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Peer reviewed|Thesis/dissertation

UNIVERSITY OF CALIFORNIA,  
IRVINE

Gendering Profession: Experiences of Nursing in the United States

DISSERTATION

submitted in partial satisfaction of the requirements  
for the degree of

DOCTOR OF PHILOSOPHY

in Sociology

by

Daniel Schneider

Dissertation Committee:  
Vice Provost Judith Stepan-Norris, Chair  
Professor Matt Huffman  
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2016



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## ACKNOWLEDGMENTS

This dissertation wouldn't be possible without the people who let me into their lives and shared their thoughts and feelings. I am forever grateful to you for accommodating my presence, constant notetaking, odd questions and attempts at humor. I'd especially like to thank "Jenny" and "Dave" who always made me feel welcome in their units and who each spent countless hours educating me.

I would like to express the deepest appreciation to my committee chair, Professor Judith Stepan-Norris, to whom I am constantly in awe. Her guidance and help were a constant horizon of assurance in the choppy sea of uncertainty, doubt and anxiety that is a dissertation.

I would like to thank my committee members, Professor Belinda Robnett, Professor Matt Huffman and Professor Ellen Olshanksy, whose unique perspectives and skills helped to shape the dissertation and my studies in innumerable ways.

Thank you to everyone that helped me navigate the process of getting into the hospital and to understand what was happening within it. Thank you to my nurse liaisons, who made this project happen by convincing nurses, managers and staff to let me into their worlds.

Thank you to the UCI Sociology 2009 Cohort for the laughs, moral support, insight and inspiration.

I'd like to thank the University of California, Irvine and the Institute for Research on Labor and Employment for their generous financial support.

To my family, I wouldn't be here without you. For that I owe you everything.

Lastly, I need to thank my wife, Helen, for her love and sacrifice. I got through the moments and days where I did nothing but write or code or read because she was there, I kept on working when it seemed overwhelming or pointless because she told me I could, and the moments of joy and pride were infinitely brighter because I shared them with her.



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# **ABSTRACT OF THE DISSERTATION**

Gendering Profession: Experiences of Nursing in the United States

By

Daniel Schneider

Doctor of Philosophy in Sociology

University of California, Irvine, 2016

Vice Provost Judith Stepan-Norris Irvine, Chair

I combine ethnographic, archival and national survey data to interrogate the social contingencies of professionalization. With a focus on nursing, this study illuminates how gender, race and class intervene and structure professional closure, the process of professionalization and professional status and interactions. The gender dynamics in professions both mirror and reinforce inequality regimes in both the United States, broadly, and within organizations. This work adds insight and nuance into theories of work and occupations that are significantly under-socialized and fail to reckon with the importance and centrality of gender and race in institutional and interactional relationships. I take a multi-method approach which explores professionalization at the macro, meso and micro levels to triangulate my analysis around a complex and dynamic process.

## **Chapter 1: Introduction – Gender and Professions**

Professions occupy a unique and central place in modern American society. Professionals experience extraordinary autonomy, status and often remuneration. They service some of our most critical, important, and/or ideologically sacrosanct social needs. But not all professions are created equal. Some have more autonomy, more status, and more pay than others. Like many realms of American life, professions are significantly segregated by gender as well as by race. In the pages that follow I will investigate how this segregation affects the professional outcomes and experiences of gendered professions. More specifically, I aim here to illuminate a more socialized account of professions and professionalization, one that seriously grapples with a multitude of complex ways in which gender is intertwined with professions. I explore these issues through the history of American nursing and experiences of hospital nurses, as well as a broad analysis of professional inequality. Theorists have created a wealth of information on the characteristics, process and ecology of professions, yet relatively little attention has been paid to the experiences of female professions or the intersection of gender and professionalization. Despite the minor attention paid to the gendering of professions in the literature, explicit examination of gender is conspicuously absent from the most significant work on the subject. Although profession is often thought about in agendered terms, historically the professions have been dominated by men (Witz 1990; 1992). This fact does not, however, preclude the existence of female professional projects. In fact, many historically female occupations have attempted to attain professional status. This project explores the possibilities and constraints of professionalization for female occupations. Utilizing a multi-method and multi-vantage approach

I will provide a holistic perspective in answer of a simple question: How does gender shape professionalization?

As one of the most successful professional projects by any women's occupational group nursing represents an important and potent example of the limits and possibilities for women's professions. Of the most common occupations for women, registered nurses are the highest paid (BLS 2011), which makes nursing uniquely positioned to interrogate these issues. According to the Bureau of Labor Statistics in 2008 registered nurses had a median annual income of 60,000 dollars making it the single highest paying occupation of those with more than 250,000 female workers (89% of nurses are women) (Cheeseman Day and Rosenthal 2008). This is especially important to note because it was not the case even into the 1960s, when nurses made significantly less than other professional working women (Enix 1966). Additionally, nursing demonstrates many of the attributes of professions (see more on this below): specifically nursing in the United States has a well-developed credentialing and licensure system, with a dedicated academic discipline to back it up. Schlotfeldt writes that "general agreement exists that there is a body of structured knowledge that professionals in the field agree represents the discipline that is fundamental to general and specialty nursing practices (Schlotfeldt 1989, p 17). Currently all 50 states have state boards of nursing populated by RNs and members of the public and carry out licensure exams (National Council of State Boards of Nursing 2013). Even so, its status as a profession remains ambiguous. Nursing is often characterized as a paraprofession or semi-profession (Friedson 1973; Hearn 1982; Forsyth and Danisiewicz 1985).

Despite its many successes, the fate of the professional project remains unclear. Registered nurses still earn less than 9 of the 20 most common occupations for men, including managers, frontline-supervisors, wholesale manufacturing sales reps, software engineers and

accountants and less than all 20 of the highest paid men's occupations (Cheeseman Day and Rosenthal 2008). As Kramer and Schmalenberg (2008) report, Nursing continues to suffer from low levels of job satisfaction and commitment, as compared to other professions. One in five nurses plan to leave the profession within five years because of unsatisfactory working conditions, including low pay, severe under staffing, high stress, physical demands, mandatory overtime, and irregular hours. In 2006 it was estimated that approximately 1.8 million nurses chose not to work as a nurse. Crucially nurses have not achieved the kind of autonomy that other professions have. In a survey of nurses from 1974 to 1991 only low to moderate clinical autonomy was reported, in 2001 39% of nurses surveyed reported having limited, unsanctioned, unsupported, or no autonomy (Kramer and Schmalenberg 2008).

Despite most readers' practical familiarity with nursing as part of regular medical care, I will provide a brief definition of nursing for clarity's sake. The American Nursing Association defines nursing as "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (ANA web 2013). In practice nurses,

- Perform physical exams and health histories
  - Provide health promotion, counseling and education
  - Administer medications, wound care, and numerous other personalized interventions
  - Interpret patient information and make critical decisions about needed actions
  - Coordinate care, in collaboration with a wide array of healthcare professionals
  - Direct and supervise care delivered by other healthcare personnel like LPNs [licensed practical nurses] and nurse aides [CNAs]
  - Conduct research in support of improved practice and patient outcomes
- (ANA web 2013)

The nursing practice provided above, also implies a hierarchy within nursing, and indeed nursing itself is fairly stratified. The most visible and most common nurses are Registered Nurses (RNs),

these are nurses that have completed either a Bachelor of Science in Nursing (BSN) or an Associated Degree in Nursing (ADN), passed the National Council Licensure Examination (NCLX) and gained a license in the state where they practice. My analysis of nursing will focus primarily on RNs. RNs can also get a Masters in Science of Nursing that would prepare them to be Advanced Practice Nurses (APNs), including nurse anesthetists, nurse midwives, clinical nurse specialists and nurse practitioners, nurse administrators and educators. There are also PhD programs in nursing as well as Doctorates of Nursing Practice. LPNs and CNAs are generally less educated than RNs and assist RNs in bedside and general care. For the purposes of this study when I use the term nurses or nursing, I will be referring to RNs and APNs and I will refer to LPNs and CNAs separately. In addition to stratification in education, nurses in the United States are also highly stratified in their work and their class backgrounds.

Understanding professions is crucial to understanding work, workplace inequality and organizations. Professions have stood apart in western economies for centuries now. As central economic and cultural institutions, I argue that navigating and constructing professionalization is “doing gender” (West and Zimmerman 1987) and thus exploring the gendering of profession will expand our knowledge of gender and gender inequality as well. Furthermore, exploring the successes and failures of female occupations to assert professional identity speaks to larger conceptions of masculinity and femininity because “[p]rofessionalism has traditionally been predicated on a masculine ideology (Davies 1996; Witz, 1992) and embodied in the ideal of the unencumbered man (Acker 1990)” (Muzio and Tomlinson 2012, pg. 456). So if women’s professions successfully assert professional identities they may transform essential understandings of masculinity and femininity.



Professions have interested sociologists and other scholars for centuries now<sup>1</sup>. In the mid-18<sup>th</sup> century Adam Smith and Karl Marx traded arguments about the nature of professional labor.

Smith in book one of *the Wealth of Nations* writes about the “liberal professions” that:

We trust our health to the physician; our fortune and sometimes our life and reputation to the lawyer and attorney. Such confidence could not safely be reposed in people of a very mean or low condition. Their reward must be such, therefore, as may give them that rank in the society which so important a trust requires. The long time and the great expense laid out in their education, when combined with this circumstance, necessarily enhance still further the price of their labor (Smith, 1976a, I, p. 118).

To which Marx replied that some “unproductive labor”<sup>2</sup> was necessary for the (physical, spiritual or other) maintenance of the working and capitalist classes. But the continued persistence of professions as a protected class hinged on the ability of the class to justify itself ideologically to the capitalist class (Marx 2000). Moving away from this discussion of the special social differentiation of professions, functionalist theorists in early and mid-19<sup>th</sup> century America focused more on taxonomic approaches to understanding the professions. These works were centrally concerned with the attributes that separated professions from other kinds of occupations. Though there was disagreement about which occupations actually were professions, generally speaking, scholars identified several attributes common to the professions: training, service orientation, lifelong dedication, common identity, a systematic body of knowledge, ethical codes and autonomy (Carr-Saunders and Wilson 1933; Parsons 1939; Cogan 1953; Flexner 1915; Goode 1969; Pavalko 1988).

Moving away from naturalistic accounts, the sociology of professions began to shift to the institutional process whereby occupations became professions, as many scholars were

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<sup>1</sup> This interest has waxed and waned to be sure.

<sup>2</sup> I.E. does not produce commodities for sale

arguing that occupations generally were becoming professionalized (Wilensky 1964). In response to these observations Wilensky (1964) and Caplow (1954) modeled the professionalization process. Though they disagreed on chronology and some significant details, both essentially argued that professionalization is a process that begins with the rationalization of the work and the establishment of a professional association, which develops a code of ethics and agitates and obtains legal protection for the occupation. Importantly, Wilensky also developed a 4 part typology of occupations and the professionalization process, writing that there are established professions, professions in process or marginal, new professions and doubtful professions. The culmination of this process is gaining “extraordinary autonomy – the authority and freedom to regulate themselves and act within their spheres of competence” (Wilensky 1964: pg 146). Nursing was one of the 18 occupations that Wilensky examined; he classified them as a profession in process, having not yet completed the necessary stages of professionalization. Building on the professionalization literature, Forsyth and Danisiewicz (1985) develop a model that focuses on power of individual professionals, specifically the power of professional “practitioners in their social exchanges with society and individual clients” (pg 60), rather than the power of the professional organization. In this light they draw our attention to the autonomy of professionals as a result of successful image building. They argue that those occupations with “predisposing characteristics” – work that is essential, exclusive and complex - promote the work group to the public, through professional associations, in what they call “image building activity.” Based on how the public responds to these claims occupations may gain different kinds or degrees of autonomy. Full professions are those occupations which gain autonomy from both clients and employing organizations, semi-professions secure autonomy from only of these interested parties, while mimic professions attempt and fail to secure either form of autonomy.

By the 1970s and 80s as the professional world was changing, the attribute model and functionalist conceptions of professions came under fire from neo-Marxian and neo-Weberian scholars for ignoring linkages to the class structure, overlooking implications of power, a generally positive bias towards the professions, and being overly static (Elliot 1972, Freidson 1973; Rueschemeyer 1964). Similar to the professionalization literature, this perspective argues that professions engage in a number of strategies to attain professional status, what they identify as 'professional projects'. Professional projects are characterized as labor market strategies designed to gain occupational monopoly over specific kinds of work. These strategies, if successful, reward professions with, in addition to occupational monopoly, autonomy and status (Larson 1977; Freidson 1983; Witz 1990). Essentially, neo-Weberian scholars argue that professionalization or professional projects are a specific type of occupational closure (Parkin 1979; Freidson 1973). Parkin (1979) goes so far as to say that under modern capitalism the professions, along with capitalists, are one of the two dominant classes. Professionalization, according to Parkin is at its core an attempt to create a social-legal monopoly that eliminates labor competition through licensure and credentialing.

These accounts also took note of the reflexive nature of autonomy. As others have noted, autonomy is a goal of professions, but Larson (1977) goes further to pinpoint the special import of autonomy for professional projects. She argues that not only is autonomy a reward for achieving professional recognition, it is a key way in which professions protect the monopoly over their work and thus increase their market value (Larson 1977). By achieving professional autonomy (in the macro sense), the profession is now in the expert position to dictate the value and need of its services. Accounts of professional projects also tend to situate professionalization

within a complex market and legal context, as opposed to portraying the process as isolated and routinized as some earlier scholars had done.

In this vein, Abbott (1988) argues for an ecological approach to professions that refocuses the study of professions away from the structure of the profession and towards work. Specifically, the link between professions and their work that he calls “jurisdiction,” essentially the legitimate claim to any particular sphere of competence, to use the language of prior scholars. In Abbott’s view, to properly understand professional development, one must examine how a profession creates a link to its work, how it is anchored by social structure and probably most interestingly how the interactions of professions and the ways in which they compete for jurisdiction determine their development. For Abbot, professions do not exist in isolation from one another, but are in near constant competition to gain, defend or expand jurisdictional control over a “heartland of work.” As a result of these competitions, professions must sometimes accept limited jurisdiction, and cooperation or subordination with other professions. The most common arrangement is a profession with full jurisdiction paired with a profession with subordinate jurisdiction. Professions often find themselves working in closely assimilated, complex arrangements. So in addition to competition on a national scale there often is contested or blurred jurisdictions in every day practice. Jurisdiction and authoritative and subordinate organizational arrangements must be maintained on a daily basis in interactional and symbolic regimes.

I present the theoretical arguments here and in this way<sup>3</sup> for a number of reasons. First, to provide an orienting body of theory that I will expand on throughout the text. Second, to set up the tensions between these theories, particularly in their differences in focus and engagement (or lack thereof) with social context. And third, and most importantly to demonstrate the failure of

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<sup>3</sup> In chronological order.

the foundational theories to seriously contend with gender or other social categories and their relationship with the professions. Up to this point (late 1980s) in the literature there had been virtually no discussion of how gender interacts with profession or professionalization. Despite the implicit gendering of professions threading throughout the literature, explicit examination of gender is conspicuously absent. In the early literature professionals were merely assumed to be men, as Wilensky (1964) writes “The professional man adheres to a set of professional norms” (pg 138). In later writings, gender remains unexamined even when distinctions between full professions and semi professions seem to be at least somewhat distinguishable by the gender composition of the occupation. In Forsyth and Danisiewicz (1985), for instance, the full professions are represented by law and medicine, two male dominated occupations, while the semi and mimic professions are represented by education, nursing, librarianship, social work, engineering and business administration, the first four female dominated occupations and the last two male dominated occupations. In Abbott (1988) his two prominent examples of full and subordinate jurisdictional pairings are medicine and nursing, and legal and paralegal, both characterized by a male dominated profession subordinating a female one. Whether the professions are subordinate because they are composed mainly of women or they are composed mainly of women because they are subordinate is an empirical question, yet no investigation (or even recognition) is offered in the analysis.

Yet gender is a powerful social institution, “a pervasive social category” (Weatherall 2000), that frames practically all social interactions and the organization of social life (Ridgeway 2010). Work of course is no exception. The division of labor into various occupations, the allocation of people within those occupations and the organizations in which people work are all profoundly shaped by gender (Acker 1990 and 1992; Lorber 1994; Martin 2004). By the same

token, as mutually reinforcing systems, the gendered division of labor also shapes gender ideology (West and Zimmerman 1987). As gender is both lived and understood, what kinds of work are seen as appropriate for men and women is based in essential understandings of masculinity and femininity (Perry, Davis Blake and Kulick 1994). And as men and women engage in this appropriate work (or risk social sanction), those kinds of work and the qualities associated with them come to be associated with either men or women. For example, women are tasked to care work because caring, nurturing and emotionality are understood to be naturally feminine qualities, then as women almost exclusively engage in care work, the work itself and its attributes are further identified with women (Ohlen and Segesten 1998; Eriksen 2006; Hearn 1982). As a result, the work is systematically devalued (England 2005).

Occupational sex segregation while on the decline has remained stubbornly persistent, particularly in women's occupations and is a driving force in the endurance of gender inequality (England 2010; Reskin 1993). The last century has seen a massive transformation in the gender system – especially in the public and legal protection of gendered exclusion and thus one of the most visible effects of this transformation has been the entrance of women into traditionally men's occupations. However, because women's work is devalued, the reverse – men entering women's professions – has been much less dramatic if not entirely non-existent. For instance, in 1970 women made up just 9.7 percent of physicians in the US and had increased to 32.4 percent by 2010. By contrast Nursing increased from 2.7 percent men to only 9.6 percent men from 1970 to 2011 (Landivar 2013). Bear in mind that nursing is a relatively highly paid occupation, and that some lower paid women's occupations like secretarial and childcare work remain over 95 percent female (Cheeseman Day and Rosenthal 2008).

As Cecilia Ridgeway (2010) argues, because gender plays an enormous role in organizing social relations, as new socio-economic arrangements emerge, gender inequality is rewritten within the new contexts. In other words, despite the introduction and rise of countervailing forces to gender inequality, this inequality is enduring. Nursing again provides an important example. Over time nursing, like much of work in modern capitalism, has become increasingly rationalized and efficient (while also becoming legally and perhaps culturally more open), which should push against gendered distinctions, yet nursing is still overwhelmingly female and gender segregated within the boundaries of the occupation (Williams 1992).

As the traditionally male professions have begun to desegregate, scholars have shown how gendered (Glazer and Slater 1987; Lo Sasso et al 2011; Wood, Corcoran and Courant 1993) and racialized (Costello 2005) inequalities have been re-written and incorporated within the professions. I hope to build on this work by focusing on female professions, their professionalization and their relationships with other professions. The assertion of professional status by women and even more so women's occupations has the powerful possibility to remake the ideology of professions and in turn stereotypical ideologies of masculinity and femininity. In other words, if the ideology of professions is radically transformed in an inclusive way it has the potential to reconfigure the sex stereotypes that assert the appropriateness of kinds of work for each gender.

Witz (1990) and Davies (1996) assert a feminist critique of the theories of professions and professional closure. They address the elephant in the room – the gender of the agents in professional projects. Fundamentally, professional projects are not only class projects, but also gender projects and they are embedded in gender relationships defined by domination and subordination (Witz 1990; Davies 1996). These scholars have focused on two distinct ways in

which professions are gendered. Witz (1990; 1992) argues that the process of professional closure is gendered. Davies (1996) argues that the attributes professions rely on to make claims of legitimacy and achieve closure are gendered. Building on the theories of Parkin (1979), Larkin (1983) and Kreckel(1980), Witz (1990) divides strategies of occupational closure into exclusionary and demarcationary strategies. Dominant social and occupational groups engage in these strategies and subordinate groups respond with inclusionary (overturning exclusionary barriers – gaining access to occupations previously excluded from) and dual closure strategies (expanding their jurisdiction into that of the dominant group while simultaneously excluding other subordinates) of usurpation.

Men engage in exclusionary strategies that create gendered criteria for inclusion and exclusion particularly through civil institutions and especially credentialing institutions (Witz 1990). In medicine women were excluded from the medical schools and the hospitals (Ehrenreich and English 1973; Group and Roberts 2001). Importantly when faced with patriarchal exclusion women engage in a gendered strategy of inclusionary usurpation by redefining gendered exclusionary criteria for admittance into the occupation with non-gendered criteria of inclusion. The most effective usurpationary tactic for American women was legal. Although individuals had overcome the exclusionary tactics of medical schools and hospitals previously, it wasn't until the passage of Title IX and the Public Health Service Act of 1975 that large numbers of women entered the field because these institutions could no longer use gender as an exclusionary criterion. In medicine these strategies have recently been very successful for women who now make up 48% of first year med school students (Barzansky and Etzel 2011) up from only 26.5% in 1980 and 5.9% in 1950 (Johnson 1983). However only 33% of physicians



and surgeons are women (BLS 2011) and those women physicians' earnings were only 60% of those of their male counterparts (Cheeseman Day and Rosenthal 2008).

Witz (1990; 1992) theorizes that the other strategy of occupational closure and professionalization is gendered demarcation, the “processes of inter-occupational control concerned with the creation and control of boundaries between gendered occupations in a division of labour” (Witz 1990: 682). Rather than excluding women from the profession, demarcation is the bounding and exclusion of related women's occupations from the provision of specific skills which may compete with men's occupations, so as to restrict competition and enforce a hierarchy of domination and subordination. Here we can see a clear parallel to the jurisdictional subordination described by Abbott (1988), who argues that in these arrangements there is a clear distinction in areas of skill and division of labor that are ensconced in legal and public boundaries and then reified in a complex, daily symbolic and interactional order.

Although some theorists argue that nursing and medicine developed in parallel and that medicine only came to dominate once the two occupations came into direct competition (Abott 1988, Nutting and Dock 1907), Ehrenreich and English assert (1973) that women's role as healers predates the rise of medicine and medical men actively took over healing work during the 13th and 14th centuries. They argue that women healers engaged in both medicine (diagnosis and prognosis) and nursing (care and custodianship), and men took over medicine and subordinated nursing prior to the development of medical science or technology, often violently to capture the social and material benefits of a monopoly. In other words, medicine was once a part of nursing, but was captured by men and the remaining nursing work was relegated to women (women practicing medicine were purged) and made subordinate to medicine (Ehreneich

and English 1973; Group and Roberts 2001). This dominant monopoly has been maintained by rhetoric and law ever since.

Like exclusionary tactics, demarcation is not without resistance. Demarcationary strategies are met with dual closure strategies, exemplified by the strategies of women's professional projects, in which the subordinate occupational group engages in both usurpation and exclusion. Usurpation involves the upward challenges against the boundaries of the dominant group, but in order to wage these demarcationary usurptions, occupational groups must engage in exclusion through credentialing and licensure thus legitimating their usurpation claims. This sort of boundary creation and dispute is endemic to the medical field, and nursing in particular (Nancarrow and Borthwick 2005; Freidson 1973; Gamarnikow 1978; Witz 1990; 1992; Davies 1995). One of the most common strategies of usurpation/jurisdictional expansion utilized by nursing in the last half century has been vertical substitution, the process of adopting tasks formerly within the purview of another profession such as prescribing medication (Nancarrow and Borthwick 2005), this strategy is most reflected in increasing specialization and advanced credentialing of APNs.

Because professional projects have historically been dominated by men, to the exclusion of women, professions themselves and the attributes associated with them are associated with masculinity (Hearn 1982; Davies 1996). Davies (1996) explains that the exclusion of women from professions was not simply "no women allowed" it was predicated on a normative system that rejected and repressed "feminine" qualities and embraced "masculine" ones. So the professions actively justified the exclusion of women based on the apparent mismatch between professional attributes and womanly ones. Simultaneously, as public facing entities the image-building activity relied on these same attributes to project a masculine, and therefore legitimate

and powerful image, in order to gain professional status. Hence the professions characterized themselves as objective and individualistic and antithetical to nurturance and expression (Glazer and Slater 1987). At the core of professional attribution is scientific expertise and autonomy, two qualities that are normatively designated as masculine (Hearn 1982; Davies 1996)

This makes an acute contradiction for women's professions, particularly teaching and nursing because caring has and continues to be central to their occupational identity (Ohlen and Segesten 1998; Eriksen 2006; Hearn 1982). Female dominated jobs generally experience a wage penalty (England 2005), but this devaluation is especially acute for female dominated jobs that involve care because care is quintessentially female (England 2005; Cancian and Oliker 2000; England and Folbre 1999; England, Budig and Folbre 2002). Or as Abbott and Meerabeau (1998) argue "the work carried out by the caring professionals is often seen as an extension of work that women are expected to carry out in the domestic sphere, and therefore as work that they can do 'naturally'" (p.7) and therefore does not require any specific training or expertise. Care work consists of both nurturance and emotion which have been identified as directly opposed to the professional values of autonomy and reason respectively (Abel and Nelson 1990). This creates an inherent problem for women's professional projects in these occupations because their attempts at professionalization rely on invoking professional qualities that clash with core matters of their identity.

So far I've discussed professionalization and professional status primarily as group phenomena. But as Forsyth and Danisiewicz (1985) remind us, professional status and autonomy is also an individual level phenomenon. Actual people experience autonomy in their daily lives. However, as is the case with a whole host of labor market experiences and outcomes, professionals of different races, ethnicities and genders are unlikely to enjoy the same kinds or

degrees of professional status (Spalter-Roth and Deitch 1999; Reskin 1993; England 2010). Although white women make up the vast majority of Registered Nurses in the United States, RNs are not racially or gender homogenous. In the U.S. 83% of RNs are white, 4% are Latino, 5% are Black and 6% are Asian or Pacific Islander, and 93% are women (U.S. Dept. of Health and Human Services 2010). California nurses are distinctly more diverse than nurses nationwide, 59% of RNs are white, 18% are Filipino, 8% are Latino, 9% are Asian and 4% are Black, and 86% are women (California Healthcare Foundation 2010).

Nurses work in complex organizations in which they must interact closely and constantly with a variety of workers. Structure and behavior within organizations operate in what Rosabeth Moss Kanter describes as a “feedback loop” in which organizational (and extra-organizational) structures and the opportunities they create shape the behavior of people within organizations and in turn those behaviors recreate structure and opportunity (Moss Kanter 1993: pg. 249). Additionally, interactional patterns at work vary significantly based on the genders, races and other identities of the people involved and these interactions tend to reinforce inequality regimes within organizations (Kendall and Tannen 1997; Holmes 2006; Acker 2006; Pierce 2003; Beagan 2003; Moss Kanter 1993). These discursive practices and behaviors marginalize minority employees and advantage white males. Additionally, there are a host of processes in the labor market more generally that structurally advantage white men. For example, employers sort and rank potential and current employees through a myriad of processes that produce a labor queue based on race and gender (Reskin and Roos 1990, Lichter and Oliver 2000, Moss and Tilly 2003, Waldinger and Lichter 2007). Waldinger and Lichter argue that employers depend on complex hierarchies of stereotypes that associate different racial and ethnic groups with particular skills and attributes to develop labor queues. These queues manifest themselves in the cognitive

schema and statistical biases (Perry, Davis-Blake and Kulik 1994, Bielby and Baron 1986) that color hiring, placement, promotion, and other on the job decisions. As Reskin and McBrier (2000, pg. 708) explain, “The discretion many personnel decisions entail invites stereotyping, evaluation bias, and attribution error by decision makers, and these almost certainly maintain inequality.” Hiring and placement in jobs significantly benefits white applicants at the expense of black and Latino (Bertrand and Mullainathan 2004; Bendick et al 1991; Pager, Western and Bonikowski 2009). Evidence also suggests that similar discriminatory processes persist within firms with regards to promotions that disadvantage women and people of color (Maume 1999). Though Filipinos, the largest non-white minority among nurses, are not typically included in these analyses, the racialized hyper-feminization of both Filipino women and men (Hoganson 1998) is likely to have a significant effect on their work experiences.

In nursing, one prominent and documented example of this sort of discrimination is what Christina Williams (1992) has termed the “glass escalator” – in which men in female dominated professions are systematically promoted and hired into administrative and higher paid specialties. Budig (2002) finds that men are advantaged in all occupations – female or male dominated – and in fact that men in female occupations are less advantaged relative to women than men in male occupations. However, Williams speaks to a deeper point about sex typing and the distribution of people into sex appropriate roles in organization. One of Williams’ most important findings is that men are promoted because it is seen as inappropriate for them to be doing care work in their occupation of choice and that they are more suited for managing the women who should do the caring. This speaks directly to professionalization and the ability of men and women to project themselves as professionals within their organizations in order to obtain autonomy over practice. I would expect then that male nurses are more readily able to deploy a professional status and

reap the rewards of the status. However, it is important to note that this is not a universal effect, Wingfield (2009) finds that Black male nurses, “[i]nstead of benefiting from the basic mechanisms of the glass escalator, [] face tense relationships with colleagues, supervisors’ biases in achieving promotion, patient stereotypes that inhibit caregiving, and a sense of comfort with some of the feminized aspects of their jobs” (pg. 22). This example is an important reminder that masculinity and femininity are varied by race and are mutually constitutive with racialized meanings (Pascoe 2007).

In this work, I am motivated by a deceptively simple question: “How does gender shape professionalization?” Despite the simplicity of the question, the answer is predictably complex. I am proposing a conceptualization of professions that reckons with the social contingency of professionalization. This synthesizes, attributional, professionalization and ecological accounts of professions and locates them within systems of gender, race and class. My primary focus is the gendering of professions, specifically how gender shapes professional rewards, operates and is deployed in inter-professional conflicts and national professionalization efforts, and the daily operation of gender in inter-professional interaction. In the following chapters, I begin to take on this question from three distinct, but interrelated angles.

### *Methodological Approach*

Professionalization, like many social processes, is a multi-level phenomenon. It occurs within and creates a national ecology that consists of many interlocking hierarchies built of professions and related occupations. These ecologies are constructed and negotiated by and within organizations that vie for jurisdictional monopoly and protections from state and federal governments. Daily, individual practitioners navigate and manifest the boundaries and relationships created in organizational competition. So, while examining professionalization at

any one of these abstractions in isolation can be fruitful, in doing so, one is necessarily looking at one side of a multi-dimensional object. Therefore, I take a holistic approach that examines the gendering of professions from several vantages and incorporates the contextual and contingent nature of the process. To understand gender's role in professionalization at the national, meso, and micro levels requires appropriate methodological approaches for each. Thus, I take a multi-level, multi-method approach that focuses on nursing as an instructive case of a female-dominated profession.

My first task is to describe the gendered professional field in the United States. Before turning to the particularities of gender's impact on professionalization and professional life, In Chapter 2 I seek to show that professional ecologies at the most basic level are not gender neutral. To do this I explore the gender inequalities in professional hierarchies in the United States over the last half century. First, I examine longitudinal trends in income inequality within three predominant gender configurations of professional hierarchies. Using Current Population Survey data on 30 occupations, I compare the 1968-2015 income trends of three distinct hierarchical arrangements: dominant male professions and female subordinate professions, male dominant and subordinate professions, and female dominant and subordinate professions. Second, I examine the potential causes of the inequalities using generalized least squares (GLS) regression of the same data. GLS regression allows me to analyze both the individual and occupational determinants of income (measured as logged inflation-adjusted annual income). In addition to individual variables I measure the effects of professions' gender composition, work characteristics, and closure strategies. I then separate the sample into historically male and historically female professions to examine how closure strategies are differently rewarded between male and female occupations. This quantitative approach to macro processes of

professional closure and hierarchy accomplishes two primary objectives: it establishes that professionalization (as represented by incomes rewards) is deeply affected by the gendering of professions and that professionalization strategies are significantly mediated by the gender of occupations that employ them.

In Chapter 3, I explore how this might happen. Here I turn to the historical process of nursing's professionalization in the United States. I primarily view this history through the trials and travails of the American Nursing Association and its interactions with the American Medical Association, various hospital organizations, state governments and competing nursing organizations (most importantly unions). In addition to secondary sources, my primary data comes from reports of ANA biannual conventions from 1900-2004, ANA communications and publications, AMA reports and recommendations on nursing, legislative text and testimony and a variety of other organizational artifacts. In analyzing these documents, I not only outline the history of the ANA, but examine how gender is deployed by both the ANA and its competitors in fights over professional protections, jurisdiction and autonomy. This approach enables the examination of professionalization as a meso-level historical process which involves many organizational actors within a dynamic structural context.

Lastly, in Chapter 4, I take an ethnographic approach to understanding the interactional/relational experience of day to day professionalization. In this spirit I embarked on nine months of unstructured observation in a West Coast hospital followed by 22 semi-structured interviews with nurses and physicians. Observations were restricted to the nurses' stations in the ER, observation, telemetry and medical-surgical units of the hospital. From here I took extensive field notes from observations on the behaviors, actions and presentations of the people in the units. Over time, my focus was drawn increasingly to the importance of the formal and informal



interactions of nurses and physicians, staff, patients and their families. While observing I intermittently conducted short, informal field interviews to clarify and contextualize my observations. Triangulating with observational findings, I conducted interviews with nurses and physicians. Interviews were flexible to encompass the perspective of interviewees. Areas of focus included: autonomy, nurse-physician relations, authority and status. I analyzed field notes and interview transcripts using open, categorical coding consistent with a grounded theoretical approach. Ultimately, what emerges from this data is an account of the ways in which the gendering and racialization of individuals and groups within a complex organization attempting to promote inter-professional cooperation, informs interactions and ultimately reinscribes hierarchical statuses, authority and limited autonomy.

Taken together, these analyses provide a complex multi-faceted explanation of the gendering of professions. To take any of these approaches in isolation is to only provide a partial picture of professionalization. It is important to understand that not only does this process happen at many levels of society, but these levels of action are interconnected. National ecologies of professions shaped and are shaped by the struggles of individual professions embodied in associations and practitioners. Simultaneously, the results of organizational struggles for professional recognition and protection, structure the context in which individual practitioners work and interact with employers and other professionals. Yet, as I will also demonstrate, differences in the experiences of practitioners can powerfully shape the agendas and viability of professional associations. Therefore, I hope that as my focus shifts to various aspects of professions and professionalization that the reader keeps in mind that these are not modular phenomena but rather interrelated parts of a dynamic process.

Despite the strengths of this approach, it is not without limitations. In choosing a single case study design, both historically and ethnographically, I have sacrificed comparative leverage for depth of inquiry. I find significant evidence that gender threads through the structural and discursive history of nursing professionalization, but without comparison to other female professions or contrast with male professions its distinguish generalizable experiences from what could be idiosyncratic or unique to the historical trajectory of nursing. However, I believe that the results of my quantitative analysis – particularly differences in closure – indicate that this is likely not the case.

Similarly, I only conducted observations in one hospital, belying claims to generalizability. Yet, the single case is a theoretically rich one. As I discuss in Chapter 4, HealthOrg (where I conducted observations) has been actively working towards expanding the role of nurses, increasing their autonomy, and improving doctor-nurse relations. As many nurses I interviewed relayed, they had experienced these changes and noted how much more collegial the environment was then compared to the past at the same organization and others they had worked for. So, while it may not be a fully generalizable case, it is instructive as an example of how gender, race and positional status emerge and operate in interactions to promote hierarchical arrangements even contra to organizational goals.

### *Chapter Outline*

In Chapter 2 – “The Unequal Distribution of Professional Reward: Gender, Hierarchy and Social Closure,” I take a bird’s eye view of gender and professions to consider inequality across multiple gendered professional hierarchies and occupational closure within these hierarchies. I analyze income inequality and social closure in professional hierarchies using national data on 30 occupations, clustered in seven professional hierarchies between 1968 and

2015. I compare inequality in hierarchies of three types, male-male and female-female gender homogenous hierarchies and male-female heterogeneous hierarchies. These comparisons track changes in inequality over time. I then move on to generalized least squares regression analysis testing the effects of gender composition, skills and conditions and occupational closure strategies on professional incomes. Finally, I compare how these effects differ when the sample is divided between historically male and historically female professions. Results demonstrate three crucial aspects of gendered professional inequality: 1) historically male professions earn more than historically female professions even when appropriate predictors of income at the occupational and individual level are accounted for, 2) inter-professional hierarchies between male and female professions are more unequal and their inequality has increased substantially more over time than either male-male or female-female hierarchies, and 3) professional closure strategies like licensing, credentialing and establishing associations unequally favor historically male professions.

Chapter 3 - “‘Un-nurselike attitudes’: The American Nurses Association and the Professionalization of Nursing” charts the history of nursing professionalization in the United States. Using primary documents from the American Nursing Association and the American Medical Association, as well supporting historical accounts I interrogate the ways gender was deployed by nurses, physicians, hospital administrators and their professional associations to promote and curtail the professionalization of nursing. Additionally, I interrogate how class divisions within nursing manifested in a serious conflict between professionalization and unionization that ultimately had serious consequences for the professional association and the profession as a whole. Here I show how the ANA deployed gendered norms in framing the professional qualities of nursing. And, reciprocally, how the medical profession and hospital

administrators utilized gendered stereotypes of nursing to oppose their professionalizing efforts. This is further compounded by internal class divisions within the profession that have substantially impacted the willingness and ability of nursing to achieve professional protections. Ultimately, I argue that the professionalization of nursing, both its successes and failures, are significantly interwoven with the gender and class structures internal to the occupation and externally in the larger professional ecology.

Chapter 4 – “Informal Interactions, Gender, and Hierarchy: Barriers to Nurse-Physician Collaboration in a West Coast Hospital” examines professional status and autonomy in daily interaction. Based on extensive observation in a large hospital and interviews with nurses and physicians, I elucidate how formal structures and the patterns of formal and informal interactions shape nurse-physician relationships in the hospital. These patterned behaviors and structures reinforce and challenge professional hierarchy. The gender and race of nurses as well as nursing units has a major influence on how their behavior is structured, interpreted and responded to by physicians. Workers in the hospital interact with one another carrying and utilizing an accumulation of ascribed, institutional and reputational statuses. These statuses coalesce and are signaled in repeated relational interactions that tend to align with normative assumptions about “appropriate” racialized and gendered behaviors. When nurses strayed outside of expected discursive behavior they were exposed to short and long-term sanctions from physicians. Formal interactions that maintained dominance of the primarily white, male physicians, were buttressed by repeated informal interactions in which physicians demonstrated significant social distance, dismissiveness and lack of consideration.

Chapter 5 – “Conclusion: The Social Nature of Professions” ties it all together. Here I connect my findings to retheorize professions and professionalization. My account is more

socialized then previous theories and argues more forcefully for the interconnectedness of micro, macro and meso processes. Ultimately, I will argue that the creation and maintenance of professions, how they are stratified, and the quotidian experience of professional life is deeply interwoven within the gendered and racialized systems that structure society at large.

In sum, this study provides a new perspective on professions that has significant implications for inequalities, work and gender. Professions occupy an important place in the American economy and cultural imagination. As such, inter-professional inequalities based in the gendering of professions and intra-professional inequalities revolving around the gender and race of individuals has serious impacts on the stratification of society. Additionally, because professions are so culturally important and visible, continued sex segregation and subsequent gendering of professions (particularly traditionally female professions) inevitably impacts gender ideologies and understandings in society writ large.

## **Chapter 2.**

### **The Unequal Distribution of Professional Reward: Gender, Hierarchy and Social Closure**

As the U.S. economy continues to polarize, professional careers represent one of few options for social mobility. Though scholars have significantly addressed the growing proportion of women in professions, their experiences and intra-professional gender inequality, inter-professional gender inequality remains largely unstudied. In this chapter, I explore two critical aspects of inter-professional gender inequality: professional hierarchies and professional closure. I aim to gain an understanding of professions as they exist in relation to one another, particularly how gendering of professions and professionalization affects income inequality across professions. Taking cues from both the ecological and social closure perspectives on professions and feminist scholars of work and organizations, I will examine the ways in which the gendered nature of occupational hierarchies and occupations themselves underlie how rewards are distributed across these hierarchies.

Professions are in constant competition with one another to obtain or maintain sole jurisdiction over bodies of work. While often this takes a horizontal form in related fields (for example between librarians, statisticians and accountants over systems of filing), as the division of labor within an industrial field becomes more complex and interrelated, jurisdictional conflicts begin to arise in more vertical configurations within industries. These conflicts are resolved in a dominant-subordinate hierarchy (for which there are many examples). It is these hierarchies that I am interrogating. How does the gender composition of these hierarchies shape the ways wages are distributed across them? Medicine and nursing exemplify this form of professional hierarchy: both professions have thoroughly developed credentialing requirements, strict licensure, professional associations and importantly have been competing over jurisdiction for hundreds of

years, yet in terms of authority and economic rewards medicine has established a stable dominant relationship over nursing.

Certainly we would expect dominant professions to be rewarded in greater fashion than subordinate ones. But is this distribution the same when considering hierarchies composed of dominant male professions coupled with male subordinate professions as compared to male/female hierarchies, female/female hierarchies and other increasingly complex configurations?<sup>4</sup> How does gendering of occupations affect the returns on professionalization in the context of jurisdictional conflict? Furthermore, there has been tremendous change in the gender composition of professions over the last century. How do these changes affect professional inequality? It is certainly well established that men and the occupations in which they dominate are more highly compensated than women and women's occupations, but income inequality across gendered occupational hierarchies remains largely unexamined. Analyzing data on 30 occupations, clustered in 7 distinct hierarchies from 1968 to 2013 – I argue that male dominated mixed gender hierarchies reward the dominate professions at significantly greater increments than do either male/male hierarchies or female/female hierarchies. I would expect the boundaries between homogenous hierarchies to be less stable and there to be greater opportunity for subordinate professions to capture larger portions of the income distribution. Additionally, if it is true that professionalization itself is a gendered a process, then differently gendered occupations should experience unequal rewards for professionalization and the historical gender of professions should mediate these effects.

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<sup>4</sup> I would certainly be interested in how rewards are distributed in hierarchies with dominant female professions and subordinate male professions – but as far as I can tell such a configuration does not exist on a large enough scale for me to test here.

### *Professional Projects and Social Closure*

As elaborated by Weber (1978), social closure explains the tendency of groups to take steps to reduce competition over limited resources. By defining characteristics which delineate eligibility these groups attempt to monopolize and thus maximize their rewards. In other words, in order to benefit the group, they draw boundaries or create criteria which exclude others and grant the in-group privileged access to some important resource. Occupational closure is a specific kind of social closure in which people organized around an occupation erect social and/or legal boundaries limiting entry into the occupation and increase the rewards for doing the related body of work. Simply put, occupational closure limits the supply of some kind of labor and thus increases its value, though occupational closure strategies may increase rewards through a number of other mechanisms as well.

Weeden (2002), in her excellent examination of social closure as a driver of earnings inequality, identifies four mechanisms of earnings enhancement which characterize five different closure strategies. These five strategies are licensing, formal educational credentialing, voluntary certification, representation by associations and unionization. Each of these strategies enhances the earnings of the occupation by one or more of these mechanisms: restricting supply, increasing diffuse demand, channeling demand to the occupation, or signaling quality of service. Educational credentialing, licensure and unionization all limit the supply of labor, which enhances earnings through fairly transparent market mechanisms. Occupations, particularly professions, can also affect earnings by creating, increasing or directing demand. Indeed, restricting the supply of labor with no demand is an exercise in futility. Such is the case in professional death, when the “specialized, knowledge based occupations” disappear as a result of changing technology, organizational arrangements or culture (Abbot 1988, pg 29). These



occupations may have succeeded in restricting supply through credentialing or licensure, but simply ceased to be when there was no longer any demand. On the other hand, occupational associations may be able to increase demand through public appeal and lobbying that would increase state spending on education, social services, law enforcement or health care.

In addition to maintaining and increasing demand for its services or products, in order for closure to be successful, occupations must ensure they are the only (or at least the most prominent) occupation to provide it. If an occupation's labor has been successfully restricted and there is adequate demand, but an alternate source for the same service is available, the more expensive labor will be devalued. For instance, several states are considering laws that would grant licensed Nurse Practitioners the ability to write prescriptions and generally practice without physician supervision; unsurprisingly physicians and the AMA have pushed hard against these changes. Writing prescriptions and routine physical examinations are a large part of physicians' work so if another occupation (particularly one whose labor is cheaper) is allowed to compete for it the cost of that labor will go down. Licensing, credentialing and voluntary certification also signal "quality of service" to potential buyers of their services or goods; successful completion of these strategies allows these occupations to communicate that they are better suited to the task than other non-licensed, credentialed or certified occupations and thus demand higher prices. Neo-Marxist and Neo-Weberian scholars have used theories of social closure to reframe professions as 'professional projects', one specific set of labor market strategies to gain occupational monopoly over a set of skills and competencies which rely on and result in the traits and claims attributed to professions (Larson 1977; Freidson 1983; Witz 1990). They argue that professionalization is simply a particular kind of occupational closure (Parkin 1979; Freidson 1973), effectively limiting the pool of competitors and thus increasing the rewards

granted to the occupation. Professions, much more than other occupations, achieve closure through licensure and credentials, which are supported by a rhetorical strategy which Forsyth and Danisiewicz (1985) refer to as “image building activity.” By making claims to the public that the occupation is exclusive, complex and essential, professions as embodied by their professional associations, gain public recognition which legitimates their monopoly over a particular “heartland of work”.

Parkin (1979) extends this argument and asserts that in modern capitalism professionals represent a dominant class. In his view the dominant classes are (1) those that control the means of production or control productive capital and (2) those that have a legal monopoly over professional services; and he defines professionalization as a strategy of exclusionary closure, that attempts to attain a legal monopoly through state licensure and credentialism. As Larson (1977, pg xvi) puts it “professions are outside and above the working class, as occupations and as social strata.”

Though professions collectively may inhabit a privileged position in the class structure of modern capitalism, it is important to note that professions are not monolithic and professional status (or closure) is not static. As Weeden (2002) reminds us:

Closure is a dynamic process. It secures advantages at the expense of another group, whether employers or consumers, who must pay a higher price for labor, or other workers, who are denied access to the occupation (see, e.g., Sørensen 2000*b*). As a result, the privileged group must constantly protect its control over an asset against attempts by other groups to usurp that asset.

Because these occupational groups control a valuable realm of work in a competitive marketplace, their control tends to be in a state of flux. Demand increases and decreases, other occupations may encroach on their work or provide alternatives to it. This is why, in Abbott’s view, to properly understand professional development, one must examine how a profession

creates a link to its work, how it is anchored by social structure and probably most interestingly how the interactions of professions and the ways in which they compete for jurisdiction determine their development. Thus:

The professions ... make up an interdependent system. In this system, each profession has its activities under various kinds of jurisdiction. Sometimes it has full control, sometimes control subordinate to another group. Jurisdictional boundaries are perpetually in dispute, both in local practice and in national claims. (Abbott 1988, pg. 2)

Within this system all professions strive for full jurisdictional control over a “heartland of work”, that is culturally legitimated by the profession’s knowledge and legal claim, [e]very profession aims not only to possess such a heartland, but to defend and expand it” (Abbott 1988, pg 71). Yet there are not enough full jurisdictions for each profession to claim, so some professions may have to accept limited jurisdiction to develop as a profession.

Nursing represents the most common form of limited jurisdiction: subordination. According to Abbott when nursing began to assert itself as an “administrative and custodial equal” with medicine and thus threaten medicine’s jurisdiction, medicine responded by arguing successfully in the public and legal arenas that the administration and provision of care in hospitals “were tasks subordinate to the medicine conducted in them” (Abbott 1988, pg. 72). In complex professional workplaces, particularly in healthcare, a high degree of assimilation between subordinate and dominant groups is required for the smooth operation of the organization, blurring jurisdictions in daily practice. Thus, subordination represents an uneasy settlement of jurisdiction that must be constantly negotiated and maintained. Occupational closure theories do not assume that all members of occupations necessarily advocate uniformly for the same rewards, but the theory does assume that these groups can and do take action to advance their collective economic interests. If we assume that all occupational groups act in this

way, that there is a limited supply of resources to distribute across them and that they don't operate in isolation we must assume that they are in near constant competition with each other.

Indeed, Abbott demonstrates this to be true for a number of important professional examples. This competition takes both horizontal and vertical forms. When new services and goods emerge this horizontal competition is most apparent. For instance, as financial planning has materialized as a valuable service, accountants, lawyers, insurance agents, stockbrokers and others have been competing for sole jurisdiction over the provision of the service. The competition between physicians and nurse practitioners over prescribing rights is an example of vertical competition. As nurse practitioners have steadily increased their responsibilities and roles, one area where they've met the most opposition is in prescribing rights. Many states with the support of nursing associations, attempting to alleviate problems of access to physicians particularly in rural areas, have proposed granting nurse practitioners the right to make diagnostic and prescribing decisions without physician supervision. Though there has been steady and vociferous resistance from physicians 21 states and Washington DC now grant these rights to APRN. Physician resistance has to this point blocked these changes in the majority of states, including the most populous: California, New York, Texas and Florida (AANP.org).

This chapter focuses on vertical competition and the dynamics of intra-industry professional hierarchies. Based on extant literature I expect that professions (and non-professional occupations) are arranged in hierarchical configurations within the same industry to demand and receive differentiated wages based on their positions in the hierarchy. I expect these positions to be directly related to occupational closure strategies and I expect for the differentiation of wages to fluctuate within this hierarchical structure. So while the basic hierarchy is likely to remain intact, the proportion of rewards will be dynamic over time.

## *Gender, Work and Professions*

While discussion of gender remains for the most part conspicuously absent or pushed to the background in much scholarship on profession, feminist scholars have focused much on work, hierarchy and inequality. As a powerful social institution itself gender is built into all other major institutions, including, importantly, work and work organizations (Acker 1990 and 1992; Lorber 1994; Martin 2004, Ridgeway 2010). Gender is intractably tied to the division of labor and the allocation of resources, as West and Zimmerman (1987) explain:

“Whenever people face issues of *allocation* – who is to do what, get what, plan or execute action, direct or be directed, incumbency in significant social categories such as ‘female’ and ‘male’ seems to become pointedly relevant. How such issues are resolved conditions the exhibition, dramatization, or celebration of one’s ‘essential nature’ as a woman or man.” (pg. 143)

Thus the division of labor into differently gendered occupations and professions (re)produces meanings of essential masculinity and femininity and in turn reinforces notions of what kind of work is appropriate for men and women (Perry, Davis Blake and Kulick 1994). Women are thus tasked to do ‘emotional labor’ (Hochschild 1983) and care work in the case of nursing (Ohlen and Segesten 1998; Eriksen 2006; Hearn 1982), which is systematically devalued (England 2005).

Important progress was made in desegregating occupations and closing the gender gap in the late 20<sup>th</sup> Century. The driving force in closing the gender gap has been the entrance of women into traditionally male work and commensurate upgrading of women’s pay. The opposite tendency, men entering women’s occupations, has occurred to a much smaller degree. Because traditionally masculine work is still valued more than traditionally feminine work, gender desegregation and pay equality has been uneven and the closing of the pay gap has made little progress over the past 2 decades (England 2010; Blau and Kahn 2016). Furthermore, even when

women gain entry in highly guarded and well-paid occupations they tend to make less than their male counterparts (Kim and Sakamoto 2008; Lo Sasso et al 2009). Additionally, recent evidence shows that as significant numbers of women enter traditionally male occupations, the overall pay of the occupation declines (Levanon, England and Allison 2009; England, Allison and Wu 2007). Male and female professions typify the tendencies of U.S. occupational desegregation – women have entered the “male” professions like medicine, law, dentistry, etc in large numbers, but men have not reciprocated by entering the “female” professions like nursing, teaching, or any other female professions to the same degree.

Gender scholars have recently re-asserted the importance of studying professions for understanding gender inequality (see Special Issue of *Gender, Work and Organization*: “Researching Gender, Inclusion and Diversity in Contemporary Professions and Professional Organizations”, especially Muzio and Tomlinson 2012). Studying the interaction of gender and profession is crucial because of both the centrality of professional work in modern life (as Abbott writes they ‘heal our bodies, count our profits and save our souls’ (Abbott 1988, pg. 1)) and the role of professions in “class reproduction, social stratification and mobility” (Muzio and Tomlinson 2012, pg. 456). Although this work is important and informative, it tends to focus on the experiences of women in traditionally male professions and the reconfiguration of inequality within. Crucially this limited perspective fails to recognize the central reality that professions do not operate in isolation from one another or that “women’s” professions (nursing, teaching, social work, etc) remain much more common and potentially less fraught paths of class mobility for women in the United States. By expanding our analysis beyond male professions to the gender dynamics of professional nexuses, we can begin to gain greater understanding of the realities and possibilities for professional women.

In the first chapter, I laid out a feminist critique to the study of professions and social closure that addresses the gender of the agents of professional projects (educational and associational leaders), and recognizes that these agents and their projects are located not only in class relationships but also in gender relationships defined by domination and subordination (Witz 1990, Davies 1996). These authors identified a number of crucial ways in which professionalization was a gendered process that systematically benefits men and male professional projects. Significantly, Witz (1990) identifies two major strategies that male professions have utilized to gain and retain professional dominance over women and women's professions. These professions engage in gender based exclusion to prevent women from entering male dominated professions. These exclusionary tactics have historically been enforced through educational and hiring institutions, as well as law, but the public and legal protection of gendered exclusion has been almost entirely eradicated over the last century and women have relatively successfully penetrated the male professions. Women who enter male dominated professions make less than their male counterparts (Lo Sasso et al 2011; Wood, Corcoran and Courant 1993), but it remains to be seen if entrance of large numbers of women into traditionally male occupations would have an overall downward effect on wages. In other words, do the historical legacies of "male" professions outweigh their specific contemporary gender composition's effects on pay?

In addition to exclusion, male professions engage in a strategy of gendered demarcation, the bounding and exclusion of related women's occupations from the provision of specific skills which may compete with men's occupations. Essentially a process of patriarchal closure is one in which a male dominated profession dictates the limits of a competing female profession despite a legitimate claim of expertise on their part. By engaging in demarcation, male

professional projects restrict competition and enforce a hierarchy of domination and subordination. Patriarchal exclusionary and demarcationary methods are made possible because the very concept of profession is enmeshed with masculinist ideals (Hearn 1982; Davies 1996).

Celia Davies explains:

Work that traces women's struggles to enter the professions in the late nineteenth and early twentieth century has suggested that these were not just a matter of doors and minds being closed to women, but of the values that were embedded in the notion of the practice of a profession reflecting a masculine project and repressing or denying those qualities assigned to femininity. (1996: 669).

The attributes that grant legitimacy to a professional monopoly are the very qualities which have been declared masculine and are defined in opposition to feminine characteristics. Glazer and Slater (1987) describe the self-characterization of the medical, professorial, science and psychiatric professions as "objective, competitive, individualistic and predictable" and simultaneously "scornful of nurturant, expressive and familial styles of personal interaction" (14). Indeed the most central (and theoretically agreed upon) characteristics of professions are scientific expertise and autonomy which have historically been designated as masculine traits (Hearn 1982; Davies 1996).

As Cecilia Ridgeway argues, gender acts as a frame by which social relations are organized. This frame based in gender stereotypes is inscribed on these social relationships in such a way as to make hierarchical relationships appear natural, particularly when men and masculinity direct women and femininity. Because professionalism or professional status are imbued with masculinity, differently gendered professional hierarchies are especially important sites to interrogate how gender organizes social relations generally and the labor market particularly. Furthermore the durability of these gendered hierarchies is self-reinforcing, as



Ridgeway (2010: 12) explains “Taken-for-granted acceptance of beliefs that men are more socially esteemed and generally more competent than women depends on people’s daily experience with positional evidence for these beliefs.”

Based on a feminist analysis of professions I argue that female professions experience significant wage penalties when compared to male professions and that the inequality and relative positions of dominance are more stable and entrenched in male/female hierarchies than in male/male or female/female hierarchies. The historical normalization of a gendered profession is likely to affect remuneration over and above specific gender composition (at least to the point of reversal), i.e. medicine is an historically male profession and is approaching gender parity, yet will still benefit from its historical designation as male. Furthermore, gendering of professions is likely to impact the professionalization process, so female and male professions would experience differential rewards and costs for social closure and their relative area skills and requirements. However, if social closure and professionalization are not significantly gendered, I would expect that inequality between gendered professions would be primarily explained by differences in occupational attributes and social closure. Similarly, if the professionalization and occupational closure processes were “gender-neutral” I would expect that the effects of occupational skills and requirements and social closure strategies would not vary by the gender composition of occupations.

### *Data & Methods*

To interrogate these propositions, I analyze individual and occupational effects on differences in income using data from the 1968-2015 IPUMS-CPS March extracts (Flood et al. 2015). The Current Population Survey (CPS) is a national survey of 50,000-60,000 households proportionally selected to represent all nonfarm wage and salary workers conducted by the

Census Bureau for the U.S. Department of Labor. The IPUMS-CPS has a number of characteristics which make it ideal for this study. CPS includes questions on demographics, human capital, labor market position<sup>5</sup>, as well as occupation and income. The majority of the variables of interest, at both occupation and individual level, are comparable between 1968 and 2015, enabling a longitudinal look at professions during an important period of growth for these occupations, simultaneous to the gender transformation of the workforce. CPS data contains designations for approximately 500 occupations in any given year, while I use this full sample in population based comparisons of gender composition, education, and unemployment, I only analyze a limited sample of 30 professions and related occupations. Table 2.1 provides descriptive statistics of select variables in the sample. Given the nature of the sample, it tends to be more educated, older and more female than the general population. Because there are many more subordinate professions than superordinate ones, and because these professions are more likely to be more female, the sample skews this way. Table 2.2, below provides a complete list of the occupations and their relevant descriptive statistics included in my models).

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<sup>5</sup> CPS March includes important labor market variables like firm size and union membership.

**Table 2.1:** Descriptive Statistics of Professional Sample from CPS-March, 1968-2015

	Professional Sample
Demographic Controls	
Percentage Female	63.9%
Mean Age	39.4
Percentage White	76.7%
Percentage African American	9.4%
Percentage Hispanic	8.3%
Percentage Asian American	3.6%
Percentage Married	61.41%
Percentage with Young Child Present	16.1%
Human Capital Controls	
Mean Years of School	14.5
Mean Years of Experience	19
Selected Labor Market Position Controls	
Percentage Part-time	21.5%
Percentage Intermittent	24.9%
Percentage Single Employer	74.5%
Percentage in Firms >500	65%
Percentage in Non-Metro Area	22.8%
Percentage Public Sector	27.5%
Percentage Health Industry	23.5%
Percentage Education Industry	23.9%
Percentage Legal Industry	3.2%
Percentage Government Industry	4%
N	687,960

I selected these professions in particular because they represent the ideal typical professions highlighted in the literature, their related subordinate occupations and a variety of gendered occupational configurations. Additional data on occupational characteristics, closure strategies, and historic gender composition were imputed from the *Dictionary of Occupation Titles*, *The Professional and Occupational Licensing Dictionary*, *the Certification and Accreditation Programs Directory*, *the National Trade and Professional Associations of the United States*, and IPUMS-USA (Ruggles et al. 2015), harmonized data from the U.S. Census and American Community Survey, 1900-1940 extracts.

Profession	Gender Composition		Skills and Conditions				Social Closure						N
	% female 1968-2015	% female 1900-1940	Cognitive (0-5)	Nurturing (0-5)	Physical (0-5)	Hazards (0-5)	Year Assc. Founded	# States w/ Licenses <sup>6</sup>	# of Certs.	Mean Yrs. Of Educ.	% Union	% Unemp.	
Physician	25.1	4.7	4.3	3.3	3.7	0.1	1847	51	221	18.8	5.9	0.5	18,540
Phys. Assis.	57.9	46 <sup>7</sup>	Not Available				1968	51	1	15.6	9.8	1.3	1,476
Nurse	93.6	96.4	2.8	4.6	2.6	0.1	1896	51	78	15.0	16.7	1.5	56,882
LPN	95.3	95.8	1.7	4.5	2.2	1.2	1949	51	1	12.9	11.2	3.0	14,357
Nurse Aid	88.8	80.2	1.1	4.7	2.0	2.5	1995	6	1	12.0	12.3	7.0	59,554
Pharmacist	40.5	4.0	3.6	1.6	2.5	0.0	1852	51	5	17.1	6.4	1.3	5,624
Pharm Tech	85.0	16.2	2.7	1.7	2.8	0.2	1999	4	0	13.2	7.7	3.0	1,722
Dentist	14.2	2.2	4.4	3.2	3.3	0.0	1859	51	26	18.7	0.7	0.3	4,478
Hygienist	98.2	96.4	2.7	4.2	3.0	0.0	1923	51	0	14.7	3.0	1.4	2,757
Dent. Aid	98.2	84.4	2.1	3.1	1.2	0.0	1924	8	5	13.0	1.9	3.6	5,980
Lawyer	25.5	1.5	4.4	3.3	0.8	0.0	1878	51	4	18.6	5.6	1.2	22,986
Paralegal	82.3	68.2	2.3	3.6	1.6	0.1	1975	0	2	14.4	4.3	3.5	8,288
Architect	18.0	1.8	4.4	4.0	3.0	0.1	1857	51	1	16.4	3.7	2.6	4,354
Drafter	16.8	2.3	3.2	1.7	3.2	0.0	1958	0	1	13.6	7.5	4.5	7,709
Accountant	51.1	10.2	3.4	2.9	1.3	0.0	1916	51	19	15.3	6.1	2.3	42,122
Bookkeeper	91.5	50.4	2.4	1.9	2.3	0.0	1987	0	1	12.9	4.1	3.8	55,171
Veterinarian	34.7	1.4	3.8	1.6	3.5	1.2	1863	51	27	18.6	1.0	1.0	1,448
Vet. Tech	82.0	79.0	1.9	3.2	1.8	0.5	1981	29	0	12.9	0.0	6.9	378
Professor	25.9	11.8	3.9	3.7	1.3	0.1	1915	0	0	17.9	16.8	1.1	5,682
HS Teacher	54.3	64.0	2.9	3.7	1.2	0.1	1857	51	1	16.7	56.3	1.1	39,659
Elem Teach	83.4	90	2.8	3.7	1.0	0.0	1857	51	1	16.5	53.0	1.4	62,670
Kind. Teach	97.9	98.6	2.3	4.0	1.1	0.3	1857	51	1	14.8	18.3	2.7	14,455
Teacher Aid	92.9	89.6	2.2	3.3	0.9	0.1	N/A	0	0	12.8	20.1	3.8	14,102
Psychologist	59.7	39.8	4.1	3.4	2.0	2.5	1892	51	13	18.1	24.7	1.4	5,043
Social Work	73.2	63.3	3.1	3.6	0.9	0.0	1917	51	6	15.7	22.9	3.1	18,601
Clergy	23.0	1.8	4.2	3.3	0.8	0.0	N/A	0	2	16.0	1.6	0.8	13,225
Librarian	84.9	87.6	2.7	3.9	1.0	0.4	1876	36	4	16.0	24.5	1.5	6,280
Library Aid	79.0	80.2	1.7	3.9	1.4	0.7	N/A	0	0	13.3	15.7	3.4	5,059
Engineer	8.0	0.7	4.0	2.3	2.7	0.3	1934	51	46	15.7	6.4	2.4	50,495
Eng. Tech	21.0	24.3	2.7	2.0	2.7	0.2	1964	0	8	13.5	13.8	3.6	16,476
Mean/Total Sample	64.5	53.4	2.2	2.7	2.0	0.9	1918	34	22	15.1	16.1	3.8	565,573
Mean All Occs.	45.4	23.6	3.5	3.2	1.9	0.3	Not Available			12.9	12.8	6.0	

<sup>6</sup> Includes District of Columbia

<sup>7</sup> Data not available until 1980

In my analysis of professional inequality, my primary measure is inflation adjusted (to 2015 dollars) annual income from salary/wages of individual respondents as measured by the CPS. In regression analysis I used the natural log of income to mediate the effects of positive skew and to aid interpretation. Independent variables fall into three broad categories of interest. First, I am interested primarily in the effects of gender composition on wages, so I measured both relative yearly gender composition and relative historical gender composition. Relative yearly gender composition is measured as the number of standard deviations from the mean percent of women per occupation each year as calculated using the 1968-2015 CPS sample. Relative historic gender composition, was the same measure but was not yearly and used data from the 1900-1940 IPUMS-USA extracts. I use a measure of relative proportion women in each occupation (as opposed to a straight percentage) to control for the overall changing demographics of the U.S. labor force during the period and between the period of inquiry and historic measure. This allows for a more accurate accounting of gender composition across multiple time periods, and measures how feminized an occupation is compared to other contemporary occupations as opposed to a non-relative measure which would fail to take into account periodic change in overall gender composition in the workforce. For example, it means something different for an occupation to be 90% male in 1920 than in 1980. To interrogate the effects of differences in occupational skills and conditions, I create and impute measures of cognitive skills, nurturing skills, physical demands and hazards<sup>8</sup> from the *Dictionary of Occupational Titles*.

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<sup>8</sup> All measures are 0-5 scale indexes combining relevant measures in the *Dictionary of Occupational Titles* and compared to population means. Cognitive skill combines questions on general education requirements, data complexity, numerical aptitude, intelligence, and training time. Nurturing skill is a combination of requirements of

The final group of independent variables concerns closure strategies. To measure the longevity and potential degree of establishment of the profession, I looked at the year the professional association was established as described in *the National Trade and Professional Associations of the United States*. All the included professions that to this point have established national associations did so between either 1847 and 1936 or 1955 and 1999. Because World War II marks both an empirical demarcation in the data and is theoretically important as a marking point in industrial change and professional growth I demarcate professional associations as either pre- or post-WWII. Using *The Professional and Occupational Licensing Dictionary* to determine the extent of each professions licensing closure, I measured the effects of having achieved mandatory licensing for practitioners in at least 26 states. I characterize achieving licensing in a majority of U.S. states to be a successful attempt at licensing.

Occupations also use voluntary certifications to increase social closure over their work, so I included a measure of certifications as well. Based on the listings in *the Certification and Accreditation Programs Directory* I utilized an ordinal variable to represent a range of certification strategies: 0 = none, 1 = single certification, 2 = 2 to 10 potential certifications, 3 = 10 to 50 certifications, and 4 = more than 50.<sup>9</sup> I also examined the effectiveness of credentialing, by measuring the effect of yearly average schooling relative to the general population.

Unionization is an important closure strategy, therefore I include a yearly measure of occupation level union membership as compared to the mean of all occupations. Because the CPS only

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talking and hearing, dealing with other people, flexibility in presenting personal viewpoints and complexity in relations with other people. Physical demands include motor coordination, finger dexterity, form perception, spatial perception, and visual requirements. Hazardous conditions include exposure to hazards, fumes, stooping, needing to climb and environmental conditions.

<sup>9</sup> An ordinal scale more accurately captures the distribution of certifications among professions. Where for instance Architects have one, Dentists have 26, but MDs have 221.

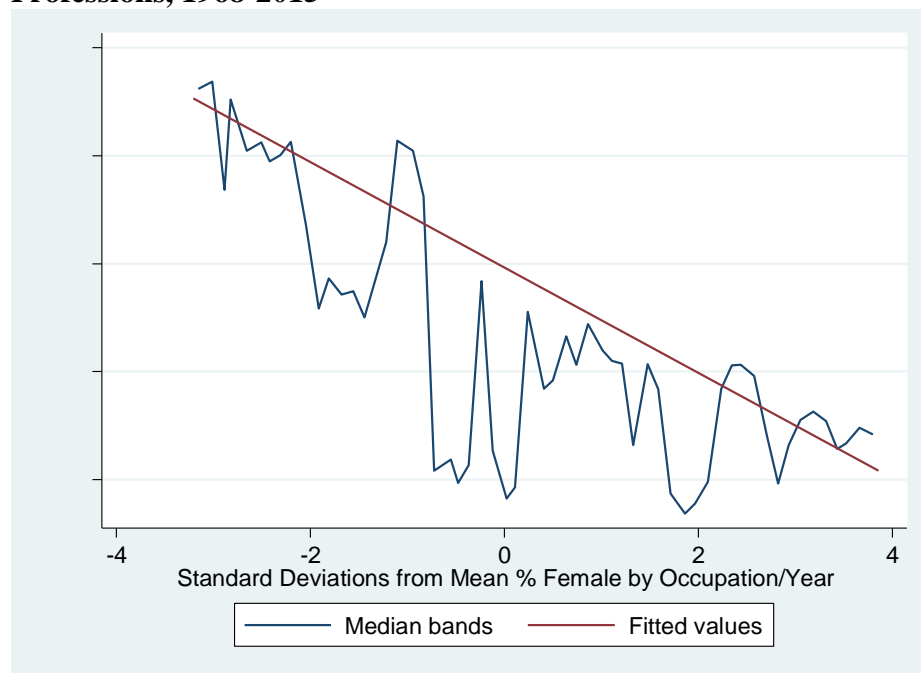
began measuring union membership information in 1990, I make only limited use of this variable to retain pre-1990 data in most models. As somewhat of a catchall measure of closure success I also include a relative measure of unemployment, like union membership and gender composition, it is a yearly relative variable. Social closure is meant to limit the supply and boost the demand of a particular occupation's labor, thus the relative unemployment in each occupation should capture residual effects for other closure strategies. In addition to the occupation level variables of interest I controlled for a number of theoretically relevant, individual level, demographic, human capital and labor market position variables which bear on earnings (see Table 2.1 for relevant descriptive statistics).

The primary statistical analysis I utilized is Random-effects Generalized Least Squares regression. The dependent variable, logged annual earnings, is affected by both individual level differences in respondents and occupation level differences, additionally the individuals within groups also effect group outcomes. In this case to accurately estimate effects at multiple levels, Random-Effects GLS regression is most appropriate. To capture yearly changes in credentialing, unionization and gender composition, I group professions by occupation\*year.

### *Results*

Figure 2.1 presents the relationship between yearly occupational gender composition and median annual income between 1968 and 2015 among professions. The results are very clear and unsurprising. The higher the relative proportion female workers in a profession, the lower the income. To gain a deeper understanding of this tendency I examine tendencies across gendered occupational hierarchies.

**Figure 2.1: Median Annual Income by Standard Deviations from Mean % Female in Professions, 1968-2015**



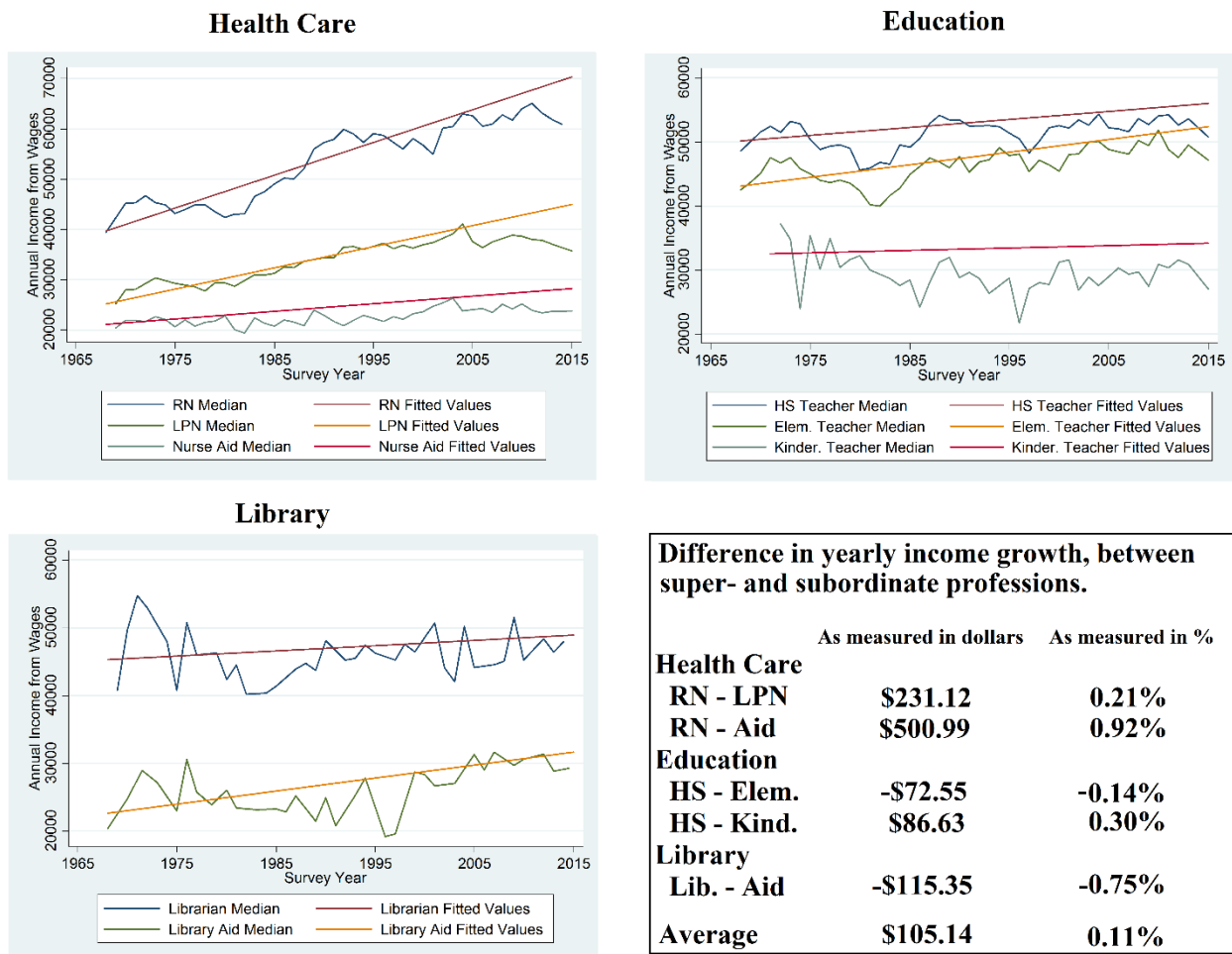
Figures 2.2, 2.3 and 2.4 display income growth between 1968 and 2015 (in 2015 dollars) in nine different hierarchical occupational arrangements. Figure 2.2 interrogates differences in wage growth within homogenous female hierarchies. In the health care field we see the starkest difference among female divisions. Registered nurses' median income began the period highest and grew the fastest at an average of \$651.26 or 1.35% per year, \$231.12 or .21%<sup>10</sup> more per year than licensed practical nurses and \$500.99 more per year than nursing aids. Yearly income growth in primary education was more closely clustered, with differences averaging less than \$100 per year between all three professions. Although median annual salaries began and remained highest among the superordinate high school educators, elementary teacher incomes

<sup>10</sup> RNs averaged 1.35% yearly growth, while LPNs averaged 1.14%, .21 is the difference in growth.



grew at a faster rate. Similarly, library aids' income grew faster than librarians over this period. Income growth among female-female hierarchies was fairly consistent, averaging only .11% yearly difference. These hierarchies also had subordinate professions which grew at a faster rate than their superordinate counterparts, indicating a less stable hierarchy (at least in terms of earnings).

**Figure 2.2: Median Annual Income by Profession in 3 Female Homogeneous Hierarchies, Full-Time Workers 1968-2015**



**Figure 2.3: Median Annual Income by Profession in 3 Male Homogeneous Hierarchies, Full-Time Workers 1968-2015**

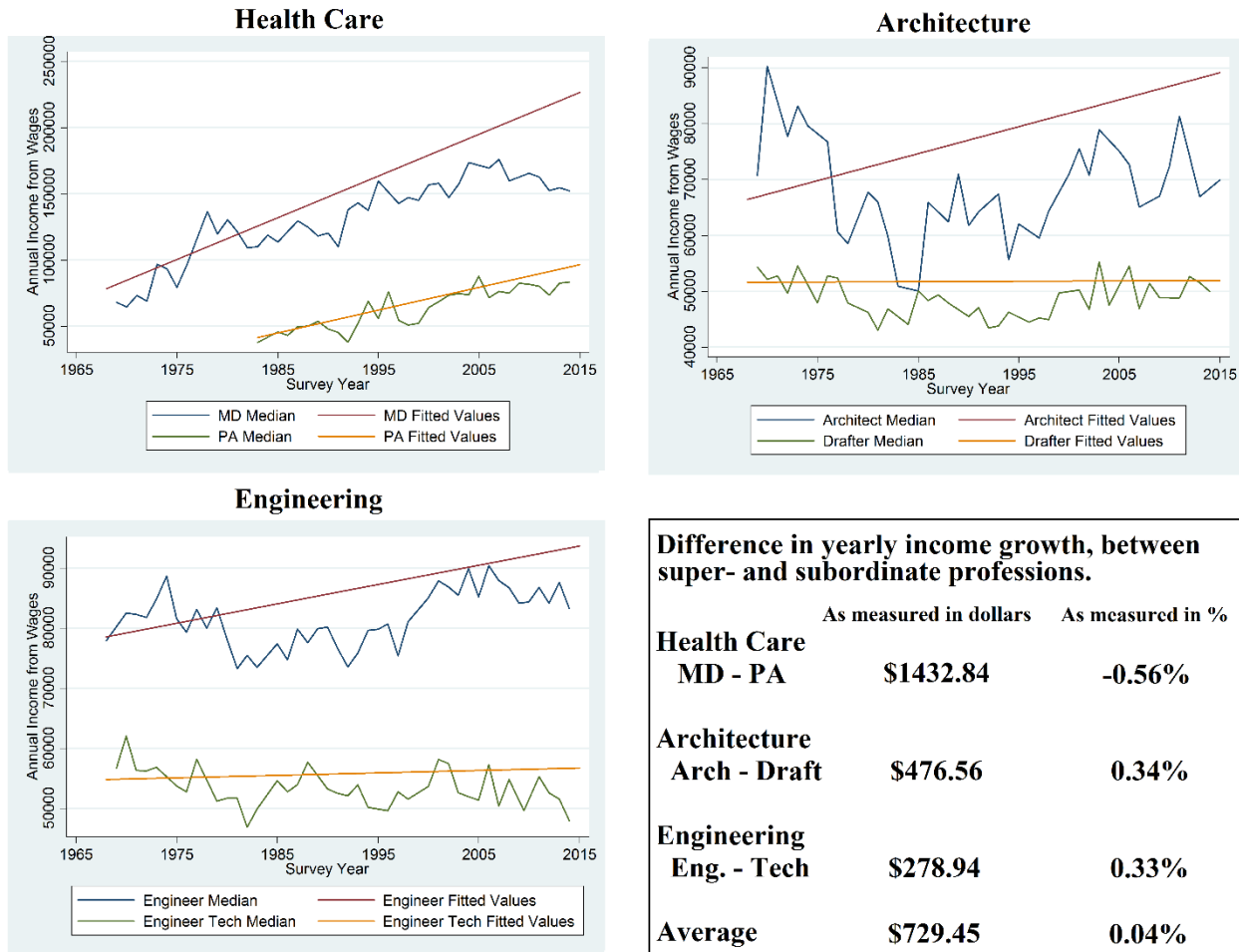


Figure 2.3 displays trends in wage growth among male homogeneous professional hierarchies. On average, the difference between male-male super- and subordinate occupations was larger than in the female-female examples; \$729.45 per year compared to just \$105.14. In terms of percent change, there was actually less difference among male-male hierarchies averaging only a .04% difference in yearly growth. Again, the largest discrepancy was in health care, where physicians’ wages grew \$1432.84 more per year than physician assistants<sup>11</sup>.

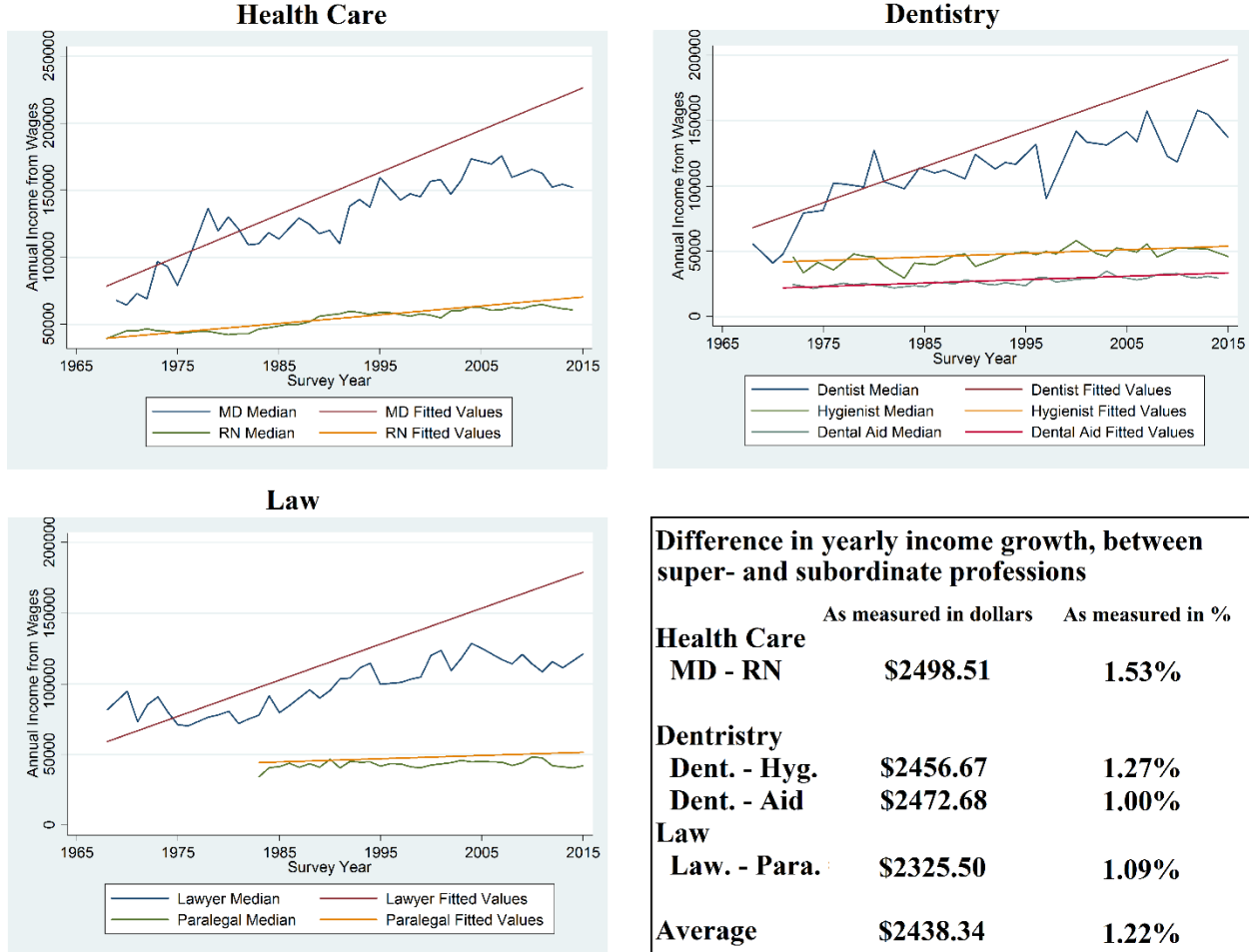
<sup>11</sup> It should be noted that while physicians assistants were initially solidly male majority, over this period increasing numbers of women entered the profession until they hovered around an even split. Physicians also became progressively more female this period, yet retained a solid male majority.

Counterintuitively perhaps, physician assistants grew faster than physicians percent wise. The relative difference in wages between architects and drafters was fairly tumultuous. Architects' wages experienced a significant and extended decline from 1970 to 1985 which they have yet to fully recover from, drafters for their part also saw their wages declining between 1968 and 1995. Still we see the yearly growth rate over the period was substantially greater among architects than drafters. In engineering, both engineers and engineering technicians in manufacturing<sup>12</sup> experienced declining wages during the 1970s. Both occupations recovered from the low points in the early 1980s, but engineers have experienced a faster and more substantial recovery. Turning our attention to male-female hierarchical arrangements in Figure 2.4, the trend is immediately clear. Within these hierarchies, male professions' wages grew at a much faster rate than the subordinate female professionals over the past 4 decades in both absolute dollars and in percentage. In the growth industries of health care, dentistry, and law, male superordinate professions averaged \$2,438.34 or 1.22% more growth per year than their female subordinate counter-parts. The trend here is plain, over the last half century professional wages, overall, have been on the rise and while same gender occupations have grown relatively parallel to one another, growth between interrelated male and female professions has been profoundly unequal. Of course there are other differences beyond gender composition that may explain this inequality. To look more closely at this relationship, I use GLS regression to examine how gender composition effects wages in professions when occupational condition, skill, and closure strategies are weighed along with individual differences in demographics, human capital and labor markets.

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<sup>12</sup> Because engineers and techs are spread across so many industries, analysis here is limited to the manufacturing sector.

**Figure 2.4: Median Annual Income by Profession in 3 Gender Heterogeneous Hierarchies, Full-Time Workers 1968-2015**



Tables 2.3 and 2.4 present results from random effects GLS regression models predicting logged annual earnings of professionals between 1968 and 2015. Table 2.3 reports individual, or within group, effects as calculated in the full model reported below. Results in all other models are substantially the same in effect size and statistical significance (all variables at the  $p < .001$ ).

Consistent with other work on gender inequality, over the period studied, women made approximately 20% less per year than similarly qualified and located men. Similarly, I find that Hispanic, Black and Asian American workers were paid four to five percent less annually than

their non-Hispanic White counterparts. Married respondents (with spouse present) and those with children tended to make more than the unmarried and the childless.

**Table 2.3:** Results of GLS – Random Effects Models Predicting Logged Annual Earnings  
*Individual Level Estimates Derived from full Model (6)*

<i>Variables</i>	
Female	-0.200*** (0.003)
Hispanic	-0.043*** (0.004)
Black	-0.052*** (0.004)
Asian	-0.042*** (0.006)
Other Race	-0.072*** (0.007)
Married	0.055*** (0.002)
Has Child	0.041*** (0.003)
Non-Metropolitan	-0.105*** (0.003)
Years of School	0.076*** (0.001)
Experience	0.037*** (0.000)
Experience <sup>2</sup>	-0.001*** (0.000)
Part-time emp.	-0.347*** (0.006)
Intermittent emp.	-0.685*** (0.006)
Public Sector	0.105*** (0.003)
Single Emp.	0.064*** (0.003)
Firm > 500	0.070*** (0.003)
State and Industry	Yes
Year	Yes
N (Individuals)	527281
R <sup>2</sup> (Within Group)	0.3337

\* p < .05; \*\* p < .01; \*\*\* p < .001; (Standard Error)

Human capital and labor market effects are consistent with existing studies of earnings; more education and experience, retaining a single employer, and working in a large firm all predicted higher wages. Somewhat counterintuitively, public sector employment was also associated with higher earnings. However, this is likely explained by the overrepresentation of women in the sample, who tend to experience less inequality in public sector work (Gornick and Jacobs 1998). This bears out when the sample is divided between historically female and historically male occupations, there is a positive effect among respondents in the historically female sample and a negative effect in the historically male sample. Workers who only worked part-time or intermittently made substantially less than full-time, full year workers. And those living outside of metropolitan areas made about 10% less than city-dwellers.

Table 2.4 presents the between group, occupation level, effects predicting logged annual income. Model 1 includes variables indicating proportion female as compared to the overall mean among all other occupations, as well as the skills required and conditions associated with each profession. As predicted, the larger the proportion of women in a profession the lower the overall wages. To be precise, compared to the mean gender composition of all occupations that year, each standard deviation more women in an occupation correlated to a four percent decrease in annual earnings ( $p < .001$ ). Because so many occupations (particularly the professions of central concern) are so profoundly segregated by gender, many of what I have been referring to as female professions are 2 or 3 standard deviations from the norm and the same is true (in the opposite direction) for many of the male professions – so there is, in some cases, a 20% resultant swing across the gender divide.

**Table 2.4:** Results of GLS – Random Effects Models Predicting Logged Annual Earnings

Variables	<i>Group (Yearly Occupation) Level Estimates</i>					
	Model 1	Model 2	Model 3	Model 4 <sup>†</sup>	Model 5	Model 6
<i>Proportion Female</i>						
Yearly	-0.043*** (0.003)	-0.046*** (0.002)	-0.018** (0.003)	-0.047*** (0.003)		0.026*** (0.004)
At Founding					-0.097*** (0.007)	-0.122*** (0.008)
<i>Skills and Conditions</i>						
Cognitive Skills	0.238*** (0.009)		0.031** (0.013)	0.192*** (0.013)	0.116*** (0.014)	0.095*** (0.015)
Nurturing	-0.036*** (0.005)		-0.046*** (0.005)	-0.019*** (0.004)	-0.001 (0.006)	0.000 (0.006)
Physical Demands	0.086*** (0.003)		0.083*** (0.003)	0.079*** (0.002)	0.089*** (0.003)	0.092*** (0.003)
Hazardous Conditions	0.003 (0.010)		-0.013 (0.010)	-0.123*** (0.009)	-0.091** (0.018)	-0.083*** (0.013)
<i>Closure</i>						
Prof. Assoc. pre WWII		0.078*** (0.012)	0.164*** (0.013)	0.0946*** (0.012)	0.194*** (0.013)	0.182*** (0.013)
>25 State req. License		0.141*** (0.011)	0.089*** (0.012)	0.156*** (0.011)	0.121*** (0.012)	0.122*** (0.012)
Certifications		0.033*** (0.004)	0.012** (0.004)	0.017*** (0.003)	0.012** (0.004)	0.018** (0.004)
Avg. Education		0.027*** (0.006)	0.013*** (0.008)	0.0156*** (0.007)	0.040*** (0.008)	0.045*** (0.008)
% Unemployed		-0.079*** (0.002)	-0.097*** (0.011)	-0.063*** (0.010)	-0.088*** (0.011)	-0.082*** (0.011)
% Union Members				-0.064*** (0.004)		
N (Groups)	1256	1311	1256	688	1256	1256
Avg. Group Size	419.8	403.6	419.8	487.5	419.8	419.8
R <sup>2</sup> (Between Groups)	0.8954	0.8862	0.9278	0.9569	0.9329	0.9329
R <sup>2</sup> (Overall)	0.5171	0.5211	0.5301		0.5311	0.5311

\* p &lt; .05; \*\* p &lt; .01; \*\*\* p &lt; .001; (Standard Error)

<sup>†</sup>Sample limited to 1990-2015

Effects of skills and conditions are consistent with Weeden's (2002) findings. One standard deviation from the mean in cognitive skill increased annual income by approximately 24% (p<.001), one deviation more nurturing skill decreased earnings by four percent (p<.001), and change in physical demands increased income by nine percent (p<.001). These skills,

particularly nurturing, are of course themselves deeply intertwined with gender – they both define who a job is appropriate for and how much compensation the work deserves. Hazardous conditions did not have a statistically or practically significant effect on earnings. Model 1 explains 89.5% of variation at the occupational level and combined with the individual variables explains 51.7% of variation in income.

Model 2 excludes measures for skills and conditions, retains a measure of yearly proportion of female workers and adds measures of closure strategies. Again, a greater proportion of female professionals was negatively associated with income, -4.6% per standard deviation ( $p < .001$ ). Turning to the closure strategies, findings indicate that all closure strategies considered are effective at increasing incomes. Looking at the historical legacy of establishing a professional association, those professions which founded their associations prior to World War Two had about eight percent higher incomes ( $p < .001$ ). Professions that had established mandatory licensing in at least 26 states had 14.1% higher ( $p < .001$ ) incomes than those that hadn't. More certifications and more credentialing (years of schooling) increased income by 3.2% ( $p < .001$ ) and 2.7% ( $p < .001$ ) respectively. Unemployment obviously is not a closure strategy, but it is a kind of measure of closure's success at creating a tight labor market and increasing demand for practitioners' labor, so as expected, the higher the unemployment the lower the income; each standard deviation more unemployment than the yearly mean correlated to a 7.9% decrease in income ( $p < .001$ ). Closure strategies and gender composition explain 88.6% of between group variation and the full model explains 52.1% of overall variation.

Model 3 combines the measure of Models 1 and 2. Though for the most part relationships between the variables under consideration and income were similar to the previous models, there were some changes in effect sizes and significance to note. When both differences in skill and



characteristics and closure strategies are accounted for, one standard deviation change in proportion women decreases annual income by about two percent ( $p < .01$ ). Unsurprisingly, when skills and conditions are considered alongside closure strategies both sets of variables see changes in predictive coefficients as compared to either set evaluated in isolation. So when closure strategies are included in the estimation, the effect of cognitive skills was considerably reduced, correlating to only a 3.1% increase in income ( $p < .01$ ). The negative effect of nurturing, on the other hand, was magnified to 4.6% ( $p < .001$ ). The correlation between physical demands, hazards and income remained relatively unchanged.

There are similar shifts in strength and significance among the closure variables. Once skills and conditions are including in the model, pre-War professional associations were associated with 16.4% higher incomes ( $p < .001$ ) and majority state licensing predicted an 8.6% increase in income ( $p < .001$ ). Increasing certifications reduced to a 1.2% increase in income and was less statistically significant ( $p < .01$ ) than in the previous model. Relative average years of education correlated to a 1.3% increase in annual earnings ( $p < .001$ ), while unemployment reduced earnings by 9.7% ( $p < .001$ ). The combined model explained 92.8% of between group variance and 53% of overall variance.

Model 4 continues the analysis of Model 3, but adds a measure of closure by unionization. As discussed above, union membership is only measured between 1990 and 2015, as a result there are some changes from the previous model in the predictive strength of the other variables. However, the general direction and significance of all the variables remains substantially unchanged and since direct comparison of the variables cannot be made, I will focus only on the results of unionization.

Model 5 retains the same skill and conditions and closure variables as Model 3, but replaces the yearly gender composition variable with a measure of the relative proportion of women in the occupation between 1900 and 1940 as recorded by the U.S. census.<sup>13</sup> Like the yearly measure, historical proportion female is measured as standard deviations from the mean percent women in all occupations. Compared to the yearly composition, historic gender composition appears to have a much larger effect on annual earnings, -9.7% as opposed to 1.8%. This likely reflects the fact that some of the most successful professions of the period of inquiry (physicians, lawyers, pharmacists) saw significant numbers of women join their ranks while simultaneously growing their relative incomes. To interrogate this further, in the next model I include both measures. Contrary to what may have been predicted, a one standard deviation increase in union membership correlates to 6.4 percent decrease in annual income. I do not believe this is a causal link, rather given the rarity of unionization among professionals, it is likely that only the lowest paying professions would pursue this strategy. In other words, unionization may not be causing lower wages, but those with lower wages are more likely to unionize.

Continuing with Model 5, the effects of closure strategies were substantially similar to the previous models (with the exception of the credentialing effect size that increased from 1.3 to four percent). But, including historical gender composition significantly altered estimates of skill and condition effects. Most notably, the effect of nurturing on annual income was not statistically significant and only estimated a .1% decrease in income. Yet, the penalty for hazardous conditions increased to nine percent ( $p < .01$ ). The effect of cognitive skill was also amplified to

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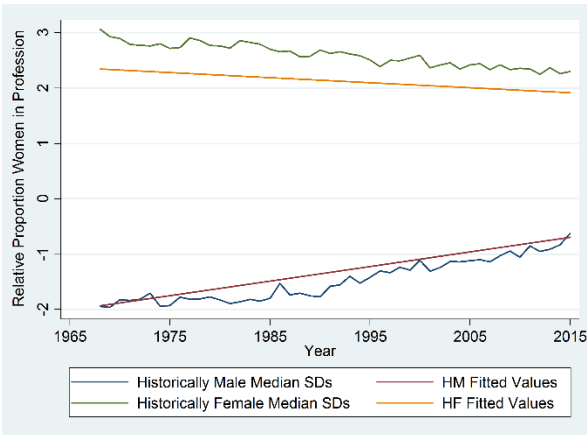
<sup>13</sup> Relative proportion women is measured as standard deviations from mean percent women in all occupations.

11.6% ( $p < .001$ ). This model explained 93.1% of occupation level variance and 53.1% of overall variance in annual income.

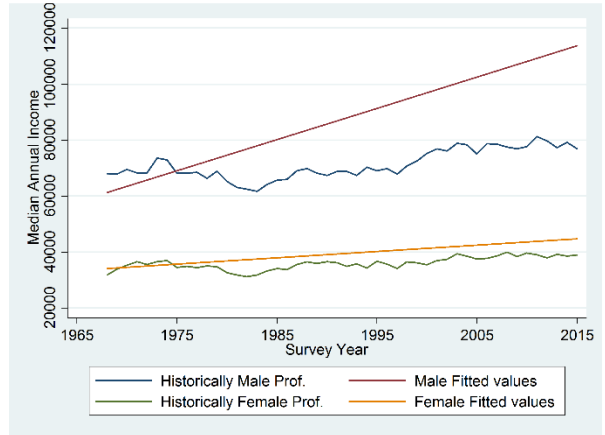
In Model 6, I interrogate the relationship between professions' historic gender composition and their contemporary composition. This model retains measures of skill, conditions and closure and compares the relative effects of historical and contemporary proportion of female professionals represented in each profession. When the historical gender composition was considered the effect of yearly gender composition actually reversed as compared to its solo measurement. Each standard deviation away from the historical mean percent women correlates to 12.2% less annual income while seemingly paradoxically each standard deviation from the mean in a given year increases income by 2.6%. However, because, to a large extent, historical proportion predicts the contemporary proportion of women, what is actually being measured in the yearly coefficient is change in proportion female. In the historically female professions there hasn't been much (relatively speaking) gender integration, but in many of the historically male occupations there has been significant though incomplete integration of women (see Figure 2.5). These results show that the historic proportion of women in a profession continues to affect the ongoing wages of that profession, but the entrance of women into the historically male professions does not impede continued success in securing higher incomes.

**Figure 2.5: Comparing Change in Historically Female and Historically Male Professions, 1968-2015**

**Change in Proportion Female Relative to Total Labor Force, 1968-2015**



**Change in Median Annual Income, 1968-2015**



To further interrogate how historical gender composition affects professionalization I separated the sample into two subsamples and estimated two GLS regression models on each. The first sample includes only respondents in professions with more women than the national occupational mean between 1900-1940 and the second sample includes those professions with fewer women than the mean. Model 1 includes all Model 3 variables from Table 2.4 and Model 2 includes all Model 4 variables. Table 2.5 presents these results.

**Table 2.5: Results of GLS – Random Effects Models Predicting Logged Annual Earnings in Historically Gender Segregated Professions**

<i>Individual Variables</i>	<i>Historically Female</i>		<i>Historically Male</i>	
	Model 1	Model 2	Model 1	Model 2
Female	-0.166*** (0.003)	-0.115*** (0.004)	-0.233*** (0.004)	-0.208***(0.005)
Hispanic	-0.027*** (0.005)	-0.033*** (0.005)	-0.091*** (0.008)	-0.085***(0.009)
Black	-0.034*** (0.004)	-0.046*** (0.004)	-0.102*** (0.008)	-0.098***(0.010)
Asian	-0.041*** (0.008)	-0.044*** (0.008)	-0.049*** (0.008)	-0.043***(0.008)
Other Race	-0.050*** (0.009)	-0.046*** (0.011)	-0.109*** (0.012)	-0.080***(0.019)
Married	0.026*** (0.003)	0.031***(0.003)	0.137*** (0.004)	0.123***(0.005)
Has Child	0.015*** (0.003)	0.030***(0.004)	0.072*** (0.005)	0.076***(0.006)
Non-Metropolitan	-0.097*** (0.003)	-0.088***(0.004)	-0.107*** (0.005)	-0.109***(0.007)
Years of School	0.073*** (0.001)	0.076***(0.001)	0.075*** (0.001)	0.079***(0.001)
Experience	0.033*** (0.000)	0.032***(0.000)	0.045*** (0.000)	0.042***(0.001)
Experience <sup>2</sup>	-0.001*** (0.000)	-0.001***(0.000)	-0.001*** (0.000)	-0.001***(0.000)
Part-time emp.	-0.350*** (0.007)	-0.270***(0.008)	-0.360*** (0.012)	-0.281***(0.015)
Intermittent emp.	-0.676*** (0.007)	-0.703***(0.008)	-0.692*** (0.011)	-0.699***(0.013)

Public Sector	0.146*** (0.004)	0.107***(0.004)	-0.068*** (0.008)	-0.130***(0.010)
Single Emp.	0.040*** (0.004)	0.017***(0.004)	0.110*** (0.006)	0.106***(0.007)
Firm > 500	0.092*** (0.003)	0.108***(0.003)	0.052*** (0.005)	0.073***(0.005)
State and Industry	Yes	Yes	Yes	
Year	Yes	Yes	Yes	
<i>Occupation Variables</i>				
Proportion female (in SDs)	-0.033*** (0.009)	-0.041***(0.003)	0.061** (0.011)	0.075***(0.012)
<i>Skills and Conditions</i>				
Cognitive Skills	-0.011* (0.011)	-0.031(0.017)	0.322*** (0.051)	0.538***(0.062)
Nurturing Skills	-0.028*** (0.007)	-0.005(0.007)	-0.201*** (0.014)	-0.239***(0.016)
Physical Demands	0.141*** (0.003)	0.140***(0.003)	0.038*** (0.004)	0.042***(0.004)
Hazardous Conditions	-0.201*** (0.009)	-0.234***(0.009)	-0.332*** (0.031)	-0.405***(0.034)
<i>Closure</i>				
Prof. Assoc. pre WWII	0.122*** (0.011)	0.113***(0.011)	0.470*** (0.040)	0.544***(0.051)
>25 State req. License	0.112*** (0.011)	0.107***(0.011)	0.144*** (0.012)	0.165***(0.015)
Certifications	0.024*** (0.004)	0.024***(0.004)	0.064*** (0.009)	0.090***(0.009)
Avg. Education	0.167*** (0.010)	0.139***(0.012)	0.065*** (0.015)	0.058***(0.017)
% Unemployed	-0.033*** (0.009)	-0.025*(0.010)	-0.006 (0.018)	0.010(0.016)
% Union Members		0.011**(0.004)		0.006(0.016)
N (Individuals)	366,102	232,728	161,179	
N (Groups)	728	403	528	
Avg. Group Size	503	875.5	305	
R <sup>2</sup> (Within Group)	0.3478	0.3488	0.3161	
R <sup>2</sup> (Between Group)	0.9504	0.9632	0.856	
R <sup>2</sup> (Overall)	0.477	0.4885	0.4478	

\* p < .05; \*\* p < .01; \*\*\* p < .001; (Standard Error)

Comparing the two samples there were clear and significant differences in the effects of variables of concern both at the individual and occupation level. To start, women experienced a substantially larger wage penalty in historically male professions than in female ones, 23.3% and 16.6% respectively. Similarly, people of color, with the exception of Asian Americans, see a much larger wage discrepancy when compared to whites in male professions than those in female professions. Professionals in historically male professions also saw a larger benefit for marriage, 13.7% vs. 2.9%, and children, 7.2% vs. 1.6%. The effects of location, schooling, experience, and part-time employment were very similar across gendered professions. However, maintaining a single employer has a larger impact on workers in historically male professions, while working in large firms impacted the female professions' income more. And as noted

above, while working in the public sector had a positive effect on income for the historically female professions, it negatively impacted incomes in historically male professions.

Perhaps the most striking difference between historically male and historically female professions, is how yearly gender composition affects annual income. In historically female professions, each standard deviation more than the overall occupational mean percent women, predicts a 3.3% decrease in annual income. However, in historically male professions, each standard deviation more women correspond to a 6.1% increase in income. Women entered into male professions at much greater rates than men entered female professions and the historically male professions also tended to grow their wages more than female professions. Historically female professions, saw both less growth in wages and less gender integration than the male professions over this period (again see Figure 5). Additionally, the most gender segregated among them had the lowest wages, i.e. nurse aids, library aids. Therefore, it is unsurprising that within the historically female professions, greater proportions of women correspond to lower annual incomes. The general tendency among the male professions over this period was to become more female and to increase wages, so in isolation, yearly proportion female corresponds to higher wages. It may appear, then, that increasing representation of women in male professions increased income, but recall that individual women in these professions averaged 23% less pay than their male counterparts and that this effect is factored into the model as well. The much more likely causal explanation is that as these professions grew, the growth both attracted women to the field and to some degree accommodated their entry (while paying them less).<sup>14</sup>

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<sup>14</sup> Because the effect here is not lagged, these findings do not indicate a long-term causal direction. It still could be the case that, overtime, as more women enter a male profession it depresses median pay, as Levanon, England and Allison (2009) show is the case with occupations more broadly.

The effects of occupational skills and conditions also varies depending on historical gender composition. In historically male professions, as expected, increasing cognitive skill is strongly associated, 32.2% ( $p < .001$ ), with higher wages. But in historically female professions, though less statistically significant ( $p < .05$ ) and to a smaller extent, increasing cognitive skill is negatively associated with income. Change in nurturing corresponded to a 2.8% decrease in income for historically female occupations ( $p < .001$ ) and a 13.2% decrease in annual earnings for historically male occupations ( $p < .001$ ). Physical demands have a significantly larger impact on the wages of professionals in historically female occupations, while hazardous conditions decrease wages of those in historically male professions more than those in historically female professions.

Closure strategies were also not immune to the effects of historical gender patterns. Establishing a professional association prior to World War Two had a strong effect on income in both historically female and male professions, but the effect size was more than triple for male professions, 47% compared to 12.2% (both  $p < .001$ ). Requiring licensing in a majority of U.S. states predicted increased incomes among both female and male professions, with male professions experiencing a larger differential, 14.1% versus 11.2%. Again, closure strategies seem to have a great impact on income for historically male occupations when it comes to certifications; certifications increased the wages of historically male professions by 6.4% compared to only 2.4% for female professions. Average years of education positively affected the annual wages of all professions, with a larger impact on historically female professions, 16.7%, compared to 6.5% for historically male professions. And though one percent increase in unemployment decreases wages in female professions by 3.3% ( $p < .001$ ), it only decreases male professional wages by .6% and is not statistically significant. So in forming professional

associations, creating licensing and certifications, historically male professions receive a significantly larger advantage than historically female professions. However, unionization is positively correlated with wages in historically female professions, increasing their wages one percent for each standard deviation ( $p < .01$ ), but was not significantly related to the wages of historically male professions. Perhaps as traditionally professional closure strategies bear less fruit for historically female professions than their male counterparts, unionization is a more viable option for them.

### *Discussion and Conclusion*

The professionalization process, ultimately, replicates and exacerbates gender inequality. Like so many issues of allocation, the rewards of professional status are significantly overdetermined by historic and contemporary gendering of the division of labor. This chapter explored how gender intervenes and shapes professionalization, professional ecologies and their relative rewards. Evidence supports the following conclusions. 1) Female professions, like other female occupations, are penalized economically over and above the individual penalty that female workers experience, even when relevant determinants of wage are accounted for. 2) Gender differences across professional ecologies/hierarchies shape the inequality within those hierarchies across time. As growth occurs in areas of female-female hierarchies, superordinate professions gain a relatively modest advantage over their subordinate occupations. On the contrary, when growth occurs in areas of male-female hierarchies, dominant male professions make huge gains over the subordinate professions and occupations in the hierarchy. 3) Closure strategies, particularly forming professional associations, attaining mandatory licensing, and creating voluntary certifications benefit historically male professions substantially more than historically female professions. Unionization presents a clear exception; the percent unionized in



an occupation increased the wages of historically female professions, but had no effect on historically male professions. 4) Though contemporary gender composition is correlated with income, the historic gender composition of professions is a much stronger predictor of contemporary earnings (at least over the time period considered).

To fully explain the complex mechanisms of occupational closure and professionalization, gender needs not only to be considered, but to be integrated into core theoretical explanations. It appears here that gender is deeply interwoven into all aspects of professionalization. Professions are historically organized around gendered demarcations that are at the foundations of their identity. So it should not be a surprise that “feminized” occupations cannot simply wield the tools of professional closure and hope to reap the same rewards that “masculine” professions have historically captured. Looking at the ideal-typical profession of medicine, for example, its professional status is intimately tied into the historical subordination of the female profession of nursing. Furthermore, the “cognitive” skill at the heart of professions - the connection to an abstract body of work – not only is historically associated with masculinity and men but is also rewarded with higher wages. Female professions are penalized, or at least substantially less rewarded, for the very same cognitive skill. Simultaneously the stereotypically feminine quality of nurturing is penalized across both male and female professions.

Professions, like other occupations, engage in closure to restrict supply, increase demand, direct demand to the occupation, and signal quality of service. If the professionalization scholars are to be taken seriously, professions do this much more effectively than other occupations – to the point of creating legal-cultural monopolies on their work and to thus separate themselves from exploitative class relationships. The closure strategies measured here, particularly licensing and credentialing require significant “image making activity” and engagement with the public,

competing occupations and employing organizations. This engagement is inescapably framed by gender. Hence professionalization is not (perhaps could not be) gender-neutral, and is in fact deeply laden with gendered meanings and inequalities.

In this chapter, I examined how income is unequally distributed across gendered professions and gendered professional hierarchies. I've shown that historically female professions are disadvantaged in the wage rewards of occupational closure. Therefore, in growing professional industries like healthcare, education and law, dominant male professions make substantially greater gains than female subordinates. While female superordinate professions, on the other hand, make only modest gains over female subordinate occupations in growing industries. To illuminate how this process works, in the next chapter I will look closely at the professionalization of nursing and the gendered conflict between nursing and medicine, as practiced by their respective professional associations. This case illustrates just how constitutive gender is in the formation of professions and how it shapes and is deployed in inter-professional conflict and hierarchical maneuvering.

### Chapter 3.

#### **“Un-nurselike attitudes”: The American Nurses Association and the Professionalization of Nursing**

Daniel Schneider

“As an idealist, I thought that nursing was a profession. As a realist, I believe that it is not a profession. I want nursing to be a profession.” – Anonymous RN, 1965 (*American Journal of Nursing* 1965; pg 58).

Is professionalization a recipe for every occupation? A little credentialing here, some licenses there, add a dash of claims-making and voila, a profession is born! Clearly practitioners of many occupations believe in at least part of this story; some 30 percent of workers now need a professional license to practice their work (Kearney, Hershbein and Boddy 2015). Unfortunately for these budding professionals the reality is, as to be expected, much more complicated. Professionalization is situated in a complex matrix of competitive professional ecologies and social and economic circumstance that make for a winding road. And while professions have traditionally been dominated by men, over the past century or so a number of women’s occupations have embarked on professional projects. How do these professions navigate the fraught waters of normalization, certification, licensure and competition when they are composed – historically and contemporarily – of women? In the last chapter I showed that the distribution of income across gendered professional hierarchies and the rewards of occupational closure tend to disproportionately advantage historically male professions. In this chapter I will explore the gendered process of professionalization in more depth using the case of nursing in the United States.

At the outset of the 20<sup>th</sup> century, nursing, as a self-described profession, was in its infancy. With a brand new professional association (or 3), few standards of practice, credentialing or licensing, professional status and rewards were still far off. Some 115 years later nursing has yet to achieve many of the goals set by its internal architects of professionalization, however it has carved a niche of dignified work and economic mobility for women of a diversity of classes and ethnicities. Paradoxically, nursing and its organizations stand a house divided, yet it may also be the best time in the history of the occupation to be a nurse. In order to better understand these apparent paradoxes, I trace the history of the American Nurses Association, nursing's primary professional association, and its relationships to its constituency (registered nurses), the American Medical Association and the American Hospital Association. It would be impossible to understand the professionalization of nursing without first grasping two fundamental contradictions which shaped the formation of the profession. First, subordinated autonomy, that nursing seeks and has achieved autonomy while simultaneously being subordinate to the medical profession. Second, conflicting interests in the desire for professionalization and the needs of frontline nurses. From the very beginning nursing elites in the professional associations recognized both medicine and nurses to be obstacles to professionalization. As American Nursing Association (ANA)<sup>15</sup> President Mary M. Riddle noted in her 1905 address to the convention, the state associations “find arrayed against them and their efforts an extremely conservative public, an antagonistic medical profession, and an indifferent nursing body” (AJN 1905, pg 733). As I will explore further, these contradictions are deeply enmeshed with the gendering of nursing.

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<sup>15</sup> Nurses' Associated Alumnae of the United States at the time, but will be referred to as it's later adopted name the ANA for the sake of parsimony.

Barbara Melosh argues in her excellent history *The Physician's Hand* that “[w]ithin the existing division of labor, nursing is not a profession, because nurses’ autonomy is constrained by medicine’s professional dominance. In broader cultural terms, nursing by definition cannot be a profession because most nurses are women” (1982; pg 20). I think she gets at the seed of nursing’s professionalization woes, but I also find the reasoning flawed in a few important ways. One, she does not here show the interdependence of these two subordinations. It is not arbitrary that medicine has dominated nursing, and as Ehrenreich and England (1973) remind us it has not always been the case that it did. The gendering of the traditions was intimate to medicine’s successful domination. Two, while I agree that the cultural notion of profession and professionals is gendered which disadvantages women’s professionalization pursuits, I don’t think that fundamentally means nursing or other primarily female occupations cannot, by definition, be professions. The gender transformation of the ideal-typical professions of Medicine and Law may be proving this untrue (or not) at the moment.

Hoping to build on these arguments, I began this research assuming it would be about the stymied efforts of nursing and the ANA to professionalize. While that is certainly a major part of the story here, what I hadn’t seen at first glance was the full extent of these setbacks. Hiding in plain sight, beyond the curtailed success of professionalization was a century old, national professional organization in crisis. By the 2010s, not only had the ANA ceased holding its biennial membership conventions (1898-2004), but its membership was the lowest it had been since 1930 and represented a smaller proportion of nurses than at any point in its history. At the current moment state nursing associations are fractured into a hodgepodge of different national union organizations, only some of which are still affiliated with the ANA. National Nurses United (NNU), a union first, professional association second that often embraces explicitly class

conscious and feminist rhetoric and tactics, now represents more than twice as many nurses as the ANA and is a leading anti-ANA voice in nursing. Made up primarily of state nursing associations that disaffiliated from the ANA, the NNU is poised to become the dominant voice of nursing in the United States. In addition to the NNU, nurses are also represented by the National Federation of Nurses (NFN) a division of the American Federation of Teachers, Service Employees International Union, and a host of other smaller unions. The dramatic decline of the ANA and the fracturing of its state associations has taken less than 20 years, but may have ultimately been built into the very beginning of the ANA's quest for professionalization.

For the vast majority of the 19<sup>th</sup> century American nursing was unorganized and "nurse" referred to a very loosely defined kind of work that described a vast diversity of skills, trainings, and competencies. At the turn of the century efforts at organization began to materialize as a national organization was formed. In addition to the serious task of organizing the professional association, the nascent association needed to normalize, rationalize and police the bounds of the occupation. Standard practices for any budding profession to be sure. But what is important to keep in mind here is that normalization does not occur in isolation. One does not merely draw professional norms from thin air. The normalization of nursing was thoroughly embedded and enmeshed in its relationships to other interested parties (physicians and hospitals) and a cultural-structural nexus of white, middle class femininity. This process of normalization then set in motion the future of the position of the profession, its goals, its limits and its relationship to its constituency. Nursing's professionalization, as guided by the ANA, had as its first task the separation, and ultimately elimination, of the remnants of the "born" nurse<sup>16</sup> in practice and in

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<sup>16</sup> Nurses without formal training who practiced based on natural proclivity were referred to as "born" nurses in contrast to "professional" or later registered nurses.

training. To do this, the profession enrobed itself in the white middle class femininity of its founders, embracing and deploying to various degrees the virtues of altruism, charity and purity while simultaneously denigrating the lower-class, untrained “born” nurses as louts, drunkards and opportunists. Not incidentally, the birthing years of the profession were significantly guided by the watchful paternalistic eyes of the medical profession who not only participated in nursing conferences and consulted in internal decision making, but often unilaterally determined nursing policies and practices within hospital settings.

The particular professional persona adopted by the early ANA made it difficult to demand or it seems even to talk about remuneration for fear of appearing crass, self-interested and potentially un-professional. However, the crisis of the Great Depression broke this silence. When the silence was broken, discussion of nurses’ economic wellbeing and pay was framed in terms of overproduction. In what would become typical of ANA’s leadership, they tended to see the problem of low nurse wages as principally a labor supply issue that could and should be rectified by restricting entry into practice through education and licensing requirements. However, the membership and perhaps nurses more broadly, have not always agreed with this strategy, to put it mildly. Rather than focusing on potential future gains of restricting labor supply through traditionally professional means, a large portion of active nurses have advocated (and in many cases acted) for unionization and collective bargaining. Although somewhat adjudicated by the Economic Security Program first adopted in 1946, which included both professionalization and unionization strategies, this tension was never fully resolved within the ANA. The conflict between unionization and professionalization ultimately appeared to be untenable and is directly connected to the decline of the ANA and the rise of the NNU.

In considering the long history of nursing professionalization and the American Nurses Association, it becomes clear that their professionalization, entwined as it were in gendered notions of service, servitude and subordination, could only go so far in achieving the economic stability and workplace autonomy that its practitioners desired. In response nursing's professional leaders incorporated, piecemeal, aspects of unionization to meet the demands of nurses and to ward off competition. But here again the rhetoric and tactics of nursing's elite, hamstrung by the ideology of its foundation and its leaders, were not enough to overcome opposition from hospitals. As time wore on, professionalization stalled and union efforts were restricted, class divisions in the organization became deeper and wider. Eventually reaching the point at which the organization could no longer bridge its internal divides.

#### *Professionalization and Unionization*

Before returning to nursing's history in more detail, let's review what we know about the professionalization process<sup>17</sup>. The 19<sup>th</sup> and 20<sup>th</sup> centuries witnessed the tremendous rise of a new class of occupations: the professions. Although many of the professions we identify today, doctors, lawyers, etc., have their antecedents in medieval Europe, they did not consolidate into their modern incarnation until much later. Beginning in the 19<sup>th</sup> century in the U.S., urbanization, industrialization and modernization more generally accelerated the rise of professions (Larson 1977). In the middle of the century, American Sociologists turned their attention to the professions as they gained greater influence and rewards. The functionalists studying professions were most centrally concerned with traits that separated professions from other kinds of occupations; these theorists identified several common attributes that professions

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<sup>17</sup> For a lengthier discussion, see Chapter 1, pgs. x-x.



exhibited to varying degrees (Carr-Saunders & Wilson 1933; Parsons 1939; Cogan 1953; Flexner 1915; Goode 1969; Pavalko 1988). Although scholars rarely reached consensus on exactly which occupations constituted professions and some argued that occupations may exist on a spectrum of completion, there are eight attributes recognized as essential to the professions: (1) systematic body of knowledge, (2) relevance to some important social values i.e. justice or health, (3) training (4) motivation, specifically a normative orientation toward the service of others, (5) autonomy, (6) commitment, generally lifelong “calling,” (7) sense of community – a sense of common identity and destiny, and (8) a code of ethics (Pavalko 1988, ppg 20-29). While these naturalistic, definitional examinations of professions have largely been abandoned by contemporary sociologists, this kind of work is important to understanding professionalization because not only has it effected colloquial understandings of “the professions”, but professions, specifically nursing, hired sociologists of this ilk to provide council and advise their actions.

Moving past description in the 1960s many scholars argued that occupations generally were becoming professionalized (Wilensky 1964). In response to these observations Wilensky (1964) and Caplow (1954) modeled the professionalization process. Wilensky argues that there are 5 major steps to professionalization (he notes that although there is a common chronology, this chronology is not essential) 1<sup>st</sup> – the work becomes full time, 2<sup>nd</sup> – the profession establishes a training school along with, 3<sup>rd</sup> – professional association – 4<sup>th</sup> legal protection and 5<sup>th</sup> – a code of ethics.

At the heart of the process that Wilensky (1964) identified is what Forsyth and Danisiewicz (1988) would later call “image making activity.” A major part of the professional

association's purpose is to dialogue with the public and promote the profession in order to establish and maintain legal protections. Wilensky (1964) emphasizes that:

the success of the claim to professional status is governed also by the degree to which the practitioners conform to a set of moral norms that characterize the established professions. These norms dictate not only that the practitioner do technically competent, high-quality work, but that he adhere to a service ideal-devotion to the client's interests more than personal or commercial profit should guide decisions when the two are in conflict.

Here, Wilensky centralizes the importance of the normative service orientation in obtaining professional status. Image making activity as Forsyth and Danisiewicz conceived it is the argument that the profession engages in a "service-task" that is essential, exclusive and complex. Though they focus on the latter three characteristics, taken for granted is the service orientation of the work.

Image making activity necessitates, by its very nature, interaction with the broader society and thus is subject to social, non-professional, norms. Image making activity is embedded in socio-cultural norms, and part of what makes it successful or not is how its claims fit-in with other cultural frames. To be specific, as professions are gendered, their claims about service orientation, technical competence, complexity, essentiality are likely to be assessed within a larger gender frame. As social relations are navigated or newly constructed they are structured and evaluated in the context of existent gender relations (Ridgeway 2010). So claims about professionalism are likely to be evaluated (and reciprocally deployed) using relevantly gendered attributes or stereotypes. In this way, gender functions, discursively, as both a resource and a constraint (a topic I will return to in the next chapter). Gender stereotypes consist of prescriptive and proscriptive standards. These standards prescribe what kinds of behaviors and traits men and women should display and proscribe behaviors and traits they should not display

(Prentice and Carranza 2002). Perhaps most importantly to the professionalization of nursing is the historic association of virtue and selflessness with femininity in the early 19<sup>th</sup> century (Bloch 1987) and continuing into the present (Williams 1991). As I will explore below, this stereotype acts as both resource and constraint in the professionalization of nursing, as it allows for association with norms of service, but sanctions self-interested claims for remuneration.

If occupations are successful in professionalization one significant reward is “extraordinary autonomy – the authority and freedom to regulate themselves and act within their spheres of competence” (Wilensky 1964: pg 146). Scholars of professions near universally recognize autonomy, nationally and individually, to be both a central goal of professions and a significant signifier of success in professionalization. Of course, it should be noted here that autonomy itself is, likely as a result of the gendered division of labor (Diekmann and Eagly 2000), stereotypically associated with men (Holmes 2006). Nursing was one of the 18 occupations that Wilensky examined; in 1964 he classified it as a profession in process, having not yet completed the necessary stages of the professionalization process. Taking a cue from Abbot (1988), I am not necessarily concerned with definitional squabbling or classification, but rather aim here to unpack the evolutionary trajectory of a feminized professional project in all its complexity. So I will note when and how nursing reaches these benchmarks and their effects, but with the understanding that they are not necessarily guarantees to some reward. Additionally, it is fundamental to understand that “professions” are not monolithic entities, but encompass a collection (more or less diverse) of institutions and practitioners that may have both complimentary and competing interests or visions.

A significant tension at the heart of twentieth century nursing is the competing visions of professionalization and unionization. The autonomy and exclusivity granted by professional

status should make unionization unnecessary and the service orientation of professions should make unionization unappealing, so it is not uncommon for scholars and professionals to claim that unionization and professionalism are incompatible. Unionism and professionalism are on face contradictory impulses at both the structural and ideological level. At the structural level, professionalization, if successful, elevates professionals to a class status above the proletarian fray. Parkin (1979) argues that in modern capitalism the dominant classes are (1) those that control the means of production or control productive capital and (2) those that have a legal monopoly over professional services; and he defines professionalization as a strategy of exclusionary closure, that attempts to attain a legal monopoly through state licensure and credentialism. Ehrenreich and Ehrenreich (1979) argue that the “new class” of professionals and managers stand in opposition both to the capitalist and working class. As Larson, puts it “professions are outside and above the working class, as occupations and as social strata” (1977, pg xvi). One aspect of professional autonomy (won through monopoly) is control or at least influence over management and the setting of wages, thus making unionization not only unnecessary, but contradictory. Take professors as an example, traditionally they govern aspects their own employing organization through the academic senate and often have influence over administration. Organizing in a union when this control is operational does not make sense because the union members have more powerful options over their employing institution.

Ideologically, unionization and professionalism are seemingly incompatible in two ways. First, unionization and professionalization offer competing outlooks in terms of strategy, goals and rewards in the workplace. While both processes are collective endeavors, ultimately, professionalization seeks to reward individuation as opposed to unionization’s emphasis on solidarity, collective identity and collective benefits. As Larson (1977; pg 157) argues,

As professionalizing occupations move to create and affirm collective worth, one of the incentives for participation, as well as one of the major goals of the movement, is to secure the supports for *individual* dignity and *individual* careers. ... For most professionals, the coveted autonomy over the conditions and the technical content of work is *also* an element of qualitative distinction between professional work and subordinate or proletarian occupations. The expertise in terms of which all this is claimed is *also* a basis on which to exact deference and compliance in personal interaction. Individual differentiation, even though it must be attained within a collectivity and by collective means, is therefore a major promise of the professional project.

Second, the orientation of benefits from organizing in a union or a profession are at least presented in opposing fashion. Organizing professionally is supposed to benefit the public as a whole, while organizing in a union is supposed to benefit the workers within that union or potentially the working class more broadly. The struggle for professionalization is one in which the profession must make claims to the public, where they must make the appeal that their professional status will ultimately be a public good, not merely, a good or even right of its practitioners. On the contrary, though unionizing workers do sometimes make claims about the public good, fundamentally their struggle is about the wellbeing of the workers they represent and the relationship between workers and employers.

Despite their differences in outlook, unionization and professionalization do share the fundamental goal to protect their members. By different means, both want to decrease the exploitation of their labor and to secure dignity. When workers join and participate in these organizations and their strategies they are implicitly endorsing them as viable means to these ends. It also follows that different individual and/or collective circumstances and needs will make one or the other more or less attractive. The ANA and later the NNU and other nursing unions claim both mantels of union and professional association. The challenge, then, is whether these seemingly competing organizing strategies can be adjudicated, and if so how? Both

professionalization and unionization historically were the realm of male workers, so perhaps in a female dominated profession neither strategy has exclusive purview and hybridization is more necessary or effective. Despite the characterization of the opposition of professionalism and unionization, increasingly these boundaries are being blurred as professions experience proletarianization and unions fight for professional goals.

One hundred and twenty years after US nursing founded its first professional association nursing has hit many of the benchmarks of professionalization, been frustrated in others and shunned and embraced unionization. This history provides a roadmap of nursing professionalization, while highlighting the challenges of professionalizing a feminized occupation.

#### *1860-1945 – Nursing Emerges in the United States*

The first major appearance of secular, paid nurses in the United States was during the Civil War when the U.S. Army established a Nurses corps to assist in battlefield medicine (Egenes 2009). By the 1870s nursing schools had been founded around the country and in 1873 the first trained nurse graduated from nursing school. These schools maintained some important characteristics of the religious origins of nursing. Schools screened candidates based on “good character” and embraced the service orientation and economic values established by religious orders of nurses, eschewing the unrespectable past of secular nursing (Judd, Sitzman and Davis 2010). Although she never practiced in the United States, it would be hard to overstate the influence of Florence Nightingale on American nursing. The first nursing schools in America were modeled after the Nightingale School at St. Thomas’ Hospital in London. Nightingale believed and taught that woman became nurses through the “disciplined honing of their womanly

virtue” (Reverby 1987, pg. 105). She stressed character development, strict adherence to hierarchy and authority based in duty rather than rights or expertise. Although nursing students did not take vows of poverty, chastity and obedience, they were expected to strive towards those values. The intense gendering and religious origins of nursing continued to characterize the profession for decades (Reverby1987).

In the 1890s two major professional associations organized to represent nurses and nursing issues. What would later become the National League for Nursing (NLN), the American Society of Superintendents of Training Schools for Nurses was formed in 1893. In 1896 American Nurses formed their first national professional association, the Nurses’ Associated Alumnae of the United States, later renamed the American Nurses Association (ANA). The earliest goal of the ANA was to normalize the profession. Part and parcel with this goal were the efforts to standardize educational requirements in nursing schools, done in concert with the NLN, and to enact licensure laws across the country (ANA 2007; Group and Roberts 2001), in other words to create a credential and legal system of closure.

The first licensure law was signed in 1903 in North Carolina and by 1923 all 48 states had enacted licensure laws. These laws met with serious resistance from hospitals, sanitariums and “sham schools” as well as state medical associations. The primary objection was “pecuniary” to use the language of nurses at the time. When these laws failed, it was often “through the influence of medical men who have private interests of a commercial character at stake,” as Sophia Palmer explained in a 1904 editorial in *American Journal of Nursing (AJN)*. These organizations and/or the people they represented recognized that the laws, as proposed, would, by virtue of denying untrained/unlicensed nurses the right to practice, drive up the costs of

nursing labor. The laws that were eventually adopted in state after state avoided this issue though compromise: unlike other professions, these first licenses were permissive rather than mandatory. Which meant “these acts neither defined nor effectively limited the practice of nursing, and although all the laws included provisions for licensure as a registered nurse, none prohibited the untrained from practicing as nurses” (Schorr and Kennedy 1999; pg 18). To illustrate, compare sections 10, 11 and 12 of the first Nurse Practice Act as proposed by the North Carolina State Nurses Association to the final adopted version (presented in Table 3.1). The section which made licensure mandatory was completely excised in the adopted version and the adopted version explicitly allows non-trained, non-registered nurses to practice the vocation of nursing.

<b>Table 3.1: Proposed vs. Adopted Wording, 1903 North Carolina Nurse Practice Act</b>	
Proposed Wording - NCSNA	Adopted Wording – 1903 North Carolina Nurse Practice Act
Section 10: This Act shall not be construed to affect or apply to the gratuitous nursing of the sick by friends or members of the family, or to any person nursing the sick for hire who does not, in any way, assume to be a registered or trained nurse.	Section 10: Nothing in this act shall in any manner whatever curtail or abridge the right and privilege of any person to pursue the vocation of a nurse, whether trained or untrained, registered or not registered.
Section 11: Every person who shall duly receive license in accordance with the provisions of this Act, shall be known and styled a ‘Registered Trained Nurse,’ and it shall be unlawful after twelve months from the passage of this Act, for any person to practice professional nursing of the sick as such without a license from the State, or to advertise as, or assume the title of trained nurse, graduate nurse, or to use the abbreviation of T.N., G.N., R.N., and R.G.N., or any other words, letters or figures to indicate that the person using the same is a trained, registered or graduate nurse.	Section 11: That this act shall be in force from and after its ratification.
Section 12: That this act shall be in force and effect from and after its ratification.	Section 12:

Source: [North Carolina Nursing History - Appalachian State University 2016](#)

State nurses’ associations accepted, if not always welcomed, physician involvement in licensure, certification and registration. Practically all of the voluntary license laws included



some degree of physician oversight, with physicians serving on registration and examination boards and allowing for physician's signatures in place of a diploma or certificate from training schools. This oversight was consistent with physicians' roles in educating nurses and legitimating nursing education.

Both hospitals and physicians had competing internal motivations where nurse training and licensure were concerned. Both groups desired superior performance as they recognized the importance of good nursing to patient outcomes, but also needed to keep the price of nurse labor low. As early as 1869, the American Medical Association was decrying the poor, inadequate training of nurses and its deadly consequences; they bemoaned that "thousands of human beings are daily lost by bad nursing" (AMA 1869) and called for the immediate establishment of nurse training schools. Yet even though they continued to call for increased training of nurses they also warned that "The trained nurse for ordinary service has become inaccessible, except to the rich and for institutional" (AMA 1924). So voluntary licensing schemes enabled the creation of guidelines for trained nurses, but also allowed for the employment of untrained nurses when the economics demanded it.

Additionally, physician support of nurse education, when offered, tended to promote "training" over "education." In their 1919 report to the AMA, the Committee on Nurse Training, argued that the 2<sup>nd</sup> biggest problem in nursing education, behind only the lack of central organization, was that "[t]here is too little systematic instruction in practical work and too much theory, and certainly a lack of correlation between the two elements," again in the 1925 follow-up to that report, they would recount:

The problem of nurse education, which has become an acute one, shows small progress, in the council's report, toward solution. The present course of nurse

education is not providing nurses willing to do the ordinarily accepted duties and accept the ordinarily expected responsibilities of nursing the sick. Science is overshadowing art in a profession which is largely, if not mainly, dependent on art for its successful practice.” [Explaining that], “In the matter of nursing education, there has been a serious situation there in that there has been a tendency on the part of the nurses' organizations to get the whole problem of nursing education out of the hands of the medical profession. We are very anxious to maintain an important and proper relationship to nursing education (AMA 1925)

Though nursing leaders hoped to step out from beneath medicine’s shadow, they maintained close-ties with physicians – consistently inviting them to speak and offer council at annual meetings, in their journals and importantly at nursing schools. In these nursing specific places physicians offered a consistent view of nursing that was and always would be subservient to medicine. While there was variation in the extent to which they granted nursing’s value, difficulty and expertise – when physicians spoke about nursing to nurses (in their official capacity) they tended to reify the dominate/subordinate relationship, downplay the importance of education (as opposed to training) and extol the virtues of nursing most closely related to “natural” femininity. Dr. William Alexander Dorland, offers a vivid example in his 1908 address to the graduating class of the Philadelphia School of Nursing.

If a little knowledge is a dangerous thing in most avenues of employment, in nursing it is more than dangerous – it is fatal. Good nursing is not facilitated by too elaborate an education in professional matters; rather it is hampered or even rendered useless thereby. ... a nurse may be over-educated; she can never be over-trained. A good nurse is born, not made (Ashley 1976; pg. 77).

In 1910, Dr. Sigmund S. Goldwater, gave the welcome address to the ANA’s annual convention. Though the subject of his welcome was primarily focused on the burgeoning area of public health nursing, he too, relies on and propagates the same assumptions. In describing the new kind of nursing, he says that:

All nurses are not temperamentally or intellectually adapted for all or for any part of the new work that cries out for attention. There is no cause for regret in this,

because the older function of ministering to the sick at the bedside cannot and should not be abandoned. Its old value remains; it has lost none of its attractiveness which it has always had for a certain type of woman, whose devotion to the ideal of personal service imparts a spiritual grace to whatever she undertakes in this kind ... While other occupations may be as good, I am sure that there is none better, none worthier of emulation and support, than that of the woman who, with humble and patient faith in the power of human effort, dedicates her life to the battle against disease... (*AJN 1910*; pp. 805-806).

Though certainly glowing praise in some respects, it also reveals a double-edged nature. While commending the moral capacity of nurses, he also reifies the qualities their humble servitude, feminine grace and for many nurses: lack of intellectual capacity.

Though the medical profession's paternalism often had the veneer of geniality, in more contested struggles this veneer was often abandoned. To defeat a nurse registry act in Pennsylvania in 1909, physicians created a publication outside the purview of the AMA to distribute a more caustic anti-nurse sentiment. The publication opened with:

Every physician knows, and every nurse ought to know that the business of nursing was created by the medical profession. The physicians have opened the door of this opportunity and put the nurses in the way of acquiring the necessary knowledge and skill.

And went on to include declarations and insults like the following:

The only latitude a nurse should be allowed is a strict obedience to orders; if she keeps the sick-room in a sanitary condition besides she will be busy enough. They require no more legal standing than a capable cook or chambermaid in the same house.

Pleasing the doctors is the surest way to add jam to your bread and butter  
Obey the doctor in all things. Be thoroughly loyal to him in all you do and say.  
The 'R.N.' ('Real Nuisance') nurse is not wanted.

Nurses of the state registration type would change that title (Angel of Mercy) to "officious meddler" or "grasping commercialist," but the rank and file of the working nurse repudiate the selfish leadership of those self-seekers and will cling to the old ideals with loyalty to physician and devotion to the patient.

(*AJN 1909*; pg 5).

Although perhaps more bluntly put than what was expressed in official communication of the AMA the same positional attitude ran deep in the more respected organization.

The ANA in its mission to weed out interlopers and normalize the profession, also made heavy use of similarly gendered and classed tropes. In the welcome address to the ANA in 1900, at the emergence of the profession, Mrs. Mary Cadwalader Jones, a prominent advocate for nursing education, typifies the characterization of untrained, “born nurses”. First they were not properly subservient to physicians:

The 'born nurse' flourished especially in country districts, and was called in often without reference to the doctor, thus becoming his colleague, so to speak, if she approved his treatment, and not if she happened to disagree with him. I can remember several cases where these 'born nurses' directly disobeyed the physician's orders (AJN 1900, pg. 71).

And, second, they violated norms of middle class femininity. They were promiscuous, they were unmarried and worked into old age, and they drank heavily:

The nurses were of two kinds, --either elderly stupid creatures who had not sense enough to be house servants, and who had usually more than a taste for drink, or else they were young women of rather lively tendencies who were always ready for a flirtation with the house staff. In those days it was a risky thing for a doctor to order liquor for a case, as he was very likely to find the nurse the worse for it and the patient none the better. If, on the other hand, he strictly forbade any stimulant whatever, the sympathetic attendant was ready, for a consideration, to smuggle some in for the patient when she brought her own supply (*ibid*, pg. 72).

Later in her address, she would assert that “I am convinced that no woman can be really a good nurse who does not love nursing and to whom each patient is not more or less like her own child” (*ibid*, pg. 72), again connecting nursing to motherhood and desirable femininity. This cultural reasoning would be embedded into the logic of nursing’s leaders and professional associations for generations to come.

With both gains and setbacks on its quest for professionalization, nursing was not soon to reap the economic or social rewards associated with professional status. In her 1920 address to the biennial convention, ANA President, Clara D. Noyes, RN, recognized that thousands of

nurses were leaving the profession. While she noted that some of this was due to the degradation of their work, she seems to take affront to the notion that low wages may be the cause.

We hear quite generally that commercialism is invading the ranks of nurses and some rather distressing stories are being told of excessive charges and of arbitrary and un-nurselike attitudes. ... It is unfortunate, however, if there is any truth in these statements, as the nursing profession because of its uncommercial attitude and high-minded devotion to the principles laid down by the founder of modern nursing, Florence Nightingale, has been able to obtain a position in the minds and hearts of the great public that I believe no other profession enjoys. While it is true that "Every laborer is worthy of his hire," we believe that we must still continue to make a few sacrifices, we are still pioneers and we should count it still a glorious honor to keep the lamp, lighted by Florence Nightingale so many years ago (*AJN* 1920; pg. 784).

During the first quarter of the 20<sup>th</sup> century most graduate nurses worked as private duty nurses and hospitals primarily utilized unpaid student nurses. This situation resulted in extremely low average incomes for nurses, documented as early as 1928, by the Committee on Grading Nursing Schools (Wagner 1980). When nurses organized or agitated for better wages or working conditions they were chastised for lacking the proper missionary spirit or womanly devotion (Reverby 1987). The internal culture of nursing, as well as the culture at large, expected nurses to embody the virtuous, missionary spirit of Nightingale's original vision. Relatedly, nurses, like many working women at the time (Ly 1985), were expected to remain single while effecting their duty; in 1920 over 80% of American nurses were single (D'antonio 2010). Because nursing schools were producing more student nurses than could be employed by the burgeoning hospital systems, graduate nurses often had to wait long periods of time for work (Alt White 1987).

The Great Depression only made this situation more dire; increasingly fewer private nursing opportunities existed and graduate nurses were willing to work for meager wages. Seeing this opportunity many hospital administrators began switching to employing graduate nurses (who would sometimes work for only room and board) rather than student nurses (Judd,

Sitzman and Davis 2010). Although institutional employment in hospitals proved more stable than private nursing care had, it also put nurses in a position of relatively little power in large bureaucratic organizations. Before the depression  $\frac{3}{4}$  of all RNs worked as private duty nurses, by the end of the depression almost  $\frac{3}{4}$  worked in hospitals. In hospitals nurses found themselves “as salaried employees with low wages, long hours and few benefits” (Alt White 1987, pg. 17), along with these changes these nurses experienced “a diminution of independence, increasing stratification, and division of labor” (Wagner 1980). After years of working at professionalizing by increasing standards of education, creating licenses and legislation, economic change and the restructuring of U.S. medicine was wreaking havoc on the average nurse’s life, both their daily work experience and their economic wellbeing. But the primary professional organization, the ANA, had little choice but to stay the course. A nurse’s letter to *AJN* in 1906, shows what kind of attitudinal challenge the ANA might have in talking about wages: “So long as we talk of ‘wage’ and ‘uniform charges,’ we put ourselves upon a trades-union basis, and need not be surprised if many people look upon our registration laws as they do upon those of plumbers, instead of as we wish them to do, viz., as upon the laws of the medical profession” (Bushey 1906; pg. 45). This dilemma meant both denying the problem was important while offering solutions that would help few nurses in the immediate term. They identify the problem of nurses’ low wages as primarily an issue of overproduction and seek to limit that production and alleviate the problem by closing small hospital schools.

As the ANA pleaded with hospitals to close their schools and to stop employing student nurses (both sources of consistent cheap labor), unions were organizing around the country. During the 1930s both the AFL and CIO recruited nurses to unionize. The ANA, long opposed to unionization, reiterated their position in a widely circulated 1938 editorial in *AJN* entitled

“Union Membership? No!”, in it they argued that “Members of the ANA, you can be partners in success through your own organization. You need no union.” And that,

Nursing occupies a unique place in the minds of the people. It is one of respect, even of affectionate respect. To our people the nurse is essentially a giver--a giver of comfort. This fundamental concept psychologically is at war with the need of the individual nurse for reasonable working conditions and for economic security. It is also at war with the methods of the unions. (ANA 1938; pg 1)

Here it appears that they don't only rely on the professional ethic to deny unionization, but invoke specifically gendered ideals of selflessness and nurturance. Despite the ANA's efforts, by 1939 an estimated 5,000 nurses had become union members and the CIO<sup>18</sup> had established nursing locals in 9 states (Melosh 1982) and a national nurses union had formed under the AFL (Geiger 1939). In a 1939 article in *RN*, Geiger describes how nursing leadership responded to encroaching unionization, “fanciful nightmare currently giving some nursing leaders a bad case of the jitters, as more and more nurses enroll under the banners of trade unions” (pg. 10).

Interestingly, it is this organizing that seems to have shifted the tide within the ANA. When the ANA's lawyer, William C. Scott addressed the biennial convention in 1944 it may have been the first time a representative of the organization publicly spoke in a neutral way towards unions. In his address, he commented that “One of the strongest arguments in favor of collective bargaining by the state nurses' associations seems to be the very definite trend toward collective bargaining as a national policy and the fact that labor unions have attempted at various times to organize certain sections of the nursing profession” (Scott 1944; pg 231).

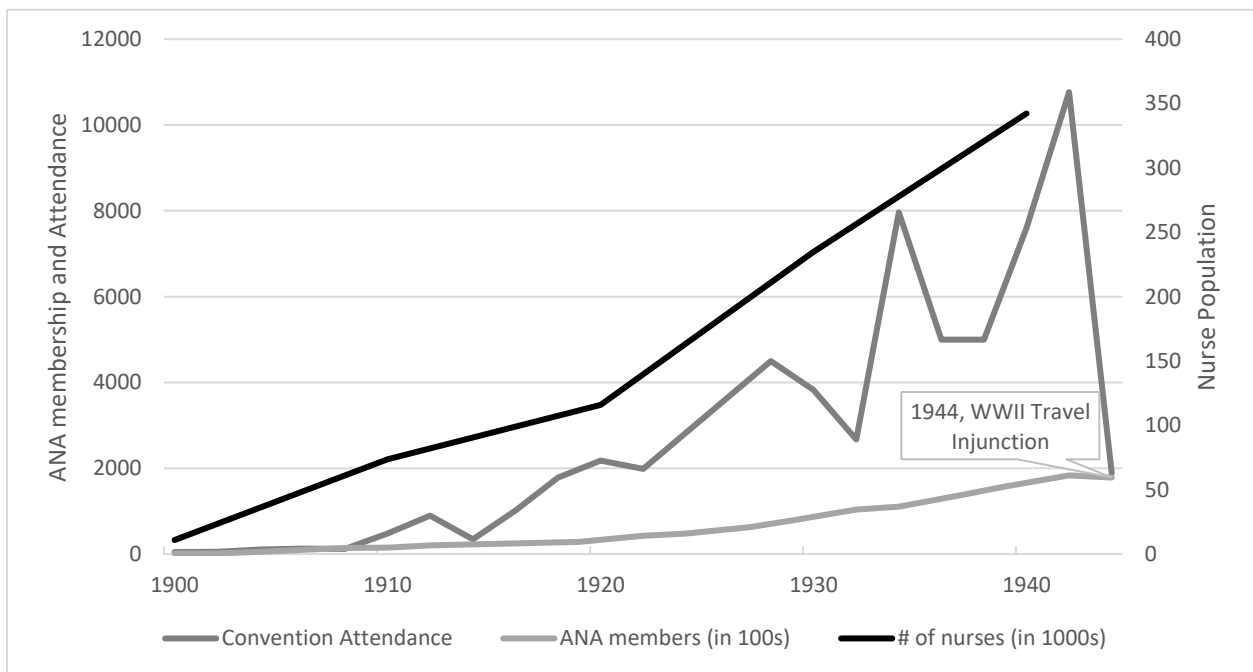
Whatever the setbacks in professionalization, undeniably the profession was growing. Between 1900 and 1940 the nurse population increased dramatically, the U.S. Census counted

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<sup>18</sup> CIO “Nurses' Union” (likely an adhoc name Geiger assigned to a collection of locals) and AFL “National Nurses Association” (Geiger 1939).

approximately 10,000 “professional nurses” in 1900 and over 340,000 in 1940. Even more dramatically, the ANA had only 1700 members in 1900, but had grown to more than 178,000 members by 1944. In just 4 decades the association grew its membership 10,000%. Importantly membership participation in the biennial conventions exploded during the period as well. Going from only 48 attendees at the 1900 convention to more than 10,000 in 1942 (attendance was below 2000 in 1944 as a result of a federal travel injunction for war). Here we see not just growth in practitioners, but healthy growth in the professional association and participation in the association. In fact, participation and membership in the profession grew at much faster rates than did the occupation itself.

**Figure 3.1. The Nurse Population, ANA Membership and ANA Convention Attendance, 1900-1942**



Sources: Nurse Population - IPUMS USA; ANA membership – “Facts About Nursing”; Convention Attendance – Biennial Convention Reports - AJN



### *1946 – 1980: Two Roads Converge in a Wood*

By the end of WWII, the nursing surplus was over, indeed, improved nursing education and the rise of hospitals had conspired to produce a shortage of nurses. However, this did not produce a significant increase in wages. “A Bureau of Labor Statistics survey indicates that the average annual salary for nurses in 1946 was about \$2,100. Many female industrial workers and secretaries, and most teachers and social workers, were paid more than this; moreover, nurses worked longer hours, more night shifts, more split shifts, and received fewer fringe benefits than any comparable group of workers” (Bullough 1971, pg. 275). Rather than the shortage providing much needed wage increases and benefits, problems of shortages were more often dealt with by further stratifying nursing work and establishing the nursing team, so we see the development and increased use of the practical nurse and nurses’ aid (D’Antonio 2010).

In response to mounting pressure, at the 1946 ANA Biennial Convention the house of delegates adopted the first economic security program (ESP) that, among other items, authorized the state nurses’ associations to act as bargaining agents on behalf of their members. The 1946 economic security program, based on the ESP developed by the California Nurses’ Association, was adopted unanimously by the house of delegates. This was a momentous change on the part of the ANA who, just 8 years earlier, had staunchly disavowed collective bargaining generally and unionization particularly. Even in 1942, *AJN*, published an editorial on low hospital salaries which explained, that “service and salaries, to most nurses and to most patients, are conflicting concepts. Real nurses like to give good care and they dislike having to argue or bargain for adequate financial rewards” (AJN 1942; pg 1294). But the California Nurses Association, led by Shirley Titus, had established its own ESP, in violation of the national association’s policies, and

had been engaged in collective bargaining for several years by 1946. Traditional unions were aggressively organizing nurses by this point as well, going so far as to sign up nurses outside of the 1946 biennial. So while the ESP made sense for the ANA it was also a necessity as competition from other organizations impinged and pressure from below grew. Because the ANA held the position that collective bargaining and the professional values of nursing were incompatible for so long, even with popular support among nurses, reversing course required a strong explanation.

ANA officials argued that the ESP was necessary because the economic conditions of nurses were unacceptable, they hurt patients and that previous methods for improving the economic conditions had failed. As explained in *AJN*:

We have tended to rely, in the past, on education and persuasion as the only tools to bring about reasonable working conditions. We have issued statements of recommended personnel policies-but we have had to depend on the understanding and good will alone of the employer to put them into effect. ... Nurses have never had a real opportunity to participate in the determination of the conditions under which they are employed; they have had to accept what was given to them. (1947; pg 70)

Recall that one of the central aspects of professional status is the autonomy of self-determination of working conditions. To this point, licensing, credentialing and claims-making had not provided those opportunities to nurses. Nurses were not afforded that standing in their employment arrangements, rather like other workers, their wages were determined by their employers. Without acknowledging it, nursing was turning to unionism, at least in part, because professionalization was not forthcoming. Even so, in turning to new strategies, nurses had to argue not simply on behalf of their own well-being, but rather asserted that their economic conditions detracted from their effectiveness in serving others.

Despite the significance of this change in policy, the ANA attempted to show in a number of ways that it was not fundamentally new and did not conflict with professionalization. In their 1947 explanation of the ESP, *AJN* writes:

The ANA has always recognized that satisfactory working conditions were essential in the production of quality nursing service, and the economic welfare of nurses has always been one of its objectives. One of its original purposes, when it was organized in 1896, was 'to promote the usefulness and honor, the financial and other interests of the nursing profession.' So the adoption of the Economic Security Program represents no new ANA objective; it does represent, however, a *new means of reaching its objective*. (pg 70)

In addition to assuring members that collective bargaining was nothing more than a new technique for addressing a long held issue, it was also important to ensure them that bargaining would not degrade the professional status of nursing. In direct contrast to claims made only a few years prior they argued that not only would collective bargaining not detract from professional status, but it would actually improve it.

Adoption of the economic security program will not alter the professional status of nursing nor the goals which nursing has always had. Our ultimate aim has always been, and will continue to be, that of providing optimal nursing service. Resolution of economic difficulties should make it easier for us to achieve that goal, thereby improving both our professional status and professional service. (*AJN 1947*; pg 72)

Again the reassurance is that there is nothing really new. Strategically, this allows the ANA to adopt a new strategy which was not just previously rejected, but was rejected as being fundamentally counter to the mission of the organization. As discussed above, collective bargaining especially as associated with unionization represents a completely different ideological stance on the part of any occupational group. So, the professional organization could not just retroactively incorporate this strategy into existing ideological lenses, but had also to simultaneously distance itself from the kind of organizations (unions) the strategy is typically

associated with. In discussing the economic security program, the ANA, reiterated time and again “collective bargaining is not to be confused with labor unionism” and “collective bargaining is used by many organizations other than labor unions.”

Collective bargaining is, of course, a core function of trade unions in the United States (Freeman and Medoff 1984), but technically speaking not all employee organizations that engage in collective bargaining are unions. Although it may seem a distinction without a difference, ideologically and strategically the ANA’s approach to collective bargaining did differ significantly from most unions at the time. The economic security program as outlined at the 1946 biennial convention and later explained in the pages of the *American Journal of Nursing* advocated that state and district nurses’ associations act as bargaining agents for nurses. But it also supplied a roadmap for attaining economic security for which bargaining was only one part. The basic strategy was as follows: 1) nurses at various levels of aggregation (workplace, district, and state) determine minimum conditions of employment (wages, overtime, sick leave, etc.) and 2) publicize these standards – to hospitals, medical groups and the public at large. At this stage, “many hospitals, once informed of these minimum employment standards, will promptly adopt them” (AJN 1947, pg 71). If, however, they do not adopt these standards, nurses should 3) engage in a public relations campaign to present your case to the public and “if public opinion thereby becomes sympathetic to your cause, that alone may be sufficient to persuade the administration to grant your requests” (AJN 1947, pg 71).

Assuming that alone is not successful in persuading an employer the nurses should 4) request that the state association represent them as a bargaining agent. If the employer

recognizes the state association as a bargaining agent<sup>19</sup>, negotiations will begin, once an agreement about your employment conditions is reached which is satisfactory to both you and the hospital management, it is usually expressed in the form of a written contract” (AJN 1947, pg 71). For the most part, the final result is presented as a foregone conclusion, but they do note “some employers, not wishing to have a contract with nurses or even to enter into negotiations, may refuse to do this. In that case, a sound public relations program as well as the repeated expression on the part of the nurses for improvement in their employment conditions, will be important in persuading employers of the desirability of collective negotiation with the professional association” (AJN 1947, pg 71).

Unlike most unions, for ANA state affiliates attempting to secure collective bargaining agreements, striking was strictly forbidden by the national association. While public relations campaigns can be and were effective, the ability or threat to collectively withdraw labor is a critical leverage point in employee/employer negotiations. The ANA specifically declared in the ESP that “Under no circumstances would a strike or the use of similar coercive measures be countenanced.” Explaining that, "The admiration and the respect which the public has for nurses is our strongest instrument; if reasonable standards are established, the public will not fail to accept and support them." (AJN 1946; pg 729). Nurses had to walk a delicate path – they had to advocate for their own economic interests to the public while maintaining their image of service. This was especially true because of the NLRA exemption for non-profit hospitals. Because hospital administrators were not required to acknowledge the collective bargaining rights of

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<sup>19</sup> This is a big if. The 1935 National Labor Relations Act made an explicit exemption for non-profit hospitals (by this point the largest employer of nurses), so they were under no legal obligation to recognize their employees' elected bargaining agreements or to negotiate with them.

nurses, nurses' only recourse was the public. Additionally, though strikes may have hurt the public perception of nurses, probably more importantly without legal protection striking nurses could simply be dismissed. This problem was further compounded by hospitals' virtual monopsony power over nurse employment. After rejecting unions for 50 years, the American Nurses Association tentatively embraced a kind of unionism with the Economic Security Program. However, ideologically, culturally and structurally the ANA's brand of unionism without unions and without typical union rights was hamstrung from its inception.

In addition to these myriad challenges, nursing still also had to contend with the American Medical Association, who were quick to condemn the ANA's decision. In their 1948 report on Nursing Problems, they wrote:

The nurses innocently erred in their action in Atlantic City in 1946 when they voted to have their state organizations act as bargaining agents for them. They are members of a noble profession. They do not need bargaining agents. The term bargaining agent carries with it the implication to strike even though it is true that they have never gone on strike. Medical men, nurses, and other hospital employees have not the right to strike anywhere, any time. They are dealing with that most priceless possession-life itself. (pg 5)

In addition to the patronizing, paternalistic tone of their condemnation, the statement invokes the dichotomy of the service orientation of professions and the orientation and tactics of unions. Despite the fact that nurses, not only hadn't ever struck as noted, and had explicitly disavowed the practice, as not noted, the AMA raises its specter. The AMA here asks that nurses live up to the "noble" obligations of professions, but also asks that when professionalization fails to reward practitioners (in the way it had for physicians) that they not advocate for themselves.

In the 1950s the ANA went about enacting its Economic Security Program. This primarily took the form of public information campaigns and attempts to negotiate with hospitals

at the local level. In 1954, the ANA resolved that the national organization should play a more central leadership role in this effort. One result of this resolution, after recognizing (counter to rosy proclamations in 1946) that hospitals by and large were resistant to nurse collective bargaining, was that in 1956, '58 and '60, the ANA petitioned the American Hospital Association and its constituents:

“to join with the ANA and its constituents in taking immediate steps to implement in all hospitals the essential procedures of collective bargaining: (1) freedom of employees to organize; (2) free choice of representation; (3) recognition of employee representatives and bargaining in good faith by representatives of employers and employees; and (4) negotiation of an agreement signed by both parties” (*AJN* 1958; pg. 981).

What they received in response was further resistance, as the *AJN* editorial staff put it in 1961 “During the 15 years of the ANA economic security program, the resistance of hospital administrators in dealing with their employees has grown stronger, more concentrated, and more organized” (pg 45). Some nurses were successful in their public fights, going beyond hospitals and obtaining special legal protections. The Oregon State Nurses’ Association was unique in its ability, in 1961, to author and pass a state law compelling hospitals to negotiate employment conditions with nurses. Four other states had similar, broader laws for hospital employees during this period, but the laws did not catch on.

In addition to fighting for collective bargaining, the ANA and state associations renewed their efforts for more comprehensive licensure. In 1948 New York State enacted the first mandatory licensure law requiring nurses to pass a licensure exam to practice in the state. Originally passed in 1935, the change was delayed to accommodate abnormal need during the Great Depression and World War II. Despite the obvious advantages of mandatory licensing, even after New York passed its law, the ANA would not adopt mandatory licensure as a national

goal until 1950. Many state associations had begun agitating for mandatory licensing laws and more rigorous nurse practice laws before the national association made it an official goal, but the support of the ANA certainly helped. Though some states achieved this goal faster than others, by 1970 the vast majority of states had enacted compulsory licensure laws (Schorr and Kennedy 1999; Egenes 2009). While strengthening licensing requirements for registered or professional nurses, many of these laws also clarified the role and requirements for practical nurses (licensed practical nurses or LPNs). As previously discussed, one response to nursing shortages was the further division and stratification of nursing labor. Though, formalized in the first decade of the 20<sup>th</sup> century, practical nursing expanded rapidly around mid-century.

Demographic changes were afoot as well. Another effect of the depression and later World War II was the increased employment of married women in nursing, in 1940 65% of nurses were single (compared to more than 80% in 1920) and in 1950 only 40% were single (D'Antonio 2010).<sup>20</sup> Interestingly the number of men in nursing decreased over the first half of the century, from a high of 9% in 1900 to a low of 2% in 1950 (D'Antonio and Whelan 2009). As periodic nursing shortages arose throughout mid-century, retired nurses were frequently recruited<sup>21</sup> back to nursing, further retrenching the demographic changes of nursing. During the post-war period U.S. culture swung back towards conservative gender roles and nursing was a conspicuous exception to the postwar ideology of domesticity, accordingly the cultural production of feminizing nursing greatly intensified (Group and Roberts 2001). Although, nurses were subordinate to physicians, they had “achieved enough expertise and authority to threaten cultural prescriptions for women” (Melosh 1983 pg. 164). Nurses took center stage in postwar

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<sup>20</sup> Only 25% of Registered Nurses were single in 2008 (Department of Health and Human Services 2010).

<sup>21</sup> Retired nurses at the time, were often still young women who left practice for married/home life.



literature in an entire genre of “nurse romances” which depicted nurses as pathetic or dangerous and in need of saving or civilizing from a benevolent doctor/lover (Group and Roberts 2001, Melosh 1983). As clearly depicted in the cover art (see Figure 3.2 for a selection of these novels from the late ‘40s to the early ‘60s), these romances also further retrenched the vision of nursing as feminine, properly submissive and naturally subordinate.

**Figure 3.2: Select Nurse Romance Novels, 1947-1964**



Between 1946 and 1966, a period that saw increased licensure laws, increased demand for nurses as a result of federal laws and a burgeoning union movement, registered nurses in the United States made significant gains in income. In 1966 their average annual salary was approximately \$5,200, almost two and a half times the 1946 average salary of \$2,100 (Alt White

1987). The mean annual earnings for women in 1947 were \$1,262 and \$2,389 in 1966. While men's average earnings increased from \$2,611 in 1947 to \$5,956 in 1966 (U.S. Census Bureau 2011). Unfortunately, over the same period the cost of living had doubled and the salaries paid to nurses still didn't compete with other professions that required similar amounts of education or as difficult hours (Alt White 1987). Speaking to a reporter at the Chicago Tribune in 1966, Dr. Mary Mullane, dean of the college of nursing at the University of Illinois, Chicago explained "anyone who wants to get rich doesn't go into nursing. We don't ask for high salaries, tho [sic] we have been treated unfairly" the article goes on to explain the average nurse's salary in Illinois was \$398/month and the top salary was \$428, compared to the \$550/month starting and \$900 top salary for Chicago teachers (Enix 1966).

Nursing and the ANA went through significant political, ideological, and strategic transformations in the 1960s and 1970s. Yet these changes were sometimes contradictory as well. A large portion of nurses and their associations, sick of the lack of economic progress experienced in the previous decades embraced a more class conscious approach to economic security, their discussion of exploitation and strikes began to stoke up. At the same time, the ANA began to move forward in professionalization as the first move towards adopting the bachelor's degree as the minimum entry to practice. By comparison, already by 1960, 42 states had adopted the bachelor's degree minimum for elementary teaching (Stinnett 1960).

Although intermittently identified as a goal over the course of the ANA's early life, in 1960 the Committee on Current and Long Term Goals formally introduced the goal of having the bachelor's degree become "the basic educational foundation for professional nursing ... within the next 20-30 years" (*AJN* 1960; pg. 832). As nurses began to formulate new educational

standards, structural changes in the provision of medicine were underway. Significantly, the implementation of Medicare and Medicaid meant a huge increase in the demands for nursing and as medical science advanced nurses began to diversify and increase specialization. Indeed, recognizing this increased need, Congress and President Johnson, prodded by the ANA and other groups, enacted the Nurse Training Act of 1964 which funded the creation of new nursing schools, the development of new nursing curriculum, expanded the training of APN's and created a special loan program for nursing students (Judd, Sitzman and Davis 2010).

Recognizing the moment, in 1965, the ANA released "The First Position Statement on Nursing Education." The Position Statement had three primary directives: 1) all nurse training should be done in institutions of higher learning i.e. not in hospital schools 2) the minimum preparation for "professional nurses" should be a baccalaureate degree and 3) the minimum preparation for "technical nurses" should be an associate degree education in nursing. Passed by the board of directors in a non-convention year, the position did not formally need the approval of the house of delegates, however, at the 1966 convention it was hotly debated. Ultimately, despite contentious deliberation, the delegates did pass a motion to "commend the board of directors for-its farsighted action in issuing the position paper on education." Though certainly moving in this direction for a long time the official declaration was monumental. In 1964, 75% of all graduating nurses in the United States graduated from hospital diploma programs (see Figure 3) and the 1965 position statement, while recognizing these nurses as qualified, also said that moving forward their education was inadequate and not fit for the professional nurse. Additionally, the statement aimed to stratify RNs into two distinct categories: professional and technical; one of course standing above the other. Naturally this wasn't universally well received – this letter to the *AJN* editor in 1965 captures the mood of negative responses well:

The distinction has been made. The degree nurse has the better position, receives better wages, and is entitled to put the letters of her degree behind her name. It seems all they think about is status. I cannot and will not support the ANA if it is working to designate diploma and associate degree nurses as technicians! Diploma school graduates take the same state board examinations, pay the same fees, and even pay the same ANA dues. Shall they then be called technicians? I hope all diploma school graduates rebel. They have always been called registered or professional nurses. If the need is so great to change the term let the degree nurses change theirs (R.N. Kansas in *AJN* 1966; pg 995).

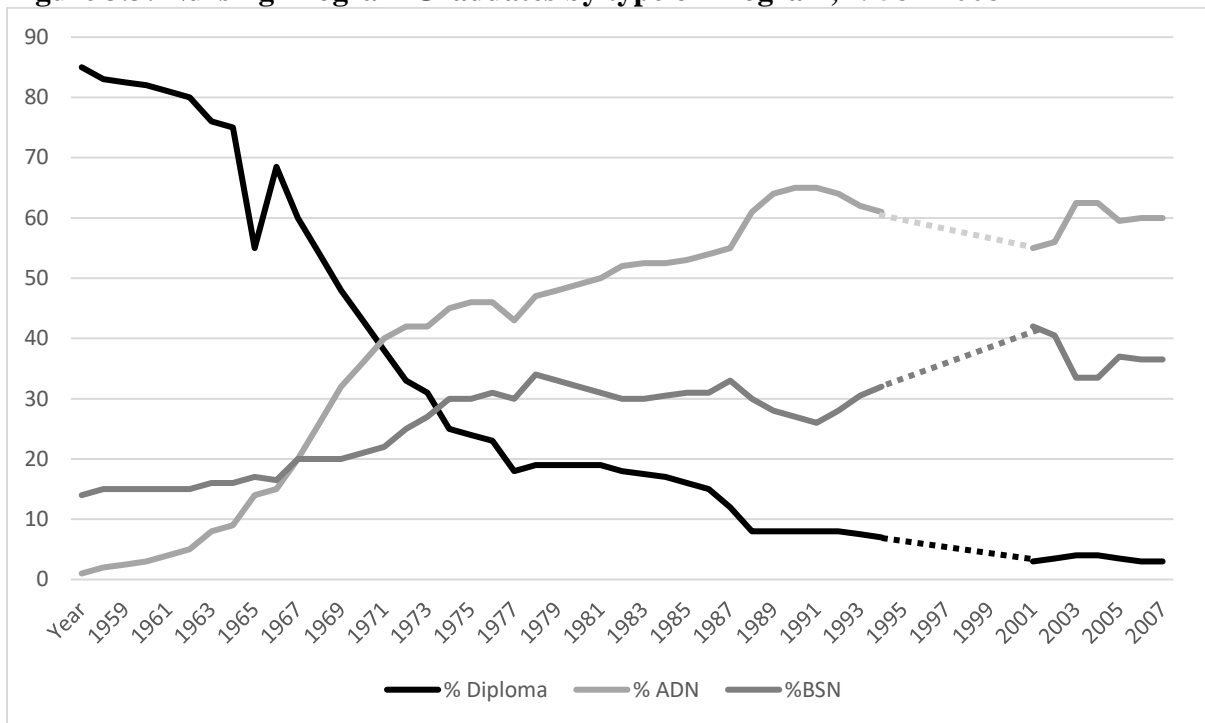
It is in this division that the cracks within the ANA and nursing begin to show. Whether or not increasing the barriers to practice was a necessary step on the pathway to professionalization, it was met with resistance from significant portions of the membership. Not to mention that at the time four out of five<sup>22</sup> professional nurses were not members of the ANA at all, the vast majority of whom did not have four year degrees.

Again as the ANA attempted to push toward a new plateau in professionalization they were met with resistance from the AMA. In 1970, the American Medical Association released a Position Statement on Nursing, responding to another nursing shortage, the direction of nurse training and the ANA. The first platform of the statement was that the number of nurses needed to increase in order to meet demand and with this end in mind also “encourage[d] and support[ed] all levels of nurse education.” They go on at significant length to praise the contribution of both diploma schools and budding community college associate degree programs, and write only that “[t]he Association also encourages baccalaureate education for individuals who plan to make education or administration their life work” about BSN programs (AMA 1970).

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<sup>22</sup> A number that would only degrade over time, but more on that later.

**Figure 3.3: Nursing Program Graduates by type of Program, 1958 - 2008**



Source: National League for Nursing, Nursing Datasource: Trends in Contemporary Nursing Education, 1981-1994; National League for Nursing, Graduations from Basic RN Programs by Program Type, 1986-87 to 1994-95 and 2002-03 to 2007-08

The number of hospital diploma schools and graduates from these programs shrunk dramatically after 1964. Increasing regulation associated with the Nurse Training Act increased the costs associated with operating hospital diploma schools and the explosion of community colleges and ADN programs provided a viable alternative. As a result, many hospitals shuttered their nursing schools in the coming decades. So to some extent, the 1965 position statement and the efforts it represented were wildly successful – they did move nursing education out of hospitals and into institutions of higher learning. As seen in Figure 3.3, between 1964 and 1977 the percent of nursing graduates coming from diploma schools decreased from 75% to just 18%. But while the ANA hoped that this education would primarily be replaced by BSNs it simply wasn't, ADN programs expanded much more rapidly. As we will see, met with resistance from

hospitals, physicians and nurses alike – the ANA was never to fully achieve its goal of making the BSN the standard for entry to practice.

In defiance of the 1950 ANA no-strike pledge<sup>23</sup>, throughout the 1960s nurses across the country, tired of the lack of response to the economic security program from hospitals, staged or threatened mass resignations. Though the use of mass resignations was discussed during the 1962 ANA biennial it is difficult to pin down when nurses first used the strategy. By 1966, major mass resignations were spreading across the United States, nurses in Ohio, New York, California, Iowa, Tennessee and Illinois (with other states to follow) hitting dead ends in hospital negotiations were putting everything on the line to secure better conditions of employment. The 1965-1966 mass resignation of nurses in Youngstown, OH and its response provides an illustrative example.

In 1965, 450 nurses at Youngstown Hospital, faced with “staffing and scheduling problems, lack of supplies, no input in decisions affecting nursing, physicians controlling promotions, a low starting wage, few benefits, and no pension” (Patton 1998; pg 80) approached the hospitals administration as a group to seek negotiations. The administration refused to see them collectively. In response to increasing pressure, the hospital offered “the most expensive nickel in hospital history”, a five cent per hour raise for part-time nurses (60% of the staff) and a

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<sup>23</sup> “In recognition of the fact that the nursing profession and employers of nurses share responsibility for provision of adequate nursing service to the public, the American Nurses Association, in conducting its Economic Security Program:

- 1) Reaffirms professional nurses voluntary relinquishment of the exercise of the right to strike and the use of any other measure wherever they may be inconsistent with the professional nurses’ responsibilities to patients.
- 2) Reaffirms its conviction that this voluntary relinquishment of measures ordinarily available to employees in their efforts to improve working conditions imposes on employers an increased obligation to recognize and deal justly with nurses through their authorized representatives in all matters affecting their employment conditions.

10 cent per hour raise for full time nurses. In response, the nurses reached out to the Ohio Nurses Association (ONA) to represent them in collective bargaining. The ONA reports that over the next year “a variety of methods was used to get the Hospital to recognize ONA as the exclusive representative of the registered nurses. However, most of them were ignored by the Hospital. The Hospital realized that ONA represented nurses were bound by the ANA no-strike policy” (ONA; pg 4).

Frustrated by the lack of progress and confronted with the reality that the hospital did not negotiate fairly, as assumed in the no-strike policy, the Youngstown nurses and the ONA decided to rely on their last recourse, the mass resignation. In September of 1966, 85% of the nurses signed a mass resignation letter to be effective two weeks later if the hospital did not recognize and bargain with the ONA. One week later the hospital association board notified the nurses that they recognized the ONA as their bargaining agent. After two and half months of negotiations with no agreement, the nurses reinstated their resignations and resigned en masse. Within two weeks they reached an agreement and were back to work. The ONA writes that “after the mass resignations in Youngstown, nurses throughout Ohio and other parts of the country received mysterious \$100 per month raises” (ONA; pg 5). Other reactions from hospital administrators weren’t quite as generous; one administrator responded with an angry letter threatening the ONA; a brief selection follows:

I’m sure that it has never occurred to you that your leadership does not really represent a great body of nurses in Ohio or the United States. Your leadership has obviously fallen into the mire of unionism and hasn’t even a faint aroma of professionalism now. You can’t keep a fire burning under the American public forever; even capable demagogues have learned this. (ONA; pg 6).

Nurses at this particular hospital organized collective bargaining with the ONA a few years later. In 1968, the ANA revoked its no-strike pledge. The decision, as explained by an *AJN* editorial,

That policy, which expressed a voluntary relinquishment of the exercise of the right to strike, was adopted in a mood of idealism and hope at a time when professional groups were just getting their feet wet in the use of collective action. After 18 agonizing and economically almost fruitless years, it finally became clear that the policy was unrealistic, practically unenforceable, and at best misleading, if not dishonest (Schutt 1968; pg. 1455).

Again, ANA policy became more friendly to labor organizing because it was pushed that way by the actions of nurses and state associations.

Aided by JFK's 1962 executive order granting federal employees the rights to collective bargaining and more substantially by the 1974 act of Congress that overturned the NLRA non-profit hospital exemption, nurses organizing flourished in a boom of unionization. Nurse organizing was not consistent across the nation, to be clear, the structure of the ANA dictated that state nurses associations were to be ultimately responsible for these issues and as a result collective bargaining was uneven across states. In 1966 the ANA alone represented 16,900 registered nurses in collective bargaining agreements; by 1974 the total rose to 66,000, 100,000+ in 1977 and 133,000 by 1988. Similarly wages for nurses in the United States consistently rose over that same period (Wilson, Hamilton and Murphy 1990).

The politics of the ANA were moving to the left as well. Throughout the 1960s and '70s, on issues of race, gender, and social programs – they increasingly embraced a liberal political agenda, having for the most part remained apolitical in previous decades. Growing closer to the feminist movement (Bullough 1971), in 1971 they endorsed the equal rights amendment, reversing their original 1952 position. In 1975, the ANA established a fund to promote the ratification of the ERA. In addition to desegregating the national association in 1946, repeatedly



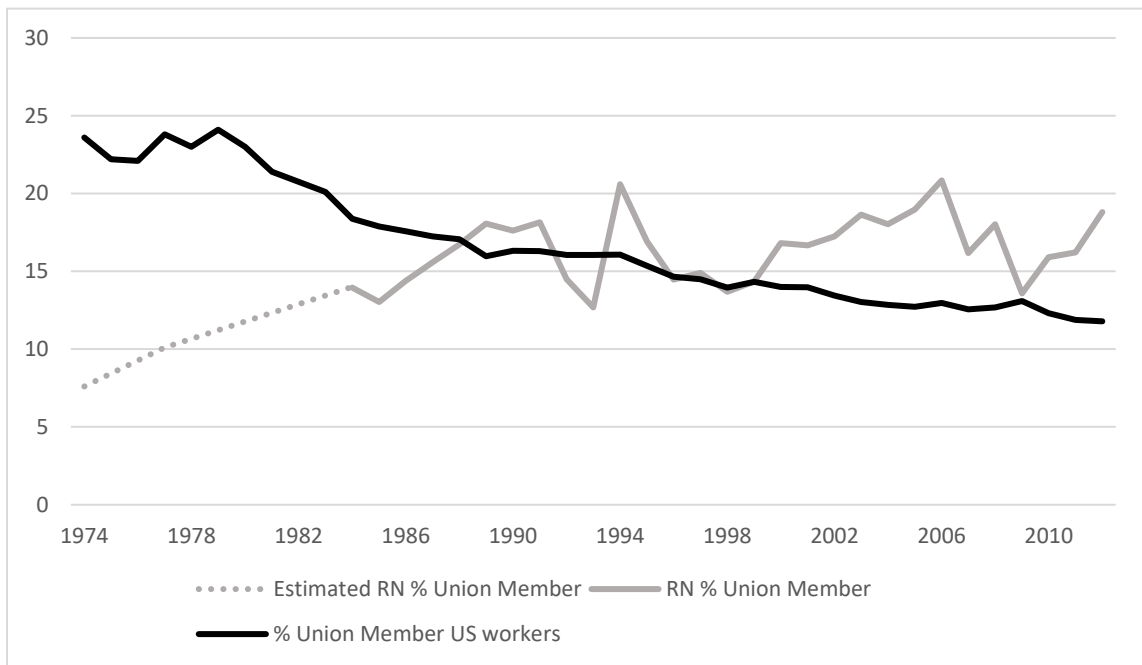
in subsequent years they pushed state associations to fall in line as well, and in 1972 they voiced support for national affirmative action and assigned a task force for Affirmative Action in Nursing. They also were leaders in the call for the right to national health care and in 1974 formally adopted support for a national health insurance program.

In the midcentury period the ANA scored major victories in its professionalization battles; nurses secured mandatory licensing in a majority of states and began to transition nursing education out of hospital schools. In addition to decrying the poor educational preparation of hospital schools, the ANA had long sought to replace hospital training because they identified this kind of schooling as “indentured apprenticeship” (ANA 1965). Hoping that these steps and the accomplishments of pre-war professionalization would propel them to new heights of prestige, authority and pay, what they found instead was greater resistance from physicians and hospitals especially. Physicians maintained their dominance socially and at work, which coupled with the image of feminine professionalization both built by and pushed on nurses, empowered hospitals to freeze nurses out of decision making, hold their wages down and saddle them with degrading non-nursing work. Stymied, nurses turned to collective bargaining as a way to ensure their economic security and long-term longevity of the profession. Their initial foray into collective bargaining, rejected unionization, embraced a “professional” ethic and pledged never to strike. Without the threat of withdrawing labor, hospitals for most part dismissed nurses’ efforts and still little progress was made on the ground. By the 1960s nurses had made progress in institutional professionalization for decades, but still earning significantly less than similarly skilled workers and lacked control or influence on the hospital floor. So they abandoned the no-strike pledge and turned up the heat on collective action. After scoring significant victories across the country and then being further empowered by the end of the NLRA hospital

exemption in 1974, nurses unionized rapidly, going from 7% unionized in 1974 to 14% just one decade later (even as other occupations saw significant declines in unionization over the same period) (see Figure 3.4).

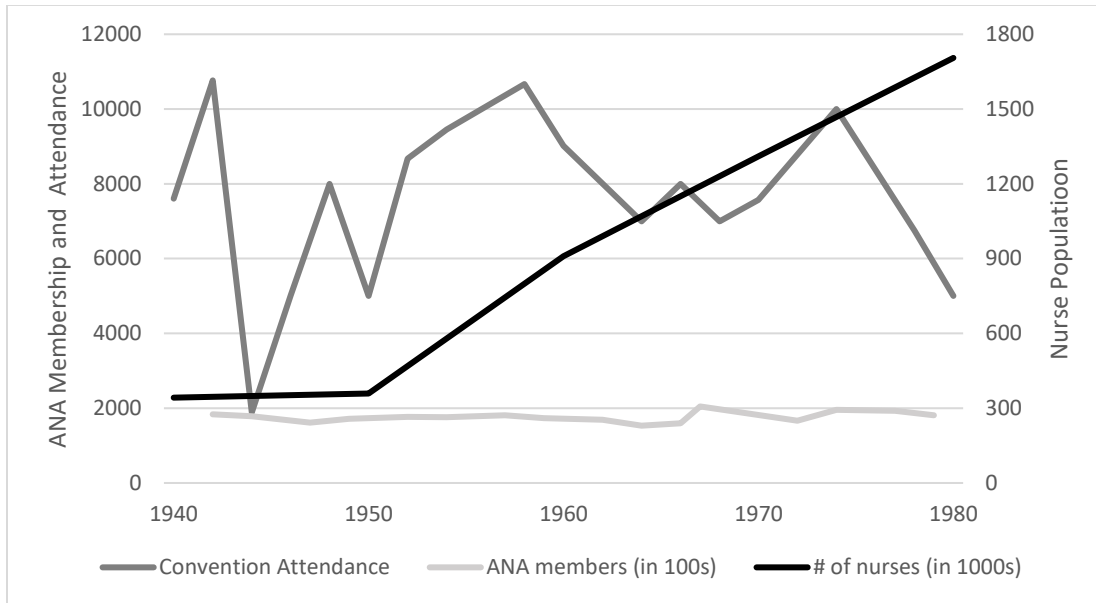
Despite gains in unionization, victories in professionalization and perhaps most importantly huge gains in the number of U.S. nurses, ANA membership and convention attendance were essentially stagnant from 1940 to 1980. The number of professional nurses in the United States, according to the US Census, more than quadrupled between 1950 and 1980, but membership in the ANA only increased by about 6%. So while in 1950, almost 50% of nurses were members of the ANA, by 1980 fewer than 15% of nurses were members.

**Figure 3.4: Unionization Trends - Registered Nurses vs. all Wage Workers, U.S. 1974-2012**



<sup>1</sup>Sources – Estimated RN % Union Member – “Collective Bargaining and Private Sector Professionals” (Levitan and Gallo 1989); RN % Union Member – American Community Survey 1983-2012 (% of Registered Nurses self-identified as union members); % Union Member US Workers – Hirsch and Macpherson 2016 and American Community Survey 1983-2014

**Figure 3.5: The Nurse Population, ANA Membership and ANA Convention Attendance, 1940-1980**



Sources: Nurse Population - IPUMS USA; ANA membership – “Facts About Nursing”; Convention Attendance – Biennial Convention Reports - AJN

*1980 – 2016: The Beginning of the End or the End of the Beginning?*

In her opening remarks to the 1980 Biennial Convention of the American Nurses Association, ANA President, Barbara Nichols, began “The United States is a society in turmoil, and the ANA is a microcosm of the larger society” (AJN 1980). Specifically referring to a contentious internal debate on the structure of the association, her statement was oddly prescient of the organization’s next 30 years. Over that time, the conflict between professionalization and unionization intensified to the point of breaking. On the one hand, during the 1980s the ANA finally attempted and ultimately failed to implement the baccalaureate standard for entry to practice. On the other, as nurses faced massive healthcare restructuring, i.e. layoffs, in the 1990s and 2000s a number of state associations broke off from the ANA to focus more on unionism and issues of frontline nursing. In 1995 the California Nurses Association and its 60,000

members left the ANA. Conflict over organizing and how to respond to a seemingly unprecedented economic threat to nurses, over the next 15 years another dozen state associations would follow.

Returning to Ms. Nichols statement, the turmoil she was specifically speaking of was an internal conflict over the organizational structure of the ANA: whether they would remain a tri-level organization or become a federation. Up to this point, the ANA membership structure dictated that individual nurses joined the national association, the state association and their district or regional association. Under the proposed federation structure nurses would only join their state associations and state associations would be the only members of the national ANA body. Proponents argued that the existing structure was overly cumbersome and reduced member involvement. The proposal was narrowly defeated in 1980, but was reintroduced and passed in 1982. While, this may seem like nothing more than an historical footnote, adopting a federation structure demonstrates undertones of state dissatisfaction with the governance of the national organization and more importantly has significant consequences when member state associations disaffiliate from the national organization.

At the same convention, the Commission on Nursing Education recommended that the ANA “move forward in the coming biennium to expedite implementation of the baccalaureate in nursing as the educational qualification for the practitioner in nursing practice;” the recommendation was soundly approved “amid applause” (*AJN* 1982). In 1984 the Board of Delegates reaffirmed its commitment to this goal, by unanimously passing the Cabinet on Nursing Education’s “plan to establish the baccalaureate for professional practice in 5 percent of the states by 1986, in 15 percent of the states by 1988, in 50 percent of them by 1992, and in 100

percent of the United States by 1995” (AJN 1986). Moving forward with the recommendation, the ANA identified 4 states, North Dakota, Maine, Montana and Oregon, that they believed it would be relatively easy to establish the proposals laid out in the 1965 statement on education: a baccalaureate degree as the minimum standard for practicing as a professional nurse and an associate’s degree as the standard for practicing as a technical nurse.

North Dakota was the only state where it was not necessary to pass legislation to change state nursing requirements and was the only state where the change was successful, however legislation overturned the BSN licensing requirement in 2003. In the three other states, legislation failed. In all four states the state nursing associations and boards of nursing faced concerted counter-efforts. Not unexpectedly, state hospital associations and long term care facilities were among the most outspoken in their opposition along with associate degree schools. Physicians presented a mix of support and opposition. But, most significant was the opposition of nurses in each of these states. The ANA and state associations did not expect and were unprepared for the organized opposition of nurses they were to face. In each state nurses formed organizations specifically to defeat the proposed educational licensing requirements. While each of these state efforts had unique timelines and idiosyncrasies, I will focus here on the similarities in the opposition and result.

Perhaps the most obvious opponents to these bills, and as we’ve seen the most consistent opponents to nurse professionalization, were hospitals and the associations that represent their interests. In North Dakota, where the nursing board changed the requirements without legislation, the North Dakota Hospital Association (NDHA) and the North Dakota Long Term Care Association (NDLTCA) filed an injunction lawsuit in 1986 to stop the change from taking

effect. When that lawsuit failed, they backed the introduction of legislation to remove the new educational requirements every year between 1987 and 2001 (excepting 1993 and 1999). In the three states where legislation was necessary to establish new licensure requirements, hospital and long term care associations were vociferous in their opposition; they lobbied state representatives, testified against the legislation and publicly condemned the efforts. Although internally the hospital associations recognized increasing costs as the primary concern with the bills, externally they presented the threat of nursing shortages (particularly in rural areas) and the attendant health costs of these shortages as the cornerstone of their concerns (Smith 2009). It is not difficult to understand why hospitals and long term care facilities are opposed to the BSN requirement - increasing educational standards decreases the potential labor pool and therefore increases the costs of that labor, hence increasing costs for purchasers of that labor. But hospitals, like nurses, are socially obligated to present their interests as public interests. So when Bill Leary, president of the Montana Hospital Association, presented opposition to the Montana Bill he reasoned that the current requirements were working fine and new requirements would only “create a crucial shortage of nurses in the immediate future”, “create chaos in the nursing profession”, and “be financially burdensome for Montana taxpayers to implement” (Montana Legislative Record 1987). His colleague and fellow hospital administrator, Mike Sinclair, added, “HB36 is illconceived [sic], poorly written, self-centered, [and] limited with special interest group preferences” (Montana Legislative Record 1987). Sinclair’s condemnation of the bill invokes the contradiction of the professional nurse – the MNA is “self-centered” and economically interested rather than self-sacrificing and servile.

In additional to hospital associations, associate degree granting institutions also came out against the proposals in each of the 4 states. In Oregon, the Oregon Community College

Association (OCCA) and the Oregon Council of Associate Degree Nursing Programs (OCAP) led the opposition to changing nursing requirements. ADN programs were a significant and growing portion of the programs in the community colleges represented by OCCA and were the *raison d'être* of OCAP, so it is clear how their interests were threatened by the proposed licensure changes. In their testimony, they argued against the changing licensure by 1) pointing to relevant literature showing no consistent differences between ADN and BSN nurses, 2) warning about potential for nursing shortages, particularly in rural areas, as well as 3) increasing costs of education which would likely be passed to the consumer and 4) reducing access to RN careers for “older and married students, single mothers, divorced or widowed people” and men (Smith 2009). Additionally, they argued, like the Hospital administrators, that the lack of unity within nursing around this issue indicated that passage of the changes would deepen nursing divisions.

What ultimately sunk the bills was the disunity of nurses. To be clear, it was not simply a lack of enthusiastic support or passive resistance, nurses in each state organized focused and sustained lobbying and legislative campaigns. While, the various state nursing associations and boards had surveyed or otherwise studied the opinions of nurses in their state and seen this disunity, they were not prepared for the extent of their opposition or its weight. Because the North Dakota Board of Nursing could act to change licensure without legislative intervention and they had seen little public interest in the issue, they recognized that nurses would present the largest challenge to the new regulations. As they reported in an internal document “The first of these barriers are nurses themselves. Nurses, like others, have a natural antipathy to change. Where nurses should be educated has been an issue since the mid-nineteenth century. Although the events surrounding the issue have changed, the issue remains alive” (Rose 2006). A survey

done in Oregon prior to the legislative effort showed that nurses were divided at best. The 1983 survey of 300 Oregon nurses, showed that only 42% of nurses in the state supported the division of registered nurses into professional and technical and only 41% supported making the BSN the minimum educational requirement. Looking more closely, support was concentrated among nurses with bachelor's degrees, who supported both resolution items at about 85%, while only 31% and 40% of ADN and diploma nurses, respectively, supported the items. Significantly, only one in four Oregon nurses had a BSN at the time. Despite recognizing disunity among nurses, it is unclear what, if any, efforts were taken on the part of the state nursing associations to educate or convince nurses that this was the right course of action.

Nurses in opposition of the licensure changes in Montana, North Dakota and Oregon organized Concerned Nurses of [state name], while in Maine the primary opposition organized under the name Consortium of Maine Nurses. Although the bills and licensure changes included grandfather clauses that would preserve the nursing status of practicing RNs, many of the objections and concerns revolved around the impacts on ADN and Diploma nurses. As the Maine Consortium put it:

Although a grandfather clause is included in this bill (LD 2061), it is no guarantee of mobility and employment for those nurses who are being grandfathered. Rather, the bill will provide an impetus for employers to regard the BSN as the only professional nurse thereby limiting career opportunities for those experienced non-BSN Registered Nurses to attain a degree. If this bill were to pass, serious discrimination against the nurses of the State of Maine would be mandated by law after 1995. Our nurses would be deprived of the freedom of choice to select that type of program which they deemed best since the two-year professional nurse program will be abolished. (Incze 1986)

The Concerned Nurses of Montana added that in addition to potentially limiting the future career trajectories of current ADN and Diploma nurses, “the cost, duration and availability of four-year nursing would make nursing as a profession an impossibility to some, especially female heads of



households and minorities” (Smith 2009; pg 132). This argument was echoed by the Concerned Nurses of Oregon and the Oregon Federation of Nurses (OFN), a rival nurse union. In all four states, the nurse opposition argued that in addition to hurting nurses, the proposed changes would hurt the public. Specifically, they claimed that the legislation would create shortages of both RNs and LPNs. There weren’t enough four-year nursing programs to support an entirely BSN nursing force and RN nurses from out of state without BSNs would be unable to practice. Because the proposals also included a recommendation for two years of education for LPNs, prospective nurses would simply go to other states where two years was enough preparation for RN status. In their estimation, nurse shortages would drive up health care costs and limit effectiveness of that care. The Concerned Nurses, the OFN, and the Nurse Consortium operated sustained opposition campaigns that included letter writing campaigns (to nurses, legislators and other interested parties), public education and legislative testimony.

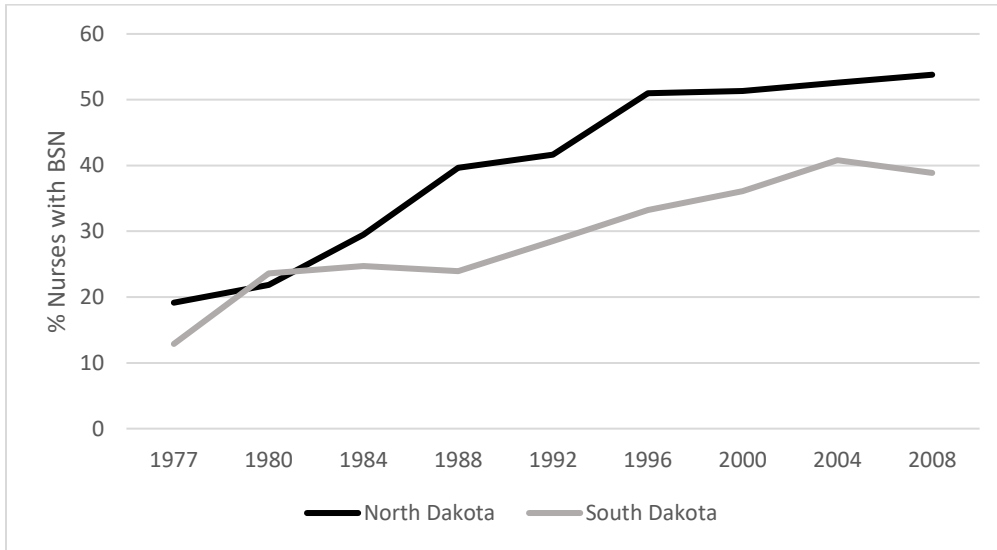
When the Montana bill was defeated (76-18), Bob Gould, the Chairman of the House Committee on Health Services and Aging, opined that the committee was “a little put out by the fact that the nurses told us two years ago that they would work out all their disagreements among themselves.” He continued, “[the legislature] should not be asked to arbitrate among nurses” (*AJN* 1987; pg 373). Additionally, the committee and the house were unconvinced that the BSN requirement would improve care and were concerned about the potential for a nursing shortage. Similar sentiments were expressed in Maine and Oregon and again in North Dakota in 2003 when legislation over-turned the nursing board decision. In all four focus states, opposition from nurses seems to have seriously compounded the weight and influence of hospital and institutional opposition, leading to the demise of each effort. Following the defeats in three of the

four focus states, the ANA abandoned the pursuit of the baccalaureate standard laid out in the 1965 Position Statement (Nelson 2002).

Even though it was eventually defeated, North Dakota did enact the propositions of the ANA 1965 position on education from 1987 to 2003. Beginning January 1<sup>st</sup> 1987 all new candidates for practical nursing licenses needed an associate degree from a postsecondary institution and all new candidates for a registered nursing license must have a bachelor's degree from a postsecondary institution with an upper division major in nursing (North Dakota Administration Code Section 54-03.1-06-02 and 54-03.1-07-02).

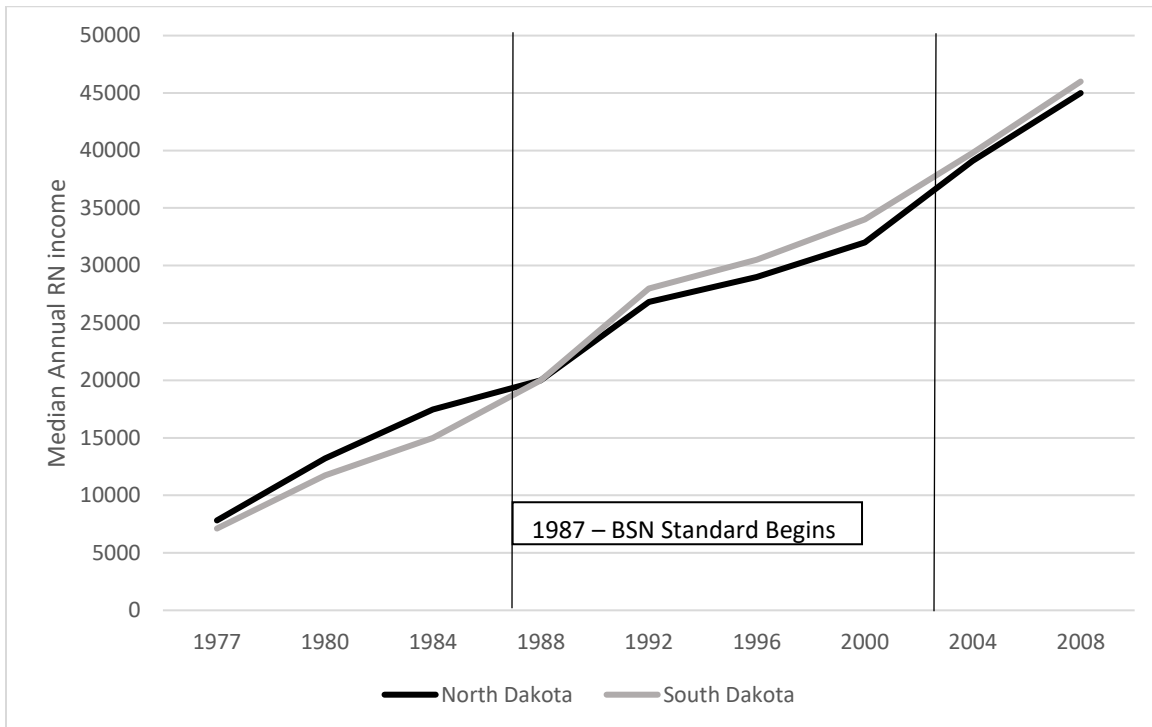
So what happened during those 16 years? Because South Dakota is geographically and demographically very similar to North Dakota and maintained the more typical multiple entry standards for registered nurses it provides an instructive comparison. Most predictably, the number of RNs with BSNs in North Dakota increased at a much faster pace than in South Dakota (see Figure 3.6). Turning our attention to nurse income, when looking at the median annual salary of all RNs in the two states there isn't a large difference. However, prior to the 1987 rule change North Dakota nurses earned more than South Dakota nurses, and earned less than South Dakota nurses in every surveyed year after. Similarly, in 1977 and 1980 BSN nurses earned essentially the same in South Dakota and North Dakota, but South Dakota BSN nurses' salaries grew faster over the next 20 years, particularly after 1992 (see Figure 3.7). In other words, implementing the BSN entry to practice requirement failed to increase nursing wages in North Dakota.

**Figure 3.6: BSN education in North and South Dakota, 1977-2008**



Source: National Sample Survey of Registered Nurses, 1977-2008

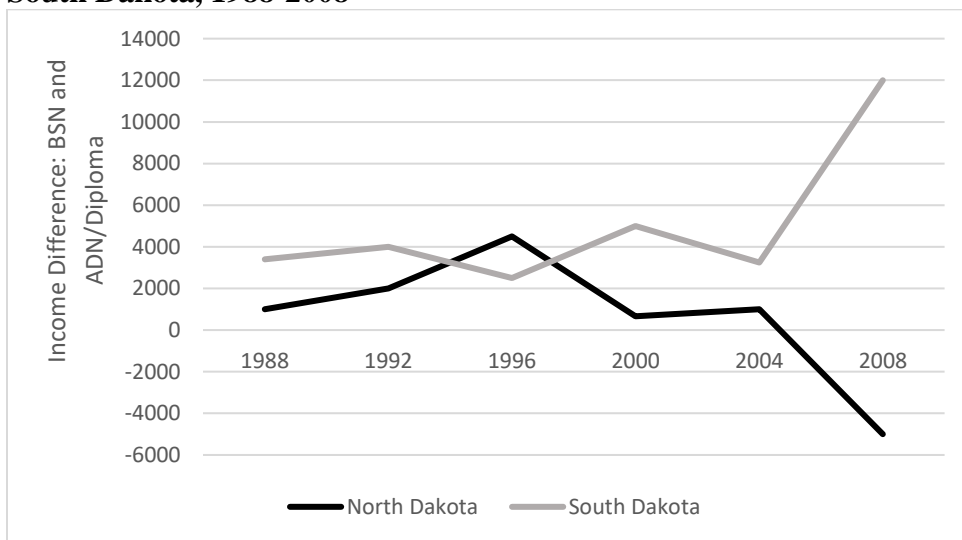
**Figure 3.7: Median Annual RN income in North and South Dakota, 1977-2008**



Source: National Sample Survey of Registered Nurses, 1977-2008

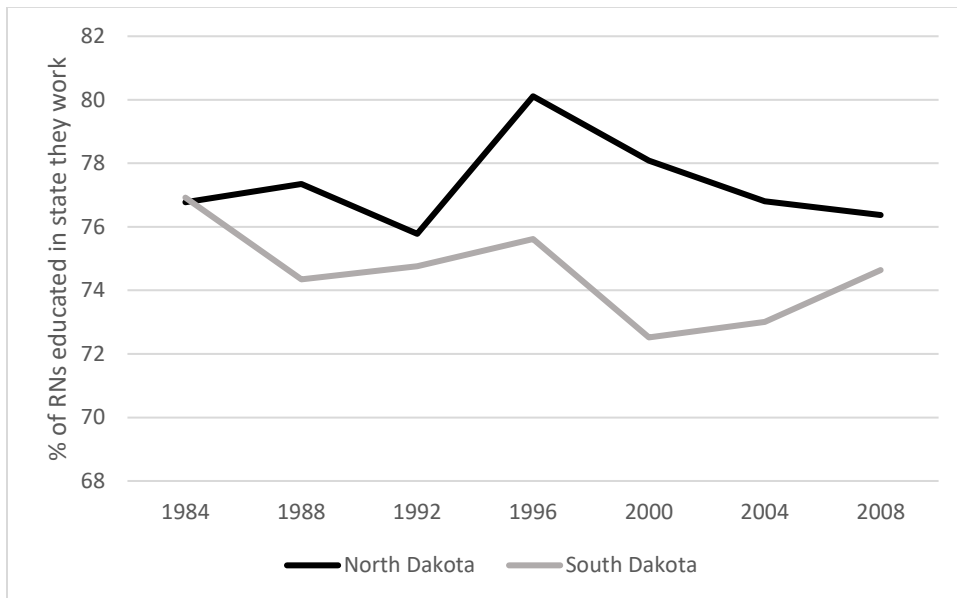
The various Concerned Nurses organizations argued that the BSN requirement would limit the future career opportunities for practicing nurses without bachelor's degrees. Comparing the salaries of pre-87 ADN and diploma RNs to pre-87 BSN RNs in both North Dakota and South Dakota, it appears that the opposite is true. In every year, except 1996, the difference between BSN nurses and ADN nurses was significantly larger in South Dakota than in North Dakota (see Figure 3.8). In North Dakota, associate's degree and diploma nurses actually did better in keeping pace with BSN nurses than their counterparts in South Dakota, suggesting that the BSN requirement did not substantially interfere with their mobility. Both concerned nurses and hospital associations argued that the BSN requirement would reduce the ability to attract out-of-state nurses and therefore contribute to shortages. When I compare in state-nurse populations in both states over the period there is some support for this argument (see Figure 3.9). But there was not an extensive difference between the states. Furthermore, had the ANA achieved their national goals it would be a moot point.

**Figure 3.8: Income Disparity between BSN and ADN/Diploma Nurses in North and South Dakota, 1988-2008**



Source: National Sample Survey of Registered Nurses, 1977-2008

**Figure 3.9: Percent of RNs Educated in State Currently Employed, North and South Dakota 1984-2008**



Source: National Sample Survey of Registered Nurses, 1977-2008

The entry into practice issue and the moderate success in North Dakota are instructive here for a number of reasons. 1) It demonstrates the disconnect between the ANA and frontline (or bedside) nurses. Enhancing entry requirements for nursing has been a key goal of the ANA for decades and is seen as central to the professionalization of nursing, yet when attempting to implement the requirements some of their staunchest opponents were nurses. These nurses felt as though nursing provided an occupation where without the expense and hardship of a four-year degree, women could attain financial stability, dignity and some degree of autonomy and that changing requirements would put that out of reach for many. 2) The defeats continue to show that when nursing professionalization and hospital interests compete, hospitals frame the professionalization efforts as self-serving and therefore against the particular professional spirit of nursing in their (successful) attempts to defeat them. 3) Increasing educational standards did not secure greater financial reward for nurses in North Dakota. If anything, compared to the

multiple entry RNs in neighboring South Dakota, North Dakota nurses actually fared worse over the 16 years that they were subject to the BSN requirement.

After the failures in escalating entry into practice, the ANA was to face an even more daunting challenge. In 1992 the ANA had 206,000 members, in just 20 years the membership declined by 58% (Weston and Wiggs Harris 2013) to approximately 86,000. At the heart of this decline was a fracture of the tenuous peace established in the 1946 Economic Security Program. In the face of economic insecurity and demoralizing downgrading of work not seen in half a century, old fault lines split anew. The dual strategy of professionalization and collective bargaining as practiced by the ANA, for many nurses and their state associations, simply was no longer acceptable.

Underlying the professionalization vs. unionization debate is class conflict. For years bedside nurses, members and not, complained that the ANA did not represent their interests – that its leaders were pulled from nurse managers, administrators and educators and the ANA’s policies and decisions diverged from their own<sup>24</sup>. Nursing while it sometimes presents itself as a unified occupational entity, in actuality is composed of a great diversity of roles and structural positions. As Ehrenreich and Ehrenreich (1979) recognize, nurses are diverse in both origin and function:

She may have been recruited from a working class, PMC [Professional-Managerial Class], or petty-bourgeois family. Her education may be two years in a working-class community college or four years in a private, upper-middle-class college. On the job, she may be a worker, doing the most menial varieties of bedside nursing, supervising no one, using only a small fraction of the skills and knowledge she learned at school. Or she may be a part of management, supervising dozens, even hundreds of other RNs, practical nurses, and nurses' aides.... So there is simply no way to classify registered nurses as a group. What seems to be a single occupational category is in fact socially and

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<sup>24</sup> This is in addition to the fact that the ANA excludes practical/vocational nurses.

functionally heterogeneous (13).

The different factions within nursing have different needs and different ideologies built around these needs. Jacqueline Goodman-Draper's (1995) labor study of nursing points to a three-tiered internal class structure: low class (staff nurses), medium class (director level) and high class (senior administrative and academic nurses). These three classes have unique interpretations of nursing professionalism. For low class nurses professionalism connotes work control over conditions, salary, dignity and security. Nurses in the high class position understand professionalism in concert with capitalist individualism. They see professionalism as a combination of improving their individual human capital through credentialism and compliance with management, and collectively gaining monopoly control over the marketing and education of the occupation. In the middle, nurses include both work control and popular individualist meritocracy in their understanding of professionalism.

For a professional association to incorporate these contradictory ideologies and needs into one organization is incredibly difficult. Particularly because while most nurses are of the low class, direct care faction, the professional leadership pulls disproportionately from the middle and high class positions. For example, in 1988 over half of all RNs surveyed in the National Sample Survey of Registered Nurses worked as Staff or General Duty nurses, in 1990 only 22% of delegates and 3 of 15 board members at the ANA were staff nurses (a significant increase from previous years). In the matter of unionization, the class tension in the ANA is especially acute on the most basic level. Frontline nurses are employees and managers and administrators are supervisors. In collective bargaining conflicts, direct care nurses and nurse administrators often, if not always, have necessarily competing interests. In the past, the national association pursued traditional professionalization, even when it conflicted with significant

portions of practitioner's desires (i.e. BSN requirement), and was pushed to incorporate unionism when professionalization faltered or external organizations threatened to compromise membership. A delicate dance to be sure, but for half a century the ANA had managed it. But what happens when the union side demands policy change that directly conflicts with the professional side?

This tension came to a head in the 1990s when hospitals around the country began to restructure and nurses were laid off in the thousands. Previous restructuring focused primarily on improving the use of RN time and then patient-focused care, but the wave of restructuring beginning in the late 1980s and continuing through the 1990s was much more focused on increasing efficiency and managing costs as a response to "new fiscal realities" (Norrish and Rundall 2001; Cummings and Estabrooks 2003). At the time, RNs represented approximately 25% of hospital workforces and were the single largest labor cost for hospitals (American Hospital Association 1996). A common practice to reduce costs was replacing RNs with unlicensed assistive personnel (UAPs) which facilitated wide spread nurse layoffs, numbering in the tens of thousands by some estimates (Norrish and Rundall 2001; Cummings and Estabrooks 2003). Between 1981 and 1993 nursing personnel (RNs and LPNs) declined by 7.3 percent nationally, but was particularly acute in Massachusetts (27%), New York (25%) and California (20%); simultaneously non-administrative personnel and other professional staff increased by 46% and 50% respectively in the US (Aiken, Sochalski and Anderseon 1996). The nurses that didn't lose their jobs saw their workloads increase, control over practice decrease, the time spent with patients decrease, and overall job satisfaction decrease (Cummings and Estabrooks 2003).



In the face of this crisis, the 1992 ANA biennial conference focused primarily on new advanced roles for nurses and the possibility of a coming single payer system i.e. it did not seriously contend with the issues facing a majority of nurses. At the 1994 meeting, staffing cuts could no longer be ignored. Massachusetts and New York State Associations introduced an action report that challenged the “considerable attention” the ANA had paid to advanced practice and urged a “national initiative” to explain the “uniqueness and diversity of nursing’s direct care role” in hospitals. The initiative was unanimously approved. The house of delegates also revised the ANA Vision Statement to emphasize “workplace advocacy”, passed a resolution demanding guidelines to define the role of UAPs, and endorsed a report that predicted that the trend in layoffs would result in a nursing shortage. ANA leadership responding to the concerns of delegates proposed “a series of strategies” to “help nurses survive in a staff-cutting climate” (*AJN* 1994), including litigation, reforming education for “the jobs of the future”, and collective bargaining. Delegates from the California Nurses Association (CNA) disagreed with the limited strategies of the ANA leadership and “argued forcefully for federally established nurse-to-patient ratios” (*ibid*), but ultimately the proposal was denied.

Meanwhile in California, the CNA was undergoing significant transformation. Like the national association, the California Nurses Association had adopted a bifurcated professional/union organizational model. The 15-member Executive Board was composed almost entirely of educators and managers, with only one staff nurse on the board. The board controlled the budget and set the association’s agenda. There was a separate governing body for collective bargaining called the Congress of Economic and General Welfare Commission (EGWC) that was composed primarily of staff nurses. Nurses and labor representatives of the CNA and EGWC report that in 1991 there was significant conflict between the board and the

EGWC surrounding issues of budgeting, governance and relationship with the ANA (Silver 2010).

This conflict came to a head in the summer of 1991. When several CNA represented hospitals in the Bay Area merged did not fight to extend the CNA contracts through the merger. But rather, the EGWC and staff nurses at the hospital decided to void the contracts in sympathy to the other unions and renegotiate them as a coalition. Six unions collectively went out on strike and after seven and a half weeks won the desired contracts in July of 1992. The action upset the CNA board by collaborating with other unions, but on top of that one of the CNA board members was a vice president at the hospital where the nurses went on strike. Staff nurses on the front line noted that over the course of the strike, none of the executive board participated in picket lines, rallies or other events. Less than six months later, the executive director of the CNA fired 13 staff associated with the EGWC and four elected officers of the EGWC were removed from office. In March of 1993 the fired employees and removed officers were reinstated by a federal court order. Later that year, the CNA held its biennial elections. Building on the momentum from the court and strike victories, the EGWC organized nurses and put up a staff nurse slate for the executive board and won 8 out of 15 seats. It was the beginning of the “staff nurse revolution” as they called it. The revolution eventually would replace the nurse management and educators on the decision making bodies of the CNA with staff nurses and organizers – moving the association away from goals of professionalization and towards more aggressive unionization and organizing.

During the internal conflict at the CNA, members of the “staff nurse revolution” saw the ANA as actively working against their cause, as one nurse put it the “ANA came in heavy and

very visibly against the staff nurse movement.” Still CNA leadership hoped to work with the ANA to combat the wave of hospital restructuring. But when they went to the 1994 Biennial Convention their proposal to push for mandatory staff ratios was soundly defeated, one CNA nurse left the convention feeling that the:

ANA had taken several positions that really didn't address the needs of the bedside nurse or the direct care nurse. They were not necessarily opposed to restructuring and substituting nursing assistants and other lesser educated or lesser skilled workers in place of nurses. In fact, they said look, restructuring is the train going down the tracks and if you're not on the train you'll get run over and so you better get with it (Smith 2010; pg 179).

Alienated from the national association and paying 1.8 million dollars in dues yearly to the ANA, in 1995 the California Nurses Association voted overwhelmingly (92%) to disaffiliate from the ANA. Kit Costello, president of the CNA explained “We cannot stand by as more people are being denied care and patient care standards are being drastically lowered. We are going to take our message to the public, and we are going to let this industry know we mean business. And we are going to have more resources for the most important fight of our professional lifetimes” (Green 1995b; pg 4). CNA cited the following complaints with the ANA as the primary reasons for leaving: a lack of commitment to fighting hospital restructuring and reduction of nursing staff, efforts to increase entry into practice to the bachelor's degree (only 30% of CNA nurses had a BSN or higher at the time), hiring of an external health care consultant who claimed that nurse-staffing does not affect health care quality, and the refusal to provide financial support to nurses suing a Northern California Medical center to challenge restructuring. As Kit Costello summarized “it is very difficult to pass along \$1.8 million every year to an organization that gives us so little in return and even takes positions that end up being used against working nurses (Green 1995a; pg 38).

Both the ANA and the California Association of Hospitals and Health Systems (CHA) were quick to condemn the disaffiliation. According to a representative of the CHA, “for hospitals, our ability to work with [CNA] in a collaborative manner will fall further behind. Their whole intent now is portraying hospitals in the worst light” (Green 1995b; pg5). ANA President Virginia Trotter Betts, claimed that the vote was the result of a “misinformation campaign” that misrepresented the ANA. “I think it’s a very sad day for nursing all across the country” (Moore 1995; pg 42), she said. “It’s a no-win situation, they’re not going to win, and I don’t feel that it’s a win for the nursing profession” (Green 1995b; pg 5).

Energized after their historic decision, the CNA expanded its organizing efforts and mobilized for serious legislative change. In the years following their departure from the ANA they made major workplace and legislative victories. Included among these victories was a two-year contract fight with 47 strikes involving 7,500 nurses against one of the nation’s largest health care providers. As a result of the strikes the union won major concessions from the health-care provider protecting them from the worst effects of restructuring. Perhaps most importantly and most famously, in 1999 CNA secured passage of AB 394 – California Safe Staffing Law, which established state minimum nurse-to-patient ratios for acute-care hospitals. Set to go into effect in 2004, the implementation of the law was challenged by Governor Arnold Schwarzenegger and CHA backers, but a year of activism including 107 protests by more than 10,000 nurses ultimately ensured passage of staff ratios in California. In 2004, CNA went national, forming the National Nurses Organizing Committee (NNOC) and organizing nurses in Illinois, Arizona, Missouri, Pennsylvania, Texas and Nevada by 2008.

In yet another attempt to adjudicate the professionalization/unionization conflict in the ANA, in 1999, the ANA formed its own national labor body, United American Nurses (UAN) separate from, but within the umbrella of the professional association. The formation of the UAN was preceded by the 1998 disaffiliation of the Pennsylvania State Nurses Association and growing unrest from more union focused state nursing associations in Massachusetts, New York, Michigan and Montana. ANA president, Beverly Malone, explained, "the United American Nurses will organize and represent RNs who want support through collective bargaining. We'll empower them to deal with issues such as staffing levels and work-place safety" (Helmlinger 1999; pg 59). Despite the creation of the UAN, Massachusetts Nursing Association (MNA), remained dissatisfied with the leadership and direction of the ANA. In 2001, 82% of MNA members voted to disaffiliate with the ANA. Citing similar grievances as the CNA, including the lack of representation of the staff nurses in the ANA, policies that were too conciliatory to hospitals and other healthcare providers, increasing costs, and the desire to create an alternate voice for nurses (Massachusetts Nursing Association 2001). Later that same year the Maine State Nurses Association also disaffiliated from the ANA. Only 3 years later, in 2002, the delegates of the UAN voted overwhelmingly to become an "autonomous self-governing labor organization" independent of the ANA, but still affiliated.

At the 2002 Biennial convention of the ANA, delegates recognized something serious was amiss. Membership had shrunk 25% in just 7 years and "revenues [were] shrinking" (*AJN* 2002), in response the house of delegates debated restructuring the national association. Despite agreement that restructuring was necessary, consensus was not reached. In 2003 an emergency meeting of Constituent Member Associations (CMAs – new name for SNAs, includes state and territorial associations) the delegates agreed on a new structure that allowed the UAN to function

independently from the ANA and allowed individual membership in both the ANA and UAN.

At the meeting, ANA executive director, Linda Stierle, “noted that in 1954, 44% of all RNs were members of the ANA; that number declined to 15% in the 1970s, and today, fewer than 6% of U.S. nurses<sup>25</sup> belong to the ANA” (Goldsmith and Kennedy 2003; pg 23). In 2004 the ANA held its final biennial member convention after over 100 years of holding the event; it was replaced by an annual meeting of the house of delegates. By 2000 attendance had dwindled below 3000, the lowest attendance since 1944 when a travel injunction due to World War 2 prevented most members from attending.

Despite restructuring, the ANA would only splinter further in the coming decade. In 2008 the state affiliates in Hawaii, Michigan, Minnesota and Washington, DC all disaffiliated. On top of that, the United American Nurses and Center for American Nurses (the non-union workplace advocacy counterpart to the UAN) disaffiliated from the ANA as well. In 2011, New York State Nurses Association was suspended from constituent status in the ANA on charges of dual-unionism. They subsequently reformed as an independent union. Several other state associations, including Illinois, formally separated their union and professional arms. In 2013, two ANA executives reported that the association’s membership had declined by 58% over the last 20 years (Weston and Wiggs Harris 2013). Because the ANA had given up publicizing membership years prior, I can only estimate based on the 1992 membership of 206,000 (*AJN* 1992) that in 2012 their membership was approximately 86,500. In 2012 there were over 2.8 million active practicing RNs (Health Resources and Services Administration 2013), meaning that the ANA represents only three percent of registered nurses as of 2012. The dramatic decline in ANA

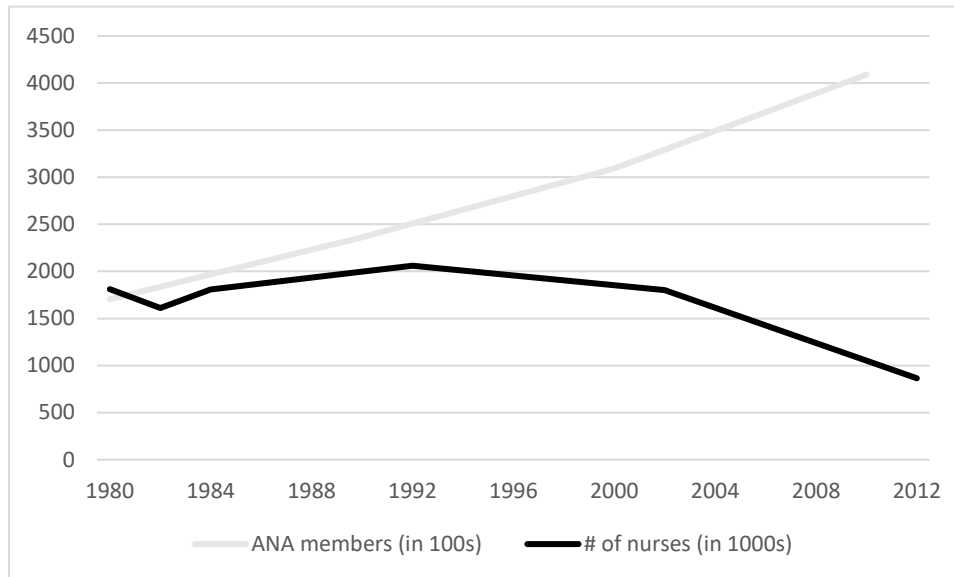
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<sup>25</sup> Because the ANA only admits RNs, I assume by U.S. nurses that is to whom they are referring.

membership is demonstrated in Figure 10, bear in mind that while the nurse population is represented in thousands, the ANA membership is represented in hundreds. In 1980 there were 181,200 ANA members and 1.7 million professional nurses in the US (according to the US census). In just 30 years ANA membership declined from ten percent of practicing nurses to just three percent.

In the wake of serious membership decline, in 2012 the ANA restructured again, eliminating the house of delegates and replacing it with a much smaller membership assembly, reducing the size of the board of directors and modifying the federation. The streamlined organization maintains its focus on pushing the jurisdictional boundaries of advanced practice nurses, has recommitted to the BSN entry into practice, does not engage in collective bargaining (and adopted an ambiguous stance in support of nurses' choice in bargaining), and supports staffing legislation which does not include nurse-patient ratio minimums. Thus, consolidating around the middle and high class nursing positions. These positions are in line with the recommendations of the Institute of Medicine's 2010 report, "The Future of Nursing: Leading Change, Advancing Health." Looking towards an increasingly complex system of healthcare provision and a more significant role for nurses in that system, the report recommends that 100% of RNs should have at least a BSN with a goal of 80% of RNs achieving a BSN by 2020, in addition to a concomitant increase in advanced degree education (MSN, APRN, etc.) (Institute of Medicine 2010). To which ANA president, Karen Daley, responded, "We at ANA support the recommendations of the IOM report and are eager to partner with others in developing effective strategies to implement these ideas, which are reflective of ANA's long standing work on behalf of the nursing profession" (ANA 2010).

**Figure 3.10: ANA membership and Nurse Population, 1980-2012**



Meanwhile, the voices of direct care staff nurses were uniting. Before the Massachusetts Nurses Association voted to disaffiliate, they provided their membership with a top ten list of reasons to do so. At the top of that list:

Disaffiliation will allow us to form a national alliance with other like-minded progressive nursing organizations. The MNA has heard from many organizations, and many more nurses across the nation and across the world who share our progressive values and goals. Disaffiliation would allow us to build coalitions that can mobilize the 93% of the nursing population not represented by ANA. (MNA 2001).

Shortly after Massachusetts and Maine left the ANA they joined with CNA, the Pennsylvania Association of Staff Nurses and Allied professionals, and the United Health Care Workers of Missouri to form the American Association of Registered Nurses, with the goal of creating a unified, progressive nurses' union. Ultimately, the state associations were not able to come to terms on structure and the union was not formed, however it did lay the groundwork for future alliance. Following its 1995 departure from the ANA, the California Nurses Association doubled its membership in just a few short years – from 22,000 (Green 1995) to over 40,000 by 2002



(Berens 2002). In 2004 they began nationalizing their effort with the formation of the National Nurses Organizing Committee (NNOC), organizing nurses in several states outside of California and rapidly grew the CNA/NNOC to 80,000 members in only five years. During this time the CNA/NNOC “earned a reputation as an active, militant, progressive, proselytizing organization” (The Association for Union Democracy 2010). In 2009, various organizing efforts coalesced when the CNA/NNOC, Massachusetts Nurses Association and the United American Nurses<sup>26</sup> merged, forming National Nurses United.

Formed in opposition to the ANA, the NNU has demonstrated at its core the fundamental difference between the professionalization and unionization impulse: its relationship to management. Unlike the ANA, the NNU does not balk at confrontation with employers, it is not a last resort. Nelson Lichtenstein, describing NNU and its president RoseAnn Demoro, explains that “behind her militancy is the knowledge that she has the workforce that will in fact confront the boss and go on strike” (Elk 2014). Like the CNA/NNOC, the other constituents of the NNU, the MNA and the remaining states in the UAN, particularly Minnesota, had exercised a willingness to utilize strikes and mass protests to achieve workplace changes. This legacy has continued with the NNU. For example, in November of 2014, nurses in 16 states and Washington DC, including 18,000 nurses at Kaiser Permanente hospitals in California engaged in a controversial two-day strike to demand safety precautions for Ebola. Strikes were coupled with pickets and rallies at hospitals and federal offices (NNU 2014). In June of 2016 more than

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<sup>26</sup> Prior to merging with the NNU, several UAN affiliate states disaffiliated for fear that the organization was joining with the Service Employees International Union – which had been feuding, including cross-accusations of raiding, with CNA and other nurse unions for years. These state associations, Montana, Ohio, Oregon, New York and Washington formed the National Federation of Nursing and affiliated with the American Federation of Teaching. New York would later leave the NFN and organize as an independent union. The NFN does not take an antagonistic stance in regards to the ANA as the NNU does.

10,000 nurses went on strike in Massachusetts, Minnesota and California to protest staffing and patient care issues (NNU 2016a).

In addition to direct care issues like staffing ratios and the use of unlicensed assistive personnel, the NNU has also championed a broad progressive agenda. They have dedicated ongoing campaigns to promote universal healthcare, a “Robin Hood tax” and environmental justice. They explain these campaigns as a part of their duty as nurses, arguing on their website that “The United States is hurting. Large banks and other Wall Street firms raided our economy, leaving millions of Americans to suffer. Around the world, poverty, hunger and HIV/AIDS threaten global health. RNs' duty as patient advocates compels a response: the Nurses Campaign to Heal America” (NNU 2016b). Their broader agenda is, perhaps, made most clear in their 2015-2016 support for self-described socialist presidential candidate, Bernie Sanders, in the Democratic National Primary. NNU nurses were a consistent presence at Sanders rallies and the union spent hundreds of thousands of dollar supporting his campaign (Overby 2015). NNU executive director, Demoro (2016a) authored an opinion piece in the Guardian titled “I'm a woman and I will vote for the best feminist for president: Bernie Sanders.” Advocating for Sanders again in a Huffington Post blog post, Demoro writes “with the 2016 election, we have a rare opportunity to break the chokehold the neo-liberal agenda has maintained for nearly half a century on the political, economic, and social life of this nation” (Demoro 2016b). Their aggressive tactics and progressive agenda, though gaining the ire of some, has made serious organizing gains in its first few years. When these unions came together they constituted 150,000 members. Major victories including organizing 7,000 veteran’s affairs nurses, have grown the organization to 185,000 members in 2016, a 23% increase in just seven years.

## *Conclusion*

As of 2016 the vast majority of nurses in the United States are not members of any nursing organization: professional or union. Those that are, are spread across a variety of different unions and professional associations (in addition to the ANA and NLN there are dozens of specialized associations). For almost 100 years the ANA was the largest organization representing nurses and their interests in the United States, but after having lost over half of its membership in the last 20 years, it now only represents a fraction of the nursing population that it did at its height. At the same time, nursing unions (the NNU, NNF, independents and those affiliated with SEIU) are growing. The split that exists now mirrors the old divisions within the ANA. The union factions within the ANA have jettisoned and what remains is focused on further professionalization – increasing educational credentials and expanding nursing roles. Perhaps then this institutionalized division of unionization and professionalization is the final adjudication of competing class interests within a diverse occupation. When professionalization faltered, nursing's professional association tentatively adopted unionism piece by piece to pick up the slack, but not only were these instincts at odds ideologically, they were structurally and legally contradictory as well. However, even with the chasm between the ANA and the NNU they still retain characteristics of one another. Unionization retains nurses' professional character by fighting for not just the well-being of nurses but for patients (the public) as well. Ultimately, the professionalization model, having been adopted and wielded from a middle and upper class position while enrobed culturally and positioned structurally in a gendered hierarchy by nursing could not attain its professional goals particularly for the majority of its working class practitioners. Unionization, offering competing strategies and perspectives, has shown up to

now to be more effective at achieving the kind of professionalism desired by those working class professionals: control of work.

Nurses having been thoroughly subordinated to medicine, strove for professional status using what cultural tools they had at their disposal. If professionalism was identified with a service orientation, early nursing ran with this and imbued it, by nature of the work and the women who engaged in it, with meanings of selflessness, virtue, servitude and subordination. So while they argued that nurses were skilled and important and therefore deserving of respect, they also posited that they were “good women”, whose skill was an extension of natural gifts and whose work was a sacrifice for the greater good. Of course, nurses often fought against these characterizations, but they were pushed back by parties interested in maintaining their submission, by the broader culture and in many cases their own leaders. In some respects, the deployment of the virtuous selfless nurse ideology is inherently a white middle or upper class position. Working class women and women of color were not typically in the position to sacrifice their own pay “for the greater good”. While certainly people of all classes are attracted to and practice nursing at least in part because of its altruistic mission, without the support of moneyed family or a future husband nurses could not do without “reasonable working conditions [or] economic security” as the ANA suggested in 1938. But the vision of the Nightingale nurse also complemented the image the burgeoning medical industry was trying to create, so as nursing pursued professionalization, medicine and hospitals, paternalistically encouraged its rationalization while promoting the status and ideal of the “good nurse.” For a time, this arrangement worked, nurses gained licensure, rationalized training and increased stature. These steps promoted professionalization and nursing elites saw progress.

Economically, however, the bedside nurse saw few gains for decades. In dire straits, nurses were leaving the profession. So the professional leaders, having attained some professional status asked for concessions, stricter licensure, changes in education and in some cases greater remuneration, but they were denied and their opponents turned the gendered rhetoric of professions against them. As unions seized on these failures and began organizing nurses, the professional association, so as to protect its members' interests and/or not to lose members, turned to collective bargaining. But here again they were denied. Their halfhearted embrace of collective bargaining, without the teeth of a strike threat, relied on appeals to hospital management. In response management simply refused to recognize them as bargaining units (as legally allowed to them by the hospital exemption in the Wagner Act) and when pressed accused them of selfishness unbecoming of a "noble profession." When the strike clause was revoked, nurses won significant gains, but again were condemned by physicians and hospitals as unprofessional. Yet when nurses again attempted to increase their status through traditional professional means, upgrading educational requirements, hospitals opposed them and physicians did not support their efforts. Furthermore, the internal class divisions within the profession further complicated and ultimately doomed the effort. When changing economic conditions spurred hospital restructuring resulting in the loss of the thousands of nursing jobs, which professionalization had failed to prevent, the class divisions within the profession could no longer be contained. In the final analysis, the complex interplay of class and gender structured the professionalization of nursing, leading to the adoption of an ineffective dual strategy of professionalization coupled with unionism. As unionism and professionalism appear to be decoupling the future of nursing remains unclear.

At the same time, health care provision is undergoing significant changes. The introduction of the Affordable Care Act and the rise of integrated care providers, may be changing the calculus for hospitals. Perhaps nursing, rather than being an expense on top of physicians, to which hospitals try to reduce at all costs, they will instead become a cheaper alternative to physicians. As hospitals rose to prominence and replaced private practices fewer doctors directly employed nurses, at the same time the roles of nurses and doctors, with some significant exceptions, were solidified. As a result, during the second half of the 20<sup>th</sup> century conflict over nurses' economic well-being was much more likely to be directed towards hospitals. But as hospitals begin to elevate nurses to reduce physician-related costs antagonisms may shift once again. Indeed, the fight over APRN prescription rights is already underway.

Both professionalization and unionization are techniques to intervene against exploitative labor relationships. For most nurses, however, unionization has proved a more effective means of preserving economic security. As seen in North Dakota, the professionalization strategy of increasing entry into practice did not appear to have a significant positive effect on the nurse wages. To further compare the impacts of union membership and increasing education, I estimated, using OLS regression, their effects on income and work satisfaction among staff nurses across the US in 2008. Though RNs with bachelor's degrees are more likely to work in management positions than ADN nurses, if we look at staff nurses, who make up approximately half of all RNs, more education does not impact wages. When comparing the effects of unionization and education on the income of staff nurses I find that while holding a BSN has no effect on earnings, belonging to a union increases earnings by almost 10 percent ( $p < .001$ ) when controlling for human capital, workplace conditions and demographic characteristics (see Appendix Table 1). On the other hand, BSN nurses were more satisfied with their positions than

their diploma and ADN counterparts, and unionization had no effect on satisfaction (see Appendix Table 2). So while nurses are not likely to be doing quantitative analyses of wage differentials, they may look around and see that their colleagues with more education don't make more money and those that work in union hospitals do. If that's the case, making the argument for professionalization as opposed to unionization may be that much harder.

Perhaps relatively unbound from the demands of direct care nurses and focused on the upward limits of the profession, the ANA will effectively achieve professional autonomy and status for APNs. The imperatives of the Affordable Care Act may facilitate this kind of high end nurse professionalization because it calls for the expanded role of APNS and presents that goal as an affordable option for hospitals when compared to physicians. Similarly, the increasing unionization of direct care nurses may continue to achieve the kind of dignity, security and control that working nurses desire. Nurses then may continue to use a mix of these strategies and see a further bifurcation of the nursing workforce.

In this chapter, I demonstrated the social contingency of national professionalization for nursing. Gender and class intervened in the image making activities of the profession, ultimately influencing the institutional and structural arrangements that constitute its material and cultural status. The gendering of nursing appears to have precluded it from reaping economic rewards of professionalization for many of its practitioners. This compounded with internal class division within the profession made unionization a popular alternative to professional strategies for a large contingent of nurses. In the next chapter I turn to professionalization as it occurs in individual and small group interactions. Utilizing observations and interviews, I examine how

gender, race and organizations impact the professional status and relationships of individual nurses and units, day to day in a large west coast hospital.



**Chapter 4.**  
**Informal Interactions, Gender, and Hierarchy: Barriers to Nurse-Physician Collaboration  
in a West Coast Hospital**

*Oh please. We're the hired help.*

Charge nurse, in response to the question “has the emphasis on collaboration improved physicians’ understanding or respect of nursing?”

*Contemporary Health Care and the Nurse-Physician Relationship*

The American healthcare system is in a moment of tremendous change. Spurred on by inflating costs, changing patient needs and the Affordable Care Act (ACA), health care providers are scrambling to meet new demands and challenges. Nurses are at the center of these changes. In addition to the increasingly prominent role of Advanced Practice Nurses (APNs) and Doctors of Nursing Practice (DNPs) as primary care providers, the ACA’s emphasis on prevention, wellness, and coordination of care requires registered nurses to play a more pivotal role in healthcare (Lathrop and Hodnicki 2014; American Nurses Association 2014). While these changes have enormous potential to improve patient care, their success in many ways depends on building collaborative relationships and good communication between nurses and physicians.

Effective patient care depends on successful communication. Communication errors in health care are estimated to lead to approximately 98,000 deaths annually in the United States and to increase health costs by billions each year (Sutcliffe, Lewton and Rosenthal 2004). Poor communication between physicians and nurses is one of the primary areas where these errors occur. Differences in communication styles, terminologies and viewpoints can contribute to

misunderstanding between the two professions; and tensions related to hierarchy (of professions, gender, race and class) often exacerbate barriers to communication (Sirota 2007).

Additionally, the quality of the physician-nurse relationship contributes significantly to the job satisfaction and retention of nurses. Verbal abuse and disruptive physician behavior have been clearly linked to job stress, satisfaction and retention (Cox 1991; Greenfield 1999). But more subtly, the subordination of nurses and curtailment of their autonomy also leads to burnout, which may eventually result in departure from the profession. Hospitals where nurses experience less autonomy report significantly higher rates of nurse turnover and burnout (Congelosi, Markham and Bounds 1998). As of 2006, 1.8 million registered nurses in the United States were not working as nurses, and that is the fewest, relatively speaking, nurses not practicing in years. The Department of Health and Human Services reports that in 2008 they recorded the highest rate of nursing employment since recording began in 1977, with only 78.5% of registered nurses working in nursing (U.S. Department of Health and Human Services 2010). Additionally, one out of five nurses reported that they planned to leave the profession within 5 years (Kramer and Schmalenberg 2008). Further contributing to a nursing shortage that is likely to deepen as the Baby Boom generation's health needs rapidly expand and millions more Americans gain access to healthcare (American Association of Colleges of Nursing 2014).

In the last chapter, I showed how gender and class impacted the historic professionalization of nursing in the United States. This chapter explores the relationship between nurses and doctors as they engage in professional communication and interact in the social space of the hospital. Gender and racial dynamics significantly influence this relationship. To examine how this happens, I focus primarily on three aspects of the nurse-doctor relationship: formal authority and autonomy; the “nurse-doctor game”; and informal relations and the

domination of social space. Because nurses have less power than physicians, they are much more likely to be affected negatively and to experience a circumscription of autonomy as a result of inter-professional conflict. While nursing has seen a fairly dramatic transformation over the last half-century in terms of professionalization, education, status and compensation, nurse satisfaction and retention remain significant impediments to the success of the professional project.

I conducted extended observations and semi-structured interviews over a one-year period in a large hospital that is part of a regional integrated health system, which I refer to as HealthOrg.<sup>27</sup> The research site represents a particularly useful example for examining the prospects and limits of change in healthcare. With the health system's strong emphasis on wellness, preventative care and avoiding lengthy hospital stays, the hospital's policies exemplify the logic that underpins the Affordable Care Act. Over the last decade, it has developed sophisticated electronic records and computer systems to facilitate coordination between physicians, specialists, nurses, pharmacists and other team members. The organization has explicitly made cooperation between providers a primary goal for delivering effective health care. Part of this effort has been the adoption of the SBAR protocol (see page 158 below for explanation) to facilitate cooperation and communication between healthcare professionals which, since its initial introduction to health providers in the early 2000s, has gained tremendous popularity among health care providers across the nation.

How has the quality of the nurse-physician relationship responded to the hospital's continued push for collaboration? While efforts at collaboration seem to have made significant strides, gendered and racialized patterns of interaction in both official and unofficial exchanges

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<sup>27</sup> The study included approximately 150 hours of observation and interviews with 18 nurses and 4 physicians.

undermine efforts at collaboration and reinforce a relationship of domination and subordination. This paper illustrates how the dynamics of formal and informal nurse-physician interactions continue to undermine efforts to improve communication through organization-level change initiatives.

The contemporary issue of collaboration echoes the traditional boundaries of the nursing profession. Historically, the doctor-nurse relationship was defined by a much stricter delineation of power (Freidson 1973); today informal relations continue to replicate this hierarchical configuration of interprofessional relations. In addition to illuminating the central role of gender in the negotiation of professional boundaries, the findings have critical implications for the changing healthcare landscape, which will increasingly rely on a collaborative relationship between physicians and nurses as well as a more central role for nurses in healthcare provision.

#### *Gender, Communication and Professional Boundaries at Work*

Gender is a “pervasive social category” (Weatherall 2000), it is an omnipresent influence in social interactions (Ridgeway 2010) and shapes institutions, including occupations, work and employment organizations (Acker 1990 and 1992; Lorber 1994; Martin 2004). As Ann Weatherall (2000; pg 287) explains:

The identification of a person as belonging to one of two gender groups<sup>28</sup> is a fundamental guide to how they are perceived, how their behavior is interpreted and how they are responded to in every interaction and throughout the course of their life.

That is not to say that gender and its constituent meanings are static categories within which people passively act and reproduce. On the contrary, individuals are active producers of gendered identities who maintain, create or recreate these and other social identities through

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<sup>28</sup> Despite the proliferation of non-binary gender identities and an understanding of gender as a spectrum, the predominant operation of gender in interactions is into binary categories.

social practice (Kendall and Tannen 1997). In other words, gender is socially constructed and dynamic.

Gender, as its own institution, contains a host of sociocultural norms that structure expectations of how men and women are supposed to act, behave, talk and interact with one another. When people interact they draw from these norms to make choices on how to frame their actions in order to accomplish particular aims. How one talks and the language they choose frames interactions, often invoking gendered norms that can act as a resource while performing gendered identities. As gendered norms of communication are differently useful for achieving different kinds of ends men and women do not always perform identities consistent with gendered cultural norms. At times, men use “feminine” talk and women use “masculine” talk. However, when behavior or speech violates these norms it tends to be perceived within a gender-normative framework and therefore the speaker is seen to be “acting like the other sex.” Thus, when men and women speak similarly they are often evaluated differently (Tannen 1994; Holmes 2006; West 1995). Norms of gendered language are then both resources and constraints (Kendall and Tannen 1997; Hall and Bucholtz 1995; Tannen 1994; West and Zimmerman 1987).

Expectations of gendered talk are derived from compounding lived experiences in the use of language that communicate diverse and layered meanings (Holmes 2006). Linguistic choices in conversation therefore convey gendered meanings and identities (in addition to other social identities and meanings). Linguists generally agree that, “Ways of talking are associated with particular roles, stances (e.g. authoritative, consultative, deferential, polite), activities or behaviors, and to the extent that these are ‘culturally coded as gendered ... the ways of speaking associated with them become indices of gender” (Cameron and Kulick 2003, pg. 57 quoted in Holmes 2006). Though necessarily incomplete and non-exclusive, scholars have established a

number of gendered linguistic strategies observed in a variety of social settings, particularly white-collar workplaces. Janet Holmes, reports in *Gendered Talk at Work* (2006; pgs 6-8) that strategies typically identified as feminine include:

- facilitative devices – intended to encourage conversation and consist of things like pragmatic particles (*you know*) and tag questions (*isn't it? Haven't they?*);
- supportive feedback – in addition to straightforward support this may also include “positive minimal responses” (*mmhmm, yeah, or nodding*);
- conciliatory behavior – to hedge and soften requests and statements, strategies such as “attenuating pragmatic particles” (*perhaps, sort of*) and “mitigating epistemic modals” (*might, could*)
- indirect rather than imperative directives – interrogative questions (*can you get this done?*) preferred over direct orders (*do this*)
- collaborative orientation; and
- minor conversational contribution

Scholars also associate a number of interactional styles with masculine linguistic strategies.

These include:

- competitive and confrontational discourse
- disruptive interruption
- direct imperatives
- powerful and assertive talk
- autonomous task orientation
- dominant conversational contribution

These strategies and styles of communication make up broad boundaries of the normative, “appropriate” ways that gender identity is signaled in the workplace.<sup>29</sup> “They constitute implicit, taken-for-granted norms for gendered interaction against which particular performances are

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<sup>29</sup> The list, as constituted here, is highly determined by class and ethnicity and tends to represent the normative orientation of middle-class whites. However, given historic and contemporary organizational realities these tend to reflect the dominant orientations of most large employing organizations in the U.S.

assessed” (Holmes 2006; pg. 7). It is important to note that, the performance of gendered identities is inherently interactional and relational – needing both the “performer” and the “assessor” and for the performance to be assessed in relation to other individuals and groups.

Gendered discursive strategies are not the exclusive purview of any one gender identity. They are available resources for any interaction. However, as noted earlier, they are not equally evaluated or rewarded when differently gendered actors employ them. Norms of gendered language are also tied to norms of authority, dominance and subordination. Kanter (1993) observed that “Organizational roles carry characteristic images of the kinds of people that should occupy them, thus encouraging incumbents to turn into those kind of people” (pg. 252), but that not all people have equal opportunity to becoming “those kind of people.” As authoritative positions have been typically occupied by men, masculine norms of communication become associated with authority. “Therefore, communicative styles of authority and masculinity are intertwined. Kendall and Tannen (1997; pg. 91) provide an illuminating description of how these processes occur:

The predominance of one sex in institutional positions creates and maintains gender related expectations for how someone in that position *should* speak. Such associations simultaneously are produced by, and serve to reproduce, gender ideologies: socioculturally defined expectations for how women and men should speak and behave. In addition, interactional styles traditionally used by individuals in authoritative positions become authoritative themselves and come to be seen as ‘speaking with authority’. The result of these combined processes is that expectations for how individuals in positions of authority should speak to subordinates are similar to expectations for how men should speak and interact.

As a result, the gender of the speaker may radically alter how authoritative behavior is understood and interpreted by other actors. Assertiveness, the ‘mythic golden mean’ between aggression and deference may not be possible for women, “too often, assertive behavior is misidentified as aggression” (Lakoff 1990, pg. 207), because “the very notion of authority is

associated with maleness” (Tannen 1994, pg. 167). In study after study, assertive women in the workplace are perceived by coworkers, peers, subordinates and superiors as being less likeable and less feminine, but potentially more competent (Crawford 1988; Carli 1990; Wiley and Crittenden 1992; Tannen 1994; Jamieson 1995). This puts professional women in a “double bind,” where they are forced to choose between being a “good woman” or a “good professional”, but cannot do both. Though this research predominantly concerns women in historically male positions of authority, it has serious implications for gendered inter-occupational interactions, particularly as shifting organizational and social needs change role expectations.

Like gender, race and ethnicity undergird communication. Racial and ethnic identities are performed through interaction. Simultaneously, race and ethnicity shape the taken-for-granted assumptions that influence how behavior and interactions are interpreted. Race, as a master-category, organizes social life (Omi and Winant). Formal and informal interactions at work both are influenced by the racial and ethnic relations of people involved and shape the racial-structural terrain of work. At work, linguistic practices and social segregation have been demonstrated to marginalize minority employees and advantage whites (Pierce 2003; Beagan 2003). Discriminatory practices and processes, thus, create what Joan Acker (2006) calls “inequality regimes” in organizations that subtly and systematically advantage whites’ hiring and promotions (Maume 1999) as well as interpersonal interaction. These processes result in the situation in which white males are extremely disproportionately overrepresented in positions of authority (McGuire and Reskin 1993). As I explained above, the disproportional representation of white men in positions of authority results in the equation of white male discursive practices with authoritative ones, further reifying their authoritative position and the racialized and gendered organizational hierarchies that creates.



Nursing is relatively diverse (for a profession), particularly in the state and context studied here. While non-Hispanic whites make up approximately 75 percent of nurses in the U.S. (Health Resources and Services Administration 2014), in California only 51 percent of RNs are white and less than 45 percent of nurses under 45 years old are white<sup>30</sup> (Spetz et al. 2015). So while the interactions of nurses and physicians are gendered primarily by the dichotomy of gender composition between the two occupations, nurse physician interaction is also shaped by complex racial and ethnic dynamics. In California and in the hospital observed, Filipino Americans make up the largest non-white ethnic group among nurses, representing 20 percent of nurses in California (Spetz et al. 2015) and a substantially larger proportion of nurses in the units studied here. Though Latinos, other Asian Americans and African American nurses make up substantial minorities in nursing state and nationwide, together they made up only 20-30% of RNs in the units observed. As such, my primary focus in this study is the experiences of white and Filipino nurses.

The migration of Filipino nurses to the United States is unique among labor migrations to the US. And the largely feminine and professional migration of Filipinos to the United States is intimately tied to the U.S. colonization of the Philippines. The colonial relationship and origins of Filipino nursing continue to influence the training, recruitment and socio-cultural context of reception for Filipino nurses. Briefly stated, the establishment of nursing education in the Philippines at the turn of the 20<sup>th</sup> century was part of a “civilizing” effort of American colonialism. Ramped up during WWII to support war efforts in the Pacific sphere, American-founded nursing schools taught, in addition to nursing, English proficiency and “American

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<sup>30</sup> Nursing is still whiter than the state population and the ethnic composition of nursing does not match the ethnic composition of the state, particularly as Latinos are concerned. Only 7% of nurses statewide were Latino, as compared to 40% of the state.

nursing work culture” (Espiritu 2005; Choy 2003). Perhaps, even more importantly, American nursing educators also had to import the gendered understanding of nursing as women’s work, a notion so foreign in the Philippines that the U.S. colonial government attempted to legislate the gender segregation of nursing education in 1909 (Choy 2003). Furthermore, the colonization of the Philippines was couched in a highly gendered racialization discourse that justified colonization on the assertion that Filipinos were unfit for self-rule because they lacked manliness (Hoganson 1998; Espiritu 2003). Thus Filipino racialization is one of hyperfeminization – where Filipino men are seen as effeminate and Filipino women as highly feminine and sexualized (Hoganson 1998). Filipino government officials and recruitment agencies deploy the stereotypes of Filipino women as naturally servile and tender to promote them internationally as caregivers (Espiritu 2005). These stereotypes are likely to affect how Filipino nurses’ behavior is interpreted and responded to by physicians and others in the hospital, reflexively affecting Filipino nurse behavior.

The interactions of physicians and nurses are further complicated as they are entangled in professional boundary work. As I discussed previously in Chapter 3, boundaries are not only contested at the national or institutional level they are also negotiated in the day to day interactions of practitioners. The structural arrangement of nurses and doctors in particular necessitates the daily maintenance of authority and subordination. While nurses are formally subordinate to physicians, the needs of hospital practice demand significant workplace assimilation in which physicians and nurses work very closely on a daily basis. As Abbot (1988, pp. 72-73) explains:

But maintenance of subordination in the workplace requires bringing all this public clarity to bear. It requires on the one hand the complex symbolic order noted above – the use of honorifics, the wearing of uniforms and other symbols of

authority, and countless similar behaviors. But it requires as well countless acts of exclusion (“nurses don’t need to know why”) and of coercion (“we do it because the doctor ordered it”). Subordinate professions are in some sense contradictions in terms. Maintenance must be constant.

Professional boundaries are dynamic and the close coupling of sets of professions in hierarchical fashion requires daily intimate preservation and negotiation of those boundaries. Hospital restructuring and the transformation of medical care continue to evolve the boundaries of various medical professions, thus boundaries are in a state of flux (Hafferty and Light 1995; Nancarrow and Borthwick 2005). Nurses are being called on to do more and hospitals are putting greater emphasis on nurse-physician collaboration, as is the case in the HealthOrg Hospital studied here.

As nurses and physicians interact they are constantly negotiating and (re)establishing the boundaries, limits, authority and structure of their relationship (within a dynamic organizational structure). The gender composition of the two occupations, contemporarily and historically, frames these interactions in a gender polarity that normalizes male authority and female deference. Hence, while, both doctors and nurses utilize gendered communicative strategies as resources in framing their interactions, these norms will tend to maintain more authoritative/dominant relational forms and resist transitioning to true collaboration. In other words, gendered interactions will tend to enforce the professional hierarchy of nursing and medicine. However, that is not to say, by any means, that doctor-nurse interactions are monolithic in nature. Rather different gendered resources of individual practitioners along with a diversity of other social resources (like race) are likely to produce a large of variety of interactional configurations.

## *Methodology*

I collected data over a two-year period between 2014 and 2016 primarily in and with the employees of a large west coast hospital. The hospital has over 400 licensed beds and an emergency department with about 75 beds. It provides a variety of services ranging from emergency care to psychiatry, surgery and primary care. The hospital is a county anchor of HealthOrg, a semi-national, private nonprofit health plan that operates through hospitals and affiliated medical groups.

HealthOrg is both a typical and atypical health care provider in the United States. At the dawn of the Affordable Care Act, HealthOrg represents one possible model for the future of health care delivery in the United States. HealthOrg is an integrated health system, meaning it includes both an insurance plan as well as a system of hospitals and clinics. As such its economic incentives are different from many traditional health care providers in the United States; to reduce overall costs it focuses on preventative care and reducing hospital stays in favor of outpatient clinical care. HealthOrg has been pointed to by the New York Times, the UK department of health and NHS, as well as President Obama as a model for future health care delivery because of its efficiency in both cost and patient health outcomes. HealthOrg, for these reasons, represents an important setting for analyzing how nurses experience professionalism and interact with other professionals in a changing medical market. Although HealthOrg has a unique structure and care model, it still operates hospitals and clinics that are organized in a typical fashion, with separate departments and units populated by doctors, nurses, medical aids and administrative staff, making it appropriate for studying the professional ecology surrounding nurses and nursing.

Data collection took two primary forms. First, I conducted over 150 hours of unstructured observations in 4 units of the HealthOrg hospital. I split my time primarily between the emergency department (ER) and the step-down unit (or DOU, definitive observation unit), but also spent significant time in the medical-surgical (Med-Surg) and telemetry (Tele) units. HealthOrg allowed me to observe these units from the nursing stations for 4 to 8 hours at a time, during which time I took extensive field notes on the observable actions, behaviors, presentation and interactions of nurses, physicians, managers and other staff as well patients and their families<sup>31</sup>. In addition to observing, I also conducted short informal field interviews when possible to clarify and contextualize my observations.

In addition to varying by acuity, specialty, patient load and physical layout the units also varied considerably by nurses' racial/ethnic composition. Though each unit consisted of 7-10 RNs in a given shift, because the units utilized a three shift system (with overlap), made use of float and contract nurses, and nurses worked four ten hour shifts with flex scheduling (schedules changed every week), it's really difficult to give a definitive demographic account of the units. However, during the 30 visits I made to the hospital for observations I kept track of the gender and race/ethnicity of the RNs in each unit. As stated there was quite a bit of variability in ethnic composition within units from shift to shift, but there were general differences between the units as well. As shown in Table 1, the telemetry unit was most predominantly and consistently white, while medical-surgical was most predominantly and consistently Filipino. Both the observation unit and emergency had high amounts of variability and were relatively more diverse. While there was variation in ethnic composition across units there was not much in terms of gender. In

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<sup>31</sup> Though HealthOrg does utilize physician assistants, they do not work out of nurses stations and almost exclusively communicate with physicians and therefore I had almost no contact with them.

the DOU, ER and TELE units there was always at least one male RN on the unit and sometimes two. But only once, in the DOU, did I observe more than two men in one unit at the same time. In the five days I observed in Medical Surgical, however, I only observed a male RN working twice.

**Table 4.1: Racial/Ethnic Composition of Observed Hospital Units**

	White			Filipino			Latino			Black			Asian		
	AVG	MIN	MAX	AVG	MIN	MAX	AVG	MIN	MAX	AVG	MIN	MAX	AVG	MIN	MAX
DOU	46%	33%	55%	35%	30%	44%	9%	0%	22%	6%	0%	13%	8%	0%	25%
ER	40%	25%	63%	34%	13%	63%	13%	0%	25%	3%	0%	13%	3%	0%	13%
TELE	62%	50%	67%	13%	0%	25%	8%	0%	13%	8%	0%	13%	10%	0%	22%
M-S	10%	0%	22%	84%	67%	100%	2%	0%	11%	0%	0%	0%	6%	0%	17%

It is more difficult to provide an accurate accounting of the genders and race/ethnicities of physicians based on the nature of my observations. Because I was situated in nursing stations in particular units and doctors were not, different physicians were constantly in and out of the units. However, the general impression one gets after spending any significant amount of time in the hospital is that the large majority of physicians are white men. That being said, there was certainly a non-insignificant minority of female doctors and east and south Asian doctors as well.

After nine months in the field I began recruiting nurses and physicians for formal interviews to take place outside of the workplace. In total I interviewed 18 registered nurses (14 worked at HealthOrg and four at other nearby hospitals) and four male physicians (three of the physicians worked at HealthOrg, but at different sites<sup>32</sup>, and one worked at a competing regional

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<sup>32</sup> Though onsite recruitment of nurses, while difficult at times, was successful, my attempts to recruit physicians on-site proved fruitless. To recruit physicians, I was forced to turn to personal networks. Though physician interviewees did not work at the same site as I observed, HealthOrg maintains a high degree of continuity between hospitals and I have no reason the sites they work at are significantly different. Furthermore, the responses they gave were substantially in line with what I had observed. I chose to interview male doctors because, despite the growing presence of women physicians, they are still underrepresented in the hospital setting in general and the high acuity areas I observed in particular. And because I interviewed relatively few physicians I also wanted to reduce variation.

hospital). These interviews occurred at a time and place of the subject's choosing and ranged from 45 minutes to three hours, most lasted about one hour. Interviews were loosely structured around one of two interview guides (one for nurses, one for physicians) and followed the same format, but allowed significant flexibility to more fully capture the perspective of interviewees. All formal interviews were digitally recorded for audio and the audio was transcribed. Names and identifying information were changed or removed to protect the confidentiality of participants.

I analyzed field notes and interview transcripts using open, categorical coding consistent with a grounded theoretical approach. Analysis focused on the professional autonomy of nurses, the structural arrangement of healthcare professionals in the hospital, and the formal and informal interactions of nurses and physicians.

### *Formal Structures*

The nurse-doctor relationship is first and foremost organized by the formal/legal structures that bound and define their respective roles. Formally, both physicians and nurses occupy autonomous roles but collaborate to deliver care to patients. However, in nurse-physician interactions, the direction of power ultimately flows from physicians to nurses. Since physicians write treatment orders for nurses to fulfill, treatment in the hospital is physician-driven. While nurses have autonomy in the management and application of patient care, ultimate responsibility over diagnoses and patient treatment decisions lies with physicians.

For much of the work day, nurses work without interaction with doctors but coordinate with each other, with the charges, and with nurses' assistants (CNAs) or medical assistants. In creating nursing care plans, nurses autonomously assess, diagnose and plan treatment for the care of patients. Additionally, nurses tend to build closer relationships with patients (and patient

families); during an average shift RNs usually are responsible for 4–6 patients, depending on turnover, while an MD might be responsible for dozens. This often leads nurses to feel that they are more knowledgeable about the patient’s particularities than the doctor. However, because doctors unilaterally make the initial overarching decisions, and because nurses often cannot act on patient care decisions without doctor approval, many nurses experience their autonomy as circumscribed.

### *Formal Authority, Assessment and SBAR*

Before turning to the particulars of the nurse-physician relationship as demonstrated in their interactions, I first consider the formal roles and structure of the occupations in relation to one another. Content of work, formal responsibilities and hierarchical arrangements are critical to understanding the behavior of people at work (Kanter 1993). Nurses and physicians are no exception.

The primary area of collaboration is in assessment, one of the principal responsibilities of nurses. The nurses I interviewed consistently located assessment as a central part of nursing, Gina’s explanation of nursing provides a typical example: “Primarily [nursing is] patient care, patient advocacy. Patient care for me is being able to assess and know my patient well enough to advise any treatment.” At the start of each shift, after going over patient reports from the nurse they are relieving, assessing patients is the first thing that nurses do. According to *Moby’s Medical Dictionary* (2014), a nursing assessment is the:

“identification of the needs, preferences and abilities of a patient. Assessment includes an interview with and observation of a patient by the nurse and considers the symptoms and signs of the condition, the patient’s verbal and nonverbal communication, the patient’s medical and social history, and any other information available. Among the physical aspects assessed are vital signs, skin color and condition, motor and sensory nerve function, nutrition, rest, sleep, activity, elimination, and consciousness.”



Because both nurses and physicians assess the patients (in different ways), assessment also represents an area where the rules of professional boundaries, hierarchy, and authority are blurred. It is the nurses' responsibility to constantly assess their patients' wellness, to take appropriate action when needed, and to convey change of condition to physicians. When the response is outside of the nurse's scope of practice, the physician diagnoses the problem and initiates treatment orders for the nurse or another specialist to carry out. In this area of assessment and recommendation, communication between nurse and physician is most problematic and perhaps also most critical. The information gathered by nurses' triage and physical examination assessments make up the foundation of physician diagnosis. This information determines the initial course and sequence of treatment.

In the event that the nurse assessment identifies a problem which necessitates physician intervention, communication between the two professionals becomes absolutely essential. Unfortunately, these interactions generate inconsistent outcomes. Physicians may be reluctant to accept the importance of the new information or to trust the assessment if it differs from the original diagnosis and treatment. Melody's experience provides a dramatic example:

*But another time I had a patient, who just didn't feel like she was doing well, she was really short of breath. But she wanted to go home, her husband wanted her to go home. The surgeon came in and discharged her. And I said to the surgeon, 'she doesn't look well, she's short of breath,' I don't really know what's going on because no one is monitored on our unit, but there's something going on here. So they [the surgeon] insisted that she could go home and her husband really wanted to get her out of there.*

*And, um, so it was all I could do was ..., there is one doctor who intervenes for us in that sort of situation, what's the term? [Surgical Officer of the Day or SOD] Anyway, there's the guy you call. I had to call him to get another doctor to come see the patient.*

*And she had had a heart attack. She wasn't having chest pain, just shortness of breath. But women especially have ... so she had had a heart attack. But nobody ever came and apologized to me about that one. [laughs].*

These moments of assessment partially invert the nurse-physician role, since information from a patient's changing condition might alter diagnosis and/or treatment. This is further complicated by differences in orientation, communication style and hierarchical relationships. On the one hand, nurses' assessments are often holistic in nature, meaning they take into account the patient's whole physiological and psycho-social condition and tend to communicate assessment in a narrative form. Physicians on the other hand tend to be oriented towards the biomedical model and to prefer discrete information. Additionally, the imbalance in social and institutional power can result in doctors' unreceptiveness to unsolicited input from nurses and nurses' lack of comfort in communicating unsolicited information to doctors.

To counteract poor communication, HealthOrg has adopted a formalized method of inter-professional communication called SBAR. Adopted from the United States Navy, SBAR stands for situation-background-assessment-recommendation and provides a framework for standardizing communication through structured conversation and common language. HealthOrg began to encourage the use of SBAR in inter-professional communication because miscommunication had been shown to significantly contribute to "avoidable medical errors" (HealthOrg publication 2007). SBAR is a highly standardized form of communication in which the nurse essentially follows a script to describe a patient's situation and needs (see Figure 4.1, for a sample worksheet designed to teach nurses how to utilize SBAR). Since its early introduction into healthcare it has been adopted in hospitals around the world as a "tool to facilitate understanding between people who interact frequently or infrequently but might not communicate in the same way" (Vardaman et al. 2011). As such, the adoption of SBAR has been shown to improve perceptions of communication between nurses and physicians (Woohall,

Vertacnik and Mclaughlin 2008) and to improve the health outcomes of patients (Beckett and Kipnis 2009).

**Figure 4.1: Publicly Available SBAR Worksheet**

**SBAR report to physician about a critical situation**

S	<p><b>Situation</b>            I am calling about &lt;patient name and location&gt;.            The patient's code status is &lt;code status&gt;            The problem I am calling about is _____.            I am afraid the patient is going to arrest.</p> <p><b>I have just assessed the patient personally:</b></p> <p><b>Vital signs are:</b> Blood pressure ____/____, Pulse _____, Respiration____ and temperature _____</p> <p><b>I am concerned about the:</b>            Blood pressure because it is over 200 or less than 100 or 30 mmHg below usual            Pulse because it is over 140 or less than 50            Respiration because it is less than 5 or over 40.            Temperature because it is less than 96 or over 104.</p>
B	<p><b>Background</b>  <b>The patient's mental status is:</b>            Alert and oriented to person place and time.            Confused and cooperative or non-cooperative            Agitated or combative            Lethargic but conversant and able to swallow            Stuporous and not talking clearly and possibly not able to swallow            Comatose. Eyes closed. Not responding to stimulation.</p> <p><b>The skin is:</b>            Warm and dry            Pale            Mottled            Diaphoretic            Extremities are cold            Extremities are warm</p> <p><b>The patient is not or is on oxygen.</b>            The patient has been on _____ (l/min) or (%) oxygen for _____ minutes (hours)            The oximeter is reading _____ %            The oximeter does not detect a good pulse and is giving erratic readings.</p>
A	<p><b>Assessment</b>  <b>This is what I think the problem is:</b> &lt;say what you think is the problem&gt;  <b>The problem seems to be</b> cardiac infection neurologic respiratory ____  <b>I am not sure what the problem is but the patient is deteriorating.</b>  <b>The patient seems to be unstable and may get worse, we need to do something.</b></p>
R	<p><b>Recommendation</b>  <b>I suggest or request that you</b> &lt;say what you would like to see done&gt;.            transfer the patient to critical care            come to see the patient at this time.            Talk to the patient or family about code status.            Ask the on-call family practice resident to see the patient now.            Ask for a consultant to see the patient now.</p> <p><b>Are any tests needed:</b>            Do you need any tests like CXR, ABG, EKG, CBC, or BMP?            Others?</p> <p><b>If a change in treatment is ordered then ask:</b>            How often do you want vital signs?            How long to you expect this problem will last?            If the patient does not get better when would you want us to call again?</p>

In some ways, the SBAR protocol can be seen as a way of transforming the person or process oriented discourse of nurses to a task or outcome focused discourse favored by physicians. As Holmes (2006) points out the person/process orientation tends to be associated with feminine styles of communication while task/outcome is associated with masculinity. So it would seem that the organization, seeing a problem of miscommunication has attempted to shift the feminized communication style of nursing (at least in this regard) to the masculine style of medicine. However, the heavily gendered informal norms of interaction between the two professions create significant barriers to full adoption.

Although SBAR is generally framed as a tool of nurse-physician communication, implying that both parties would make equal use of the protocol, SBAR in practice is more one-sided: nurses use SBAR to communicate to doctors. SBAR structures much of the written communication between doctors and nurses, but has not taken as strong a hold in verbal communication. In my observations it was not commonly used and when it was, it was often used in a highly modified way. Some newer nurses seem to have robustly adopted the protocol, but more experienced nurses tend not to utilize the rigid communication structure. Interviews and observations suggest that younger, less experienced nurses tend to incorporate SBAR into their communication more easily. Many older, more experienced nurses indicated that, while SBAR may be helpful for others, they had already developed a workable system for communicating with doctors.

As Melody, a veteran nurse of 25 years, explains:

*They have a format at HealthOrg called SBAR that you're supposed to follow when you call a doctor to help them understand and you're not just randomly talking about – I don't use it. [LAUGHTER] Because we always have physicians on the ICU. So we just call it, hey, you do rounds with them every day on the ICU*

*patients. So they know your patient. Or they know the problems they possibly are having. So then we just say, hey, we need this.*

Melody's response was a typical justification for not using SBAR among older nurses who saw the formal structure as unnecessary given their well-developed relationships with physicians. All of the veteran nurses I spoke with had worked at HealthOrg for at least a decade, many for more than 20 years. Over this time, they developed relationships with physicians and explained that because they *knew* the doctors they worked with, they communicated effectively already. Of course the obvious problem with this reasoning is that nurses inevitably have to communicate with physicians they don't know, either new hires or from other departments. Additionally, as I explore below, the well-developed modes of communication, favored by veteran nurses, while perhaps are effective in some ways, tend to reinforce a hierarchical, rather than collaborative, relationship between nurses and physicians.

HealthOrg developed and uses SBAR as a tool to help nurses collaborate with physicians. Nurses at HealthOrg attend mandatory training on how to use the communication system and are reminded to use it in department meetings. Ultimately it is seen and presented as a tool for nurses and they are given leeway in how and when to use it, there is no enforcement that I saw. Nurses did report that it gave them a way to structure their thoughts before calling or speaking with doctors – so that they could be clearer.

Veronica, a relatively new nurse who had learned SBAR in her BSN program, explained:

*Yeah, it's Situation, Background, Assessment, and Suggestion. So – or Recommendation. And then, recommendations. So, I try to stick – I don't use it. Like, I don't go down the line, but I do try and plan it out. Like, what's going on? Why am I calling about this? Why am I questioning this, and what do I suggest? It's kind of like a formula we can use to order our thoughts, it helps.*

In explaining SBAR, Veronica makes an error, which she quickly corrects, she substitutes suggestion for recommendation. Though this mistake appears to be minor, it is telling. While the two words have overlapping meaning, both communicate possibility and preference towards a course of action, to recommend is more forceful. On one hand, nurse's suggestions inform the doctor of possible courses of action. On the other hand, a nurse's recommendation communicates what they believe should be done. A suggestion and a recommendation are thus two very different actions. As I will discuss further below, suggestions maintain the authority of physicians, while direct recommendations challenge this hierarchy. In other words, one suggests something to a superior, but recommends something to a colleague. So while it appears that newer nurses have embraced SBAR more substantially than their veteran counterparts, unless there is further intervention, it seems likely that overtime they may replace the most troublesome/ component of the communication model: recommendation.

Nurses also expressed utilizing SBAR– or something like it – strategically with specific doctors with whom they have trouble communicating. As Candace, a 15-year veteran nurse originally from the Philippines and with 10 years of experience at HealthOrg related to me:

*[The doctors here are] pretty nice, like I said I'm proud to work at HealthOrg. Like some of them have an attitude, but at least if they have an attitude they know what they're doing. Before you call, one of them, you better know what you're calling about, you know with the SBAR thingie. I've been working there a while so I know which and which doctor, some are easy, some are just kinda like -- I'm going to try most especially, like Doctor so-and-so is not on call tonight so I know this doctor is especially strict with pain medication. Then I want to make sure I know what I'm going to say, so the doctor will make the order.*

Though Candace doesn't use the SBAR format consistently, when she does it's more of a guideline for organizing her thinking than a strict script, it is a valuable tool for her when addressing unfamiliar or difficult doctors.

In addition to implementing the SBAR protocol, the hospital has also begun to implement a program of patient-centered RN-MD collaboration. The program aims to increase collaboration by having physicians include nurses in walking rounds and requiring the presence of nurses when physicians communicate the treatment plan to patients. This is meant to avoid the common situation in which the doctor comes to see the patient and leaves written orders for the patient while the nurse remains unaware of the interaction. To enforce these changes, the charge nurse asks each nurse daily if the doctor fulfilled the requirements, and the charge sends his or her report to a coordinating physician. Doctors who are outside of compliance can be taken into "captain's mast," as one doctor called it, and questioned about their behavior, which they have to justify at the risk of possible repercussions (the nature of which were unclear).

These changes seem to be successful to a point. Interviewed nurses reported that doctors at the research site tend to be more responsive to their calls, more receptive to their insights and less likely to be abusive than at other hospitals. Additionally, nurses who had worked at the hospital for 15 years or more indicated that, in recent years, their relationships with doctors had markedly improved. Not infrequently, veteran nurses referred to the 1990s as "the bad old days" or "the dark years". A period they perceived HealthOrg to be rolling back their commitment to nurses with restructuring that included layoffs and wage cuts. During the same period, they report that physicians were much more combative, authoritarian and unresponsive. When asked to explain the change, a typical response was that the "old guard" of physicians had retired and been replaced by younger more amenable physicians who were educated and socialized

differently. A few nurses pointed to the hospitals' newfound emphasis on nurse-physician collaboration, and Dave, the veteran charge, specifically pointed to disciplinary action against disruptive physicians. However, every nurse interviewed also expressed some frustration that doctors remain insufficiently responsive and often act annoyed when nurses attempt to provide insight into a patient. Nurses find a significant minority of doctors, surgeons in particular, simply difficult to work with because of their arrogance, poor-attitude, lack of respect, etc. Despite reporting good relationships with many doctors - characterized by a sociable rapport, a general lack of conflict, and perceived professional respect - many nurses appear to struggle to effectively communicate their concerns and ideas to those very same doctors.

### *The Nurse-Doctor Game*

First identified by Stein in 1967, the "Nurse-Doctor game" (Stein 1967) continues to shape the interactions between doctors and nurses in their official capacities in patient care, particularly when a nurse disagrees with a physician's order or recognizes an error. Drawing from his own experience as a physician, Stein argued that the cardinal rule of the "game" of doctor-nurse interactions dictates that nurses and doctors never appear to disagree and that nurses would never offer direct recommendations to a physician. Rather, nurses learn that while offering significant advice and showing initiative, they must always appear to passively defer to the doctor's authority. Nurses then communicate recommendations using "nonverbal and cryptic verbal communication." Ultimately, it remains imperative that any recommendation appears to be initiated by the physician. It should be no surprise that this game closely mirrors sociocultural gender norms of male/female communication. Given the extreme gender segregation of the two occupations, combined with the power imbalance between them, we would expect that gender normative forms of communication would come to be associated with the respective



occupations. These norms both reinforce and normalize hierarchy based both in the structural relationship of work relations and a gender frame of natural hierarchy.

In the nearly 50 years since Stein's report, the nurse-physician relationship has certainly transformed, with doctors now recognized as fallible and nurses venerated as far more than passive handmaidens. However, with important exceptions, nurses very rarely directly challenge the doctors' expertise when they disagree with physician decisions. Instead nurses are more likely to ask questions or to offer passive suggestions which allow the doctor to come to the "right" conclusion on his or her own. In some cases, nurses say nothing at all. When questioned about handling disagreements with doctors, nurses repeatedly reported some version of the same answer: "I try to get them to realize the problem and think it's their own idea." Physicians that I interviewed praised nurses, and extolled their value on the medical team, but also cautioned that when it comes down to it they, the nurses know that physicians have much more education/training and that ultimately the buck stops with them. The social structuration of nurse-physician communication constantly reinforces the hierarchy of their relationship and the boundaries of their jurisdiction.

In situations calling for nurses to make recommendations or to assert their point-of-view, they tended to employ methods that fall under two general approaches: suggestive or direct. Silence was also quite typical. In several cases, either before or after an interaction with physicians, nurses would talk to other nurses about the proper course of treatment for a patient but would fail to discuss it when actually speaking with the physician.

Suggestive approaches include suggestive questions and quiet (or easily dismissed) suggestions. These methods fall in line with the imperative to make recommendations appear to have originated from the doctor. Suggestive questions were generally paired with key

information that when taken together would lead physicians to come to the conclusion that the nurse wants. The following phone conversation between Veronica, a young Latina RN, and a MD<sup>33</sup> is typical of this technique:

*[The patient has two separate daily orders for potassium. At this point the patient's potassium is in the low normal range (represented in the patients chart) – continuing the daily order (as opposed to an as needed order) may result in her going above the normal range of potassium.]*

*“Hi Dr., the patient's order is for two doses of potassium one for 40 and one 20 daily”*

*“Fine, go ahead and give the 60.”*

*“I can do that, the patient's potassium is at 3.5, is that what you want?”*

*“I see that. You know what? I'm going to change the order to 20 mgs as needed. Thanks.”*

In another example, Jennifer, a young white RN in the ER, had a patient who had been ordered two 325 milligram doses of aspirin. Later she told me: “I thought, ‘that's a strange dose,’ because I've only given amounts of 325 and the patient wanted double that which I'm sure would harm them.” So she walked up to the patient's doctor who was sitting at a computer station.

*“Hey Doctor, what's the max order of aspirin that you can give?”*

*“It depends” as he looks at the chart on the computer. “Well, let me just change the order.”*

*He changes the order on the chart and Jennifer walks away.*

Ultimately, in both cases, as the nurse was hoping, the order was changed, while the doctor maintained his authoritative position by making the recommendation on his own accord. The quiet suggestion is similarly structured to the suggestive question, often paired with information but communicated in a low volume or with the inflection that conveys passivity and allows for dismissal without contention.

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<sup>33</sup> Sitting next to Veronica, as she talked I could clearly hear her as well as most of what the doctor said, after she got off the phone I asked her to fill me in on what I had missed.

In the Med/Surg unit, Grace, a Filipina RN, had a patient who had been constipated following surgery (a common side effect of anesthetics) and suggested a stool softener.

*After responding to the doctor's questions about her assessment of the patient, Grace quietly suggested "Maybe we should give her a stool softener." Looking down at the chart on the computer, the physician said back "everything looks good here" clicked out of the digital chart and left the nurse's station.*

Suggestions tend to be uttered in a soft, lilting tone and often go unacknowledged by the physician. However, this does not necessarily mean that the suggestion failed. In fact, the outcome frequently coincided with the suggestion, but positional authority again was maintained. Even when quiet suggestions elicited a successful response from the physician, the nurse's contribution would frequently go unacknowledged.

Less frequent than suggestive approaches, direct approaches to communication include the prepared method and the assertive method. Utilization of these approaches varied by acuity of the unit, gender and race of nurse, official authority of nurse, and status signaled by a combination of education and nursing tenure. The higher the acuity of the unit the more likely nurses were to use both direct approaches, nurses in the ICU and ER made the most use of these strategies, the direct approach was most common in the ER. Male nurses were much more likely to use the direct approach than their female counterparts. White nurses were more likely than Filipino nurses. The charge nurses (more authority) made use of both approaches more frequently than staff nurses. BSN RNs utilized the prepared method more consistently than the ADN RNs (this seems to be a result of training, as the distinction was most predominant among new nurses). These different characteristics are, of course, combined in different practitioners. So, for example, the male ER nurses tend to be very direct with physicians and the highly

educated younger nurses in the ICU use the prepared method more than less educated nurses on their floor and nurses in other units.

The prepared method involves either formally utilizing the SBAR protocol or informally applying a similar strategy. In these scenarios the nurse approaches the physician with all available, relevant information ready and makes a recommendation (or suggestion) on a course of action. Gabby, a young 2<sup>nd</sup> generation Filipina nurse, is a committed user of this approach.

Her conversation with Dr. Miller about a diabetic patient is instructive here:

*Gabby: ... Mrs. Gomez's telly readouts look good. But you know she's diabetic –  
Dr. Miller: Right.*

*G: She's new to insulin and at night she's been hypo, her blood sugar has been dropping down to around 40.*

*Dr. And she's on NPH overnight?*

*G: Right. [voice drops a little] I think we should try an analog.*

*Dr.: What's her glucose intake like?*

*G: Normal.*

*Dr.: OK I'll write the order for detemir.*

Gabby is relatively new to the profession and the hospital and has not yet established rapport with most of the doctors, utilizing the prepared SBAR method facilitates her communication with doctors, even so, when making recommendation she lowered her voice, possibly signifying deference. In an interview, Veronica, explained how she came to utilize the SBAR system:

*I apply it because – when I was first out of school – I had been taught to use it [SBAR] in college. I had a patient I gave Benadryl to, IV, and she just, like, passed out. So I called the Dr. and I'm like “I gave the patient Benadryl and she went to the bathroom, and they came back and passed out on the bed. You need to come see them!”*

*And the Dr. said “well, what are their vital signs?”*

*“Oh, I don't know off the top of my head”*

*“Call me back when you know them” [CLICK]*

*So from then on, before I call, I need to know their blood pressure [...continues listing vitals ...]. So when I do call, I start with the vitals, what the issue is, why am I calling, and what do I suggest.*

This nurse, having come into nursing with the expectation of a collegial relationship with physicians, learned to adopt preparation as the best available option for ensuring productive collaboration.

In a more common modified approach nurses present all information, but do not make a recommendation and allow the physician to come a conclusion on their own. In my conversation with Maria, a veteran Hispanic nurse, she describes a typical scenario of her assessment and how that leads to treatment orders:

*I continue assessment, look at the chart, sometimes you get the report the patient is clear, because they just had the treatment and this is a few hours after and the patient is more wheezy so there's two things you can do either you request that the treatment be done more frequently or you request that they be put on continuous oh I mean you just review it with the doctor. I don't request it, I just tell him what the condition of the patient is and sometimes I tell him what I would like to be done and they'll come and they'll do an assessment and they may agree with my assessment or they might disagree.*

***Sometimes you have to communicate your assessment to a physician or you make a recommendation what is that like?***

*Well um say for example I've completed my assessment. Because you don't want to call the doctor based on one system you want to check all the systems, condition of the skin, patient's mentation, when you call the doctor you want to be prepared, and also you do the vital signs, because when you call the doctor you want to be prepared. When you give him your assessment or you voice your concerns you want to be able to give him evidence about what you feel about the patient or you can report everything and they can make an assessment based on that. I mean if you say the patient's wheezing more they'll come and they'll listen and they'll say "yeah let's increase the albuterol" or "yeah let's put them on continuous" but it's not always based on one system. You look at the whole patient you report on the vital signs, on the O2 saturation, you report all those things so he can make a broader – you may also report labs too – so he can make a decision.*

***You've been practicing a long time, and it seems like from this last example you might anticipate that increasing the albuterol is the best course of action.***

***Would that be something you would say to the doctor?***

*No. I would not. What I would say is "the patient had albuterol at such and such time and he's increasing wheezing, I don't know if its lasting long enough can you come check the patient? These doctors know. You don't really need to tell them, you just tell them what you see and either they'll check the patient or they'll write the orders.*

***So if you report your assessment and the doctor's orders are totally different from the course of action that you would recommend what would you do?***  
*I would defer to his assessment and if he felt like the patients not wheezing as much. I'll continue to watch the patient and sometimes I'll even ask a coworker to come listen as well or sometimes I'll ask before I'll see if someone else concurs with me and I think we as nurses do that a lot. So if they concur then I'll call the doctor and say "you know this patient seems like the albuterol's not lasting long enough can you come look at the patient?" "Or do you think maybe the patient might need you to increase the treatments?" Then they'll either come see the patient or they'll increase the treatment.*

Maria, unprompted, corrects herself. She wanted to be very clear that she did not make recommendations to the doctor. Maria felt that her role was to monitor the patient, assess the patient and if the patient seemed to require intervention she would present the available information and defer to him so, as she says, "he can make a decision." Notice that throughout this exchange she refers to the generic physician as he. This was standard practice among the nurses, in the 18 interviews I conducted with RNs not one referred to a physician as she when giving generic examples. So when Maria asserts that her role is ultimately deferential it is framed within a larger gendered system of role assumptions.

The assertive method was utilized by three categories of nurses: ER nurses, charge nurses, and male nurses. Differences in trust and relative power likely afford these nurses more leeway in physician interactions. The fast pace and urgency of care in the ER demand a high degree of cooperation and trust between physicians and nurses. Additionally, the ER has robust standing orders which allow nurses to act without physician approval on a number of treatments in a manner that is unavailable to nurses in other units. This expansion of autonomy requires organizational trust and conveys expertise and status. As a result, the nurse-physician relationship in the ER is qualitatively different than in other units. However, even ER nurses applied the assertive method only in a minority of cases, although male ER nurses and male

charges deployed the tactic far more regularly. Typically, the nurse makes an assessment, sees a problem, knows the solution, and then calls the doctor with a direct request for the appropriate order. This is a typical example of an assertive phone call in the ER:

*“Hi Dr., this patient is retaining urine and they are in pain. I need you to order a catheter.”*  
*“OK.”*

The assertive suggestion circumvents the rules of the nurse-doctor game entirely. The nurse initiated the recommendation, leaving no pretense that the doctor must come to the idea on his or her own.

Outside of the ER the assertive method is rare. Dave, a white, male charge nurse with over 25 years of experience, was a noticeable exception. On the very first day I observed in the hospital, Dave called a physician and told him that their patient’s condition had changed and “you need to change the order.” While the physician voiced objections, Dave stood his ground and the order was eventually changed. On my time in that unit, when Dave interacted with physicians it was usually in this manner. When I later interviewed Dave, he explained to me:

*Well let’s just say this Daniel, that having worked there for 25 years and worked with all those patients, I feel that my case is rather unique. Because when I call a doctor and I say to them come to me now, they will drop everything and come to me. And you know after years and years and years of knowing me and knowing how I practice and knowing that I’m not you know prone to wild imaginings and what have you, they have come to the conclusion that when I tell them that I need them, I am not exaggerating, there is a crisis, there is a problem, you need to come now.*

In comparing physician responses to his requests vs. other nurses, it is not entirely clear whether he is referring to physician perceptions of nurse behavior or his own evaluation of their behavior when he references “wild imaginings.” However, my impression based on many conversations with Dave and time spent on his unit, is that his statement probably reflects both possibilities.

While he is sympathetic to what he perceives as patriarchal behavior on the part of doctors and their reluctance to embrace the expertise of nurses, he can also be critical of the practice of other nurses. When I asked him about the difference between his approach to physicians and the staff nurses in the unit, he explained that many of the nurses are Filipino women and he as a white male, was uniquely able to stand up to physicians.

*The people who come from the East, specifically the Philippine nurses, in their country, they—the doctors are like Hitler, they are never questioned, they are never anything. You would never open your mouth no matter what happened, you know. You calling a doctor is almost verboten because you don't want to disturb them and so they—and also the whole you know women are second rate citizens kind of thing and you know it's amazing to me, I have stepped in and taken you know male doctors to task over the fact that they've, you know belittled or humiliated an oriental woman just because they could. I don't tolerate that at all. I have zero tolerance for bullying and you know I—boy I have publicly just called them out on it and embarrassed them. When you have somebody who's 6'3 and weighs 175 pounds who works out with weights and runs tell you, as they're towering over you that would you talk to me like that? And do you think you'd get away with it?*

Though Dave's representation of Filipina nurses is certainly an essentialist one, in my observations of his unit, I never saw one of the first generation Filipina women utilizing one of the direct approaches. In the observation unit, the preferred methods for communicating with physicians were suggestive. Dave points out, in his own way, his privilege as a white male nurse. His status, both earned and unearned, give him much more leeway with physicians and allows him to be much more assertive. Both Paul and Mari, the other two charges in the observation unit, are Filipino and used the suggestive method or a hybrid of suggestive and prepared methods in communicating with physicians.

Paul's methods and orientation of interaction with physicians contrasts sharply with Dave's. Paul is in his mid-thirties, was born in the Philippines and was raised in the United States. He has been a nurse for seven years and worked at HealthOrg for the last six. He is



cheerful and generally well liked. He's average height and build. In our interview he related a recent event when he made a recommendation to a physician regarding a patient's nutritional intake:

*So I called up the doctor and I said, "You know, Doctor, the patient's wife is concerned about, this patient hadn't had anything except fluid for I don't know how many days, and I know you've got a deal, but do you want to change the orders?" It's like, he started yelling at us. So they're the doctor who watches over the patient but they're gonna yell at us and try to blame it. And it's –*

*You're just gonna stop it there, 'cause, so what do you want to do now? There's no point in trying to argue with – and that's one of the things that I learned in this profession is, you pick your battles. You don't – I mean, they just kinda happen. Now I kinda just say, 'Whatever.' You just, just take whatever they're gonna dish at you and just move on, because you've got other things that you need to do.*

In this example, Paul uses the suggestive method of recommendation and simultaneously distances himself from the request by including the wife as the impetus. When the physician reacts poorly, he does not defend the suggestion, but chooses (probably wisely) to "pick his battles." The contrast between Dave and Paul's experiences is instructive. Both men hold the same position in the same department, are well liked and respected, but one being white and one Filipino, they are treated differently by physicians and adjust their own behavior accordingly. Paul as a Filipino man, is less able to be assertive with physicians and perceives physician opposition as just part of the job. Dave, on the contrary, demands and expects physicians to respond to his directives.

However, Jenny, a young Filipina nurse with two bachelor's degrees from Filipino Universities and works in emergency was one of the most outspoken users and proponents of the direct approach. When one of her patients was in need, she did not hesitate, and went so far as to type in the order for the doctor to approve. Moreover, she does not restrict herself to the assigned physician to advocate for her patient.

*If they're – again, if they have been vomiting, still vomiting, they look like shit and they're still throwing up and there's no doctor, I won't override a medication but I'll talk to any physician I see. They don't have to be a triage doctor or we have the medical officer of the day. I'll talk to any physician so I can get a medication for the nausea.*

Jenny has a number of roles in the ER, in addition to staff nurse, she works as team lead, bed czar, breaker and triage. She is passionate about her work and often pushes the limits of her practice. Though she can sometimes rub people the wrong way, her sense of humor, outgoing personality and nursing capability make her popular among doctors, other nurses and staff. Though she often uses crude language and is assertive with physicians it is possible that her looks (she has done modeling both in the Philippines and the United States) act as a feminine resource which mitigates some of her use of masculine communicative norms. Given her commitment and willingness to challenge physicians, she is often frustrated by the lack of initiative shown by her nursing colleagues. She told me about a time “where this nurse is just letting this patient be in pain because she said that, ‘well the doctor hasn’t seen the patient yet.’” In a follow-up she expressed her frustration with nurses who she perceived as overly subservient to doctors.

*Unfortunately, I don't know if most or some, but there's a good number of nurses who are just like – who act like robots. Oh, OK, yes, doctor. Dude. Fuck. You didn't study – I don't know how many years they studied, but you didn't study for this number of years just to say yes. Use your fucking brain. What the hell?*

When I asked Jenny if she noticed if any nurses were more or less likely to act “robotic” in their interactions with physicians. She replied: “Yeah. [PAUSE] I think there’s a cultural difference too, and there’s definitely a gender, like for some old females from different nationality, they’re more like, ‘OK, let’s just wait or something.’” She added “there’s a lot of Filipinos.” When I

prompted her to explain, she backed away from generalizing about Filipinos, saying “not all, I don’t know.” But re-iterated that female nurses, in her unit, were more likely to passively follow physicians.

One female nurse outside the ER, Brooke, utilized a hybridized communication style of the assertive and prepared method. Although she reports strong receptivity from physicians she also told me that she consistently goes up the administrative ladder to bypass orders and “pisses people off.”

*So I would call them up and I would say “Doctor so-and-so you ordered 60 aliquots or 60 ml equivalents of this medication and usually I only give them 40, so I just want to make sure you want to proceed because this is a pretty heavy dose and this is not a cardiac floor” and he would “oh yeah, you know what I only meant to say 40” or “you know what? I tried 40 the other day and it didn’t work. So I want to try 60 today”*

***Have you ever been in a position where you have a disagreement with a physician and weren’t able to come to an immediate resolution?***

*Oh Yeah all the time! I mean in medicine, nothing’s ever cut and dry in medicine. You know what I mean? There’s always all kinds of issues, and social issues, what’s the right thing and what’s the wrong thing? I mean that’s why we have other departments, and we have an ethics team and we have an ADA [assistant department administrator] and we have a charge nurse to go to. I mean I’m constantly advocating and going up the chain of command.*

***So that’s normal for you to go up the chain of command to advocate for a patient?***

*Yeah*

***And are there ever any social consequences for doing that...***

*Well you don’t want to be, you always want to be careful and polite. You know what I mean? You don’t want to step on anybody’s toes. Some people are more sensitive than others, that’s just a normal thing. [pause] Yeah I piss people off. [laughs] It happens, that’s life.*

Brooke, a white female in her twenties, is currently pursuing a master’s degree in nursing practice and explained that her motivation to become a nurse practitioner was the possibility of increased autonomy. She specifically felt that as an RN she was constrained by her scope of practice. Her confidence made the assertive position with

physicians seem natural to her. However, unlike the ER nurses or male charges her behavior is more outside the lines of hospital norms and thus needs institutional support (which was provided) and upset people.

Physicians also displayed varied responses to nurse-initiated recommendations, ranging from receptiveness, to annoyance and dismissal, and even to ignoring the suggestion. Regardless of whether or not the nurse's recommendation is adopted, receptive physicians seriously consider either alternative and explain the reasoning behind the decision to decline or to adopt the recommendation. The nurses' suggestive and direct communication methods tended to elicit different kinds of receptiveness from physicians. When a physician was receptive to a recommendation communicated using a suggestive approach, he would often frame his acceptance as his own decision, as in the example above after the doctor has been asked the suggestive question "*You know what? I'm going to change the order.*" In these instances, after the nurse would make a subtle suggestion, the doctor would frame his affirmative response as "I think" or "I will." By contrast, when nurses utilized direct approaches, physicians would be more likely to frame their acceptance inclusively ("let's do this") or with a simple affirmative. Additionally, when rejecting a recommendation from nurses who communicated using the direct methods, doctors were much more likely to engage in a dialogue with the nurse about their reasoning.

When physicians were approached with suggestive communications that they subsequently rejected, they were much more likely to unceremoniously dismiss the suggestion outright – typically with a simple "no" or reiteration of the original order without explanation. Dismissal is often coupled with annoyance. The majority of these signals are non-verbal: rolled eyes, a lifted brow, or a change of tone that communicates "are you really bothering me with

this?” Sometimes, the physician expresses dismissive annoyance through rudeness or verbal abuse. This doctor’s sarcastic remark exemplifies these kind of interactions:

*Mari, a Filipino woman who is sometimes charge on the floor, but was not at the time, explained to a young male Doctor that a patient no longer warranted the level of acuteness of the floor and asked,*  
*“Would you want to move the patient to Med/Surg?”*  
*“Why? So she can get even worse care?”*  
*At this point the conversation was dropped and the doctor left the unit.*

Mari, made a strong case for her recommendation, but was not only dismissed, she was insulted. These kind of interactions, however infrequent, discourage collaboration and clearly delineate the hierarchical relationship between physician and nurse. Afterwards everyone went back to their business. The reverse, where Mari would dismiss the doctor, simply does not occur.

<b>Table 4.2.</b> Typical Nurse Suggestion/Recommendation and Physician Response		
Nurse Communication Strategy	Type of Response:	
	Agreement	Disagreement
Suggestive Strategies - questioning - quiet suggestion	- Acceptance, reframed exclusively	- Ignore - Dismiss - Annoyance
Direct Strategies - prepared - assertive	- Simple acceptance - Acceptance, framed inclusively	- Explanation

Table 4.2 summarizes the typical relationship between nurse communication strategies and physician responses. Direct communication strategies tend to provoke collaborative responses and suggestive strategies tend to elicit non-collaborative responses. However, this does not mean that the inverse cases do not occur. Suggestive questioning did very occasionally result in collaborative, explanatory responses and Candace, who utilized the SBAR (prepared) approach specifically for communicating with difficult doctors, expressed that while it was helpful in getting a physician to adopt her suggestion the doctor may still express annoyance. Depending on the gender or ethnicity of the nurse in question, direct approaches may also

provoke long-term consequences that inhibit the kind of relationships needed to maintain the daily intimacy and efficiency of the nurse-physician interaction. That is to say, while it appears that direct communication strategies universally produce better outcomes for nurses, this strategy is not equally received the same for all nurses and therefore is not equally available to all nurses. My observations did not include many interactions with female physicians, however from what I did see, there was not significant difference in the ways nurses approached female physicians. I did not see or hear stories of difficult or rude female physicians, however, nurses still tended to utilize suggestive strategies when engaging with them. Assertive behavior, broadly speaking, is not interpreted the same for men and women or for nurses of all ethnicities. Dr. Blumenthal's<sup>34</sup> interpretation of nurse assertiveness vividly exemplifies the double bind that female nurses face. In a follow-up conversation about nurse assertiveness with physicians, he related to me:

*Right, but male nurses when they are assertive are more collegial. For some reason when women nurses are assertive they don't act collegial they act like B-I-T-C-Hs ... not all but a lot. I don't know what it is, if it's hard wiring or cultural or whatever, but women act like they need to prove something.*

Although he knew it was an opinion that was not politically acceptable, something he demonstrates by spelling out the slur and hedging immediately after, even after being pressed he stuck to his basic premise and denied that it may have been a matter of his own interpretation. In his view most female nurses are either appropriately subordinate or inappropriately collaborative, while male nurses were perfectly capable of behaving collegially collaborative. Though he was firm in his interpretation he struggled to provide particular behavioral differences outside of a kind of nebulous "tone". While the other physicians I interviewed did note that they noticed

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<sup>34</sup> Dr. Blumenthal is a white male in his 50s, who after working for two decades in a smaller regional hospital, had begun working at HealthOrg as a general practitioner only 6 weeks prior to our interview.

more male nurses interacting with them assertively they weren't able to provide an explanation for these differences and did not express distaste with female nurse assertiveness.

The direct methods of nurse communication – preparation and assertiveness – were much more likely to elicit a collaborative response from physicians. The more common methods of suggestion – both through suggestive questions and quiet suggestions – facilitated the physician's maintenance of a traditional hierarchical and unidirectional relationship with nurses, where the nurses-physician relationship remains characterized by female deference and male authority. Additionally, both subtle and unsubtle displays of impatience and annoyance discourage collaboration. The implicit threat, even if unlikely, that nurse assertiveness will be greeted with unpleasantness makes it that much more of a risky proposition for nurses to engage in the behavior. In other words, sanctions that govern the boundaries of social norms make people more likely to comply with those norms. The hierarchy in the hospital tends to fall along gendered lines and as gendered norms also overlap with norms of organizational hierarchy, the norms then maintain that hierarchy. Gendered interactional styles are available as resources for all nurses, but differences in gender, race and status provoke different interpretations of those strategies and inhibit the use of assertive strategies and promote indirect strategies for most nurses. The established forms of communication, particularly those which mirror gendered norms, informally reinforce hierarchy and reduce collaboration, despite the organization's formal steps to the contrary.

#### *Informal Relations and the Dominance of Social Space*

The informal ways in which doctors and nurses tend to interact in the social spaces of the hospital also maintain their hierarchical positions. Observations in the nursing stations of four hospital units reveal that while these are primarily nurses' spaces, the presence of doctors

consistently disrupts (both directly and indirectly) the character of the setting. When doctors enter nursing stations where two or more nurses are engaging in conversation, the ensuing social interaction tends to express the dynamics of professional hierarchy in various ways. Most commonly nurses' conversations are changed without direct intervention on the part of the doctor. When a doctor enters the nurses' station, conversation quiets or ends; or shifts in focus to centralize the doctor. For instance in the Telemetry floor:

*Patrick and Lauren are sitting in the nurse's station working on charts. Earlier that week the hospital had begun issuing nurses cell phones to keep on them at all times. Patrick and Lauren were complaining that they already had multiple alarms and pagers on them to monitor the patients on the floor.*

*Lauren: Look at all this stuff. [She methodically takes out each phone, pager, alarm, and other electronic device and piles them on the desk.*

*Patrick – I know its crazy, I feel like my pants are going to fall off!*

*Lauren – There's only one good thing about these phones.*

*Patrick – What's that?*

*Dr. Budniz enters.*

*Lauren – Trails off.*

*Dr. Budniz goes to work on a computer and Lauren and Patrick turn to their computers and work through the charts they have open.*

This happened all the time. Though they weren't talking specifically about work, these kind of abrupt ends of communication only happened when physicians or in some cases nurse managers entered the station. Conversations would continue in the presence of patients, patients' families, and other hospital staff and of course other nurses. Often rather than stopping abruptly, the conversation was redirected to focus attention on the physician as they enter the space, as we can see in the example below:

*Brit and Mari are sitting at computers charting, while they do this they are discussing the upcoming turn team. Dr. Wang enters the station and sits at a nearby computer.*

*Mari – "Hi Dr. Wang, how are you?"*

*DW – "Good, thanks"*

*Brit – "We don't see you enough around here"*

*DW – "Hey I try, I actually wanted to talk to you about Mr. Cole in 14."*



*Dr. Wang and Brit talk about Mr. Cole briefly.  
Meanwhile, Mari finishes her charting and goes to check on a patient.  
Brit returns to charting.*

Less typically, when nurses do not end or shift their conversations on their own, doctors will interrupt ongoing conversation between nurses, insert themselves into the conversation, and/or change the topic entirely. In the example below, as two nurses were talking through a particularly stressful ordeal with a patient, a doctor enters, interrupts and attempts to change the topic.

*Patient in bed 14 was just assigned a sitter (someone to monitor a patient with Alzheimer's, dementia or other psychiatric issues), he had been getting out of bed and wandering around the unit confusedly. To assure that he wouldn't hurt himself, at the insistence of the unit charge Nurse, Dave, Dr. Wang had ordered the sitter to keep watch and assure he would stay in bed. After the sitter arrived, Dave and Helen (an RN) expressed their relief.*

*Helen – “Finally, he'd been wandering all morning.”*

*Dave – “Yeah, he could have easily been hurt or lost or who knows what...”*

*Helen – “You know, I'm not really sure that Dr. Wang was allowed to order the sitter”*

*Dr. Schwartz enters.*

*Dave – “Either way we needed it, if he had hurt himself or hurt someone else, and there wasn't a sitter there we could've easily been sued. I mean - ”*

*Dr. Schwartz – “Hey, the weather this weekend was crazy. 20 foot swells coming up over the piers.”*

*Dave – [pause]*

*Dr. Schwartz – “I've got enough going on I don't want to hear about the courts.”*

*Dr. Schwartz then goes to see the patient. Dave and Helen each turn to a computer and work on their charts.*

Self-regulation of conversation by nurses, avoids uncomfortable experiences like this one.

Despite the one-sided nature of these conversations, informal interactions between nurses and physicians were generally genial and good natured. Physicians and nurses, like any other co-workers, exchanged pleasantries, jokes and related stories about family, vacations and current events. Nurses and physicians were more likely to talk amongst themselves, for the most part, but cross-occupational fraternizing was not out of the norm. But the predominantly Filipino

medical-surgical unit presented a stark contrast in style. While most interaction here was still congenial, with important exceptions, the lack of informal interaction between nurses and physicians was palpable. During my first visit to Med-Surg, after previously observing in the DOU and TELE units, it stood out clearly. On that first day there were three or four doctors on computers almost the entire time I was in the central nurses' station – they were having a great time with each other - laughing, joking, discussing family life, etc for a long time – yet they barely interacted with the nurses there at all. To be clear, the central nurses' station in the unit is a small room<sup>35</sup> ringed by eight computers and chairs, and for four hours the same 10 people exited, entered and worked in the room without speaking to each other except when professionally necessary. This pattern continued mostly unchanged during my entire time in the unit. Nurses on the floor did have casual conversations with the unit coordinators, nurse assistants and other non-physician staff, regardless of ethnicity. When I turned to Liezel, the unit charge and 20+ year veteran on the verge of retirement, for insight into why nurses and doctors in the unit didn't really talk outside of work matters, she told me simply, "that's just the way it is."

In the most extreme cases doctors demonstrate callous assertions of dominance by disregarding the space and needs of nurses while seemingly refusing to acknowledge their presence. The following example took place in the Med-Surg unit and exemplifies both the lack of communication between physicians and nurses in the unit and how that can easily be transformed into disrespect and hostility.

*Analy, the unit charge, is sitting at her computer station, unlike other units this one has designated desks where the charges work (rather than using whatever*

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<sup>35</sup> Unlike other units, the medical surgical unit nursing station was an enclosed room in the center of the unit. In other units the nursing station was a space with desks in the center of the unit and open to all the patient rooms or beds.

*computer is available) and her name is posted at the module. She gets up from her computer for a second to do something else – in the meantime a white male doctor sits down at her computer despite several other available computers in the nurse station. Shortly after the Doctor sits down, Analyn returns to the station – she sees that the Dr. is sitting in her chair and that he is resting his arm on papers she needs. So she, deferentially, says “excuse me Dr”, he doesn’t look up from the computer, so she pulls papers from under his arm and sits down at another computer. He finishes up his work, gets up and leaves. Over this entire exchange the Doctor never said a word to Analyn or even acknowledged her presence.*

Despite the fact that the nurse’s station is the nurse’s home space and that in this unit in particular where the charges’ seats were designated, the offending physician demonstrated ownership over the space. Analyn, though visibly annoyed, worked around the rude behavior rather than confront it. In their interactions in an all Filipino unit, physicians displayed the most socially distant and authoritarian behavior. They rarely initiated or made informal social interactions, and at times openly disrespected the unit nurses (including the charge).

Somewhat atypically, the conversation of the nurses will continue unchanged in tone, tenor or topic while doctors go on with the work they need to do in the station (look up a chart, talk to the appropriate nurse, etc). From my interviews it seems like this was a much more common practice in floors where the physicians worked exclusively on that floor as opposed to coming and going. Though in some ways more subtle than the “nurse-doctor game,” the disruptive occupation of social space also works to reinforce the boundaries between nurses and doctors and to reassert professional dominance.

Nurses typically failed to recognize this phenomenon until confronted with it during the course of interviews. In follow-up encounters, nurses confirmed noticing the behavior on the part of physicians and nurses, but few were able to provide an explanation. Older nurses recounted that, earlier in their careers (the 1980s), nurses still stood at attention when doctors entered the

nurses' station. They theorized that the current behavior was an extension of historical practice. One nurse told me that it was a show of respect. Though doctors have do have more authority in the hospital than nurses, it should be made clear, that they are not their bosses. It is also possible that the time needs of physicians necessitate this interactional pattern. Because physicians see many patients and are only on any given floor for a short period of time, it may behoove the nurses to make themselves conversationally available. Perhaps it is simply more efficient to be quiet when doctors arrive on the floor so that they don't have to interrupt you when communicating important information. However, physicians also interrupted or recentered the conversation to interject non-work and non-crucial information. Additionally, these interruptions are buttressed by subtle and not-so-subtle hostile or dismissive behavior and social exclusion. This social exclusion was most distinct when the unit was comprised primarily of Filipino nurses. Of course, I also observed a few physicians that regularly maintained conversations with the nurses, and most had friendly relationships with the nurses. Dr. Schwartz, for instance, regularly engaged with nurses in their ongoing conversations when he did his rounds in the DOU. Though doctors regularly traded niceties with nurses they did not regularly engage in significant social conversations with nurses, frequently when more than one doctor was in the nurse's station the doctors carried on long conversations with each other. Though I didn't observe enough female doctors consistently to generalize, their informal interactions in the nurses' stations did appear different than male physicians. Rather than centering themselves in the physical and social space of the unit, female doctors tended more to keep to themselves when working in the station.<sup>36</sup>

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<sup>36</sup> Again, take this with a heavy grain of salt as the sample was very small.

Interruption, particularly intrusive interruptions, interruptions by a single person within a larger group, and the physical intrusion of space are socially masculine acts (Anderson and Leaper 1998). As similar practices maintain traditional gender roles in the broader society (Hanson Frieze and Ramsey 1976), it is no wonder that they not only encroach into the workplace but also go largely unnoticed. Ultimately ending conversation upon physician entrance serves the same social purpose as nurses standing at attention; it is recognition and re-inscription of hierarchy. When nurses don't follow social procedure they risk being interrupted and decentralized from conversation, further reinforcing hierarchical relations. Social exclusion also increases distance and reifies gendered, racialized norms that maintain and normalize differences in status and authority. Furthermore, acts of carelessness, callousness or aggression, however infrequent, when contextualized in the broader hierarchical systems at work, support physician dominance.

### *Conclusion*

The nurse-doctor relationship lies at the core of nurses' work life and professional status. Over the past century, the nursing profession has worked diligently to improve the esteem of nurses and to solidify their position as a partner in medical care through professionalization in education, credentialing, and licensure – not as a subordinate to physicians. There has been much resistance, of course, from physicians, as well as from hospitals and hospital associations that have tried to maintain nurses as a relatively cheap source of labor. Even so, nursing has made significant progress. And as national social change in the provision of medicine necessitates a larger role for nurses and more collaboration between nurses and physicians we may be on the brink of further progress. In this chapter, I attempted to assess how the nurse-

physician relationship functions in an organization that has attempted to foster collaboration, as opposed to authoritarianism.

Ultimately, socio-cultural gender norms maintain a hierarchical relationship between nurses and physicians. Behavior in both formal and informal interactions reinforces the deferent, subordinate position of nurses. Though nurses utilize feminine and masculine communication styles to achieve needed ends, subtle and less than subtle responses from physicians tend to promote gender normative behavior. As such the subordinate status of nurses is deeply enmeshed with the subordinate status of women and the socio-cultural gender system which sustains it. Nurses' status and relationship with physicians is similarly influenced by ongoing racializing processes. In addition to differences in interaction and interpretation of differently racialized individual nurses' behavior, the organization of hospital units into racially heterogeneous or homogenous nursing teams seems to have produced differently racialized communities of practice that have substantially different kinds of relationships with the physicians with whom they work. The gender, race and capital resources of individual nurses tend to shape their interactions and relationships with physicians.

Workers in the hospital interact with one another carrying and utilizing an accumulation of ascribed, institutional and reputational statuses. These statuses coalesce and are signaled in repeated relational interactions that tend to align with normative assumptions about "appropriate" gendered and racialized behavior. As these norms also overlay the professional hierarchy in the hospital they also serve to reinforce and normalize the hierarchical professional relationship. So despite HealthOrg's efforts to restructure nurse-physician communication into more strictly routinized, outcome focused and collaborative communication, in practice, nurses either modify this routine to fit more closely with gender normative communicative styles or

eschew it completely. Nurses then tend to communicate using suggestive rather than assertive talk that facilitates the maintenance of physician-driven decision-making. The use of the suggestive communicative strategies was not monolithic, usage was highly predicted by the gender and race of nurses. White males were most assertive in their communication with physicians. Filipino men, sometimes were assertive with physicians, but “had to pick their battles” as Paul explained. While some white female nurses made use of some assertive strategies, those that did ran into resistance and most learned to play the nurse-physician game to get by. Outside of the very visible (and potentially tokenistic) counter-example of Jenny, Filipina nurses (within some generational variation) were least likely to utilize assertive talk with physicians. Given the pattern of social distance and dismissiveness experienced by Filipina nurses on behalf of physicians in informal communication, this reluctance to assertion is entirely understandable. Again, these informal interactions, like their more formalized counterparts, are steeped in the gendered and racialized relationships of the constituent actors. The interruption of feminine space and social interaction by men both falls within the gendered norms of interaction and serves to reinforce the dominant status of the men (physicians) who interrupt. The interruption, as it were, is most extreme in the Filipina dominated nursing station, where physician entrance not only interrupts nurse sociability but precludes it entirely and was coupled, at least once, with outright spatial aggression.

Though not reported here, the gendering of nursing is not limited to interactions with physicians. Nurses generally experience a high degree of autonomy from their patients when administering care, but there are important exceptions. As HealthOrg moves increasing to “customer-focused” care, tensions between professional autonomy and service are heightening.

Often these tensions take the form of gender-work stereotypes; female nurses repeatedly related being made to like a maid or waitress by patients or their families.

In recent history, several important healthcare and governmental institutions have begun to push for a more collaborative patient-centered approach to health care. The healthcare system under study here has implemented several important organizational policies to encourage physician-nurse collaboration. Formalized communication and enforced collaboration seem to have returned uneven success. Although collaboration has increased and the physician-nurse relationship has improved markedly compared to other settings and to its own past, the interactions between nurses and physicians remain heavily determined by gendered and racialized patterns which reinforce hierarchy and create barriers to effective collaboration. Moreover, these issues have implications for the retention of skilled nurses and for the quality and coordination of care.

The adoption of the Affordable Care Act and the expansion of medical care necessitate large scale structural change in health care provision. This will entail reorganization and restructuring of professions. Aspects of these broad changes hinge on the nurse-physician relationship. Collaborative practice is crucial to meeting the new challenges of increased complexity and efficiency demands. Unfortunately, at the moment, old professional hierarchies inhibit effective collaboration, leaving the responsibility to nurses to adopt a mix of formal and informal strategies to promote productive communication with physicians. These strategies vary in their composition and effectiveness. Even within organizations that explicitly and aggressively pursue the goal of improved collaboration, serious impediments remain. Successful implementation of nurse-physician collaboration on a large scale will demand sweeping changes. In addition to the widespread implementation of institutional policies like enforced MD-RN



rounding and joint MD-RN patient communication, training in collaboration for both professions will need to be greatly expanded within organizations and academic settings. As women continue to enter medicine and approach parity in other occupations, a commensurate gender exchange has failed to occur in nursing; less than ten percent of Registered Nurses are men. Radical reformulation of the gender composition of the two professions may ultimately be needed to completely overcome the deeply engrained gender dynamics that act as barriers to robust, successful nurse-physician collaboration.

## Chapter 5.

### Conclusion – The Social Nature of Professions

*“Some people ... don’t look at you like you’re a professional. I don’t know why. Some people think that you’re a maid.”* – Registered Nurse, 2015

Professions are socially constructed and as such professions and professionalization are subject to social forces. In some ways this seems self-evident, but to this point the majority of theorizing on professions, with notable exceptions, has provided an under-socialized account of the creation and maintenance of professions, their stratification, and the quotidian experience of professional life. *The System of Professions* (Abbot 1988), perhaps the most important contemporary text on professions<sup>37</sup>, for example, confines its only explicit discussion of gender to two short footnotes in reference to feminization as a form of professional degradation. Yet sociologists have long established the centrality of gender, race and class to the organization of social life and their influence in virtually all social organization and interaction. Whether we think of these categorizations as organizing frames, group positions or resources, it is clear that they are likely to interdict, if not completely structure, social negotiations. I have shown that in the negotiation of professionalization – especially as it has been experienced by nursing – gender, class, and race are inseparably linked to the process.

Examining professionalization and professional status from three distinct vantages, evidence suggests that success in these arenas is highly contingent upon the gendering of the work and its practitioners. Professions, like most occupations tend to be sex segregated. As a result, professional hierarchies take on a number of gender configurations. I considered the three most common – male/female heterogeneous, male/male homogeneous, and female/female

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<sup>37</sup> To this point, the book has been cited in over 9500 academic works.

homogenous hierarchies – and found that inequality is greatest in the male/female heterogeneous arrangements. In these hierarchies, when the fields experience growth, the dominant male professions make much larger gains than the subordinate female professions. In the sex homogeneous hierarchies, growth over time was much more comparable. Professions engage in occupational closure, in part at least, to reap economic rewards. Licensing, credentialing, educational requirements and the activities of professional associations direct demand and limit supply and should, therefore, increase wages. While this is true, it is not equally true for all professions. Between 1968 and 2015, for 30 professions and relevant occupations, historically male occupations had significantly higher incomes than historically female ones, when controlling for a host of relevant factors. Perhaps even more central to the discussion here, occupational closure strategies also increased incomes in historically male professions more than in historically female professions. Comparison of a diversity of professions over almost 50 years shows that professional rewards, in the form of income, are stratified along gender lines and that professional occupational closure strategies produce unequal rewards for male and female professions. To better understand why, I turned to the history of nursing and its quest for professional status.

The first thing that becomes immediately clear in studying the history of the nursing profession is that the professionalization process is not nearly as simple as early professional process scholars suggested. Becoming full time, establishing training schools, professional associations, legal protections and ethical codes just isn't enough. Perhaps these are necessary conditions of professionalization, but they are certainly not sufficient to gain full autonomy, professional recognition, or much less a special class standing. For nursing, as Abbot (1988) and Larson (1977) would predict, the professional association and practitioners were confronted by a

complex ecology in which they had to face both professional and economic competition. The expansion of nursing's professional standing, mandated licensing, and increased education posed threats to both physicians and hospitals. Limiting the supply of nurses increases labor costs for hospitals and private practice physicians. Increasing jurisdiction, autonomy and status of nurses threatens the authority of physicians and hospital administrators. Yet, at the same time, the rationalization of nursing and its institutionalization in hospitals was critical to the growth of the hospital industry and the medical profession. As a result, through the 19<sup>th</sup> and early 20<sup>th</sup> century, physicians maintained a paternalistic role in the professionalization of nursing – encouraging and guiding education, while maintaining nurse subordination and restricting autonomy. During this period, the medical profession and representatives of the hospital industry actively worked against strict licensing and higher education for nurses<sup>38</sup>. As nursing sought to professionalize and work against its detractors, the American Nursing Association, in addition to making the standard claims of essentiality and complexity, relied on the gendered resources of its white, middle-class leadership and historic past – portraying nursing as a noble profession, embodied by virtuous, self-sacrificing women eager to nurture and offer their care. Physicians and the American Medical Association also invoked gendered norms in the matter. Physicians framed nurse subordination to a male dominated occupation as natural, care work as merely an extension of domestic duty and decried economic self-interest as counter to the virtue of nursing in order to justify and maintain their own dominance. Though the ANA made great strides in achieving key professional goals: licensure, education and credentials, facing resistance from hospitals and the medical profession, it still, into mid-century, had made little economic progress.

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<sup>38</sup> Preferring voluntary licensing that supported the rationalization and recognition of training, but also provided a pressure valve should labor become too scarce.

Although nursing's leadership came from and represented the upper and middle class, a presentation that lent credibility to the burgeoning medical/hospital industry, most of its practitioners were working class (Manley 1995). The lofty goals of professionalization did not meet the needs of these working nurses; they needed economic security. The ANA had for decades decried collective bargaining and unionism (invoking tropes of selfless femininity and sacrifice), but facing increasing internal disunity and external encroachment from unions, the ANA halfheartedly and with restrictions embraced collective bargaining as a legitimate strategy. A tenuous truce, the ANA would never fully bridge the differences in professional goals, needs and strategies of its internal class structure. The class division within the ANA, indicates the particularly classed nature of professionalization as an occupational closure strategy. In the case of nursing, it is clear that the pursuit of professional status required the kind of patience and foresight that are the privilege of material resources. Professional closure may not lift the economic circumstances for its practitioners in the near-term, particularly if they are women, but direct, collective action seems to be more effective in that task. However, without fully embracing unionism, nurses continued to meet resistance to professional expansion<sup>39</sup> from hospitals, that in addition to providing inadequate wages, regularly engaged nursing in menial non-nursing labor and provided them with little self-governance or autonomy. In contentious battles, hospital administrators and their organizational representatives dismissed and wrote off nurses, accused them of selfishness and of betraying the noble traditions of nursing. In the wake of these disappointments, the ANA further embraced a unionization strategy, but it also aggressively pursued a professionalization path exemplified by its pursuit of the entry into practice issue. Here they were met with hostility from hospital associations, ambivalence from

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<sup>39</sup> Not to imply that had nurses embraced unionism more fully, hospitals would not have resisted.

medical associations and disunity among nurses. Again the hospitals charged professionalizing nurses with abandoning the selfless (subtext womanly) character of nursing, while internal disunity mostly broke down along class divisions. In the end, the ANA has so far failed to upgrade the education requirements to enter nursing.

Changing economic conditions in the 1990s, characterized by aggressive hospital restructuring resulting in the loss of thousands of nursing jobs, tore the ANA's class divisions (exemplified in the union vs. profession debate) apart. As many of the largest state associations left the national association to reform as unions and eventually unite under the NNU, the NNF and other organizations, the ANA entered the 21<sup>st</sup> century with a fraction of its peak membership, and represented fewer than five percent of registered nurses in the United States. The NNU has pursued an aggressive union organizing strategy, making liberal use of strikes and mass demonstrations all while openly embracing a class conscious, ant-racist and feminist rhetoric. The ANA has turned its focus primarily to the upper echelons of nursing, focusing on the expanding role of advanced practice nurses and returning to entry into practice issues.

The professionalization of nursing, both its successes and failures, are significantly interwoven with the gender and class (and though mostly unexamined here, race) structures internal to the occupation and externally in the larger professional ecology. Time and again, gendered stereotypes of nursing were deployed both in pursuit of and in opposition to its professionalization. As a result, nursing has remained in a subordinate role to the medical profession, it has failed to upgrade educational requirements to substantially limit labor supply<sup>40</sup>, and unionization has emerged as a more attractive option for many of its practitioners. As I noted

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<sup>40</sup> There are periodic nursing shortages to be sure, however, these are cyclical and as nursing advocates explain, are due to the large number of nurses who leave the profession.

in the introduction, nursing is one of the highest paid occupations primarily composed of women. In that regard professionalization and unionization have been relatively successful. At the same time, nurses work in health care the fastest growing industry in the country and their wages have not kept pace with the rapid growth of physician, pharmacy or physician assistant salaries. Some health care organizations are responding to research that shows that communication errors and authoritarian nurse-physician relations are detrimental to patients and are pushing for greater nurse-physician collaboration and by extension increasing the relative status of nurses. To examine how professional status and autonomy are affected by gender and race in this kind of organizational context, I conducted ethnographic research within one-such hospital.

The working relationship between nurses and physicians is not only critical to the successful operation of hospitals, it is central to understanding the status and autonomy that nurses experience on a day to day basis. Jurisdictional negotiation does happen on national and state levels, but it also occurs in daily interactions. Both formal and informal interactions define boundaries for behavior, establish status and determine hierarchical (or other) inter-professional arrangements of power. These interactions are structured by legal limits on scope of practice and responsibility as well as formal organizational policy, to be sure, but gender and race also appear to play a significant role in the character and negotiation of interactions. Through observation and interviews with nurses and physicians, I found that the discursive and interactional patterns, both in formal and informal instances, between nurses and physicians were significantly influenced by the gender and race of nurses. The patterns of gendered and racialized interactions tended to reinforce the dominance of physicians and the subordination of nurses.

One of the most crucial and difficult nurse-doctor interactions is in the communication of nurse recommendations. In these instances, the nurse may need to contradict physicians and

potentially convince them to change the course of treatment. Though direct, assertive recommendation was the most collaborative approach for nurses in this situation, it was typically utilized by white male nurses (a minority of nurses) and only rarely by male Filipino nurses or female nurses. More commonly nurses utilized suggestive approaches that allow physicians to come to the recommendation on their own. White and Filipino female nurses as well as male Filipino nurses faced social consequences in the near and long-term when they stepped out of prescribed subordinate communication styles. Hierarchical formal communication was further buttressed by informal interactions when physicians entered nurse's work stations. When physicians entered these spaces they re-centered conversation, interrupted or otherwise disrupted nurse socialization (work related or otherwise). Disruptive behavior and social distance between nurses and physicians was especially acute in the predominantly Filipino medical surgical unit. When nurses, physicians and other hospital employees interact they bear and make use of an accumulation of ascribed and institutional identities and statuses. These coalesce and are signaled in repeated relational interactions. Professional interactions tend to align with normative assumptions about "appropriate" gendered and racialized behavior, and are sanctioned when they don't. Because gendered and raced statuses mirror professional ones, interactions in the hospital reinforce and normalize hierarchical professional relationships

### *Re-theorizing Professions: A Socialized Account*

Based in these observations, I propose a re-theorization of professions that is substantially socialized and places the "system of professions" within systems of gender, race and class. To do this, I will first clarify my understanding of professions and professionalization.

Do we measure professions by what they do (and who the professionals are), by what they've achieved or the special rewards they reap? Professions are primarily conceptualized in



one of these three ways: 1) their traits (i.e. the type of work, relationship to work, normative expectations, etc.), 2) their institutional arrangements (i.e. whether they have secured licensing, education system, etc.) or 3) their outcomes (secured autonomy, monopoly over work), or alternatively, by some combination of the three. By professionalization I refer to the process whereby occupational groups develop those traits, secure institutional protection and gain monopoly and autonomy. In invoking professionalization, I offer two important caveats, 1) I do not mean to imply, as others have, that this process is unidirectional or deterministic and 2) I recognize that occupational groups, professionalizing or not, are not particularly well organized. By which I mean even in the occupations pursuing professionalization many, if not most practitioners, are not consciously engaged in professionalization and that there may be significant divisions between those that are (as I describe in nursing's history). The professionalization framework therefore recognizes the interconnectedness of all three aspects of a profession. Situating professionalization as a process also implies that 1) it is ongoing and 2) that the three aspects of professions are internally scalar and continuous rather than discrete categories. Professional traits represent, in combination, degrees of professionalism<sup>41</sup>, for lack of a better word. To put it differently, occupations exist on a spectrum ranging from not professional to very professional in all aspects of professionalization. As much as this is true for occupational groups, it is also true for individual practitioners, who project various degrees of professionalism, have more or less institutional protection, and experience varieties of autonomy. To build on this, I argue that the attributes, institutional protections, and outcomes of professions

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<sup>41</sup> Here I do not mean the colloquial sense of professionalism, but rather professionalism as a status or identity indicating that the occupation or practitioner is professional

are deeply interconnected and mutually reinforcing, and that each are deeply embedded in systems of gender, race and class.

Professional attributes include the qualities of the work itself, the relationship of the occupation to the work, and norms of the work. Professional qualities of the work include the essentiality and complexity of the work (Forsyth and Danisiewicz 1985), and the basis of the work in a 'science' (Brante 2011) or systematic body of knowledge (Pavalko 1988).

Professional occupations are also expected to be uniquely (Forsyth and Danisiewicz 1985) connected to their "heartland of work" (Abbot 1988). Norms of professions include: commitment or a calling to the work, service orientation, and scientific expertise and objectivity (Pavalko 1988; Wilensky 1964; Hearn 1982; Glazer Slater 1987). I would argue that rather than being atomistic traits they are cumulative and operate in combination to make up a holistic professional identity. To be a profession in terms of occupational traits is essentially a cultural argument about the kind of traits that we socially attribute to professions. So occupations, in projecting a professional identity, may make use of any of these traits in combination to make their case. "Image-making activity" to secure institutional protection over a body of work, relies on reference to these qualities.

The institutional arrangements central to professions are legal and social strategies to achieve occupational closure. To give professions the benefit of the doubt, occupational closure is not necessarily antithetical to the service-orientation of professions; it is not necessarily or purely self-interested. For sufficiently important and difficult work, limiting the labor supply to the highly trained and qualified may prevent disaster. Moving on, the two most important institutional arrangements are licensure and educational credentialing. Formal degree granting institutions prepare and socialize new practitioners to work in the profession, restrict access to

the work, and signal importance and quality of the work to employing organizations and the public. Licensing requirements legally restrict entry into the professions, while potentially controlling for quality. Institutional protections, like professional work traits, are also scalar. Even within nursing, historically and state to state, restrictiveness of licensing and education has been variable. Achieving licensing and credentialing protections relies on making convincing claims to relevant institutional actors that the occupation has the traits to justify closure<sup>42</sup>. In other words, occupations engaging in professionalization by seeking licenses or to establish schooling are more likely to succeed (and to succeed more robustly) if they have the traits that are associated with professions. At the same time, having legal and educational protection grants the profession legitimacy and makes its attributional claims stronger.

Power gained through institutional protections and professional claims may result in special privileges in the labor market. If professionalization is successful it should provide a unique class position for its practitioners: exemplified by autonomy at work (both in national regulation and within organizations) and higher wages resulting from restricted competition. Like institutional protections professional autonomy is self-reinforcing. Professionals have autonomy, so having autonomy supports the claim of professionalism.

Professionalization, the process in which all of the professional traits come together, is dynamic and necessarily social. Professions must fight for their status against competing occupational groups and/or employing organizations and within existent legal-social structures (Larson 1977; Abbott 1988). Professionals that work in concert with others must also negotiate and maintain jurisdictional and hierarchical arrangements in their day to day activity. In studying

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<sup>42</sup> Though successful claims-making is a necessary condition of gaining institutional protections, it is probably not a sufficient one. State intervention may also depend on market conditions (particularly market failures) (Dingwall 1999), and response to counter-claims.

the professionalization of nursing, what becomes clear is that the process, taken as a whole, is deeply gendered.

Here I'd like to return to the attributional model of professions. I have already argued that professional identity, for an occupation or a practitioner, is an accumulation of a multitude of attributes. This is especially important in considering contemporary professionalization because the idea of a profession is already established, so the contest is not merely whether the occupation is essential, scientific, complex, etc. but whether or not the occupation is or should be "professional". So in addition to considering the traits already highlighted in the literature as potential constituent parts of an overarching professional identity, I'd like to broaden the view of what constitutes the professional. Thinking of the attributes already noted as a matrix of potential resources that can be combined to assert professionalism, in practice this matrix is evaluated and deployed through broader social frames. In other words, how we think about professions, is couched in understandings of gender, race, class and other socially relevant categories.

At the most basic level, the historic domination of professions by men, is likely to have associated professions with masculinity. As I previously noted, Kendall and Tannen (1997; pg. 91) argue that "the predominance of one sex in institutional positions creates and maintains gender related expectations. ... Such associations simultaneously are produced by, and serve to reproduce, gender ideologies." As the most prominent professions were almost exclusively occupied by men, expectations about professions and professionals are bound to be gendered. Barbara Melosh (1982) argued that women simply could not be professionals, because professions were equated with men. This is born out in part in early taxonomic accounts of professions that almost exclusively refer to "professional men." Even if we assume that the strong argument that professions are simply equated with men is untrue, it's unlikely that the

historically sex-segregated division of professional labor does not impact the social interpretation of professional status. The individual norms and attributes of professions are gendered or subject to gendered interpretation. Scientific expertise and objectivity, for example, are socio-culturally more associated with men and masculinity (Hearn 1982; Davies 1996). Conversely, nurturance is associated with women and has been traditionally distanced or actively scorned within professions (Glazer and Slater 1987). Ultimately, claims about professionalization mimic socio-culturally gendered discursive strategies, understandings and stereotypes. Claims about an occupation simply are not evaluated the same if the occupation primarily consists of women as opposed to men. Additionally, authority and autonomy are associated with maleness (Tannen 1994), which further reinforces the “naturalness” of male professions and problematizes female professions. The constituent parts of professionalism tend to be gendered, are interpreted in gendered terms and taken together the entirety of claims of professionalism are also understood in these terms.

The reality of that statement is implied in the gendered inequality in rewards on professional closure, and is made clear in the historic and day to day experience of nursing professionalization. When nurses assert their recommendations to physicians – it is an act of professional assertion. Professional status for nurses would include the ability to collaborate with physicians in a non-subordinate manner. But recall the comments of Dr. Blumenthal – assertive male nurses are collegial, but assertive women are “bitches.” Men tend to be perceived as more professional, granting them higher status and greater autonomy. If it were the case that professional status was not mired in gender, one might expect that professional behavior would be interpreted and responded to the same regardless of the gender of the practitioner. Furthermore, status and identity are complex intersections of a multitude of individual and group

characteristics. So, while white male nurses tend to experience a great deal of professional status, Filipino male nurses occupy a kind of middle-ground status, between white males and white and Filipino women – they get some glass escalator effects<sup>43</sup>, but they are not granted the interactional leeway with physicians that white male nurses receive. Hence, professional status is not evenly bestowed upon all practitioners within the same profession. How professional one is interpreted to be is filtered through cultural understandings of what kinds of characteristics, behaviors and people are professional.

Historically, too, the professional status of nursing has been over-determined by the gender character of its composition and work. Licensing laws, were defeated or severely restricted, in the first half of the 20<sup>th</sup> century by physicians who subtly or unsubtly, invoked gendered stereotypes to assert and maintain the subordination of nursing. Recall how Pennsylvania physicians publicly argued against, and defeated an early mandatory licensing law in 1909. These physicians proclaimed, that “[t]he only latitude a nurse should be allowed is a strict obedience to orders; if she keeps the sick-room in a sanitary condition besides she will be busy enough. They require no more legal standing than a capable cook or chambermaid in the same house” (*AJN* 1909; pg. 5). In comparing nurses to domestic laborers, the physicians indicate it is all equivalently women’s work, rendering it unworthy of status, autonomy or legal protection. At the same time, nursing leaders projected a nursing identity that attempted to align compatible professional values with gender stereotypes and did succeed to a degree in popularizing that image and gaining prestige for the profession. But, the feminized professional identity championed by the early ANA leadership, and even earlier by Nightingale and her devotees, was a double-edged sword. As much as the nursing profession gained from this image

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<sup>43</sup> Among Filipino nurses, Filipino men were over-represented in the charge nurse position.

construction, it was also thrown back in their face when they advocated for economic security and greater autonomy. Here again, gender can be both a resource and a constraint for professionalization.

Professionalization takes place daily between coworkers and employers and on the national scene between professional organizations, employer organizations and the state, and both of these spheres of activity influence one another. Furthermore, achieving and retaining institutional protections and extraordinary autonomy are reliant on and assist successful image making-activity that centers on professional traits. Therefore, I conceive of professionalization as a heavily interconnected process that at all levels is significantly shaped by categorical systems of inequality along gender, race and class lines. The consequences of this are twofold: 1) intra- and inter-professional inequality, in material and relational rewards, is maintained and 2) the maintenance of this inequality reinforces patriarchal cultural understandings in the broader society.

Both of these consequences result from the centrality of professions in modern life. This is true practically, culturally and economically. From a practical perspective the work of professionals (generally speaking) is intuitively critical to our lives. We trust professionals to care for us in our most vulnerable moments, to represent us when the most is at stake, and to shape our minds when they are most malleable. It is highly likely that at one point or another the growth, prosperity, wellbeing or even life of most of us will be in their hands. Of course this is the argument that professions make in hopes that the state and the public respond to by providing professions with protection from the market and autonomy in self-regulation and work. The work is so important and the profession so proficient that to allow market forces (i.e. competition) to decide who is best suited for the work would result in critical harm. And the work is so difficult

that to allow intervention in decisions from employers or clients would do the same. Of course to some degree this is hyperbolic and the adjudication, as shown, of these claims relies on more than their veracity. But there is undeniably some truth here. None among us wants bridges to collapse, surgeries to fail, children to be ignorant, or innocent people to waste-away in prison. The significance of professionals in crucial life moments and the inherent melodrama surrounding much of the work have located professionals right in the middle of much of mass culture in the US. In television and film, the professions are significantly over-represented (Potter 2013), particularly the medical and legal fields. All that is to say that professions are, culturally and socially speaking, very visible and important.

Additionally, because the professions base themselves in the praxis between theory and practice, and because the occupations present themselves as normatively altruistic and fundamentally fair, achievement and access within the professions is supposed to be gained by routinized education and measurable competence. In other words, professions should be meritocratic. The individual level results from my quantitative analysis of professional inequality indicate that they are not. In both historically male and (to a lesser extent) historically female professions white workers and male workers tended to make more even when controlling for demographic, human capital and labor market discrepancies. Despite the persistence of inequalities, in the contemporary period professions are more open than they ever have been in the past; there is less exclusionary closure. Hence we've seen significant entrance of women and to a lesser extent people of color into some professions – medicine being a particularly visible example, but accounting and pharmacy are undergoing even more dramatic gender transformations. Even so, there is profound inequality within and between professions. Claims about meritocracy can function both as leverage to undo inequalities when the inequality is



clearly not meritocratic, but it also serves to obscure and justify inequality as well. However, the professions' ties to a direct educational pipeline make them an appealing (in its clarity – go to this school, get these grades, etc.) route to social mobility in an increasingly bifurcated and opaque economy. To put a finer point on it, with fewer economic options for a “middle class” life, the class position carved out by the professions is especially important as one of few options, however fraught, for mobility. The intertwining of professions and ascribed characteristics presents a significant challenge to this possibility.

Professions, then, hold the promise of uplifting any and all candidates willing and able to put in the work while simultaneously excluding people of color.<sup>44</sup> Once in the professions themselves, women and people of color are systematically disadvantaged both in terms of income and status. Furthermore, the system of professions is organized into hierarchical inter-professional configurations that tend to reward historically male professions and penalize historically female professions. Hierarchical inequalities are maintained and normalized by the coupling of gendered and racialized meanings with professional attributes. Ultimately, the real life effects of gender, race, and class on professionalization are its inequalities, within and between professions (and other occupations). The juxtaposition of meritocratic ideals and gender and race inequality, is likely to reinforce patriarchal and racist cultural understandings of inequalities, roles and norms. On the one hand, the appearance of meritocracy obscures systems of power that produce unequal reward and simultaneously blames victims for not succeeding. On the other, the maintenance of white men in positions of authority, particularly highly visible ones, further retrenches the assumed naturalness of the arrangement and continues to associate

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<sup>44</sup> In addition to inequalities in the broader educational system that systematically benefits whites and results in their over-representation in professional schools, subtle mechanisms within these schools also benefit whites and push out people of color. See Costello 2005 for an excellent discussion of this topic.

white male behaviors with authority. Because professionalization is significantly shaped by systems of inequality based in gender, race and class it is, in its own right, necessarily a major driver of inequality. However, because professions also hold such cultural weight in the US, the reinscription of gendered and racialized inequalities within them, also serves to maintain cultural understandings of gender and race in the larger culture which benefits the status quo.

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## Appendix Tables

**Appendix Table 1: OLS Regression Predicting Logged Annual Income from Nursing Position**

	<i>Model 1</i>	<i>Model 2</i>
<i>Independent Variables</i>		
Represented by Union	0.212*** (0.012)	0.098*** (0.011)
BSN (ADN is comp.)	-0.005 (0.011)	0.015 (0.009)
<i>Control Variables</i>		
<i>Human Capital</i>		
Nursing Experience		0.018*** (0.002)
Experience <sup>2</sup>		0.000*** (0.000)
Years not Nursing		-0.017*** (0.003)
Fulltime		0.319*** (0.013)
Est. Yearly Hours (in 100s)		0.038*** (0.001)
Same Employer		0.047*** (0.011)
Certificated		0.037*** (0.008)
Speaks Foreign Language		0.032* (0.014)
Educated in US		-0.060* (0.024)
<i>Workplace</i>		
Hospital		0.202 (0.010)
Region (Incl)	No	Yes
Metro Area		0.086*** (0.009)
<i>Demographics</i>		
Age		0.017*** (0.004)
Age <sup>2</sup>		0.000*** (0.000)
Male		0.050*** (0.014)
Black		0.033 (0.019)
Hispanic		0.024 (0.019)
Asian		0.045 (0.024)
Other Race		0.005 (0.023)
N	15014	13411
R <sup>2</sup>	0.0243	0.534

\* p < .05; \*\* p < .01; \*\*\* p < .001; (Standard Error)

Sample is composed only of staff nurses. Data from 2008 National Sample Survey of Registered Nurses.

**Appendix Table 2: Odds Ratios from Ordered Logistic Regression Predicting Work Satisfaction**

	<i>Model 1</i>	<i>Model 2</i>
<i>Independent Variables</i>		
Represented by Union	0.987 (0.048)	0.937 (0.054)
BSN (ADN is comp.)	1.187*** (0.046)	1.153** (0.051)
<i>Control Variables</i>		
<i>Human Capital</i>		
Nursing Experience		1.005 (0.008)
Experience <sup>2</sup>		1.000 (0.000)
Years not Nursing		0.997 (0.010)
Fulltime		1.095 (0.067)
Est. Yearly Hours (in 100s)		0.991* (0.004)
Same Employer		1.116 (0.063)
Certificated		1.079 (0.046)
Speaks Foreign Language		1.157 (0.098)
Educated in US		0.794 (0.105)
<i>Workplace</i>		
Hospital		0.742*** (0.038)
Region (Incl)	No	Yes
Metro Area		1.033 (0.051)
<i>Demographics</i>		
Age		0.969* (0.015)
Age <sup>2</sup>		1.000* (0.000)
Male		0.842* (0.067)
Black		0.716*** (0.066)
Hispanic		0.742* (0.089)
Asian		0.652** (0.083)
Other Race		0.756* (0.100)
N	15025	13412
R <sup>2</sup>	0.0008	0.0098

\* p < .05; \*\* p < .01; \*\*\* p < .001; (Standard Error)

Sample is composed only of staff nurses. Data from 2008 National Sample Survey of Registered Nurses.