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PATRIARCHY AND NURSING EDUCATION: ANALYSIS AND MODEL

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PATRIARCHY AND NURSING EDUCATION:

ANALYSIS AND MODEL

by

Linda Compton Hodges

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A concern for nursing's lack of a unique identity and failure to achieve professionalism served as focal points for inquiry, analysis, and the development of an alternative nursing curriculum model. The belief that nursing's failure to realize its aspirations of professionalism is directly related to the fact that it is predominately a female profession, served as the basis for inquiry in the first two chapters. To develop a better understanding of the nurse as a woman in a patriarchal society and the woman as a nurse in the patriarchal health care system, the concept of patriarchy was employed as an analytical tool of analysis. A review of the literature on patriarchy revealed that the elements of role, temperament, and status serve as the supporting framework in its reproduction. These elements were selected as a lens for reviewing the literature on women and nurses. An analysis of the literature revealed a direct relationship between the stereotypical role definition, temperament, and accompanying lower status of women in the larger society and nurses in the health care field. The findings in this analysis were then applied to nursing's failure to achieve professionalism and a unique identity in an effort to demonstrate their influence.

In Chapter III, the influence of nursing curricula, both past and present, was analyzed in an effort to determine

its relationship to nursing's difficulty in realizing its aspirations. In this chapter, four curriculum models were examined: the Nightingale model, the apprenticeship model, the medical model, and the integrated model. In addition, five specific nursing curriculum models developed between 1970 and 1980 were reviewed. Also included in this chapter was a discussion of the influence of the Tyler rationale on the development of nursing curricula. A critique of nursing curriculum models was made. An analysis of the influence of current nursing curriculum models on nursing's problems of identity and lack of professionalism, to a large degree, indicated that present-day nursing education, instead of improving the situation, is in all probability compounding the problems through its emphasis on control, compliance, and role socialization.

Based on the inquiry and analysis completed in the first three chapters of this dissertation, a platform for an alternative nursing curriculum model was developed in Chapter IV. The vision of the nurse as a competent, autonomous person committed to humanistic practice served as the direction for the platform development. The conception of human liberation provided the foundation for the platform and four additional elements were selected to complete it. These were the conceptions of individuation, psychological androgyny, critical consciousness, and environmental competence.

Based on the platform developed in Chapter IV, an alternative nursing curriculum model was developed in Chapter V. This model emphasized the development not only of competence in nursing knowledge and skill, a firm foundation in the liberal arts, sciences, and humanities, but also the development of the whole personality.

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CHAPTER I

INTRODUCTION

Introduction to the Inquiry

Since 1860, when Florence Nightingale opened the Nightingale Fund School of Nursing at St. Thomas' Hospital in England and instituted the beginning of modern-day nursing, the role of the nurse has become increasingly complex and increasingly difficult to define. Nightingale, a product of the Victorian era, promoted nursing as a natural and acceptable career for ladies of the upper class and petit bourgeois who did not marry or assume the respectable occupation of governess. The duties of the nurse, as proposed by Nightingale, had great similarity to those of motherhood and homemaking--roles stemming from woman's biological function as chief reproductive agent and nurturer in the family (Gamarnikow, 1978).

The attitude that women have natural abilities for the role of the nurse and the notion that patients tend to regress to infantile status was prevalent at the turn of the century:

> Nursing is distinctly woman's work . . . Women are peculiarly fitted for the onerous task of patiently and skillfully caring for the patient in faithful obedience to the physician's orders. Ability to care for the helpless is woman's distinctive nature. Nursing is mothering. Grownup folks when very sick are all babies. (Cited by Garmanikow, 1978, from Hospital, July 8, 1905, p. 237)

In keeping with the establishment of nursing as an extension of the natural role of the mother, Nightingale was careful to support the maintenance of woman's subordinate role in the patriarchal health care triad--physician, nurse, and patient. To Nightingale, the role socialization was clear:

> Training is to teach a nurse to know her business, that is, to observe exactly, to understand, to know exactly, to tell exactly, in such stupendous issues as life and death, health and disease . . . Training has to make her, not servile, but loyal to medical orders and authorities . . . Training is to teach the nurse to handle the agencies within our control which restore health and life, in strict obedience to the physician's or surgeon's power and knowledge. (Nightingale, 1882, p. 6)

In time, the nurse became defined as the principal agent for executing medical orders and directives. In this position, she was never to question the physician's authority or skill in the management of the patients' care. According to Vintras (1894):

> The nurse must recognize in the medical man her scientific chief, and it is only by assuming this view of the position that she will thoroughly understand the importance of the duties she has undertaken, and comprehend the necessity of that rigid discipline that should not be second even to that of the soldier . . . A sense of duty, an absolute obedience to orders, a thorough comprehension of these orders as the fundamental principles of nurses. (p. xxiii)

The notion of absolute obedience to the authority of the physician demanded by Nightingale parallels the vows of obedience taken by the military and religious nursing orders of the Middle Ages (Bullough & Bullough, 1964).

Household tasks were also considered a part of the nurse's role. Bullough and Bullough (1964) noted: "Since the average housewife was still scrubbing her own floors and doing the family washing, it was assumed that these and similar chores were part of the work of a nurse" (p. 140). Domestic work was a glorified role in nursing under the auspices of asepsis:

> Scrubbing and cleaning used to be considered the very lowest and least skilled class of labour. But the knowledge of aseptics has changed this idea, and it is now understood that the process of keeping things clean is one which requires great accuracy, together with the use of proper materials and methods. (Cited by Gamarnikow, 1978, from Hospital, August 22, 1908, p. 559)

According to Bullough and Bullough (1964), the concept of the nurse's role as defined by Nightingale first entered the American scene of nursing education through the influence of Elizabeth Blackwell, the first American woman to earn a medical degree. Blackwell and Nightingale were friends before the Crimean War. During 1859, Blackwell was introduced to the plans for the Nightingale Training School at St. Thomas' Hospital during a visit to England. After her return to the United States, Blackwell mounted a campaign for nurses trained according to the Nightingale plan. In response to her influence and the appearance of Miss Nightingale's Notes on Nursing, in an American edition in 1860, three training schools patterned on the English model were established between May and November of

1873. These schools included Bellevue Hospital Training School in New York, Connecticut Training School in New Haven, and Boston Training School at Massachusetts General Hospital, Boston.

The roles of mother and housekeeper advanced by the Nightingale plan for nursing education took on added dimensions in the United States as the complexity of hospital departments increased. Ashley (1976) described the management role of the nurse to be:

> . . . caring for the "hospital family." Their purpose was to provide efficient economical production in the form of patient care; they were to be loyal to the institution and devoted to preserving its reputation. Through service and self-sacrifice, they were to work continuously to keep the "family" happy. All the departments of the hospital--from wards and operating rooms to storerooms and kitchens--depended upon the continuous presence of nurses. For 24 hours a day nurses were expected to be versatile in their skill, to demonstrate their ability to take care of whatever needs might arise, whether in the area of patient care, medical treatment, housekeeping, dispensing drugs, or supervising the diet and the kitchen. Like mothers in a household, nurses were responsible for meeting the needs of all members of the hospital family--from patients to physicians. (p. 17)

In the absence of the physician, nurses "were expected to assume full responsibility for their decision-making functions by taking on the male role themselves" (Ashley, 1976, p. 17). Once the physician returned, the nurse relinquished the role of decision-maker and assumed a subordinate position.

As time passed and nurses began to assume more and more medical tasks in the physician's absence, the

difference between nursing and medicine became less distinct. For example, nurses began to remove sutures, administer intravenous fluids and medications, and administer treatments formerly performed only by physicians. As the curative aspects of the nurse's role increased, domestic duties, and with time basic bedside care, were passed on to licensed practical nurses, nursing aides and, in some instances, maids.

Today, nurses' roles have changed and been extended under the auspices of the concept of the "expanded role." The expanded role takes nursing beyond traditional care functions and includes such activities as making extensive health appraisals which require skills in physical assessment and history-taking (formerly included only in the physician's education and role), developing nursing diagnoses, and providing treatment prescriptions based on these diagnoses. These roles "require independent nursing functions in addition to the dependent functions delegated by the physician" (Yeaworth, 1976, p. 9).

According to Rowland (1978), the development of the expanded role occurred in the 1950s when a number of nurse leaders, increasingly concerned with nursing's moving further and further away from direct patient care into administrative functions, began a movement to refocus nursing on patient care. During this interval several new roles for nurses with advanced skills evolved: nurse

clinician, nurse practitioner, and nurse midwife. Today many baccalaureate degree programs require students to do extensive health assessments and include in the curriculum courses on physical assessment skills (Rowland, 1978).

Present-day nursing practice has advanced to include dimensions of care and cure; however, confusion persists as nursing struggles to establish its own unique identity and develop professional status. Nursing's identity crisis is currently reflected in its paradoxical image. This is the blend of the highly technical bureaucratic role of the surrogate physician and administrator (physical assessment and ward management) and expressive and nurturant role (mother-surrogate).

Simmons (1962) reviewed the research on nurses' images and found that certain dominant themes were incompatible and conflicting when combining the care and cure role dimensions. These include:

> 1. businesslike and efficient versus the sympathetic and self-giving; 2. loyalty to the physician versus loyalty to the patient; 3. quality-type versus quantity-type with respect to the service rendered; 4. bedside versus deskside image of the nurse; 5. formal versus informal images of relationships with the patient; and 6. task-oriented versus patient-oriented. (p. 31)

In addressing the fractured image of nursing, and the paradoxical cleavage between the instrumental role associated with the scientific-technical realm and the expressive role grounded in the humanitarian aspect, Simmons (1962) wrote:

> Nursing cannot turn back to the traditional image of the ministering angel if this means becoming any less professional and technically competent. The way forward seems threatened for nursing without cultivation, also of the "human side" of patient care.
>
> Thus, the ideal image of the nurse for the future would appear to call for a special blending of the old and warm Nightingale spirit with the new and cool professional skills. Perhaps the lamp as a symbol of nursing can still serve its purpose--providing nurses can come to combine with the light of the lamp (professional skills) the warmth of the light (supportive personal response) (p. 33)

Simmons' call for redefining nursing's identity is supported by other major writers. Lysaught (1970), Director of the National Commission for the Study of Nursing and Nursing Education, called for a new nurse--a professional practitioner who would embody both the nurturing needs of the public and the technical requirements of other health associates. He identified five characteristics that would be associated with nursing professionalism. They included: (1) commitment to practice; (2) a disciplined educational process; (3) a unique body of knowledge and skill; (4) an active and cohesive professional organization; and (5) discretionary authority and judgment. Currently, nursing is limited or inadequate in reference to Lysaught's criteria.

In most professions, members are usually active in their occupation most of their lives. Nurses, however, leave their profession at a much higher rate than teachers, lawyers, physicians, and engineers (Lysaught, 1970). The American Nurses' Association (1968) reported that in

1966 only 49 percent of the 909,131 nurses in the United States were employed full time. Findings from a study by Kramer (1974) demonstrated that one-third of a nationwide survey of baccalaureate nurses left practice within four years of graduation due to dissatisfaction and disillusionment. Recent findings reported by the National League for Nursing on nurse career patterns show that only 33% of diploma graduates (NLN Data Digest, 1978), 43.5% of associate degree graduates (NLN Data Digest, 1976), and 36.6% of baccalaureate degree graduates (NLN Data Digest, 1979), were employed full time ten years after graduation. These statistics suggest a low level of commitment to active practice as a career and indicate a continuing decline in the number of full-time employed nurses since 1966 (Lysaught, 1970).

The second characteristic Lysaught (1970) associated with a profession is education--"a lengthy and rigorous process that incorporates both theoretical and applied content" (p. 36). At the present time, approximately 20% of registered nurses hold baccalaureate degrees. The remaining registered nurses in this country were educated in hospital-based diploma programs requiring a minimal number of courses in the liberal arts, and associate degree programs requiring a total of two years of study in the liberal arts and nursing. Graduates from all three programs take the same licensing examination and all assume similar

beginning practice positions. Only nurses in baccalaureate degree programs receive any instruction in research. The limited number of nurses educated in research methods has been associated with the profession's difficulty in identifying its own unique body of knowledge and skills (Lysaught, 1970; Christman, 1976).

Regarding the third characteristic of a profession--a unique body of knowledge and skill, a clear definition of professional nursing is yet to emerge. In addition to nursing's inadequate research, the failure to clearly delineate a unique body of knowledge and skills is also associated with its close historical relationship with medicine (Lysaught, 1970; Partridge, 1978) and past attempts to define itself in terms of social role with emphasis on procedures and techniques instead of knowledge and understanding. An example of this can be found in a publication by the National League for Nursing Education (1932) which identified 659 nursing activities (National League for Nursing Education, 1932). I believe that one of nursing's greatest problems lies in its failure to establish a clear direction for practice and througn research clarify its unique contributions to our society's health care.

The performance of nursing, as related to the fourth characteristic of a profession--an active and cohesive professional organization--is very poor. Stanton (1978) reported that only 20% of registered nurses belong to the

American Nurses' Association (ANA) and only 2% belong to the political arm of ANA. The ANA serves as the profession's spokesman in matters related to health care legislation, standards of practice, and issues related to control of practice.

The last characteristic of a profession identified by Lysaught (1970)--discretionary authority and judgment--still presents problems for nursing. Most medical and nurse practice acts place limits on authority and the exercise of judgment in the nurse's role. Although most states have broadened laws to accommodate the extended role of the nurse practitioner, nurse midwife, and clinical specialist, independent practice, requiring third-party payments, is still prohibited and those with advanced skills must practice under the supervision of a physician. General staff nurses continue to be unsuccessful in setting standards of care even when patients' rights are in jeopardy or the setting is so poorly staffed it is unsafe (Kalish & Kalish, 1980).

In addition to Simmons' (1962) and Lysaught's (1970) calls for a new professional nurse, other writers have challenged nursing to redefine itself. Brown (1972), a sociologist and author of two major studies of the nursing profession, called for the profession to "define what it believes should be the nature of health care, how such care can be provided, and what responsibility it is

itself willing to assume" (p. 3). The need to establish a new direction was also affirmed by Gadow (1980). She wrote:

> Turning points occur in the history of a profession when radical questioning and classification of major tenets become essential for further growth. We recognize such a turning point now in nursing. The direction in which nursing develops will determine whether the profession draws closer to the medical model, with its commitment to science, technology, and cure; reverts to historical nursing models, with their essentially intuitive approaches; or creates a new philosophy that sets contemporary nursing distinctively apart from both traditional nursing and modern medicine. (p. 79)

In order for nursing to accomplish its social mission, it must define itself by establishing a sound philosophical base for professional practice which will transcend a choice between the aspects of care and cure. In order for nursing to accomplish this task, an essential first step is the development of a clear understanding regarding the current role it plays in the present patriarchal health care system and the contribution of nursing curricula to that role. Through the development of this understanding it is hoped that a change in the social consciousness of nurses and nursing educators will occur, which, according to Macdonald (1978), is a necessary precondition to later changes in the social and political arenas. A logical second step would, I believe, include the development of an alternative model for nursing education which would seem to move nursing into a valued societal position

with commitment first to the patient, provide for equal professional collaboration between other members of the health care community, and include a practice incorporating both caring and curative aspects.

The following are specific questions that I consider important in this inquiry.

1. What should be the philosophical base for professional nursing practice?

2. What political considerations are important in the development of professional nursing practice?

3. What manner of professional nursing practice will gain acceptance socially and culturally?

4. Are the components of care and cure compatible in nursing practice?

5. Why is there a gap between the aspirations and the realities of the nursing profession?

6. What is required for the gap to narrow?

7. What should be the theoretical basis for nursing education?

8. Are there alternative models for nursing education which might contribute to closing the gap between aspirations for professionalism and present-day realities?

There are two hypotheses that I view as essential to this inquiry. These are:

1. The failure of the nursing profession to realize its aspirations can be linked to the fact that it is predominately a woman's profession and as such, suffers from problems similar to those of women in the general society; and

2. Nursing curricula, both the formal and hidden, have functioned in the past and continue to function to thwart the development of a unique identity and professionalism.

As a nurse educator, I believe that a beginning point for inquiry into the problem of nursing's identity and failure to achieve professionalism can be found in the illumination of the relationship between nursing and the sexual division of labor in male-dominated society. Thus an exploration of patriarchy as the primary ideology in contemporary society, its basic elements, and an analysis of the dialectical relationship between the elements seems essential.

The Nurse as Woman in Patriarchal Society

The fact that nursing is predominately a female occupation is believed by many nurse leaders to be the root of the majority of problems nursing faces as it struggles to gain full professional status and meet society's demands (Cleland, 1971; Levinson, 1976; Rodgers, 1975; Yeaworth, 1976). Many believe that the problems of stereotypical role definition and accompanying lower status of women in the larger society are carried over to nurses in the health care field. Yeaworth (1976) addressed this relationship when she wrote:

> I believe that the most fundamental problems of nursing are: (1) the fact that it is a woman's occupation and (2) the fact that the majority of nurses along with the larger society do not perceive this as a problem at all. (p. 7)

To develop an understanding of the nurse as a woman in patriarchal society, the concept of patriarchy will be

employed as an analytical tool in an effort to illuminate the relationship between the nursing profession and sex in our society.

Patriarchy Defined

Goldberg (1973) defined patriarchy as:

> any system of organization (political, economic, religious, or social) that associates authority and leadership primarily with males and in which males fill the vast majority of authority and leadership positions. (p. 30)

Other uses of the term as described by Rowbotham (1979) include "an ideology which arose out of man's power to exchange women between kinship groups; as a symbolic male principle; and as the power of the father (its literal meaning)" (p. 970). In addition, it has been used to "express men's control over women's sexuality and fertility; and to describe the institutional structure of male domination" (Rowbotham, 1979, p. 970).

Patriarchy, as a concept, is inadequate to fully explain the position of women in society today. Rowbotham (1979) wrote:

> It implies a universal and historical form of oppression which returns us to biology--and thus it obscures the need to recognize not only biological difference, but also the multiplicity of ways in which societies have defined gender. (p. 970)

Moreover, she posited it is not sexual differences which present the problem, but

> the social inequalities of gender--the different kinds of power societies have given to sexual differences,

> and the hierarchal forms these have imposed on human relationships. (p. 970)

Therefore, for purposes of this inquiry, the concept of patriarchy is defined as an ideology which supports the power of the male through sexual roles institutionalized in the nuclear family, and found throughout the hierarchal power structure of institutions and society.

Macdonald and Macdonald (1981) suggested that the ideology of patriarchy is so pervasive in our culture that it can be described as "common sense" and that its foundation can be attributed to an "emotional and perceptual base upon which this sense stands" (p. 299). Moreover, these writers asserted that the ideology of patriarchy fits well with Gramsci's conceptualization of hegemony as explained by Boggs (1976),

> . . . the permeation through civil society . . . including a whole range of structures and activities like trade unions, schools, the churches, and the family . . . of an entire system of values, attitudes, beliefs, morality, etc., that is in one way or another supportive of the established order and the class interests that support it. To the extent this prevailing consciousness is internalized by the broad masses, it becomes part of common sense . . . For hegemony to assert itself successfully in our society, therefore, it must operate in a dualistic manner: as a "general conception of life" for the masses, and as a "scholastic programme" or set of principles which is advanced by a sector of the intellectuals. (p. 39).

The history of patriarchy as the prevailing ideology in society is so old that no one knows its origin. Beauvoir (1952) however, argued that continued support of the concept can be found throughout history in the writings

of the intellectual elite in religion, politics, and in the art representative of the various cultures. Examples she cited include the legends of Eve and Pandora, and Plato's prayers to the gods thanking them for creating him free and not enslaved--a man and not a woman.

Specific arguments offered in support of patriarchy are often found in religion, biology, and anthropology. An example of a religion-based argument can be found in the seventeenth-century writings of Sir Robert Filmer (Butler, 1978). He relied on the Book of Genesis as the basis to support the absolute rule of the king, the divinely ordained father of his people. Using the same basis of scriptural exegesis, Filmer placed women in a subordinate position in the family, state, and society.

Modern proponents of patriarchy find their main contemporary supporter in Goldberg (1973). He argued that patriarchy is inevitable since it is universal, having been found in all societies, and is firmly grounded in aggression related to male physiology. He related dominance by the male to the

> hormonal systems which generate a greater capacity for "aggression" (or a lower threshold for the release of "aggression" . . .) than those individuals whose female anatomy leads to a social identification as "female" and that socialization and institutions conform to the reality of hormonal sexual differentiation and to the statistical reality of the "aggression advantage" which males derive from their hormonal systems. (p. 81)

Thus, he asserted, anatomy is destiny and the male will always hold the dominant position in power relationships due to his physiological advantage.

Millet (1969) and Beauvoir (1952), modern feminist writers, have rejected all arguments rooted in religion as well as biology and anthropology. They emphasized that relationships between men and women can only be viewed through a human perspective. Beauvoir (1952) wrote:

> man is defined as a being who is not fixed, who makes himself what he is . . . man is not a natural species: he is a historical idea. Woman is not a completed reality, but rather a becoming, and it is in her becoming that she should be compared with man; that is to say, her possibilities should be defined. (p. 34)

Moreover, she contended that the possibilities "depend upon the economic and social situation" (p. 35).

Millett (1969) argued that the economic and social situations are controlled by consent through the socialization processes of both sexes with regard to role, temperament, and status. She suggested that the inferior status of the female is related to general assent to the prejudice of male superiority. Temperament, on the other hand, can best be related to formation of human personality in accordance to stereotypical gender role (feminine and masculine characteristics) (Davidson & Gordon, 1979; Duberman, 1975). Millett (1969) asserted that those characteristics most prized in the culture and considered as norm (Freud, 1950, 1952) are assumed by the

dominant group (males) and those the dominant group find convenient in the subordinate are assigned to the female (Boverman, Vogel, Boverman, Clarkson, & Rosenkrantz, 1972). In terms of role, the socialization of each sex to elaborate and separate codes of behavior seems to support the domestic role in the female grounded in her biological sexual functioning and all other roles in the larger culture to the male. According to Millett(1969), the distinct division of labor in the work structure is directly related to the status of each sex.

The dialectical relationship between the elements of role, temperament, and status, which constitutes the supporting framework for patriarchal ideology as described by Millett(1969), provides for analysis at various levels. In analyzing the dynamic forces which maintain the sexual division of labor within the culture, status can be viewed as arising from the political-economic level; role can be considered as derived from the sociological level; and, temperament can be related to the psychological sphere. All of these elements, at their various levels, can be viewed as interacting and influencing each other in an effort to support and maintain patriarchal ideology. For example, Millet (1969) asserted that higher status is awarded to those in roles requiring mastery, and mastery can be linked to a temperament of dominance. In order to illuminate the dialectical relationship of the elements of

role, temperament, and status, which tend to support the reproduction of patriarchal ideology in capitalistic society, I will review major theories supporting each element.

Role: The Sociological Element

Major feminist writers (Beauvoir, 1952; Eisenstein, 1979; Millet, 1969) support the notion that roles inherent in the nuclear family serve to underpin the ideology of patriarchy. Millet (1969) asserted that it is within the family that prototypes of roles are learned which serve to reproduce patriarchal relationships in the greater culture. She contended that this learning of roles occurs through the socialization of the young within the family (largely through the modelling of parents). Hartley's (1960) research findings tend to support this notion. In this study, girls between the ages of eight and eleven related their future plans to their mother's work role. If the mother was nonemployed outside the home, the daughter's main career choice was housewife. If the mother was working, the daughter saw a career throughout life and was likely to show interest in nontraditional areas such as law and medicine. Findings in additional studies cited by Weitzman (1979) revealed that career women most often had working mothers during childhood. Thus sociological research cited by Weitzman (1979) seems to strongly support Millet's (1969)

argument that the family serves as a keystone for the sexual stratification system and guarantees its future continuation.

Beauvoir (1952) addressed the aspect of role assumption within the culture from an existential perspective. She asserted that man defines himself as humanity and places woman in relation to him. In her view, woman's role as it exists in the culture, is not that of an autonomous being but instead is "sex--absolute sex, no less" (Rossi, 1973, p. 676). Moreover, she argued that within a role defined and differentiated with reference to man, woman becomes incidental and unessential. According to Beauvoir (1952), this relegation to a role primarily based on sex, as opposed to autonomy, defines man as Subject--the absolute and woman as Other.

As "Others" within a patriarchal society, women's roles have been ascribed as those related to the biological function of reproduction. Work roles grow out of the natural sphere--the home and family, and consist of wife, mother, and housekeeper. Male roles encompass the home as well as the larger culture. They include husband, father and as breadwinner, all other roles within the society. In instances when the woman is employed in work roles outside of the family or domestic sphere, the work role is expected to assume a secondary position to

her primary natural roles of wife and mother. Research findings by Holstrom (1973) and Rapoport and Rapoport (1971) on dual career families indicated that women with full-time career commitments still had major responsibilities in the domestic sphere. A woman who defies the roles supported by patriarchal ideology and defines herself as Beauvoir (1952) terms Subject or career woman, is regarded as a deviate or masculine-identified being, alienated from her natural sphere (Deutsch, 1944; Freud, 1950, 1952).

Beauvoir (1952) upon examining the reasons women fail to affirm their subjective existence through roles in the cultural sphere, asserted there is a failure to take the economical and metaphysical risks in liberty. She posited:

> Along with the ethical urge of each individual to affirm his subjective existence there is also the temptation to forego liberty and become a thing. This is an inauspicious road, for he who takes it--passive, lost, ruined--becomes henceforth the creature of another's will, frustrated in his transcendence and deprived of every value. But it is an easy road; on it one avoids the strain involved in undertaking an authentic existence. (Rossi, 1973, p. 680)

Roles in the contemporary sex-segregated labor market of the society at large support the roles of the natural sphere related to women. Affirmation of this can be found in current statistics related to female participation in the work world released by the Bureau of Census (1979). These statistics show women's greatest employment participation to be in the area of service. More specifically, of the total workers in the area of personal services (private

homes, hotels, and lodging places), 74.4% were females. In the area of professional and related services, females were employed at a rate of 75.8% of the total in hospitals and 79.2% of the total in elementary and secondary schools. These statistics clearly illustrate women's tendencies to assume work roles in the labor market which reflect their normal roles in the domestic sphere. The majority of these work roles involve little commitment, limited knowledge and skill, and allow women to maintain their primary roles in the family.

In summary, it would appear that women in society continue to assume work roles, in the majority of cases, which reflect those in the nuclear family. Work which extends the natural roles of nurturing and household management, and demands little education and commitment, seems to support woman's role in society as Other--limited in autonomy and transcendence. The continued participation by women in these roles can be linked to the prevailing feminine psychology which calls for a psychic structure fitting the reproduction of traditional female role choice. An examination of the development of traditional feminine temperament will serve to clarify the relationship between woman's psychology, traditional role choice, and the reproduction of patriarchal ideology.

Temperament: The Psychological Element

Temperament in our society is basically related to one's gender role, meaning the socially learned patterns of behavior which serve to differentiate men from women. Duberman (1975) asserted that gender role (masculinity and femininity) is "acquired during one's lifetime through learning, role taking, imitation, observation and direct instruction" (p. 26). According to Weitzman (1979), the argument for socialization processes as the chief determinant of gender-role characteristics is well supported by research. She suggested that:

> around the age of three to four, the child begins to make sex-role distinctions and express sex role preferences . . . by age six they are able to distinguish the male and female role clearly, and to identify themselves appropriately. (p. 158)

Traditionally held gender-role characteristics tend to form a dichotomous relationship according to sex. Commonly ascribed feminine characteristics include being emotional, intuitive, subservient, dependent, passive, weak, submissive, noncompetitive, sweet, and sensitive. Those commonly associated with masculinity include being stoic, rational, intellectual, independent, aggressive, competitive, moral, and achievement-oriented (Chafetz, 1974). This dichotomy of characteristics defines the female as relative to the male in that the characteristics of masculine gender role are identified by the culture as more valuable and the norm, whereas characteristics of

the feminine gender role are less valued and defined as negative (Rahrbaugh, 1979).

Findings reported in a study by Boverman, Vogel, Boverman, Clarkson and Rosenkrantz (1970) support the continuation of traditionally defined gender roles. In this study 79 practicing mental health clinicians including clinical psychologists, psychiatrists, and psychiatric social workers ranging in ages from 23 to 55 years, and including 46 men and 33 women completed a sex-role questionnaire. Subjects were given three sets of instructions: (1) to describe a mature, healthy, socially competent adult man; (2) to describe a mature, healthy, socially competent adult woman; and (3) to describe a mature, healthy, socially competent adult person. Findings in this study showed that the clinicians' ratings of the healthy man and healthy adult did not differ from each other. The ratings of the healthy adult and the healthy adult woman, however, showed a significant difference. Thus the researchers' hypothesis that a double standard of health exists for men and women was confirmed. According to this sample's descriptions, women were either inferior or not really women.

The fact that women are believed to have less desirable characteristics was also demonstrated in a recent study by Stockburger and Davis (1978). These researchers

reviewed half of the issues of American Journal of Psychiatry published between 1963 and 1974. In this study, human images displayed in advertisements for psycho-active drugs were analyzed according to sex and role. Findings from the study indicated that women were portrayed as mentally ill significantly more often than men. Men on the other hand were usually portrayed as physicians or other helping professionals.

A bias in favor of men was also demonstrated in the findings of a study by Goldberg (1968). In this study, 40 college women evaluated written articles for quality and professional competence. In one booklet, the articles had male authors' names on them and in the other booklet the same articles had females as authors. Of the total 54 comparisons reported, 44 favored the "male" author while seven favored the female. These findings support Rahrbaugh's (1979), Beauvoir's (1952), and Millett's (1969 views that feminine gender traits are generally considered more negative than masculine traits and are less prized in our society.

Perhaps the most profound influences on commonly held views of gender-role characteristics can be found in the works of Freud (1950, 1952) and Deutsch (1944). These suggested and supported the notions of masculinity as positive and the norm, and femininity as negative.

Walstedt (1976) asserted that Freud's influence on modern psychological thought has led women to "internalize a complicated set of psychological restrictions, which made outer restraints upon them unnecessary" (p. 1). Moreover she posited:

> He updated man's fear of feminine evil: saw inherent danger in sexual intercourse, anticipated fantasies of poison mother's milk, and found in the menstrual cycle a feminine outrage with mystical overtones. (p. 7)

Freud's (1950, 1952) views on the psychological development of women suggested that the normal woman is characterized by passivity, masochism, narcissism, and a deficient maturation of the superego. The origin of the normal feminine psyche as described by Freud is associated with the castration theory surrounding the Oedipus complex. He maintained that discovery of castration by a female child serves as a turning point in her life. According to Freud (1952):

> the castration complex in the girl . . . is started by the sight of the genital organs of the other sex. She immediately notices the difference, and--it must be admitted--its significance. She feels herself at a great disadvantage . . . and falls a victim to penis-envy, which leaves ineradicable traces on her development and character formation. (p. 859)

Out of penis-envy, Freud (1952) believed that in women, three types of development could occur. These include: "sexual inhibition or neurosis . . .; modification of character in the sense of masculinity complex . . . ; and, normal femininity" (p. 859). Normal femininity was believed

to be established when a wish for a penis was replaced with a desire for a child. Freud (1952) contended that the normal woman desired motherhood and assured herself a firm marriage by "making her husband into her child" (p. 863).

Other tenets set forth by Freud's theories on female personality development are equally supportive of the culturally ascribed gender role of femininity and its resulting negative female characteristics. He attributed bitterness between daughter and mother as normal due to the mother bringing the daughter into the world without a penis. In terms of female sexuality, Freud described as normal the female giving up clitoral sensations to passive vaginal orgasms upon maturation. Regarding those women who develop a "masculine complex" and seek a career or intellectual pursuits, Freud viewed them as deviant, and because of their perceived anatomical deficiency, unaccepting of their normal gender identity or temperament.

Perhaps the most damaging belief espoused by Freud (1950) regarding female personality can be found in the notion of deficient superego development. He maintained that men develop stronger or more mature superegos than women because they fear castration. Women, in his view, having already perceived themselves as castrated, lack adequate motivation for mature development of morality. The criticism Freud (1961) made regarding women's inadequate moral development lies in what he viewed as the

female's compromised sense of justice. This he associated with their refusal to use blind impartiality in moral matters. Research findings based on Kohlberg's (1973) six stages of moral development support Freud's view (Gilligan, 1979). Using Kohlberg's scale, with justice identified as the highest stage, women are often found to be deficient in higher level moral development. They appear to more closely exemplify stage three of his six-stage sequence conceived in terms of relationships and associated with pleasing and helping others (Gilligan, 1979).

Gilligan (1977) raised the question regarding similarity in moral development in each of the sexes through her research on women contemplating abortion. Based on her review of psychological and literary sources, and research on women, she posited that the highest stage of moral development in women can be characterized by love. This stage she associates with a responsibility orientation as opposed to a rights orientation found by Kohlberg. Gilligan (Note 1) asserted that women develop a "different" not "better" orientation of moral development than men due to their different social experiences. She suggested that the responsibility orientation represents "the connected self" in that the self is seen as being in relationship with others or a part of other selves. Thus in women, the social world is experienced as a world of

relationships among people as opposed to the social world of men experienced as relationships between self and others or between self and the rules and expectations of society. Gilligan argued that one orientation cannot be assumed to be "more moral" than the other since each "orientation offers both strengths and weaknesses in the development of the capacity to live and interact with others in a coherent way" (p. 40).

Further arguments regarding the development of women's temperaments have been made by Deutsch (1944), a disciple of Freud. Specifically, her work gives further credence to the notion that antiintellectualism is the norm for women. She wrote:

> The intellectual woman is not Autonoë, the Wise One, who draws her wisdom from the deep sources of intuition, for intuition is God's gift to the feminine woman; everything relating to exploration and cognition, all the forms and kinds of human culture or aspirations that require a strictly objective approach, are with few exceptions the domain of the masculine intellect, of man's spiritual power, against which women can rarely compete. All observations point to the fact that the intellectual woman is masculinized; in her, warm intuitive knowledge has yielded to cold unproductive thinking. (pp. 290-291)

The early founders of psychoanalytical theory (Freud, 1950, 1952; Deutsch, 1944) supported the notion that woman's temperament is considered normal when it is perceived to be in opposition to that of men. This thinking promotes the idea of gender role existing as a dichotomy--man as Subject, valued and positive, woman as Object, less valued

and negative. Chodrow (1974, 1978) writing from a psychoanalytical perspective, challenged Freud's theory on female personality development grounded in the Oedipus complex. Her major thesis concerning the reproduction of differences in temperament from one generation to the next lies not in anatomy, but is drawn from "the fact that women, universally, are largely responsible for early child care and for (at least) later female socialization" (Chodrow, 1974, p. 43). She argued that because the social environment is experienced in different ways by the sexes, basic personality differences continue to reoccur.

According to Chodrow (1974), as a result of the girl's experience, "feminine personality comes to define itself in relation and connection to other people more than masculine personality does" (p. 44). The result is a less well defined ego boundary and less individuation in the female. Within the mother-daughter relationship, Chodrow (1978) argued that mothers

> tend to experience their daughters as more like, and continuous with, themselves. Correspondingly, girls tend to remain part of the dyadic primary mother-child relationship itself. This means that a girl continues to experience herself as involved in issues of merging and separation, and in an attachment characterized by primary identification and the fusion of identification and object choice. (p. 166)

Further, Chodrow (1978) asserted that boys' development follows a different path in that they are experienced by the mother as the male opposite. Thus, "boys are more

likely to have been pushed out of the preoedipal relationship and to have had to curtail their primary love and sense of empathetic tie with their mother"(p. 166). Due to this early separation in the mother-son relationship, boys develop "a more empathetic individuation and more defensive firming of experienced ego boundaries" (p. 167).

Given the traditional parenting patterns in our patriarchal society, Chodrow (1978) suggested that instead of women having weaker ego boundaries and increased chances of developing psychoses as proposed by Freud, their early experiences of individuation and relationships assure that they will"emerge from this period with a basis for empathy built into their primary definitions of self in a way that boys do not" (p. 167). Moreover she posited,

> Girls emerge with a stronger basis for experiencing another's needs and feelings as one's own (or of thinking that one is so experiencing another's needs and feelings). Furthermore, girls do not define themselves in terms of the denial of preoedipal relational modes to the same extent as do boys. Therefore, regression to these modes tends not to feel as much a basic threat to their ego. From very early, then, because they are parented by a person of the same gender . . . girls come to experience themselves as less differentiated than boys, as more continuous with and related to the external object-world, and as differently oriented to their inner object-world as well. (1978, p. 167)

The differences in the development of autonomy and personality traits related to dependency, intimacy, and risk taking, Chodrow viewed as directly related to early parenting by the mother. Her theory places the reproduction of feminine characteristics in the failure to separate,

in the inability to develop, and in the continued defining of self as Other.

Chodrow's theory of woman's psychological development is rooted in the sexual division of labor within the family. As a solution to the continued reproduction of polarized gender characteristics, she offered the idea of equal parenting. She suggested, in this method of child rearing,

> Children could be dependent from the outset on people of both genders and establish an individuated sense of self in relation to both. In this way, masculinity would not become tied to denial of dependence and devaluation of women. Feminine personality would be less preoccupied with individuation, and children would not develop fears of maternal omnipotence and expectations of women's unique self-sacrificing qualities. This would reduce men's needs to guard their masculinity and their control of social and cultural spheres which treat and define women as secondary and powerless, and would help women to develop the autonomy which too much embeddedness in relationship has often taken from them. (1978, p. 218)

An additional result of this method of parenting, Chodrow (1978) argued, would be the development of positive characteristics of each sex without the destructive extremes currently present in the concepts of masculinity and femininity. Women could retain the foundation for love and nurturance, and men would develop these. Autonomy would be retained by men without being characterized by differentiation, both rigid and reactive, and women would be able to define themselves as Subjects in the larger culture.

In summary, temperament in today's society to a large degree, exists as a dichotomy of personality characteristics related to gender. The traditional woman is viewed as passive, supportive, and nurturing, while the traditional man is viewed as independent, aggressive, and active. Research (Goldberg & Lewis, 1969; Kagan, 1964; Goodenough, 1957; Weitzman, Eifler, Hokada, & Ross, 1972) indicates that socialization methods for sex-specific gender-role behavior continues to be a major factor in the reproduction of traditionally held temperaments of masculinity and femininity. Chodrow (1978) posited that changes in parenting from major responsibility held by the mother to equal involvement by both parents offers the best possible solution to problems of current gender-role socialization. She maintained equal parenting will promote the development of temperament in each sex which reflects the positive characteristics currently associated with separate traditional gender-role behavior.

The continued participation by women in roles related to the domestic sphere and the reproduction of traditional feminine temperament through socialization in the culture were considered by Nielson (1978) to be major factors affecting woman's lower status in society. In order to illuminate the relationship between woman's status and the continued reproduction of patriarchal ideology as it exists in capitalistic society, an analysis of status as

assigned through social stratification according to sex in the political-economic sphere appears essential.

Status: Social Stratification in the Political Economic Sphere

Nielson (1978) identified a number of factors which serve as important determinants of social status. Among these she included age, race, and social class. She argued, however, that particularly important is the effect of sex on status. She defined status as "the relative rank of a person, role, or group in a social hierarchy" (p. 10). The degree of status is indicated by the type and "variety of rewards associated with social positions and, more specifically, with sex-specific social positions" (Nielson, 1978, p. 11). After an analysis of current statistical data and research findings relative to material rewards, prestige, power, and psychological gratification, Nielson (1978) concluded that:

> women as a group have less status than men as a group. They have less power, less prestige, and less opportunity for development and personal gratification; and they receive less material reward for their work than men. (p. 55)

Moreover, she asserted that the increased participation by women in the industrial labor force and the continued practice of maintaining the primary work role in the home, simultaneously, have resulted not in improvement of status but in some respects have increased the status gap between the sexes rather than decreased it.

Other writers view the measurement of status for women as particularly problematic in that woman's work world is defined by patriarchal ideology as the domestic sphere. Therefore, her status is seen to primarily arise from the position in the larger culture held by the men in her life. Walpe (1978) noted,

> The position of women in the status hierarchy is generally treated as deriving unproblematically from the position of men. Status . . . is seen to be determined by occupation--incumbency of an occupational role carries with it a certain estimation of prestige both within the job situation and in the broader social world. . . . Since the position of women in the occupational structure is treated as peripheral, the allocation of their status is derived from that of men. (p. 294)

According to Engels (1942), the political and economical forces which impact on woman's status in society can be traced to the power relationships which exist in the patriarchal family. He posited that "the modern individual family is founded on the open and concealed domestic slavery of the wife, and modern society is a mass composed of these individual families as its molecules" (p. 65). Moreover, he contended that the nature of class struggle as related to the tension between slavery (the proletariat) and private wealth (the bourgeoisie) can be studied by analyzing the monogamous marriage, the cellular form of civilized society. Engels located the first class opposition in history to the development of antagonism between the sexes within monogamous marriage. He suggested "the first class

oppression coincides with that of the female sex by the male" (p. 158). He explained this relationship by noting:

> The husband is obliged to earn a living and support his family, and that in itself gives him a position of supremacy, without any need for special legal titles and privileges. Within the family he is the bourgeoisie and the wife represents the proletariat. (p. 66)

In keeping with Marxist theory, it takes both the labor of the husband and wife to earn the wage; however the wife's work is used up in reconstituting the family and providing for the husband's needs so that his labor can continue to be exchanged in the market place for a wage (Aron, 1968).

Eisenstein (1977), a leading feminist theorist, argued that the oppression growing out of woman's role in the sexual division of labor within the society cannot be adequately examined through Marxist theory alone. Instead, her analysis calls for the consideration of a dialectical relationship and mutually reinforcing systems between the capitalist class structure and the prevailing power relationships within the patriarchal society. She posited,

> Capitalism uses patriarchy . . . and patriarchy is defined by the needs of capital. . . . at the same time that one system uses the other, it must organize around the needs of the other in order to protect the specific quality of the other. Otherwise the other system will lose its specific character and with it its unique value. . . . patriarchy (as male supremacy) provides the sexual hierarchical ordering of society for political control, and as a political system cannot be reduced to its economic structure; while capitalism, as an economic class system driven by the pursuit of profit, feeds off the patriarchal ordering. Together they form the political economy of the society; not merely one or another, but a particular blend of the two. (p. 13)

Using the Marxist tools of historical and dialectical method, Eisenstein (1977) examined the material and power relationships in capitalist patriarchy, the prevailing ideologies of Western culture. In keeping with traditional Marxist theory, she described the sexual division of labor as predating capitalism; however, she argued that through the advent of capitalism, the division of labor became even further institutionalized and defined through the needs of the nuclear family.

According to Eisenstein (1977), in precapitalistic society, the family worked together within the home setting to produce the necessities of life. Although women served as the principal reproductive agents (mothers and child raisers), they were still actively involved in production, often exchanging their products for goods or money in the market place. This home production tended to limit to some degree the sexual role distinction characterized by that accorded women in industrial society.

With the rise of industrial capitalism, productive labor was removed from the home setting as men moved out into the labor market to earn a wage. This left women solely relegated to the reproductive and domestic roles found in mothering and homemaking. The work women carried on in the home was not viewed as work since it did not produce a wage; this work was use-valued work which demanded no price. Productive labor came to be defined as

wage labor and it was this labor which produced surplus profit or capital (Eisenstein, 1977).

Within the Western culture, where profit is of prime importance to the ruling class, a system of political order and control is necessary to maintain the work structure. The sexual division of labor, according to Eisenstein, maintains that structure by serving as the organizing principle of patriarchy. Domestic labor is considered use-value labor and affords housewives no pay or limited pay. Work in the larger society which has characteristics of domestic work is similarly viewed as woman's work and carries with it a lower wage than work usually assigned to men.

According to Eisenstein (1977), domestic work serves to reproduce the existing society in many ways. She noted,

> (1) Women stabilize patriarchal structures (the family, housewife, mother, etc.) by fulfilling their very roles. (2) Simultaneously, women are reproducing new workers, for both the paid and unpaid labor force. They "care" for the men and children of the society. (3) They work as well in the labor force, for lesser wages. (4) They stabilize the economy through their role as consumers. (p. 14)

Society, as structured according to the ideology of capitalist patriarchy, profits from the arrangement of women's work. In addition, individual men benefit from the labor done for them in the home regardless of their status in the hierarchical system of the market place. Thus, the sexual division of labor is carefully guarded to

maintain not only dominance through the ideology of patriarchy but also the continued maintenance of the capitalistic system of production.

For women in the domestic sphere and as workers in the labor market, the work arrangement results in exploitation and oppression. Nielson (1978) asserted that this arrangement creates two primary work roles for women while men have only one. Rapoport and Rapoport (1971) found in their study of dual career families that although men helped their wives with domestic activities, they still regarded the domestic division of labor "as her job they were helping with" (p. 304), and no evidence of equal sharing of responsibility in domestic duties of the families studied was found. This situation results in exploitation of the woman by the man as well as exploitation in the labor market in that the wage earned only represents that portion of the work necessary for the maintenance of life. The bourgeoisie realizes the profit, the surplus labor which accounts for the difference between the actual and the necessary labor to maintain life. Marx posited that this arrangement predisposes the worker to the development of a sense of alienation from his work, the seed which provides the potential for revolution in the system (Aron, 1968).

The theory of alienation through participation in the capitalistic work structure is important to understand when

applied to woman's position in the sexual division of labor. This theory allows that in order for man to realize his humanity, he must perform those activities which define himself. Thus, since man defines himself through the creative efforts of his work, work which denies an expression of self becomes dehumanizing and promotes alienation from self. In capitalism, Marx posited, man sees his work not as a creative expression of self, but as an instrument in the machinery of production, lacking in "species being," the state of creative labor, social consciousness, and social being (Aron, 1965). Man as a worker in capitalistic society, in existential terms, lacks transcendence; he becomes in his alienated state an Object instead of Subject.

For those women who participate only as domestic workers and reproductive agents, realization of existence in the larger culture occurs only through the man in her life. This lack of creative work in the larger culture can produce alienation from self in that her work is lacking in transcendence. She remains defined as Object with potential to become Subject. Of women, Eisenstein (1977) wrote,

> . . . the possibility of their freedom exists alongside their exploitation and oppression . . . conflict between existence and essence lays the basis for revolutionary consciousness and activity. It allows an internally critical appraisal of any particular moment. (p. 4)

In summary, for women, the dialectical relationship between ascribed roles, temperament, and status, as supported by the ideologies of capitalistic patriarchy serves to perpetuate their subordinate role in the larger society. The feminine temperament, traditionally held as normal in the culture, is particularly suited to workers in the domestic sphere and those in service, sales, and semiskilled operatives in the labor market. Because these work roles are viewed as arising from use-value work and basically viewed as woman's work, lower status is assigned their social position in society.

The critical analysis of the elements supporting the prevailing patriarchal ideology as described in this chapter, it is hoped, serves to clarify the current system of exploitation and oppression encountered by a large majority of American women. For understanding the causes of one's situation serves as the first step in identifying possible ways to bring about change. Similarly, it is my belief that in order for nursing, a predominately female occupation, to define its role as a profession, the relationship between the elements of role, temperament, and status as defined within the patriarchal health care system must be analyzed. In Chapter II this analysis is undertaken to expose the mechanisms which have operated to keep nursing as an occupation oppressed and exploited as documented by Ashley (1976). With increased insight, a way to a more autonomous future should be apparent.

CHAPTER II

THE WOMAN AS NURSE IN THE PATRIARCHAL HEALTH CARE SYSTEM

In many ways, the relationship which exists between the physician and the nurse can be linked to the sexual division of labor in the patriarchal family unit. Since "it is the medical profession which possesses the sole right of decision as to who is to be defined as a patient" (Garmarnikow, 1979, p. 97), the physician embodies the incumbent of the "rule of the father," placing nurses in a subordinate position. This arrangement of power relationships takes on the characteristics of the triad father-mother-child--father-physician, mother-nurse, and child-patient (Garmarnikow, 1979).

Healing, or the production of health in the patient, can be seen as divided into two work spheres. These spheres include: cure--the exclusive province of the physician reflective of the cultural sphere of man in the larger society demanding exchange value rewards; and, care--relegated to the nurse reflective of the domestic sphere in the work structure viewed primarily as use-value work. Within these sexual divisions of labor, physicians, practicing in the mystique of science and technology are credited with the patients' recovery, while the nurses' activities characteristic of servants, lack magic and claim

to credit (Beletz, 1974). Healing, irrevocably split into cure and care, results from a combination of complementary but unequal roles. The physician is seen as idealized man--combining intellect with action, and abstract theory with hardheaded pragmatism, decisiveness, and curiosity. The nurse is viewed as idealized woman--eager and willing to serve, nurturant, possessing tenderness, innate spirituality, and obedience to man, all characteristics fitting her service role (Ehrenreich & English, 1973). The following is an examination of the forces which promote the stereotypical view of nurses existing in society today. This includes the relationship of nursing to the elements of role, as well as temperament, and status which operate to produce the patriarchal ideology exemplified in the physician-nurse relationship.

The Nurse's Role: The Sociological Element

Prior to the Nightingale era in nursing, the nurse was simply defined as "the competent mother or neighbor who cared for the sick in the home" (Bullough & Bullough, 1964, p. 140). During the nineteenth century before the hospital reform movement, hospitals did employ nurses but the care was scandalous. In many cases, the nurses were of the pauper sector having poor reputations and including prostitutes, drunkards, and thieves. Hospitals during this era were viewed as places to die or havens for the sick

poor who did not have relatives to care for them in the home (Ehrenreich & English, 1973).

After the Crimean War, the image of the nurse was transformed in the glow of the popularity of Florence Nightingale, the "lady of the lamp" and her nurses. No longer was the nurse viewed as a tipsy, promiscuous man-chaser but was instead seen as a "lady nurse"--"strong yet compassionate, controlled in the face of suffering, yet seeking only to relieve the distress of her fellow man" (Bullough & Bullough, 1964, p. 101).

In 1860, Nightingale applied the 45,000 pounds received as contributions to a general fund in her honor to the organization of a nurses' training school at St. Thomas' Hospital (Bullough & Bullough, 1964). With the help of Mrs. Wardroper, Nightingale recruited probationers from the upper class and the petit bourgeoisie who had not married or entered a career as governess. For the single woman, Nightingale promoted nursing as an honorable and natural occupation since it had much in common with traditional roles of motherhood and homemaking--roles representative of woman's place as chief reproductive agent and nurturer (Gamarnikow, 1978).

Early writings of the reform period promote and support nursing's relationship to motherhood. According to Vintras (1894):

> In the bearing of a nurse towards her charge there must be something of the indulgence of a mother for her child; that is why women are better nurses than men . . . It is astonishing what can be done with gentleness, especially when dispensed by a woman, and as the medical man is there, I think it would be well if the so-called firmness, when needed, were left up to him. She can always invoke the physician's order for the refusal of any unreasonable request. (Hospital, April 28, 1894, p. xxxv)

The analogy of the nurse's role to that of the woman in the family mirrors the common practice in parenting of the father assuming the role of disciplinarian and in his absence, the mother using the threat of the father's power as a means of maintaining discipline. At the turn of the century, nursing was viewed as distinctly woman's work since caring for the sick required mothering skills in moving the regressed adult to a state of mature functioning (Gamarnikow, 1978).

In promoting the establishment of nursing as a natural extension of the roles of mother and housekeeper, Nightingale was persistent in her efforts to keep nursing in a subordinate position to medicine. In this respect, the role she promoted required the nurse to be in strict obedience to the physician. At times during the Crimean War, nurses knowing more about the care of the sick than the surgeon, would attempt to supplement medical orders. Nightingale refused to allow them to make changes and insisted they "do nothing not authorized by the medical men" (Bullough & Bullough, 1964, p. 99). The relationship between the physician and nurse (addressed as "Sister," the

name given the earlier nuns who were nurses) was automatically associated with traditional male and female relationships:

> The comfort and well-being of a ward depends upon whether the house surgeon and sister work well together or whether they swim in different currents. This will rest chiefly with the sister. Never assert your opinions and wishes, but defer to his, and you will find that in the end you generally have your own way. It is always easier to lead than to drive. This is a truly feminine piece of counsel and I beg you to lay it to your heart. (Hospital, January 8, 1898, p. 127)

This advice, offered by Sister Grace, seems to follow the traditional view that women are responsible for the quality of relationships and that objectives can best be obtained by using feminine strategies such as deference and charm.

Since the physician was solely responsible for cure--naming an individual as patient, diagnosing him, and prescribing for him before a nurse could act, all power and authority resided in the physician. This placed the nurse in a position of being a servant, dependent totally upon the physician:

> A nurse should never diagnose. When required she should report clearly and concisely upon the symptoms she has been able to witness, but she should stop there. A nurse who realizes her part of the work may be of invaluable service to the doctor and patient. She may by careful watching and timely reporting save time, assist correct diagnosis and thus facilitate a good result. We nurses are and never will be anything but the servants of doctors and good faithful servants we shall be, happy in our dependence which helps to accomplish great deeds. (Cited by Gamarnikow, 1978, from Hospital, April 6, 1906, p. 11)

In time, as the Nightingale nurses proved their abilities, they became defined as the primary agents for executing medical directives and orders. As the physicians' executive officer the nurse was never to question the manner in which a case was conducted. Hawkings-Ambler (1897) wrote:

> That duty (of the nurse) is to obey him and recognize his sole responsibility for treatment, and her own responsibility as an executive officer. Rightly or wrongly, one cannot have any subaltern of genius discussing his superior's orders. Only one battle has been won in a century by the disobedience of orders. But let not the nurse think of herself as Nelson!" (Hospital, July 31, 1897, p. 163)

A part of the nurse's role was also centered in domestic tasks. Indeed, domestic work became a glorified part of the nurse's duties within Nightingale's concept of "nursing the room." Scrubbing and cleaning were elevated to a place of prime importance under the auspices of asepsis and nursing was firmly connected to housework:

> The elements of making the true nurse must be in the woman. The bottom of the whole question is home training; women who have had good mothers, who taught them obedience and self-discipline with a thorough domestic training, are the women who will make the best nurses. (Cited by Gamarnikow, 1978, from Hospital, September 1, 1917, p. 445)

When Nightingale's position on the relationship between nursing, cleanliness, and housework was challenged, arguments to reaffirm the notion that domestic work was a part of nursing were forthcoming. Sister Grace (1897) wrote:

> Now let me say a little on the subject of so-called 'menial' work. To my mind it is an incorrect term; no work is 'menial' that ministers to the comfort of the patient; and if a nurse is ambitious to be one day a ward sister, a thorough and practical knowledge of 'menial' work is essential . . . You will frequently hear the opinion expressed that this sort of work is unnecessary for a nurse. Do not believe it. (Hospital, July 3, 1897, p. 121).

In early American schools of nursing, the family also served as the institutional model for the operation of hospitals. In addition to the roles of mother to the patient and housekeeper, as the "household" became increasingly complex, nurses assumed a greater management role. Nurses were perceived to be responsible for caring for the "hospital family" through service and self-sacrifice. They became responsible for the smooth running of all the departments from the operating room to the kitchen, twenty-four hours a day, seven days a week (Ashley, 1976).

As the practice of medicine grew and became more complex, nurses began to assume more and more of the tasks traditionally done by physicians. With the increase in management and curative aspects of practice, many of their domestic duties, and in time some of the direct basic nursing care, were relegated to individuals with less training and education.

Nursing practice today has changed drastically from the limited roles associated with the Nightingale era and the first half of the twentieth century. A recent

publication by the American Nurses' Association (1980) sets out the dimensions of the current scope of nursing practice. According to this statement:

> One of the most distinguishing characteristics of nursing is that it involves practices that are nurtritive, generative, or protective in nature. They are developed to meet the health needs of individuals as integrated persons rather than as biological systems . . .
>
> Nurses are guided by a humanistic philosophy having caring coupled with understanding and purpose as its central feature. Nurses have the highest regard for self-determination, independence, and choice in decision making in matters of health. . . .
>
> Nurses are committed to respecting human beings because of a profound regard for humanity. This principle applies to themselves, to people receiving care, and to other people who share in the provision of care, as well as to humanity in general . . . .
>
> Nursing care is provided in an interpersonal relationship process of nurse-with-a-patient, nurse-with-a-family, nurse-with-a-group. It involves privileged intimacy--physical and interpersonal. Nursing is a laying-on-of-hands practice in which nurses have access to the body of another person in carrying out assessments, comfort, care and definitive treatments. At best, nurses carry out such physical ministrations with compassion and with recognition for the client's dignity. Nursing is a practice in which interpersonal closeness of a professional kind develops and aids the investigation and discussion of problems, as nurse and patient (or family or group) seek jointly to resolve those concerns. Nursing therefore includes an array of functions, including physical care, anticipatory guidance, health teaching, counseling, and the like. (p. 18, 19)

This statement on the social policy of nursing also recognizes two types of nursing practitioners, generalists and specialists. The generalists are described as those who serve most of the people at any point in time in whatever their situations. The generalist "has a comprehensive approach to health care and can meet the

diversified health concerns of individuals, families and communities" (p. 19). Specialists are those with particular expertise in a part of the whole of nursing practice or relations among parts. These nurses usually have, in addition to the generic base of nursing practice, advanced study and competencies in a specialized area of practice. Examples of specialists are clinical specialists in cardiology, rehabilitation, and nurse practitioners.

Although present-day nursing practice has advanced to include the generalists and the specialists, dimensions of care as well as cure, according to Beletz (1974), patients still view the nurse as a "composite image . . . of a female nurturer, medicator, physician's assistant, maid, and administrator" (p. 454). This view of the nurse's role reflects the early sexual division of labor instituted by Florence Nightingale and described by Ashley (1976).

The Nurse's Temperament: The Psychological Element

Nursing as an invented paid occupation was organized and defined by Nightingale as woman's work. Relegated to the domestic sphere of caring, nurses were characterized by their personal attributes and virtues. Among these, Gamarnikow (1979) found the following traits listed in Nightingale's writings and early issues of Hospital journal articles:

> . . . qualities relating implicitly or explicitly to subordination (patience, endurance, forbearance,

> humility, unselfishness, self-control, self-sacrifice, self-abnegation, self-effacement, service orientation, self-surrender, devotion, loyalty, discipline, obedience); to personal qualities (orderly, neat, cleanly, strong, quiet, sober, punctual, dutiful, persevering, self-reliant, courageous, principled, chaste); to the manner of relating to others (cheerful, kindly, gentle, generous, courteous, discreet, grave, considerate, thoughtful, understanding, tactful, tender, calm, firm); to attitude to patients (goodwill, love, sympathy, pity, comforting, charitableness); to qualities relating to the nurse's role as observer and reporter of symptoms (guilelessness, sincerity, honesty, trustworthiness, truthfulness, reliability, accuracy, watchfulness, precision, observing); and to characteristics relating to skill and technical competence (ingenious, ready, quick, intelligent, skillful, competent, alert, practical, keen, sensible). (p. 115)

Nightingale, a product of the Victorian era, was particularly concerned about the nurse's character. For her, femininity was equivalent to moral attributes and qualities. She wrote:

> To be a good nurse one must be a good woman, here we shall all agree. . . . What is it like to be 'like a woman'? 'Like a woman'--'a very woman' is sometimes said as a word of contempt: sometimes as a word of tender admiration. . . . What makes a woman good is the better or higher or holier nature: quietness--gentleness--patience--endurance--forbearance, forbearance with patients, her fellow workers, her superiors, her equals. . . . As a mark of contempt for a woman, is it not said, she can't obey?--she will have her own way? As a mark of respect--she always knows how to obey? How to give up her own ways? . . . You are here to be trained for Nurses--attendants on the Wants of the Sick--helpers in carrying out Doctors' orders. . . . Then a good woman should be thorough, thoroughness in a nurse is a matter of life and death in a patient or, rather, without it she is no nurse. . . . Now what does 'like a woman' mean when it is said in contempt? Does it not mean what is petty, little selfishnesses, small meannesses: envy, jealousy, foolish talking, unkind gossip, love of praise? Now, while we try to be 'like a woman' in the noble sense of the word, let us fight bravely against all such womanly weaknesses. Let

> us be anxious to do well, not for selfish praise but to honour and advance the cause and work we have taken up. (Nightingale, 1881)

With the passing of time and as nurses began to assume more of the duties inherent in the role of household administrator (Ashley, 1976) and executive officer for the physician (Gamarnikow, 1978) characteristics needed for effective and efficient bureaucratic management became desirable. The earlier characteristics equated with nurse equal mother expanded to include those associated with technician and manager. Olesen and Whittaker (1968) included the following views as associated with this change in role:

> high technical skill; emotional control and restraint; human drama and excitement; clear-cut lines of authority; order and routine; hard work; meticulousness; close supervision and direction; and clearly defined work tasks; each person responsible for her job and her job alone. (p. 126)

As the nurse's role expanded from mother-surrogate to include physician's assistant and household manager, the image of nursing took on conflicting characteristics (Simmons, 1962). Evidence of the presence of paradoxical images was confirmed in a study by Holliday (cited in Simmons, 1962, p. 31). In this study on the image of nurses, small groups of nurses and lay students chose a mixture of traditionally held functional and expressive characteristics as those associated with a nurse. The traits selected by the subjects in this study included: functional--well-trained, punctual, instructive, efficient, neat

appearance, nonspecialized, communicative, well-educated; and expressive--tender touch, sympathetic, anticipative, empathetic, cooperative, happy, and supportive. Thus, the ideal nurse, as viewed by this sample, was androgenous, a blend between the technical and the personal, possessing both characteristics traditionally viewed as characteristic of masculine and feminine gender roles.

Research conducted in the last decade on the congruence of sex-role identity and the image of nursing has produced conflicting views. A study to determine whether a relationship existed between sex-role identity and the image of nursing was conducted by Stromberg (1976). Instruments used in this study included the m/f scale of the Minnesota Multiphasix Personality Inventory (MMPI) and Frank's (1969) Image of Nursing Questionnaire (INQ). The Frank's Image of Nursing Questionnaire was developed by a group of randomly selected nurse educators who served as judges in determining whether a list of 70 image items were characteristic or not characteristic of the image of nursing advanced by the profession. The sample in the study by Stromberg (1976) included 430 female senior nursing students in two baccalaureate nursing programs, five associate degree nursing programs, and five diploma nursing programs. Findings in this study indicated that the students' image of nursing was more in harmony with the image advanced by the profession when the student's sex-role

identity was more masculine. Students with a high feminine sex-role identity were found to be in disharmony with the image advanced by the profession as measured by the INQ. Among those students studied, those in baccalaureate and associate degree programs had images of nursing more consistent with that advanced by the profession than those in diploma programs.

Sex-role identity and the image of nursing were also studied by Till (1980). In this study she used the Frank's (1969) INQ and Bem's Sex-Role Inventory (Bem, 1974) which allowed subjects to be categorized as masculine, androgenous, feminine, and undifferentiated by receiving both masculinity and femininity scores. Subjects in this study included 96 female nursing students, 56 at entry level, and 36 at exit level from a baccalaureate nursing program. Results of the study showed that students exiting from the program endorsed more masculine characteristics than entering students; however "nearly half the graduating students described themselves in highly feminine terms without high-level endorsement of masculine competency characteristics" (p. 299). Students exiting from the program endorsed more feminine characteristics than females in the general college population studied by Bem (1974), and both the entering and exiting students and Frank's (1969) judges held significantly ($p < .01$) different images of nursing. According to Till (1980) only the endorsement of masculine characteristics was

positively related to the professional image of nursing as measured by Frank's INQ. Based upon her research, she concluded that there was a discrepancy between the professional image of nursing and that held by women entering nursing education. This conclusion is consistent with Muhlenkamp and Parsons' (1972) review of personality studies published from 1960 to 1970. This study showed the nurse as characterized by submissiveness, dependence, high religious and social interest, low concern for economics, and desirous of having a helping role--all characteristics commonly associated with the feminine stereotype. Till (1980) also suggested that the change in entering and exiting students' endorsement of masculine characteristics could be associated with the positive influence of the nursing education program, although further improvement in curriculum is needed to support the development of masculine competency characteristics. By using Bem's Sex Role Inventory rather than the MMPI used by Stromberg (1976), Till raised the question as to whether it was masculine characteristics which were consistent with Frank's INQ or the masculine sex-role as suggested by Stromberg since the MMPI gave only a masculine or feminine sex-role choice. Both studies, however, appear to indicate that nursing leadership supports the view of a profession more closely aligned with traditional masculine traits.

A recent study by Rosenow (Note 2) confirms the view that nursing leadership is more closely aligned with masculine traits than feminine or androgynous ones. Using Bem's Sex Role Inventory, Rosenow compared two groups of demographically similar nurses. One group of 275 were ANA members and the other group of 275 were members of the American Academy of Nursing, individuals recognized for leadership and achievement in nursing. Findings in this study indicated that 53% of the Academy sample as compared with 33% of the ANA sample endorsed masculine characteristics. Furthermore, 42% of the remaining Academy subjects were identified as androgynous as compared with 33% of the ANA subjects. Only eight persons in the Academy group were feminine sex-typed; however, 33% of the ANA members sampled were profiled in this manner.

It is apparent that the changing image of the nurse necessitates a change in the view that nursing is the hallmark of traditional femininity. The intuitive obedient image of the Nightingale nurse no longer fits the description of the contemporary nurse described by Olesen and Whittaker (1968)--one possessing originality, solid intellectual content, creativity, imagination, insight, and innovative problem-solving. Nor does it fit Aroskar's (1980) view of the nurse as decision-maker.

In summary, it appears that the changing role of the nurse has created a need for a change in the temperament

traditionally ascribed to nurses. Temperament as a pristine form of femininity demanded by Nightingale no longer seems adequate. Today the temperament of the nurse appears to require characteristics commonly ascribed to the masculine personality. Research indicates there is dissonance between the layman's image of nursing (Beletz, 1974), the nursing students' views of nursing (Stromberg, 1976; Till, 1980), and the nursing leaders' views of nursing (Frank, 1969; Rosenow, Note 2). Clearly, there is need for successful integration of the masculine and feminine elements which would support the dimensions of practice described by the social policy statement of the American Nurses' Association (1980). Without this integration it is doubtful that nursing can achieve its social mission and provide the care and cure needed by society.

The Nurse's Status: The Political-Economical Element

The sexual division of labor, arising from power relationships within the family through traditional roles of male-husband and female-wife, can be found in relatively pure form in the case of nursing. As cited earlier, the labor in the production of health or healing has been traditionally divided into two distinct spheres by medicine, the controlling force in health care. These spheres, commonly referred to as cure and care, are reflective to respectively, the cultural area--the work sphere of man in capitalist

society which calls for intelligent creative invention, and the domestic area--the work sphere of woman arising from her biological role in the family calling for support and nurturance.

The relationship between these two spheres and their respective roles in the production of health take on the characteristics of those defined by Engels (1942) within the family unit. Thus, the physician can be viewed as the bourgeoisie and the nurse as the proletariat. The physician possesses the sole right to define the patient and as such can be seen to own the raw material for production of health. In this respect, he rents the labor of the nurse and other health care workers and pays a wage that supports the necessities of life. Aron (1968) described this application of Marxian theory: "Labor power is rented at its value, and the value of labor power is determined by the value of those articles indispensable to the life of the worker and his family" (p. 166).

In the case of nursing, primarily a female occupation, the labor rented in the production of health or care is seen as "woman's work." Identified with domestic work, normally representative of use-value work in the family, salaries have been minimal. This concept of nursing as woman's work has been credited as the underlying cause of low salaries. In the early era of nursing in the United States, nursing labor was exchanged for room, board,

uniforms, a small salary, and diplomas from the numerous hospitals, frequently owned by physicians, operating apprenticeship schools of nursing. Ashley (1976) noted:

> Many of the hospitals were small, private "doctors'" hospitals, which were financially remunerative to the physicians who operated them because of the free labor of student nurses. Reliable statistics for the year 1905 indicate that more than half of these private, profit-making hospitals had "schools" for women. Though the "hospital" may have been limited to 40 beds, it established a so-called "school" for nurses in order to obtain nursing service at the least possible cost. Innocent girls, thinking they were getting special training, provided the best source possible. (p. 21)

In 1896, Nutting addressed the problem of exploitation of nursing students at the Society of Superintendents of Training Schools:

> There is no work sufficiently like nursing to serve adequately for purposes of comparison, but to take the first that comes to mind it may be said that from 56 to 60 hours a week are generally considered fair working hours for the laboring men. I believe I am right in stating that few industries require their employees to work more than 10 hours daily and their Sundays are usually free. We cannot actually compare industries with training schools, nor wage-earners with pupils receiving their training in an educational institution, but we can state that a pupil in a training school may work harder to receive her training than a laboring man to support his wife and family, for here we find in one of the most difficult and responsible careers a woman can undertake, that her only method of receiving a certain kind of education is not to work 60 hours per week, but a number of hours varying from that number to 105. (Cited in Ashley, 1976, p. 35)

The profit realized by student nurses' labor in the early 1900s can be found in testimony given by a San Francisco Labor Council representative:

> Investigations have shown that they [student nurses] are both underpaid and overworked. Undergraduate nurses received from $15 to $12.50 a month while the patients are charged $25 a week for their services and $7 to $10 for their board, giving the hospital a profit of some $125 a month for each girl. (Cited in Ashley, 1976, p. 41)

Other methods of exploiting students' labor included a common practice of placing student nurses in private homes to provide care. The money received in payment for this care was taken by the hospital and became an additional source of income. The families who received the services from the student were unaware that the nurse assigned was not a graduate (Ashley, 1976).

In time, labor practices changed, nurses had shorter hours, and the practice of exploitation took on a different perspective. This practice of exploitation is best described as related to Marx's second method of increasing profit, the reducing of "necessary labor time to a minimum" (Aron, 1968, p. 169). This principle for increasing profit can be applied to the shift of nursing tasks to duties which involved more cure than care under the mystique surrounding the role of the executive officer of the physician. As nurses began to carry out duties which were traditionally defined as falling within the realm of cure--for example, suturing, delivery of babies, and today, treatment of cardiac arrhythmias--the line between medicine and nursing became blurred. Although performing many tasks relegated to physicians, nurses

continue to be paid for care since their role is defined by licensure and nurse practice acts to fall only in that realm. The physician, however, realizes additional profit from the extended activities of the nurse since it requires less time for him to practice healing acts.

The sexual division of labor, which keeps the physician in control of the production of health, works to reinforce the system of patriarchal capitalism. This can be clearly demonstrated in that physicians enjoy the highest status of all occupations in our society and one of the highest salaries. The comparative differences in status and salary afforded nurses and physicians offer a primary example of patriarchal political and economic control.

Through the extension of the nurse's role as mother surrogate to include manager and executive officer of the physician (pseudo-physician) and the subsequent relinquishing of domestic services and direct patient care, the nurse eventually appeared to suffer a sense of alienation. This alienation of self, as a profession, is currently being expressed in what many nurse authors describe as an identity crisis. Clearly, nursing's long existence in a patriarcnal health care system has contributed to this crisis.

Impact of Patriarchy on Nursing's Identity

Nursing's current problems with establishing its own unique identity are, to a large extent, defined by its relationship to medicine. Partridge (1978) addressed

nursing's lack of autonomy when she wrote:

> One of the major problems of nursing lies in the unitary relationship between nursing and medicine. The patients were, and still are, the doctor's patients; the orders were, and still are, the doctor's orders. If women came from Adam's rib, then nurses, I fear, must come from the physician's rib. (p. 356)

The role of nursing in the production of health has been defined and differentiated with reference to physicians, and as such, it has been viewed to a large degree as incidental and unessential. Its curative elements are submerged in the role ascribed to the physician and its caring elements are associated with the natural nurturant role of women in general. The relegation to a role primarily based on sex, as opposed to autonomy, has left the nurse defined as Beauvoir (1952) terms "Other" rather than "Subject" in the health care system.

Nursing has failed to affirm its own subjective existence as evidenced by its long history of shaping its roles in response to the demands of hospital administrators and medicine (Ashley, 1978). It has of late sought to identify with medicine through some aspects of the expanded role such as physical examinations and has placed greater emphasis on science, technology, and research requiring quantitative techniques (Gadow & Spicher, 1980). Yeaworth (1976) warned nurses who identify with physicians in an effort to gain legitimacy as a professional that they will always be in an underdog

position. She suggested that an appropriate model for nursing can be found in the ideas behind the Black Power movement. She wrote:

> Blacks made progress when they stopped trying to use whites as models and developed pride in their qualities, culture and capabilities. Likewise, women should not use males as models. We need to decide on the qualities and capabilities that are considered feminine that need to be valued, preserved, built upon--qualities in which women can take pride. In the same vein, nurses should not try to use physicians as models, but should decide what we want to preserve and strengthen in nursing and what we want to change. (p.9)

Moreover, Yeaworth (1976) argued that nurses need better psychological and educational preparation in order to prepare them to exert influence and gain status without alienating would-be supporters. She advocated educational programs which would afford women an opportunity to identify their own values, goals, and skills, and to do life planning. In addition, she promoted programs directed at improving interpersonal skills, problem-solving, decision-making, and organizational skills. Yeaworth warned that progress will require energy and determination, and that it will be tempting "to avoid the fray as long as we are individually comfortable" (p. 9).

Freire (1970) seemed to have captured nursing's current dilemma of choosing to become more autonomous or remaining embedded and identified with medicine when he wrote:

> the conflict lies in the choice between being wholly themselves or being divided; between ejecting the oppressor within or not ejecting him; between human solidarity or alienation; between following

> prescriptions or having choices; between being spectators or actors; between acting or having the illusion of acting through the action of the oppressors; between speaking out or being silent, castrated in their power to create and re-create, in their power to transform the world (p. 33).

I support Gadow's (1980) belief that nursing as a profession is at a turning point and must take the economic and philosophical risks involved in defining its own subjective existence. I believe nursing will discover its unique identity not by asking others or identifying with the masculine role but by critically questioning itself.

Impact of Patriarchy on Professionalism in Nursing

The ideology of patriarchy supports the view that woman's major commitment lies within the home. Research findings affirm this view in that women employed in the labor market still assume major responsibilities in the home (Holstrom, 1973; Rapoport & Rapoport, 1971). According to Nielson (1978) this arrangement creates two instead of one major work roles for women with the major one located in the home. In order for women to meet the obligations of both roles, they tend to choose jobs in the labor market requiring limited commitment, education, and skills (Nielson, 1978). These jobs are more commonly found in the areas of services.

Nursing, predominately a female occupation closely associated with roles in the home, meets the criteria for

suitable female work participation in a patriarchal society. Statistics previously cited indicate low participation in full-time employment and rapid turnover rates. Nurses tend not to consider their work as a lifelong career commitment but instead view their education as providing employment if they need or want to work. Nurses' work patterns show a lessening of participation after marriage and during childbearing with increased participation after children enter school (Rowland, 1978). Rapid turnover, in some instances as high as 30 to 50 percent in California costing an estimated 187 million dollars a year in recruitment and training (Kalish & Kalish, 1980), can be associated with the following factors: (1) women tend to move according to their husbands' career needs (Neilson, 1978); (2) salaries are comparatively low (in Denver, local supermarket checkers were found to earn more money than registered nurses); and (3) there is widespread general dissatisfaction with working conditions (Kalish & Kalish, 1980). The poor salaries can be associated with the view that nursing represents use-value work and as such is rewarded in a nominal way. This often leads some married nurses to view employment financially unjustifiable in view of child care and taxes.

In summary, patriarchy, as the prevailing ideology, affects professional commitment to nursing practice in a variety of ways. It promotes the notion that woman's

place is in the home and that appropriate work in the market place should require limited education and skill, thus allowing women to maintain their primary commitment to the family. Patriarchy supports a system of work characterized by insufficient monetary rewards and limited job satisfaction which contributes to the nursing shortage. In addition, nursing is seen as a female occupation and thus fails to attract a large number of men who normally maintain a higher level of job participation than females (Rowland, 1978).

A Disciplined Educational Process and a Unique Body of Knowledge and Skill

Patriarchy, as the "common sense" of hierarchal relationships in our society, supports the notion that rigorous intellectual endeavor falls within the masculine domain (Deutsch, 1944). Freud's view of women's psychology supports the position that the intellectual woman is lacking normal femininity. Thus the founder of modern-day psychological thought promoted the idea of anti-intellectualism as the norm for women. Several nurse leaders (Christman, 1976; Yeaworth, 1976) have asserted that a sense of antiintellectualism or failure to engage in university-based education has had a profound effect on the development of professional nursing.

Christman (1976)linked failure to develop experts in the profession to a climate of disinterest in graduate education. He asserted that intelligence, creativity, and

ambition are not sex-linked. Moreover, he criticized the trend for young talented nursing graduates to withdraw into marriage and childbearing at an age when graduate school is easiest, leading to a loss of the bright, well-prepared intellectuals nursing needs so desperately. He advocated the concept of dual-career families and increased commitment to intellectual growth.

Yeaworth (1976) argued that nursing's failure to resolve the question of entry level into practice (presently only 20% of registered nurses hold baccalaureate degrees) relates to its lack of affirmation of professional education founded on a minimum of the baccalaureate degree. She wrote:

> The fact that so much of nursing's education has been outside of accredited, degree-granting colleges or universities has hampered nursing's efforts to professionalize and created blocks to educational mobility for large numbers of nurses. (p. 8)

Furthermore, she asserted that nurses themselves have been responsible for some of the greatest resistance of moving nursing education into the mainstream of higher education.

The lack of commitment to higher education and nursing's image of femininity fit well with research findings of Horner (1972) and Tobias (1978). As a result of Horner's experiment on fear of success in women, she argued that the motive to avoid success or the fear that success will have negative consequences arises from women's belief that

success can be equated with masculine achievement and thus loss of femininity. Similarly, Tobias (1978) associated women's math anxiety with concern that high achievement in math and science would be viewed as deviant since these areas are considered in the masculine domain. The tracking of women in high schools away from the hard sciences reduces the number of female students prepared for nursing programs in higher education. Moreover, the general perception that nursing education is lacking in intellectual rigor is probably bolstered by the fact that approximately 80% of registered nurses do not have baccalaureate degrees. This fact may also be responsible for brighter, academically prepared female and male students failing to enter nursing and instead, according to Yeaworth (1976), tending to choose careers such as medicine, pharmacy, and law.

The lack of commitment by nursing to higher education has also contributed to the slow development of graduate level study. The limited availability of nurses with master's and doctoral degrees has resulted in inadequate numbers of nurses with research skills, the intellectual development to design and complete projects, and establish theoretical perspectives needed to authenticate nursing's unique contributions to health care.

An Active and Cohesive Professional Association

The traditionally held gender-role characteristics attributed to the feminine temperament in patriarchal society

call for the female to be emotional, subservient, dependent, passive, weak, submissive, and noncompetitive (Chafetz, 1974). In addition, the status attributed to a woman is most commonly that of the men in her life rather than that centered in her own unique contributions to society (Nielson, 1978). I believe this state of consciousness regarding traditional temperament and status has contributed to the production of an apolitical nonassertive posture by the overwhelming majority of registered nurses in this country. This is evidenced by a membership of less than 20% in the American Nurses' Association, nursing's professional organization. This passive, apolitical posture, I believe, is a primary factor in the continuation of poor working conditions, low salaries, and lack of control over nursing practice. As Beauvoir (1952) has said, it is easier to forego liberty and let another determine one's direction, but the consequences can be loss and ruin. Nurses' lack of political activity, closely related to the feminine socialization in patriarchal society, is clearly exemplified in the absence of a viable, strong, and unified professional organization.

Discretionary Authority and Judgment

The lack of discretionary authority and judgment over nursing practice can be directly related to the patriarchal

relationship which exists between nursing and medicine. The view that the physician is the authority in all matters related to healing and that the nurse's role is subordinate and insignificant leaves nursing with little over which to exert authority. The roots of this subordination are long and deep; they extend back in history, beyond the Nightingale era.

Christy (1976) traced the issue of nursing's lack of authority and judgment historically to the religious and military orders. She argued that nursing's early roots in the religious orders promoted the development of a passive, humble, docile individual who unquestioningly carried out the orders of the priests (males) in the early monastery hospices, and later the physician. In this way her authority was embedded in her obedience to others--the primary characteristic of a good nurse. The ideas of servility, humility, and unquestioning obedience, Christy maintained, were promoted by the Nightingale philosophy and further promulgated in most schools of nursing through the role modelling of instructors and a hidden curriculum which promoted the "good" student as one who did what she was told. Students who questioned too often usually fell into a category termed "personality unsuitable for nursing" and frequently were dismissed from school.

Christy (1976) also cited the influence of militarism upon nursing which she argued stemmed from the early military orders which cared for the sick in the Middle Ages. The custom of awarding stripes on nurses' caps as they proceed educationally from level to level, the language--"reporting for duty," "inspection," and "doctor's orders" all reflect the idea of authority and judgment residing in the physician.

Today in nursing the failure to assume leadership and assert authority and judgment in matters related to practice are currently being related to a leadership vacuum in the field. In recent years there has been a decline in the number of graduate students in administration. Wilsea (1980) reported a drop in graduate students selecting nursing administration from 11.3% in 1966 to 3.8% in 1976. Leininger (1974) reported that many top leadership and administrative posts such as deanships and nursing service positions are currently unfilled due to lack of interest and qualified nurses. Cleland (1971) related this lack of interest to the female's fear that positions in top leadership are viewed as inconsistent with the traditional feminine image, thus undesirable.

In summary, I assert that patriarchy with its traditional views of woman's role, temperament, and status, has had a profound effect upon the problems nursing has and continues to experience in establishing its unique

identity and developing full professional status. Clearly, a new model for ordering of social relationships is needed if it is to accomplish its social mission in the health care field.

Critique of Patriarchy

The ideology of patriarchy seems to be so pervasive in present-day culture that it appears to be "natural" or have a "common sense quality." This seemingly natural way of ordering power relationships among the sexes in society can be related to the fact that patriarchy is so old its beginnings are unknown. Recorded history, however, reveals it has enjoyed the sanction of all major institutions including the family, religion,and government. It appears to be reproduced from generation to generation by consent of both sexes to male supremacy.

Patriarchy, as the mechanism for the hierarchical ordering of power relationships in today's society, primarily finds support through the continuation of the sexual division of labor, the assignment of dichotomous gender characteristics, and the unequal status between the sexes. Its reproduction calls for: (1) woman's role to be primarily in the domestic sphere, or if participating in the labor force, to be in a domestic type of job; (2) the "feminine" personality--nurturant, passive, dependent, and intuitive; and (3) assignment to the husband or father's status, or if single, to a status usually lower than men since

most females work in jobs associated with use-value work requiring less reward.

The nursing occupation, approximately 98% composed of females, appears to be plagued by the same stereotypes that women face in the larger society. The impact of patriarchy is apparent in the respect that nursing is regarded as women's work, with its social roles closely aligned with mothering, housekeeping, and assisting the physician. History (Ashley, 1976) has shown that it has suffered from subordination, oppression, and exploitation perhaps like no other woman's occupation.

The ideology of patriarchy which underpins the relationships in the present-day health care system, however, is not inevitable as a future way for ordering power relationships in our society. Beauvoir (1952) reminded us that man is not a fixed being but creates his own reality. This notion points to a major criticism of patriarchy in that it implies fixed relationships grounded in biology, lacking the kaleidoscope of forms within which men and women encounter each other. It obscures from view all the ways that women resist subordination. It also fails to produce any notion as to how women might act to transform their situation as a sex. Accordingly, Rowbotham (1979) suggested the term in a real sense implies a rather fatalistic submission which allows little space for the complexities of woman's defiance. It would

seem that this particular criticism parallels Giroux's (Note 3) concern regarding the use of the correspondence principle in schooling. He argued that it is not that neat and simple, and resistance to the oppression in schooling does exist just as in the assembly lines of capitalistic society. Implying that patriarchy has a similar correspondence principle--the relationships in the traditional family are reproduced in the larger society, does not allow for the resistance and struggle which forms the cutting edge of change currently reflected in the woman's movement.

I believe patriarchy as a concept for analysis is helpful in developing an understanding of the historical and traditional view of power relationships between men and women in our society, but a new concept is needed to point the way to change. It seems the work of Chodrow (1974, 1978), Dinnerstein (1976), Gilligan (1979), and other feminist writers points the way to a new paradigm for structuring a more humanistic society. Their work seems to support Rossi's model (Kaplan & Bean, 1976) for social change, a hybrid model based on the concept of androgyny. This model rejects both traditional forms of social interaction and the patriarchal structure on which society is currently based. According to Rossi, the hybrid model would promote both at the societal and personal levels a synthesis of the best of both traditional

feminine and masculine qualities. This model would call for sexual equality in all spheres of life and profound and drastic changes in the social and economic system.

In summary, I believe Gilligan (1979) has captured the essence of the argument for Rossi's hybrid model in her analysis of the myth of Persephone. Of Persephone she wrote:

> Persephone, the daughter of Demeter, while playing in the meadows with her girl friends, sees a beautiful narcissus which she runs to pick. As she does so, the earth opens and she is snatched away by Pluto, who takes her to his underworld kingdom. Demeter, goddess of the earth, so mourns the loss of her daughter that she refuses to allow anything to grow. The crops that sustain life on earth shrivel and dry up, killing men and animals alike, until Zeus takes pity on man's suffering and persuades his brother to return Persephone to her mother. But before she leaves, Persephone eats some pomegranate seeds which insures that she will spend six months of every year in the underworld. (p. 445)

Gilligan suggested that this myth reminds us that narcissism leads to death, that the fertility of the earth is in some mysterious way linked to the continuation of the mother-daughter relationship, and that life itself arises from the dialectic between the worlds of men and women. I believe that the continuation of the dichotomous thinking that supports the ideology of patriarchy is destructive to both sexes and the future of our world. It seems there is need to reconsider patriarchal society with its overemphasis on masculine traits. In my view the notion of androgyny, which will be more fully developed in Chapter IV, offers that opportunity. At this point,

however, it seems essential to inquire into the relationship between nursing's major socialization vehicle, the curriculum, and its current problems with identity and professionalism. Chapter III affords the opportunity to further this understanding.

CHAPTER III

RELATIONSHIP BETWEEN NURSING CURRICULA AND NURSING'S CURRENT STATUS

I believe that nursing education is in a state of disarray. Partridge (1978) affirmed this belief by noting: "The problem, I believe, is not so much that we have lost our way, but rather that we are using the wrong compass to find the right path" (p. 358). If one believes, as does Macdonald (1978), that "schooling is a major social vehicle for socializing the young and conserving and transmitting our culture" (p. 27), then it seems reasonable to assume that nursing curricula, both past and present, have played a role in socializing nurses to accept their current position in the patriarchal health care system. Thus, it seems logical that nursing curricula have also had an impact on the problems of establishing nursing's identity as a discipline and its development of professionalism. This chapter of the inquiry deals with an analysis of nursing curriculum models both past and present.

Specific models described include the Nightingale model, the apprenticeship model, the medical model, and the integrated model. In addition, five specific curriculum models, developed between 1970 and 1979 (Bevis, 1978; Chater, 1975; Conley, 1973; Torres & Yura, 1974; Wu, 1979) are reviewed. Also included in this chapter of the

inquiry is a discussion of the influence of the Tyler rationale on the development of nursing curriculum from 1953 to the present. In addition, a critique of current day-nursing curriculum models is included. The chapter concludes with an analysis of the relationship between nursing education and the current problems of nursing's identity and the development of professionalism.

Nursing Curriculum Models: The Nightingale Model

Modern nursing education was initiated by Florence Nightingale in 1860 when she opened the Nightingale Fund School of Nursing at St. Thomas' Hospital in London (Gamarnikow, 1978). Prior to Nightingale's work, nursing had been the responsibility of religious orders and poor, lower-class women of questionable reputation. Historically, Nightingale is given credit for the beginning of modern-day nursing in that her work as a nurse and her reform efforts clearly established secular nursing as not only necessary but also worthy of middle- and upper-class women's talents. (Bullough & Bullough, 1964).

The primary components of the Nightingale Curriculum were focused on character training, a concern for hygiene or "nursing the room," and assisting the physician. In 1882, Nightingale described the role of the nurse and the curriculum components she considered essential:

> Nursing is performed usually by women, under scientific heads--physicians and surgeons. Nursing is putting us

> in the best possible conditions for nature to restore or to preserve health. The physician or surgeon prescribes these conditions--the nurse carries them out. . . . Sickness or disease is Nature's way of getting rid of the effects of conditions which have interfered with health. It is Nature's attempt to cure--we have to help her. Partly, perhaps mainly, upon nursing must depend whether nature succeeds or fails in her attempts to cure sickness. Nursing is therefore to help the patient to live. . . . Nursing is an art, and an art requiring an organized practical and scientific training. For nursing is the skilled servant of medicine, surgery, and hygiene. . . . Nursing proper means, besides giving medicines and stimulants prescribed, or applying the surgical dressing and other remedies ordered: 1. the providing, the proper use of, fresh air, especially at night, that is ventilation, of warmth and coolness. 2. the securing of the health of the sickroom or ward, which includes light, cleanliness of floors and walls, of bed, bedding and utensils. 3. personal cleanliness of patient and nurse, quiet, variety, and cheerfulness. 4. the administering and sometimes preparation of diet (food and drink). 5. the application of remedies. In other words, all that is wanted to enable Nature to set up her restoration processes, to expel the intruder disturbing her rules of health and life. For it is Nature that cures: not the physician or nurse. (As cited in Gamarnikow, 1978, pp. 115-116)

The character component of the curriculum received due consideration in the Nightingale school. Every month a report was completed on each probationer by Mrs.Wardroper, the matron of St. Thomas Hospital. According to Bullough and Bullough (1964), students were graded on "punctuality, quietness, trustworthiness, personal neatness, cleanliness, ward management, and technical efficiency" (p. 103). The students were strictly disciplined and flirtation was punished by instant dismissal from the school. When leaving the nurses' home, probationers were required to go in pairs (Bullough & Bullough, 1964).

Nightingale's concern for character training as an explicit part of the curriculum was so strong that she refused to support independent examination of nurses. A proposal to create an independent body of examiners to examine all nurses separate from examinations of training schools was put forward by a group of nurses in 1886. According to this plan, nurses satisfying the examining board would be entitled to have their names on a registry and thereby be considered registered nurses. Nightingale refused to support the idea and cited two reasons for her opposition: (1) she thought nursing was too young and disorganized for such an organization and (2) the qualifying of a nurse by examination failed to account for character training, an essential component in her view (Bullough & Bullough, 1964).

The Nightingale curriculum became the model for the first American nurse-training schools. The nursing care components of the curriculum continued to emphasize nursing in relationship to a healthy physical environment for the purposes of preventing and treating disease (Reilly, 1975). The theme of traditional feminine Victorian values characterized by service, self-denial, and spiritual growth through "doing good" supported Nightingale's concepts of the role of the nurse as housekeeper, mother-figure, and subordinate to the physician (Ashley, 1976).

The primary difference between English schools and American schools of nursing during the early period was one of funding. In England, the training schools were endowed, while those in the United States were not. In an effort to overcome financial chaos, the American schools of nursing eventually resorted to establishing agreements to provide nursing service to hospitals in exchange for the use of clinical laboratory facilities. This arrangement eventually led the way for hospitals to develop their own schools of nursing and firmly established a model of curriculum based on apprenticeship which in many instances included no formal program of study (Ashley, 1976).

Nursing Curriculum Models: The Apprenticeship Model

As each hospital established its own training school as an inexpensive means for meeting nursing service demands, formal instruction based on the Nightingale model soon gave way to an apprenticeship model which involved long hours of grueling and intensive service (Ashley, 1976). Kalish and Kalish (1975) described the lack of formal instruction during the years of apprenticeship education:

> Hospitals made few attempts to nurse patients scientifically and little effort to teach nursing as a science was made. In most schools of nursing the 'education' consisted of 95 percent service and less than 5 percent instruction in theory. Despite this mix, physicians of the early 1900's constantly complained that nurses were overly trained. (p. 233)

Bevis (1978) further described the apprenticeship form of curriculum as "few formal classes, training was done on the units while care was given to patients and explanations of care were offered as an unplanned bonus from physicians" (p. 34).

During this period, formal classes and faculty were at a minimum. Ashley (1976) cited a survey in Nursing Schools Today and Tomorrow published in 1934, which indicated that formal classes did not become a reality in most schools of nursing until the 1930s. In 1932, approximately one-fourth of the schools did not employ any full-time faculty and only one-fifth of faculty employed had one year of college education.

Nursing education had practically no formal classes and consisted of basic skills learned during apprenticeship, minimal medical knowledge, and character training in traditional feminine attributes. Therefore, it is no surprise that nursing education's emerging formal curriculum reflected the medical model of education and was aligned with hospital patterns of clinical service such as medicine, surgery, pediatrics, and obstetrics. Clearly, nursing, having grown out of the traditional sex-role related division of labor and having served as the oppressed under the paternalistic system of hospitals and physicians (Ashley, 1976) turned to the oppressor as Freire (1974) described, "internalizing the image . . . adopting his

guidelines" (p. 31). Thus nursing education adopted a medical model of curriculum--medical nursing, surgical nursing, pediatric nursing, obstetrical nursing, and psychiatric nursing based on these five major areas in medical education (National League of Nursing Education, 1932).

Nursing Curriculum Models: The Medical Model

The evolution of the nursing curriculum from one of apprenticeship to the medical model is described well by Bevis (1978). She noted:

> Historically, nursing moved slowly into the theoretical arena, since most of nursing content was appropriated from medicine. The nursing curriculum was watered-down medical information with a few hints about "nursing implications" thrown in to sweeten the dose of "medicine." (p. 19)

This move to the medical model was further described by Reilly (1975):

> A medical model of care thus became the framework for health workers--a model that focused on disease and its treatment rather than prevention of illness. Soon, the nurse was viewing the patient through the doctor's eyes, and nursing curricula followed the medical model which emphasized disease process and was organized according to body systems. Some of us old timers can remember the courses in which a doctor told about the disease in one lecture and then a nurse described the nursing care related to that disease in another. (p. 568)

Freire (1970) addressed this state of "seeing with the doctor's eyes" in his description of the relationship between the oppressor and the oppressed as one of prescription. He wrote,

> Every prescription represents the imposition of one man's choice upon another, transforming the consciousness of the man prescribed to into one that conforms with the prescriber's consciousness. (p. 31)

With the adoption of the medical model for nursing education, some nurse educators began to recognize its narrowness. They fought to lengthen training programs and place foundational courses in institutions of higher education in an attempt to broaden nurses' educational experiences. Although these efforts provided a better foundation for the medical model, according to Rogers (1961) "training schools continued to be apprenticed in nature and remain outside the mainstream of higher education" (p. 2). When under the umbrella of higher education, training schools were additive rather than integrated. An early example of a nursing program under a collegiate umbrella was the Cornell University-New York Hospital School of Nursing which became a reality after much negotiation in April, 1942. The graduates of this program were awarded baccalaureate degrees in nursing, having met the required two years of college acceptable to Cornell prior to entering the nursing school, which included three years of study--the basic nursing diploma program of New York Hospital School of Nursing and a course in community health (Jordan, 1952).

Nursing Curriculum Models: The Integrated Model

The shift from a medical model for nursing education to experimentation with an integrated nursing model began

in the late 1950s. The roots of this change can be found in nursing's increasing awareness of the narrowness of practice confined to nursing the hospitalized sick, and its increased strivings to gain autonomy and professionalism. As nursing services expanded to include increased emphasis on preventive care, rehabilitation, home and community nursing, the medical model with its focus on medically defined areas of practice such as pediatric and medical nursing with primary emphasis on pathology seemed too narrow. Nurses began to seek their own knowledge base apart from that of medicine. In addition, nursing research and theory development began to grow as nurse educators struggled to more clearly define the nature of nursing (Bevis, 1978). In noting nursing's concern with a broader scope of practice, Bevis (1978) wrote

> Humans became the most important factor to nurses, not spiritual salvation, not service to God, country, and physician, and not disease, and diagnosis but what happens to people in all their possible groupings and environments. (p. 36)

Efforts of educators to move from medical specialities associated with the medical model as an organizing strategy for nursing curriculum to a more holistic model led to an early and late integrated form (Figures 1 and 2). Bevis (1978) suggested that these designs do not reflect holism but instead represent summative dualism in that the old medical specialities are not shown as separate but cutting across major areas of content (Figure 1) or major concepts (Figure 2).

	Medical nursing	Surgical nursing	Obstetrical nursing	Pediatric nursing	Gynecological nursing	Eye, ear, nose and throat	Neurological nursing	Orthopedic nursing
Pharmacology								
Nutrition								
Diet therapy								
First aid								
Public Health								
Epidemiology								

Figure 1. Early integrated model

(Bevis, 1978, p. 37)

	Growth and development	Perception	Grief and loss	Oxygenation and metabolism	Fluid and electrolyte balance	Ingestion, digestion, and elimination	Pain	Motion-locomotion	Orientation and cognition
Psych-mental health									
Medical-surgical nursing									
Maternal-child health									
Community health									

Figure 2. Late integrated model

(Bevis, 1978, p. 38)

The years since the late fifties and sixties have resulted in a variety of integrated curriculum models. According to Reilly (1975), these models can be classified into three types:

> 1. systems models, such as stress/adaptation or behavioral; 2. developmental or longitudinal models, such as Erikson's states of man or the health-illness continuum; and 3. life process models such as Roger's model. (p. 569)

As nurse educators attempted to define nursing curricula in nursing terms, a conceptual framework became the accepted organizing principle. In 1972, the Council of Baccalaureate and Higher Degree Programs of the National League for Nursing (NLN), the national accrediting body for nursing education programs, voted to require that curriculum be based on a conceptual framework. Thus, the NLN criteria for accreditation of these programs state: "The curriculum implements the philosophy, purposes, and objectives of the program and is developed within a conceptual framework" (NLN, 1976, p. 13). According to the League the conceptual framework is a unique, systematic organizational construct that stems from the stated philosophy and purposes and provides direction for the curriculum (NLN, 1976).

At the present time, the meaning of a conceptual framework as applied to the curriculum process remains confusing. In some instances it serves as the organizing pattern of the curriculum (Torres & Yura, 1974; NLN, 1975;

Wu, 1979) and in the opinion of other nurse curriculum theorists, it serves to combine elements of educational philosophy and the operational design of the curriculum (Chater, 1975; Bevis, 1978).

The degree of uniformity as related to the conceptual framework among nursing programs accredited by the NLN Board of Review for the Council of Baccalaureate and Higher Degree Programs was revealed in a survey conducted by Torres and Yura (1974) in 1972-73. The major concepts identified in the conceptual frameworks of programs surveyed included: ". . . Man, Society, Health and Nursing. These concepts seemed basic to all the baccalaureate programs reviewed" (p. 4). According to these writers, the conceptual framework is the "identification, clarification and development of subconcepts and/or theoretical formulations related to the major concepts of a particular curriculum that established the uniqueness of the particular baccalaureate nursing curriculum" (p..4). Chater (1975) made an argument for the use of a conceptual framework as the beginning point in nursing curriculum development. She wrote:

> . . . the usual general statement of a philosophy--that is, beliefs and values--does little to influence the curriculum. Being a statment of beliefs and values, a philosophy consists of "shoulds" and "oughts." These cannot be evaluated. Nor can they act as guides for predicting outcomes as a conceptual framework can, nor can they explain the "whys" of a curriculum. Statements of philosophy do not describe the "what is"; they describe the "shoulds." In other words, a philosophy is not an operationally defined set of concepts and propositions whose theses can be tested or demonstrated empirically. (p. 429)

Chater (1975) viewed the philosophy as a "meaningful discussion from which to select specific concepts, theories, and propositions that make up a conceptual framework" (p. 429), but maintained that "values per se have no place within a conceptual framework if one expects curriculum to become more scientific than intuitive" (p. 429).

Although numerous changes have occurred in nursing curriculum models over the years, nursing education per se remains a source of confusion to the public and the profession itself. This state of confusion is reflected in the fact that currently there are three different and unequal types of nursing education programs all leading to the same license -- registered nurse. These program include: (1) hospital diploma programs requiring a minimal number of liberal arts courses and a total of three years to complete; (s) associate degree programs, usually located in community or technical colleges, requiring a minimal number of liberal arts courses and a total of two years to complete; and (3) baccalaureate degree programs located in a college or university requiring a sound liberal arts base and a total of four years to complete. Graduates from all three programs take the same licensing examination, usually begin practice at the same entry level and receive, in most instances, the same beginning salary. The origin of the diploma programs can be found in the original hospital programs based on the Nightingale model. The initial baccalaureate degree programs

were developed as some nursing diploma programs moved into higher education. The rapid development of Associate degree programs has occurred as a result of Mildred Montag's conception of the "technical nurse" educated to do technical nursing under the supervision of a professional nurse (baccalaureate degree nurse) thus requiring a shorter educational program. The continued operation of diploma and associate degree nursing programs contributes to the small number of nurses holding baccalaureate degrees (approximately 20% of registered nurses).

In an effort to upgrade nursing education, the American Nurses' Association adopted a resolution at its 1975 convention to establish by 1985 the baccalaureate degree as the minimum preparation for entry into professional nursing practice (McGriff, 1980). The implementation of the intent of this resolution, however, appears slim. There has been intensive resistance from practicing nurses, the American Medical Association, the American Hospital Association, and a lack of endorsement of the resolution by the National League for Nursing. In the face of the current nursing shortage (Kalish & Kalish, 1980), it would appear the American Nurses' Association, lacking control of educational accreditation and representing only 200,000 registered nurses (American Nurses' Assn., 1979) of the approximately 1.4 million (Moses & Roth, 1979) will have little impact on state associations' efforts to force implementation of the 1985

Resolution. Consequently, it is likely that nursing education will continue in a state of disarray.

In summary, nursing curriculum models have undergone numerous changes since the early institution of the Nightingale curriculum at St. Thomas' Hospital in London. In America, nursing curriculum has evolved from a beginning form much like Nightingale's model (Bullough & Bullough, 1964), to an apprenticeship model (Ashley, 1976), a medical model (Bevis, 1978), and finally to a variety of models including the medical and integrated models currently being used in the three different types of nursing education programs. In spite of the apparent variety, closer inspection of current nursing curriculum models indicates a considerable degree of commonality among the models in that they all clearly reflect the impact of the Tyler rationale.

The Tyler Rationale

In 1949, Ralph Tyler composed a small book entitled Basic Principles of Curriculum and Instruction. According to Kliebard (1975) and Macdonald and Purpel (Note 4), Tyler's syllabus for Education 360 at the University of Chicago, has become the most dominant model for thinking about schooling in our society.

Tyler (1949) introduced his book by stating that the purpose for explaining the rationale was to provide "for viewing, analyzing and interpreting the curriculum and

instructional program of an educational institution" (p. 1). He identified a framework for this purpose by posing four questions he viewed as essential for making decisions about schooling. These include:

> 1. What educational purposes should the school seek to attain?
> 2. What educational experiences can be provided that are likely to attain these purposes?
> 3. How can these educational experiences be effectively organized?
> 4. How can we determine whether these purposes are being attained? (p. 1)

In addressing the first question, Tyler identified three basic sources as providing areas to be considered for possible objectives. These sources include the learner, contemporary life, and subject specialists. Regarding learners as a source of objectives, Tyler stated that they must be studied to identify the behaviors needed to be changed by the institution. In these he included changes in thinking and feeling as well as overt behaviors. In addition, he recommended identifying needs of learners and their areas of interest as providing data for the development of objectives.

Objectives derived from contemporary life can be seen as stemming from numerous areas. Tyler introduced the notion of job analysis in the larger society in a way to identify possible objectives for schooling as well as consideration of what knowledge is needed to maintain functioning in the society. An example used to illustrate this pragmatic idea

of learning was his proposal for a math course built around common problems faced in everyday contemporary life.

Objectives derived from subject specialists were viewed as those from textbooks, instructional materials, and experts in a particular field. He recommended that consideration be given to objectives which relate to major functions the subject area can serve by virtue of itself alone, and more specifically, contributions it can make to other educational endeavors.

After surveying the three sources identified for possible objectives, Tyler recommended they be filtered through a philosophical and a psychology-of-learning screen. Tyler identified the purposes of the philosophical screen as including: (1) the selection of the most important objectives; (2) the selection of those that are consistent with the social and educational philosophy of the school (beliefs about the good life, good society, nature of man, and purposes of education etc.); and (3) the selection of those that can be obtained in a given time period. According to Tyler, the purpose of a psychology-of-learning screen is to enable a selection of objectives that can reasonably be expected to be accomplished in the learning process from those that cannot.

After the objectives identified from the three sources have been passed through philosophical and psychology-of-learning screens, Tyler next addressed how those finally

selected are to be stated. He suggested they have two aspects, behavioral and content. More specifically, he maintained they be stated in a way that addresses the type of behavior to be developed in the student and the content or area of life in which the behavior is to operate. He discussed three types of objectives: overall programs, area (math, science, etc.), and instructional related to specifics in an area. After final identification of objectives, Tyler turned to consideration of the second question, selection of learning experiences.

In the selection of learning experiences, Tyler identified two major concerns requiring consideration. These include identification of the kinds of experiences likely to produce given educational objectives and the ways to set up situations which will evoke or provide within the students the kind of learning desired. A list of guiding principles and criteria was provided by Tyler to assist the curriculum developer in managing these concerns.

After consideration of how to effectively select learning experiences, Tyler addressed the third question which deals with organization of learning experiences so that effective instruction occurs. The major points include organizing for continuity, sequence, and integration. In order to develop curriculum according to these principles, Tyler maintained there needs to be: (1) identification of the elements of the curriculum which serve as organizing threads;

(2) identification of organizing principles by which the threads can be woven together; and (3) identification of an organizational structure, for example, broad fields, area curriculum, and specific subjects.

The last question Tyler dealt with in his rationale was evaluation. He defined evaluation as a process used to determine to what extent the educational objectives are actually being met by the program of curriculum and instruction. The method he advocated centers on determining the degree to which behavioral changes as stated in program objectives have been realized. He recommended appraisal of knowledge of content and behavior as previously stated, more than a single appraisal (earlier and later points), and followup of graduates to determine permanence of learnings acquired in school. Further, he recommended that consideration of the results of the various forms of evaluation be used as a means for determining the weaknesses and strengths of program objectives so that revisions can be made.

The following schema (Figure 3) by Macdonald and Purpel (Note 4) illustrates the Tyler rationale:

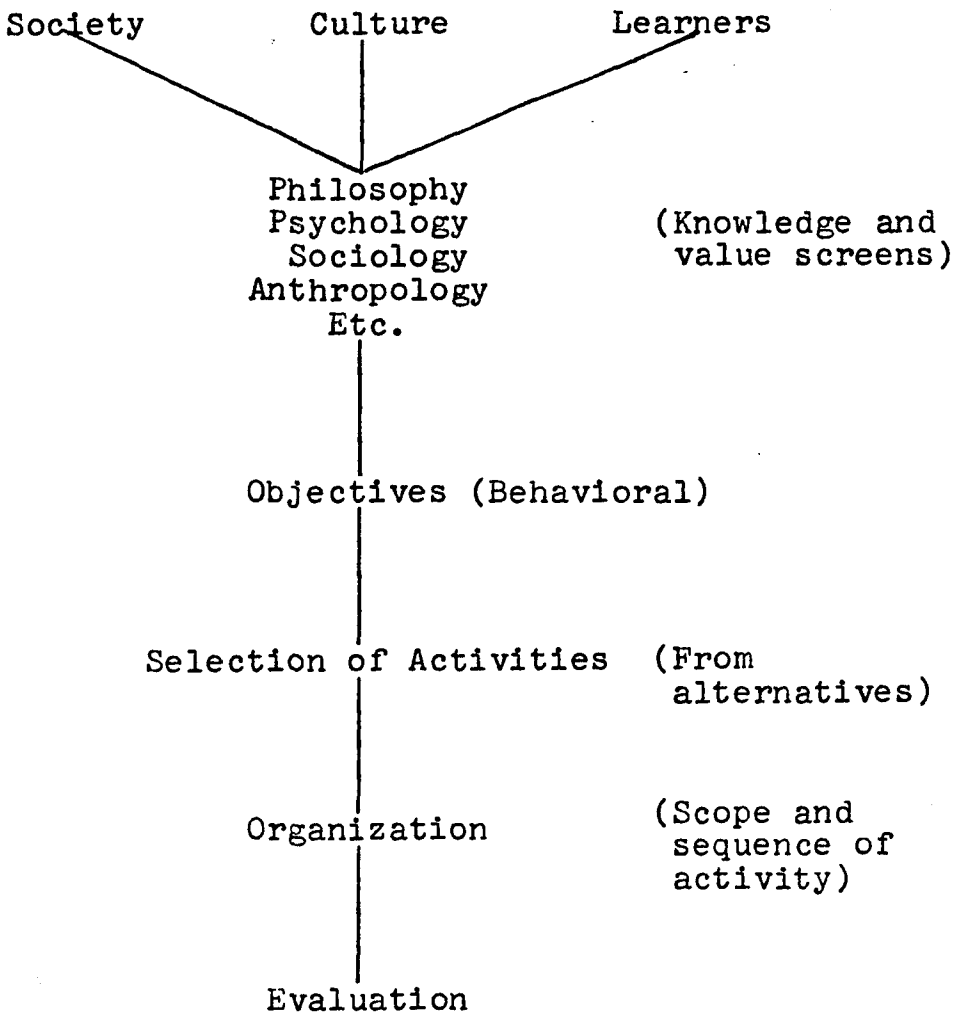


Figure 3. Tyler Rationale

According to Macdonald and Purpel (Note 4) the Tyler rationale appeared on the curriculum scene at a time when the three major referents for curriculum--subject matter, social interests, and learner needs--were well defined and held essentially in opposition. The attraction of the Tyler rationale to educators during the 1950s was described by Heubner (1980):

> The Tyler rationale served useful purposes in the late 1940s and early 1950s because of the differences

> among those educators who saw the curriculum as being devised from and serving the student, social interests, or subject matter specialists were comfortably healed by Tyler's interpretation that all three were legitimate sources of objectives. The technical focus of the rationale served to bring the curriculum person into closer alignment with the behavioral scientists and emerging technical developments in the scientific and industrial sector. The management character of the rationale, which followed in the spirit the orientation of Tyler's predecessor at Chicago, Bobbit, permitted greater centralization and necessary control over curriculum development. Evaluation became a major instrument of control. (p. 5)

The Tyler rationale had particular appeal for nursing educators during the 1950s. Due to nursing's long history of apprenticeship education, primarily focused on techniques and skills, and its identification with the medical model of education, based on skills and care of patients organized around separate body system disturbances, the Tyler rationale offered a relatively simple and logical process for organizing the highly technical and fragmented content more efficiently and effectively. Tyler's focus on education based on job analysis and the reproduction of social roles fit nicely with nursing educators' concerns for producing nurses capable of multiple roles. Similarly, the notion of accountability that Tyler offered served as an attractive feature to nurse educators since the health care industry, along with other institutions such as the school, had adopted the "factory" metaphor with its concern for quality control and cost accounting as a model for operation.

Impact of the Tyler Rationale on Nursing Education

The influence of the Tyler rationale can be traced back historically to 1953 when Ralph Tyler served as an educational consultant to the University of Washington School of Nursing's five-year Curriculum Research Project in Basic Nursing Education (Sand, 1955). This project, funded by a joint effort of the National Institute of Health and the Commonwealth Fund of the State of Washington, was headed by O. Sand and served as one of the most highly funded and extensive single curriculum projects in nursing education. The purpose of the project was to study the nursing curriculum in an effort to develop plans for restructuring which would, according to Sand (1955), prepare"the best possible professional nurse in the shortest period of time" (p. vi). The results of the study were published in three volumes (Sand, 1955; Sand & Belcher, 1958; Tschudin, Belcher, & Nedelsky, 1958).

The specific aims identified to guide the project were Tyler's four basic curriculum questions previously identified in this chapter. Reports of the project described in the three volumes resulting from the study clearly confirm that the faculty, students, and curriculum consultants followed the Tyler rationale. In a speech at one of the work conferences in 1953, Tyler argued that a production model based on efficiency was needed for nursing education:

> The problems of more efficient education stare us in the face in every field, not just in nursing. We must have more efficient education, because the job of educating people becomes increasingly more difficult in the time available unless we learn how to make our education more efficient. (p. 16)

He emphasized that nursing's curriculum study would not only be valuable for nursing but other fields of education as well.

Further evidence of Tyler's influence during the nursing curriculum project relates to his work with the committee assigned to develop a statement on learning theory. The definition of learning formulated by the nursing faculty reflects that found in Tyler's (1949) book Basic Principles of Curriculum and Instruction. For example, "learning is manifested by a change in behavior . . . a student has not really learned unless the change in behavior persists" (Sand, 1955, p. 16).

The last volume of the published work from the University of Washington School of Nursing curriculum project (Tschudin, Belcher, & Nedelsky, 1958) contains further evidence of Tyler's influence on graduate nursing education. Tyler advocated that faculty study specific problems as they arise in the field, in the actual operation of hospitals and other health agencies and in the performance of nurses as a way to identify important curriculum problems. This notion is in keeping with his original support for job analysis as a means of identifying program objectives that relate to contemporary life (Tyler, 1949).

The three volumes (Sand, 1955; Sand & Belcher, 1958; Tschudin, Belcher, & Nedelsky, 1958) published on the curriculum project were the first of their kind in nursing education. They served as a model for curriculum development and evaluation in schools of nursing throughout the country. There is no question that the publications describing the University of Washington School of Nursing curriculum project and the numerous single publications appearing in nursing journals which further described it promoted the spread of nursing education based on the Tyler rationale.

Tyler continued his involvement in nursing education and in 1957 delivered an address entitled "Changing Horizons in Nursing Education" at the inauguration of the Chancellor of the University of Pittsburgh. In this address, he advocated changes in nursing education that would: (1) support the development of a science of nursing care; (2) promote the reconstruction of nursing education to make it a true program of professional education; and (3) support the design of graduate professional schools of nursing (Sand & Belcher, 1958).

In 1966, Tyler was listed as a primary speaker at the Twentieth Conference of the Council of Member Agencies of the Department of Baccalaureate and Higher Degree Programs of the National League for Nursing. As previously stated, the NLN serves as the professional accrediting body for

schools of nursing and exerts a powerful influence on nursing curriculum. In his address Tyler advocated experimentation to produce a more effective and adequate instructional program by using his four classifications for curriculum concerns. These and related questions of nursing education included:

> Objectives: What are we trying to teach? Learning experiences: What kinds of things can students do, and how can we help them to do that which will enable them to achieve these objectives? The Organization of learning experiences: How can we organize courses so that there will be more effective interrelations among them? The proper use of evaluation: so that we may continually guide our own teaching in terms of what we learn about the effects of what we are doing. (NLN, 1966, p. 5)

Tyler argued that through experimentation using his rationale as a framework, the quality of education could be increased and people who had not been reached before, such as minority groups lacking in cultural capital, could be educated.

Tyler's influence on nursing education also extended into the 1970s. The National Commission for the Study of Nursing and Nursing Education (Lysaught, 1970) listed Tyler as one of the nine Commissioners for the study.

When the various curriculum designs developed during the last decade are reviewed (Table 1), the influence of the Tyler model on nursing curriculum theorists' thinking is clearly evident. Conley (1973), the first nurse educator to write a book on curriculum and instruction in nursing,

Table 1

Nursing Curriculum Designs 1970-1980

Author	Conley (1973)	National League for Nursing Yura & Torres, 1974	Chater (1975)	Bevis (1978	Wu (1979)
Curriculum Design Process or Model	1. Sources of curriculum decisions--philosophical considerations a. Cultural values--social & scientific forces b. Nature of nursing and nursing education c. student-psychological and learning theories. 2. Identification of terminal objectives 3. Identification of content in nursing 4. Design and structure content by use of behavioral objectives 5. Evaluation	1. Development of philosophy 2. Determination of program objectives 3. Statement of terminal behaviors 4. Definition of a theoretical or conceptual framework 5. Statement of expected level objectives 6. Statement of expected course behaviors, with specification of particular learning needed to meet the course objectives 7 Evaluation	1. Development of conceptual framework considering a. student b. setting c. subject 2. Use philosophy as a value base from which to select specific concepts, theories, and propositions for the development of the conceptual framework 3. Establish objectives 4. Design learning experiences and content using behavioral objectives flowing from conceptual framework 5. Evaluation	1. Development of a conceptual framework with consideration of: a. philosophy b. the setting c. the students d. knowledge of subject matter 2. Course vivification a. define the conceptual framework b. write terminal behavioral objectives c. establish content d. design learning experiences using sequencing according to natural grouping and level of complexity e. use behavioral objectives to establish course objectives and learning experiences 3. Evaluation--evaluate minimal competency directly related to terminal objectives	1. Establishment of goals, purposes, and educational objectives by considering a. the student characteristics b. societal needs/expectations c. institutional constraints d. subject matter filtered through one's beliefs about nursing and learning 2. Design the curriculum a. Using a conceptual framework identify major concepts that will appear and reappear at each level b. Consider: continuity, sequence, and integration c. Structure the design around terminal and level behavioral objectives d. Establish content and learning experiences based on behavioral objectives 3. Evaluation

defined the purpose of curriculum as being "to direct and control behavior of the students so that they may acquire the behavior required for the specific roles that they wish to assume as members of society" (p. 13). She described the role of faculty as determining "the pattern of curriculum events that they believe will help students acquire the necessary behaviors in the most effective and efficient manner" (p. 14). Conley further suggested that the process is prescriptive or normative" in that what is offered within the curriculum is thought to be good for the student in relation to the goals of the curriculum" p. 14).

The role of behavioral objectives in the curriculum process holds a position of prime importance in all nursing curriculum models shown in Table 1 and parallels their treatment by Tyler (1949). Conley (1973) wrote, "objectives . . . specify in operational terms the actions, feelings, and thoughts students are expected to develop as a result of the instructional process" (p. 222). Yura and Torres (1975), curriculum consultants for the NLN, supported both Tyler and Conley's notions regarding behavioral objectives. They asserted:

> It is necessary to maintain a clear focus on the nursing graduate, keeping in mind the descriptive behavioral statements that identify the end product of the baccalaureate degree program. These statements clearly delineate what the graduate will be like, what the graduate can do and with whom. (p. 19)

The extent to which nursing education has moved in the use of behavioral objectives within curriculum development is further clarified by Torres (1974). She noted,

> We in nursing have gone from few objectives to objectives for every learning experience. This concept of program evaluation avoids the necessity of having to go back to orient ourselves toward broad objectives before attempting curriculum evaluation. (p. 13)

In reviewing the curriculum process espoused by nursing curriculum theorists, Tyler's four fundamental questions are answered in a very similar fashion. All complied with the need for identification of terminal behavioral objectives. Each theorist considered the setting, the student, society's needs, and knowledge as sources for choosing objectives. The subject of learning experiences and their organization was addressed by each and all used evaluation methods based upon meeting expected outcomes as identified in the terminal behavioral objectives.

In summary, the last decade has been characterized by increased experimentation in nursing curriculum as advised by Tyler in 1966. New approaches using the concept of the integrated curriculum have resulted in the organization of content away from clearly defined specialized fields such as medicine, surgery, and obstetrics to curriculum models showing major concepts such as pain and stress threaded through specialties such as surgery

and medicine. Although much reorganization and broadening of curriculum have occurred, its development is still highly consistent with Tyler's (1949) conceptualization of schooling. However, the resulting innovations have not provided the change in nursing education needed to produce a fully functioning professional nurse practitioner as evidenced by the data previously presented in this inquiry. The following critique is offered in an effort to illuminate some of the problems associated with the continued use of the Tyler model as a basis for nursing curriculum development.

Critique of the Tyler Rationale

This critique of the Tyler rationale deals with the major assumptions underpinning the rationale, some of the results that flow from them, and specific criticisms offered by other curriculum theorists.

1. Establishment of program objectives is the most crucial and first step in the curriculum development process since all else flows from the objectives. This assumption establishes a production-oriented model with predetermined ends. Skills and knowledge to be learned are predetermined in advance of the learning experience by the teacher or some other authority. This can lead to the establishment of an authoritarian value position because of standardized technical control. In this model,

according to Kliebard (1975), the student is viewed as raw material to be processed as effectively and efficiently as possible in order to establish behaviors as stated in the objectives. This positivistic technological model for schooling, according to Macdonald, Wolfson, and Zaret (1973), disallows learning as a liberating pluralistic, participating process and instead, prepares individuals for role-oriented skills needed by the larger society. As such, the model raises moral, ethical, and political questions.

2. <u>All sources for possible objectives, studies of learners, studies of contemporary life, and subject matter specialists are equally acceptable and important to consider</u>.

Studies of learners as described by Tyler (1949) include identifying their needs. In order to do this he recommended collecting data about their status and comparing it to norms. The current practice in education of testing, labeling, and tracking in our schools is reflective of this notion. The complex question of diagnosis of gaps and alleviation of needs clearly constitutes a concern for values (Kliebard, 1975). For example, what norms are to be used as a standard--those based on the cultural capital of the white middle class? Who decides what are acceptable norms? And are not prescription and the establishment of norms moral enterprises? These are significant value questions that Tyler has failed to address.

In regard to subject matter as a source of objectives, Tyler (1949) basically viewed this element in a pragmatic fashion. According to Kliebard (1975) it is viewed as "mainly one of several means by which one fulfills individual needs such as vocational aspirations or meets social expectations" (p. 73). Knowledge takes on a utilitarian aspect and is not viewed as offering intrinsic value for human development. This pragmatic emphasis promotes learning which is valued primarily for its effectiveness and efficiency (ends/means) (Eisner, 1979).

In viewing contemporary life as a source of objectives, Tyler (1949) urged that data be collected about various life activities so that objectives for learning how to function in those activities can be identified. This notion reflects Bobbit's activity analysis. The results of activity analysis and "dividing life" into manageable categories, fragments or separates out social and personal experiences of the individual and, in addition, supports the status quo. Giroux (Note 3), Pinar (1975), and Apple (1975) have written extensively on the social and political aspects of this model. Some of the ways these writers have suggested that schools serve to prepare future workers to fit the slots of society include sorting (testing), tracking (establishment of various special educational programs such as vocational, gifted and talented), and participating in the "hidden

curriculum." Giroux and Penna (1979) defined the hidden curriculum as "the unstated norms, values and beliefs that are transmitted to students through the underlying structure of meaning in both the formal content as well as the social relationships of school and classroom life" (p. 22).

In summary, treating the three sources of objectives similarly without a value direction or consideration of their differences represents a major flaw in the rationale.

3. Statement of program objectives in behavioral terms must be consistent with the developer's philosophy and beliefs about learning.

This assumption, according to Kliebard (1975), does not in any significant sense address the question of what objectives to leave in or eliminate--only that curriculum developers must make choices and that choices are acceptable as long as they are consistent with their value systems. He wrote: "It makes all the difference in the world what one's guiding philosophy is since consistency can be as much a sin as a virtue" (p. 78). According to Macdonald (Note 5) by proposing a "value-free" curriculum model, Tyler fails to deal with the most "fundamental aspect of curriculum and instruction--the definition and selection of values translated into goals" (p. 2).

4. The learning experiences are to be selected and arranged to produce the behavior in the student as stated in the program objectives.

This assumption of the Tyler rationale places the curriculum developer in control of the students' learning experiences. In so doing, it fails to consider the students' active role in learning and reduces them to passive empty vessels to be filled, or as Freire (1970) terms them, a "depository." In this model the student becomes a thing, an object, to be programmed according to a prescribed blueprint as effectively and efficiently as possible. As an object, the personhood of the student is denied and alienation results as s/he is removed from subjective grounding centered in personal experiences (Pinar, 1975). The fragmentation of the learning experience for measurement and study as proposed by Tyler, is in opposition to the view of man's experiencing holistically. Macdonald, Wolfson, and Zaret (1973) warned that such fragmentation "may not give us insight into holistic functioning and experiencing of human beings" (p. 8). For example, they cited studying the human heart by dissection as providing limited information regarding its function in living man. The cutting off of lived reality and meaning through fragmentation of learning according to Greene (1978), sets up a "false consciousness" in the learning process. In addition, learning as described in the Tyler model, supports the behavioral approach. Kliebard (1971) described the behavioral model of learning when he quoted

Van Bertalanffy (1967) : "people are manipulated . . . as overgrown Skinner rats" (p. 95). By denying the student's right to choose, and instead manipulating him through a prescribed curriculum, the hope for development of autonomy is precluded. When autonomy is inhibited, Macdonald (Note 6) argued, the student's dignity as a person also suffers.

5. Learning experiences are organized in an effective and efficient manner with consideration to continuity, sequence, and integration.

This assumption supports the notion that the most efficient and effective means for reaching the ends (predetermined objectives) should be used. Thus consideration of any useful experience emerging outside of stated objectives is wasteful and inefficient. This model supports "smooth sailing" or lack of conflict which, according to Macdonald (Note 6) can retard the development of moral and ethical growth. In addition, Macdonald criticized the Tyler model for promoting standardization of learning and a static conception of learning. Similarly, Pinar (1975) posited that the results of education based on such a bureaucratic, positivistic model hinders critical thinking and creativity, and promotes a tendency to interject the standard imposed by society through the devaluation and denial of self. He argued

that continuation in such a controlling environment precludes psychic development or the process of individuation.

6. Evaluation is the process of determining to what extent the educational objectives are actually being realized by the programs of curriculum and instruction.

According to Kliebard (1975) this view of evaluation presents a narrow picture of the aims of education. Instead of evaluation of what effect (positive or negative) the educational experience has had in its entirety, it considers only the predetermined objectives. Both Kliebard (1975) and Eisner (1979) have argued that evaluation according to the Tyler model fails to take account of what might be the most significant dimensions of the learning activity--those that emerge unplanned and unanticipated.

In summary, the Tyler rationale conforms to the values of control, standardization, and efficiency. In addition, its structural-functional design has embedded a hidden curriculum that establishes and promotes social relationships in education characterized by dominance and subordination. According to Freire (1970), students in this type of system cannot learn from each other since they are viewed as unknowing and teachers cannot learn from students since they are viewed as all-knowing. This form of authoritarianism promotes the development of hierarchal relationships in the larger society and has been associated with

reinforcement of the class structure and certain social norms (Apple, 1975; Giroux, Note 3). The control found in the Tyler model clearly does not foster the development of an autonomous, creative, critically inquiring free human being. Instead, it represents a deterministic outlook on human behavior and contributes to the development of Marcuse's (1964) one-dimensional man, dehumanized and alienated from self.

Critique of Nursing Education

A review of the literature reveals that most of the criticism regarding current nursing curriculum models has a narrow perspective in that it centers on organization of content and learning experiences. The major themes of present criticism include: (1) the tendency to jump on the bandwagon of the integrated approach to curriculum design; (2) the use of a conceptual framework as a guide to curriculum development; and (3) the detailed structuring of curriculum using behavioral objectives. No criticism was found regarding the relationship between nursing curriculum and the Tyler model, the basic underlying paradigm for nursing education.

Several nurse writers have criticized the use of the integrated approach to curriculum design. Styles (1976) described the concept of integration as a "magic word nursing has adopted to cast out the devil of the medical models" (p. 744). She suggested that the adoption of

such an approach has resulted in the following positive outcomes:

> 1) cooperative planning, based upon a set of assumptions of framework, leading to a more coherent curriculum; 2) introduction of a process matrix to learning and problem solving; 3) emphasis on organizational strategies to make the fullest use of individual faculty expertise; 4) broader use of a wide range of educational materials; and 5) experimentation with a variety of teaching-learning strategies in the classroom and clinical areas. (p. 744)

The negative outcomes, as viewed by Styles include "ponderous courses, ponderous teams, ponderous decision-making, ponderous groupiness, ponderous uncertainties" (p. 744). Moreover, she questioned whether students engaged in an integrated curriculum experience integration of mind or develop harmonious personalities.

Levine (1979) described nursing education's efforts to change to an integrated curriculum as epidemic change for change's sake. She contended, "modern nursing educators have jumped upon the bandwagon of the integrated curriculum, and it is difficult, if not impossible, to identify specific rationale consensus for so doing" (p. 43). Although the move to the integrated model is massive, Levine questioned why there is so little published in the literature on the curricular plan and a total lack of published research. Hall (1979) confirmed the question of a lack of research on the use of a conceptual framework and integrated model through a survey conducted in the spring of 1977. The data confirm that "little

research has evolved in programs of nursing from the conceptual frameworks on which their curricula are based, and no program identified a publication stemming from research based on their identified conceptual framework" (p. 29). Levine (1979) and Styles (1976) called for nursing to rethink the integrated curriculum before it becomes relegated to the graveyard of discarded ideas of a comet nature.

The use of a conceptual framework, as the organizing principle of nursing curriculum, has created concern for some nurse educators. Levine (1979) wrote:

> Nursing was for so long a matter of discrete, unrelated things to be done for or to the patient that we welcome anything that establishes a rationale, a set of cause and effect relationships, a scientific base to our practice, so to speak, by almost overstructuring, overintellectualizing what we are doing--embedding what is still a pretty small body of nursing knowledge, sometimes relevant to only one circumscribed aspect of learning or practice into a top-heavy, elaborate structure. Thus, in these days of open-ended systems, we are creating with our models, closed systems, ones that often represent attempts to solidify information before it has even started to gel. In the process, the model becomes an end in itself, and we run the risk of losing the content in the framework designed to carry it. (p. 307)

Fuller (1978) addressed the effect of the use of a conceptual framework on the practice of nursing. She wrote:

> To mandate that a curriculum be based or organized upon a single conceptual stance is to obscure the dynamic nature of the science and ultimately of the practice of nursing. Similarly, to expect nurses in practice to function well from such a global base is probably unrealistic and may unintentionally render them incompetent. (p. 704)

Hall (1979) further described nursing's efforts to abide by the 1972 NLN mandate, requiring the use of conceptual frameworks as a basis for curriculum development, as contributing to increased disorder. She asserted "nursing is groping for a uniqueness about itself while remaining a source of confusion to itself and those it serves" (p. 27).

A review of current nursing literature reveals only three writers' critiques of the use of the behavioral stance in nursing education. Pilette (1976) pointed out the limitations of behavioral objectives as including: (1) denying the students prior learning, habits, and dispositions for learning; (2) disallowing a student's personal interest; (3) assuming that the student is a passive organism and thus conditioning an "other-directed" rather than a "self-directed" learner; (4) taking behavior out of context; and (5) lacking in spontaneity or as Dewey described "free play of the individual." This writer posited that the degree of conformity required of the behavioral stance thwarts creativity and produces growth failure rather than a dynamic ongoing process.

The skepticism of wisdom to total commitment to the behavioral model is shared by Styles (1975). She wrote,

> after years of aberrance tempered with circumspection, I now feel rather strongly that the behavioral objective will save neither the world nor the nursing profession and, when pursued with singularity, may even retard the free flowering of both. (p. 311)

Carter (1978) also questioned the commitment to the behavioral model in nursing education given the humanistic stance nursing educators and theorists espouse as the basis for practice. She argued that humanistic goals and ideas are incapable of expression in strict behavioral terms. She wrote:

> Behaviorism and humanism are not the same. Man is not both a complex, predictable machine and a self-actualizing, meaning-giving, unique individual. Words and actions usually evince the teacher's choice. "Programming," "product," and "efficiency" are thing words; "meaning," "commitment," and "caring" are people words. While the behavioristic teacher may think in terms of molding or programming the student and determining her behavior, the humanistic teacher thinks in terms of facilitating, assisting, and encouraging the student's self-actualization. While the behavioristic teacher prescribes minimum, predetermined outcomes, the humanistic teacher looks to maximum, even unanticipated growth. (p. 556)

She pointed out the inconsistency of current practice to speak of holistic care but engage in and model for students a strict behavioral approach.

Although the previous critiques address the organizing principles of integration and the use of a conceptual framework for curriculum development, the authors fail to reflect a concern for a solid foundation of moral and ethical values which could serve as a guide for curriculum development and assure moral ends. In addition, the critics inadequately address the issue of control (a major feature of the "hidden curriculum") and its resulting alienation of relationship, the keystone to nursing

practice as described by the American Nurses' Association (1980). These issues, I believe, impact on nursing's current problems of identity and professionalism.

Nursing Curriculum and Its Impact on Identity

I believe the most significant problem in current nursing curriculum models impacting on nursing's identity lies in the failure of curriculum developers to incorporate a sound moral and ethical value base as the beginning point for curriculum development. The lack of a firm moral and ethical value base is reflected in current philosophical foundations for curricula. Indeed, Weitzel (1980) noted that a review of the literature produced no identifiable philosophical base which supports current integrated nursing curricula. She suggested, "without an explicit philosophical base to provide guidance for the development of a curricular approach, systematic and consistent curriculum progress is unlikely" (p. 18).

The continued lack of a stated moral and ethical value base among the beginning points for curriculum development has resulted in nursing curricula focused on social roles--mother surrogate, physician's assistant, and institutional manager--rather than concerned with the question of what should nursing be? Macdonald, Wolfson, and Zaret (1973) argued that questions answered and decisions made in education are mostly 'should' questions and decisions rather than descriptive 'is' questions and

decisions" (p. 15). Nursing's failure to come to grips with the 'should' questions has for years created problems and continues to serve as the crux of the current identity crisis. The confusion over the direction the profession should take is evident in the argument over a more scientific-technical model or a more humanistic one (Gadow, 1980; Lysaught, 1970; Simmons, 1962). It is also reflected in the unanswered question regarding the entry level into professional practice--a baccalaureate degree representing a longer and more liberal education or the current baccalaureate degree, diploma, and associate degree with emphasis on technical education or training.

I believe the continued emphasis on "what is" or social roles continues to support the reproduction of the status quo, roles which in the past have been ascribed primarily by physicians and hospital administrators (Ashley, 1976). By responding to the role demands of these more powerful components of the health care system, nursing curricula have contributed to the move away from the patient care realm. The continued adherence to a positivistic technical model in nursing education with its failure to address the moral and ethical value questions and its focus on job analysis and activities, is in direct opposition to the scope of nursing practice set forth by the American Nurses' Association (1980) described in Chapter Two.

The lack of an established identity for nursing can also be attributed to the control exercised in current nursing curricula. Nursing faculty impose the curriculum on students using a form of "malific generosity" (Greene, 1978) as their rationale (Conley, 1973). The lack of opportunity for active involvement in curriculum decision-making on the part of the student results in a sense of powerlessness and self-devaluation and leads to passive conforming behavior. This further compounds similar negative feminine traits resulting from traditional feminine socialization and contributes to the shaping of nursing's identity by more powerful groups. Existing in the "every-dayness" of powerlessness (Greene, 1973) nurses fail to risk choosing to define self.

In summary, it is my firm belief that nursing education cannot escape the moral and ethical value dimension as a prime consideration of curriculum or the issue of control in a highly positivistic curriculum model. Rogers (1976) placed nursing's problem of autonomy on its own doorstep when she wrote, "In reality the resolution of nursing's problems begins with nurses. Confrontation with nursing's well-documented anti-education-ism, dependency, low self-worth, naiveté is a necessary condition for creative and productive change" (p. 4). I would argue that in confronting itself, nursing education must also rethink the value of the current rational

scientific-technical stance to curriculum development if it is to realize its own identity.

Nursing Curriculum's Impact on Professionalism

The control imposed by the current models of nursing curriculum and their support for learning as a positivistic rational linear process have contributed to nursing's difficulties in meeting the professional criteria described by Lysaught (1970). In terms of commitment to practice, it seems reasonable to assume this would be limited among individuals who feel alienated from self and who experience reality shock (Kramer, 1974). Nurses educated with fragmented experiences and predetermined objectives perceive a false clinical reality currently expressed in the growing gap between nursing education and the reality of clinical practice. When students experience fragmented relationships divided into cognitive, affective, and psychomotor realms as posited by Bloom and associates (Bloom, 1956; Krathwohl, Bloom, & Masia, 1964) and currently employed by nurse educators to structure behavioral objectives for clinical experience, the possibility of realistic holistic experience in the nurse-patient relationship is suspect. For example, students experiencing the nurse-patient relationship as a predetermined focus on the heart one week and the lungs the next perceive the patient not as a person but as fragmented disconnected human parts--

an object. Learning, as experienced in this environment, perhaps might be associated with the current problem of a lack of humanism in patient care reported by Carter (1978), Moody (1973), and Stanton (1978).

A recent study by Flaskerud, Hallorn, Jenken, Lund, & Getterlund (1979) confirmed a lack of humanism in nursing practice. These researchers applied various nursing theories to different health care settings and made observations of nurse-patient interactions. Upon examining their data, one major theme emerged. They concluded that nursing behaviors in all settings were characterized by distancing and avoidance of relationship with the patient. The lack of relatedness as demonstrated in this study and promoted by a rational positivistic technical model of education (Macdonald & Macdonald, 1981) is in direct conflict with the values and needs attributed to women (Gilligan, 1979) who make up the majority of participating nurses. I would argue that nursing practice that lacks in relatedness (currently modeled in nursing's stated and hidden curriculum) is unattractive to a majority of nurses and as such contributes to job dissatisfaction and low levels of career commitment.

In addition to producing a sense of alienation from self and others, and a false reality in the health care setting, current nursing curriculum legitimates the

development and continued reproduction of hierarchical relationships. Stein (1968) discussed the relationship between student and instructor (an aspect of the hidden curriculum) as restrictive and lacking in autonomy. He wrote:

> The relationship between student and instructor . . . is more like that between recruit and drill sergeant than between student and teacher. Open dialogue is inhibited by attitudes of strict black and white, with few, if any, shades of gray. Straying from the rigidly outlined path is sure to result in disciplinary action. (p. 104)

Further he associated the relationship between the nursing instructor and student as a training ground for passive behavior with physicians. He wrote: "the inevitable result of these practices is to instill in the student nurse a fear of independent action" (p. 104). Thus he argued that the fear of making a blunder when acting independently with physicians is more a reflection of the type of education they receive than the prevalence of abusive physicians. The sense of powerlessness and fear of initiating action learned in the "hidden" portion of current nursing curriculum affects commitment to practice through reduced job satisfaction, participation in professional organizations, and nursing's efforts to exercise discretionary authority and judgment.

Garant (1978) addressed the issue of conformity promoted by nursing's hidden curriculum when he wrote:

> If any profession destroys spontaneity and creativity, it is nursing. Students who ask 'why,' who develop alternative interventions, who have healthy outside

> interests are labeled as having problems with authority figures and as being 'too aggressive' (p. 158). What we need are courses in schools of nursing on the use of power, politics, and public speaking, with strong emphasis on logic and deductive reasoning. We are more in need of debating teams in schools of nursing than of glee clubs (p. 164).

Kalish and Kalish (1978) supported Grant's recommendation. They suggested:

> The benign neglect of political factors in the education of nurses fosters the omission of a critical element in understanding, planning and executing nursing services . . . . Nursing is unique insofar as applying the principles of politics is concerned, and a course in politics of nursing is desperately needed. (p. 33)

I would argue that the traditional socialization of females to be apolitical is further augmented by the hierarchical relationships experienced in current nursing curricula, especially the hidden dimension, and the lack of concern for political involvement.

Nursing's concern for the other criteria related to professionalism--a lengthy and rigorous education and a unique body of knowledge and skill--is also influenced by current curricula. The models (Table 1) can be basically described as engineering paradigms which focus on linear technical thought processes and lack concern for other realms of human experience and meaning (Phenix, 1964), including the ethical, political, and aesthetic (Huebner, 1975). Education associated with these models promotes the production of technicians as opposed to

liberally educated persons capable of critical and creative thinking.

Nursing education's effect on creativity is documented in studies by Eiseman (1970) and Thomas (1979). Both studies revealed that creativity decreased as students matriculated through the curriculum. Thomas (1979) suggested, "one might conclude that there is, at present, too much emphasis on the technical, one-right-way-to-do-it aspects of nursing" (p. 18). All three types of nursing education programs employ positivistic technical curriculum models; thus, training in nursing instead of education in nursing occurs at all levels. Perhaps this factor accounts for the current difficulty in distinguishing unique differences in the practice of the three graduates--associate degree, diploma, and baccalaureate degree.

The lack of liberally educated nurses has contributed to nursing's difficulty in developing a unique body of knowledge and skill. The need for quick minds, creativeness, and a spirit of inquiry as essential to the field of nursing research and theory development is recognized by nursing leadership (Conley, 1973; Bevis, 1978; Donley, 1978; Haskins, 1979; Gundmundsen, 1979; Rogers, 1976; Schlotfeldt, 1975; and de Tornyay, 1977). Kalish (1975) in addressing the relationships between nursing education and the creativeness needed to advance the profession posited, "Creativity won't just happen, however, without

a special effort on the part of nurse educators--especially if those educators are mainly concerned with behavioral conformity and standardized achievement" (p. 316). I believe the continued reliance of nurse educators on curriculum characterized by control and manipulation inhibits the very characteristics most needed to advance nursing's body of knowledge and skills through research, theory development, and humanistic practice.

In summary, it seems clear that in order for nursing education to accomplish its goal of producing a valued professional practitioner having equal partnership with other health professionals, an alternative model for nursing education must be found. I believe the model must be built upon a sound foundation of moral and ethical values that permeate the entire curriculum process, must value the feminine concern for relationships as well as the masculine concern for autonomy, and should provide a liberating educational experience for all involved. Chapter IV will serve to lay the theoretical foundation for an alternative curriculum model for baccalaureate nursing education.

CHAPTER IV

ELEMENTS OF A MODEL FOR NURSING EDUCATION

Nature of a Platform

Macdonald and Purpel (Note 4) argued that the development of a platform is a critical element in any curriculum planning process. According to these writers, a platform provides for the planning process "historical and transcendent metaphysical qualities as well as its moral, ethical, political and aesthetic characteristics" (p. 16). Thus it supports the vision inherent in the curriculum model and provides for evaluation of the planning process.

Walker (1978) used the term platform to delineate one of the elements in his process for curriculum development. Other elements included deliberation and design. Concerning the nature of a platform, Walker wrote:

> The curriculum developer does not begin with a blank slate. He could not begin without some notion of what is possible and desirable educationally. The system of beliefs and values that the curriculum developer brings to his task and that guides the development of the curriculum is what I call the curriculum's platform. The word "platform" is meant to suggest both a political platform and something to stand on. The platform includes an idea of what is and a vision of what ought to be, and these guide the curriculum developer in determining what he should do to realize his vision. (p. 269)

The primary components of the platform as described by Walker include conceptions, theories, and aims. He described these components as: (1) conceptions--"beliefs

about what exists and what is possible" (p. 272), (2) theories--"beliefs about what relations hold between existing entities"(p. 272), and (3) aims--beliefs about the good and the beautiful in education" (p. 272). Less explicit platform components he labeled as images and procedures, entities and courses of action desirable as a given. Walker viewed the selection of platform components to involve a process he called deliberation. Deliberation consists of a critical review of alternatives and the justification for inclusion of chosen platform components.

The final outcome of the process of curriculum development as described by Walker is the design. He defined this element as the significant theoretical output captured in a Gestalt representation, a "set of abstract relationships embodied in the designed object" (p. 272). In keeping with Walker's model, a vision of nursing is presented which informs the elements chosen for the platform of an alternative nursing curriculum model.

A Vision of Nursing

In recent years the public has become increasingly disillusioned with the ability of the current health care system to meet its expressed needs (Wertz, 1973). According to Partridge (1978) patients and their families are experiencing marked difficulties in getting needed care and, once receiving it, find it unsatisfactory. The health care consumer is openly questioning as never before the

value of the medical model for delivery of health care, rightfully claiming that care focused on disease is inadequate to meet society's needs (Ashley & LaBelle, 1976). It is obvious that a new era in health care is here and those in nursing education cannot avoid the need for change. Anderson (1968) asserted:

> The challenge to collegiate nursing is then immense. If the medical specialist becomes the model, the behavioral aspects of patient care will languish and be preempted by lesser trained nurse types, de facto. If the patient-as-a-person orientation can be the model, then, it would seem, professional nursing has a viable role to develop in its educational programs. (p. 31)

I believe the type of practice characterized by a patient-as-a-person model is exemplified in a humanistic approach. Ashley and LaBelle (1976) affirmed this as an appropriate approach when they identified nursing's goal to be the providing of human nourishment. They suggested, "Understanding and providing human nourishment in sickness and in health can be nursing's contribution to the creation of a healthier society" (p. 53). Similarly, Partridge (1978) supported the value of humanism as the goal for nursing. She wrote:

> . . . nursing is a human service. This means more than services directed toward human beings; rather, it implies that our practice is concerned <u>with</u> humans and is humanizing. Nursing should humanize both the client and the provider. Whether in teaching, practice, research, or administration, nursing should be concerned about the humanity of those involved. (p. 360)

I believe the nursing curriculum models reviewed in Chapter III are, to a large extent, inconsistent with the

espoused values and commitment to a humanistic approach to patient care as expressed by Ashley and LaBelle (1976), Partridge (1978), and the social policy statement on nursing (ANA, 1980) previously outlined in Chapter II. Furthermore, I believe the continued commitment to a positivistic technological model of education will only result in a further widening of the gap between aspirations of the nursing profession and the realities of daily nursing practice.

Christman and Kirkman (1978) challenged the ability of nurse educators, using current curriculum models, to educate nurses capable of meeting the needs of patients. They maintained that historically nursing has tended to remain inflexible and ritualistic. Furthermore, they argued:

> Very sharp breaks with traditional patterns of education must be attempted in an effort to interrupt this history of uninspired education and to enable the patient of new generations of nurses to receive innovative and scientific care. (p. 33)

Similarly, Ashley and LaBelle supported the notion of a need for alternative curriculum models. They contended:

> New ideas, exploration, innovation, and experimentation must be the focus of nursing education. Outdated approaches to education cannot produce scholarly practitioners who can create innovative patterns of health care delivery based on new and developing knowledge. (1976, p. 50)

Moreover, they maintained that limitations present in current traditional educational approaches have thwarted

the development of models of care based on an understanding of human behavior and strength. They called for nurse educators to design and implement educational programs which would free the mind for creating new knowledge. Accordingly, these writers suggested that the most important goal for nursing education be:

> . . . freeing persons to think in a manner consistent with their maturity, experiences to date, and ability to translate existing knowledge into a conceptual framework that has personal meaning. (Ashley & Labelle, 1976, p. 57)

To accomplish this goal they suggested there is a need for rebels, both students and teachers, who are unafraid to ask questions lacking in preconceived answers and non-reflective of the status quo.

In redefining the goals of nursing education, Partridge (1978) argued that in addition to "freeing the mind," as promoted by Ashley and LaBelle (1976), there must also be a valuing of androgyny. She warned that nurses must not abandon the values commonly associated with women in an effort to gain power and status as professionals. Thus, she questioned the overemphasis on the scientific, cognitive, and quantifiable in nursing education.

Partridge's (1978) concern for a balance in instrumental and expressive aspects in health care is in keeping with the ideas set forth by the Institute for the Study of Humanistic Medicine (<u>The Masculine Principle, the Feminine Principle, and Humanistic Medicine</u>, 1975):

> It is now becoming apparent that underlying all the separate movements is a unifying purpose--that of human liberation--the right of each person to be all that he is. This unifying goal has been suggested by the Rev. William Sloan Coffin in his comments on the profound questions of human potentiality raised by the woman's liberation movement: "The woman who most needs liberating in this country is the woman in every man, and the man who most needs liberating is the man in every woman." (p. 8)

For Partridge (1978) the goal of human liberation as a foundation for nursing education (Ashly & LaBelle, 1976) also incorporates the ideas of equality and a valuing of both the masculine and feminine aspects. Moreover, she argued that the notion of an existing dichotomy between care and cure, traditionally assigned in accordance with the sexual division of labor, is erroneous in present-day health care. For today, both nurses and physicians nurture and foster the healing process in the patient and in so doing promote cure.

I firmly endorse the views of Ashley and LaBelle (1976), and Partridge (1978) regarding a need for new goals in nursing education. In order for nursing to provide humanistic, holistic patient care and to humanize institutions and systems of health care, a vision of nursing directed toward maximizing humanization in all concerned is needed. Therefore, I believe the curriculum focus must be shifted from the reproduction of the status quo and be directed instead to transcend current practice through the development of competent autonomous nurses who exercise critical consciousness in nursing practice--a moral art.

According to Curtin (1979), the purpose of nursing can be found in its concern for the welfare of other human beings. This purpose rests in a moral end that involves the seeking of good and the development of authentic relationships. The knowledge that is learned and the skills developed inform the moral end--the nurse-patient interaction. Thus, Curtin (1979) asserted that nursing can be viewed as an art form, a moral art which involves the wise and human application of knowledge and skill in the promotion of what can be viewed mutually among nurse and patient as "good" health.

In describing nursing as an art form, McCarthy (1980) compared it to other performing arts. She argued that just as no performance in music, dance, or dramatics can ever be exactly the same since audiences, artists, and settings change, the essence of nursing, the nurse-patient interaction, is "different as people are different, as changeable as human beings are changeable, and as inaccessible to measurement as any whole, and wholly human act can be" (p. 723). Therefore, I believe nursing as an art, finding its expression in the medium of human relationships, should not be morally predetermined or controlled through a prescribed social role assumed by the nurse. Travelbee (1966) affirmed this view by stating: "The role of 'nurse' needs to be transcended in order to perceive and relate as human being to human being" (p. 33). The importance of

spontaneity and intuition in authentic human relationships was further emphasized by Buber:

> In spite of all similarities, every living situation has, like a newborn child, a new face that has never been before and will never come again. It demands nothing of what is past. It demands presence, responsibility, it demands you. (Cited in Lamm, 1976, p. 172)

The vision of an authentic responsible nurse not only calls for maximum development of the nurse as a unique human being but also demands competence in nursing knowledge and skill. This means that the nurse must bring to the relationship a broad understanding of the nature of man in sickness and in health. In addition,s/he must be thoroughly grounded in the nursing arts and sciences so as to intentionally influence the environment in such a way that healing will result.

The vision of the nurse as described I believe provides a firm foundation for nursing practice. It assumes that within the nurse-patient relationship, the nurse will assist the patient to:

> 1. determine the meaning of his/her state of health as it relates to the lived world; 2. make decisions regarding a course of action based upon a full awareness of the possible and probable consequences of various medical alternatives; and 3. become self-regulating by meeting his/her expressed needs through both caring and curing measures throughout the health care experience.

In summary, the vision of nursing which seems to inform the platform for an alternative nursing curriculum model assumes that the essence of nursing can be found in

the human art form--the nurse-patient relationship. The nurse brings to this relationship a unique authentic self, a broad base of knowledge and skill, and a commitment to creative, moral and ethical practice informed by a critical consciousness.

Elements in the Platform

The major framework underpinning the platform which serves to support the vision of nursing delineated and the possibility of all other elements is human liberation. The conception of human liberation has been cited by a number of educators and theorists as the primary goal of education (Freire, 1970; Rogers, 1969; Scheffler, 1976). Regarding the role of human liberation in education Macdonald and Purpel (Note 4) wrote:

> The most fundamental and highest goal of education then becomes human liberation, in both a negative and positive sense. Negatively liberation means being free from unnecessary constraints and barriers to human dignity and potential such as those that come from being poor, frightened, misguided, ignorant, and unaffirmed--in a word, controlled. Human liberation in a positive sense refers to the capacity for full consciousness, fulfillment, joy, integration, in a word freedom. (p. 20)

Freedom from control with the opportunity to become all that one can be is founded in the democratic ideal on which the society is based.

Scheffler (1976) suggested that a commitment to the democratic ideal as the organizing principle for society has far-reaching consequences when applied to education.

According to Scheffler (1976), this radical approach to curriculum would demand the rejection of

> the conception of education as an instrument of rule; it is to surrender the idea of shaping or molding the mind of the pupil. The function of education in a democracy is rather to liberate the mind, strengthen its critical power, inform it with knowledge and the capacity for critical inquiry, engage in human sympathies, and illuminate its moral and practical choices. (p. 35)

Moreover, in Scheffler's view, a curriculum based on human liberation grounded in the democratic ideal rejects the "rule of dogma and of arbitrary authority as the ultimate arbiter of social conduct" (p. 26). Instead, it supports, according to Macdonald (1978), the "rights, responsibilities, and practices--leading toward better realization of justice, equality, liberty, and fraternity" (p. 27).

Greene (Note 7) asserted a similar view when she called for educators to create new situations that make possible what Freire (1970) has called "the pursuit of fuller humanity" (p. 32). These situations she described as allowing human beings to be constantly in "pursuit of themselves, always futuring, always struggling to create themselves in the changing situations of their diverse lives" (p. 7), always in the practice of becoming more complete, more possibly human.

In creating situations where freedom becomes a possibility, Lee (1976) cited the cultural framework of a society as having major influence. She argued that not

only does the framework furnish the conditions necessary for the actualization of freedom, it can also be viewed as capable of evoking the thrust of freedom. Thus, Lee implied that removing constraints to freedom may not be enough: education for liberation may also require that those participating in the process extend encouragement and support to would-be creators of new realities.

Human liberation with its concern for integration, full consciousness, and critical inquiry, and its rejection of shaping and molding the mind, provides the supporting framework for the possible realization of all other significant platform elements. These include individuation, psychological androgyny, critical consciousness, and environmental competence.

Individuation

Individuation has been proposed by Lamm (1978) to be the most significant goal of education in a world faced by rapid change brought on by the knowledge explosion and the electronic age. He defined this conception as "a process in which the individual actualizes his unique personality and crystallizes his unique identity" (p. 128). In making an argument that individuation should serve as the goal of schooling, Lamm contrasted it with two other goals--socialization and acculturation.

In describing socialization as the goal for schooling, Lamm (1978) maintained that it embodied the assumption that

functioning in society requires a knowledge of "specific things, understanding specific things, valuing specific things, being able to do specific things, and believing specific things" (p. 125). Thus, knowledge, as identified in this framework, is valued for its utilitarian function in that it consists of skills, beliefs, and information valued by the student's society. The end to which a person uses this knowledge need not be considered narrow, however; Lamm (1978) asserted the end result remains the same--the development of a single pattern of behavior. Furthermore, he argued that this conception of the purpose of education is training, ". . . a process mainly concerned with the practicing of skills according to models of roles" (p. 126). Indeed, the student in this curriculum is expected to imitate the behaviors of the model (actions, feelings, and thoughts), and use the behaviors as social situations demand.

In regard to the notion of training versus education as a goal of curriculum, Johnson (1978) made a further distinction. He argued:

> Training implies learning for use in a predictable situation; education implies learning for use in unpredictable situations. The development of a training curriculum begins with job analysis in which the tasks to be performed and the knowledge, skills, and attitudes needed to perform them are identified. The uses of training are, in the terminology of Broudy, Smith, and Burnett (1964, pp. 46-55) replicative and applicative. The uses of education are associative and interpretive. (p. 476)

Thus Johnson's notion of training is similar to Lamm's (1978) conception of socialization in that they both viewed training as resulting in a single pattern of behavior that has a utilitarian function.

The second conception of schooling as outlined by Lamm (1978) is acculturation. He defined this conception as "the process by which the individual becomes a member of a specific society" (p. 126). Moreover, he maintained the conception is used to enforce ritual through the transmission of knowledge controlled by the disciplines and principles of morality. Furthermore, Lamm (1978) asserted that the knowledge of acculturation has no purpose beyond the nurturance of human qualities. He viewed its use as not confined to situations that are familiar but useful in unfamiliar situations as well since the principles learned are internalized.

The common denominator of these two approaches according to Lamm (1978) lies in the notion that schooling serves as a bridge between the forms of knowledge (socialization and acculturation) and the learner. The learner is viewed as lacking in something, empty, or as termed by Freire (1970) a depository. This notion supports the idea of learning as a process outside of man--carried out by manipulation of the person instead of manipulation of the knowledge according to the person's need.

The third conception of schooling described by Lamm (1978) is individuation. In this approach the student is viewed not as an object to be humanized through the schooling process but as being already inherently human. Schooling within this framework is considered a process by which the individual actualizes his unique humanity. According to Lamm (1978) individuation does not seek to reduce the differences between human beings, making them into one-dimensional beings (Marcuse, 1964) but instead celebrates diversity as a basic characteristic of humanity and human beings. He asserted as did Maslow (1959) that the energy and drive to actualize one's full human potential is present in all persons and is not imposed externally. Regarding the process of individuation, Maslow (1959) wrote:

> Man demonstrates in his own nature a pressure toward fuller and fuller Being, more and more perfect actualization of his humanness in exactly the same naturalistic, scientific sense [that] an acorn may be said to be "pressing toward" being an oak tree, or that a tiger can be observed to "push toward" being tigerish, or a horse toward being equine. Man is ultimately not molded or shaped into humanness or taught to be human. The role of the environment is ultimately to permit him or help him to actualize his own potentialities, not its potentialities. The environment does not give him potentialities and capacities; he has them in inchoate or embryonic form, just exactly as he has embryonic arms and legs. And creativeness, spontaneity, selfhood, authenticity, caring for others, being able to love, yearning for truth are embryonic potentialities belonging to his species-membership just as much as are his arms and legs and brain and eyes. (p. 130)

Individuation, as a radical conception for schooling, was favored by Lamm (1978) not only because it supports the actualization of hummanness in the person but it also supports the promise of survival and growth of the human race through creativity and change. He maintained that since it is impossible to predetermine the quality of humanity, control of its growth in one direction or another courts disaster.

Ashley and LaBelle (1976) seemed to support Lamm's disfavor of manipulation, control, and one-dimensionality in nursing education when they called for the freeing of minds to create new knowledge. Regarding the wisdom of the continuation of socialization for multiple roles as a primary goal in nursing education they wrote:

> We cannot acquire pieces of knowledge from numerous fields and simultaneously hope to become experts in our own area of knowledge. The diversity of roles assumed by nurses is an outgrowth of their usefulness rather than their expertise. The everchanging roles in which nurses have engaged have hindered them from becoming experts in any one sphere. . . . As domestic hospital-keepers, amateur doctors, psychiatrists, medical and surgical technicians, we have not in a single-minded fashion utilized our intelligence and energies in examining nursing phenomena . . . Diversity of roles and the continuing emergence of new ones bring forth new terminology but not necessarily new knowledge. (p. 54)

Regarding the conception of acculturation as the goal of curriculum, they criticized nursing educators' continued concern with transmitting subject matter from the perspective of the known instead of supporting the exploration of the unknown. They contended that nurse educators usually

confine content presentation to knowledge they view as important. In those instances when students are given learning options, the teacher, in most instances, has already confined the parameters to units of content deemed necessary to master. Lacking is the opportunity to explore, to follow intuitive hunches, to play with creative ideas, all characteristic aspects of scientific endeavor resulting in new knowledge. I firmly believe that nursing education that focuses primarily on the learning of roles, skills, and current knowledge as absolute instead of tentative is totally inadequate in view of the rapid rate of change in health care stemming from research, advancing technology, and changing views of human relationships. Furthermore, nursing education primarily based on socialization and acculturation is inconsistent with the vision of nursing as a moral art realized through person-to-person relationships.

The need for the curriculum focus to be grounded in the development of the person as a primary goal, proposed by Lamm (1978) is supported by Jung's (1963) theory of individuation as the principle process in life. Like Lamm and Maslow, Jung (1963) viewed the process as leading to holism, unity, and the realization of full human potential. He defined individuation as "the psychological process that makes a human being an 'individual'--a unique, indivisible unit or 'whole man'" (p. 3). This process of coming to know and be self, he conceived of,

as did Lamm (1978), as arising from within the individual. He wrote:

> We are in reality unable to borrow or absorb anything from outside, from the world, or from history. What is essential to us can only grow out of ourselves. When the . . . man is true to his instincts, he reacts defensively against any advice that one might give him. What he has already swallowed, he is forced to reject again as if it were a foreign body, for his blood refuses to assimilate anything from foreign soil. (p. 31)

Jung (1963) emphasized the significance of knowledge validated subjectively and created through the personal making of meaning. Phenix (1964) affirmed Jung's view when he described the unique role of personal knowledge in all the realms of meaning. He maintained:

> Every linguistic attainment, every empirical insight, every esthetic perception, every moral judgment, every integrative perspective belongs to a developing person and is colored by the quality of his relations to himself and others. Since a meaning in any realm is a meaning to a person, the value of that meaning depends on personal well-being. (p. 297)

Phenix (1964) further argued that the driving force in life was not satisfaction of biological needs but instead was a "real longing for meaning . . . the enlargement and deepening of meaning" (p. 344).

Regarding the process of individuation and the making of meaning, Jung (1963) rejected completely the elements of control and manipulation as positive motivating forces. He asserted that the individual chooses for himself/herself to undertake the process and in so doing must find his/her own way. Moreover, he maintained that the helper

could not grant the individual wisdom from without. Jung (1963) wrote:

> it is the part of wisdom not to tell man anything, or give him any advice. The best cannot be told, anyhow, and the second best does not strike home. One must be able to let things happen . . . a way is only the way when one finds it and follows it oneself. (pp. 31-32).

According to Jung (1963) the process of individuation or coming to know the self through the development of personal meaning is not an easy or painless task. Regarding the role of the helper, Jung viewed it as "somebody with them" (p. 43). The helper does not reason or argue against the facts presented but provides a certain understanding or sympathy, a sense of trust and freedom that allows a sharing of ideas, even the inappropriate. His role also involves help with interpretation--a reviewing of what has happened in the experience so that it can be assimilated and integrated into the whole of the human personality.

This sense of wholeness or self involves a centralizing process through transformation or what Jung called the production of a new center of the personality. The development of the self involves the maturation of all the psychological functions--sensation, thinking, feeling, and intuition. Furthermore, it involves a recognition and cooperation of the moral opposites found in the unconscious.

Personal knowledge as a fundamental pattern of knowing is perhaps the most essential to understanding the meaning

of health as it relates to well-being. Since nursing's medium is the interpersonal process that involves transactions, interactions, and relationships between the nurse and patient, the phrase "therapeutic use of self" has significant meaning. Mitchell (1973) has indicated that "there is growing evidence that the quality of interpersonal contacts has an influence on a person's becoming ill, coping with illness, and becoming well (p. 495). In commenting on the therapeutic use of self, McCarthy (1980) noted:

> I could not help noticing that the response of a client to similar treatments differed, depending on the nurse with whom the client worked. Or, to put it another way, when the science was held constant, nurse-client patterns of interaction varied, and so did the client's state of health. (p. 723)

In a nurse-patient relationship characterized by the therapeutic use of self, the nurse attempts to actualize an authentic person-to-person relationship. This means the nurse respects the patients' rights to create themselves in the continuous process of becoming, even in the face of refusal of treatment and possible death. Furthermore, the nurse refrains from categorizing and stereotyping patients and instead encounters each as a unique person, a unique "self." The nurse engaged in the process of becoming more his/her "self" (individuation) shows evidence, according to Lamm (1978), of increased creativity, subjectivity, and self-awareness.

According to Lamm (1976) creativity can be viewed as a state of personal well-being that fosters the development of meaning in life. The relationship of knowledge to creativity is instrumental in that knowledge serves as "raw material with which and by means of which the individual activates his creative drives" (p. 155). In this view, knowledge is not organized so as to determine individual behavior but instead it is manipulated according to the needs of the creative individual. Therefore, the inherent prescriptive structure of knowledge is rejected in favor of what Macdonald (1978) has called pattern making, "the creative and personal ordering of cultural data as the individual engaged in activity" (p. 118). Pattern making, or meaning making, has been viewed by Macdonald to include three distinctive processes. These include meditative thinking, imagining, and playing. Meditative thinking is needed to bring into awareness the presence of a lack of meaning in accepted cultural patterns by examining the foundations of these patterns. The dissonance between the old and meaningless, and the perceived need to establish new meanings serves to motivate the individual to reorder cultural substance into new patterns. This reordering or reshaping of cultural substance requires the use of the imagination. Imagination has been defined by Macdonald (1978) to be "the ability to picture in the mind what is not present to the senses" (p. 119). According to Phenix

(1964) it is a perceptual power that belongs to the active inner life of the individual located in the "conscious center of his psychic existence" (p. 345). From this conscious center, the imagination as guided by intuition (Polyani & Prosch, 1975) produces all manner of cultural substance for individual consideration in developing new realities. In the creative process, the products of imagination are then played with in constituting new forms until one emerges that expresses meaning for the pattern maker. In this way, the creative process serves to give birth to new knowledge and new forms grounded in personal meaning. A sense of well-being emerges from this process as the individual satisfies his/her creative drive.

There is a need to promote the creative process in nursing at all levels. This ranges from the simplest of patient care situations to the creating of nursing theories that could guide research and practice. Carper (1978) noted that "nursing science" is greatly lacking in "the same degree of highly integrated abstract and systematic explanations characteristic of the more mature sciences" (p. 14), although the profession has established this as an ideal. A review of the nursing literature today informs the reader that a sense of urgency is in the air, regarding the development of a body of empirical knowledge specific to nursing. The hopes of establishing this body of knowledge, I believe, are slight, unless nursing curriculum

is reordered to provide for individual creativity. Similarly, changing the current oppressive and unsatisfactory social patterns stemming from the ideological structures underpinning present-day nursing practice will not occur unless nursing education provides for and encourages the creative process.

Subjectivity, as an outgrowth of individuation, informs knowledge with meaning. An individual who possesses knowledge disconnected from the self, Lamm (1976) viewed as dehumanized, only "a vehicle carrying a load of knowledge for which he is not responsible" (p. 156). He argued that meaningful knowledge can only be validated through subjectivity. Greene (1973) expressed a similar view when she described the influence of phenomenology on existential thought. According to her, existential thinkers view knowledge as beginning with the subject, the existing person. She wrote:

> Only as a "single one" . . . can a person know who he is and discover what is fundamental in his experience. Only as a "single one" can he overcome the separation traditionally perceived between subject and object. When a gap exists between the human being as subject and the phenomena he tries to know, the subject becomes a spectator. (p. 136)

In this sense, subjectivity supports the view that knowledge can only be acquired, understood, and imbued with meaning when it is chosen by the person and incorporated into the self.

An increase in subjectivity in the nurse is particularly important in producing a sense of confidence

in decision-making. Nurses, for too long, have relied upon others to define what constitutes and determines good nursing care, what knowledge and skill is needed to deliver good care, and the role nurses should play in the health care system. Indeed nurses have carried a "load of knowledge" borrowed from numerous fields, especially medicine, instead of defining what knowledge constitutes nursing phenomena. There is an urgent need to discover and validate what is meaningful to nursing by plumbing the depths of individual subjective nursing experiences.

Increased self-awareness was also posited by Lamm (1978) to result from the process of individuation. The purpose of the interaction between knowledge and the individual in this view is to provide for greater understanding of the world and the self through the exercise of reason tempered by emotions, imagination, and instinct. Lamm viewed self-awareness as important to mental health through the lessening of the need to utilize defense mechanisms such as repression, suppression, and rationalization. Furthermore, he suggested that self-awareness results in becoming more completely oneself through the separation and crystalization of identity--the becoming of an autonomous human being. In addition, he argued that self-awareness implies the acknowledgment and acceptance of individual responsibility for choice. This means becoming aware of the alternative choices and consequences of

choosing one over another. In this way, Lamm (1976) posited "the individual accepts reality with its limitations and responsibility for his actions within that reality" (p. 158).

An increase in self-awareness holds special meaning for nursing as a profession and the nurse as a person. The identity of nursing as a separate autonomous profession from medicine is just beginning to emerge. Since its inception, its authority has been embedded in others (Christy, 1976). Thus, nursing has not chosen for itself, but has allowed others to choose for it. Consequently, it has not assumed responsibility for its own practice. This is exemplified in the limited authority nursing has to set standards of care in health settings and the lack of personal accountability illustrated in such excuses as "the doctor ordered it" when faced with unfavorable consequences of action. An awareness of nursing as separate from medicine is needed as well as personal accountability for practice if nursing hopes to establish its own unique identity as a profession.

Self-awareness is of significant importance to the individual nurse. If the nurse is to be successful in the therapeutic relationship, s/he must know the strengths and limitations of the self s/he brings to the nurse-patient relationship. For example, a nurse unaware of his/her need to dominate others will be unable to give

patients the freedom they need to become self-regulating. The nurse must be open to the experience and encounter the patient as a separate authentic caring person. It is doubtful that a nurse who channels energy into defense mechanisms used to protect the self can be very successful in the nurse-patient encounter.

In summary, the interaction between knowledge and the nurse within the context of individuation is aimed at developing creativity as a style of living and practice, subjectivity as a measure for determining the truth, and self-awareness as a means of becoming autonomous. The end result should be a nurse who demonstrates self-regulation, described by Macdonald (1978) as striving "toward unity, toward integration of inner and outer realities in a meaningful wholeness" (p. 108). Individuation and with it self-regulation become a possibility in an environment committed to human liberation.

Human liberation and the possibility of individuation according to Jung (1963) also give rise to the notion of integration of the contents of the opposite sex archetype, the anima in man and the animus in woman found in the unconscious. This theory lays the foundation for the possibility of realizing the second element in the platform--psychological androgyny.

Psychological Androgyny

According to Bem (1978) psychological androgyny is a concept that has emerged in recent years predicated on the assumption that it is possible, in principle, for an individual to be both masculine and feminine, assertive and compassionate, and instrumental and expressive (Parsons & Bales, 1955), depending upon the situational appropriateness of these various modalities. It further includes the notion that a blend of these modalities is possible. For example, an act illustrating such a blend cited by Bem (1977) is being able to discharge an employee who has failed to fulfill job requirements but with sensitivity for the human emotion that such a task unavoidably produces. Bem (1978) has argued that strict adherence to traditional sex roles serves to inhibit development in significant human ways. For example, she asserted that a review of the literature indicates that high femininity in females has been consistently related to "high anxiety, low self-esteem and low social acceptance" (p. 6). In males, high masculinity in adulthood has been correlated with "high anxiety, high neuroticism and low self-acceptance" (p. 6). In addition to these findings Maccoby (1966) has reported that cross-sex typing has been found to be consistently associated with increased intellectual development--higher spatial ability, greater creativity, and higher overall intelligence. Bem (1978) suggested that development in

the domains of both masculinity and femininity is essential to functioning in our society and that the extreme and unadulterated development of each separately by gender is dysfunctional. She noted:

> Thus, the extreme femininity, untempered by sufficient concern for one's own needs as an individual, may produce dependency and self denial, just as extreme masculinity untempered by a sufficient concern for the needs of others, may produce arrogance and exploitation. . . Thus, for fully effective and healthy human functioning, both masculinity and femininity must each be tempered by the other, and the two must be integrated into a more balanced, a more fully human, a truly androgynous personality. (p. 7)

This concern for the development of an androgynous personality is also shared by other feminist writers such as Chodrow (1974, 1978), Dinnerstein (1976), and Rossi (1976).

Bem's (1978) notion of the possibility of an androgynous personality can be grounded in the theoretical thought and work of Jung (1963). Jung posited that an essential part of the process of individuation includes the integration of the contents of the opposite sex-archetype. The archetype in man he called anima (the function of relationship), and that in woman, animus (the functions of discrimination and cognition). Regarding the need to integrate the anima and the animus, Jung maintained that to become fully human, the woman in man must be liberated as well as the man in woman.

In making his argument for the presence of the anima and animus, Jung (1963) pointed to the physical and psychological changes that occur in the sexes with aging. He wrote:

> It is easy to observe that women at a more advanced age develop masculine qualities, grow a moustache, acquire a rather acute and sometimes obstinate mind, and often develop a deeper voice. Men of advanced age, on the contrary, become mellow, "lovely" old men--soft, kind to children, sentimental, and rather emotional; their anatomical forms become rounded, they take interest in the family and home life, in genealogy, gossip, and so on. It is by no means rare for the wife to take over business responsibilities in later life, while the husband plays a merely helpful role. (p. 18)

Research findings in studies concerned with the shift of sex-role perceptions with aging lend credence to Jung's theory of the presence of the anima and animus and their integration during the process of individuation (Gutman, 1977; Lowenthal, 1977; Neugarten & Gutman, 1958).

Although these archetypes' positive influences become apparent in many during later life, Jung argued their integration is not age dependent since they exist a priori in the individual. It is through the process of individuation that their contents become positively integrated. In describing the different behavioral manifestations arising from the activity of these archetypes prior to the process of individuation Jung (1963) noted:

> Sometimes the change is quite remarkable: a man who is ordinarily altruistic, generous, amiable, and intelligent becomes, when a certain mood seizes upon him, a slightly mean, nastily egotistical, and illogically prejudiced character. A woman of a usually kind and peaceable disposition becomes an argumentative, obstinate, narrow-minded shrew if it should come into her head to use a half-understood idea heard in a conversation six weeks or months ago. (p. 19)

With the process of individuation, the contents of the anima and animus exert a more positive holistic influence on the personality as it becomes more centered in the self. Jung wrote:

> Just as the anima becomes, through integration, the Eros of consciousness, so the animus becomes a Logos, and in the same way that the anima gives relationship and relatedness to a man's consciousness, the animus gives to a woman's consciousness a capacity for reflection, deliberation, and self knowledge. (Campbell, 1971, p. 154)

Thus, through integration of the contents of these archetypes, the male personality loses its strict adherence to ascribed masculine characteristics and takes on the feminine concern for relatedness and the female personality abandons its strict commitment to relationship and develops the ability to act in an autonomous fashion.

Jung's (1963) argument for a dualistic relationship between the individual and his/her opposite sexed archetype as significant to the fully functioning human psyche in the psychoanalytic tradition, fits well with Bakan's (1966) notion of the coexistence of the masculine and feminine principles in all living organisms.

Bakan (1966) adopted the terms agency, to describe the masculine principle, and communion, to describe the feminine principle. He associated these two fundamental modalities in living forms as the existence of the organism as an individual (agency) with the existence of the organism as a participating member of a larger whole

(communion). In describing the characteristics of agency and communion he wrote:

> Agency manifests itself in self-protection, self-assertion, and self-expansion; communion manifests itself in the sense of being at one with other organisms. Agency manifests itself in the formation of separations; communion in the lack of separations. Agency manifests itself in isolation, alienation, and aloneness; communion in contact, openness, and union. Agency manifests itself in the urge to master; communion in noncontractual cooperation. Agency manifests itself in the repression of thought, feeling, and impulse; communion in the lack and removal of repression. (p. 15)

Bakan argued that if the society or individual is to survive, both agency and communion must come into a degree of balance. Moreover, he maintained that domination by a sense of agency or communion if unchecked is destructive. Therefore, Bakan argued that the developmental task of each sex is different: men must learn to mitigate agency with communion and women must learn to mitigate communion with agency. Buber affirmed Bakan's view when he described the significance of agency and communion in human relationships:

> Only when the individual knows the other in all his otherness as himself, as man, and from there breaks through to the other, has he broken through his solitude in a strict and transforming meeting. It is obvious that such an event can only take place if the person is stirred up as a person. In individuation the person, in consequence of his merely imaginary mastery of his basic situation, is attacked by the ravages of the fictitious, however much he thinks or strives to think, that he is asserting himself as a person in being. In collectivism the person surrenders himself when he renounces the directness of personal decision and responsibility. In both cases the person is incapable of breaking through to the

> other: there is genuine relation only between genuine people. (Cited in Greene, 1973, p. 69)

The significance of the dialectic between agency and communion, as proposed by Bakan (1966), can be paralleled with the anthropological work of Lee (1976), in her conception of autonomy and community as it applies to several non-Western cultures. Lee maintaintained that autonomy, far from being separate and independent of community in the Dakota Indians, depended upon the community and the individual's sense of community for its very existence. Moreover, she argued that an individual can only set out to develop autonomy (defined by her to include authenticity, active choosing, and involvement) if s/he has experienced true community. After years of studying the Dakota, a society in which she found autonomy and community in constant transaction with no "and" between them, she wrote:

> I came to the conclusion that autonomy existed only as design in the newborn individual; perhaps a right, to be recognized by community, a readiness to be afforded an opportunity. But not a capacity. The potency which will transform the pending into a capacity has to come in transaction with the enabling community. And community itself has to be felt; there has to be a sense of community. (p. 31)

Lee (1976) suggested that in order for an individual to become autonomous there must exist a dialectic among autonomy and community. There is no preference to one over the other since they both are essential to the existence of each, not only within the individual but between the individual and the society.

A similar variation of the themes posited by Bakan (1966) and Lee (1976) can be found in the work of May (1969). He chose the conceptions of will and love to express the notions agency/autonomy and communion/community. These themes mesh well with the notion of will as the masculine agency principle "reaching out to influence others, molding, forming, creating the consciousness of others" (p. 9) and the feminine communal principle, an opening up to the influence of others. May suggested that these two conjunctive processes of being are interdependent and belong together in the fully functioning human being. Regarding their existence as separate, he, along with previously mentioned writers, viewed them in a negative light. He maintained:

> . . . will without love becomes manipulation . . . Love without will in our own day becomes sentimental and experimental. (p. 5)

May asserted that "man's task is to unite love and will" (p. 283). With this accomplishment, he maintained, the way to maturity, integration, and wholeness can be found.

The thinking of Jung, Bakan, Buber, Lee, and May points to the possibility of psychological androgyny as representative of a more fully functioning human being. According to Kaplan and Sedney (1980) this conception as a model of well-being contains several premises: (1) a broad repertoire of responses; (2) flexibility in response to situational demands; and (3) effectiveness. Research

findings in studies on psychological androgyny have supported these premises in that androgynous persons were found to have higher self-esteem than traditional or reversed sex-typed individuals (Bem, 1977; Spence & Helmreich, 1978), a greater repertoire of behavioral responses (Bem, 1975; Bem, Martyna, & Watson, 1976), and the ability to engage in cross-sexed activities with comfort (Bem & Lenny, 1976). These findings appear to suggest that a strong relationship exists between perceived sex-typed attributes, behavior, and self-concept. Moreover, the conclusions drawn in the research support the arguments that many in society have made against socialization of individuals to strict sex-role stereotypes and the increasing disregard for communal values.

In summary, the possibility of psychological androgyny is a view of personality development that incorporates both masculine and feminine characteristics into a single human personality. This view provides an alternative to strict sex-role stereotyping with its associated narrow repertoire of characteristics and behaviors. Therefore, the conception as an element in the platform for an alternative nursing curriculum model is of primary significance since it provides a possible means for transcending the argument of a role confined to care or cure as dictated by the sexual division of labor. Instead, it affords the possibility of development in the nurse of attributes and behaviors

commonly associated with each sex that can be activated depending upon the situation. In addition, psychological androgyny which supports the effectiveness and well-being of all organisms as proposed in Bakan's (1966) and May's (1969) perspectives, establishes the view that care (communal values associated with love and responsibility as exemplified in the feminine principle) is as similarly important as cure (agentic values associated with will and right as exemplified in the masculine principle) in the maintenance of a healthy society. Both agentic and communal values can be seen as guides to moral decision-making in nursing practice.

Having an androgynous personality does not ensure that an individual will choose to act in a given situation; it only means s/he has the capacity to act as the situation demands. In order to act congruently with situational demands in either a nurturing or instrumental fashion, or both, a critical consciousness is needed to demand the action. Thus, critical consciousness has been selected as the third element in the platform of an alternative nursing curriculum model.

Critical Consciousness

The need for the development of a critical consciousness in nurses is important in several significant ways. First, there is the need for nurses to view as problematic the position of nursing in the current sociopolitical

economic reality of the health care system. Secondly, there is a need to confront the limitations imposed by the present-day level of nursing knowledge and skill in such a way as to move beyond the known to the creation of better and more satisfactory patterns of patient care. And lastly, in a less dramatic sense, critical consciousness is needed to modify and adapt existing procedures and practices to the unique needs of each patient in daily situations. Through the development of a critical consciousness and the commitment to praxis it demands, I believe nurses can act to transform the lived reality of everyday practice into one centered in humanistic care. I also believe interpersonal relationships between health care providers can be recreated into a form more consistent with the notion of professional collaboration.

The call for critical consciousness as a desirable goal for education can be found in the writings of a number of educators (Freire, 1970; Giroux, Note 3; Green, 1973; Macdonald, 1978; Scheffler, 1976). Scheffler (1976) used the term, the development of "reasonableness" to address this curriculum consideration. He associated the term with the student's ability to critically examine prevalent ideologies by questioning, seeking new evidence, and developing fresh alternatives. Scheffler also viewed "reasonableness" as the ability to critically examine others' ideas as well as one's own. Such a view of

education requires that educators trust and have faith in the ability of learners to seek the good and recreate for themselves new more meaningful realities. In addition, the teachers must have the ability to risk their own personal conceptions to the critical review of students.

The development of reasonableness in Scheffler's view does not equate with a lack of discipline. Instead, it requires an immersion in the tradition of the knowledge, rules, obligations, rights, and demands inherent in the discipline in order that the learner gain a broad perspective of the choice of actions that can be taken and the rules that can be changed. This notion of education therefore does not equate content with students' interests but is instead consistent with Macdonald's and Purpel's (Note 4) concern for going beyond what is "interesting" for the student to include "education that involves the most important questions of human existence" (p. 22). The need to move beyond the known to the unknown rests in the assumption that knowledge, like man, is never perfect, never finished, and is in constant need of recreating.

In advocating the need for critical consciousness, Giroux (Note 3) suggested that educators work "for modes of reflexivity that allow people to examine the taken-for-granted that shape their discourse, actions, and consciousness" (p. 19). In so doing, he proposed that reality must be seen as problematic and its inherent contradictions traced

to their "source and transformed through praxis" (p. 19). Moreover, he viewed praxis as a possibility in rejecting the notion that constraints within the system render an individual powerless, simply "bearers of imposed roles" (p. 21).

Likewise, central to Greene's (Note 7) conception of freedom as possibility is the need to develop a "wide awake consciousness" in both student and teacher alike so that emergence from the "everydayness," the taken-for-granted, the unproblematic can occur. This involves the freedom to critically question existing ideologies in society that have become a natural part of consciousness. In her view, the possibility of a fuller humanity requires an awareness that all knowledge is but a humanly constructed reality, an interpretation of experience of those in the past and present. For Greene (Note 7), to problematize with a critical consciousness is to "see the gap between what is and what might be" (p. 16). Critical reflection demands choosing to act, and acting requires that human beings "transcend what appears to determine and define and limit them. It is to require them to refuse indifference to act to close the gaps that exist: to pursue justice, to repair the insufficiencies in their lived worlds" (p. 16).

Freire (1970) and Macdonald (1978) have both addressed the critical role of consciousness in the restructuring of social realities. Freire (1970) like Greene, asserted that

the ideology that operates to oppress man "absorbs those within it and thereby acts to submerge man's consciousness" (p. 36) rendering him compliant and docile. To be released from this state, the person must emerge from it by "confronting reality critically, simultaneously objectifying and acting upon that reality" (p. 37). Macdonald (1978) shared this view when he posited "change in human social consciousness is necessary and a precondition of later political change" (p. 5). Given these views on the relationship of critical consciousness to the development of a more equitable and just society, and the creation of new knowledge, it is imperative that it become a major priority in nursing education.

In order to function effectively in the nurse-patient relationship, not only must the nurse bring to that relationship an authentic self, endowed with a critical consciousness and a concern for the moral, ethical, and metaphysical aspects of life, s/he must also be competent in his/her nursing knowledge and skill. The fourth and last element in the platform for an alternative nursing curriculum model therefore deals with needed knowledge and is addressed within the conception of environmental competence.

Environmental Competence

Newmann (1975) has defined competence as the "ability to behave in such a way, or to use one's efforts in such a

manner, as to produce the consequences that one intends" (p. 12). Behavior characterized by competence then is reflected in purposeful behavior, not activity that appears without cause, involuntary, or mindless. Given that competence reflects intentionality in behavior, Newmann (1975) identified two types of intentions and consequences requiring attention in curriculum development. These he described as intentional activities directed at making an impact on the environment beyond the self (objects, persons, events), and self-oriented intentions concerned with affecting one's being. Examples of competencies directed at impacting on the nurse's environment would include the abilities to: (1) prepare an injection (object); (2) administer cardio-pulmonary resuscitation (person); and (3) successfully advocate for a patient (event). Examples of competencies directed at affecting the nurse's person, mind, sensitivities, or body (self-oriented intentions) would be: (1) learning medical vocabulary, so as to interpret and make sense of medical histories; (2) getting in touch with one's feelings concerning death so as to understand personal reactions to these events in the clinical setting; and (3) giving up smoking or dieting so as to maintain one's health. The distinction Newmann makes between these two types of competence can be seen less as a distinction and more as an interrelationship. For clearly if one intends to influence his/her environment

intentionally, s/he must have developed the personal competencies with which to do so. I believe one must first develop the competencies related to mind, body, and sensitivities before s/he can intentionally impact upon environments with success. Therefore, I view Newmann's (1975) conception of environmental competence, defined by him as "the ability to act in accord with the intentions one has for making an impact on the environment external to oneself" (p. 16), as including self-oriented competence.

Environmental competence, as a way of thinking about needed competencies, is a particularly meaningful conception for nursing education since nursing involves practice, and practice involves activities directed at influencing the environment external to the self. As a conception fitting practice, it calls for action and reflection. Newmann argued that since activity is said to be purposeful as defined by environmental competence, "action presupposes reflection, for in order to act one must have conscious thoughts as to one's aims" (pp. 19-20). Furthermore, he posited that although the degree of reflection prior to action varies, "successful" action requires a more sophisticated or in-depth amount of reflection. Newmann made the point that reflection without action can occur, however, within the confines of the definition of environmental competence, both reflection and

action are called for in order to intentionally influence the environment.

In examining the rationale for including environmental competence as a goal in curriculum planning, Newmann (1975) cited morality and psychological development as significant. Regarding morality, he pointed out that one has limited opportunity to act as a moral agent if s/he has limited ability to exercise influence in the environment. Newmann (1975) defined a moral agent as "someone who deliberates upon what he or she ought to do in situations that involve possible conflicts between self-interest and the interests of others, or between the rights of parties in conflict" (p. 29). He suggested that a moral agent must deliberate not on what ought to be done but what the individual himself/herself should do. He noted:

> deliberating upon what ought to be done in a general sense and upon what others ought to do is important, but, unless this is supplemented by a concern for what I as an individual ought to do, I cannot properly be considered a moral agent. (p. 29)

Thus, the less one is competent in his/her own ability to affect reality, the less one has the opportunity to engage in decision-making as to what one should do.

Nursing as a moral art calls for the nurse to act as a moral agent when providing health care. Without competency to act, s/he is limited in his/her practice. An example can be found in the nurse-patient relationship in coronary care. Should the patient develop a life-threatening

cardiac arrhythmia and the nurse lack competence in interpreting the cardiac monitor, his/her opportunity for engaging in decision-making and acting as a moral agent is severely limited. Regarding the need to develop environmental competency in relation to moral considerations, Newmann (1975) noted:

> The challenge for moral education is not simply to improve the process of reasoned verification of ethical choices, but also to build competence to affect the environment so that authentic ethical choices will actually present themselves to students. (p. 32)

Just as the ability to affect the health care environment is critical to the nurse's identity as a moral agent, it is also significant in meeting the psychological need in nurses for what White (1963) has termed "feelings of efficacy." He described this psychological need in the following manner:

> The feeling of efficacy is a primative biological endowment as basic as the satisfactions that accompany feeding or sexual gratification, though not nearly as intense. We are most familiar with the feeling of efficacy at a level of behavior where we act with intentions to produce particular effects. We feel efficacious when we throw the ball over the plate, swim to the raft, or mend the broken household appliance. But the feeling does not have to be connected with the achievement of a particular intended result. With exploratory behaviors, where results cannot be anticipated, it seems a better guess to say that feelings of efficacy accompany the whole process of producing effects. The activity is satisfactory in itself, not for specific consequences. (White, 1963, p. 35)

According to Newmann (1975) as the individual grows and develops, feelings of efficacy become more directed at

mastery within the environment. This results in an increase in competence or the "actual ability to bring about specific results in one's environment and the sense that one can bring about such results consistently" (Newmann, 1975, p. 35). Newmann argued that the sense of competence derived from mastery serves as the foundation to one's self-esteem based on self-respect. The ability to act with competence in the environment, Newmann claimed, can be seen as the core of the competent self.

Environmental competence as a means of meeting the nurse's need for "activeness" is essential for the development of personal self-esteem and satisfaction in practice. Nurses lacking in knowledge and skill, and failing to achieve satisfactory results in the health care environment experience frustration, powerlessness, and a sense of failure leading to loss of self-esteem. Kramer's (1974) research findings confirm that lack of competence is a major reason new graduates drop out of nursing. To avoid the loss of nurses to active practice, nursing curriculum must provide for the development of competence.

The need for development of environmental competence can serve as a rationale for the decision-making process involved in determining learning environments that should be addressed in an alternative nursing curriculum model. In terms of specific knowledge that nurses need to effectively act as moral agents and satisfy their need for efficacy,

Phenix' (1964) work on realms of meaning offers a guide. Since nursing involves the health care of individuals in all their relationships (self, family, community, society), there is a need to develop a thorough understanding of the person as s/he exists in all realms of meaning. This would include not only the knowledge learned in formal educational settings but the everyday knowledge (Polyani & Prosch, 1975) or cultural capital one acquires through daily life in a given culture.

Phenix (1964) has identified six realms of meaning and their disciplines as a way of organizing knowledge. These include:

1. symbolics: ordinary language, mathematics, nondiscursive symbolic forms;

2. empirics: physical sciences, life sciences, psychology, social sciences;

3. esthetics: music, visual arts, arts of movement, literature;

4. synnoetics: philosophy, psychology, literature, religion, in their existential aspects;

5. ethics: the varied special areas of moral and ethical concerns; and

6. synoptics: history, religion, and philosophy.

As can be seen, and as Phenix (1964) has pointed out, these realms demonstrate overlapping of disciplines. The six realms, however, offer a guide to the consideration of

content needed to supply a broad base in the liberal arts and sciences for a nursing curriculum model. This basis supplies what Phenix has called fundamental studies or studies in the disciplines focused "on the pure forms of meaning, having regard for their distinctive forms" (p. 273).

In addition to a solid foundation in fundamental studies or studies in the disciplines, nurses must be educated in what Phenix (1964) terms derivative studies. These studies stem from practical considerations in which practitioners attempt to find "solutions to problems without regard to purity of logical type" (p. 273). According to Phenix, derivative types of studies are demonstrated in skilled crafts like medicine, engineering, and nursing which represent an integration of meanings drawn from the fundamental fields. Specific studies needed in nursing can be found in derivative studies developed around the concepts of man, health, society, and nursing. These broad concepts form a framework on which knowledge from the other realms of meaning are integrated. These derivative realms of meaning form what Carper (1978) has called the fundamental patterns of knowing in nursing: (1) empirics, the science of nursing; (2) esthetics, the art of nursing; (3) personal knowledge; and (4) ethics, the moral component. Examples of knowing in each of the patterns identified by Carper (1978) include:

(1) turning a patient every two hours prevents decubitus ulcers (the science of nursing); (2) making a bed in such a way as to allow a wet cast to dry (the art of nursing); (3) comforting a dying patient's spouse (personal knowledge); and (4) intervening in the health care system to protect a patient's rights (ethics). To Carper's realms of knowing in nursing, I would also add nursing history. For I believe, as does Ashley (1978), that the study of history "gives people their identity and their philosophical reasons for being" (p. 35). It lays the foundation for new questions that will advance the developing science and art within nursing. Therefore, the knowledge needed to develop environmental competence in nursing would include not only the fundamental realms of meaning as delineated by Phenix (1964) but also the derivative realms of meaning associated with nursing. Each of these would be essential to the vision of nursing set forth in the platform.

In summary, I believe that human liberation offers a sound supporting framework for the realization of individuation, psychological androgyny, critical consciousness and the development of environmental competence--all necessary conceptions to praxis in nursing leading to the creation of more favorable health care realities. Within this platform, the reality of nursing's secondary status in the patriarchal health care system, with its oppressive social, political, and economic constraints,

rendering the nurse as Other, can be viewed as problematic resulting from humanly constructed knowledge incorporating strict sex-role stereotyping. The platform also makes questionable the desirability and wisdom of adopting a masculine sex-role as an answer to current problems of power distribution within the health care system, given the humanistic mission of nursing espoused by the profession (ANA, 1980). Through the inclusion of psychological androgyny as an element in the platform, the issue of care versus cure is transcended in that both agency and communion are deemed necessary in the fully functioning healthy human being and the fully functioning nurse. And finally, the platform moves the goal of nursing curriculum into the realm of education as opposed to training through its commitment to the development of the person and environmental competence. The concern for education as a priority is in keeping with the essence of nursing, the authentic nurse-patient relationship which requires interpretation and association instead of application and replication.

CHAPTER V

AN ALTERNATIVE NURSING CURRICULUM MODEL, CONCLUSIONS, AND RECOMMENDATIONS FOR FUTURE STUDY

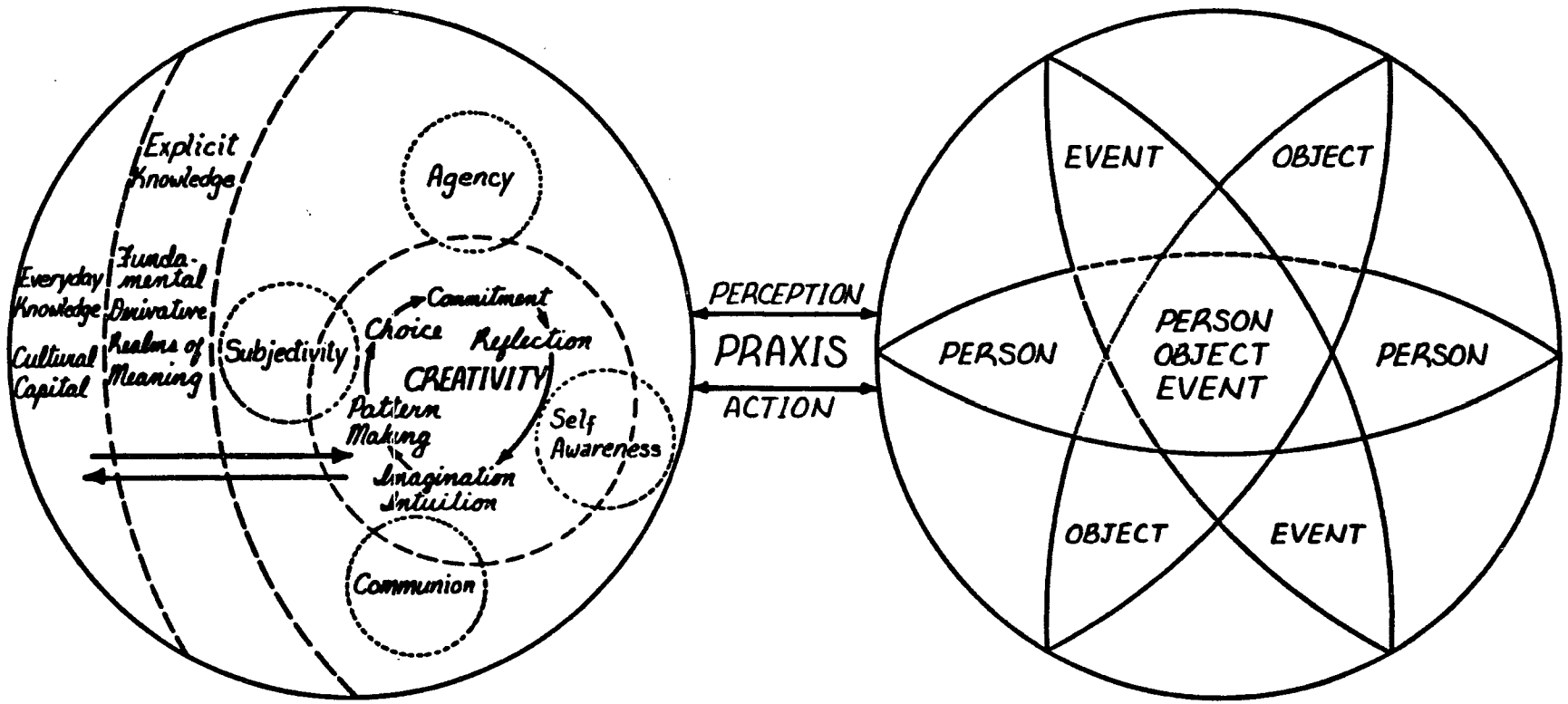
According to Hazzard (1971) a model can be defined as "a symbolic depiction in logical terms of an idealized relatively simple situation showing the structure of the original system (p. 392). The nursing curriculum model illustrated in Figure 4 (p. 174) is intended to represent development of the nurse (learner) as a creative, competent, and autonomous human being. In addition, the model could also serve as a guide to nursing practice. The following assumptions derived from the platform delineated in Chapter IV were used in developing this model:

1. the person as a human being, represents an integrated unified whole and manifests characteristics which are more than and different from the sum of his/her parts;

2. the person is characterized by the capacity to perceive, think, sense, feel, judge, and act in his/her life-world;

3. the person, though a separate unit, does not exist alone, but is a part of a larger whole, the community, the society, and the cosmos;

4. the person's action in the world demands moral consideration;



A - INTERNAL ENVIRONMENT-LEARNER

B - EXTERNAL ENVIRONMENT

FIGURE 4

COMPONENTS OF THE CURRICULUM MODEL

5. the driving force in a person's life is the longing for wholeness or unity found in the development of greater and deeper meaning;

6. the person develops meaning through interaction with the environment;

7. the person's environment consists of two dimensions, the individual being (internal environment consisting of all the elements of mind and body) and the environment beyond the self (external environment consisting of objects, persons, and events representing the present and the past);

8. the person throughout life is in a state of struggle to develop meaning through the recreating of self as situations in the environment change;

9. meaning is developed in a "from-to" fashion involving "three centers of tacit knowing: first, the subsidiary particulars [everyday knowledge and explicit knowledge]; second, the focal target [the internal and external environment]; and, third, the learner who links the first to the second" (Polyoni & Prosch, 1975, p. 38);

10. creativity is necessary in the development of meaning;

11. self-awareness results in a more accurate perception of reality and more effective action in the environment;

12. in the development of meaning, knowledge is chosen by the person and validated subjectively;

13. all knowledge is personal knowledge; and,

14. the development of personal knowledge leads to wholeness and self-regulation.

The aim of the nursing curriculum model (Figure 4) is to provide a unifying focus for approaching nursing curriculum design through the development of a greater understanding of the basic phenomena--the development of wholeness in the person through transforming action in the environment. The model is based upon a person's relationship to change which requires new patterns of knowing, and is thought of as dynamic in nature. Theoretically, the model can be viewed as similar to Gestalt theory, which suggests that each person is surrounded by a perceptual field that is in dynamic equilibrium. Field theories support the view that all parts are intimately interrelated and interdependent (Edelsen, 1970). Emphasis is placed on the entire organization of the field. In the nursing curriculum model depicted, the field consists of: (1) the environment, which is everchanging and is a composite of the internal and external; (2) the learner, the integration of all the elements depicted; and (3) the dialectical relationship between the learner and his/her environment. An understanding of the relationships represented in the total field provides insight into the functioning of the model.

Definition of Terms

A thorough understanding of terms is a prerequisite to the use of any model. The terms employed in the model and thus applied definitions follow:

1. Praxis--the action and reflection of the person upon his/her environment in order to transform it (Freire, 1970).

2. Self-regulating processes--personal processes that promote integrative and internally controlled action through self-imposed standards.

a. Self-awareness--a self-regulating process which involves a knowledge and understanding of strengths and weaknesses of the self as a separate, unique, and physical being.

b. Creativity--a self-regulating process which is manifested in the production of new outcomes in a variety of forms--ideas, events, materials, and interpersonal relationships (Lamm, 1976).

c. Subjectivity--a self-regulating process by which a person validates what is true or fundamental in his/her experience.

d. Agency--a self-regulating process manifested by an intentional thrusting forward of the self into the world.

e. Communion--a self-regulating process manifested by a concern for the moral considerations of justice,

equality, love, compassion, and responsibility in relationships with other persons.

3. Reflection--critical conscious deliberation prior to action.

4. Imagination--the ability to form mental images without the presence of a stimulus.

5. Intuition--the spontaneous knowing that occurs without the use of conscious reasoning.

6. Playing--free, spontaneous activity.

7. Pattern-making--a personal activity which requires the creative structuring of material mobilized by the imagination (Macdonald, 1978).

8. Choice--a conscious process involving decision-making and selection.

9. Commitment--a pledge to carry out a chosen action.

10. Explicit knowledge--knowledge learned through formal educative processes.

11. Everyday knowledge--knowledge about the self and the world obtained informally through living in a given culture (Polyani & Prosch, 1975).

12. Functional realms of meaning--explicit knowledge found in the realms of symbolics, empirics, esthetics, synnoetics, ethics, and synoptics (Phenix, 1964).

13. Derivative realms of meaning--explicit knowledge related to nursing.

14. Object--thing toward which action, thought, or feeling is focused.

15. Person--individual, group, or community.

16. Event--happening or occurrence.

An Explanation of the Model

In order to better understand the dynamic interaction of the elements in the model, the relationship between the components will be described. The learner is represented by a solid circle A. Within the solid circle, broken, overlapping, and connected lines are used to show that each component is open to the influence of the others through interrelated and integrative action. Knowledge, represented by two broken arcs, can be viewed as dwelling within the learner and open to the influence of the self-regulating processes of creativity, self-awareness, communion, subjectivity, and agency. These are illustrated by the five intersecting and overlapping broken circles. An internal dialectic is shown to exist between the self-regulating processes and knowledge. This dialectic, illustrated by the two arrows, indicates that knowledge used by the learner is filtered through the self-regulating processes. Therefore, none of our knowledge can be said to be objective and since new knowledge is also exposed to the integrative action of the self-regulating processes, all knowledge can be said to be personal knowledge.

The process of coming to know may be described in the following manner. The learner, solid circle A, encounters and focuses on the environment which can be either his/her internal environment (him/herself) or the external environment represented by the solid circle B. The focus requiring a new pattern of knowing in the internal environment may arise from the mind, sensitivities, or body (Newmann, 1975). The focus requiring new pattern-making in the external environment may arise from one or be a combination of the elements (object, person, and event) depicted by the intersecting parabolas shown within the solid circle B (Newmann, 1975).

Upon encountering the environment (A or B), the learner perceives a focus through a "from-to" awareness which requires action. This awareness, according to Polyani and Prosch (1975), results from a knowledge of the "functional relation of the subsidiaries [items or particulars] to the focal target" (p. 34). For example, the meaning of this sentence can only be derived from a knowledge of the meaning of each of the words (subsidiaries) as they bear on the focus--the entire meaning of the sentence. If critical reflection upon the focus does not prove meaningful to the learner or if the perceived focus necessitates a new pattern of action, an extension of an intention or a state of inquiry occurs. For example, should a learner

encounter in a clinical situation an order for skin traction to be applied to a patient with a newly amputated limb, a new pattern of action, different from the routine one involving an entire limb, would be required. The learner's need to discover a new pattern of knowing would activate the creative process and bring about a dynamic interaction between the focus in the environment B (the patient with the amputated limb), the self-regulating processes of the learner A (creativity, self-awareness, communion, agency, and subjectivity), and his/her stored knowledge.

According to Polyani and Prosch (1975), two functions of the mind are teamed together from the beginning to the end of inquiry. There are the active powers of imagination and intuition. Intuition "senses the presence of hidden resources for solving a problem and that launches the imagination in its pursuit" (Polyani & Porsch, 1975, p. 60). The imagination mobilizes material from the stored knowledge. The learner plays with the material guided by the intuition and other self-regulating processes until eventually one pattern is validated subjectively.

In the example cited, the learner would use his/her imagination and intuition to uncover and restructure knowledge regarding bandaging, skin care, traction, physical comfort, circulation, etc. until a pattern for action was discovered. This pattern, however, must to achieve final

form, be integrated with all the self-regulating processes if praxis is to be achieved. Therefore a new pattern for applying the traction may become known to the learner through the interaction of creativity and knowledge; however, this pattern may not be the final course of action chosen. For example, the learner could decide (subjectivity) to refrain from applying the traction (agency) due to an awareness of insufficient experience (self-awareness) and a concern for the pain that would result from inexperienced manipulation at this period in the patient's care (communion). Praxis in this case would be based on a pattern of knowing that is meaningful and true within the personal experience of the learner.

Application of the Model in Curriculum Design

The nursing curriculum model developed in this inquiry can serve as a guiding framework to multiple and diverse curriculum designs. In applying the model to curriculum development, a helpful guide to consider is what Eisner (1979) has posited to be the three curricula all schools teach. These curricula include: (1) the explicit curriculum, the formal content selected to be intentionally taught; (2) the implicit curriculum, the salient and pervasive features of schooling which are taught and learned largely unintentionally through participation in the school culture; and (3) the null curriculum, the knowledge and skill the school fails to teach. In

developing curriculum designs, I believe all three curricula must be considered since the outcomes of educational programs "emanate from values that are explicit and operational as well as those that are tacit and covert" (Eisner, 1979, p. 92). To illustrate how the values in the model can be integrated into a nursing education program using Eisner's framework, the value of communion will be discussed as an example.

Communion as a conception is included in the explicit curriculum of baccalaureate nursing programs throughout the program of study. Students are taught the value and use of supportive relationships in healing, including interactions with other health professionals, families, community agency personnel, and the larger society in such federal programs as Medicare and Medicaid. A study of patients' rights is also included in the explicit curriculum.

The relationship of community to the patient, in which values of equality, compassion, love, and relatedness are viewed as essential to good health, however, is often a capricious consideration in the implicit curriculum. Within this curriculum, schools of nursing are most often characterized by separation instead of communion. Relationships between faculty are lacking in collegiality (Beyer, 1981) and the significance of mentorhood in nursing has only recently received attention (Hamilton, 1981).

Relationships between faculty and students are characterized by a hierarchy; faculty are considered the authorities and students, the subordinates. Most communication flows from the top down with students offered little chance to give input. Consequently, policy within the school setting is usually determined by administration and faculty, affording little opportunity for students to assert themselves through the sharing of governance. In instances when close, supportive relationships, characterized by equality and mutual sharing (more in keeping with a collaborative model) develop between faculty and students, they are often viewed negatively within the internal culture.

In addition to the lack of communion among individual faculty, and students and faculty, relationships among students are often similarly characterized. This can be related to the constant competition for grades and the lack of learning opportunities which support cooperation and open dialogue. Lecture and assigned readings, considered to be most efficient methods of content delivery, are usually favored over other teaching methods such as seminar, group work, and projects. These methods, which would foster communion among students, are considered by many nurse educators to be less desirable since they are less controllable, more time consuming, and more difficult to evaluate.

Regarding communion and the null curriculum, rigorous, scholarly examination of the ethical dimension is not consistently included in baccalaureate degree curriculum. Aroskar's (1977) survey of 86 baccalaureate schools of nursing revealed only six programs requiring a course in ethics as a part of the liberal arts requirements. Additionally, Munhall (1980) has argued that the opportunity for moral development through cognitive conflict and disequilibrium is largely absent from nursing curriculum. As causation, she cited its emphasis on control and compliance stemming from the authoritarian aspects of nursing education (Group & Roberts, 1974; Kelly, 1976).

Communion, as a value to be developed in nursing curriculum designs, must be given consideration when planning both the explicit and implicit curriculum if this model is employed. In the explicit curriculum, the ethical dimension should be considered when determining course requirements in the liberal arts. In the nursing major, in addition to content and experiences that address community in nursing, consideration should be given to explicit content and learning experiences related to values classification, professional ethics, and moral development. In structuring learning environments, opportunities for students to experience cognitive conflict and disequilibrium should be included.

In the implicit curriculum, a greater emphasis and commitment to the development of communion among all persons

at all levels in the school environment should be considered. This commitment would extend beyond present student support groups, counseling and advisement, and student associations. An implicit curriculum firmly committed to communion, I believe, would be characterized by relationships permeated with the following attributes: social interrelatedness and integration of human functions such as attachment (love, bonding); adaptation (work, coping); renewal (play, relaxation); planning (deciding, conflict resolution); celebration; and commonality of myth and meaning (Oliver, 1976).

In summary, when applying this nursing curriculum model to curriculum design, it is suggested that nurse educators consider how each value is addressed in each of Eisner's curricula. Planning at both the explicit and implicit levels is essential if the vision of nursing previously described is to be realized.

Conclusions

The model developed in this inquiry calls for numerous changes in attitudes, beliefs, values, and the structuring of relationships in nursing education. Many of these changes are implied in the analysis conducted in the first three chapters and the discussion of the platform in Chapter IV. Other changes have been made explicit in the previous discussion of the model and its application. Since

the model has not been tested, it is impossible to know all of the changes that would be necessary for its implementation. The following changes inherent in the model, however, seem of such import that I wish to conclude this dissertation by stating them explicitly.

1. The emphasis of nursing education must shift from role socialization and adherence to learned principles to the development of the whole personality.

2. The goal of a predetermined "product" as an outcome of nursing curriculum must be replaced with an emphasis on the process of continuous self-realization through inner-directed inquiry.

3. Emphasis must be placed on freedom, flexibility, openness, originality, and diversity in an effort to combat the social pressure for rigid adherence to trained responses, models, and stereotypes.

4. The emphasis in nursing education on teacher intentionality as the major consideration in the learning process must be shifted to include student intentionality since in the model presented, the learner is considered in control of and responsible for the personal development of meaning.

5. If a model of collaboration is to be realized as a model for nursing practice in the health care setting, the same model must also be utilized in the development of relationships within the learning environment. This

change is advocated based on the belief that nurses will practice what they have lived as students.

How can nursing educators make these changes? I believe they can only be realized through a radical change in consciousness. Nurses and nurse educators alike must critically inquire into the relationship between current problems and socialization at all levels. New insights gained as a result of the inquiry, it is hoped, will support the liberal focus underlying the model delineated in this work and the changes suggested. Brown (1972) has written, "nurses, like almost all other groups of women, are in need of 'consciousness raising' by whatever means possible" (p. 3). The analysis offered in this dissertation, though modest in perspective and certainly lacking in completeness, possibly may serve as a beginning point for Brown's recommendation. In addition it is hoped that it will lead to a clear vision of nursing's unique identity and the growth of professionalism.

Suggestions for Further Inquiry

Some sage advice given at the beginning of this inquiry was that a dissertation is never finished, that it can only be abandoned. In the spirit of this understanding, I recognize the incompleteness of this work, both the analysis in the first three chapters and the model developed in chapters IV and V. It is hoped however, that others will consider the concerns addressed and the ideas

presented of significant import to warrant further study. The following suggestions are offered as possible directions that further study might take: that

1. Nursing curriculum designs be developed using the model as a guiding framework.

2. Curriculum designs based on the model be implemented in schools of nursing in an effort to validate its effectiveness in realizing the vision of nursing delineated herein.

3. The model be applied to nursing practice and evaluated in terms of its effectiveness in improved patient care and satisfaction.

4. Further inquiry utilizing supplementary and complementary research methodologies be conducted in an effort to refine the model presented.

Reflections

The time I have spent in the writing of this dissertation has been characterized by tremendous personal and intellectual growth. It has been a very special time like no other ever before experienced and never to be experienced again.

From the beginning it was a time out from the normal routines in my life of work and family; a time set aside and designated for the nurturing and filling out of an embryonic idea conceived in the spring of 1980; an idea that grew out of a union of personal concerns grounded in a continuing search for identity as a woman, nurse, and a nurse educator interacting within the larger world of the health care system and society.

The early time was marked by ambivalence. I became acutely aware of the reality bound up in my commitment to the dissertation process. It was a period of great expectancy as I contemplated the journey, yet a time of self-doubt as I searched deeply within my being for strength and resources that would make possible the birth of my idea.

Gradually my self-doubt gave way to feelings of joy and wonder as I filled up and grew out with insights discovered in long, quiet peaceful hours alone in dialogue

with such scholars as Buber, Jung, Freud, Marx, Engels, Greene, and Macdonald. My intellectual growth took on the rhythm of starts and stops, spurts and plateaus. I experienced the merging and separating and merging again of the dissertation parts as it grew and took shape into a more unified whole.

And again came the self-doubt, fear, frustration, and humility arising from my struggle with conceptual cloudiness, writer's block, and an awareness of having turned into a dimly lit corridor as a result of not knowing. I had to learn anew patience, trust in my ability to find the way, and the particular way my projections color reality.

Near the end there were times of being tired, forcing myself to write when words wouldn't come, feeling my cup was totally dry, wanting it to be over, looking ahead to a new challenge, and knowing the leaving of this time was near.

And finally my chairman said, "I don't want to see this any more." That was a time of affirmation arising from the realization of achievement. And then, for me the final reality crept in; the pages you see before you are not what this dissertation is all about. It is instead all about the times, the many meaningful times I experienced in its creation.

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