Pitts, Hilda Pickney

THE SOCIALIZATION OF BEGINNING NURSES IN THE HOSPITAL SETTING: AN INTERPRETIVE INQUIRY

The University of North Carolina at Greensboro ED.D. 1982

THE SOCIALIZATION OF BEGINNING NURSES IN THE HOSPITAL SETTING: AN INTERPRETIVE INQUIRY

by

Hilda Pickney Pitts

A Dissertation Submitted to
the Faculty of the Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

Greensboro
1982

Approved by

David E Purpel

Dissertation Adviser

APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of the Graduate School at the University of North Carolina at Greensboro.

Dissertation Adviser David E. Pugel

Margaret V. Harvell

March 29, 1982
Date of Acceptance by Committee

March 29, 1982
Date of Final Oral Examination

PITTS, HILDA PICKNEY. The Socialization of Beginning Nurses in the Hospital Setting: An Interpretive Inquiry. (1982) Directed by: Dr. David Purpel. Pp. 173.

The purpose of this study was to inquire into the socialization process in which the individual nurse mediates this experience in the first years of employment in the hospital setting. Six registered nurses who had begun the socialization process within the past three years were interviewed in order to examine their interpretation of this process.

This study was guided by the phenomenological method of dialectical hermeneutics. Underlying the methodology is the concept of intersubjectivity which connects social interaction with the shaping of consciousness from which a consistent reality is experienced by the individual. Attention during the course of the study was centered on variance between quantitative and qualitative research and the contributions made to the acquisition of knowledge by these forms of research. Support was presented for broader use of quantitative forms of methodology to provide better understanding of social phenomena by a repositioning within the context of society's values and belief systems.

Focus for the study consisted of four issues identified in nursing literature as significant areas of concern to the profession of nursing. The issues of gender, agency, community, and bureaucracy were found to resonate with the

four themes of socialization emerging from the interviews and identified as sources of commonality by the individual nurses.

The study suggests that belief systems within the hospital, combined with the isolation and fragmentation imposed by the bureaucratic organization of the hospital, contributes to the powerlessness of nurses who are employed within the system. Another insight indicates that female bonding is expressed in different terms than male relationships. These differences are expressions of socialization patterns and suggest one possible source of the nurses' inability to draw on collective strength in their working relationships. The study is concluded with a discussion of the responsibilities encountered in conducting interpretative inquiry aimed at discovering the relationships between truth, goodness, and beauty.

ACKNOWLEDGMENTS

It has been my privilege and pleasure during the course of my doctoral program to have engaged with Dr. David Purpel in a dialogic process from which this study has emerged. It is my feeling that I have come away from this experience with a sense of enrichment, liberation, and greater insight into the meaning of the word "teacher."

I am indebted to the members of my committee who have given freely of their time and wisdom on my behalf. Dr. Svi Shapiro has contributed significantly to my understanding of qualitative research and issues of the hidden curriculum, while adding to the learning process with his own style of gentle humor. Dr. Virginia Hargett has demonstrated the excellent collaborative effort of which the nursing profession is capable by identifying resources and providing me with the opportunity to test and clarify ideas. And Dr. Dwight Clark, as the first faculty member to make me feel welcome as a graduate student at UNC-G, has continued to indicate a genuine willingness to furnish assistance throughout my course of study.

I would also like to express my appreciation to Dr. Robert O'Kane for the intellectual stimulation derived from his classes and for his sensitivity in understanding that the setting for learning can be extended to acknowledge the beauty around us.

Mrs. Elizabeth Hunt has provided me with valuable assistance in the preparation of this manuscript, and her expertise and wealth of information have been most helpful to me.

Very special assistance has been given to me through the support and advice of my husband, who is a scholar in his own right. He has provided me not only with editorial advice and assistance, but also with the intangible but necessary support that comes from deep personal interest and caring.

Pearl Buck in advice written to her own daughters once wrote:

> The hope for mankind lies in the rebellion of the young against the individual selfishness, the nationalism, the inequalities of the present. Upon the profound discontent of the young in every country do I set my faith. I beg you, the young, to be discontented. I pray that you may rebel against what is wrong, not with feeble negative complaining but with strong positive assertion of what is right for all humanity.

I would like to acknowledge the influence of my own daughters' presence and love in my existence and on this study with the hope that they, too, will be discontented and rebel against those things that are wrong and will act with positive assertions for what is right for humanity.

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION AND REVIEW OF LITERATURE

Introduction

This dissertation is an inquiry into the process by which the beginning nurse is socialized into the hospital setting. Olmstead and Paget (1969) describe the process of adult socialization as one in which the individual is confronted with situations that produce conflict between what has previously been learned and emergent needs and expectations of a new situation. Out of the mediation of this process is shaped a view of reality that has an impact on the sense of self and sense of the occupational role.

The need to understand the process of the socialization of beginning nurses is evident in the concern expressed by the nursing profession over the inability of nurses to exert influence in health care. Nurses often fail to take an active role as patient advocates and are rarely participants in political decisions which affect the direction or delivery of health care (Brown, 1971). Lysaught extends this critique by concluding that the reason that nurses tend to accept the status quo and decisions made for them by groups outside the profession is due to the way they are socialized:

> Nursing service organizations, schools of nursing, A.N.A., N.L.N., A.A.C.N., and almost any other nursing 'groups' abound with acceptance of the status quo--and little protest from those who are led. The role induction process by which students are socialized into the role of the nurse does not seem to include the internalizing of risk-taking as a desirable quality. (1971, p. 76)

The present status of nursing and the continued reproduction of powerlessness in nurses justifies a study which attempts to deal with this crisis in nursing in view of the fact that a disproportionate number of nurses are indicating their unwillingness to participate in a profession that is powerless and alienated. Kramer describes the growing frustration among nurses and states that as a result of the inability to deal with conflict and "reality shock" encountered in the medical system, fewer than a third of all graduate nurses are practicing nursing (1974, pp. 27-32).

My own interest in nursing socialization evolves from experiences as a nurse and as a teacher of nurses and from a sense of dissatisfaction with my own and other nurses' status within the area of health care and society. The sense of powerlessness and inadequacy that permeates the nursing profession affects me as a nurse, as a woman, and as a member of society. Katz alarmingly describes this status as one in which the nurse exchanges the right to social justice and social esteem for the privilege of caring for patients.

> The nurse is expected to react with moral passivity to her knowledge of happenings in the hospital. . . .

> It is as though the nurse receives the right to engage in her traditional tasks as a bonus for accepting second-class citizenship in the dominant medical system. (1969, pp. 59-70)

The lack of self-confidence in nurses, and the inability to deal with the environment, according to Kramer, is actually a lack of interpersonal competency.

> The neophyte nurse is socialized into a set of values that are different from those operative in the work situation. . . . When individuals are placed into a social system that is governed by a different set of values, they are no longer able to predict accurately their interpersonal impact on others or others' impact upon themselves. They therefore are or become interpersonally incompetent. (1974, pp. 29-30)

It is my belief that the examination of socialization of nurses will shed light on the process by which the present crisis in nursing has evolved. I base this belief on my own experience of socialization which influences the ways that I interpret and respond to the situations of nursing. The definitions communicated to me in the process of socialization continue to intervene in my existence in a variety of ways, of which it appears, I am only partially aware. These experiences influence not only my past and present as a nurse, but are also carried forward and participate in the future of my nursing career and in the interpretations of nursing which I provide to other beginning nurses. It is due to my own experiences and beliefs that I feel it is necessary to examine the processes by which other beginning nurses are socialized.

Nurses who leave the formalized educational setting of the nursing school to enter the hospital in a new

occupational role encounters socializing forces from which they must shape a perception of the "reality" of nursing. Information and skills must be acquired in order to function effectively. More important, there must be a restructuring of values, attitudes, and beliefs, taking into consideration the understandings and feelings that are found to be operating within the world of the hospital. Of significance is the degree to which the nurse emerges from the socialization experience free to explore and invest in action that is self-directed. It is the process involved in the restructuring of perceptions in the course of socialization which this study is intended to examine.

The obstacles and hindrances which interfere with the nurse's ability to determine a course of self-reliant action can be best discovered, I believe, through an examination of the ways in which shaping of consciousness occurs in the process of socialization. To understand this process it is necessary to delve into the subjective experiences of the beginning nurse and the problematic events which are encountered during socialization. Clues to the ways that the nurse comes to view and to interpret the nurse's role in the hospital may depend on the significance attached to the communications and definitions that are given within the context of the setting.

An example of the significance of definitions in the socialization experience exists in the demarcation of time

that is provided by the hospital organization. The marking of time by the scheduling of hospital routines and procedures influences the subjective meaning of time and the way that it is used. Control of time shifts from individual determination to organizational needs. Other features of the hospital organization, such as the division of tasks by various categories of personnel and the spatial arrangement of people and equipment, assume dimensions beyond the arbitrary distribution of a constructed system. Eventually the hospital is consciously recognized as a "real world" which exists by itself as a powerful force in its own way.

The nurse's perception of reality, however, and the development of consciousness in the socialization process is not a passive process with the nurse being acted upon. There is an intentionality in what one selects to become aware of in the environment. External stimuli cannot arbitrarily require attention from the consciousness and thus control it. S. L. Frank provides some understanding of this concept by stating:

> If we were completely plunged into a ground which surrounded us and interpenetrated us, we should be buried and dissolved in it, losing our individual being. The analogy of atmosphere is more appropriate . . . an element through which we maintain our individual existence and the freedom of independent life. . . . For to have a reality of one's own means precisely to participate--more or less--in reality as such. (1966, p. 49)

The concept of intentionality allows an understanding that the nurse does not bring a blank slate to the hospital

setting. There is within each would-be nurse a perception of reality that has been negotiated and interpreted through exchanges within the individual's social and cultural background. Much of what is perceived as real has been socially constructed through a personal filtration of the communication of significant others' taken-for-granted concept of reality. Schutz (1967) explained that tacit beliefs and the stock of knowledge at hand are transmitted through the assumptions and procedures of social interactions. The unquestioned assumptions and seemingly innocuous customs of everyday life, through socialization, produce ways of perceiving one's own and others' roles in future interactions.

When conflict occurs between the individual's ways of thinking, acting, and believing, and newly encountered concepts of reality which evolved outside the area of personal experience, then the individual must reorder perception. But tension is produced when personal perceptions are found to be inharmonious with those which are predominantly expressed in the socializing context and there is an impending threat to the person's own existential being. The struggle that emerges is dialectical in the sense that the core of values which are brought to the socialization process must be realigned within the complexities and limitations of the newly encountered reality.

Values which are found to dominate a setting reflect the actual goals and purposes which underlie the particular

context. Garfinkel (1964) alludes to this when he states that the meaning of expressions are not understood without knowing or assuming something about the background and the purposes from which the expression originates as well as the circumstances and relationships surrounding the expression. More important, however, is the intrusion of social and cultural values which reflect the dominant interests and goals within the culture. Giroux (1981) and Spring (1972) indicate that these values go unquestioned since they most often take the form of tacit perceptions of reality expressed in everyday life, and Natanson (1962) recommends that looking at social phenomena requires taking into account the meaning of social activities since people exist in a reality based on the subjective interpretation of these meanings.

When communications of tacit beliefs enter into the consciousness of the individual, according to Bowers (1974), they are then internalized and become divorced from their origination in human thought and action. A perception evolves of an objective form of reality from which the individual views and interprets the world. While the objective form of reality is significant in the sense that it provides external glimpses of ways in which the individual responds to the world, it is my belief that the world is subjectively experienced and must be subjectively interpreted in order to gain access to the regions of activity which determine what reality becomes. Bowers describes this activity as one

between subject and object as aspects of the environment are incorporated into the consciousness:

> The person's experiencing of the world and himself in the world. . . . The sense of touch, awareness of form and color, the seeing of relationships, the recalling of past experiences, the making of choices, and the feeling of rightness or ambivalence that accompany decision-making are an equally fundamental part of his taken-for granted sense of reality. (1974, p. 16)

The incorporation of the world-as-given into the nurse's consciousness holds implications for the "possible" and the "perhaps" of the nurse as person and as a member of the community of nursing since it is through this personal filter of reality that future goals and directions are formed.

Review of Literature

A review of the literature on the socialization process of beginning nurses points to the concern for this process as a possible source of the present crisis in nursing. This concern is reflected in studies such as one by Delamont (1976), who investigated the relationship between power and definition of the situation. According to Delamont, individuals who retain power are better able to impose their definitive model of the situation throughout the socialization process. Thus members of a dominant-bureaucratic medical system impose the definition of the situation on nurses who are relatively powerless in the situation.

Simpson (1967), in researching the socialization of nursing students, found that students moved away from a broad socially derived definition of the professional nursing

situation to one more consistent with that of their nursing instructors, who retained power through the mechanism of grading. Simpson suggests that as contact between colleagues and insulation from "outside pressures" increase, values of the profession became more internalized (p. 53).

The dependency of nursing students on instructors, while contributing to increasing internalization of professional values, may be interpreted by the student as demonstrating a need for passivity rather than autonomy. Dewar (1978) alludes to the tendency of the "good client" to assume a dependent role and to submit to control by the helper. Student nurses are often praised for their cooperative dispositions and willingness to follow prescribed objectives during their educational process. Traits carried into the occupational setting seem to be consistent with the passivity which Freire (1970) characterizes as contrary to critical awareness.

In a five-year study of professional socialization among collegiate nursing students, Fred Davis (1968) found six stages of doctrinal conversion in the socialization process of student nurses. One state is described as the "psyching-out state" where students attempt to discover what instructors want of them and "how best to go about satisfying such expectations" (p. 244). Davis indicated that some degree of moral discomfort and ego alienation occur with acts of inauthenticity. Inauthenticity may also

transcend the barrier of school to hospital where nurses often learn to communicate in indirect fashion in order to accomplish particular goals for their patients without challenging medical authority.

Contrasting with the concept of developing personal characteristics as an outcome of professional socialization, Alutto, Hrebeniak, and Alonso (1971) found results indicating that women with particular personality traits tend to self-select into various types of nursing programs. Jones (1976), however, concluded that role conceptions were formed in the socialization process of formal nursing programs.

Ziegler and Sietz (1978), writing about changing trends in socialization theory, view socialization as a function, not only of the family, but of social institutions and public policies. The effect of institutions on professional development is the subject of a study by Olmstead and Paget (1969) who investigated the organizational systems' effect on medical students. Findings indicated that the students were "consciously and legitimately manipulated in subordinate positions" (p. 664). Although the manipulation served the function of role transformation from student to professional, it was also noted that adult socialization typically does not occur in settings of widely varying power differential. Olmstead and Paget contend that childhood socialization is based on dependence, while adult socialization is rooted in autonomy.

The dominant influence of the bureaucratic setting on professional nursing values was the subject of research by Kramer (1974), who concluded that nurses respond to dilemmas between bureaucracy and profession by moderating their professional ideals. Additionally, nurses in the study did not concentrate their efforts on confronting the discrepancies between their professional ideology and values of the controlling bureaucracy. The conclusions drawn by Kramer take on special significance when compared with the sociological perspective of nursing provided by Dingwall (1974) and Etzioni (1969), who suggest that the social organization of hospital work is such that functional autonomy for any group other than physicians is impossible. Nursing is not seen as a profession, rather a semi-profession dominated by women.

In an analysis of femininity in nursing and its influence on the nursing status within the medical hierarchy, Victoria Wilson states:

> Historically, nurses have functioned on the terms laid down by a doctor (usually a man). They are passive in his presence, and aggressive (managing) in his absence. . . . Nursing has been unilaterally exploited by the medical profession, hospital administration, and the paraprofessional. (1971, p. 214)

This review of the literature on nursing socialization indicates that several significant issues within the socialization process of nurses have been identified as inherent in problems experienced by the nursing profession, and the literature has served to focus my attention on four of these issues. They include the issue of gender, that is, the ways

in which the beginning nurse interprets and responds to interpretation of sex roles and the issue of agency which considers the ability of the nurse to exert power and influence. Additional issues include the dimensions of community or how beginning nurses share interest, concerns, and interpretations with other beginning nurses in order to mediate socializing influences, and finally, how bureaucratic arrangements within the hospital setting impact on the socialization process from the nurses' interpretation of these arrangements.

In addition to focusing attention on particularly significant issues within the socialization process of nurses, the literature has pointed up the absence of interpretive research on this subject. Studies are largely restricted to the type of investigations which attempt to objectively determine the effects of people, places, and events on the shaping of the nurse's role. Such factors as the entering personality traits of nursing students and self-selection into varying types of nursing programs (Jones, 1976), achieving behaviors in beginning students (Webb & Herman, 1978), teaching behaviors of nursing instructors (Given, 1975), and role-model characteristics of nursing faculty members (Stiehl, 1977) have been investigated. Missing from the subjects investigated is inquiry into the subjective experience of the nurse as the socialization process is experienced and interpreted as a means of shaping and ordering the individual nurse's reality.

Lack of subjectivity exempts from consideration the way in which the individual's view of reality is determined by an interchange between the consciousness and society. Failure to deal with the subjective ignores the dialectical relationship between the improvisational nature of consciousness and the controlling forces of society which restrict and limit action. Socialization is described by Berger and Kellner (1971) as a process of externalization, objectivation, and internalization which occurs through interactions of everyday life. Externalization occurs when cultural ideas are transformed into communicating forms which allow socialization to take place. As a human activity, it may be as creative as art, or as simple as an explanation. What is communicated has already been largely determined by society which legitimates knowledge. However, as the person interprets what has been heard from others, improvisation or modification may occur. The improvisation is a subjective phenomenon which is externalized when it is communicated to others and contributes to the development of another's view of what is real. The content is internalized by the receiver and made objective when the communication is separated from its human origins and incorporated into the individual's stock of personal knowledge as something which exists outside of human interpretation.

When separation occurs between the subjective and objective aspects of socialization, the question of how and why

particular constructions of reality persist over time fails to be asked. The fallible and interpretive nature of humans argues against a society that reproduces features such as the perception of sex-roles and class distinctions with a large degree of faithfulness, yet it is pointed out that such features do persist (Giroux, 1981; Spring, 1972). Whitehead (1929), in considering the nature of persistence in society, indicated that goodness exists only when there is a balance between persistence and change.

The concern for goodness in society has focused attention on the ways in which knowledge contributes to the balance between persistence and change in the social world. Habermas (1971) suggests that the present dominant form of knowledge, through separation of subject from object, hides the values and interests contained within objectivity behind the illusion of facts which have become law-like in their separation from human knowledge. Unquestioning acceptance of objective facts tends to preclude the imaginative rehearsal which could introduce variations and maintain the balance within society and between order and flux.

The reduction of variation is significant in the objective stance of modern inquiry which is a partial and discriminative reflection of earlier derivations of knowledge. Traditionally, knowledge has been located within the arts as well as in science. The traditional view is largely eroded, however, and in its place is erected a perception of

knowledge which becomes legitimate only when it originates within the confines of the empirical-analytical model. Habermas refers to this form of knowledge as "monologic" and describes it as separated from underlying values through an abstract and linear process of inductive organization.

Dissatisfaction with monologic knowledge centers on inadequacies discovered in extending understanding to the cultural expressions of everyday life which provide the context within which social activities occur. Bowers (1974) indicates that the events which together make up the sum total of experience of socialization take place not only between individuals but within a broader context of interaction between individuals, environment and elements of culture which permeate experience. The shaping of consciousness is directly influenced by the context within which the process of socialization occurs since values inherent in the context are reproduced in the consciousness of the individual through the process of social interaction. The difficulty of logical systems to gain entrance into the subjective realm of social activity is described by Breuer, who states:

> The basic assumption of the strict alternative of true and false, characteristic for classical logic, leaves no room for bridging the abyss by "perhaps" or "possibly." However, the major part of statements in our everyday life which have a vital meaning for us and communications are not of this rigourous nature. (1958, p. 287)

The imposition of logical measurement systems impedes the examination of concepts of reality and their underlying values by accepting social reality as given.

Values which remain obscured from consciousness are often of paramount importance since they become embedded in the consciousness and personality structure and find expression in the individual's beliefs, feelings, and attitudes. Of particular significance are the ways in which values and beliefs contribute to the reproduction of a society which remains essentially sedimented as though barriers inhibit what should normally be expected in the way of shifts and upheavals. Macdonald (1975) questions why objectivity obscures rather than illuminates values since the historical development of society is intimately connected with values and the achievement of individual goals and desires.

The areas of goals and desires within human intent must be considered when attempts are made to discover why forms of monologic knowledge have gained ascendency over dialogic knowledge. Macdonald argues that "All knowledge is grounded in human interest" (1975, p. 286). The possibility that a singular form of knowledge would emerge as dominant through random trial and error are judged by Habermas (1971) and Macdonald to be highly improbable.

The pragmatic and rational effectiveness of means-to-ends methodology combined with the ability to order events so that they may be counted, described, classified, and

measured argues for the adoption of objective and monologic forms of inquiry. Purposes, however beyond the efficient production of knowledge, may be served through the partitioning of subject from object, and the resultant development of equivalent classes for data. Precluded is the critical reflection which would question the automatic status assigned to social categories. Precluded also are alternative conceptualizations of the "perhaps" and the "possible." The emphasis on efficiency and objectivity is predicated, according to Macdonald (1975), on the aim of social control.

Gilligan (1979) provides a metaphor for illustrating the method by which constraints are placed on a segment of society through the separation of subject from object and through failure to consider context. The ordering of gender in an equivalent status category, in order to facilitate pragmatic and efficient inquiry, is both misrepresentative and debilitating in effect. Gilligan suggests that life cycle theories which provide a foundation for "comprehension and ordering" of the events of human development are selective in considering only the masculine mode of development (p. 431). By following the early lead of Freud whose theory of psychosexual development is based on the male oedipal relationship, developmental theorists have continued to make pragmatic assumptions about the adequacy of using male developmental sequences as the standard in life-cycle

theories. Women, when evaluated in terms of the masculine developmental models, have been judged incomplete and are, in a sense, devalued because of such measurement.

One of the major problematics found in the utilization of male life-cycle theories has to do with the contradictions between the woman's developmental history and the concern for achievement and autonomy, traits which are intimately connected to the development of masculine gender identity. Through sequences unlike the male, women become centered within matters of intimacy and attachment.

Psychoanalytic perspectives drawn from the works of Chodorow (1974, 1978) indicate that through initial relationships with care-takers of the same sex, females develop a reflexivity in the interpretation of future social interactions based on the norm of early childhood experiences. Socialization by a person of the same gender allows relationships to be perceived through the lens of interpersonal dynamics where daughters experience their mother as similar and continuous with themselves. This relationship, unlike the relationship between mother and son, requires no separation and delineation of ego boundaries in order to acquire appropriate gender traits. While the male requires an instrumental separation of subject from object, women continue to merge subject and object. The result of the differing socialization process is one of differing perceptions of reality in which the male perceives a need for competition,

for instrumentality, and for separation. By contrast, the female consciousness perceives reality in terms of assimilation expressed through a sensitivity and concern for others through community. The persistence of the female concept of community can be noted in the universal expressions of women nursing students who give as their reason for wishing to become nurses "the desire to help people."

The woman who is confronted with knowledge based on masculine traits finds that she is situated within a conflicting interpretation of social existence. This conflict has implications in the development of concept of self and the world, particularly in areas where gender and perception of environmental competence are interwoven. There is a struggle between the personal biography of the individual and the taken-for-granted reality of a world based on masculine concepts.

The concentration in developmental theories on instrumental achievement in which means are significant as they are related to obtaining specific ends is in opposition to woman's history and being. The need to consider and evaluate the means within the context of caring is an important aspect of being female. This can be better understood in terms of the fear of success which has been attributed to the woman's unwillingness to pursue goals of achievement. Horner (1972), drawing on the earlier projective data of McClelland (1961) on achievement motivation, proposes that women

apparently experience conflict over competitive achievement and this conflict is centered on fear of social rejection and loss of femininity. Gilligan, however, provides support for the argument that fear of success is probably due to the feminine understanding of the costs involved in competitive win-lose situations where one person succeeds at the expense of another. Conclusions usually drawn from female non-conformity to male standards of development are that "something is wrong with women" (p. 438).

The research of Gilligan points up issues related to cause-effect research which are usually obscured in the objective view of social reality. Scientific and rational research provides a concept of what is real in terms of what is functional, what is pragmatic. The rhetoric of objectivity, however, causes the underlying values which are the essence of research activity to be overlooked. Concealed values in the taken-for-granted aspects of cause-effect research allow the power to shape and control human existence to serve the interest of dominant social groups to go unexamined. Henry Giroux (1981) suggests that the motives and purposes which reside in dominant values should be examined within the context of social and political forces which contribute to the perpetuation of a society characterized by domination, exploitation, and inequality.

Research, such as Gilligan's, which questions the underlying values of the "objective" inclusion of women into

taken-for-granted categories effectively demonstrates that objective forms of research often provide justification for the continuation of the status quo and the domination of a segment of society. In the case of women, according to Gilligan's research, inferiority becomes a "fact" which is effectively separated from the contextual grounds from which the concept originated. Tacit understandings and the unquestioned contexts within which scientific research is grounded prevent the ability of individuals to move beyond the restraints of a narrowly defined and imperfect view of their present existence.

It is my belief that entrance into the subjective experience of the beginning nurse's socialization provides access to the means by which contextual values are reproduced in the consciousness. When subject is reunited with object, insight may be provided into the tendency described by Giroux (1981) for elements of the culture to be reproduced with a faithfulness and consistency that is atypical of cultural reproduction as a whole. The consistent reproduction of the status of the nurse suggests a need for going beyond the objective aspect of the socialization process of the beginning nurse to inquire into the subjective interpretations and contexts of the construction of consciousness in the hospital setting.

The focus of this study will be guided by the following questions which serve as a structure for entering into the

socialization of the nurse within the hospital and for eliciting meaning which the experience has for the nurse. The questions which guide this study are:

1. How does the nurse integrate the events of hospital socialization into the understanding and interpretation of self and profession?
    a. Does the beginning nurse rely on particular assumptions in the interpretation of socializing events?
    b. What effects do social explanations offered in the hospital setting have on the beginning nurse's frame of reference?
2. How does the nurse come to understand the relationship between her gender and role?
    a. Does the nurse's own perception of sex-roles influence the mediation of the nurse's role in the hospital setting?
    b. Is there awareness on the part of the nurse of ways in which perception of sex roles may influence others' expectations of the nurse's role?
3. How does the bureaucratic hospital structure affect the development of community among graduate nurses? For the purpose of this study, community will be defined as the affiliation among nurses within a particular occupational setting which leads to consultation and collaborative efforts among peers in the maintenance of professional nursing values?

a. Does the beginning nurse look to her peers or to perceived authorities within the hospital setting for interpretation of events within that setting?

b. What criteria does the beginning nurse use in selecting particular individuals to interpret events?

c. Are the criteria for selection of interpreters influenced by experiences in the nurse's formal educational program?

d. Does the fragmented and specialized nature of nursing within the hospital influence the nurse's development of community?

4. How is the development of agency among graduate nurses influenced by social interactions which occur in the hospital setting?

a. How does the nurse deal with conflict within the hospital setting?

b. Does the nurse believe she is powerless in construction of her role?

c. Are possible alternatives of roles apparent to the beginning nurse?

d. What influence does the nurse believe her education to have had on her ability to deal with conflict? With the development of alternative roles?

CHAPTER II

METHODOLOGY

The methodology I have employed to learn about the socialization experiences of beginning nurses is the non-linear method of dialectical hermeneutics. This method of inquiry is concerned with the study of the interpretation of meanings and acknowledges "that the observer in part constitutes the scenes he observes" (Mehan & Wood, 1975, p. 208). The appropriate form of inquiry for attempting to understand how another constructs a particular view of reality is described by Polyani, who writes:

> Feats of intelligence can be observed only if we dwell in their parts as being intelligently integrated, thus identifying ourselves (in this sense) with the person whose intelligence we appraise. Our capacity for making sense of understanding another person's actions by entering into his situation and by judging his own actions from within his own point of view thus appears to be but an instance of the techniques of personal knowing. (1968, p. 44)

Dialectical hermeneutics in the phenomenologic tradition provides a way of entering the interiority of the person's experience. It provides a means for addressing the individual's own interpretation and mediation of the socialization process. It specifically addresses the issue of how individuals make sense out of social interaction and is described as a reflexive examination of everyday reality. The methodology provides for the comprehension that

consciousness is a subjective phenomenon which is grounded in socially shared understandings. It is a methodology which seeks for broader understanding through careful examination of the phenomenon of social interaction and the ways that social interaction contributes to a shared view of what is real among participants.

Blumer (1971) describes the focus of this form of research as taking the role of the actor and seeing the world through the actor's eyes. Interpretive and qualitative methodology affirms the complex and varied human experience from which unique individuals are conscious of the world around them. It illustrates the diversity of social interaction and the rich variation to be found in the human condition. It examines what Berger and Kellner describe as "The process . . . that constructs, maintains, and modifies a consistent reality that can be meaningfully experienced by individuals. In its essential forms the process is determined by the society in which it occurs" (1971, p. 23). Contrary to the empirical goal of establishing categories of human behavior, phenomenological methodology relies on the concepts of indexicality and reflexivity to bring new depths of understanding to social interaction.

Indexicality, the understanding growing out of past experience, creates a particular lens through which the world and events within the world are viewed. As new experiences occur, understanding serves as a guide or measure

for interpretation of the new experience. Neither reflexivity of interpretation nor indexicality of understanding are fixed, rather modifying and adjusting as new experiences are added to the old. There is both persistence and change as layers are built on the core of human consciousness through interpretation, action, and reinterpretation.

Underlying this methodology is the concept of intersubjectivity which Schutz (1967) describes as the development of a view of the world through the reciprocity of perspectives. From this perspective individuals come to believe that the ways in which their world is interpreted is also the ways in which others around them interpret reality. The sharing of perspectives through consciousness which is social in nature allows the development of what Berger and Kellner describe as "a consistent reality that can be meaningfully experienced by individuals" (1971, p. 23).

Cox has provided an outline of the steps of the dialectical-hermeneutic method which has served as a model for this study. These steps are:

1. A careful effort to discover the pre-history of the event or phenomenon to be studied.
2. A rigorous attempt to learn about the larger setting within which the activity takes place.
3. A thorough observation of the phenomenon itself.
4. A meticulous awareness of the meaning it all has for me. (1973, p. 147)

The purpose of the dialectical hermeneutic methodology, according to Cox (1973), is to learn from people's lives rather than to investigate them. My role as inquirer in

this capacity is to seek to learn from others through the meanings which they attribute to their life experiences by becoming deeply aware of the phenomenon itself. The process of learning within this method focuses on the phenomenon of social interaction and the events contributing to the status and activity of the phenomenon.

The learner and inquirer engages in this discovery by searching for the historical events which influence the individual, as well as seeking to discern the surrounding universe within which the individual resides. By placing the phenomenon within a context, illumination and understanding are acquired in a manner reminiscent of the artist's provision of perspective through attention to the nuances and shadings of background.

Following the tradition of art, details are given careful attention since they provide cues and direction towards integration and wholeness of the undertaking. Cox states of this methodological requirement, "It demands a rigorous attention to subtle detail--pace, mood, and the minutiae of expression . . . it proceeds on the assumption that nothing is trivial" (1973, p. 148). The learner must exercise sensitivity to the ways in which expressions are given as well as the expressions themselves since the means by which the artist chooses to apply his paint and the colors he uses to depict his subject are fully as significant as the subject he chooses to paint.

Akin to the dialogic communication between the painter who interprets a subject and the viewer who must then interpret the painter's interpretation, dialectical hermeneutics extends beyond the phenomenon itself to the one who would learn from the phenomenon. Contextual framing through the gathering of historical data and descriptive information must be accomplished and combined with the examination of interpreted meanings. Eventually the learner comes to a point where some interpretive response must be made and the acknowledgment is made that the observer does indeed constitute, at least in part, the scene he observes.

As the learner, I must decide what meaning it has for me and within the circle of the dialogic process, my own voice must be acknowledged. I am bound to discover not only those tensions, paradoxes, and ambiguities which emerge from another's interpretation of meaning but I am bound to discover some of my own as well.

This discovery has special significance since it welds subject to object and allows perception to move beneath the surface of external realities. The penetration is neither precise nor flawless since it is human, but it provides a momentary glimpse of the layers to be found beneath the surface. It is only made possible through the sounding of one's own interiority to discover the values and beliefs that reside there. Cox says of this process:

> He will eventually let the story he has heard meet his own story. He will appropriate, question, reject, and accept aspects of what he has seen. He may change his own story in view of what he has learned. Most importantly, however, he will always evaluate provisionally. No final judgments are made. Also, no evaluation at all is made until the question of what it meant to everyone involved, including the observer, is answered. (1973, p. 149)

The reasons for undertaking such an imprecise and imperfect project may be found in the effort of the individual who wants to discover not only what is true, but what is beautiful as well. The learner may begin by examining the singular dimension of a photograph which can be said to represent one objective form of truth. But critical judgment evolves only when added dimensions and representations are considered. Repeated viewings must be made with a willingness to reconsider and revise estimates and opinions. From this inefficient effort is developed a larger vision and a greater capacity for understanding gained through the viewer's involvement in the learning process. Cox states, "It can make it more self-critical. It could even serve in part as an example of how a humane science should operate" (1973, p. 150). It is with this view in mind that this study is undertaken.

Design

This study is based on interviews with six registered nurses who have begun the occupational socialization process within the past three years. The nurses are graduates of an associate degree nursing program in a small community

college. Ages of the graduates interviewed range from 20 to 47, and all are female. Three of the six interviewed were licensed practical nurses prior to admission to the associate degree nursing program. Two of these three were previously employed in the hospital where socialization into the role of graduate nurse is currently occurring for the six registered nurses. Nurses taking part in the study were selected from recent graduates known to me who agreed to participate. There were no refusals to be interviewed and the first six nurses contacted provided interviews for this study. The consideration of articulate responses was a factor in the selection of participants.

The associate degree nursing program from which the nurses are graduates provides a two-year technical nursing course which leads to examination for professional licensure as a registered nurse. Approximately 30 students are admitted to the community college nursing program each year and students are drawn from the community in which the college is located. Students represent a broad variety of backgrounds and ages and include both men and women.

The site of the occupational socialization process is a moderate-sized, nonprofit, community hospital located in an area that serves a population of over 40,000. It is the only hospital located within a radius of 30 miles and offers a full range of health services. The organization of the hospital is pyramidal in structure with the department of

nursing located horizontally on organizational lines with other professional and nonprofessional departments, such as housekeeping and food-management, below the positions of assistant and chief administrators. Management of the hospital is contracted through a professional management firm which provides services for profit. Although physicians are considered as staff members, they are not incorporated into the direct authority lines of the hospital's organizational structure but are designated as autonomous with communicating lines drawn to the hospital's administrative offices and board of directors.

A preliminary pilot study based on the interviews with two additional registered nurses was conducted in preparation for this inquiry. The first interview was conducted in a restaurant setting using a battery-operated tape recorder and a list of open-ended questions to initiate discussion. The nurse interviewed had graduated from nursing school seven years ago and seemed eager to share her experiences and interpretations with me. One of the phrases which I became accustomed to hearing in the interviews was introduced in this interview when the nurse told me that the nursing school was the "ideal world of nursing" but graduates had to learn that the hospital was "the real world of nursing."

My initial fears that the interview would be strained and nonproductive were not realized when the interview (over lunch) extended well beyond the two hours I had

initially established as a time limit. Questions I asked led to discussion which then provided material for additional questions. The interview was finally terminated at my request and after I had used up the supply of tape and discovered that a battery on the tape recorder had inadequate power to continue. The nurse confided to me that she had really enjoyed our discussion and I felt this to be true since she had been a particularly active participant in the interview. She also asked that I share with her the completed study since she felt that the questions I had asked were significant to nurses.

The second interview for the pilot study was held in a college faculty office for the convenience of the nurse who was attending classes at the college. During the course of the interview I found that the surroundings were not conducive to the informal dialogue which I hoped would be forthcoming. Even though the nurse and I were acquainted and had a common ground for communication, I discovered that the office setting at the college placed a strain on the interview. The desk, tables, and chairs in the room were upright and formal and the conversation proceeded along the same lines. An additional problem was discovered when an electrical outlet chosen for one of the tape recorders was found to be nonfunctional and a short segment of the interview was lost.

This interview, unlike the previous one, was tiring to the nurse whom I interviewed and to me as well. It was a

strain to try to fill the two hours I had allotted for the interview and we mutually agreed to end it at the end of a 90-minute tape. The nurse, however, did indicate that the questions had been thought-provoking and she felt that she would be interested in reading the final study. An interesting highlight of this interview was the comparison made by the nurse, who had trained in a diploma nursing school in Canada, between hospitals in the United States and Canada. She did not choose to describe the American hospital as "the real world" but rather described the differences she found between the systems and the people with whom she worked.

During the process of listening to tape recordings of the first two interviews, I found that significant subjects for discussion had been introduced by both nurses and I had failed to recognize or pursue these topics. This failure stemmed in part from my efforts to have the nurses answer all the questions on my list and from my failure to pay close attention to subjects emerging from the conversation. I also discovered that at times there were seeming contradictions expressed in the interviews, and I had not identified these or questioned the nurses concerning the discrepancies. It was only later when I reflected on this that I discovered that what I first had identified as contradictions were rather expressions of ambivalence. As the course of the study progressed I found that ambivalence was shared not only by the nurses interviewed but by the interviewer as

well. An example of this ambivalence became clear to me when at one point I found myself indicating how much I was enjoying the interviews in the study and at another point indicated how glad I was to "get them over" since the interviews were the part I liked least about the study!

From the pilot study I derived the following guidelines for the major study:

1. The study should be guided by informal questions focused on issues identified in review of the literature, but the interview format should remain flexible and open to the introduction of new material.
2. The interviewer should develop listening skills and remain attentive to previous statements which were made in the course of the interview, comparing statements with later expressions which indicated ambivalence.
3. Two tape recorders should be used in conjunction with reliable electrical energy sources.
4. Interviews should be restricted to 90 minutes.
5. The setting should be comfortable and informal, preferably a social one, which would be conducive to relaxed and informal dialogue.

Preliminary preparation for this study included making arrangements at a local restaurant where interviews could be held. Lunch was provided as a means of establishing a

social atmosphere. Since the management of the restaurant was apparently intrigued by the interview process, every effort was extended to provide an adequate setting. A table was reserved for the interviewer and the management offered to modulate recorded music which might interfere with the taping. Adequate electrical outlets were also made available for two tape recorders and waitresses indicated their interest in the proceedings through repeated trips to the table to offer additional tea or coffee. I cite these seemingly unimportant details because of the belief that surroundings have an effect on conversation and the surroundings in this study were arranged to place both the interviewer and nurse to be interviewed at ease.

Arrangements for the interviews were made by contacting each nurse by telephone, giving a brief description of the study, and asking for the nurse's participation. Once agreement to participate in the study was indicated, appointments were established for an interview date during the nurse's off-duty time. After an early participant had her hospital work-schedule changed and was unable to keep the appointment, the decision was made to contact each participant on the day before the scheduled interview to confirm the appointment. Every other participant appeared promptly at the agreed-upon time for the interview and the missed interview was rescheduled at a later time.

The nurses indicated that they enjoyed the prospect of being interviewed and were happy to share opinions when I

expressed interest in them. There was curiosity about what I was trying to discover and in each interview I was asked the purpose of the study and for more information than I had given in my brief description. Some suggestion of the tone of the interviews may be noted in the general willingness to continue conversation after the tape recorders automatically shut off at the end of 90 minutes. The questions asked seemed to tap a responsive chord and I found evidence in the prolonged conversations that the nurses were probing their own interior feelings about nursing and the events that surrounded their own socialization.

The ambivalence I experienced about the interviews was rooted, I believe, in the learning unfolding for me and the effort required of me. Subjects were introduced into the conversation from vantage points outside my own and I found myself discovering facets of socialization not previously considered. Descriptive phrases such as "the facelessness of nurses" and the comparison of socialization to "a log rushing downstream to the falls" prompted additional reflection and insight on my own part. There was also the simple pleasure of discussing common concerns with friends.

But my role as learner required more than is usual for the normal conversant. It became necessary not only to listen carefully, but to hear at a greater level of intensity in a manner that I had not heard before. The energetic nature of my own listening moved the conversation beyond the

normal level of comprehension to one I had not experienced and involved my own awakening to the discontinuities that are present in the forming of consciousness. Efforts to use my own perceptions to enter into and to comprehend the perceptions of another were costly in terms of the demands this process made on my own application and endurance. I came away from the interviews feeling both elated and exhausted and in one instance, one of the nurses indicated that she felt as though we had been "working" in the interview and that she, too, was both physically and mentally tired.

The distillation of interviews was more intricate and complex than a simple recovery and analysis of material from the tapes. Immersion into the dialogue became necessary and involved an active search for themes and patterns of interaction with the accompanying false leads and sometimes fruitless production that is associated with nonlinear activities. When a disclosure forced its way through the concealment of abundant material, I experienced a sensation unlike that of mild satisfaction normally accompanying the achievement of an objective. The absence of any specific objectives left me open and freer to experience the frustration of wasted energy and the sheer joy when one chances onto discovery. Situated between these extremes were the doubts and struggles I experienced in my own engagement with the issues.

Another phase of the study was begun when the rough drafts of the interviews and my interpretations were ready

to be presented to the nurses for reading. Approaching this step caused me to experience apprehension and misgivings when I considered that my interpretations focused on the ambivalence and paradoxes of consciousness that I had perceived in another human being. I felt some humility in understanding that I too shared such tensions and it became necessary for me to cast my own discontinuities in as strong a light as I felt I had cast those of the nurses I interviewed.

The reaction of the nurses was not the reaction I had anticipated. My surprise came when Joan told me that during the course of the interview she had become increasingly aware of her own ambivalent responses. She since had found herself reflecting on how and why she had come to hold certain beliefs and attitudes about nursing and their effect on her. Joan's thoughtful, and at times emotional, response was the first in a series of admissions that the interview had caused re-examination of events in the nurses' experience. Martha said she had talked about the issues with other nurses and both she and Linda indicated that the interview had caused them to become thoughtful about why they had come to perceive nursing in a certain way. Debbie was surprised to discover how much she said in the interview and perhaps was a little concerned about the impression she had given. But she gravely concluded that the interview and the interpretation I had presented were, in her estimation, accurate.

Kathy said that she found the interpretation of the interview accurate and had since been thinking more about what she wanted from nursing; and Delois, though somewhat reserved in commenting on the interpretation, said that she was still concerned about teaching cardiac patients the things they needed to know.

The final step in this study is for me, as the learner-inquirer, to discover those things which I believe that I have learned from this study. At the beginning of this stage it was necessary to pause, to reflect, and to move into my own solitary recesses to consider the meaning this study held for me. My own answer to this need was to move away from the activities that normally fill my daily routines to a place that means restoration in its peace and tranquility. I took time to walk along the beach, to pick up sand dollars, and to consider the infinite variety and wonder that is to be found in nature. There was a similarity in the shells I picked from the beach for my collection. The general placement of the sand dollars' central figures were alike and the pierced markings of the shells were predictable in their placement. Yet each shell, when closely examined, was different in some unique and special way. I have come to the belief that I will know these shells better when I examine them more carefully, when I consider their differences as well as their similarities, and when I remember that they are part of nature. I suppose I could place

the shells in categories according to their size and weight and color variation. But I would miss the beauty that is available only to the more careful examiner. The discovery, in the case of the shell and in this study, is, I believe, worthy of the effort.

CHAPTER III

INTERVIEWS

Presentation of Interviews and Analysis

Presented here are the interpretations and expressions of six nurses who have experienced the transition from student to beginning nurse. These nurses have begun to form their own perceptions of what it means to become a nurse, and they have begun to interpret the hospital as a "real world" in which they participate in the work of nursing. The nurses responded to predetermined questions as well as to topics which they chose to introduce in the course of the dialogue, and their expressions are recorded here. My own concerns were focused on four major issues which are identified in the nursing literature as matters of interest to the profession of nursing and matters which I had come to believe had some bearing on my own nursing experience. These issues are (a) gender, (b) community, (c) agency, and (d) bureaucracy and will be discussed more fully later.

The tone of the interviews was established by the qualities and interests which each nurse brought to the interview and by my own responses to them. Equally significant were my own characteristic pattern of interaction and the responses which were prompted by the nurses' reaction to me

as a person and as an inquirer. The basis for previous interactions cannot be excluded as a possible source of influence on the dialogue. One possible indication that I might have been perceived as an authority was sensed in some cases where there seemed to be a "testing of the waters" to discover whether or not I was searching for a particular response. I believe this was not true in all of the interviews, but I believe it is a phenomenon that is not at all unusual in the process of inquiries and was dealt with by indicating my interests in the person's own opinion. The nurses were also assured that there were no "right" or "wrong" answers, and efforts were made not to reinforce particular attitudes through verbal or facial gestures.

Discrepancy in ages seemed to be a factor in determining how free the individuals felt in discussing their own personal history. Little difficulty was experienced in conversation dealing with nursing since it provided a background of language and concerns that served as the basis for exchange, but the lack of shared experiences in age-related matters seemed to inhibit younger nurses from elaborating on their own histories and feelings about their experiences. It could be argued that the youth of the nurses prevented them from having more extensive histories and that the tendency of the women may be to look forward to their future rather than to reflect upon their past. Their inhibition, however, was shared in part by me since I found myself more reluctant to

probe deeply, interpreting such an action as a form of intimidation which I had not considered or experienced with those closer to my own age.

The relevance of personal factors was present in each interview. Whether the nurse was expressive and willing to venture into unexplored areas on her own initiative or whether she was cautious and waited for questions to stimulate discussion had some influence on the direction of the interview and my response to the person being interviewed. My preference was for the interview to move beyond the issues introduced by me since I believed that it would add dimensions that I could not otherwise include in the study. Perhaps the most surprising (to me) element of the study came when I discovered that the nurses whom I knew and liked best were more likely, during the course of the interview, to stimulate some feeling of anger and annoyance on my part. I found myself wanting to say to them, "Can't you hear what you are saying? How can you let this happen to you?" And the feeling was strong enough that in one interview I found myself pointing out to the nurse an area which I felt she had not carefully examined. Later, when I gave her the draft of the interview for reading, I asked her to "take better care of herself."

There was a degree of commonality in the responses but I also found unique aspects in each of the nurse's interpretations of the socialization events. The personal history

and life events from which each nurse viewed this experience were identical with no one else's. The interviews, I believe, reflect these differences in a variety of ways through tone, patterns of speech, choices of topics, and through the colorful and personal elaboration of hospital events. It seems noteworthy then that each of the nurses discussed three topics in addition to the four topics I presented them in this study. These topics are notable in presenting the ways in which socialization is negotiated and the values and beliefs in the hospital setting which influence the socialization process. These topics are as follows:

1. A sense of participation in the socialization process. Each nurse indicated she believed she had been an active rather than a passive participant in her own socialization by admitting that she had selected some trait or characteristic to deliberately incorporate into her definition of the nursing role. Some suggested that they were careful to avoid traits which they judged to be unappealing in other nurses and in one case a nurse stated that her translation of what she saw in other people was changed in the course of her own interpretation. She believed that she did not automatically reproduce what she observed but rather altered the trait in her own process of reproduction.

2. Conventions of the rookie role. Signals of what was expected of the rookie nurse were given to the beginning nurses through the verbal and nonverbal communications of the professional and nonprofessional personnel with whom they worked. Rookies, according to the delineated role, were encouraged to avoid demonstrations of assertiveness or authority during this particular aspect of socialization. The expectations were conveyed that they should develop proficiency in technical skills and that they should learn to adapt to personal idiosyncrasies of staff members so they could earn the trust of physicians. During the period of indoctrination, the nurses' demeanor was expected to be one of reticence and restraint.
3. Fragmentation in the hosopital. Isolation through the organizational structuring of nursing units and the regimentation of time and routines separated nurses from each other and interfered with the development of support networks in the hospital. Nurses who normally used more technical skills found themselves with greater power than nurses who exercised interpersonal skills and, as a result, misunderstandings of one another's motives and concerns occurred. A consequence of the fragmentation was a sense of divisiveness, dependency, and

an inability to respond to one another's needs and concerns.

4. The changing consciousness of physicians. Five of the six nurses perceived that a difference existed between older and younger physicians in their estimation of the nurse's ability to provide them with useful information. Younger physicians were more willing to express their personal feelings and to seek information from the nurses while older physicians appeared not to value the nurses' opinions by not responding to their suggestions and requests. Although the older physician might eventually incorporate the nurses' suggestions into the patients' plan of care, this action was taken in such a way that the nurses' input was not openly admitted or acknowledged.

At the conclusion of the presentation and analysis of the interviews I will discuss the relationship between the topics introduced by the beginning nurses and the four issues of gender, community, agency, and bureaucracy.

Kathy

Kathy is 23 and graduated from the associate degree nursing program two years ago. She is single and lives with her parents and a younger sister. When I asked Kathy how she would describe herself, she said that she had been a fairly quiet person while growing up and that her teachers often told her parents that she was a "good student but a meek child." When I asked if this was still true Kathy laughingly shook her head and said, "No, I don't think I am now. I'm far more assertive now." But I discovered when I tried to learn more about her that Kathy continues to be quiet in some ways. Questions directed toward "Kathy the person" were often redirected into answers having to do with "Kathy the nurse" and I found myself having to search for Kathy within this framework.

I discovered that Kathy is very "southern" in manner, i.e., she is very respectful and courteous to those who are older and she addresses teachers and supervisors as ma'am. Her respect is more than surface decoration and it extends beyond supervisors to those around her. While participating in a leadership exercise in nursing school, Kathy interpreted her role as team-leader as one of helper and consultant to her fellow students rather than authority and their evaluations of her performance indicated a feeling of appreciation of her respect toward them.

The respect that Kathy demonstrates towards others, I believe springs primarily from her feelings about herself. Although Kathy often indulges in a kind of gentle humor about some of her own shortcomings (rather than others'), she seems secure in her own beliefs and is willing to tolerate views that do not coincide with her own. During the course of the interview there were times when she would not agree with issues I raised, but would indicate her willingness to accept my right to a particular viewpoint. Her tolerance, however, does not extend to sacrificing those things which she values as consequential.

In her decision-making, Kathy seems inclined to a thoughtful deliberate process as opposed to impulse. When I pressed her for details about her plans for the future, Kathy indicated that she did not wish to rush into any commitment without considering what her commitment might involve. She says, "I have a lot of time to make those decisions and I want to try to make the best one for me."

Since Kathy was 13 when her younger sister was born, she spent her childhood years as an only child. Even though her parents were very loving, Kathy said that as the only child, a good deal was expected of her. She in turn has high expectations of others' capabilities and she said that this is especially true of her younger sister who she feels should meet the same standards that her parents set for her. Although her parents did not farm, Kathy grew up in a rural

setting. Her father works as a manufacturing supervisor in a knitting mill, and until her younger sister was born, Kathy's mother was employed in a large nylon manufacturing plant. She says that it was necessary for tasks at home to be shared and she grew up believing that there was no such thing as "man's work" or "woman's work" in her home. "Everyone had to cooperate" and Kathy recalled that cakes baked by her father were usually better than those prepared by her mother.

Kathy was quick to point out that she is not "perfect" and laughingly said, "I'm a redhead with everything that goes with it." This description prompts a picture of someone with a fiery disposition and ungovernable temper but it is not compatible with the Kathy I know. Most of the time Kathy is calm and self-possessed but it is obvious from the interview that she does not mind making a stand when she feels that it is right to do so. If she commits herself to a principle it is because she holds strong convictions and she usually draws on a solid grasp of information. Conflict in her case would begin with the premise that Kathy is on solid ground, and she seems to have learned to accept conflict as a necessary part of working with a variety of people who do not always share the same purposes.

Kathy said that one of the most important events in her life was her father's experiencing a coronary attack when she was in the first year of nursing school. She said, "It made

me more determined than ever to become a really good nurse." Her belief that the event profoundly influenced her to become "a good nurse" is supported by the fact that she was named "most improved student nurse" at her graduation. She indicated that her attitude toward nursing is essentially positive. "I love nursing. Sometimes I get irritated when you don't have enough nurses and you find yourself working so many extra hours. You get so tired that you get a 'don't care attitude' and that really bothers me." But Kathy sees nursing as a way to help people and she is willing to put up with some of the disadvantages of nursing so she can look after people like her father who are in need of the care she can give.

Interview. In discussing how she was socialized into the hospital as a nurse, Kathy talked about deciding what she liked best and about the people she looked to for guidance. Co-workers had a lot of influence, and according to Kathy she tended to "follow their pattern." But her own choices were important in picking and choosing the qualities she wanted to adopt for her own use. "You hope you make your own decisions. . . . Sometimes new graduates tend to fall in the groove of being just like somebody, which I think is a bad idea. You've got to be your own individual." Kathy said that when she went into the hospital, she ran into problems. "They don't tell you about the problems in school. But you fall back on things you were taught in school."

Things that co-workers say or offer as interpretations influence the ways that Kathy fashions her own concept of nursing. "I try not to let it. But when you go in, everybody is telling you things, it influences you whether you want to let it or not. It's always in the back of your mind." But Kathy does not always accept things as given, "just because you see a nurse that seems to be ideal, you shouldn't try to be exactly like her." She believes that if she doesn't follow her own personal convictions it will be harmful to her own self-esteem.

Kathy sees a good deal of pressure to fall into someone else's concept of nursing. She said, "It's probably from peer pressure and just like when we were in college, you go along with the group." But she also said, "I'm kind of independent. If I'm not satisfied with doing it, I won't do it." Kathy said of herself, "I'm a darned good nurse and I think, when I'm right, I know I am right, it doesn't matter who I'm with." This was stated as a simple belief and Kathy seemed to be saying that she is unwilling to give up certain personal beliefs.

In responding to a question about the perceptions of sex-roles and how they influence nurses, Kathy offered this information. "It's a man's world. Even though we've come a long way, most of the doctors think the nurse's being female, I'm not sure whether it's being female or just being a nurse, they think our opinion isn't that valid. For the older

doctors that holds true. The younger ones, they want your opinion, they respect it, they trust it. You say 'I've got somebody bad and I need to do this, this, and this. They'll listen. Some of the older ones, you might as well talk to the moon. . . . Things have changed, the younger ones are willing to listen."

Kathy said that the nurses where she works in the emergency room have to be "on their own" a good deal and she seems to feel that confidence in their judgment is justifiable because of the responsibility that they assume. But some "older doctors" will not recognize their ability to make independent judgments and refuse to listen to the nurses or heed their suggestions. "Some of the doctors, they would have done it if you had not suggested it. They just feel threatened. One of the younger doctors said that the older ones feel threatened by the nurses. And I think he is probably right. It used to be that nurses just answered the phone, made up beds, and sat there looking nice, that's about all." But Kathy was unable to put her finger on what the threat to the older physicians might be and at one point wistfully said, "I wish I did know."

The feeling of fragmentation in the hospital is evident in some of Kathy's observations. She described the area she works in as one where "you have to stay close family . . . the whole little nest is going together." But separation from other nursing areas makes it difficult to understand

the problems of other nurses and they are often seen as having different motives and goals. "I had misconceptions and when _____ another nurse came down from the unit, she told me stories I just couldn't imagine. Things I just took for granted, I felt different after talking to her." Kathy said it's "Because you don't work with each other and you don't know what goes on. The ideal thing would be to let everybody work each area and at intervals change units. That would be the best thing, but it's not feasible . . . well you are isolated. And everybody says, well, that is that unit's problem, let them work it out." Kathy related an incident of another nurse who had come to work part time in her area and who later wrote a letter to them. The nurse admitted that she had labeled the nurses in their area as "uncaring." But Kathy said, "After she saw what the nurses go through, she changed her opinion."

The role of the novice or rookie nurse was spelled out by Kathy. She feels that she was often given the message "You just be quiet and go along. . . . Stay in my place." Many of these cues Kathy interpreted from other nurses' actions and she said that part of it comes from wanting the experienced nurse's approval and acceptance. "If you knew deep down something was a wrong order, and you knew the doctor wasn't doing right, if you said something about it, the nurses would say 'you just go along, you don't dispute the order'. . . they gave the message that you're new, you want

to be accepted. It's ironic because they don't go along with it. Faced with the problem, they stand right up and say 'this is not right!'" Kathy believes nurses have a reason for responding this way. "It's just because you're new. They don't do it. They've proved they don't do it." The message Kathy selected for herself from these conflicting cues, she said, is "When something is wrong, you say something about it. I don't care who I make mad, or who doesn't like me."

Acting on the message which Kathy chose, however, prompted some feedback from the experienced nurses. "Even though you did what you believed in, the nurses would say, 'Well, the next time, you know, maybe you shouldn't blow your stack.'" And Kathy learned "In a couple of situations I've had, if there was any 'iffy' situation to it, and if they kept on, they put the pressure to you, you might back off. . . . One thing would be your co-workers. Making sure you don't screw up." Kathy believes that people "tried to put you in your place," but she says, "I was taught in school, if you don't have confidence in yourself, nobody else will. I took that philosophy."

In the area where she works, Kathy said that nurses and physicians are on a more equal footing. In the emergency room "the assertive nurses" are admired the most. Even though beginning nurses are told not to "make waves," many of the E.R. nurses are observed to be "strong" and Kathy

indicates that you "pick up on it." Sometimes a doctor will say "where is the boss?" But the physician's comment is less important, Kathy observed, "when they have a bad patient, or need someone to assist them, that is the nurse they pick. Even though they act like they don't particularly care for the nurse, that's the one they want doing the procedures. So I think they don't know which way to turn either. You pick that up, that even though that's the way they feel, that's the nurse they ask questions when they come in."

Kathy's socialization into the hospital is influenced by her own desire to hold on to beliefs which she feels are valuable and by the people with whom she works who interpret events and provide models through their own activities. Kathy recognizes that it is not easy always to do the things which you believe in. She finds pressures surrounding her and she finds that looking to her co-workers for guidance causes her in many cases to follow their patterns of behavior. But Kathy also believes that to simply follow these patterns will not achieve what she wants to become as a nurse and so she attempts to be selective.

One of the values which Kathy seems to hold is that of assertiveness and of working from a firm ground of knowledge which serves as the basis for the conviction. She confirms this value in nurses in the emergency room who caution her as a rookie not "to dispute," "just be quiet and go along,"

but who demonstrate a very different approach in their own responses. She selects their behavior rather than the nurses' words as a guide for her own model of nursing and Kathy feels that she is accepted even though acceptance seemed to be attached to the verbal messages. "When something is wrong," she said, "you say something about it. I don't care who I make mad, or who doesn't like me."

Kathy believes there is a conflict in the emergency room between the younger and older physicians' attitude toward nurses. Older physicians are unwilling to accept information or suggestions from the nurses and Kathy senses that there may be a difference between the nurses of today and nurses who used to "just make beds, and answer phones, and sit there looking nice." The younger physicians depend on the nurses for help and hold no previous views which prevent them from accepting the nurses' judgments. The feeling of being threatened, which the younger doctors attribute to the older physicians, may be discovered in the older physician's own socialization. The need to retain power and authority perpetuates a system of domination-subordination, but it also traps the older doctors in a web of necessity. The doctor is unable to evaluate the contributions of recent nursing graduates and part of his unwillingness may stem from the desire not to evaluate his own medical education against the qualifications of younger physicians. He must resist the nurse's suggestions at

whatever cost because it threatens his own tacit acceptance of the nurse's inequality and his own superiority. The younger physicians continue in the process of their own socialization and, while they do so, their concept of the nurse within the medical system remains flexible and open to the clues and pressures of their environment.

The fragmentation of the hospital environment influences the perceptions which nurses develop about one another. Kathy described her own area as a "nest" indicating a comfort to be found with those with whom she works closely. But she also has an idea that separation from other nurses contributes to the persistence of some of the nursing problems in the hospital because nurses are only interested in solving their own unit problems. She believes that if the nurses could step into each other's shoes for a while by working on one another's units, it would create better understanding; but she, like other nurses who have been interviewed, accepts the structuring of the present system as "the real world" and believes that other approaches are not feasible.

Kathy questions whether nurses are treated as they are because of perceptions of sex-roles or whether their simply being nurses influences their position in the medical system. Her perceptive question indicates that she believes that complex factors are involved in the reproduction of the nurse's position in the hospital. Her perception further influences the choices she makes about what kind of nurse

she wants to become and she says of herself, "I'm kind of independent. If I'm not satisfied with doing it, I won't do it. . . . I'm a durned good nurse."

Joan

Joan is 35 and graduated from the associate degree nursing program 18 months ago. She is married and has two sons. Her husband teaches in the public school system. Before she entered the associate degree nursing program, Joan worked at times in the hospital and in a physician's office as an office nurse. While she attended the college nursing program, Joan continued to work part-time and she says she did this because she feels "responsible for things" and knew that her family needed the extra income from her job.

Joan grew up as a foster child in the home of a great-aunt and uncle. Her father drowned while she was still an infant, and her mother committed suicide when Joan was 18 months old. Joan says that she learned what "giving" was from her great-aunt who was nearly 60 when she started caring for Joan. Her great-uncle was a furniture factory worker, and Joan grew up in the same area where she now lives.

Although Joan had no brothers or sisters, she was not alone as a child in her great-aunt's house. When her great-aunt's daughter-in-law died, room was made for three additional granddaughters who were all younger than Joan.

Joan says these events had positive and negative effects on her. She became aware of other people's needs, but at times felt herself to be an "outsider" since her ties were not as close to her aunt as were the three granddaughters' ties. She says that at times she wondered why her mother cared so little for her that she would leave her.

Joan takes responsibility for other people in a number of ways. She has a friend in her forties who has terminal cancer, and Joan, in spite of the demands of her job and home life, contributes to the care of her friend. I cite this instance, not because of the pathos, but because I believe that it is representative of Joan's overall behavior of extending herself for others' needs. She is deeply sensitive in responding to others and often gets caught up in helping other people resolve problems.

Right now Joan says that she is going through a mid-life crisis. "I have been giving and giving with no rewards but I'm becoming more aware of things." At one point Joan said that she felt that when people were being "smothered" in their situation they should change their situation, but she also said that if things got bad in her job she would "stick it out."

Joan says she has a "positive attitude" about nursing. She enjoys it and, even though there are things about nursing which she believes are not satisfactory, she feels good about the profession. Her dissatisfactions with nursing

center on the lack of financial rewards, lack of time and money for continuing education, and work conditions which leave her physically exhausted. But Joan said she believes that if someone is not happy in nursing they "wouldn't be happy" in something else because "maybe they just aren't aware. If someone is unhappy in nursing, it is within the person and they would carry their unhappiness with them wherever they went."

Interview. When Joan was asked what clues she had gotten within the hospital about what was expected of her, she responded that one of the things she felt she had to adjust to was the resentment felt by people with whom she had worked earlier as a licensed practical nurse. As a practical nurse it is necessary to accept supervision and direction for nursing care from the registered nurse or physician since the practical nurse's education is limited to the functional aspects of patient care. Joan's change in status meant a change in relationships with her former peers and she was prepared for some of these changes by a course in the college nursing program in which some of the aspects of the job were considered and role-playing was used to explore what might happen to the new R.N.

Joan said she anticipated some resentment in her new role because she had worked in the hospital area where she was assigned before as an L.P.N. "Six or seven years ago, and I knew all these people I had been their equal as an

L.P.N., and all of a sudden, I'm giving them instructions, or not necessarily instructions, but assignments. There is resentment, just knowing the individual. So I had to do a lot of thinking about that before I even accepted the position." Joan indicated, in response to a question about how she was able to know that resentment was present, that it was "Probably more actions. I think at first there was sort of a coolness, an aloofness, the atmosphere, and the way I handled it was, I tried to go in--well, you know, other people, and even physicians would say 'you're a new graduate, how do you spell this word?' and naturally you knew them, you're right out of school; and so I try to be real careful. I try not to be the 'smart-aleck' that knows everything. I have to be real conscious of that. I try to deal with a lot of things by asking 'do you think this would be a good idea?' or 'how do you feel if we did it this way?' rather than saying 'let's do it this way' even though I knew it's the way it should be done." Joan said that she did this even though "There were some situations I felt like it had to be done, but I tried to be careful about letting them have input." One of the things Joan said she had to be careful of was that her nursing coordinator (head nurse) was fond of her, and other people in the unit, especially R.N.'s, sensing this, would make "super-nice compliments" about Joan. She said "I really had to be careful about responding to that." I asked if she felt that she had to "put up a front" to

respond as something other than herself in the situation and she said "Yes, sometimes. At least the first 4 or 5 months, there were a number of times. I sort of had to play myself down. A lot of the physicians were glad I had gone on to school. Even Dr. _____ (whom Joan had worked for as an L.P.N.) would come in and say, 'How is the chief doing?' But that was when I could feel and see that type thing. But I kind of expected that. It was harder, I think, than if I had gone into a whole new set of friends."

When Joan was asked why her coordinator had "bragged" on her, she said that it was because "Maybe I'm doing what she thought I should be doing; her expectations of me. But I wasn't doing just what she (the coordinator) wanted." And she felt that the coordinator would accept Joan's interpretation of what she should do. When I asked if Joan felt she was sensitive to what other people want, she said, "Definitely, I guess we all are, maybe some people are more than others." While Joan's sensitivity is valued in the way that she responds to patients and to co-workers, it also seems to lead her to situations where she must risk her own sense of self. The qualities which prompt her to remark that she has "given and given" are also the qualities which help complete her sentence "without reward" and her behavior must be considered as a response to conditions within the past, present, or future environment.

Joan says that she had a strong sense of what she wanted to be when she went to the hospital as a new R.N.

I asked if that had changed and she indicated that it had not. "School is the ideal situation, and when you get out, being able to balance your see-saw, being able to make modifications, but yet stick to the principles you were taught; I think you do have to modify somewhat from the ideal textbook situation. You get out there and I think it's sort of being able to modify yourself but yet still retaining your strong principles to be the right way, the right thing. When I use the word 'modify', I don't mean that you give in, you still stay very strong in your beliefs, in the way things should be done. In order to stay comfortable with myself, I have to stay strong in what I believe. I can live with that better than I can live with giving in." I asked Joan what she thought caused nurses to give in at times and she said, "I think it's the person herself not being strong enough. It's more comfortable to give in, less pressure maybe. Maybe. Nurses get burn-out. I see tremendous numbers. They are just tired, not only physically exhausted, but in a lot of aspects of their life, and it's easy to just give in. Workwise they are not rewarded. Financially they're not rewarded. We talked a lot about that in school, and I'm thankful. That's been good for me to fall back on." At one point I asked Joan why nurses continue to carry on in the same routine. "Just tradition and thinking this is the way it's got to be. If I don't do it I will look out of place with my peers and I'll be the oddball if I don't do it;

if I don't do it, how it's been done for years. And I feel like if we had more inservice (continuing education)-- it's why you see so much burnout, I think, I see that with my peers. I haven't been that long out of school. I'm still pretty excited about it, I'm still in the honeymoon phase compared with those who have been there twenty-five years. I think if it was made aware to those girls that there are things, but they aren't aware of it. They don't know how to get out of it." I asked why we couldn't see those alternatives on our own without having some sort of stimulus and Joan said, "I think there is a different trend in nursing in the past few years that makes you aware of doing those things, but back maybe 20 or 30 years ago, these things weren't evident. They weren't aware."

The new trends are found not only in nurses, according to Joan. She said that she had a hard time seeing the difference between men and women in the hospital. She saw them as a team, and herself as a nurse. "As far as the ones that I know, administration and physicians see them that way too. I haven't seen them deal with men I work with (male nurses) any differently. But it's hard for me to see them as if they were all men. I don't know why. . . . I see them a lot in the same way as wanting to share, wanting someone to care. But I cannot see them ever willing to go that tenth mile. They'll go eight but not ten. I think it's the way they are brought up. I can see younger, teenage guys;

patients, friends of my children, younger doctors, they are willing to give of themselves. Their time, their energy, their feelings, their thoughts, that I don't see the ones who are older giving. Like all these new doctors, they just get in there and roll with everybody. They get in there and cry, they are willing to touch; they are willing to give time, to give energy and I see that more in teenage boys, too, more than even in men my age or in their forties and fifties. I think it's a new trend of being brought up. That it's okay now. It's okay to touch or to cry if somebody hurts. Or because you're frustrated and angry. It's okay, but it wasn't okay with society before."

Joan believes that feelings are important to women. "A lot of times women are willing to sacrifice physically, financially, a lot of different ways because they feel stronger about something. And sometimes I feel like men aren't as willing to sacrifice for feelings as women are. That's my personal thought." When I asked if the issue of feelings influenced the way nurses go about doing things she replied, "Definitely, because I think if you're a feeling type person you're not only willing to give a bit more, but to express it. I think, to me, that's important, I think someone who isn't won't give as much. You're able to be more perceptive. I think it can cause us a little more discomfort and pain sometimes. . . . Overall I see it as beneficial because you are able to see more. Give more,

feel more, and get more rewards, too . . . but it does cause you some pain." I asked what kind of rewards we get that men don't and Joan said, "What rewards do nurses get? I think the number one thing is that the reason nurses get out, the number one thing is financial. Maybe work situations, compensation for having time off to go to educational experiences, you know you aren't paid for the time you're off duty. You're not given any money to help do those type things. If you made enough to begin with to do them. . . . Nurses who stay in are the ones who are still getting some of the things they went in there for. Just the self-satisfaction--that type of thing. I remember one time hearing that people who are nurses are getting their own needs met. And at first I resented that! I thought how ridiculous! Then after I thought about it a long time, I realized they were right. I was getting some of my needs met there. . . . When I looked at it honestly, I thought, I too was there for some of those reasons." I asked if we got the message that we shouldn't have our needs met and Joan said, "Yes, at first I thought that would be selfish, you're there for the wrong reasons, you're there to be selfish. You're weird. Then after I really looked into it, I realized. And maybe some maturity too, I realized that it's okay." I asked what gave the message to nurses that they shouldn't have needs met. "I think it would have to come back to your individual feelings about yourself. . . .

I think that they would feel unhappy, their self-esteem would have to be low. Not feeling like they were giving--getting any rewards."

Joan recognizes that it is acceptable to meet some of her own needs through nursing. She readily admits that when the idea of such a thing was first suggested that she was not attracted to it. But I believe that she continues to feel that this should be a secondary concern of nurses. There is more an indication that the nurse should be emotionally strong and secure and able to draw rewards from some internal mechanism.

In addition to the lack of financial rewards in nursing, Joan also cited the routines of the hospital and isolation as a problem. Because Joan has worked on one of the surgical units, as well as the emergency room, she has some understanding of the problems on the nursing unit. But there is a message conveyed in the hospital that when nurses aren't busy, when they are seen talking together, that they are not performing as they should. In the emergency room, when nurses spend time in the lounge together, many older doctors complain. "If older doctors don't have the nurse right there to put the cap on their pens if they fall off, they complain." The belief that nurses should be discouraged from sharing concerns and information with one another was reinforced when some nurses wanted to get together outside of the hospital, on their own time, to discuss

problems. Joan said of this incident that the activity was considered by administration to be "union activity" and that nurses who continued the activity were threatened with being fired. The routines of the nursing units also cause problems for nurses. In her own unit there is variety. But not in all nursing units. "I worked on the floors as an L.P.N.; not very long though. I don't know whether it's a true picture, but in the emergency room it's a change. On the floors . . . I think sometimes they are doing the same type thing so much they get in a rut . . . it becomes such a routine, if everybody doesn't turn the patient every two hours, cough and deep-breathe him (expand the lungs), it just becomes a routine. Instead of thinking for themselves, I'm not trying to label them. That's what I see." When I asked what would get nurses out of "falling into ruts" Joan said, "if more nurses were allowed more time for seminars, for getting together to air their differences, to sort of diagnose what is going on with themselves. I think maybe sometimes it would be to rotate areas, not stay on one floor for twenty years. . . . I think they get isolated; maybe we get isolated, too. I guess different nursing units are isolated. . . . I've often thought how it would work if maybe 5 days out of the month we could work in a different area. Sometimes the emergency room thinks that if they get the patients up to the floor, they (the floor nurses) can do it. But I remember very well how it was at

2:30 in the afternoon when everyone is coming up and needs I.V. fluids, nurses notes; and I think the emergency room could see that they don't just change beds and take blood pressures, temperatures, and pulses on the nursing unit.

In becoming a new nurse, Joan tries to "balance the see-saw" by modifying herself while continuing to hold on to the beliefs that are important to her. She feels that she is now in the "honeymoon" stage and still feels excited about her job, a feeling which she attributes to her educational experience. Presently she believes that she is holding onto those beliefs even though she had to respond to some situations by being inauthentic in deferring to others when she was well aware of what needed to be done. She has gotten the message from the practical nurses, with whom she was an equal before becoming an R.N., that she should be careful in her treatment of them. The coolness and aloofness is interpreted by Joan as a need for "being careful about letting them have input." Of the R.N.'s, Joan feels that their compliments are attached in some way to the coordinator's appreciation of her and, as a result, she has to be "careful about responding to that." There is an interesting interplay in which physicians indicate that her recent educational experiences have equipped her as a spelling consultant and the doctor for whom Joan previously worked calls her "chief". Joan senses that she has to be particularly careful about demonstrating authority (power)

in the situation and attempts to be "real careful. I have to be real conscious of that. I try to deal with things by asking 'do you think this would be a good idea?'"

The interview seems significant in the things left unsaid as well as those that are said. Joan does not indicate that the compliments given her by the nurses might be due to admiration or support. Their remarks are interpreted as a need for being careful in relationships, especially with the nursing coordinator who is seen as having some power. And it appears that she believes she should not appear powerful even if it is power derived through association with the nursing coordinator.

By contrast, Joan seems to see the physicians' asking her to spell complicated medical terms or being referred to as "Chief" as complimentary even though it makes her feel that she must "play herself down." While the nurses' evaluations are attributed to deeper motives, no such motives are attached to the physicians' statements. She also feels grateful that her instructors in the nursing program had helped her consider the problem of possible resentment from co-workers.

Her estimation of the younger physicians and their willingness to express emotions and to share their sensitivity parallels statements made by Linda and by Kathy. Joan sees the young doctors as analogous to younger patients, friends of her children, and teenage guys, who are willing

to give of themselves. Because she sees it more in the teenage group than in men her own age, she believes that it reflects a recent change in the way people are brought up. In effect it has become permissible for men to have emotions and feelings. The question remains, however, whether the young physicians' actions are similar to teenage boys because they hold a similar, adolescent position in the hospital between the nurse who mothers and socializes them and the authority of the older physician who must eventually be imitated for full status, or if there is indeed a reordering of the previous belief system in which men remain analytical, detached and objective? Due to personal experience, my own belief is that younger physicians, as a group, are usually more vulnerable and dependent and tend to express feelings more freely. Regardless of when such behavior emerges, it seems evident that it is a response to conditions within the individual's past, present, or future environment.

The confusion in stating "giving-getting rewards" is illuminating. Must Joan feel that she must accept her own giving as her own reward? There is awareness in her attempt to "balance the see-saw." Joan wants time to reflect, to attend seminars, and to increase continuing education time. She recognizes that the routines of the nursing units can dull the nurses' perceptions of pressing needs. And she sees that nurses become "not only physically exhausted but in

a lot of aspects of their life, it's easy to give in." But her belief that nurses "carry their own unhappiness with them, that it is the individual person who is responsible for their own well-being" effectively prevents her from recognizing the assaults from within her environment. There is assumption of a reciprocity of perspectives so that in the hospital Joan believes she will "give-get rewards" and in return the medical system will "give-get" rewards. The expectation of reciprocity continues although the hospital has provided little or no time for reflection, restricts salaries so that Joan is financially limited in attending seminars on her own time, and provides little continuing education within the structure. The isolation from other nurses, other than her own unit, is something which Joan regrets because she is a sensitive, caring person. But she has not experienced the support she might obtain from a more strongly welded nurses' group and therefore accepts the necessity of her own and other nurses' isolation.

When Joan indicates that she tries not to be a "smart-aleck who knows everything" and that "I have to be real conscious of that," she is acknowledging what her sensitivity has led her to discover as the expected role for nurses, that of powerlessness. By trying to be conscious of the needs of others and the system within which she works, Joan remains insensitive to some aspects of her own needs. The fragmentation of her work is both interior and exterior

since Joan has developed no framework of her own from which she can question and judge the technology that surrounds her. Her education has helped her to fulfill the needs of others but fails to provide her with a lens to examine how society repays her.

Joan says that if situations are "smothering" an individual that they should consider alternatives, but she believes that if her job goes bad she will continue to "stick it out." I suspect that Joan will continue to "give and give without rewards" because her wholeness and awareness will not be nourished in its present environment. She is accurate in stating that the nurse needs to be strong within herself.

Linda

Linda graduated from the associate degree nursing program 18 months ago. She is 34 and describes herself as "something of a loner." Her description of herself is based, I believe, on the investment she chooses to make in maintaining friendships rather than any characteristic which would restrict friendship. I see Linda as one who determines her own time and place to be with people. She was relaxed and friendly during the interview and seemed to enjoy it. Even though there were other questions I would have liked to focus on, subjects introduced by Linda were significant to both of us, and as a result I preferred to follow Linda's inclination in this interview.

Linda grew up as the daughter of a noncommissioned army officer. She says that unlike many army families, her family lived in the same Southern city for eight years. "The only difference was that my father put on a uniform when he went to the office." Linda's father's position had "something to do with supplies" and she feels that her early childhood years were more typical of stable suburban families than of army families who must move frequently. Linda has an older sister and a younger brother and she says that she liked being a "middle-child," but she would not elaborate on why she felt this. Linda's mother never worked outside the home, instead spending her time caring for family. Linda said that in some ways she thought growing up was a form of the "grieving process." When I asked why she felt this she indicated, "Because it's a process of giving up your illusions, of believing that someone will always be there for you and finding out that you're really alone in the world."

One of the events in Linda's life which she feels influences the ways that she looks at the world was the transfer of her father to Germany when she was 13. Her family moved from a suburban environment to an army base in a foreign country, and Linda says that it was unsettling for a 13-year-old to find herself in such a strange and different world. "The cultures were so different and at 13 it was something I had to work at getting used to."

When Linda's family returned from Germany and it was time to choose a college, she decided to attend an institution in a town where her older sister lived so "I would have someone with me." Following college she married and taught school for six years. When Linda's marriage was terminated by mutual agreement, she says the greatest problem for her was having "to learn to live alone in the world." She says of herself that since her divorce she has had to do a good deal of questioning about her own needs and those of others.

During the interview Linda related an incident in which a friend stated at a time when Linda was emotionally upset that "Linda would be all right." She said that the comment made her angry at the time because she saw it as uncaring. But now she had come to understand the meaning expressed in the words (and the implicit acceptance of her own capability) and had come to share this belief with her friend and to understand the motive behind the statement.

Nursing is not Linda's first career choice since she taught six years in an elementary school before she decided to become a nurse. She says of this experience, "When things get bad in the hospital, I just look back on that experience and think 'things aren't so bad after all.'" When asked what her attitude was towards nursing, Linda said that she sees nursing as an opportunity to "get something for myself f there weren't something in it for me, I wouldn't do it." At another point in the interview, however, Linda said, "It

takes me a long time to figure out why I'm doing something, and as I figure out 'what's in it for me,' I may find that's not what I want to do, that my motives weren't that great. But I have seen some things change. Some are intangible but they have changed. I think it starts with a change in attitude. And that takes a lot of time. A lot of patience." Linda's entry into nursing has been marked by changes which have at times been "unsettling" and when she says she believes that change should come about by "working with people rather than mass movement" it seems to reflect the changes in Linda's life which have resulted in a change of attitude about people and her own place in the world.

Interview. Linda said of her socialization experience that she had to become a nurse "by playing it by ear" since she had no set opinions of which she was aware about what a nurse should be. She said that when she first got out of nursing school and began working as a nurse she was trying to take responsibility for things she really couldn't. "I came home exhausted . . . then I figured out, I could try to take responsibility, but it wasn't going to do any good. I shifted that attitude in my mind." She said that in learning to become a nurse she "looked around" and saw things she liked. "Some things I liked and didn't like in the same person. I sort of picked things I liked in certain people and tried to develop that in myself. Or at least my version of that." I said of this, "It wasn't exactly the same?" and

Linda responded, "Right, it loses something in the translation when it comes through me. I didn't know anything about being a nurse. You have to look around; that's where I started. I'm not saying I thought this through. I wasn't aware that's what I did, but you're asking me what I did, and then I would think how I felt about things and I would decide. And I would make mistakes. Situations I handle now so easily that were so hard. I was scared." I asked Linda if she felt vulnerable to "picking" things up during the early period in the hospital which she now considered "excess baggage" and she replied "Yes . . . a couple of things. I picked up that technical skills were some . . . almighty kind of thing. It was like whoever had technical skills came close to the Virgin Mary. I couldn't, I didn't know how to do everything. All of a sudden I'm in charge of a 36 bed surgical floor. The only R.N." Linda said she believed technical skills were important but that anyone can learn to do them. She has now come to believe that what is important is "Sorting. The ability to sort mountains of stimuli coming in. To pick out an order in a certain way. Some way of being efficient in the sense that you don't waste your energy. Dealing with people. Not in the way I used to think. Not as a mother . . . I care about their (patients') problems, I care that it's explained and they are given support if that's what they need. I care about them. It's like I don't care in the sense that I have an emotional

involvement with that person." Linda says she believes that patients often check in to the hospital to be "mothered" and that it is a real temptation to become a mother. "People will ask you to make the damnedest decisions for them but I just do not buy into that. It's good for your ego, but the price is too heavy. . . . I quit doing that. I was so tired I felt drained. I had vampire dreams. I got the message. I was either going to have to do something about it or check out of the business." She says of her patients, "I care about them because I care about myself."

Linda said she feels that part of the belief that seems to come across in the hospital is that caring means making things easier for people. "Caring means taking responsibility for them . . . emotional responses--even when you have to dig them up. Basically sentimentality." But she says, "There are times when grown adults need some real, what you call 'mothering'. It just doesn't seem to come up all that often. And a steady diet of it.?!" Linda said of physicians and "mothering", "I think physicians particularly, most of them,have some idea about what that is, too. They're in a double bind of doing the masculine version of father, but they have some idea of what that means. The authority figure. This is a 'good nurse.' I just finally decided I wasn't going to make it if that's what a good nurse was. I would say 'I don't know--the patient was breathing the last time I saw her' and they would laugh and say 'Are you sure?'

I don't have any intention of pretending. I think it's a mistake, nurses covering up. Yeah . . . madame mother was in charge and was going to take care of it. I would just say, I don't know. I haven't seen the patient." Linda said that at first she was afraid of doctors and would hide from them. Finally one day when a physician stood in the middle of the hall and yelled for her she said her reaction was, "It scares me to death and I haven't done anything" and told the physician, 'Please don't yell at me'."

Linda did not single out doctors in their attitudes along age lines. She did feel that nurses with technical skills were more valued by physicians than those who nurture. "The beauty of the technical is that it's there, it works, it saves people's lives, there is a real high to that. That's good and I like that. But it's not enough, it's like anything else in excess; technology in excess becomes an evil, intuition in excess becomes an evil. There's got to be some sort of blending. Not damage one for the other. . . Doctors, well it's fact--if you can't see it, taste it, touch it, then it doesn't exist."

Linda related an incident of a doctor who couldn't understand how the patient could feel better when the patient's x-ray looked worse. Asked what he chose to believe, the doctor had to struggle with believing the patient's own feelings. "It never occurred to him that was something you could do." But Linda says, "Nurses deal with

people, they know things lab work won't show you. It must be frustrating for doctors to look at all the technical data. He is locked into one mode and they can't consider the patient. The feminine mode accepts that better. We can all relax in a certain way."

What stands out in Linda's interview, in the way she felt about the hospital in the beginning of her nursing career, is an impression she gives of a nurse working on the unit. "I'd see this nurse standing there, and 16 doctors are giving her orders, and she is taking it all down, she's doing one thing with one hand, and one with the other, and I thought, 'If I ever get to where I can do that, I will be so proud of myself!'" She says that the way nurses are expected to act is "in the system." She says that nurses are treated as though they are interchangeable and "if you feel that way about yourself, it just perpetuates it. There is nothing wrong with being a human being. I have to learn. Somebody said once, 'Why don't you know this' and I said 'forgive me, I skipped medical school. I'm not a mini-physician.' It's a different thing entirely. I value what nurses do. They are not doctors. It bores me. I'm not interested in it. I gave up and concentrated on what made sense to me. Sometimes we get the uniform mixed up with the person inside, the patients, the doctors."

Of the hospital system, Linda says, "You know the biggest thing that has surprised me is that the place where

you're supposed to care is set up to be so inhumane. I don't know how that happened. I think technology overran us. You get so bogged down with routines. There is not much left over. I don't want to be mother, but there are some things I would like to do, some interchange with the patients. It's as important as some other things we do. It's set up in such a way--you're locked into that system. It's frustrating." I asked if she believed the hospital had to be that way and she said she believed "It's so deeply ingrained. Something far deeper is going to have to change. . . . I know it's pretty rotten all the way through, except in some situations like in your specialty areas. That's one of the reasons I left the surgical floor. I'd scrub streets before I'd go back. It's hopeless. The nurses don't feel good about themselves. The nurses perpetuate it. I know they do. They feel powerless. It's like the technical skills, which tend to be more masculine. Whatever nursing is--is feminine. You don't have very good technical skills on the floor. The physicians know that. The emergency room nurse has a lot of technical skills; the physicians value us more highly. Nurses do, too." Linda related how, when E.R. nurses wanted a raise, they decided they were not concerned about the remainder of the nurses in the hospital because "If every single nurse on the floor got together, it wouldn't carry as much weight as the more technical specialty nurses. And there were some good nurses up there. I ran--

it's a hard job. It takes an amazing amount of skill, knowledge in dealing with people, families, staff. But they aren't tangible. You can't see them. I think that's what nursing should be. I don't think people will value that until nurses value that. When I started out, I could do some of these things, but I didn't value them. They were feminine, not tangible things."

When I asked Linda how nursing school had influenced her attitude she stated, "Interestingly enough, my impression was that nurses are educated different verbally--you're not just a handmaiden of the doctor, etc.; they tell you that, and that's good, but I don't know. When you don't know anything about nursing, your instructors are going to give you that intangible attitude without a word having been said. You pick up from them because you don't have anywhere else to start. I felt like I was told one thing and yet I saw that attitude that had some of the same stinking rotten problems that the rest of them have. They are women who have been educated in the same society. Yes, I learned it in nursing school. But I didn't pick it up from anything I was taught. I was taught just the opposite. But you know what you're taught. I think they (the teachers) would be horrified. They sincerely do not want to pass that attitude on. But it continues to perpetuate itself and it starts in nursing school. Because most of your instructors are females and it goes back beyond nursing. Not really valuing yourself. I think

it's changing. And one of the reasons that I have gotten where I am is not because they had cleaned up their act but because they were struggling with it. It's not have you cleaned it up, it's are you questioning? Trying to change things; it's made a difference to me."

Changes for Linda, I believe, are not always positive, and the transition from student to beginning nurse poses some degree of threat. Linda recognizes that choosing her role of nurse is more of an interpretation process but she believes that something is lost, rather than gained, in the process. In translating what she saw that she liked in other people, Linda recognizes that variations occur through her own re-creation. Her initial feeling of having to accept responsibility for things which were outside her personal control took energy which could be used in more productive ways. I believe that once this was recognized on a deep personal basis, energy was conserved and used for the things she could control, such as indicating feelings about being yelled at by the physician.

The message that "mothering" is part of nursing is one that I believe many nurses (and women) accept in attempting to help others. It can also be found in nursing education. Helping comes to mean the assumption of responsibility for people (and students) by attempting to make things "easier" for them. Telling patients and students what to do instead of encouraging their own objectives and goals tends to feed

the ego but at the same time costs the helpers a good deal. It creates tremendous burdens for the "helper" and encourages the continuing dependence and the absence of personal esteem and power of the one who is helped. It seems that Linda's is a deeper, more adult form of caring in that it reflects the message her friend gave her, that the person helped "will be all right," recognizing the innate capability of individuals to determine what is best for them. Her admission that she had feelings akin to terror about the expectations of her job and the authoritarian figure of the physician, points up her acceptance of her own humanness and frailty, and a rejection of the need to reproduce authority in herself. By refusing to become "madame mother," many of the traditional rules of interchange between nurse and doctor are broken and by approaching the doctor-nurse game with irreverence and humor, Linda perhaps allows others to see the cost of such games. I can only wonder at what might happen if more nurses felt freer to express their ignorance, their terror, and their inability to be the super-efficient nurse in terms which are not demeaning. At present I believe that many feel unable to do so because it appears to be a win-lose situation where rules are handed down for playing the game by those who have learned well how to continue losing it.

The perception of technology in the hospital is one that had not occurred to me before. Nurses who are considered

technically proficient are more valued than are nurses with the more human skills for nurturing. It is such a tacit understanding that it goes unquestioned. The technical skill produces tangible results which can be easily observed. Teaching someone about the disease process or listening to someone explore their own feelings provides little that can be in Linda's words "seen, tasted, or touched." Acceptance of others' valuation of technical over intangible human concerns reproduces this system and causes the feeling that nurses are interchangeable (because technical skills require little creativity), and causes nurses to feel powerless in a masculine (technological) system that does not recognize their worth. But nurses and teachers of nurses perpetuate the system. Nurses accept others' estimates rather than their own of what is valuable and reproduce what they have learned when nursing teachers fail to examine and question the values that are obscured in the technological system of teaching by objectives. The fragmentation of values from nursing practice and from nursing education prevents more conscious decisions about choices made in nursing.

The fragmentation of the hospital divides rather than supports nurses in a feeling of community. Nurses who specialize bask in the reflection of masculine values while feminine, intangible skills go unrecognized and there is awareness that greater power remains in the hands of those who accept and act on these values. Even though Linda says

she had some of these skills when she entered the hospital, she was not really conscious of them and could only be impressed by the nurse who seemed to be "doing one thing with one hand, and another thing with the other." It was only after she reflected that she could become aware of less tangible assets. The isolation of being the only R.N. on a surgical unit and the responsibility for 36 patients probably contributed to the priority for development of technical skills since the demanding routine left little time to "sort mountains of stimuli coming in, to pick out an order in a certain way, and to learn to be efficient in the sense that you don't waste your energy."

Linda's help in working through this mountain of stimuli came from her friend, who once stated that she believed Linda "would be all right." Linda says of her friend that many times they do not see issues in the same way. They often disagree; "they rarely had the same approach or answers, but it really helped" because the friend had "given her credit."

In one part of the interview Linda talked about how nursing is a reflection of the feminine psyche. "I don't believe the male and female psyche are the same. There is some kind of built-in capacity (in the female) for putting your own wants and needs aside. We just do it. Nature made it that way. But that's for people who are "two-foot-three." When people get to be "six-foot-four," well, they need to take care of themselves, and that's, well, I'm sure it goes on

in other walks of life, but nursing in particular, it's mixed up in the helper role, whatever that means."

There is some ambivalence expressed in Linda's estimation of nursing. While she sees the helper role as misinterpreted by many nurses, she nevertheless indicates that the intangible, nontechnical, people-caring skills are what nursing should be. She is obviously aware that these skills are not valued and even though Linda wants desperately to hold on to her own values, she also wants to feel good about herself, something which she says nurses who practice the less technical skills do not do. The dilemma is to gain approval of those who would make one feel good about oneself as a nurse while holding on to the beliefs that are important to one's own sense of worth. When Linda is torn between the value placed on technical skills and the value she places on the less tangible people-related skills, she must make a choice. In one part of the interview Linda said, "You know, I found myself getting confidence as a nurse and I thought, I'd get a compliment from a physician and it didn't mean anything. I thought, I didn't know what he means, 'be a good nurse'; what I appreciated was that he was thoughtful. So it's not 'to die' for strokes. I much prefer picking up on something I value." But Linda's denial of the need for affirmation must be reconsidered in view of the fact that she leaves the nursing unit where nurses carry on activities of which she says, "That's what nursing should be," to go to a unit that

is highly technical. She understands that the nurses do not feel very good about themselves on the less technical units and is sensitive in recognizing the threat of remaining in an area where the skills she values are not esteemed by the people with whom she must interact.

In one part of the interview Linda related a personal experience to the hospital situation: "I was either going to have to do something about it or check out of the business. It wasn't that difficult because I had checked out of some personal situations which were similar." Linda said that sometimes it was like saying, "Oh, I remember this one," indicating that it is sometimes necessary to leave a situation because of the threat to individual worth and well-being. The recognition of an earlier threat in her personal life makes it easier to perceive a similar threat in the hospital and she responds by choosing the course which appears less threatening to that existential self.

In addition to the personal need for approval, there is also a recognition that an imbalance of power exists between the masculine and feminine aspects of the medical care system and within nurses who are seen as more or less technically skilled. This is evident in the beliefs of the emergency room nurses that their small group could attain what all the other nurses in the hospital collectively could not. The identification with the masculine technical skills and the masculine power which accompanies them may account for the

labeling which Kathy C. describes in her interview. When nurses on other units refer to emergency nurses as "uncaring," it is an expression of a belief that there has been a sacrificing of the less-tangible female aspects of caring.

Linda's choice was significant, however, when she said, "I think that's what nursing should be. I don't think people will value that until nurses value that," and it becomes more significant when her reasons for becoming a nurse are examined. When asked why she chose nursing, Linda replied: "I haven't the foggiest idea. I thought it was something to help people. That was part of it. But there is some intangible thing--I've gotten something out of it. I think the motive was a selfish one, that there was something in it for me. I don't know how I knew that . . . you learn to trust your instinct." Linda emphasized in the interview that when something is done to help people it must be done so that it is helpful for both parties rather than just to help herself. The reverse of this coin, however, is that she cannot care for others' needs without caring for her own needs, but this caring includes sacrificing some personal values to acquire a feeling of worth from others. The balance of power indicates that masculine approval is more significant than the disapproval of other nurses who have labeled technically skilled nurses as "uncaring", and Linda responded to the dilemma by choosing the course which she believes to be less costly to her own being. At the same

time she reaffirmed her statement that women have "some kind of built-in capacity for putting your own wants and needs aside." But it appears that rather than nature's causing women to put aside wants and needs, it is more likely that it is this imbalance of power requiring the sacrifices women make in exchange for the parsimonious doling of limited worth and esteem by a society dominated by masculine values. Nature is really the effects of socialization writ large.

Martha

Martha is 34 and graduated from the associate degree nursing program six months ago. She is divorced and has a son who lives with her and her parents. Before graduating from the associate degree nursing program, Martha worked as a licensed practical nurse at the hospital.

Martha grew up as the oldest child in a family of four children. She said she believes that being the eldest was best because "I had the best of my mother and dad's time. We've always been closer to one another." Martha's father is a postmaster in the small industrial town where her family lived while she was growing up. She says that she knew everyone and that many of the people in the town were "kinfolks." Martha's mother spent her time caring for family and home.

After high school, Martha attended a nearby college but she said, "It offered no challenge. The people there were the same kind of people I grew up with and I wanted

something different." Martha dropped out of college and joined the army, where she met her husband. She describes her experience in the army with great pleasure. "I met the best and worst of people. It really gave me a different picture of life."

While Martha's husband was stationed in Germany and her son, who was born in Germany, was still a small infant, an automobile accident caused severe and permanent brain damage to her husband. Martha found herself isolated in a country whose language she did not speak. She was also without funds since the army, through a bureaucratic error, stopped all allowance payments to her. She was forced to rely on family and friends to get through a very difficult period. When the family finally returned to the United States, several years were spent commuting to army hospitals in the treatment and rehabilitation of her husband. As the once bright and articulate man had to learn to accept his mental and physical limitations, Martha found his attitude toward her changing. She says that "The very things about me which he had liked the most became the things which he hated the most." Eventually a divorce became necessary and she entered a practical nursing program so that she could support herself and her child.

Martha is capable of investing a great deal of energy in work which she finds interesting. She is spirited and independent and does not easily sacrifice that which is important to her. She recently took a trip to New York City

because she says she had "promised herself such a trip" and "I loved it so much, I have every intention of going back." Martha is capable of play as well as work and is a witty and fun-loving person. She once indicated that the first year of the associate degree nursing program was very "trying" for her because much of the material covered was something she had previously learned in the L.P.N. school or in the hospital. She finds repetition and routines difficult to tolerate and in the interview points to the routines of the hospital that cause her to be uncomfortable because "I need a lot of stimulation and challenge. . . . I'm bored easily." I believe Martha's hatred of repetition and routine comes from a keen intellect and an awareness of her own needs. She is interested in growth and satisfying a deep curiosity about things in the world. She brings her experiences and her need for continued growth and stimulation to nursing and interprets it from her own unique vantage point.

Martha says of nursing, "I have ambivalent feelings about it. I love what I am doing right now. I am gaining more confidence and I can see other people's trust in me grow. But there are things on the periphery of nursing that I don't like. I don't think I want to be in the same place ten years from now. And if I had a daughter who was 18 and considering nursing as a career, I would try to talk her out of it. I'd tell her if she was interested in medicine

to go to medical school." The ambivalence which Martha expresses is representative of the way in which she approaches the task of developing a view of the role of the R.N.

Interview. Martha said that she thinks she is not "there" yet in learning to become an R.N. "It's still developing, the ideal of what I want to be--I'm not there yet. I'm still feeling my way and there are a lot of things that I want that I'm not yet, that I want to be, but I'm not there yet. What I wanted and what I am are different. I just haven't got there yet. I recognize that I need a lot of stimulation, challenge, just in my own personal need. What I need to do is get more comfortable with the routine, the everyday things. I'm not now, I'm bored and I see that. I need to accept things easier without immediately fighting back or getting on the defensive. I see so many times that there are things that are wrong, that there is nothing to do. Nothing I can do. I need to be more accepting of that than giving myself an ulcer over it." Martha says that she gets angry sometimes. "I feel myself getting angry and that's not going to help. I have to say 'well, that's the way it is. I might as well accept it.'" Martha felt this anger because she often has a hard time not pointing out problems and she says "it seems people get tired of hearing that, they don't want to hear it." I asked how she got this message and she said, "I guess I can kind of read it, well, one thing is that nothing is ever done. And I can see it in the feelings of the people. It's like 'here she goes again.'

I have learned to hold back until it's something big. If you fight for everything then they don't listen, you have to wait until it's something major, then throw a fit." Martha, in becoming a new R.N., is being told here that the role of the new nurse (rookie) is not to criticize or point out flaws in the system. She said at one point, "When I see something new and I want to bring it up, they'll just say, I just feel I'm making waves and should just keep my mouth shut. I feel like maybe it's just my boredom, just because I'm looking for anything, change for the sake of change. I feel, well, maybe that's the reason." But Martha has her own idea of what a nurse should be, and even though she tries to accommodate what she believes are the messages given in the hospital, she says she believes that many of the nurses follow routines because "I think it's security in a big way. Some people don't like anything new. I feel like they get into the routines and they're scared to accept, to try out. I don't know what they think will happen, but they're afraid they'll have to change. You can tell when you meet people, who will accept change, which ones are going to be enthusiastic about new things, which ones aren't. I'm prejudiced, I want new things. I think that's the best kind of nurses." Martha indicated here that she looks to nurses who want change as models to emulate. It is an unstated but apparent criterion by which she judges the elements she finds most desirable.

Her feeling of being a rookie and, therefore, one who should not criticize came when she said, "There is a lot of responsibility we take on; we have no business. We (the nurses on her unit) talk about it and it's easy to say, well, just tell somebody. But there is no back-up." But when Martha says that she has learned to hold back "until it's something big," she indicated that one of the things she has learned in her role as rookie is that she must be very careful to save criticism for the things which are "major" and then to throw what she calls "a major fit" as a way of demanding attention.

In the interview, I asked Martha if our roles as women influence the way that nursing is interpreted, and she said, "I think so. A lot of people see nursing as what mother did. It's a mothering type thing. Mother is a sacrificing kind of person. I don't think people want to know about nurses. I find people amazed at the things you have to know in nursing. They don't have any idea. They think it's--you know! My own mother--she said, 'I didn't know you had to know all that.'" Martha said she doesn't know what is being taught in medical schools, "But it does seem to me that the younger ones (doctors) have more idea and are more willing to listen to you. I feel that. I see that. I don't know whether they feel intimidated and you help them along, or what. The younger doctors we're seeing respect your knowledge, are willing to listen to you and what you're saying.

Of course there are some that don't listen to anything. I think nursing is partly to blame for that. Over the years, the games doctors and nurses have played. You never came out and said, 'I think your patient needs _____ and _____.' You hinted around, you know. And I think younger nurses aren't as willing to play the game. And that's very hard for the physicians. Especially the older physicians. There are just certain physicians, you know, if you suggested it on 'days', they are not going to write an order for you. They'll wait and come in on the 3-11 shift and write the order so it won't look like your suggestion. So you try to anticipate so that the patient's problem won't be worse than it should be." When I asked Martha if that sort of happening gave her a message, she said, "It gives me the message they are very insecure, it gives you the message physicians are very protective of their domain. They are really afraid." I asked how this made Martha feel about herself and she replied: "Sometimes I feel a little superior, a little above them, they are just childish, but many times it also makes me feel very frustrated for the patient, because they are the ones who eventually suffer. They end up suffering. Of course I end up suffering from my frustrations. It is very irritating."

When I asked Martha why nurses don't do something about this, she said, "One thing is that it's very unorganized. Each individual as one feels powerless. It's not until you

pull together. The hospital is one of the worst reasons for the way it is. I think it started back when student nurses were used way back when and lived in the hospital and worked. It's just continued on. I think hospitals are one of the major reasons why nurses feel powerless, and I think the hospital likes it that way. And they are not really interested in changing it. They are not interested because they want it that way. You do feel a little isolated. You feel isolated when you've worked there for six years and yet no physician knows your name. No one in administration knows your name. People in administration are amazed and have no idea who you are. I hate feeling like, it makes me feel like there is something wrong with me when I'm very pleased that a physician says, 'Martha, would you . . .?' I feel like 'what difference does it make?' But you do feel that way. That someone knows your name and knows you're there. Trusts you. You're just a voice on the telephone. Sometimes criticism is too general. I want to know 'Am I doing it?' Don't call me 'the night shift.' I don't know whether they are talking to me or not. You rarely get individual recognition. I think men get that more than women do. In most fields, men get some kind of recognition; if you do a job well, or poorly, it's pointed out to you faster. Men just expect that. Women don't get it as often. In a way I feel weak because that's important. I shouldn't need that. If I know I'm doing a good enough job, I shouldn't need that." I asked

Martha if it was because other people were important to her that she felt this way and she said, "Yes, their opinions are important to me. Not overly important. Not a need; something I like. It would make me feel, well, it's more pleasurable." Although Martha indicates that she believes her own feeling of depersonalization may be a personal "weakness" she also can see that other nurses in the hospital have the same problem. She describes her own feeling as "You feel faceless at the hospital. I don't get any sense that she (the nurse) is a person. You're just somebody as long as you show up every night and don't cause any problems. It's the major thing. I feel that way now." It was most interesting here that when Martha referred to herself she used the third person, she, as if she were referring to someone or more likely something, perhaps an object. But Martha also says, "I doubt the power of nursing in the hospital. I feel that way because we're low man on the totem pole. I'm not sure that the director of nursing is not faceless too . . . people don't recognize it because they don't want to see it. You can see people are frustrated in nursing. But can't tell you exactly what it is. There is something there and then when somebody steps out and makes waves, they find out what it is. I think that's why nurses don't stay in nursing. Especially hospital nursing." I asked Martha if women didn't go into nursing because they care for people and she responded, "I don't think they've lost it. It gets buried under

the frustrations. They aren't going to put up with it forever and maintain a sense of their own self. . . . I can't think of any other profession, other than teaching, that puts up with as much. It's because it's female. You are powerless. You're not considered very important, somebody to listen to."

There is a lot of ambivalence in Martha's statement about her becoming a nurse. Her deep feelings are those of "fighting back" and when she says she is on the defensive, I believe that this statement goes beyond the normal definition of "defensive." Martha may be talking more about defending her sense of self than she is telling about defending a particular belief or position. She finds the routines boring and antithetical to the person she wants to be, a person who does not become too secure in the routines, one who wants change. But her fight against routines is costly. When she says that she needs to get "more comfortable," "not give herself an ulcer," she seems to be saying that negotiating the role she wants is so costly that it may be too high, and she may have to give in to what she believes are external pressures. She has given up some ground by waiting now until something is major in order to "pitch a major fit." She is saving her energy for the most important things. But when Martha says that she "pitches a major fit," her wording is such that it appears that there is something not quite right about pitching "a fit." The word

"fit" conjures up visions of someone who is out of control of their faculties, with ineffective tremors accompanied by frothing at the mouth, and an incontinence of the body orifices, something, in effect, which no person with any self-esteem would deliberately choose for themselves. It is as though Martha believes that she cannot become the nurse she wants to be if she gives in to the routines, the security, the boredom, but if she fights she must give up self-esteem in activities that are at best undesirable and, at worse, demeaning.

Some explanation of this ambivalence comes from Martha when she says, "Women are more sensitive to what their friends say about them than men are . . . women would have our feelings hurt, try to make up, bend over backwards for making it up to a job. I see that; I see myself doing that as an R.N. and I try to stop doing it because I worked too hard. I deserve it. But I see myself trying to make up for it." When I asked if she thought she was apologizing for getting ahead, Martha said, "Yes, for stepping out of my place. I don't know why it's that way. It was instilled in you from the beginning, that if you stayed, had a nice home, weren't aggressive, that's all you had to do to be a woman." From this point of view, being a woman means not involving oneself in conflict, and by "pitching a fit," the woman becomes a deviant. When co-workers indicate through gestures and attitudes "here she goes again," it is clear

that this is not the behavior expected or desired. It is unwomanly to "pitch a fit." There is a loss of control of one's own gender identity.

Martha is not just willing to pick and choose those things which she finds most desirable in others. She wants to effect change. From one level of the understanding of her own needs, she recognizes that change must take place. The present status of the hospital and the nurses in it is recognized as a threat and, by falling into the routines, the boredom, and the security, Martha will become faceless, a non-person. "You're not considered very important, somebody to listen to." She feels, or has been made to feel, that wanting to be known by her name is a sign of personal weakness. But it continues to be important, in spite of the fact that resentment of her own depersonalization is interpreted as an individual personality defect.

Ambivalence about her own "facelessness" is apparent, however. Martha states that she is not alone in this problem, that even the director of nurses suffers with the same problem. And in this Martha recognizes the common threat which weaves through the facelessness nurses find in the hospital setting. All are women.

Martha acknowledges that being a rookie (or beginning nurse) means that she is not the nurse she wants to become yet. But she sees about her evidence that she will never be able to achieve that goal unless change takes place. She

says, "Most of the nurses I know who have been working for 10 years are doing it because they need that job for the income. I seldom hear anybody say, 'I'm in nursing because I love nursing.' After they've been in it for 10 years, you don't hear that." Martha feels that nurses who have been at the hospital for as long as 10 years are not the nurses they wanted to be because they don't indicate any love for nursing. They have not made it what they would like it to be. And Martha knows that if she remains faceless, becomes secure in the routines, stays true to her gender, she will not be able to change it.

Gender identity may also be involved in the differences Martha finds between the attitudes of older and younger doctors towards nurses. Contrasts may emerge from different educational systems, but there is also a similarity in the newer doctors' behavior and the masculine child's attachment and dependence on the female caretaker. Young doctors are initially dependent on the nurses for "learning the ropes," for the nurturance needed in a new and threatening world. But full identity comes about when the mother is rejected. Is there a need not to listen to the nurse because she, like the mother, must be relegated to a less significant status in order for the physician to become a fully acceptable masculine figure? Whatever the reason, older doctors communicate to nurses in not-so-subtle ways that the nurse is not important by failing to listen to her and by

withholding power, i.e., not giving the patient what is needed. The nurse is made aware repeatedly that she is in a supplicant's role. There is also the possibility that young doctors are also in a "rookie" role and that their socializa tion is unwittingly carried on by the nurses who "help them learn the ropes," as well as by the older physicians who convey through their behavior the expectations of a full-fledged authority. To admit dependence on the nurse is akin to returning to the infantile stage of dependency and the nurses contribute to the socialization by completing the doctors' education and by acting out their roles with older physicians.

Martha, I believe, is perceptive in understanding that she looks for affirmation in her role as nurse. And she also seems to recognize that her own earlier socialization in the female role is creating an obstruction to achieving the changes that are necessary to achieve affirmation. She feels that she cannot look to other nurses for help in this struggle. At one point she says, "I don't think women are willing to sacrifice. They're concerned with getting home, fixing dinner. But women in other fields have families. A lot of women went into nursing because they didn't see a choice." And "Men know better how to present themselves to get what they want. Occasionally you meet a woman who knows that, but men, especially ones I know, know exactly what they wanted and how to get there. Men stick together more."

Part of the problem, according to Martha, is that women often sabotage other women for "getting ahead." "A woman well a man was promoted and there was no resentment, but if a woman had come into that situation, a lot of women would have been resentful. . . . When a woman moves out into that, it's threatening to your image of yourself. Most women don't want to say I could do that because then they'd have to change a lot of the other things in themselves. Get another picture of themselves. It threatens the image women have of themselves when they see others moving up."

Martha's insights suggest that women are often reluctant to accept positions of power because of their early socialization. Women give up power in return for being protected, and female "cattiness" is a reminder that other women should reinforce rather than make suspect the traditional roles for women. But Martha has discovered through her own experiences that the promise of protection is one that cannot be made. It is beyond the capacity of fragile humanity.

Martha knows she has some capacity for power. She says of herself, "I'm pretty good at politicking. I keep adding things until I can get the group to do something." In one case she "raised cane, griped, and fussed" until a change was made. "Some things won't go. But you know I'm aware." On one level Martha believes she is powerless, but on another, she knows she is not. She recognizes that she is capable of

instituting change, but there are restraints which she cannot identify or deal with.

Delois

Delois is 47 and graduated from the associate degree nursing program nearly three years ago. She is the mother of three sons. Her husband died of a coronary attack three months ago. Delois started working at the hospital as a nurse's aide several years ago. She attended a Licensed Practical Nursing course while she was an aide and at the same time operated a tax-return business in her home. When Delois entered the associate degree nursing program, she was employed on a surgical nursing unit on the night shift and she continued working in this position either full- or part-time while she attended school.

Delois grew up in a small rural area dominated by a furniture plant. She is the youngest of six children, three of whom died in infancy. Delois' father worked in the furniture plant for several years while her mother remained at home, caring for home and family. She says that she always "looked up to her father" and she believes that her feelings about her father have influenced the way that she treated her husband and sons.

When Delois was about 11 years old, her father left home to seek work in a coal mine. At about the same time her older two brothers went into the army. She says of this period that it made a real difference in her life because

work normally done by her father and two brothers was now left for her and her mother. She recalls learning to chop and carry wood and laughingly states, "I really learned what work is." Delois' father was unable to return home to work even though he eventually stopped working in the coal mines. Delois says, "He worked for saw mills and could only come home on weekends so my mother and I had to do most everything for ourselves."

Delois is a warm, witty, and generous person whose life centers around her family. She often spends time helping care for a grandchild when she is not working and much of her love and energy is directed toward helping her children. There is a constant occupation with activities, usually not for herself, and she is, in a very traditional sense, a "mothering" kind of woman.

She says that she tries to keep everything at the hospital running smoothly and to keep peace because "I've got to stay there, it's the best place for me, the best place I could work." The hospital is the only one close to Delois' family and home and she is correct in her estimation. She says of her job and of nursing, "I'm really happy where I am" and she searches for the positive aspects of her job and the people with whom she works. She is inclined to accept people at face value and reflects back to those with whom she interacts an image that selects out the strengths and best qualities of each individual.

Delois recounts how, when she was in the associate degree nursing program, she experienced difficulty in the nursing course on mental health and illness. Her willingness to accept things at face value proved a handicap in analyzing events from subtle clues in interaction. It was in some ways as though Delois was in a country whose language she did not understand.

Interview. Delois says that she had already been at the hospital so long as an L.P.N. that she really "almost had the role of what an R.N. was down pat. I think I might have been a little disappointed because I thought everybody was supposed to say 'well, she's an R.N., I'm supposed to do what she wants,' but the mistake I made was in going back to the same department where I had worked as an L.P.N. I didn't seem to have as much influence over, in doing the things I really wanted to do. I found that made me a little less of a leader."

I asked Delois if she believed that anyone or anything had helped her decide what an R.N. should be or whether she had figured out for herself the role of the nurse, and she responded, "That goes back a long way. I've talked to other people about this and the different role-models that they want to be like and mine goes back a long way. A long time ago when I was in L.P.N. school, I was working part-time at the hospital and I used to say, 'Oh, I wish I knew everything that _____ did. I wish I could be like her and I talked to several nurses about that and everybody has

a role-model. I remember one time I was working and I had to get this little fellow ready for surgery and I couldn't get his blood pressure and _____ came by and helped get his blood pressure and everything ready for surgery, and later I found out I didn't have to have his blood pressure and I'm sure _____ must have known that but probably had enough faith in me that she thought I knew I was supposed to do it." Delois says, "There are other people that I'd really like to know as much as they do and then there are people, different R.N.s that I've worked with, that I'll do anything different. And I've tried to strike a happy medium. So far, I really haven't had any comeback on things I've done. I've never heard anybody say 'I don't like to work with you' and I think they would have. Some of the L.P.N.s working with me thought they were only supposed to give medicines (rather than give physical care to patients) and I got real upset numerous times because they wouldn't do anything but give medicines. And sometimes on the third (night shift) there may only be six medicines to give."

Delois admires her present nursing coordinator (head nurse) and says that she influences the kind of R.N. Delois wants to be. "She makes you want to keep on learning. I've worked harder since I've been there than in the whole R.N. program." I asked if Delois believes the "person above you" has influence over the way she interpreted her role and she said, "I definitely do. You have to be motivated to do a lot of

things. When I've gone out of there (the hospital) all upset, you get stale. You get to where you don't even care. You get to where you end up not doing anything because you say 'who cares if I do something.' I think it's true with a lot of them."

One of the reasons Delois believes that she looks to the person "above you" in the hospital is because of the isolation she experienced working on a nursing unit at night in the hospital. "You very seldom have nurses on your own level on the floor. I was on a floor for two years, and for eight hours I never left the floor. I didn't feel that I could leave. The staff was such that I couldn't leave the floor. I could talk to other nurses but they seemed to have the same problems I did. Some of them did not because they would leave their unit. Somebody might come down from another unit and talk but that happened very rarely. If you had a problem, you either figured it out on your own, or after they (the hospital) started having night supervisors again, that really helped me, because at least twice a night I would have someone I could talk to, and they would be on call. Then, too, they had ones you really didn't talk to because they didn't give you much feedback on anything. So you didn't care to seek them out. _____ was really good, a good teacher. Some didn't have a lot you could draw on."

I asked if Delois believed that being a woman influences the way that she looks at nursing, and she said, "Well, I've

always thought, well, a man-nurse to me didn't, well I know that they are smart and everything, but they just didn't, ones that I have worked with, they are good, I'm not saying they are not, I don't know, they just don't seem as interested in what's going on as far as the patients are concerned, and I'm old-fashioned enough to think that women, especially the older women, should have a woman nurse to take care of her." But Delois remembers a male nurse. "Now _____ was excellent with all patients. Some of the older patients, to them they were either doctors, or orderlies. They didn't really look on them as being a nurse. But those I have worked with have been really good. We have one L.P.N. that is a man, he's gone back to school and he is excellent."

Delois said that some of the doctors, "the really old ones, from the old school, they tend to think that nurses don't know what they are talking about. Most of the ones that we have coming in now, especially the newer ones, value your opinion and discuss it with you just like you're an equal with them. Some, they just will not give up their role that 'they're the doctor, you're the nurse.' And you just do exactly as they say. They don't value your opinion. Now, it's really remarkable how the ones that come in now really value your opinion. We've been having a seminar where different doctors come in and talk, and on one occasion Dr. _____ that was doing the seminar on diabetes, it got back to us that he told somebody that 'I'm really having to

work and study on this because those girls are no fools and I don't want them to ask me a question I can't answer.' And it was at our level. Everyone understood and numerous people said that was the best one we've had." Delois said that some of the seminars were "over their heads" and gave the example of a neurosurgeon who went into infinite detail in his own specialty area on the anatomy of the microcirculation of the brain. "Things which I barely remember from anatomy and really will never care about. If a particular patient has that problem, then I will look it up and know exactly where it is. But you don't remember things like that."

Delois, who now works in an intensive care unit, finds doctors' attitudes towards nurses on the general nursing care units to be different from the attitudes expressed in the more specialized and highly technical care units. "It is so much different in the upstairs, in the nurse and doctor role upstairs, downstairs. Even though I say that they don't really listen to you, even though they pretend not to hear you, they are listening. Usually, if they really value your opinion, say if you suggest something that should be done, they won't do it that instant. But they'll come back, or order it later, or sometimes they have it in mind and if you mention it they pretend 'oh, that's not the thing to do.' I know Dr. _____, you mention something to him and he will not order it at that particular time. But within two hours, he's been known to come back and do it after he's

thought about it for awhile." I asked why that happens and Delois said, "Well, he's just had time to think about it and he doesn't like for you to put ideas in his head." Asked if we, as nurses, put ideas in doctors' heads, Delois said, "I think they do a lot. A lot of times you have to let them think it's their idea. And that has been so for a long time. But after all, you're with the patient eight hours. They are with the patient ten minutes, luckily. Most of them do value your opinion because they know you see what is going on. When you make a telephone call to them, nine out of ten will respect what you say. Some of them will say, 'I don't know what else to do. What do you suggest?' I'd say 50% of them will say that. The other half will say, 'Do this and call me back.' But it's completely different upstairs (on the nursing unit). I have really been called everything when I've called a doctor. They really think the girls on the floor, the nurses on the floor, they don't value their opinion that much. It's just completely different. They finally get to where, after they've been here awhile, they know who they can trust, whether you call them over a trifle. And you do it three or four times; they know. You establish a trust there. Don't ever call a doctor at night for someone who wants a sleeping pill. Stay with the patient, hold their hand, or whatever, but don't ever wake that doctor up."

One of the things that bothers Delois about the hospital is that she sees things which need to be done, but because

of time pressures and other factors don't get done: "I got very angry a lot of times because the patients weren't getting the things they should have. And I talked a lot about that. And finally, at night, we had cassettes and things that we could use to teach and they (the patients) really appreciated it. . . . One of the things the hospital is lacking in is sex education following an M.I. (a myocardial infarction or coronary) and the last person they had to teach sex education was _____ before she left. The doctors won't tell the patients what they need to know. There are people who won't talk to them about sex education. You see the same patient coming in time after time and eventually D.O.A. (dead on arrival). And we've talked about the fact that one of the things they need is education. But it still hasn't gotten done. You need someone that is qualified and has the time to educate. It's not like the diabetic where you can play a tape and show him pictures. A coronary, you really need to sit down with them and talk." When I asked why the nurses didn't do this, Delois said, "They really can't. They don't have the time. They need somebody who really has the time to go sit down and talk with them. They need a qualified person and the hospital doesn't have that, they just don't see it in their budget to hire somebody."

I asked Delois what takes up nurses' time. "Well, a lot of what takes up the R.N.'s time on the floor on days is mostly making rounds with the doctors, maybe I.V.s, taking

orders off, and so much paper work that has to be done. On every shift you have to write on the chart. And you only have one R.N. and she is supposed to sign and O.K. everybody's nurse's notes. And that's been going for a couple of months. And some of them would have the time, but they aren't qualified. Sex is something they don't talk about."

Part of the problem with nurses' failure to deal with sex education is that they "feel comfortable talking about other things." But nurses leave out other things which they feel are important, too. Delois said, "They are geared to having things run as smoothly as possible. And if anything comes up to interrupt their smooth schedule, a lot of them would just rather not talk about it. Try to stir something up. Things have to run smooth and they just forget about it. In that hospital I've worked as an aide, as an L.P.N., and then almost three years as an R.N. and during that time I'd say that there's never been over a dozen times that an issue has come up that people have really done something about." Delois said "I think it's because some of them have tried and not succeeded and just give up, it's just not worth the effort and you try and don't get anything done, it's just not worth the effort. The ones who are frustrated, they're not there any more. We've had so many good nurses leave. It has to be a reason . . . that they leave. We've had people go other places, and they are happy . . . it's because the things they wanted to get done, they couldn't.

And the ones who are still there, they've got nowhere else to go."

Delois is influenced not only by her present situation but by her past experiences in determining what the role of the R.N. should be. She expects to influence her co-workers and some of her expectation is based on the way that she interpreted other R.N.s' influence when she worked as a nurse's aide and as a licensed practical nurse. Because the roles of the aide and the practical nurse in the hospital are both powerless and at the lower end of the hospital hierarchy, Delois hoped that becoming a registered nurse would allow her to exert some influence over the way that patient care is given. She said of this period, "I felt their opinions about me made me doubt myself. I had seen the way other R.N.s functioned and they (the staff) wouldn't do the things for me they would for others. I didn't try to be aggressive or anything. It was just getting the work done that had to be done. I found out I was out there doing most of it (the work) myself."

Delois has looked up to other R.N.s and it is difficult for her to comprehend why her staff does not respond in the same fashion. She recalled the nurse who helped her get the child's blood pressure and assumes that there will be some of the same cooperative effort exhibited by the nursing staff working with her. But the L.P.N. who usually gives medications feels that she should not do anything beyond her

assigned task even if it includes giving "only six medications" on her shift. Delois finds that she is doing much of the work on the nursing unit and finds that the unexpected response makes her doubt herself and her "leadership". Even though she has worked in the capacity of an L.P.N., she is unable to understand the motives for the unwillingness to take on additional tasks and finds that her own sense of responsibility causes her to be doing much of the work. There is a questioning of her own ability to lead rather than a recognition of the arrangements in the hospital which causes the L.P.N. to assert herself and struggle for a degree of control in a relatively powerless situation.

One of the things that Delois finds important to her role is the recognition that comes from someone else. She feels good about her present nursing coordinator because of the recognition the coordinator provides and she finds that she is willing to work much harder because someone "cares if I do something." Because her nursing coordinator has a greater degree of authority (and power), Delois finds affirmation in the coordinator's evaluations.

There is another reason for Delois' admiration of her nursing coordinator. Delois indicates that when you become an R.N. "you think I'm going to get in there and get things done. I'm going to make things happen. And it doesn't really work like that. . . . It's because of the ones above you and whether they believe in what you're doing. You really

have to have someone above you. You can't do it as one; you've got to be a group." In her present situation Delois finds that the nurses "just don't see eye to eye. There is not enough of them to see eye to eye to go as a group to get anything done. . . . In my unit they are like one little 'clique'. It's probably because of the coordinator. She makes them that way. What they want to do and if she (the coordinator) believes in it. It just seems that most of us, though, don't have that much in common to get together and do something."

The nurses do not recognize their commonalities but rather their differences, and the only way that they can be welded into an effective "clique" is by having the support and backing of the nursing coordinator. This sense of isolation which the nurses feel is especially keen for Delois when she is working on a nursing unit at night as a beginning R.N. Since many beginning nurses are forced to accept the less desirable evening and night duty shifts, it is a common occurrence for the beginning nurse to find herself separated from colleagues. Delois has a rare visit from other R.N.s but she feels she cannot leave her unit and she is grateful when the nursing supervisor visits her floor twice a night. As a result she becomes accustomed to looking to someone with more authority to help her solve nursing problems. Since many of the other nurses on her shift are also inexperienced, they tend to have the same problems as

Delois and are not seen as helpful. After nearly three years, although there is among her colleagues a shared concern for resolving nursing problems and a variety of experiences from which to draw, Delois continues to draw her major support from the nursing coordinator because "we don't see that there is maybe one problem that everyone would be interested enough in to get together to work on."

There is a problem, however, with relying on "those above you" for the resolution of nursing problems. Delois has found that some nursing supervisors or coordinators weren't helpful because they "didn't give you much feedback . . . some didn't have a lot you could draw on." The dependence on the authority of the supervisor then is risky, and Delois has discovered there are times when she cannot count on the positional authority for help. But she is unable to detect other sources in her environment which would help her solve nursing problems and at the same time make her feel that "someone cares."

Delois does not incorporate all the characteristics she sees in other nurses into her own concept of what the nurse should be. Some nurses demonstrate traits that she finds unacceptable and she is selective in not emulating these nurses. Delois is favorably impressed with nurses who appear knowledgeable and she said, "I'd really like to know as much as they do." She also said that sometime in the future she would like to return to school "mainly because

it would make me feel better about myself . . . it gives more insight." Right now Delois is seemingly unaware of her own significant strength and knowledge despite the fact that the physician admits that "those girls are no fools."

Although she is traditional in her views of the place of men in nursing, Delois is generous in estimating the contributions of the male nurses with whom she has worked. She also appreciates the failure by younger or "newer" physicians to categorize her in a particular way. She is delighted that "the newer ones value your opinion and discuss it with you just like you're an equal."

Categories, and more significantly, specialization in the hospital, determine the responses accorded to nurses in various settings. In the highly technical area of the intensive care unit, nurses are treated with courtesy and their expertise is acknowledged. On the nursing unit, however, Delois, who is the same nurse who receives respect in the I.C.U. said, "I have really been called everything." Delois recognizes the difference but is unable to account for it. She suggested that part of the reason has to do with trust and not calling the physician for insignificant matters. On the general nursing unit she believes that it is necessary to learn the physician's idiosyncracies in order to gain trust and not to be "called everything." The irrationality is adjusted for by Delois who "holds the patient's hand and sits with him." But the unreasonableness of a

response determined not by what kind of nurse she is, but rather by the degree of technicality of her practice is more resistant to analysis or adjustment. It resists analysis in the same fashion that Delois' belief that male nurses should not care for older women resists analysis. Because it goes beyond simple cause-effect relationships it often remains unquestioned.

The physicians' attitude remains a puzzle in their unwillingness to listen to nurses. Dr. _____ must come back later to write the requested order and the nurses must learn how to "put ideas in the doctors' heads" so that they do not overstep their submissive positions. Delois recognizes that the neurosurgeon's seminar is not appropriate for her own learning needs but tends to believe that the failure is at least partially her own inability to remember earlier anatomy lessons. But she knows that she has been capable of learning what is needed when patients have specific disorders. The need to be a "good" nurse and the need for earning respect in her own working relationships prompts Delois to consider seeking more formal education. She sees education as a way to "feel better about myself, to gain more insight."

Delois values knowledge and part of her value is expressed in her concern for the lack of knowledge that prevents patients from achieving full rehabilitation. She recognizes a particular need for sex education in the coronary patient and connects the lack to the failure of survival of

many of the coronary victims. Although she can help the diabetic patients by using cassettes and teaching aids, Delois looks to "someone who is qualified and to someone who has the time" for teaching the coronary patient. The imperative of the need is offset by Delois' perceived inability to resolve this nursing problem and she looks to "someone above her," as she has learned to do in other nursing situations, for an answer to a very real nursing problem.

The pressure of time is interpreted as another handicap in the resolution of nursing problems. Delois feels ambivalent about the use of time because she believes that nurses often choose the course of action that will maintain a smooth operation of the nursing units. Delois said, "It helped me a lot to have a guideline to go by to be able to get done the things that needed to be done. It was really great so that I didn't leave anything out in the intensive care unit in the first couple of months I was there." Delois said she has done some restructuring since then and finds more time now to do things she wants to do. She said, "You can find time to do things you want to do." But a good deal of paperwork must be done and nurses' notes must be signed. Delois said, "We're having a lot more paperwork to do now because they have laid off the secretaries and pulled some from days to night, and rotated them so that they are not familiar with the routine. We have to do it to make sure it gets done." But in another instance Delois said of the

paperwork, "I hardly ever do it. I do patient care and assign it to someone else."

Delois said that if I had talked with her seven months ago that she would have had more to say about the hospital. "There was so much on my mind, I was so upset; and now I feel better since I've transferred to the intensive care unit." Time was one of the major problems. "I couldn't talk with the patients or have any relationships with the patients. If you talked with one, there are ten more down the hall that need you. And that bothered me a great deal. There were things you had to do. People that had surgery that had to be cared for, while this little old lady up the hall needs you desperately. Needed somebody to talk to, really sad and depressed. You had to walk out and leave them talking. That bothered me so much. Now we only have eight patients and you can always find time to at least spread yourself to talk to that many."

To resolve the problem that she experienced, Delois requested a transfer to the intensive care unit. She said that, if she had stayed on in the situation, there would have been nothing she could have done about it "unless we had more help and I think that is impossible. I don't think they will have more than three people working on that unit and I think that is really sad." When Delois leaves the nursing unit, another nurse is found to replace her who must face the same problems which Delois could not resolve. She will be isolated

from other nurses. She will feel the pressures of the patients' needs and her inability to meet all of those needs. She must adjust to the irrationality of working around patients' problems which have occurred as the result of the physician's oversight and his unwillingness to attend to them when the need arises. And she must finally adjust to being "called everything." The constant attempt to maintain a smooth routine and the implied promise "that those above her" will help address the problems of nursing are at least partially accountable for Delois' inability to resolve her earlier problems by anything less than flight.

An additional factor is the belief that her own choices are limited. Attachment to family and the community led Delois to accept the unacceptable. She said that she tries to "look on the bright side." She tries to keep things running smoothly and tries to keep everybody happy. "Some," she said, "will fuss about anything." But in another moment Delois said, "Those that are still there, they've got no place else to go."

Debbie

Debbie is 20 years old and graduated four months ago from the associate degree nursing program. She entered the two-year nursing program in the fall following her graduation from high school. At present, nursing holds many unknowns for Debbie. She does know that she likes the response of people who are surprised to discover that despite her youthful appearance, she is a registered nurse.

Nursing was not a lifelong ambition for Debbie. She said that she really liked mathematics in high school and was good in the subject. One of her teachers tried to persuade Debbie to consider engineering because of her "math" ability. She was unable to explain why she did not. And in deciding what to do following high school, Debbie chose nursing. Her mother, whom Debbie resembles and looks up to, is a nurse and they both now work in the same nursing unit in the hospital.

Debbie is the older of two children in her family. She recalled that her mother, who had been employed before having children, elected to stay at home while they were growing up. Her mother is a very warm and friendly person whom many of her colleagues describe as "feminine and sympathetic," and Debbie is in many ways similar to her mother in both appearance and manner. Debbie's father is a sales engineer who runs his office from the family home. His need to remain reasonably close to the company he represented resulted in a suburban environment for Debbie.

Debbie confessed that she is concerned about what people think of her, and she believes that this concern is largely due to her youth. This concern was evident in the interview when it was difficult for Debbie to talk about herself because she wanted, admittedly, to "put her best foot forward." She had dressed more carefully than the other nurses who were interviewed and her words were more carefully chosen.

Her wish to make a good appearance was also apparent when, at a later meeting with Debbie, one of her friends mentioned that they might go out to "have a beer." Debbie did not indicate that she heard this remark but blushed furiously in my presence. Her mother's conclusion that "as you get older you become less concerned with what others think about you" seems valid to Debbie and she anticipates reaching what she sees as a more self-sufficient maturity.

Debbie's concern for the ways that other people see her and interpret her actions has, on some occasions, presented problems for her. When she applied for admission to the associate degree nursing program, she was interviewed by its director, who told Debbie that she would be considered by the admissions committee as soon as her application was completed. Debbie said that she followed the director's instructions and mailed to the school all of the required admissions material. When she heard nothing from the school, Debbie accepted the continuing silence as an indication that her application had been rejected. She said that she was afraid to call or write the school for fear of what the director might think of her, even though she had been an "A" student in high school and could not understand why she had not been admitted to the associate degree program.

Debbie's eventual admission to the program was a stroke of luck. Her mother, in a random encounter with one of the school's nursing instructors, mentioned Debbie's rejection.

The instructor urged Debbie's mother to contact the school, and a subsequent investigation which resulted revealed that Debbie's application materials had been misfiled. The nursing class had been filled without consideration of Debbie's application, but because of the special circumstances she was given a belated acceptance. She had, however, experienced considerable anxiety and bewilderment over her application and its apparent rejection.

Debbie spent much of her childhood in Florida, and she and her family like the area so well that they continue to return for vacations whenever they can. Because of a change in her father's job, Debbie's family moved during her teenage years and she said that she was really afraid that when she moved away from Florida she would not like the new area and would make no new friends. She was especially anxious about changing schools, but contrary to her fears, found that she "really enjoyed" the new school and the friends she met there. Eventually, she said, she became very much attached to both the school and the people in it. Her anticipation of her future in nursing is viewed from this perspective.

Debbie said that she isn't sure yet how she feels about nursing. She sees things that she "isn't too crazy" about in nursing, especially the long hours and the scarcity of nurses in the hospital. But she says that she is hopeful about nursing and she knows that she really hasn't had time to judge yet. She is willing to give it a "chance."

Interview. Debbie said that when she first went into the hospital as a beginning nurse she had to look for someone who could help her. "Well, some of the people I knew in nursing school, and some of the people up there (on the nursing unit) were more helpful than others," she said. "When you first start you kind of try to make friends, hang around anyone who will be halfway friendly to you. Some of my mother's friends were overly nice to me because I'm _____'s daughter, but a lot of the staff nurses, well a lot of the L.P.N.s and aides--I learned a lot from them. The R.N.s, they didn't have as much time and I learned a lot of procedures and stuff from the aides, the L.P.N.s. Some of them were more helpful. I don't think I had one certain person I looked up to. You pick good and bad points out of everyone."

When asked whether she had made up her mind what an R.N. should be or whether she got some sort of message from someone about what she should be, Debbie indicated, "It was a mixture of both. You kind of get your idea. And then little things happen along the way. You kind of get the idea of it. . . . I don't know. In school you have a certain ideal and then as you go along you get little points, you know, little ideas that you just kind of throw in between. It goes together and makes your own idea." Debbie said of being an R.N., "I don't know if I've gotten it all yet. I think I'm still throwing in ideas." When asked if other people's

ideas would influence this process, Debbie said, "They do have an influence . . . personally, me they would. Other people they may not." When asked why she said that, Debbie replied, "Just my personality type. I really shouldn't, but things people think of you, expect; it affects me. I have to stop and think, what should I do, how should I act? I have a different attitude by how they treat you, what they expect out of you." In Debbie's view, physicians in the hospital have some bearing on how the nurse comes to see herself. "Each one has their own idea. Some are just so much more--well, some just don't want to hear from you and other ones, younger ones, are just glad to get the information--a few, a very minute few. A lot of them will ask, 'What do you think?'. . . They do have an influence, I always believe that it does. It's just the same old thing you know. Some men want to be over-domineering over a woman. Even though some won't admit it. There are some--there are always exceptions. . . . Some of them are 'ahem', a little flirty, some of them may even try a little this and that, they try to remind you." I asked if flirtation is a reminder that nurses are in a particular place and Debbie said, "Maybe they think they are going to throw you off guard, something. Some of them don't try to be domineering by it."

Later, in the same context, Debbie indicated that other things in the hospital influence the beginning nurse. "It's just a reality shock sort of thing. Some nurses are so full

of what they are going to do. I think it's kind of unrealistic. I think they should be real energetic, but when they get into it, when they start, they think they are going to do all these things and when they try they just aren't able to. . . . Well, one example, _____, she was raring to go. She was looking through rose-colored glasses. When she got into the whole routine you just couldn't do everything. . . . If you already realistically know what's going to go on, you get into it, you sometimes can kind of put your own little things into it. It's a little dabble there. It's hard when you first start. You've got so much pressure on you right off. I wouldn't try any extra. I would wait a while until I got into the routine, got to where I was comfortable with everything and then just start doing little things. I think you would have to go at it slowly. Just add little things of your own slowly. Do a little bit at the time." Debbie said that she felt she would be more successful by doing things a little at the time. "If you add all that stuff in at once, at least for me, I couldn't do it all. It would be overwhelming. I couldn't handle it all."

When I asked Debbie how she handled things which came up, she said, "Some of them I just ignore. It may be something is easier. I don't come up with that many things. I don't come up with that many brilliant ideas. If they were important enough, I'd try to tell someone about it." I asked Debbie why she thought she would have to be brilliant and

she couldn't think of a reason. "No, I guess I just don't stop and think 'now what do we need to change' probably because I'm so busy. The time thing again."

Time has had an impact on Debbie. She said that when she went to the hospital, "You would work with other nurses. They would tell you how it really is. They would say, 'Well, when you get up here, you're not going to have time to go by the book. You've got to take a few short cuts.' It helped," Debbie said, "There's little shortcuts, they helped you, made you feel more comfortable. At first it was like you could never get everything done. But you learn to figure out what things need to be done. What things you can leave out." I asked if that included things Debbie wanted to do. "No, I don't get to talk with patients, there is no time. I hate to say it, but in the back of your mind you're saying, when one patient gets upset and needs to talk 'oh, my goodness, I'm supposed to be in number 4 doing a dressing.' And sometimes I feel like I'm not really helping them or comforting them. I hate to give the appearance of rushing out of the room. It's bad. That's one thing I don't get to do. You've only got time to ask them, "Have you had a B.M.?"

When I asked if Debbie felt she had any influence over what her role as nurse is, she said, "No, well, it's a matter of time, I think. You could do things. I could try, but it's just like you've got to get things done. . . . Some people have this thing 'I don't care' but most people, well, I have

to get things done. If I could stop and think, I could have some pretty brilliant ideas."

I told Debbie that I would bring back the write-up of the interview for her to read, and she said, "I'll probably have a different attitude from what I do now." When I asked her why she thought that, she responded, "I don't know, I'm still new, really. And I'm still forming an attitude, I guess. I mean I know things, but little things I've got to run back and ask people. Not that that would humiliate me, but you don't feel like some of the ones that are more into the routines. It's like trying to catch a log before you go over the waterfall. Catch onto a rock or something. I'm still going downstream, I still have a few more chances to catch on." From other nurses Debbie gets a message. "They just say give her a little time, she'll get into the things. I've gotten into the swing of a lot of things."

Debbie said of the hospital administration, "They aren't in touch with us (the nurses) enough. If you brought things up, they'd take it too lightly. They are for the patient, but they get wrapped up in policies and procedures. When the nurse wants something they don't think its important, they don't stop to listen." I presented a hypothetical situation, asking Debbie if the other nurses in her unit would, through group support, help her to improve matters if she believed patients on her unit were not getting safe care. She answered that she thought she would receive their support.

When I asked the same question about salaries, Debbie said, "People always want to increase their salaries, but if it's a union or something--oh! the hospital is going to hear this! Don't let them hear it! If it's something like that ugh!" Debbie seemed worried that discussion about salaries might lower the hospital's opinion of her and I asked her about this. "Uh huh. It's kind of the whole thing. It comes back to like I wonder what people think, that kind of thing." I asked if other nurses feel that way, too, and Debbie said, "Yes, some do. It depends on the personality. But yes, I think so." But Debbie also believes that these feelings have something to do with being a nurse. "I think if a man were a nurse, he would be the same way, too. It's not like they open a book one day and say this is what you're going to be. I guess it's from all of it. Somewhere along the line it just jumps out. As a nurse you're dealing with people. You've got to take into consideration their feelings. If you didn't it could make your job a lot worse."

Debbie sees the organizational hierarchy in the hospital as one based on traditional sex-based roles. "It's the whole thing of where men are over women. Administrators are over the staff and the staff are women." She recognized that there is a division in the hospital but said, "Everyone expects it." Debbie doesn't see alternatives to the way the hospital is organized because "It isn't realistic. They do things that way because of money. Sometimes things wouldn't get done that need to be done."

When the interview started, Debbie told me that she was not in the most "optimistic mood at the moment." When I asked her if she would like to elaborate on her mood, she said, "No, well sometimes, you know how moods come and go. Something happens to lift your spirits, other times you're just stuck in the dull routines." Routines have precipitated a mood which is not optimistic, yet Debbie feels she must fit herself into the routines of the hospital in order to become "more comfortable." Her belief in learning routines is a way of gaining control of a situation, which she compares to "trying to catch a log before you go over the waterfall." She senses that there is a need for some stability in a situation where events surround her in a rush of activities over which she has little control, and she feels that the only order to be found is in learning the routines.

Debbie wants to invest some of herself in her nursing. She waits and tries to put in "little dabbles" in small ways as she goes along. She tries to pick and choose things which she likes in other nurses for her own concept of the nurse's role. But many of the R.N.s on the floor have demands on their time and Debbie finds herself going to the L.P.N.s and aides for advice, for having things explained to her. Her feeling about being stuck in the dull routines is reminiscent of the problems expressed by many L.P.N.s and aides who are in the least powerful of positions in the hospital and who are given little choice in what they do or how they do it.

Many adhere to the routines in an uncompromising fashion as a form of protection against what they believe to be contradictory interpretations offered by the different people who have authority over them.

Debbie's need for affirmation is attributed by her to a need for increased maturity, an age-related concern. Because of this need she looks to those around her to reflect an estimate of her own worth. Some of the nurses who are friends of her mother are overly nice and Debbie, I suspect, feels that she is seen only as her mother's child. While some of the doctors, a very small portion, ask her for an opinion and thus treat her as an adult, others flirt, or try a little "this and that" and she is categorized as an object for sexual attention. In such a case they need not "try to be domineering by it" since objects need no domination but she is thrown off.

There is an inkling that Debbie is not completely susceptible to the evaluation mirrored in these conflicting reflections. She says with some spirit that given time she can have brilliant ideas. But her belief that the time must be given to her provides a major obstacle. She cannot take it for herself. The acceptance of the idea that her time is not her own is influenced by nurses who tell her that when she gets to the nursing unit "You're not going to have time to go by the book." When Debbie figures out the things that need to be done, within the time frame which has been interpreted to her, she finds that they do not include the things

which she finds important. And by not having time to talk to patients, to remember them only as the dressing in number 4, and to inquire if they have had a B.M., the patients become depersonalized objects for Debbie. The help offered by other nurses is interpreted by them and by Debbie as helpful. But being made comfortable helps move Debbie "into the stream and away from the rock" of her own values and choices about what the nurse should be. Debbie feels that she is overwhelmed. "If you add all that stuff in at once, I couldn't handle it all," indicating that she is unable to hold onto all her beliefs and values. It is difficult for her as a beginning nurse to swim upstream in an effort not to "go over the waterfall." When the nurses say "just give her a little time, she'll get into things," it is a form of irony which they innocently express. Debbie is given no time.

Early in her socialization, Debbie recognized the hospital to be compartmentalized. She said that nurses are taken "too lightly" and that the administration is not in touch with the nurses. Yet, when she began talking about nursing salaries and about unions, Debbie became agitated and said, "Oh! the hospital is going to hear this! Don't let them hear it!" so that she also sees the hospital administration as selective in its attention. It is wrapped up, according to Debbie, in policy and procedures, but she senses that any suspected dissidence brings an immediate focus of attention. Debbie thinks her feelings and

sensitivity in worrying about what the hospital will hear are due to her own personality traits which she earlier described as "things people think of you . . . affects me." But she is also ambivalent about this because she thinks other nurses may feel this way too. And Debbie knows that their personalities and sex may not be the deciding factor in this trait.

The organization of the hospital is based on the criteria that administrators are men and the staff are women. But Debbie feels that if the nurse were a man that he would respond in the same way within the hospital that women do. "As a nurse you're dealing with people. You've got to take into consideration their feelings. If you didn't it could make your job a lot worse." Debbie can see no alternatives to the way things presently are in the hospital and she believes that the scarcity of help and her lack of time is determined by "money." When she says the hospital is like "the whole thing of men over women," she continues to concentrate her energies and concerns on learning the routines of the hospital because she believes it is necessary for her survival. She has few resources left for discovering why other social organizations within her experience reflect the organization of the hospital even though she knows they do.

Debbie, in the interview, describes a friend who comes into the hospital "raring to go. She was looking through

"rose-colored glasses." When she got into the routine "you just couldn't do everything. . . . If you already realistically know what's going to go on, you get into it, you sometimes can put your own little things into it. It's a little dabble there." The hospital is becoming the real world for Debbie and she accepts it because "Sometimes things wouldn't get done that need to get done." Debbie is trying hard to become realistic and at the same time to reach self-sufficient maturity.

The Meeting of Issues

These recollections and interpretations of entry into the "reality" of the hospital world provide a small window for viewing and analyzing some aspects of the socialization process. Women who enter this complex and humanitarian setting as beginning nurses do so with a concern for providing sensitive care to patients, working cooperatively with others who participate in that care, and finally to achieve some sense of their own dignity and self-worth. Some insights into why there may be difficulty in achieving these professional and personal goals may be found in the retelling of these nurses' experiences. Individual events and the concrete examples provided here suggest, in my estimation, a connection between the issues of gender, community, agency, and bureaucracy and the issues of concern expressed in the interviews. The occurrences of the nurse's everyday world,

when reexamined from the lens of social criticism, suggest arbitrary social barriers as impediments to the accomplishment of individual and professional goals.

In this study I chose to examine the effects of belief systems and social arrangements on the development of consciousness and the nurse's capacity for influencing the environment in which she works. The sense that gender may influence the status and activities of nursing is powerfully expressed, I believe, in these nurses' description of their working relationships with male physicians and in their responses to the image of themselves which they find in the reflections of others.

Although the nurses did not indicate awareness of any overall effect such attitude might have in a broader social context, they were able to detect in the contrasting attitudes of older and younger physicians a basis for their own feelings and responses to situations within the hospital. The value which younger physicians appeared to place on nursing judgment and opinions allowed nurses to respond with appreciation and acceptance of the masculine expression of inner feelings. Communications were characterized by straightforwardness and clarity and, above all, there was the intimation that the reflected estimates of the nurses' worth provided them with a feeling of dignity and self-worth.

By comparison, responses to the barriers imposed by older physicians' attitudes indicated reactions of individuals

who feel powerless and devalued. Energies were diverted from open communication to the identification of idiosyncrasies of the physicians in order to circumvent anticipated obstructions. Manipulation was evident in the "planting of ideas in the doctors' heads" and again in the provision of extra time for the physicians to seemingly reject or ignore requests so they might be acted upon at a later time. The nurses in turn provided estimations of the physicians' worth in belittling terms such as "childish", acknowledging a pervasive element of the physician-nurse relationship even though hospital protocol of dominant-subservient position is dutifully maintained.

It should not be concluded that the issue of gender is identical with the issue of professional relationships introduced by the nurses since there are factors interfering with a clear-cut analogy. Although there are present in the tradional views of gender roles and nurse-doctor relationships an assumption of dominant-subordinate positions, other complex factors may prohibit correspondence. There are opportunities for women to become physicians, as there are opportunities for men to become nurses. The predominance of males in the practice of medicine and the predominance of females in nursing is an issue that has yet to be carefully examined and may or may not be related to gender issues. Furthermore, differences in education and the presence of licensure law specifically granting power to physicians over the practice

of nursing serve to further obscure whatever effects gender might have on the traditional subordinate role of nurses.

There is, however, in my estimation, a way in which the issue of gender resonates with the portrayal of nurse-doctor relationships found in the interviews. I believe this exists in the elaboration of the effects on human dignity of persisting role interpretations in an environment of inequality. In such circumstances, a cycle of increasingly negative effects is generated, in which communication is impaired, energies are diverted from more humanistic accomplishments, and individuals are deprived of the mutual respect which can only be shared among equals.

In the same way, community and bureaucracy can be found to resonate with the fragmentation and isolation which the nurses identify in their perceptions of hospital arrangements. Separation accomplished through the division of labor on nursing units and the subtler, but more pervasive division of technical versus humanistic nursing practice provokes divisiveness among nurses and a sense of "facelessness" which leaves them feeling depersonalized and powerless. While they recognize that hospital authority is insensitive to their needs, the nurses continue to remain docile towards this authority and blame themselves for the loss of dignity which they suffer.

While there is a demonstration of some degree of agency through active participation in their own socialization

process, the nurses find that the demands of the "rookie role" which is interpreted to them by co-workers interfere with the kinds of nurses they wish to become. The vulnerability of the beginner's role, the pressures of routines, and the lack of time for reflection and development of alternatives prevent the nurse from having any significant personal influence on their own working environment. Even though routines are recognized as the sources of loss of initiative in practicing nurses, there is the professed desire to become better acquainted and more comfortable with routines. The nurses indicate their desire for more humanistic interaction with their patients but allow their time to be consumed by the demands created by paperwork and inadequate staffing. There is a seeming inability to critically examine the guidance given them, as beginning nurses, by other nurses who are unable to influence their environment, and the beginners admit to an erosion of their own values and beliefs.

This erosion, in my estimation, provides the strongest link between the issues of gender, community, agency, and bureaucracy to the topics of concern identified in the interviews. The conceptual issues are translated here into the substance of everyday reality by nurses who illustrate how their own value systems are eroded through the arrangements and activities of their environment. The issues provide a focus and indicate the way in which dominant values restrict the ability of specific social groups to have greater

influence on their own reality. In this reality, individuals find themselves unable to detect or surmount social barriers that leave them susceptible to exploitation and continuing powerlessness.

Through the socialization process a form of consciousness emerges, providing the individual with a concept of how one fits into the social world. In this study, the nurses appear to have emerged with a form of consciousness that leaves them insensitive to the overall effects their working envirommment has on them. They maintain hope of an improved situation in the face of evidence belying their hope. They defer to authority and are unable to detect in authority the elements impeding their progress. Their desire to nurture leaves them subordinate to others' direction and goals. Finally they are unable to summon the collective strength available to them to reassert their humanity and to determine their own future. Bowers provides an eloquent summary of these events in a description of the socialization process.

> His ability to grow toward the kind of maturity where he is able to participate in the reconstruction of socially acquired beliefs and values in a way pertinent to his own experience is dependent in part, on his socialization experience. . . . Understanding is likely to be restricted to what can be decoded through the socially acquired stereotypes, pre-definitions, and ideologies that make up his explanatory system. The social determinism can also become an absolute force as he unquestioningly internalizes the definitions of his society in their reified forms . . . he may never realize as an adult that he possesses the power to reinterpret them; without this awareness he cannot take control of his own existence. (1974, p. 35)

I believe these interviews illustrate an instance of the inability of beginning nurses to question the pre-definitions and ideologies that constitute the explanatory system of the hospital in which they are socialized. There is evidence of stereotypical views of protocol between nurses and physicians which may be gender related. There is an acceptance of the need for isolation and fragmentation in the bureaucratic setting and a concomitant definition of their own professional group as powerless. There is an inability to exert agency in their own environment since the environment is dominated by value systems other than their own. The nurses, having internalized into their consciousness this definition of reality, have come to the events predicted by Bowers (1974) in which they are unable to take control of their own existence. The possibility is also strong that they will, in future times, unwittingly create for other beginning nurses the conditions of their own socialization events, thereby helping to perpetuate the process.

CHAPTER IV

PERSPECTIVES OF THE LEARNER-INQUIRER

This study has focused on the socialization of beginning nurses and their mediation of the experiences of socialization in the hospital setting. The recounting of the experiences of six individual and unique women, who have entered the hospital for the first time to begin work as graduate registered nurses, is not in any sense a neutral account. The interpretation of how these nurses respond to the world within the hospital and how that world in turn responds to nurses is reflective of my own history and experience as a nurse. In letting the beginning nurses' stories meet my own story, I have moved away from claims of detachment and objectivity which I might make. These claims have been supplemented in this instance by both empathy and understanding that comes from being a nurse. It also includes a particular viewpoint and convictions which have resulted from my own involvement as beginning nurse, staff nurse, supervisory nurse, and teacher of nurses.

Some of the stronger convictions and concerns that I hold about nursing have to do with the persistent powerlessness of nurses and how that powerlessness affects the democratic values of the society in which we live. My own

history as a nurse, in a female-dominated profession, indicates a position of subordination and submissiveness that is contrary to the democratic principles of an equal and just society. The domination of the nursing profession and the arbitrary distribution of rewards by our society have not been justified, it seems to me, since it deprives nurses of the human dignity that is the right of each individual.

The acquiescence of nurses to their subordinate status in the health care system is prompted, in my estimation, by a desire to provide for those in need of care. But the powerless position that nurses are assigned does not result in the quality of health care that the profession of nursing envisions. The failure of the system is identified by Barrow (1978) who writes that in two-thirds of the world, large numbers of people are outside the reach of health care as it is now provided; and in the United States health care does not adequately meet the needs of the total population. Part of this failure and the concomitant powerlessness of nursing may be due to the priority that is assigned to the technological aspects of the health care system and the decreased significance that is attached to the human side of caring. One example of this priority is found in the procedure of cardiac bypass surgery, an expensive and elective procedure, which remains outside the reach of the economically deprived patient, but one that diverts medical resources to a limited group of beneficiaries.

The importance of technology in the delivery of health care cannot be underestimated since without it many of the accomplishments of modern medicine would not have been possible. But technology, according to Illich (1976), has come to overshadow the humanistic aspects of health care and has increased the dependency of society in the process. The bureaucratic organization of the hospital, as a form of technology, has in my opinion had a negative effect on the delivery of health care. Those whom we profess to serve have indicated an increasing sense of dissatisfaction with a hierarchical system that provides fragmented and impersonal service. What is perceived as depersonalization contributes to the willingness of patients to express their concerns and desires to improve what they judge to be an inadequate method of providing care.

There are, in addition to the problems created by fragmentation, indications that the large sums of money invested in hospitals are not justified in the quality and kinds of care provided. Alternatives to hospital-dominated health services are presently being sought through such options as home deliveries by nurse midwives, health maintenance organizations, store-front clinics, and hospice-supported home care for terminally ill patients. For those who are in need of hospital care, assistance can be both adequate and beneficial, but there is, in my estimation, awareness that hospital care is often insensitive in consideration of the individual as a total human being.

The rationalization for bureaucratic structures on the basis of efficiency and economy does not appear to hold true in the hospital setting where present care may be distinguished by poor communication, errors, and unreasonable cost. Patients often find their needs do not fit into the categories determined by the hospital organizational needs, and they are further dismayed by the costs of services which they feel they did not want or need. The absence of choice in such matters does not prevent the addition of standardized fees to the patient's already burdensome bills, and it further contributes to the patient's feelings of vulnerability and powerlessness.

The effect of the patient's inability to exert some control and direction over personal care is a feeling of fear and mistrust that may interfere with the achievement of health. In the hospital setting, both patients' and nurses' sense of powerlessness is underscored by their inability to communicate needs since the flow of communication is directed downward through a rigid structure that is not designed to respond quickly to individual and nonstandardized requirements. In the case of both patient and nurse, rigidity of rules, regulations, and routines often require accommodation to the structure rather than accommodation to individual and human needs.

The necessity of human accommodation to the demands of technology is, in my estimation, largely responsible for the

status of nurses who find that submissiveness and docility are both requirements and consequences of providing care in the hospital system. The dominance of technology, exemplified in the hospital's hierarchical arrangement, emphasizes the instrumental and pragmatic nature of "man for work's sake," thus depriving individuals of the dignity due them as human beings. The encouraged dependency of patients and the alienation of nurses in order to obtain particular health goals (at the cost of others) appears contrary to the categorical imperative of Kant that individuals should be treated as ends, not simply as means. The social injustice resulting from the application of techniques of science and technology to human and social concerns results in devaluation of the individual and denial of the human capacity to determine one's own existence.

In this study I have chosen to believe that social justice is not what Polyani refers to as a "mere convention" but rather a concept (and a hope) worthy of risk-taking as a non-neutral observer (1968, p. 23). From this position, human issues become intricately connected to the vision of a continuing moral progress and the belief that beauty as well as truth is a valid concern. Contrary to the concepts that underlie behavioral science and the application of technology to social concerns, human convictions are seen as relevant and there exists the belief that human thought (and feeling) cannot be equated with the status of the machine.

Polyani writes of the growth of scientism and its effects:

> Behaviorism had started on the course that was to lead on to cybernetics which claims to represent all human thought as the working of a machine. Sigmund Freud's revolution had started too, reducing man's moral principles to mere rationalizations of desires. Sociology had developed a program for explaining human affairs without making distinctions between good and evil. Our true convictions were being left without theoretical foundation. . . . Our morally neutral account of all human affairs has caused our youth and our educated people in general, to regard all moral professions as mere deceptions or at least as self-deceptions. For once we induce ourselves to regard all established rules of moral conduct as mere conventions, we must come to suspect our own moral motives, and thus our best impulses are silenced and driven underground. (1968, pp. 22-23)

The claims of neutrality, described by Polyani and accompanying behavioristic and monologic approaches to research provide for the acceptance of society as a given rather than raising questions concerning the ways in which social order is constructed, maintained, or changed. Yet in an accounting of society which seeks to avoid moral professions and convictions are found justifications for the reproduction of injustices in the social world. Contrary to the claims of neutrality which presently dominate the field of research, my own awareness of convictions having to do with nursing and with health care, along with a decided empathy for nursing colleagues have, it seems to me, a rightness of fit with the methodology I have chosen for this study. In this study I have celebrated my convictions while attending to the responsibilities which I felt and which Gilligan (1979) attributes to the feminine perspective.

According to Gilligan, women are often reluctant to make public moral pronouncements in their own voice. There is a tendency toward qualification and self-doubt. This wavering is balanced against a sensitivity to the needs of others and it causes women to assume the responsibility for considering others' points of view over our own. Gilligan states:

> Women's deference is rooted not only in their social circumstances but also in the substance of their moral concern. . . . Women's moral weakness, manifest in an apparent diffusion and confusion of judgment, is thus inseparable from women's moral strength, an overriding concern with relationships and responsibilities. (1979, p. 440)

The methodology of this study has been, for me, both additive and synergistic in combining the concern for others, which I believe I share with other women, with a need for attending to the convictions which I have come to hold about nursing. Responsibility in this study is both broadened and extended and it is this responsibility that I have felt most strongly and on which I wish to elaborate.

Responsibility to Self

In discussing the responsibilities which I have encountered in this study, it seems appropriate that my disclosure should begin with the responsibility to myself which I have discovered to be a neceesary factor in my role as inquirer and learner. In my own case it would be more comfortable to examine and scrutinize the events of socialization which influence other nurses, and to examine their histories with a detachment derived from not having to consider how I have

experienced and negotiated my own reality of nursing. Any conclusions I might have drawn from such a study and any recommendations I might have made would be freed from the constraints of my own contextual material. However, the dialectical nature of this inquiry prevents such a position.

I found, instead, a necessity during the course of my dialogues with other nurses, to enter into a kind of internal dialogue within myself. It was no longer possible to accept my own perceptions as objective forms of reality and I found myself sifting through events in my own nursing socialization and re-evaluating choices I have made about the kind of nurse I wanted to become. Seemingly unimportant pictures from the past have been reframed for me, and I have found in them the locus for directions I have since taken, the kind of nurse I have become, and the effects these events have had on the development of my own perception of reality.

From the unfolding of my own story in concert with the unfolding stories of six beginning nurses, I have found the need to question more carefully some perceptions which I have held and the means by which I acquired these perceptions. I have been forced to reconsider activities with which I have filled my time and the priorities that I have assigned. In some cases, it has become necessary to question and revise beliefs and attitudes which would not hold up in the light of critical viewing. One example is my newly developed reluctance to accept preordained routines and to adapt to

regulated order in the name of duty. Duty can no longer be wedded to the acceptance of isolation and submissiveness since it cannot supersede dignity and self-respect. The need to remain constantly occupied as a condition of nursing has been replaced with a need for time to survey, to assess, and reflect as a participating member of the society in which I live and work.

I have also discovered some validation of my own perceptions about the socialization of nurses and the influence that socialization has on the kind of care we presently give. The tendency of women in general, and of nurses in particular, toward qualification and self-doubt becomes less of a hindrance and burden when other nurses add their own voices through similar perceptions and concerns. My responsibility becomes evident in this process in not considering others' views over my own but rather to clarify, to refine, and finally make known to those who are interested what I have learned in this process.

My learning in this study has centered on the ways in which we, as nurses, come to interpret our obligations for loyalty and duty. Of particular concern is whether or not we choose for ourselves principles on which we base our nursing practice or whether we derive these principles from rules and social agreements which exist within our environment. I have formed no firm conclusions from my study. Instead I have gathered impressions of forces which may intervene in

the formulation of personal principles and the resolve to follow through on such principles.

The disposition of women to consider others' viewpoint over their own seems a relevant factor in the way that individual nurses deal with the conflicts and uncertainties of their environment. Gilligan (1979) suggests that this disposition is amply illustrated in the qualifications and self-doubts expressed by women and in their unwillingness to adhere to firm estimates of their own environment. This is evident, I believe, in the acceptance by female nurses of others' evaluation of the greater worth of technical skills over their own preference for interpersonal skills and sensitivity to others.

The empathy and concern for others becomes the source of a dilemma when caring induces women to become captured by their concern for others. In the hospital, nurses find their desire to help others translated into the need for their silent acceptance of expressing care on others' terms rather than their own. Such terms include the acceptance of nursing contributions as a matter of course and the ever-increasing demand for productivity and efficiency. The question must be raised if this is the inevitable price nurses must pay for extending themselves to others? My own inclination following this study is to listen more carefully to my own inner belief, and an additional responsibility I have identified is in helping other nurses in this resolve.

Responsibility to Participants in the Study

In addition to the responsibilities to self in a study that admits to a dialogic process, there are other responsibilities which must be considered. I have come to believe that individuals who participate in a study must be given some assurances regarding their representation in the study and furthermore that the inquirer contracts a particular debt to the participant. This responsibility was to me particularly burdensome and one which caused conflict in the resolution of my obligation. At the beginning of this process, I interpreted my responsibility as a need to represent the nurses whom I interviewed as accurately and faithfully as possible. I also believed that material which I chose to use from the interviews should not be hurtful of the individual nurses who had demonstrated a sense of responsibility to others by consenting to participate in this study. As the interviews took form, it became more and more apparent that some of the material which I considered vital to the study could be interpreted as causing pain or embarrassment. My own anguish in this concern made me reluctant to show drafts of the interviews to some of the nurses and I considered alternatives such as showing each nurse abbreviated versions of the interviews.

My final decision to present each nurse with a complete draft of the interview was reached through an internal struggle in which I considered the right of the nurses I had

interviewed and what these rights really meant. Was it a right to be shielded from a critical evaluation of nursing and socialization practices in the hospital? Or was it a right to re-examine practices which we as nurses have taken for granted and which contribute to the persistence of an unjust system of health care? Many nurses, on reading the final draft, told me that our dialogue had stimulated a good deal of reflection on their part and a re-examination of issues we had discussed. One answer came in the form of a statement by Debbie who read the draft thoughtfully and finally said, "That's really the way it is, you know."

The acceptance of my interpretation of hospital events of socialization as representative was gratifying. A more important aspect of this process, however, came in the ability of the nurses to participate in evaluation of the data and to exert some control over the information they had provided me. The individual opportunity and right to disqualify or reinterpret information in the study was judged by me to be a necessary part of my responsibility to the nurses in acknowledgment of their contribution. The rights of participants to maintain some control of the information provided by them was further underscored by the nurses who indicated their appreciation of this opportunity and in my own sense of justice in this effort.

Intermingled within the concern and responsibility I felt towards the nurses in this study emerged another insight

which I believe is of some significance having to do with feminine forms of friendship. Women who have been socialized from an early age to remain in the seclusion of the home, to accept protection from masculine family members, and finally to play the supplicant's role for their children (as nurses do for their patients), when placed in the ambiguous situation of the hospital often demonstrate the effects of their earlier socialization. Cicourel refers to this practice as "returning to the normal form," an accounting of why individuals choose to act in particular ways in social situations which provide unclear signals on what is appropriate behavior (1974, p. 86).

In the social situation of the hospital, ambiguity regarding the traditional sheltered role of the female places nurses in a double bind. The separation from other nurses through specialization and fragmentation is reflective of the woman's earlier socialization as is the physician's paternalistic promise of protection in exchange for female submission to his professional guidance and domination. Because the nurse, in a sense, is "returning to the normal form," these conditions of nursing activity are often accepted without question. But nurses find that they are also in positions that are exposed and unprotected since their professional and legal obligations, through licensure, require them to accept responsibility for themselves. The responsibility is especially keenly felt since the nurse is rarely able to

call on the empathic support and wisdom of nurses who find themselves in similar positions.

The real injustice of women's separation, however, comes in the interpretation of this separateness as an incapacity for friendship and bonding within the female gender. Tiger in Men in Groups (1970), along with Fox in The Imperial Animal (1971), argues that women are unsuited genetically for cooperation and bonding, indicating the doubt that exists regarding the possibility of friendships among women. And one may conclude from the interviews in this study that nurses are, for the most part, unwilling to cooperate in finding resolutions to one another's problems.

During the course of this study, however, I have drawn other conclusions and I have come to believe that a strong bond exists between women, and among nurses. Part of this bond was deeply felt in my own concern to be helpful rather than hurtful towards the nurses whom I interviewed. On reflection, I discovered a caring going beyond the level of social duties and amenities. In the process of the study I have begun to compare the type of friendship expressed among women and the friendship found within masculine relationships, and I have come to believe that there exists a difference in the expression of friendships between men and women, determined at least partially by socialization.

Competition and achievement, as Gilligan (1979) indicates, are the products of masculine socialization and are

not significant factors in the socialization of women. While men reach maturity through separation and achievement, women reach maturity through a process of extending themselves to others. Unlike men, women, I believe, do not demonstrate friendship by assisting one another in bids for power and achievement. It is difficult to identify any sense of the "old boy network" among the nurses interviewed, and I believe this to be fairly representative of nurses in general. Women do not guard a particular domain through the privileged communication between friends and allies that is found predominating masculine undertakings. While some professional women may approach this trait through an adaptational process, it remains, I believe, the exception rather than the rule.

The depths of women's friendship, as expressed in this study, are to be found in the willingness to assist one another in finding better ways to care for others. Debbie indicates that nurses would work together for safer care for their patients, but not to improve their own working conditions or salary levels. Delois expects her nursing coordinator to help resolve her problems, and Martha indicates that women are "catty" towards other women who accept promotions into administrative levels. A feminine form of friendship was expressed, I believe, in the nurses' willingness to participate in this study. It is a friendship I have experienced before but accepted without question as a taken-for-granted part of my own reality.

At the termination of the interviews, my nursing friends indicated how much they enjoyed the interviews and I interpreted their pleasure as an opportunity to talk about themselves. But in the course of analyzing the interviews it became clearer that these women would not expend energy on their own behalf so much as they would in an attempt to help someone else. It is an insight gained from this study that I especially cherish, but one that also points up some possible reasons for the inability of women to move effectively beyond the barriers formed through their own socialization.

Responsibility to the Profession of Nursing

Consideration of the ways in which nurses are socialized leads to an additional responsibility contracted in this study, my responsibility towards the profession of nursing itself. I have interpreted this responsibility as a need for trying to discover why the status of nurses continues to be consistently reproduced in our society and why a profession which is predominantly female remains relatively powerless in a health care system dominated by male professionals.

Giroux has suggested that one of the ways in which inequality and social order is maintained is "through the production and distribution of 'acceptable knowledge'" (1981, p. 37). In this regard, Giroux combines political understanding and critical thinking with the ability of individuals to step outside the "commonsense assumptions" that prevent achievement of liberation in a just society. From this

perspective, responsibility towards the profession of nursing includes raising questions regarding the accepted and dominant method of scientific inquiry, which has yet to provide the needed impetus for change in the status of nursing.

The acceptance of common sense assumptions on which scientific research is based outside the laboratory setting, and on which much of nursing research is initiated, is rarely questioned. Yet the persistence of common sense assumptions in the face of incontrovertible evidence to the contrary exists, and their effects are evident in this study as it is in other critical views which might be made in nursing studies. In the interview with Delois it is made clear that there persists a common sense assumption that the purpose of those in higher authority in the hospital is to help resolve problems related to nursing care, and this belief persists in spite of abundant evidence contradicting such an assumption. Debbie believes that routines will help her in becoming the kind of nurse she wishes to become in spite of the observed effect such routines have on other nurses. Joan makes a common sense assumption that problems in her new role as an R.N. will be in her relationships with other nurses, but it is not other nurses who create stringent coverage of the hospital units, provide inadequate salary and time for educational pursuit, or devise working conditions that leave Joan and other nurses like her in a state of mental and physical exhaustion.

The continuing use of methodology which is based on common sense assumptions and which removes nursing from its social context does not, in my estimation, provide an objective and neutral view but rather one which represents the dominant interests within our society. Nor does it fulfill a responsibility to a profession dominated by women whose concerns are directed towards others. Nurses who are unable to critically examine issues of their own profession within a social context will identify nursing problems and the problem of their own powerlessness as an isolated phenomenon peculiar to the profession alone. The narrowness of goals directed toward resolution of the profession's problems are antithetical to women and to nurses, even though they care deeply about nursing, since their tendency is to help others rather than themselves. A qualitative, hermeneutic methodology that repositions the concerns of nurses within the broader context of social inequalities is, in my estimation, more appropriate to the needs of nursing, as it is to other areas of our society where domination and exploitation persist. In this study it was found that nurses accepted their separation and isolation as a prerequisite for caring for the needs of others. When this isolation is reexamined critically in the context of its ultimate effect on the nurses' ability to provide care for others, in the way they deem best, then it becomes a powerful motive and signal for future action.

Responsibility to the Reader

The consideration of common sense assumptions in nursing research and in nursing practice are factors not only in the responsibility I have towards the nursing profes sion, but towards the reader as well. In this study I have attempted to refrain from making assumptions regarding the shared reality of an objective world, choosing instead to indicate, whenever possible, the presence of my own interpretation of reality within this study. As a learner and inquirer, this requires a position of greater vulnerability since I must expose for public scrutiny the attitudes and beliefs which I believe are the core of any research proposal. The responsibility in this study then becomes an additional dialogic process in which I must communicate the attitudes and beliefs which I hold and the reader must interpret information provided through a personal and critical lens.

Responsibility to the reader is further underscored by the belief that meaning is a subjective experience and dependent on the reader's participation in this account. Viewing of this study will be filtered through the reflexivity of interpretation and an indexicality of understanding growing out of individual and social experiences. It is for the reader of this work to determ ne what is meaningful based on these subjective factors and to determine what use the information may have.

Responsibility in Identifying Problematics of the Research

In deciding how information gained through qualitative research is to be used, an additional responsibility becomes apparent in determining how rigorous the research effort has been. The aims of the research and the methods by which research studies are conducted provide the criteria for determining whether or not precision has been maintained in the course of the study. Eisner differentiates between quantitative and qualitative research by characterizing quantitative studies as "inquiries that use formal instruments as the primary basis for data collection, that transforms the data collected into numerical indices" (1981, p. 5). By contrast, qualitative research is discerned as an artistic approach to science, concerned more with form and the relationships to be discovered between truth, goodness, and beauty. From this explanation it becomes apparent that the conventional standards of rigor by which traditional modes of inquiry are judged are not uniformly applicable.

The researcher who wishes to substantiate a quantitative study with claims of rigor must do so through the mechanisms of firm evidence and a concomitant detailing of the absence of bias. Such qualifications, however, have minimal significance to a qualitative form of inquiry that moves away from the literal and formally defined categories of observable behavior toward the use of what Eisner (1981) describes as poetic and metaphorical representation. Rigor,

in qualitative terms, is assured through the clarity provided in the detailed and diversified expressions that are incorporated into the fabric of the study.

In the case of the hermeneutic study, data are less firm since they carry with them no literal or formal statements of categories from which the findings may be converted into statistical estimates of probability. But significant data which might otherwise be overlooked or excluded in the strict categorization of the quantitative study have an opportunity, through the hermeneutic method, to be included and assessed. Such data are derived from participants who have been given the opportunity to qualify, to explain, and to clarify so that the meanings their statements have for them become more precise and lucid.

The inclusion of data that are obtained through the expressions and perceptions of participants in this study leads to problematics of the quantitative methodology in the way that meanings may vary with changing circumstance. Allowing individuals the freedom to digress and expand also means that on another day, in a different set of circumstances, specifics of the interviews may vary along with the interpretations which I contribute to them. That all methodologies have both strengths as well as limitations is evident in the remarks of Campbell and Stanley, who state of the problematics of experimental research in nonlaboratory settings, "the selective, cutting edge of this process is

very imprecise in the natural setting. The conditions of observation, both physical and psychological, are far from optimal" (1963, p. 4).

While any form of research must acknowledge the limitations within which it is structured, the problematics that attend qualitative research should not diminish this methodology's importance. Through this form of inquiry, cultural context is reestablished, providing a clearer form with which to view the events of social interaction. Cultural values are made visible for careful scrutiny and socialization is recast within the environment of value and belief systems that inform its progress. Eisner illustrates the contributions of qua titative research by stating:

> One of the strengths that artistically oriented research possesses is that liberties in portrayal are wider than they are in scientifically oriented studies. Making things vivid through selective reporting and special emphasis occurs inevitably in any form of reporting. Artistically oriented research acknowledges what already exists and instead of presenting a facade of objectivity, exploits the potential of selectivity and emphasis to say what needs saying as the investigator sees it. (1981, p. 8)

By indicating what I have come to see in the socialization process, it is my hope that I have drawn from the interviews of particular individuals some insights into significant and human characteristics which may be useful in some future application. While the study is concerned with aspects of nursing socialization that are unique in the time and space they occupy, it has been my intention to discover through the particularities of the given incident

some understanding of the broader realm of socialization in human occupations. Understanding, in this instance, is conveyed through a dialogic form that admits to tentativeness and variegation and as such is subject to acceptance or rejection. It is not my belief that understanding gained through the interpretive method of inquiry should be considered as a substitute for answering questions of truth and logic. It does, however, provide enrichment to an otherwise singular and restricted portrayal of our own realities and suggests alternatives to the social inequities obscured through the monologic view.

BIBLIOGRAPHY

Alutto, J. A., Hrebiniak, L. G., & Alonso, R. C. A study of differential socialization for members of one professional occupation. Journal of Health and Social Behavior, 1971, 12, 140-147.

Ashley, J. A. Hospitals, paternalism, and the role of the nurse. New York: Teachers College Press, 1976.

Austin, R. Professionalism and the nature of nursing reward. Journal of Advanced Nursing, 1978, 3, 9-23.

Bandura, A. Modeling theory: Some traditions, trends, and disputes. In R. D. Parks (Ed.), Recent trends in social learning theory. New York: Academic Press, 1972.

Barrow, R. N. The present role of the nurse in the delivery care. In The Changing roles and education of health care personnel worldwide in view of the increase of basic health services. Papers from a consultation sponsored by the Society for Health and Human Values, Bellagio, Italy, 1978.

Becker, N. S., Geer, B., Hughes, E. C., & Strauss, A. L. Boys in white. Chicago: University of Chicago Press, 1961.

Berger, P. L., & Kellner, H. Marriage and the construction of reality: An exercise in the microsociology of knowledge. In B. R. Cosin (Ed.), School and society. Boston: M.I.T. Press, 1971.

Blau, P., & Scott, W. R. Formal organizations. San Francisco: Chandler Publishing Co., 1962.

Blumer, H. Sociological implications of the thought of George Herbert Mead. American Journal of Sociology, 1971, 23 (25), 535-544.

Bond, J., & Bond, S. Sociology: In touch with reality. Nursing Mirror, 1980, 150 (9), 27-30.

Bowers, C. A. Cultural literacy for freedom. Eugene, Ore.: Elan Publishers, Inc., 1974.

Breuer, J. Introduction to the theory of sets. (H. F. Fehr, trans.) Englewood Cliffs, N.J.: Prentice Hall, 1958.

Brief, A. P., Sell, M. O., Aldag, R. J., & Melone, N. Anticipatory socialization and role stress among registered nurses. Journal of Health and Social Behavior, 1979, 20 (2), 161-166.

Brown, E. Nursing reconsidered: A study of change. Philadelphia: J. B. Lippincott, 1971.

Buck, P. S. To my daughters with love. New York: The John Day Co., 1967.

Burgess, G. The personal development of the nursing student as a conceptual framework. Nursing Forum, 1978, 17 (1), 96-102.

Campbell, D. T., & Stanley, J. C. Experimental and quasi-experimental designs for research. Chicago: Rand McNally College Publishing Co., 1963.

Chodorow, N. Family structure and feminine personality. In M. Rosaldo & L. Lamphere (Eds.), Women, culture, and society. Stanford, Calif.: Stanford University Press, 1974.

Chodorow, N. The reproduction of mothering. Berkeley: University of California Press, 1978.

Cicourel, A. Methods and measurement in sociology. New York: Free Press of Glencoe, 1964.

Cicourel, A. V. Cognitive sociology. New York: The Free Press, 1974.

Clegg, S. The theory of power and organization. London: Routledge & Kegan Paul, 1979.

Cleland, V. Sex discrimination: Nursing's most pervasive problem. American Journal of Nursing, 1971, 71, 1542-1547.

Cox, H. G. The seduction of the spirit. New York: Simon & Schuster, 1973.

Czmowski, M. Value teaching in nursing education. Nursing Forum, 1974, 13 (2), 192-206.

Davis, A. The phenomenological approach in nursing research. In N. Chasha (Ed.), The nursing profession: View through the mist. New York: McGraw Hill Corp., 1978.

Davis, F. Professional socialization as subjective experience: The process of doctrinal conversion among student nurses. In H. S. Becker, B. Geer, D. Riesman, & R. S. Weiss (Eds.), Institutions and the person. Chicago: Aldine, 1968.

Delamont, S. Interaction in the classroom. London: Methuen, 1976.

Devine, B. A. Nurse-physician interaction: Status and social structure within two hospital wards. Journal of Advanced Nursing, 1978, 3 (3), 287-295.

Dewar, T. R. The professionalization of the client. Social Policy, 1978, 8, 4-9.

Dietrich, M. C. Work values evolution in a baccalaureate student nurse population. Journal of Vocational Behavior, 1977, 10 (1), 25-34.

Dingwall, R. W. Some sociological aspects of "Nursing Research." Sociological Review, 1974, 22 (1), 45-55.

Di Renzo, G. J. Socialization, personality, and social systems. Annual Review of Sociology, 1977, 3, 261-295.

Eisner, E. W. On the differences between scientific and artistic approaches to qualitative research. Educational Researcher, 1981, 10 (4), 5-9.

Etzioni, A. A sociological reader on complex organizations (2nd ed.). New York: Holt, Rinehart, and Winston, Inc., 1961.

Etzioni, A. Modern organizations. Englewood Cliffs, N.J.: Prentice-Hall, 1964.

Etzioni, A. (Ed.). The semi-professions and their organization: Teachers, nurses, social workers. New York: The Free Press, 1969.

Frank, S. L. Reality and man. New York: Toplinger Publishing Co., 1966.

Freire, P. Pedagogy of the oppressed. New York: Herder & Herder, 1970.

Friedman, N. The social nature of psychological research. New York: Basic Books, 1967.

Garant, C. A. The process of effecting change in nursing. Nursing Forum, 1978, 17 (2), 153-167.

Garfinkel, H. Studies in ethnomethodology. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1967.

Gilligan, C. Woman's place in man's life cycle. Harvard Educational Review, 1979, 49 (4), 431-446.

Giroux, H. A. Ideology, culture, and the process of schooling. Philadelphia: Temple University Press, 1981.

Given, J. The nurse educator and professional socialization: Issues and problems. Nursing Papers, 1975, 7 (2), 11-13.

Glebe, W. A. Faculty consensus as a socializing agent in professional education. Nursing Research, 1978, 27, 89-97.

Grissum, M., & Spengler, C. Woman power and health care. Boston: Little, Brown, & Co., 1976.

Habermas, J. Knowledge and human interests. (J. J. Shapiro, trans.). Boston: Beacon Press, 1971.

Hockey, L. The future nurse: Selection and training autonomy; should her health care role be modified for future patient demands? Journal of Advanced Nursing, 1978, 3, 571-582.

Horner, M. Toward an understanding of achievement-related conflicts in women. Journal of Social Issues, 1972, 28 (2), 157-174.

Husserl, E. Phenomenology and the crisis of Western philosophy. New York: Harper & Row, 1965.

Illich, I. Medical nemesis: The expropriation of health. New York: Pantheon Books, 1976.

Johnson, M. M., & Martin, H. W. A sociological analysis of the nurse role. American Journal of Nursing, 1958, 58 (3), 373-377.

Jones, S. L. Socialization versus selection factors as sources of student definitions of the nurse role. International Journal of Nursing Studies, 1976, 13 (3), 135-138.

Katz, D., & Kahn, R. L. The social psychology of organizations. New York: John Wiley & Sons, Inc., 1966.

Katz, F. E. Nurses. In A. Etzioni (Ed.), The semi-professions and their organization. New York: The Free Press, 1969.

Kluckhohn, C. Culture and behavior. In G. Lindzey & E. Aronson (Eds.), The handbook of social psychology (Vol. 2). Reading, Mass.: Addison-Wesley, 1969.

Kramer, M. Reality shock: Why nurses leave nursing. St. Louis: The C. V. Mosby Co., 1974.

Kramer, M. Path to biculturism. Wakefield

Kriteck, P., et al. Nursing: A feminist perspective. Nursing Outlook, 1978, 26 (3), 182-186.

Litwak, E. Models of bureaucracy which permit conflict. The American Journal of Sociology, 1961, 67, 177-185.

Lysaught, J. P. An abstract for action. New York: McGraw Hill

Lysaught, J. P. Leadership is more than rhetoric. Nursing Digest, 1978, 6 (2), 76-77.

Macdonald, J. B. Curriculum and human interests. In W. Pinar (Ed.), Curriculum theorizing: The reconceptualists. Berkeley, Calif.: McCutchan, 1975.

McClelland, D. The achieving society. New York: Van Nostrand, 1961.

McFarland, D. E., & Shiflett, N. The role of power in the nursing profession. Nursing Dimensions, 1979, 7 (2), 1-13.

Mehan, H., & Wood, H. The reality of ethnomethodology. New York: John Wiley & Sons, 1975.

Miller, G. O. Professionals in bureaucracy: Alienation among industrial scientists and engineers. American Sociological Review, 1967, 32, 755-768.

Montagna, P. D. Professionalization and bureaucratization in large professional organizations. American Journal of Sociology, 1968, 74, 138-145.

Natanson, M. Literature, philosophy, and the social sciences. The Hague: Martinus Hyhoff, 1962.

Natanson, M. Alfred Schutz on social reality and social science. Social Research, 1968, 35, 217-244.

Novak, M. The experience of nothingness. New York: Harper Colophon Books, 1971.

Olmstead, A. G., & Paget, M. A. Some theoretical issues in professional socialization. Journal of Medical Education, 1969, 44 (8), 663-669.

Polyani, M. Logic and psychology. The American Psychologist, 1968, 23 (1), 27-43.

Schutz, A. The phenomenology of the social world. Evanston, Ill.: Northwestern University Press, 1967.

Shuval, J. T., & Adler, I. Health occupations in Israel: Comparative patterns of change during socialization. Journal of Health and Social Behavior, 1979, 20 (1), 77-89.

Simpson, I. H. Patterns of socialization into professions: The case of student nurses. Sociological Inquiry, 1967, 37 (1), 47-54.

Sorbin, T. R. Role theory. In G. Lindzey & E. Aronson (Eds.), The handbook of social psychology (Vol. I). Reading, Mass.: Addison-Wesley, 1969.

Spring, J. H. Education and the rise of the corporate state. Boston: Beacon Press, 1972.

Stiehl, R. R. Characteristics of role-models and a description of their influence on professional socialization as perceived by students in two elementary education and nursing programs.(Doctoral dissertation, University of South Florida, 1977). Dissertation Abstracts International, 1977, 38A, 740-741.

Stokes, R., & Hewitt, J. P. Aligning actions. American Sociological Review, 1976, 41, 838-849.

Tetreault, A. I. Selected factors associated with professional attitude of baccalaureate nursing students. Nursing Research, 1976, 25 (1), 49-53.

Tiger, L. Men in groups. New York: Vintage Books, 1970.

Tiger, L., & Fox, R. The imperial animal. New York: Holt, Rinehart and Winston, 1971.

Ventura, M. R. Related social behaviors of students in different types of nursing education programs. International Journal of Nursing Studies, 1976, 13 (1), 3-10.

Waltz, C. F. Faculty influence on nursing students' preferences for practice. Nursing Research, 1978, 27, 89-97.

Webb, M. R., & Herman, L. Achieving behaviors in beginning nursing students. International Journal of Nursing Studies, 1978, 15 (2), 75-82.

Welch, L. B. Symposium on the nurse as change agent. Nursing Clinics of North America, 1979, 14 (2), 305-306.

Wheelis, A. The quest for identity. New York: Norton, 1958.

Whitehead, A. N. Process and reality. New York: Macmillan, 1929.

Wilson, V. An analysis of femininity in nursing. American Behavioral Scientist, 1971, 15, 213-220.

Wong, Q. Nurse-teacher behaviors in the clinical field: Apparent effect on nursing students' learning. Journal of Advanced Nursing, 1978, 3 (7), 369-372.

Ziegler, E., & Child, I. Socialization. In G. Lindzey & E. Aronson (Eds.), The handbook of social psychology (Vol. 2). Reading, Mass.: Addison-Wesley, 1969.

Ziegler, E., & Sietz, V. Changing trends in socialization theory and research. American Behavioral Scientist, 1978, 21 (5), 731-756.