resulted in a subordinate position for nurses vis-à-vis physicians, ". . . the encirclement of women within a related but distinct sphere of competence in an occupational division of labor and . . . their . . . subordination to male-dominated occupations" (Witz, 1992, pp. 47–48). The early state medical practice acts were penned in the nineteenth century before any of the other health occupations had practice acts. These acts made physi-



cians responsible for all health care. Thus, in the next century, when other practice acts were drawn up, physicians' territory was challenged. For dentistry and veterinary medicine, this was not a problem. Their independence did not encroach on physicians. However, in the case of nursing and some other professions, it was difficult to create a niche (B. Bullough, 1983, 1994). In fact, the profession is still negotiating psychological separation from medicine and its boundaries vis-à-vis the more expansive medical practice acts. This negotiation is more arduous than it might have been because nurses acquiesced to the boundaries originally created by physicians and to the expansive definition of their prerogatives. Nursing's present-day attempt to expand its clinical authority has received diverse responses depending on the particular state involved. The reduction of the historically strict physician supervision and use of protocols has been especially difficult. Challenges from the state medical societies have been formidable. Several factors work against a general victory for nursing whose battle, some argue, was lost when the production of physicians dramatically increased and the profession was not aggressive in carving out a larger space in the health care system. With a surplus of doctors, the prospect for enlarged scope of nursing practice is not favorable. Moreover, another difficulty is finding allies when government and business have a single interest: cost containment.

Although nursing's boundaries have always clashed with those of medicine, the recent decline in the latter's power in the health care system and in the political arena may not be enough to fully enhance nursing's professional status. It might be that a change in gender ideology is needed for promotion of greater nurse autonomy. A recent survey of British and American medical students (Levinson, McCranie, Scambler, & Scambler, 1995) did not indicate more general support for role sharing between physicians and nurses. However, female respondents were more sympathetic to the notion. In any case, such jurisdictional disputes are major determinants of professional history. In fact, they provide the impetus and pattern to organizational developments (Abbott, 1988; E. Greenwood, 1972; Manley, 1995).

Given the dynamic nature of closure, knowledge-based groups must continually maneuver for position in the professional arena to maintain or enhance their power and to meet the competition for professional space. Nursing's task in this regard is more severe than

that of many of its professional counterparts, due to its failure to clearly and forcefully stake out its turf from early in its development and define its special role in the delivery of health care. Not having convinced society and the professional health care realm that nobody else can carry out its work without endangering the patient, the importance and nonsubstitutability of nursing activity have not been demonstrated. Nurses have been challenged by new occupations claiming professional mandate and by the increasingly sophisticated demands of the consumers.

There is competition from others who display an overlap of boundaries of practice. Other practitioners, whose skills and training overlap, are ready to provide similar, substitute or complementary services, whether they are dieticians, laboratory or operating room technicians, social workers, physician assistants, psychologists, occupational or physical therapists, orderlies, licensed practical nurses, financial management officers, or clerks. These folks can offer their substitute services on a legal basis. It is noteworthy that physicians have no such legal substitutes. An examination of the state nurse practice acts demonstrates that professional nurses have overlapping functions with these other health care providers. Moreover, the professional nurse is often brought into direct conflict with the physician because of direct medical supervision requirements and those mandating medical permission (Levi, 1980, 1995). The profession has not been able to use autonomy to prevent outside interference and supervision.

A major problem confronting nursing today is that of functional redundancy. There is no task that nurses perform that is not also carried out by another type of practitioner. To eliminate functional redundancy, the nursing profession will have to define its domain in such a way that its boundaries are distinct from those of other health care groups, achieve internal consensus on its unique role and rally the forces of its political power network to implement closure. A knowledge base distinct from social knowledge in general and the establishment of a special claim to it are essential ingredients of professional status and power.

Nursing occupies a sensitive and uncomfortable position in the health care delivery system from which it is difficult to respond to challenges to its territoriality. Given the role of medicine in the hierarchy, nursing faces a fierce obstacle if it attempts to move upward

and invade the medical arena. It is equally unwelcome if its upward movement is toward administration, another male-dominated world. Lateral actions are no more comfortable in that the territory on both sides is occupied by professions with overlapping boundaries to whom nursing over time has been relinquishing tasks. There is also pressure from below from support workers. The profession in this structure is a lonely crusader and has few friends. This is the special dilemma that nursing faces in terms of closure. It is especially severe because the profession lacks control over its labor supply in general and particularly over cycles of shortage and surplus (Levi, 1995; Walby & Greenwell, 1994). The professional complex as it relates to closure continues to be permeated with conflict. Its battles take place at the workplace, in public opinion, and on the political stage.

## EDUCATION

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Education has played an important part in readying women for particular work roles at the same time that it differentiated the female labor force along class and ethnic lines (Blackwelder, 1997). An important variable in the determination of professional behavior and how professions are regarded by others is education and, more specifically, the nature and type of educational institutions as well as the way knowledge is transferred. A source of debate in nursing, especially since the second half of the last century, is the amount, nature, and location of professional education. There has been a long and severe conflict internal to the profession over educational preparation for entry into practice.

Hospital-based nursing education programs historically have been the cornerstone of professional preparation. Known as diploma programs, they represent the oldest form of educational training leading to licensure as a professional nurse. At their foundation is a heavy emphasis on clinical experience and the skills needed to care for the acutely ill patient. These programs, originally based on the concept of apprentice education, reflected the model of the American family in that the roles of nurses and physicians were reminiscent of male and female roles in the family. Apprentice nurses heard of obedience and stringent discipline. They were docile and instilled with respect for

authority and unswerving loyalty to the institution and physicians. In part, a lower status and less power for the nursing profession in comparison with other knowledge-based groups results from this apprentice-type nursing educational system dominated by the male model. Concentration on task-oriented courses has fueled a parochial outlook, discouraged participation in the larger community, and definitely not stimulated self-assertion (Bergman, 1985; Lowery-Palmer, 1982; Montgomery, 1994). It is interesting that, historically, critical thinking was not nurtured, even though Florence Nightingale, the founder of the nursing profession, based her activities on intelligence, thought and analysis. Moreover, in this original arrangement, combining service and education, service needs often took priority over the learning needs of students. Those who complete these hospital-based programs, which grant no college credit, receive a diploma. Graduates, not possessing an academic degree, encounter difficulties in continuing their education. For a wide variety of reasons that are beyond the scope of this work, diploma programs have experienced a severe decline in number. There has been a trend in nursing education away from these programs toward those in colleges and universities.

In the post World War II era a new approach to the preparation of nurses emerged that featured more flexible educational methods. As hospital programs became standardized in the late 1940s and early 1950s at the behest of the National League for Nursing, the organization responsible for all accrediting functions in the profession, many of them for educational and economic reasons, affiliated with an institution of higher education, principally a community college. Associate degree nursing programs, in which there is a required distribution between nursing and general education courses, first emerged in 1951 and it is these programs that have experienced the most growth. Their appearance brought about a change in the nursing student body, creating a more diverse group. However, Lynaugh and Brush (1996) observe: "Relocating nursing education from its traditional base in local hospital schools to mainstream educational institutions . . . acted to segment nursing, creating a caste system with discriminating racial and ethnic undertones" (p. 12). In fact today, as diploma programs have decreased in number, most minority graduates from basic nursing education programs possess the associate degree from a community college and most minority students currently enrolled in basic nursing education programs participate in associate