

Feminism and the future of nursing

By Donald Sabo, Ph.D.

The intent of this article is to entice readers to think about nursing and the profession of nursing within the purview of the "feminist paradigm." A paradigm is a way of "seeing or experiencing" the world or any defined aspect therein. The first step toward this end is to explain how the healthcare professions have been shaped by the patriarchal tradition.

Secondly, the impact of patriarchy and sexism on the occupational structure of the health professions will be examined. In this examination, we will look at the ways physicians have historically perceived and treated women. Finally, we will highlight several contemporary nursing issues for which feminist analysis may have particular relevance to the future.

Nursing and patriarchy

The emergence of patriarchy not only originated in our primordial past, it influenced subsequent social evolution as well. It was out of highly patriarchal, agricultural societies that much of today's advanced industrial economies developed. Within the broader scope of social change, therefore, many of the customs, gender expectations, institutions and status differences between the sexes in our own industrial societies came to bear the imprint of the patriarchal past. Today, gross and subtle influences of patriarchy on our contemporary lives remain essential elements of all institutions - including medicine.

In what way is patriarchy evident in the medical professions of today? Male dominance of the medical professions is rooted in history and politics and not patriarchal providence, testosterone levels, or left

brain/right brain differences between the sexes. Today, in Canadian medicine, as in the provincial and national governments, men predominate in numbers, power and influence.

The lopsided professional reality in which nurses now function in Canada, strikes feminists as unjust, strange and oppressive. For instance, the vast majority of health care centres are institutions in which women are a majority of the workers, as well as a majority of patients. Women consume the majority of over-the-counter drugs and are given the majority of prescribed drugs. Women also undergo the majority of surgical procedures. Within the same institutions, men make the majority of decisions, derive a majority of the status and prestige, and enjoy the majority of the financial rewards.

Diagnosis and treatment of women

The results of male dominance of medicine are not limited to control of the health professions and institutions. Gender stereotypes and discriminatory practices have powerfully influenced the ways in which the medical profession views and treats patients.

Diagnosis - Analysis of medical writings show that women are often portrayed as being inherently weak, sickly, hypochondriacal, and intellectually incapable of understanding medical matters and their own bodies. These beliefs were especially evident in 19th century medicine's depiction of upper class women. Because of their "innate" frailness and intellectual deficiencies, many medical scientists reasoned

that women's activities had to be limited to the moderate demands of motherhood and homemaking. When illness struck, the "ladies" of the upper classes were confined to their beds for weeks or months.

Barbara Ehrenreich and Deidre English (1979) argue that physicians had a financial stake in maintaining this "myth of female frailty" because it helped disqualify women as doctors, and it insured access to a larger number of paying patients.

A content analysis of gynecological textbooks showed that medical stereotypes of women are by no means buried. Diane Scully and Pauline Bart (1981) found that women's traditional role as wife and mother received repeated emphasis and, as one doctor put it, childbirth was thought to be the "crowning fulfillment of a women's sexual adjustment." Female sexuality was described in problematic, masochistic, and infantile terms. An overall paternalistic attitude echoed throughout the texts.

Menopause is another example of how gender stereotypes form medical views of women. Menopause is depicted in very negative terms, as the end of a women's fertile years rather than the beginning of a new life phase. The passing of reproductive capacity is mourned, while the other aspects of women's lives are ignored. In one physician's words, it is the "death of the woman in the woman." Menopause is regarded as another disease, an incurable ill or metabolic deficiency.

Gender stereotypes often interfere with the physician's ability to diagnose a women's ills at all. A Canadian sociologist (Cooperstock, 1971) asked doctors to describe the "typical complaining patient," 72 per-cent referred to women in their statements while only four percent referred to men. She found that male patients were taken more seriously. Men 'describe' symptoms, women 'complain' about them. Women's reports of pain are sometimes seen as exaggerated rather than accurate appraisals of biofeedback.

Treatment - Male dominance in the health care professions and gender stereotypes have also influenced the ways women are treated. Examples of maltreatment range from the regrettable to the perverse. Let me cite a few examples that have received particular attention from feminist scholars and researchers. It is interesting to note, in light of this O.R. nurses' conference, that many of the following examples pertain directly to surgery and the O.R.:

- It is estimated that women have twice as many elective surgeries as men. Elective surgeries account for about 85% of all surgeries.
- North American women were prescribed and sold

oral contraceptives in spite of a lack of thorough longitudinal research which attested to their safety. Side effects ranging from headaches to life-threatening conditions have since been documented.

- Today, many young women have been diagnosed with a form of vaginal cancer which resulted from their mother's use of DES during pregnancy. Indeed, even after the association between DES and vaginal cancer had been discovered, it continued to be prescribed as a "morning after" pill on some American college campuses.

- Radical mastectomy, caesarean section, episiotomy, hysterectomy, etc., are fraught with controversy. In numerous instances these invasive therapies can be equated with surgical maltreatment. The incidence of surgical procedures performed on women is almost double that performed on men (Connors, 1985).

According to several Canadian medical journals while the hysterectomy rate in Canada has declined somewhat in recent years, it is still considered to be the most frequently performed major surgical procedure in North America. One estimate goes so far as to state that one out of every two women will have their uterus removed before they reach the age of sixty-five.

Only 20% of hysterectomies are done because of an indication of cancer, and a small number are being performed because of obstetrical hemorrhaging. Most hysterectomies are done for conditions which are not considered life-threatening and for which alternative therapies may be available.

Often, the risk of death due to surgical complications is higher than the risk associated with the specific disease (e.g., uterine cancer). In the United States, in 1975, of the 787,000 hysterectomies performed, 22% were deemed unnecessary and 1700 women died as a result of complications of their operations. (Connors, 1985).

As a nursing master's student so powerfully stated it, "every day a male surgeon removes parts of a women's body that he has lived his entire life without." This student might have been referring to the obstetrician-gynecologist who holds the view that, "when the patient has completed her family total, hysterectomy should be performed as a prophylactic procedure...Under these circumstances, the uterus becomes a useless, bleeding, symptom-producing, potentially cancer-bearing organ and should therefore be removed." (Schiefelbein, 1980, p.15.)

- Cosmetic surgery is a growing practice in which the formula is, "thin women = fat profits." Writing

on the subject of the continued medicalization of women, Catharine Kohler Riesman (1989) argues that, "like menstruation, women's physical appearance has come under the lens of the medical establishment. Cosmetic surgeons treat everything from facial wrinkles to breast size. The medical beauty business has concentrated with special intensity on the bodily changes associated with women's aging.

Another subject receiving medical scrutiny is weight. "Obesity" is now a medical condition. Riessman found a relationship between the production of medical literature on obesity and the growth of the modern women's movement. The number of citations to obesity in *Index Medicus* by year was insignificant in 1960. However, by 1981, more than seven pages of references were found. The number of references referring to surgical remedies went from seven in 1970 to 73 in 1976. I wonder what Hugh Hefner and the medical profession have in common?

Historically, politically and culturally, I believe the growing medical beauty business illustrates how power relations between the sexes are maintained through medical social control. Tragically, it also demonstrates how women, desiring to be thin, often internalize their oppression by asking their doctors for help.

Feminist issues in nursing

Feminist perspectives highlight the gender inequality that exists within the healthcare institutions as well as raising serious questions about the diagnosis and treatment of women. Similarly, a number of issues faced by O.R. nurses seem to gain more critical mass when irradiated by feminist analysis.

1. Teamwork vs. hierarchy

In the operating room physicians are in control. O.R. nurses are powerless in terms of the human experience of the patient. Nurses focus on the environment and this is the only control they have. They exert no control over the process of surgery itself and are facilitators of the physician's goals. There is often minimal caring in the O.R. and this tears up a lot of O.R. nurses. How can more holistic models of care be developed and maintained? Can more co-operative links be made between nurses and physicians, the O.R. and families, and the psychological and physiological aspects of recovery?

2. Caring vs. curing

Should the dichotomy of the care/cure myth be abandoned? Can the traditionally "masculine" technic-

al side of medicine be melded with its traditionally "feminine" caring/nurturing side? And can physicians be expected to restructure the treatment process in order to incorporate the traditionally feminine side of patient care?

3. Status battles: professional or laborer/technician

The nursing profession has come a long way from its "subordinate helpmate" status in the 19th century. Educational achievement and professionalization have bolstered the skills and image of nurses. Yet, there exists an incipient trend to reduce the nursing presence in the O.R. from an informed professional to a lower-level technician. Such administrative moves may be cost-effective, but do they serve women professionals and O.R. nurses? Who will benefit? Nurses, physicians, or patients?

4. Medical mutilation of women

If feminist critics are even partly correct concerning the misdiagnosis and maltreatment of women by physicians, then where does that leave O.R. nurses? What policies should be adopted for patient advocacy? How are O.R. nurses to deal with the spectre of unnecessary surgery? If O.R. nurses buy the assumption that physicians are systematically oppressing women, then they have to begin to analyze their role within the system.

Dr. Gertrude Torres, a prominent nursing theorist and educator, suspects that nurses are often not protective of female patients. Like other victims of oppression, she contends, nurses tend to mimic the values and practices of their oppressors. She wonders if, by their passivity, nurses are not complicit in the medical mutilation of women. If this is the case, then how to respond?

"Power," says Torres, "is often in the eyes of the beholder." Nurses lack power, at least in part, because they assume that they don't have power. The oppressor creates a distorted reality which dehumanizes both the oppressor and the oppressed.

Some critical questions surface. Have nursing organizations developed a policy or taken a stand on cosmetic surgery? Why has there not been more advocacy for women? Have any nursing organizations taken a stand on the medicalization of women? If not, why not?

5. Toxicity in the operating room

A systematic review of the research literature on the potentially harmful effects of anaesthetic gases

on reproductive functions in women working in the operating room was compiled by Lenox (1988). Some of the findings are striking.

One 1971 study by Cohen, Belville and Brown found a significantly higher rate of spontaneous abortions among O.R. nurses and female anaesthetists. In contrast, other studies done in the U.K., the U.S. and Scandinavia found no statistically significant results. However, these latter studies have been criticized for their methodological flaws. The bottom research line is that the question of potential harm from exposure to noxious gases in the O.R. has not been settled. The scientific verdict is still out!

But, in spite of this fact, the medical profession continues to encourage nurses to accept the status quo, a status quo that saw a 1977 National Institute of Occupational Safety and Health publication estimate that 214,000 persons were potentially exposed on a daily basis. Moreover, as the literature research by Lenox points out, the majority of these people are nurses.

At issue here is your right as nurses to a safe workplace and clean environment. This is a right guaranteed by the International Declaration of Human Rights. More rigorous research is called for so that answers can be forthcoming. This is not only the right thing to do, it is your right to do it!

6. AIDS in the operating room

The AIDS epidemic, as it continues to grow, has generated tremendous fear and anxiety and "raised difficult issues of medical ethics and social control." (Brown, 1989) How will O.R. nurses respond? Do nurses have the right to know? And, if they do know, what influence should they expect over outcomes? Should patients be tested prior to surgery? How can nurses share decision-making in life and death situations? Policies need to be developed which ensure patient care and a safe O.R. environment for nurses as well.

7. Communication: using the media

Like members of other professions, O.R. nurses need to use modern media to communicate with larger audiences and constituencies. This means that the profession in the 1990's needs to think more about mass education and public relations.

Strategizing also needs to be done on how to present to the Canadian public accurate images of professional and labour issues within nursing. The media has not done a very good job in accurately portraying the nursing profession. Gender stereo-

types of nurses abound, ranging from man-chasing vampires to overly dependent and dutiful helpmates for middle-aged male physicians.

A recent controversy in this regard revolves around the TV show "Nightingales." This prime-time show (not shown in Canada) continuously shows nursing students in varying states of semi-nudity, their lives revolving more around relationships with men than professional aspirations.

The American Nurses Association vigorously protested this distorted portrayal of women and the nursing profession with good results. Several of the show's major corporate sponsors, including Coca Cola, severed their involvement with the show.

Professional organizations and protests can make a difference. As nurses become better organized and more knowledgeable about the workings of the mass media, they will be in a better position to transform the media into vehicles for promoting rather than debasing the profession.

Feminism: a theme for nursing unity

This address is an invitation for you as O.R. nurses to think about the future of nursing from within a feminist framework, to ponder what may be old issues in new ways. I have tried to illustrate how feminist analysis can expand understanding of issues and opportunities within the operating room and the healthcare delivery system at large.

The door to feminist analysis has too often and for too long been equated with and limited to the work of women's studies and women liberationists. In fact, the feminist paradigm is an emerging innovation in scientific thought such as those generated by Copernicus in astronomy or Einstein in physics. The feminist paradigm has its own unique set of concepts, methods, and assumptions about its subject matter which allow both sexes to rethink all aspects of human existence.

What kinds of general strategies for change flow out of the feminist paradigm? The first strategy that comes to mind is sisterhood. United you stand proud; divided you fall prey.

I am not recommending that "sisterhood" become a militant bannerhead for the exclusion of men. I would not be making this address if this were so! I am, however, asserting that feminist values and feminist visions of health and illness and care offer some extremely worthwhile alternatives to the patriarchal values and practices that have typified traditional medicine. Both females and males can embrace and benefit from these values.

A second general strategy which comes to mind is consciousness raising and education on women's

health issues. As Cheryl Ruzek (1986) writes, "...it is crucial for women to come together and share their personal experiences of health and illness... These groups must also incorporate a political analysis, and point out the ways in which interest groups ranging from medical specialties to drug companies are not to be relied upon to act in the best interests of women." (p.569) Operating room nurses, as a professional nursing specialty, would do well to follow the same prescription.

Finally, I leave it to you, the true experts in the field of O.R. nursing, to ascertain the relevance of feminist analysis to your profession, to adopt and modify the feminist paradigm, to identify and analyze the key issues, and to plot the directions for future change. The challenge is yours. Remember, social change is seldom measured by days or months or even years, but rather in terms of life-times. In the words of the 19th century feminist, Susan B. Anthony, "the road is long, but failure is impossible." ■

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About the author

Donald Sabo, M.Ed., M.S., Ph.D., Associate Professor of Social Science, D'Youville College, Buffalo, N.Y., is a practitioner of feminist theory and research. This submission was prepared for publication from a keynote address by the author at the First Provincial Conference of the O.R. Nurses Association of Ontario.

Letter to the editor...

Lives lost because medical professions are locked into hierarchical roles

In a "Letters to the Editor" column of the Toronto Star recently, a nurse, commenting on the findings emanating from the investigation into the cause of the Air Ontario crash in Northern Ontario, had these remarks to say about communication and the way people work in the medical profession:

"Regarding the Dryden air crash inquiry: when people board an aircraft, they believe they are trusting their lives to the latest in science and technology. What a shock to discover that they are instead entrusting themselves to a medieval thought-pattern based on hierarchical dominance-submission roles, and on a sense of honour that used to result in senseless duals."

"The stewardess looked at the ice on the wings (of the aircraft that eventually crashed) and buckled herself resignedly in her seat because pilots, we have heard, 'don't take kindly to being given suggestions on how to do their jobs by stewardesses'..."

"A guest pilot also saw the ice on the wings and settled in beside his family, risking their lives rather than insult his colleague in charge of the plane by questioning his judgement - even though he could probably see what the pilot could not."

"As a nurse, I know that this happens in another profession every day. Nurses bend in circles, playing mind games, in order to give life-saving suggestions without seeming to tell doctors what to do - which might arouse their ire."

"And medical colleagues, even though they may see what the doctor who 'owns' the case cannot, will not give unrequested advice or criticism. Lives are lost because professionals are locked in hierarchical roles, especially male-female, dominance-submission roles."

"The remedy? Professionals who treat each other as equals, whether male or female, whether paid less or paid more, who listen to and respect each other's knowledge and opinions, and who work collaboratively, not defensively. These are goals the women's movement has always held. Other societies, males and females together, have also worked this way. It is not an impossible goal to get beyond the present macho way that our professions operate. As the guest pilot said on the (investigation) stand, 'Something has to be done about the way people communicate and work together'..."

Anna Scott, R.N., Williamsford, Ontario



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