5 A Social Semiotics of Nursing*

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INTRODUCTION

This paper attempts to open up a way of considering the crisis in nursing, a problem of shortage of registered nurses, as the effect of the way nursing is defined in society. It is argued that nursing is a degraded commodity in a mass circulation of career commodity values, where the prestige values in a hierarchy of cultural capital are autonomy, sovereignty over the conditions of work and the ability to appropriate the capital generated by one's efforts. After considering the manner in which the nursing crisis is expressed, the redundancy of the problem of professional status and staffing in the history of nursing, we address the homology between the language of nursing career research and the reproduction of the problem by comparing this research to the feminist critique of sociology. We continue with a description of the types of nursing, focusing on inpatient hospital-based nursing as the locus of high turnover and constant nursing recruitment. We conclude that nurses are recruited from symbolically disprivileged sectors of the hierarchy of cultural capital and the same symbolic system that disprivileges these sectors also degrades nursing careers in the face of alternative prestige careers.

The approach of the paper differs markedly from most nursing personnel or career research. What is proposed is a social semiotics[1] of the way nursing is reproduced in a system of cultural capital.

THE EXPRESSION OF A CRISIS

It is said that there is a crisis in the ability to adequately staff inpatient and outpatient direct health care services in Hawai'i and across North America. Patient care units, even whole wings, have been reportedly closed due to the shortage of R.N.s. Surgery and other procedures are delayed because of inadequate nursing coverage. Many institutions in the United States and Canada report vacancy rates from 13.6 % to 25%.

Nursing agencies abound in the U.S., operating nationally and internationally, recruiting nurses for six month tours of duty. The recruitment of "flying" nurses is very common in intensive care. Up to seventy percent of nurses working in intensive care in Hawaii are flying nurses from out of state. Most of these nurses stay for only one contract period, three to six months, accelerating the circulation of nurses and the business of the recruitment agencies. Many nurse working on regular floors in Hawaii are flyers, as well.

When the story is projected out into the future it becomes even more frightening. North America has an aging population. The need for registered nurses will explode as the number of elderly people grows. Related, in part, to the graying of the population is the increase in acuity of inpatient care. More registered nurses will be required to deliver this type of hightech care. This is the care involving complex life support equipment. In survey after survey of future employment needs, registered nurses are among the fields expected to grow the most. It is pointed out that the number of students studying nursing are not enough to fill the anticipated short- or long- term need for nurses.

The nursing personnel problem has become a national problem in the United States and Canada. The governments have commissioned national studies and have formulated national strategies to meet the problem. In the U.S. the master text of nursing personnel assessment and planning is the *Secretary's Commission on Nursing* (1988), a two volume report from the United States Secretary of the Department of Health and Human Services.

Regionally, state and provincial departments of health have initiated similar studies and have sought ways to attract and retain nurses. Hospital associations in Hawai'i and across the nation and Canada have examined the problem (Healthcare Association of Hawai'i 1987). Consortia of university nursing departments, nursing associations, state and county health administrators and planners, hospital management, legislative committees, legislative auditors, and others have systematically investigated the problem (Hawai'i Task Force on Nursing Education and Service 1987). In Ontario, Canada's most populated province, there has been a spate of studies on the nursing situation: *The Nursing Shortage in Ontario* (Goldfarb 1988); *Report on Nursing Manpower* (Advisory Committee 1988); *What Do Nurses Want? A Review of Job Satisfaction and Job Turnover Literature* (Frisina, Murray, and Aird 1988); *Agency Nurses In Toronto: Who Works For Supplementary Nursing Services, And Why?* (Murray 1988); *Nursing Morale In Toronto: An Analysis Of Career, Job, And Hospital Satisfaction Among Hospital Staff Nurses* (Murray and Smith 1988); *Nurses Resigning Their Hospital Jobs In Toronto: Who Are They, Why Are They Resigning, And What Are They Going To Do?* (Murray and Frisina 1988); *Morale Among Registered Nursing Assistants In Toronto's Long-Term Care Hospitals* (Murray 1988); and *Report of the HCMT Nursing Manpower Task Force* (Hospital Council of Metropolitan Toronto 1988)

Added to this technical report literature is a further expression of concern about the problem in academic nursing and social science research publications (e.g. Barker, 1987; Curry, Wakefield, Price, Mueller, and McCloskey 1985; Kosmoski and Calkin 1986; Lowery and Jacobsen 1984), in the glossy nursing literature, or those periodicals read by most R.N.s (e.g. Ackerman 1986; Aiken

1987) and in the nursing management literature (e.g. Barhyte, Counte, and Christman 1987; Calhoun, Williams, and McCready 1988). These three streams of writing, though different, all focus, in large part, on how to assess the nursing shortage, how to plan for future nursing needs, and how to retain current nurses. One important feature of this literature, taken as a whole, is the generation and maintenance of a historical record of the problem. The present nursing shortage is not novel (Aiken 1987). It is a cyclical and chronic problem. It may be argued that the problem has existed since the beginning of the recruitment of young women to work as nurses.

A public or mass expression of the crisis can be found in the feature stories in the newspapers. Locally, the *Honolulu Star-Bulletin* and *Honolulu Advertiser* have run many stories about the nursing shortage. The problem is also represented in the paid public service spots on television, advertisements designed to show appreciation for nurses' work and attract nurses to the sponsoring agency. In Hawai'i the Department of Health has run appreciation spots. Kuakini Medical Center has run frank solicitations for new nurses. The Department of Health has used TV advertisements for recruitment for the neighbor island hospitals. Queen's Medical Center has used elaborate panels of oncamera interviews of nurses testifying to how much they enjoy nursing at Queen's. St. Francis Hospital has broadcast spots showing nurses at work. Now the State of Hawai'i has new recruitment campaigns, including T.V. spots, for professionals, nurses, social workers, and engineers. The T.V. ad campaigns for nursing recruitment have been episodic and reciprocal among institutions, when one employer advertises the rest tend to follow suit.

Responding to the information circulated in the mass media and to initiatives from hospitals and other agencies to use public capital or tax revenues to train more nurses, the state legislature has appropriated additional funds for schools of nursing. In Hawai'i, the legislature has increased support for the University of Hawai'i, Manoa B.S.N. program and for the two-year R.N. or A.D.N. program at Kapiolani Community College and at Maui Community College. The intent of additional support is to graduate more nurses for local institutions. In the context of the crisis proportion of demand for nurses, Hawai'i Loa College, a private institution, has a burgeoning R.N. training program.

The Queen's Foundation, associated with Queen's Medical Center, is supporting nursing education on Oahu at the University of Hawai'i and at Kapiolani Community College. The Foundation, set up by Queen Emma Kaleleonalani, has extensive commercial real estate holdings, primarily in Waikiki.

The problem of the nursing shortage reticulates through many social institutions. It is of concern to hospitals, physicians, professional nursing organizations, nursing training programs, licensing bureaus, university researchers, health services regulators and planners, the press, government and even advertising agencies. This concern is a practical activity, topically structuring and maintaining small, albeit significant, amounts of the substance of these institutions. By structuring we mean, in accordance with Anthony Giddens' notion of structuration (1981;1984), that this concern, topic of the nursing shortage, is knowledge at hand, a practice of symbolic exchange, used for building and reproducing interaction. In this manner, it structures institutional life, at least parts of institutions. This preliminary positioning of the nursing shortage crisis in an ontology of social structure is not equivalent to the position that the crisis is not real or that the crisis is relative to a specific configuration of social structure. That the nursing shortage is real, independent and objective is not at issue. How it is independent and objective is the target of a desconstructional analytic.

RECRUITMENT

There are other expressions of the nursing shortage crisis. One is the effort to recruit nursing labor. Recruitment takes multiple forms.

The first recruitment strategy is directed at the "active supply" of licensed registered nurses. There is a large pool of licensed registered nurses, about two million in the United States. Most of them are not working in nursing. There are 11,129 nurses licensed to practice in Hawai'i (Sakoda 1989). Among these nurses 8,487 reside in Hawai'i. The remaining 2,642 nurses live on the mainland and in foreign countries. Because of the large military population in Hawai'i, many nurses come into the state, work for the duration of a husband's tour of duty, and then move on in the next assignment. One estimate of the number of R.N.s working as nurses in Hawai'i is 3,501 (Hawai'i Task Force 1987, p. i). This means that less than half those licensed and living in Hawai'i are working in nursing.[2]

One recruitment initiative has been to attract licensed nurses who are not currently working in the field. This has included advertising in the newspapers and on television. The Office of the Legislative Auditor in Hawai'i has sought to learn if more people can be employed from this pool if job sharing were offered in nursing positions (Robillard, Johnson, and Robillard, 1989). While most surveyed R.N.s in Hawai'i are in favor of job sharing, less than 10 % of 4,849 mail survey respondents plan to take a shared position in the next two years if such a position were offered. The attraction of nurses to shared positions, as a labor recruitment strategy, is less than anticipated.

Operation Nightingale is a project funded by the State of Hawai'i, designed to provide additional training to foreign-trained nurses. The training is both clinical and didactic. It has the objective of recruiting foreign-trained nurses who are already resident in Hawai'i, providing the extra experience to enable them to pass the State licensure examination. The program has been successful in having 90% of its graduates obtain licensure as R.N.s. The program has about thirty students in each cycle of training. Most of the students are Philippine trained nurses. Many of the Philippine trained nurses have been working in health care as L.P.N.s or as nursing assistants. Previous to State funding, the program was supported by the community hospitals, providing a channel of upward career mobility for nurses employed by local institutions.

Another recruitment strategy has been looking overseas, primarily in Ireland, the Philippines and more recently in Taiwan and Korea. One large hospital on Oahu has recruited from Ireland. The Hawai'i hospitals have not recruited from the Philippines. There is a substantial family reunification migration, also known as chain migration, to Hawai'i from the Philippines. Most of the Filipino nurses working in Hawai'i have come through family sponsored immigration.[3] However, the *Manila Bulletin* is full of large display advertisements for clinical nurses from metropolitan hospital systems on the U.S. mainland, principally from the east coast cities. Up to over 90% of some of the graduating classes from the University of the Philippines College of Nursing are working in the United States or Canada.

A new source of nurses is New Zealand. The Board of Nursing in Hawai'i has taken special measures to give temporary licenses to these nurses. However, the New Zealand government is not too happy about losing nurses to Hawai'i, or anywhere else. Most of them have been trained at public expense, from tax revenue-supported institutions. New Zealand has experienced an outmigration problem, exacerbated by an economic recession and a low population. New Zealand is arguably not a peripheral country in the world economy but the shift of trained nurses to Hawai'i and North America is a shift in capital resources. The United States is meeting its need for nurses, in part, by transferring the fruits of capital intensive training from other countries. There is little cost to the United States in recruiting nurses that other countries have paid to train.

In the Philippines the overseas nursing market in the United States, Canada, Australia, Saudi Arabia, and Europe has distorted the number of students in nursing schools and the numbers of licensed nurses in the country. The Philippines has a surplus of nurses. This is a concentration of public and private capital which could be used for alternative ends. The Philippines, India, Afghanistan, Pakistan, South and Central America, and now Ireland, New

Zealand, and Canada have been free resources of trained medical personnel, at no cost to the United States.

THE REDUNDANCY OF THE PROBLEM

The shortage of nurses is not a new phenomenon. Nor is it new to research. It has concerned professional nursing associations since the turn of the century. Problems in nursing, like the shortage, have the status of unsolved social problems.[4] An unsolved social problem is chronic. It does not get solved because its problematic character structures not so much a solution as it maintains a set of social institutions.[5] We will return to this discussion below.

In 1901 the New York Nursing Association surveyed its members about a number of issues. Among them were: (1) educational requirements for practice; (2) title for nurses; (3) job design; (4) recruitment; (5) career development; and (6) turnover. At the turn of the century, nursing or what was considered the work of females in health services was in a transitional state. Like medicine, it was being increasingly articulated as an independent way of making a living, a full-time occupation (Starr 1982). Nurses were maneuvering for some degree of control over their work in the emerging and rapidly expanding institutional structure of a health care system. The work of nurses was rapidly changing from the informal and independent curing ministrations of women, in a largely agrarian economy, to a cash compensated job in the context of a complex division of labor. The role of women in the delivery of health care services was transformed from a life long-avocation, handed down within families, to a proletarian vocation, subordinated to the physician and to those who bought their labor time.

In 1903 North Carolina became the first state to license nurses. Previously, nurses had established registries, with minimum requirements for training. These registries were like membership in the Better Business Bureau. Membership was not required to practice. With licensure by the states, entry into nursing practice became legally regulated and integrated into a system of accredited schools of nursing. Soon licensure examinations were established. These examinations evolved into the standardized national examination currently used by all states and territories in the United States. In Hawai'i, the Board of Nursing, a division of the Department of Commerce and Consumer Affairs, administers the examination.

Many of the early schools were free-standing hospital schools of nursing. These schools were not affiliated with a college or university. However, as health care became more and more technologically complex, particularly after World War II, the training of nurses was shifted to public and private

universities, with substantial basic and science educational requirements. It should be remembered that the shift to university-based training was not so much a technological imperative as the rationalization and ascendancy of capital bourgeoisie, their philanthropic foundations, and the increasing vertical national integration in mass production and distribution and in penetration of government in everyday affairs (Brown 1979).

Even schools of nursing in a private university received public funding from the U.S. and state governments. The costs of nursing education have been incrementally transferred to the public. The same can be said of the training of physicians. Federal research grant overhead (an additional outlay often 65% of direct costs), construction and capitation grants underwrite over half of the cost of medical education at some institutions. State financing also plays a substantial role. Tuition plays a minor role.

With licensure and accreditation of schools of nursing, in the late 1960s, the American Nursing Association and the National League for Nursing began advocating, a further increase in standards. The two organizations have proposed that the professional registered nurse should have a bachelor of nursing degree (B.S.N.), a four or five year curriculum. The product of the two-year training program (A.D.N.), usually located in community colleges, would be downgraded to an associate nurse. At present in Hawai'i the two-year nursing program is offered at Kapiolani, Maui, and Hilo Community Colleges. The University of Hawai'i at Manoa used to offer the A.D.N. program but it was transferred to Kapiolani Community College.

This proposal had the manifest objective of creating a professional identity, better pay, and increased autonomy for nursing. The proposal was to increase the quality of health care and stabilize the career paths of nurses. The proposal has not been adopted in most states, including Hawai'i. While the nursing organizations argued that this would attract and maintain a pool of working nurses to meet national needs, the primary employers of nurses--hospitals and governments--have effectively resisted the proposal. The employers argue the two-year nurse or A.A. nurse programs provide the "troops" in the nursing corps in any institution. They say that the B.S.N. prepared nurse is often dissatisfied with the field because of unrealistic high expectations and too frequently enrolls in a master of nursing program, thereby limiting availability to clinical work. Supervisors of nursing recruitment and personnel management say they already have too many master's nurses.[6]

The interests of the employers of nurses apparently have not been the same as the interests of nurses in professionalization. While the nurses have sought autonomy and sovereignty over their own affairs (the *sine qua non* of a

profession, as in medicine, law, and theology), the employers have sought to maximize their access to a stream of newly trained nurses. We emphasize the interest is in new graduates, young, unmarried individuals at the bottom of the pay scale, who are professionally unsure of themselves, and who are relatively complaint.[7] The employers feel that if the B.S.N. is the threshold to nursing practice, they will be denied access to the community college trained nurse in an occupational field with a reputation (a reputation which may be more rhetorical than real) of high turnover and a short active work life span. The employers expect nurses to leave the field after four or five years.[8] The vision the employers have of the increase in the standards of licensure is that it would cut off an important source of nurses.

Throughout the long quest for sovereignty in the United States, a state that continues to elude it, nursing has been researched on an annual basis. There have been studies and revisions of nursing curricula. There have been studies of the nursing labor market, compensation, career development, work satisfaction, clinical skills and performance, record keeping, foreign nurses, and even research on nursing research. This is to mention only a few of the nursing research categories. The point here is to demonstrate that nursing is a well-researched field. The research has been conducted by nursing school faculty, nursing associations, hospital associations, and the government. The financial support for the research has been from the hospital associations and government, the primary employers of nurses.

When we were asked to research nurses in Hawai'i by the Department of Health and the Board of Nursing, Department of Commerce and Consumer Affairs, we were struck by the recurring nature of the issues of high turnover, recruitment, job dissatisfaction, and requirements for entry into practice. These issues have been on the table since the late 1880s. In reviewing the literature for our research on nurse retention in the services operated by the Hawai'i Department of Health and for our research on the entry into practice issue for the Board of Nursing, one of us began to think of Friedrich Nietzsche. Nietzsche postulated the law of eternal return, the same things keep being reproduced through time, thereby maintaining the sensibility and order of experience. We began to wonder if the research questions about nursing preparation, recruitment, and retention have remained the same for a long time--at least at a level of abstract equivalence--what this constancy represented. We began to conceptualize the problem of nursing as a recurring conversation, being used to reproduce a social order in the same way Anthony Giddens talks about knowledge-at-hand being used interactively to structure a social order. We began to think that if the issues were recurring, without solutions, maybe the approach or posture--including the assumptions--of the research and the problem it sought to solve were not "supposed" to change. Perhaps the research and its

political application (including recurrent calls for more research on the same topic) serve to mystify and maintain the structure of the problem, a chronically unsolved social problem.

FEMINIST SOCIAL THEORY

The fleeting reference to Nietzsche and the law of eternal return of history made us start to think we might survey and interview nurses, counting and associating responses to variables of interest, forever without learning why nurses work for a few years, become alienated, leave the field, and cannot be enticed back to the field. Counting is not useless but we recognized--maybe from the volatile phone calls and letters we received from nurses in connection with our survey research--that the semantic categories which defined our measure variables are from a vision of a social order. Their use reproduces this vision. Many of our respondents were not happy with this Giddens-like structuration. Our interview and survey schedules were deductive extensions of preceding research and were developed in collaboration with nursing management in the Hawai'i Department of Health and the Board of Nursing. What our respondents said to us in the calls and letters (including three threats of lawsuits) was that they felt subordinated by the language of the survey schedule. They said the language of our questionnaire carried forward the problems of nursing employment and as such are incapable of detecting the organization of the problems, no less offering solutions.

We did not know what to do with the reorientation of our attitude about nursing shortage research until the February 1990 issue of the American Sociological Association's *Footnotes* arrived. *Footnotes* is the Association newspaper. In this issue there is a shockingly naive attack on feminist theory, "The Trouble With Feminist Theory," by Michael A. Faia (1990). Until the Faia article we did not know much about feminist theory. It had been sequestered beyond the pale of funded research. We still do not know enough about feminist critical theory.[9]

Faia, like someone from the European Enlightenment, argues that positivistic sociology is value neutral and as such it can only serve the interests of feminists in righting injustices. He cites the work of legendary female sociologists as examples of the proper utilization of positivistic methods. He is arguing against the thrust of the assertion, exampled by Stacey and Thorne (1985), that the methods and theoretical orientations of sociology assume, albeit unconsciously, a social order, one repressive of women and subordinate classes. The feminist critique of sociology has gone right by Faia. Obviously, it takes some knowledge of the constitutive role of language to understand the feminist critique.

Now we have moved to the tentative position that the research on nursing and the shortage has been informed by the same language that constitutes, institutionalizes the problem. This is biting off a lot. To begin to explicate this position, we will discuss a number of issues: (1) The unconscious reification of capitalist power and proletarianization of women in nursing personnel research; (2) The subordination of nurses to science; and (3) The attempt to set-up an independent science of nursing based on the phenomenology of the person.

The research on nursing personnel, such as that cited above, can be characterized as highly focused. The research zeros in on nursing, framing it closely as an occupation, neglecting the wider phenomena of why people are compelled to seek full-time employment, to undergo training to make their labor saleable in the capitalist division of labor and commodified exchange. Without becoming a pataphysist, or one who adores romanticized versions of traditional cultures, we can say there are other ways to spend your life than as a fulltime proletarian.[10] The usual approach of nursing research assumes a background of wage employment and treats entry into nursing education and practice as individual choices, rather than the channeling effects, the limitation of horizons, by class position. Because of the unquestioned assumption of proletarianized society, already divided up into occupations, how one could come to view this kind of social order as the natural reality is undescribed. Further, because of an essentialized individualism, how this kind of naturalized proletarian social order differentially recruits segments (like upper-lower and lower-middle class women for nursing (Muff 1988, Reverby 1987) of the population to the occupational structure is uninteresting. The entire circuitry of a system which prepares individuals, mostly females, for nursing employment and who become, because they are individuals, dissatisfied and alienated with nursing is literally a priori to where nursing research begins.

We are suggesting a political economy investigation of nursing education, entry into practice, and the shortage. That it seems beside the point, that nursing appears as a fully formed employment field meriting our complete attention, is a noncritical posture toward the social institutions which reproduce the unsolved and chronic problem of a nursing shortage. We concede that the vocabulary of proletarianization, division of labor, capital, naturalization, class, and the method of studying nursing vis-a-vis a political economy of the entire society may sound strange and far out. They are items from a Marxist lexicon, even though no attempt is made here to represent a Marxist or neo-Marxist perspective. But as in the feminist critique of sociology, the use of a vocabulary representing what is apparent about the vocational order and about nursing simply reifies the existing society. This is not analysis but, rather, acting on behalf of the values, ideologies, opinions, vocabularies, and deep assumptions

which naturalize or make normal, over the life of professional nursing in the United States, the short-term working career of women in nursing.

Moreover, the absence of a political economy of nursing in nursing research leaves unavailable or at least marginal the values that draw women into nursing, values which may not be easily commodifiable, as a sustaining basis of the structure of nursing. The value of political economy will have to stand here as an assertion. There is insufficient space to demonstrate a political economy of nursing here. We will explore it further below in the discussions of science in nursing and in the attempt to found a science of nursing in the phenomenology of caring.

Many nursing leaders subscribe to the idea that nursing has to become more scientific if it is to gain the autonomy of a profession. Will the study and practice of science really make nurses sovereign over their own affairs? What is the status of laboratory technicians or radiological technicians or inhalation therapists, people who work within a relatively more confined scientific circumspection than nurses? Nurses are not only responsible to science but to the practice of "caring," or the skills of face-to-face communication with the patient, giving emotional support and patient education, among other tasks (Benner and Wrubel, 1989).

It is apparent that science is not the tail that wags the dog in health care career status. For example, a physician who earns a Ph.D. in a science, as in computer science or rehabilitation engineering, and elects to pursue the practice of the science in the context of health care has a lower status than the clinically active physician who does not have a Ph.D. More is involved than the practice of science in professional sovereignty.

Recently, Benner and Wrubel, in *The Primacy of Caring*, have sought to formalize the process of caring, thereby giving nurses an independent role. This effort seems to recognize the fact that most nurses are not scientists, in the sense of creating new scientific knowledge for health care. The average floor nurse, the clinic nurse, and the state public health nurse are not basic research or clinical scientists in the sense of publishing their work in *The New England Journal of Medicine, Lancet, Nature, Nursing Research*, or any of the basic science disciplinary journals. The science in clinical nursing is derivative, as it is in the everyday practice of medicine. It is learned and practiced by nurses but rarely created by clinical nurses. Nursing school curricula are not geared to producing hypothetico-deductive scientists in physics, the life sciences, computer science, engineering, or any other applied science. The training in nursing in mathematics, chemistry, logic, physics and other sciences is not enough to be prepared to enter the sciences as a practitioner of basic research. Except for the

first two years of nursing study, when a liberal arts experience takes place, students are relatively isolated from bench science or the hands-on practice of any scientific discipline. Furthermore, nursing students are recruited from social classes unlikely to become scientists and go mostly to colleges and universities which supply few research scientists. These are "teaching schools," the state colleges and universities and the community colleges, largely without Ph.D. programs in the sciences and the federally funded research infrastructures. There are nursing schools at elite universities but the number of nurses graduated from them is small, compared to the number produced by non-research universities and colleges.

Even the nursing faculty who have Ph.D.s have them mostly in disciplines other than nursing, usually in the social sciences or in education (Ed.D.). There is now a doctorate in nursing and it is receiving vigorous support from nursing leaders. The degree is a Doctorate in Nursing Science, or the D.N.S.[11] Some universities offer the Ph.D. in nursing. But nursing faculty who have Ph.D.s in the social sciences, education and even the "hard sciences" are not mainstream practitioners of their graduate training disciplines. They teach, research and write about nursing, a multidisciplinary applied field. Benner and Wrubel (1989) have tried to distill what nurses do best or should do best and have prescribed the role of nurses as providing "caring." They have tried to create a new science of nursing built upon a Heideggerian phenomenology of the person (Heidegger 1962).

If everyday nursing is not doing disciplinary science, if nursing education does not prepare scientists and if nursing faculty do not practice disciplinary science, will the scientificizing of nursing really bring the hoped for autonomy of nursing? We think not. It is clear from the other sciences in health care that science in itself is not the path to high status and professional autonomy. A more serious question is if nurses do not do disciplinary research, researching instead the applied field of nursing, and if nursing is creating its own doctoral programs and if the likes of Benner and Wrubel are attempting to provide an independent theoretical basis for nursing, maybe nursing has a free-standing core of knowledge and practice different from disciplinary science. We will argue, in part, that nursing has little power over its own affairs because the core of nursing, caring, is institutionalized at the margins of the commodified exchange system. In fact, nursing, as primarily the work of females, is institutionalized on the margins of commodified exchange. As women who are housekeepers for their families, raising their children, cooking and maintaining shelter, thereby reproducing the force of laborers and consumers without compensation, nurses provide relatively underpaid work for a system that depends on labor intensive and diffuse "caring" to function financially. Capitalism depends on uncompensated and underpaid sources of production, domestic household work

carried out by females and publicly financed infrastructure (schools, roads, hospitals, police, courts, harbors and airports, to mention but a few) to, in part, create a surplus for private appropriation. The tremendous differential returns on capital in health care depend on the undercompensated labor of nurses, as well as the low paid work of others in health care.

The notion that nurses do caring as the centerpiece of their work and its proper execution is based on a Heideggerian definition of the person does set out a horizon of nursing sovereignty as a profession. However, is this formalization of nursing knowledge nothing more than a retreat into a rhetorical position? We are struck, however popular phenomenology is in nursing, at how much things would have to change if the kind of nursing Benner and Wrubel advocate were put into general practice. The assignment of nursing contacts with the patient and the number of nursing hours per patient would dramatically increase. The program of Benner and Wrubel and others like them ignores the locus of control of health care units: the rational calculation of treatment against outcome by the rate of reimbursement from insurers and government programs, like Medicare and Medicaid. If the phenomenology movement in nursing does not fit the acuity of nursing care systems figured out by Big Eight accounting firms, such as Peat Marwick, designed to calculate simultaneously with the Diagnostic Related Groups (DRGs), the program is merely a pipe dream of academic nursing.[12]

The phenomenology of caring, as the unique science of nursing, is highly attractive on humanistic grounds. Perhaps the attention on the subject, the individualist grounds of its European humanism, and the exclusion of the social are really indications of a socially structured ignorance of power (certainly not unique to nursing). The structured avoidance of discussing the problems of implementing a program of phenomenology of caring, depending on the rightness of the idea to win the day, mystifies members of this discourse, reproducing the conditions of the subordination of nurses, as well as the impersonal character of health care. The nurses who practice this discourse--and all of us are partial members of this classical Enlightenment vocabulary--cannot find or formulate the structure of subordination of nurses.

There are other problems with the phenomenology of caring. Among them are the Eurocentric basis of the person, the structure of the subject. Another is in ignoring the social it becomes an elitist ideology, iteratively mystifying the nursing faculty who produce it.

THE WORK OF NURSES

We have to back up for a short digression on the range and nature of nursing labor. There are many kinds of work under the label of nursing. There are nurses working in the traditional hospital roles in acute care: medical-surgical, critical care, OB/GYN, pediatrics and inpatient mental health. In Hawai'i, our survey of all licensed registered nurses generated data to indicate that 64.78 percent of RNs work in acute care settings in hospitals (Robillard, Robillard, and Johnson, 1989a). This figure may be higher (70.31%) if we add the nurses working in geriatrics (5.53%), often in long-term skilled nursing facilities. Other nurses work in nursing training, patient education, ambulatory care, administration, home care, community health, school health, community mental health, maternal and child health, health planning and for insurance companies. However, the numbers and percentage of nurses in each of the non-acute care categories is low.

In a separate interview study of a sample of 300 nurses employed by the State of Hawai'i Department of Health the distribution of nursing assignments were the following: medical-surgical 12.3%; critical care 7.35%; OB/GYN 6.0%; emergency room 5.3%; operating room 3.0%; inpatient pediatrics 2.7%; inpatient psychiatry 7.0%; long-term skilled nursing facility/intermediate care facility 12.7%; long-term facilities for the mentally retarded 4.3%; long-term psychiatric care 3%; community and home care 25.3%; administrator 3.3%; supervisor 2.7%; alcohol abuse 1.3%; other 3.3%; don't know/refused .3% (Robillard, Robillard and Johnson 1989). Among nurses employed by the State of Hawai'i 43.65% work in acute care. Add to this the percentage working in long-term care facilities and the institution-based nurses are increased to 63.65%, beginning to approximate the distribution of nurses at large in the State, both in the public and private sectors. In Hawai'i the State operates hospitals on Maui, Hawai'i, Lanai, and the TB and Hansen's Disease hospitals on Oahu (Leahi) and on Molokai (Kalaupapa), Hawai'i State Hospital in Kaneohe, several facilities for the mentally retarded and multiple long-term care facilities. The point is Hawai'i, unlike most other states, operates general community acute care hospitals and may have a higher ratio of RNs in the State Department of Health in acute care than other states.

The focus on ratios of RNs working in acute care settings and other institutional circumstances has a rationale. First, nursing is very heterogeneous, with many dissimilar skills and different levels of technological sophistication. Nurses are not functionally interchangeable. Second, our research on nurses in Hawai'i found a greater career satisfaction and relatively low turnover among public health nurses and free-standing State-operated outpatient clinics than in hospital acute care settings, both private and public. The nursing shortage is

concentrated in the acute care services of hospitals, where most nurses work and where the public imagination places most nurses, uniformed, moving from bed to bed twenty-four hours a day.

Acute care nursing is labor intensive. It requires twenty-four hour staffing, divided into three shifts. One dimension of labor intensity is that a shift is rationalized into a schedule of cycles of repeated procedures, like vital signs or changing IV fluid bags, and single time events, as in a patient shower or a stool sample. This rationalization is tight as the discrete continuum of the shift is composed--for the nurse and supervisor, alike--of these cycles of repeated and single events. There is no time out in nursing coverage of patients, except for scheduled breaks and even then coverage arrangements are made for absent nurses. The intensity of the labor in the entire shift is subjectively and objectively claimed by a sequence of duties. Floor nursing requires stamina and able-bodied people. It is an on your feet and lifting kind of work.

Except for medical residents, where they have them, RNs are the top tier of in-house medical staff, carrying out treatment plans ordered by physicians and supervising LPNs, nurses' aides and ward clerks. They interact, also, with the technical staff, e.g. respiratory, radiology, laboratory and others. RNs and residents are in direct communication with the patient's physician, both during rounds and by telephone. RNs are the implementors and managers of most bedside care in most hospitals.

This work is routinized, with a procedure for every contingency, and often performed under the stress of having to deal with extremely ill patients. Actually, there are two issues here. One is routinization and the subordination to regimes of treatment decided collectively or by third parties, like physicians or, even, accountants (see above). While the hospital department of nursing administration will plan--within national standards--nursing procedures, the individual floor nurse will have little freedom in carrying them out. There is an overriding notion of effective medical procedure and responsibility, requiring equivalence between the sequential implementation of the same procedure across multiple implementations. The idea of step-wise equivalence in effecting the same procedure, with little tolerance for deviation, produces its own kind of stress. Not everyone can perform in an environment where actions have a constant and an equivalent identity, especially as health care becomes more and more technological, embedded in unforgiving computer digitalization. This may be responsible for some of the high turnover in acute care, people without proper educational backgrounds or without the necessary cognitive orientation are filtered out or transfer to less demanding nursing environments.

The second issue is the reaction to dealing with acutely ill and terminal patients, people who are often disfigured by wasting, surgery or accident trauma. Most people die in the United States in acute care hospital services, like oncology, cardiac care, intensive care, and medical-surgical, and nurses are the first contact with death. On busy services death is an everyday phenomenon, made increasingly so by a rapidly aging population and a rising level of patient acuity.

Death, disfigurement and any form of physical decline are the *sine qua non* of failure and debasement in American youth-oriented culture. Death is sequestered in hospitals in a proletarianized society of full-time wage employment. No one has time to care for the dying. It is not that death, disfigurement and decline are inherently undesirable, no less unexpected, but that American social and economic structure and the cultural knowledge used to construct and maintain it systematically disvalues death and illness, to the extent that mere presence to dying, death and disfigurement may reflexively erode one's sense of competence. It is as if there is no future with the presence of death or physical decline in a secularized America, where gods and an after-life have long since departed (Baudrillard 1976). Death work and dealing with patients with irreversible illnesses are warrantable reasons (expressed in conversations heard everyday throughout the society) for leaving hospital nursing and for leaving the care of the sick, generally (Sontag 1988).

One last factor deserves attention, albeit all too brief. We have already mentioned the dependence on relatively low wage labor of nurses for the generation of capital and we have talked about the labor intensity of nursing. However, we have not directly addressed the issue of the appropriation of the generated capital and what may happen to the consciousness of nurses in the face of this appropriation. The greatest percentage of the total annual national health care bill is spent on hospital care in the last six months of the patient's life, usually on life-extending treatment requiring intensive nursing. Hospital suppliers, manufacturers, administrators, physicians--indeed the entire medical economic sector--relies on hospital-based care for maximum capital growth. The capital growth generated by nurses is not appropriated by nurses and to even consider a claim by nurses to the capital produced by their work--above the prevailing wage for nurses--can be said to be confused about the ownership of productive capital, including the labor of nurses. Nevertheless, nurses are acutely aware they benefit differently from their labor than do physicians, hospital management, and the owners of medical investment capital, even at $19.00 per hour.

Nurses are hourly employees, not withstanding the rhetoric about nursing being a profession. Nurses sell their labor and the time and fruits of their work

are owned by the institutions that employ them and are appropriated by physicians and investment capital suppliers of the health care industry. The maintenance of the hourly labor contract belies any comparison with physicians and management. The authorizing symbolism of greater professional freedom, of charging fees or being in charge of capital (physical plant or admitting patients), is not available to nurses.

It is an irony of social structure that the proletarianization of women into nurses, and the general society-wide division of labor, are the conditions of a calculative and accelerating individualism, the basis of discontent. Nurses are leaving nursing to take other employment because of dissatisfaction with the relative rewards of pay or because of a feeling of no personal future in the field, often feeling taken advantage of or being uneasy with strict subordination to routines of care, physicians and management. More nurses are working outside of nursing than in nursing. Moreover, as we will argue below, nurses are leaving nursing because nursing is symbolically presented in society as a transitory female occupation.

CONCLUSION

We have argued that the nursing shortage and related problems of standards of entry into practice and licensing are not new. They have been chronic problems since the rationalization of nursing into full-time wage employment. In part, the history of nursing since the late 1800s has been the unrealized struggle for professional autonomy and sovereignty. We suggested that the redundancy of the problem, even after decades of research, may lie in the unexamined premises of the language used to formulate the problem, what is assumed and what remains silent, not even capable of formulation. To illustrate this point, we used the analogy of the feminist critique of sociology.

An ethnographic observation was entered on the resistance by nursing employers to raising the preparation of nurses to the bachelor's degree, the BSN. Employers say they must maintain access to the two-year-curriculum trained nurse, mostly from community colleges, to meet staffing needs. Access to a stream of newly-trained nurses is considered critical. In fact, there is a stated preference, by some employers, for nursing graduates of two-year programs. Some reluctance was expressed about "over-educated" nurses, meaning they wanted "troops" and not nursing leaders, of whom they had an ample supply. The personnel officer's problem is conceived as continual replacement of floor staff nurses who work for a comparatively short number of years. Observations were also made on the recruitment of nurses, both as an indicator of the shortage and as an example of uneven exchange between the United States and Third World suppliers of nurses. Hawai'i has only recently entered into direct

recruitment of foreign nurses, having relied on Filipino nurses who migrated to Hawai'i in family reunification immigration. Philippine trained nurses comprise a substantial number of the active clinical nurses in Hawai'i.

The desire to maintain recruitment from two-year training programs and the expansion into overseas recruitment reveal the implicit inscription of gender and class subordination of nursing. The maintenance of the "fiction" or the rhetoric of nursing being a short-term career of females permits the structure of nursing jobs, possible changes in terms of employment, and the exploitation of women, made possible by such rhetoric, to remain hidden. Furthermore, the class origin of most American nurses and the attraction of foreign-trained nurses--amplified by structured rapid turnover--maintains the class hegemony of physicians and hospital management. Such nurses are well ordered and orderable in a relatively integrated hierarchical system of values and symbolic codes, where the differential access and performance of cultural capital is one of the class sorting mechanisms.

In Hawai'i it is no mistake that the health careers program financed by the private hospitals and the State is focused on Farrington High School in Kalihi. One might ask why the health careers program (nursing and allied health) are not focused on Kalani High School in Kahala or at Kaiser High School in Hawai'i Kai. These high schools and neighborhoods are far different from Farrington High School and Kalihi, an area that has traditionally been the home of recent immigrants, native Hawaiians, and the working poor. Kalihi has been through successive waves of migrants but today may be characterized as having a large Filipino and Samoan population. Good intentions aside, the concentration of health careers recruitment in Farrington in Kalihi is a statement and class channeling device of where these careers fit in the structural hierarchy of Hawai'i, what cultural skills are needed and not needed and, moreover, the differential access that children from various neighborhoods have to the cultural capital of controlling their own employment and career development. Women in high school in Kahala and Hawai'i Kai, if they are not in private school, where the occupational orientation is even more pronounced, are planning careers in the professions, finance, university professorships and commerce. Nursing is literally below them.

Nursing is a broad field of employment, with many different specialties and career development paths. However, it is in hospital, inpatient care where most nurses are employed and where the turnover is the highest, and the shortage is concentrated. We have characterized this work as routinized and increasingly tied to technology. The work is composed of repeated and single sequence tasks for the entirety of a shift, hence the labor intensity of nursing.

The work is tied to the symbolism of the labor contract, hourly wages. Nurses are the front line of acute care but have, because of the labor contract, no claim to the enormous capital growth their labor in large part generates. Nurses implement the orders of physicians, who are largely absent from the service floor, except for rounds and in emergencies. Capital growth is appropriated by physicians, hospital management, suppliers and equipment manufacturers, among others, and, yet, it is the labor of nurses which in large part is responsible for the implementation of care and the consumption of equipment and supplies.

Routinization, labor intensity and the expropriation of the fruits of labor are not new and not intrinsically sources of complaint. Traditional and class divided or feudal societies certainly were composed of agrarian routines and rituals and the chiefly elite and the lords of the manor expropriated their measure of production (Giddens 1981). This is still happening in agricultural societies, where the under classes have been socialized to think of themselves as lesser beings than the elites, to whom they willingly give a large measure of their production. In modern societies this is decidedly not the case.

In modern capitalist societies[13] upper class values of self-determination are circulated throughout the social structure, almost as if a commodity for sale and upper class status emulation. This context permits the realization of relative deprivation of those employed in routinized and subordinated jobs. As we progress into a postmodern social structure, where signs are the main product, the desire for a self-determined career with professional autonomy and access and control of the capital generated becomes a prestige commodity. The free circulation and consumption of signs in society opens up unlimited possibilities and unhappy comparisons among those subjects formed, socialized within an "information" society. Upper and middle-class women in American society are already within the self-hermeneutic circle of autonomous careers and increasingly regard nursing as a low status job.[14] Lower-middle and upper-lower class and foreign women are not as firmly embedded in the same milieu (the information society of infinite possibility) and more readily accept, at least rhetorically, and are targeted for nursing recruitment. Once in nursing, however, and as the circulation of prestige signs penetrates more and more of society these recruits have the same structural grounds for unhappiness with hospital nursing.

The structure of the problem of contemporary nursing, and perhaps over a longer term, is that it is lodged in a social system that recruits females from the literate lower middle and upper lower classes and at the same time commodifies all prestige values, presenting and diffusing throughout mass society alternative autonomous careers and the foundations for comparative discontent. The rhetoric of the hierarchy of cultural capital, the vertical array

of values and signs, increasingly subject to com-modification, defines the dimensions of society: who knows the dimensions; who does not know the comprehensive dimensions; who has the right to inform who about what it means to be "informed"[15]; who has the duty to learn from the "informed"; who should be restricted or unrestricted to acquiring what job skills; and even how long a nursing career should last before it becomes a degraded commodity. Nursing employers, nurses themselves, and nursing training programs, albeit implicitly, inhabit a structure of commodified symbolic exchange wherein all become mutually reinforcing poles of formulating nursing as an unrewarding career, requiring a constant stream of new recruits, like the enlisted ranks of the armed services.

NOTES

* This is to thank Divina Telan Robillard for timely assistance in writing and completing this paper.

1. We are using semiotics as a theory of signs but with the following qualifications. First, the world is not reduced to a positivistic reality of signs or some linguistic construction, as the world as constructed by language. Second, we are not using the theory of signs as a metaphor, as the world as if it were constructed by language. We are using semiotics or signs as a topic, a referent of modern social organization. In capitalist social organization signs are both what is produced and the means of production, especially in late capitalism. For a political economy of signs see Baudrillard's *For a Critique of the Political Economy of the Sign*. This paper draws on the work of Baudrillard and contemporary French social theory, but makes no attempt to be a faithful representation of any single author or style.

2. The number of nurses licensed in Hawai'i is derived from the Board of Nursing, the licensing agency. The number is from 1989 license renewals. The number of nurses estimated to be working in Hawaii is from a 1987 survey of health care agencies in Hawaii by the Hawaii Task Force on Nursing Education and Service. We recognize the problem of comparing 1989 license renewals and 1987 survey data but only enter the comparison to make a rough indication of the gap between the number licensed and those working in nursing.

3. Mention should be made of the large number of Filipino nurses who fail to qualify for Hawaii licensure by reason of low scores in the State R.N. licensure examination. Many are working as L.P.N.s or as nursing assistants.

4. The idea of an unsolved social problem in the context of the nursing shortage was suggested by Deane Neubauer.

5. We are aware that sounds like simple functionalism, a position we hope to elude.

6. This information was gathered in field work in Hawaii. The identity of the sources must be protected.

7. We are thankful to an unidentified member of the audience at the Hawaii Sociological Association meeting on March 24, 1990 for this observation. This observation is confirmed by nursing personnel officers at major Hawaii health care institutions. This ideological belief about young nurses contrasts markedly to the actual age structure of working nurses and probably points to the culture of gender bias more than to the empirical distribution of nurses.

8. Some in nursing report that nursing administrators actually desire high turnover of nurses after a few years of employment.

9. Recently we discovered a feminist series of papers in *Images of Nurses: Perspectives from History, Art, and Literature*, edited by Anne Hudson Jones (1988).

10. See Baudrillard's discussion of gift and sumptuary cultures in *The Mirror of Production* (1975) and Ferrarotti's, *The End of Conversation* (1988), use of non-European cultures to get an idea of non-proletarianized social orders. For a criticism of fetishization of non-European cultures see Kellner's *Jean Baudrillard* (1989).

11. We are thankful to Pat McKnight for materials on graduate training in nursing.

12. There is a process of ever and ever tightening control over health care by the rationalities of financial management. The Peat Marwick acuity system is the latest phase in Max Weber's tightening cage of rationality.

13. Including the socialist countries.

14. Men are subject to the same phenomenon.

15. Those of us who read *The New York Times*, *Nation*, *The New Republic, The Wall Street Journal*, and *The New Review of Books* think we are better informed than those who do not read these publications and we feel this knowledge gives us the power to make decisions on behalf of the "uninformed."

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