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Care, Autonomy, and Gender in Nursing Practice: A Historical Study of Nurses' Experiences

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ABSTRACT

Background: Care is the essence of the nursing role and is closely related to the concept of professional autonomy. Autonomy is implicated in power relations between doctors and nurses and between men and women. These relationships are closely linked to care practices and the inequality of nursing and medicine.

Purpose: The aim of this study was to analyze nursing discourse regarding the concept of care and its relationship to the concept of autonomy and gender.

Methods: This is a historical study based on oral interviews that took place between November 2008 and February 2011. We interviewed 19 nursing professionals who currently worked at the Hospital of the Holy Spirit (near Barcelona) or had worked there between 1961 and 2010. Semistructured interviews were recorded, transcribed, and analyzed.

Results: We highlight four main themes: "a real nurse"; "more technology, less care"; "the fragility of autonomy"; and "the invisibility of nursing work." These themes show the contradictions in the nursing profession that are based on the concept of care. However, in daily practice, the concept of care varies. Time pressure distances the nursing practice from its theoretical context. Changes in the concept of care are related to transformations in the health system and nursing work.

Conclusions/Implications for Practice: Changes related to the autonomy of nursing are related to changes in the concept of care. In practice, care has a biomedical orientation. Care has become technologized and bureaucratized, which reduces the time that is spent with the patient. In a context in which medical authority predominates, nursing's struggle for autonomy is based on the recognition of the value of care. When care becomes invisible, the autonomy of nursing as a profession is threatened. This conclusion allows reflections about shifts in the concept of care and how they affect clinical practice and the autonomy of the nursing profession.

KEY WORDS:
professional autonomy, nursing care, nursing practice, gender, Spain.

Introduction

In this article, we describe the nursing discourse about the concept of care and its relationship to the concept of autonomy. Care is the essence of nursing, but recent research on the autonomy of the profession has not explored the meaning of care. Rather, the definition of "care" has been taken for granted (Baykara & Şahinoğlu, 2014; Cole, Wellard, & Mummery, 2014; Skår, 2010). Care is the essence of the nursing role, whereas the notion of autonomy reflects a power struggle between nursing and medicine. The concepts of "care" and "autonomy" are linked to the dimensions of gender both in the emergence and definition of the nursing profession and in the unequal relationship between nursing and medicine. On the basis of these assumptions, our focus is two-fold. First, we show that the concept of care is accepted and redefined by nursing professionals in their struggle for greater autonomy. Second, we show that, as the nursing profession becomes technologized and bureaucratized, care practices are modified such that some key functions of nurses are becoming invisible. Nursing professionals typically use two contradictory processes to achieve recognition and power.

Background

Care Women and Nursing

Care is an essential human need that is basic to the sustenance of life and to social reproduction. Most forms of assistance and care take place in the domestic environment. This situation has contributed to naturalizing the link between women and care and to reducing the recognition of its importance (Carrasco, Borderías, & Torns, 2011; Daly & Lewis, 2000; Himmelweit, 2007). Professionalized care in health centers is one of the forms of care that defines the nursing profession. The act of caregiving has a feminine connotation, which has influenced the composition of professions that have a marked helping function. The distinction in the health realm between treating and caring for a patient not only differentiates medical acts and nursing acts but also hierarchizes these activities. Medical treatments do not substitute for care. However, nursing care is valued less than medical intervention (Collière, 1996; Fajardo Trasobares & Germán Bes, 2004), and the same thing occurs in terms of

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the social recognition of the nursing profession (del Pino Casado & Martínez Riera, 2007; Liu, 2010).

Nursing care still has features that are attributed to women as caregivers, and nursing is a feminized profession. At the same time, nursing is subordinate to medicine within the health sector. Both of these aspects have strong gender-related components. Gender has a direct influence on the association between nursing care and women and on the difficulty that nurses face in receiving social recognition for their profession. Furthermore, gender affects power relations between doctors and nurses, which symbolically reproduce the allocation and hierarchization of roles between men and women, although the entrance of women into the medical field partially modifies this relationship (Arroyo Rodríguez, Lancharro Tavero, Romero Serrano, & Morillo Martín, 2011; Carrasco Acosta, Márquez Garrido, & Arenas Fernández, 2005; Fajardo Trasobares & Germán Bes, 2004). The small but growing number of men entering nursing does not break with these power relations based on gender but rather reproduces them within the profession (Evans, 1997; Kouta & Kaite, 2011).

Nursing Care and the Autonomy of the Profession

The concept of autonomy in the field of nursing has been widely studied. In their examination of the relationship between autonomy and satisfaction in the workplace, Iliopoulou and While (2010) pointed out that, despite this abundance of studies, the concept of "autonomy" has been poorly defined, operationalized, and measured. Skår (2010) adopted a qualitative perspective and delved into the experience of autonomy in the work of nurses, identifying four elements: "to have a holistic view," "to know the patient," "to know that you know," and "to dare." Rowe (2010) rightly considered that, of all these elements, the only one that actually links to autonomy is the fourth, "to dare." This concept expresses the ability to make decisions and the capacity to act. Decision making is the central aspect of nursing autonomy. Karra, Papathanassoglou, Lemonidou, Sourtzi, and Giannakopoulou (2014) identified eight categories of clinical nursing decisions: (a) evaluation, (b) diagnosis, (c) prevention, (d) intervention, (e) communication with patients, (f) clinical information seeking, (g) setting of clinical priorities, and (h) communication with healthcare professionals (pp. 89–91). They concluded that nonurgent decisions were 78% of the total and that 60% of nurses' intervention decisions were independent of medical order and related to basic nursing care.

Nursing autonomy has a relational dimension (MacDonald, 2002). On one hand, nursing decisions affect patients directly. In this sense, a person receiving care is in a subordinate position with respect to caregivers. Providing good nursing care means meeting the needs of the patient without the patient feeling inferior (Cole et al., 2014). On the other hand, nursing decisions are related to those of medical professionals. The historical subordination of nursing to the medical model limits the decision-making power of nurses and sets up a conflict between biomedical logic and care-based logic (Baykara & Şahinoğlu, 2014; ter Maten-Speksnijder, Grypdonck, Pool, Meurs, & van Staa, 2014).

Prior research on the concept of nursing autonomy did not examine the relationship between this concept and the notion of care. Because care is a cultural construction (Leininger & McFarland, 2006), the evolution of the nursing profession and its struggle for autonomy influence the meaning and practice of care. Care and autonomy are closely related concepts that are embedded in gender relations. Our hypothesis is that the trend toward technologizing and bureaucratizing nursing work contributes to making care invisible and to changing the very concept of care and its practice within nursing. The process is dialectical and contradictory in that gender and power structures influence it.

Among the factors that affect the relationship between care and autonomy, we must keep in mind the social and historical contexts of changes in the nursing profession, the organizational culture of health centers, the types of patients and their attitudes, and the nature of the health system.

This study aims to analyze nursing discourse regarding the concept of care and its relationship to the concept of autonomy and gender.

Conditioning Factors

In Spain, the transition from the religious model of care to the professional model occurred relatively late compared with other European countries. This transition was led by nursing professionals who undertook major changes in some hospitals. Although these changes were initiated in the 1960s, they did not become generalized until years later. In the case of the Hospital of the Holy Spirit (HHS), the reform of nursing began in 1985 when Pilar Argelès Masó, a pioneer in nursing professionalization, joined the staff. From a conceptual point of view, this does not mean a rupture with the previous religious model, but it does introduce important changes in the organizational structure of nursing, in the management of labor, and in the systematization of the process of nursing assistance. The nuns who worked as nurses beginning in 1917 gradually disappeared from the staff, and new nurses entering the hospital after 1953 were certified as technical health assistants ("ayudante técnico sanitario" in Spanish). Those entering after 1977 had university degrees. The replacement of religious carers by professionals was because mainly of the limited technical training of the religious carers and the weakening of the emphasis on service within religious orders (Galbany-Estragués, 2012).

Methods

Design

Historical studies were conducted based on oral and documentary sources to explore the development of nursing

autonomy in relation to changes within the hospital. Data collection was carried out between November 2008 and February 2011.

Participants

The study population included 19 nursing professionals who currently or had worked at the HHS in Santa Coloma de Gramenet, near Barcelona. The selection criterion was having worked as a nurse at the HHS between 1961 and 2010. This criterion included both religious and lay nurses. The oldest participants had no official qualifications, whereas the younger ones had qualifications in accordance with the professional regulations that were in force during the latter 20th century. We excluded persons who did not meet the selection criteria and those who were not physically or mentally capable of participating, for example, not being able to place memories in the social and political context, not expressing themselves clearly, or not remembering their experiences clearly. We identified the nurses with the support of Human Resources staff, and, after interviewing the first nurse, we contacted the remainder of the participants using the snowball method because there was a lack of registration of the oldest nurses in the HHS. The participants were between 34 and 74 years old. Sixteen participants were women, and three were men. To guarantee diachronic reliability (Kirk & Miller, 1986), we selected participants who worked at the HHS at different periods: P-1 and P-2 began working during the 1960s, P-3 to P-6 began working during the 1970s, P-7 to P-14 began working during the 1980s, P-15- to P-18 began working during the 1990s, and P-19 began working in 2001.

Finally, to cover all of the profiles that were identified as relevant, we took into account the following dimensions in selecting participants:

- Professional categories: All categories in nursing are represented by at least one participant—director of nursing, nursing supervisor, head of unit, and nurse.
- Units or services of the HHS: Inpatient nurses and nurses for special services are represented by at least one participant.
- Work shifts: The pool of participants included nurses from all shifts (morning, afternoon, and night).

Data Collection

A semistructured interview approach was used to collect data. The content of the questions focused on the following aspects: personal data, training and professional experience, description of workplace, perception of the meaning of care, perception of the autonomous role of nurses in providing care, and changes in record-keeping related to nursing activities. Three interviews were conducted at the homes of participants, and 16 were conducted in a private room at the HHS. The interviews lasted between 1one and 1.5 hours and were audio-recorded for later transcription. The data collection and the analysis were conducted by P. G., the author of this article, while she was studying for her PhD.

Ethical Considerations

The HHS Foundation's research committee approved this study (No. Gen-001-2014-01). Furthermore, this study was separately approved by the Department of Human Resources and the Nursing Department. Participants signed an informed consent waiver, and results were stripped of participant identification information (the letter P followed by a number).

Data Analysis

We organized the data that were obtained from the interviews into codes and categories (Lincoln & Guba, 1985). The analytical category was "nurses' perceptions of the role of care." The codes were perception of the concept of care, perception of the concept of autonomy, and changes during the period in which the participant worked as a nurse.

Rigor

The quality standards for qualitative research were defined by Lincoln and Guba (1985) as credibility, transferability, and dependability. Delgado, Vargas, and Vázquez (2006) noted the importance of the theoretical–epistemological framework, confirmability, and relevance.

To guarantee the credibility of the data, interviews were recorded and transcribed. We conducted a literature search for points of comparison and contrast, and we consulted experts in qualitative methodology. To guarantee the transferability and consistency of the findings of this study, we followed the project methodology carefully after consulting experts. To ensure theoretical and epistemological adequacy, we tailored the research question to the study design. To maintain confirmability in the discussion, we compared this study with similar studies. Our response to the specific objectives and our new findings regarding the concept of autonomy indicate the relevance of this study.

Results

A Real Nurse

HHS nursing professionals fully identify with the concept of care based on a comprehensive concept of the person. Nurses manage for the patient the tasks that he or she cannot handle alone. The model emphasizes the care dimension above the biomedical one.

> *Providing care is my role as a professional. It encompasses everything related to the person. I mean, helping [to address] the needs that the person might have. I like Virginia Henderson's model a lot, because it's true. That's how it is.* (P-12)

> *I think a job well done is when the patient leaves here grateful because he was okay, because it didn't*

hurt, he was warm enough, he felt supported, he didn't feel alone, and he was able to talk to you or tell you about his fears (...). This is what gives you the satisfaction of saying, 'I did a good job. I cared for this patient well'. (P-18)

Caring is looking after a person in the things that he can't do. (...) It's being available to him. For me that's what nursing is: greeting the patient, letting him know that you're there, not ignoring him, asking if he's in pain or not, etc. It's not just giving shots and medication. (P-9)

These statements show close alignment with Henderson's theoretical concepts. This theoretical homogeneity is because in part of the training given in nursing schools and also to the organizational culture introduced to the HHS by the first director of nursing, who served from 1985 to 1999. Pilar Argelès Massó was called by her successor (P-19) "a real nurse" because she applied the theory of Henderson in clinical practice. This expression identifies the essence of nursing with the priority given to care.

However, the concept of care varies when it is applied in daily practice. In such cases, the meaning is not the same across contexts. One element that varies is the type of activities that nursing includes in practice. In the past, nursing activities were not systematic. This came after 1985. There were no nursing records or patient care plans until 1995. The concept of care was very broad and included many activities that are excluded today from nursing.

When I started in 1968 (…), you were a nurse, a cleaning lady, a nurse's assistant, you did a bit of everything…. We wore a white coat with a white apron (…) but you put on a coloured apron when you had to clean the floor or serve lunch so that you wouldn't stain your white coat. (P-2)

In 1983, I started in a surgical unit and I did the delegated functions on my own. Also, I did what was necessary. I mean, I was the nurse, the nursing assistant, and the stretcher-bearer. (P-8)

Today, the opposite is happening: The concept of care is becoming restricted. Participants report not having enough time to offer comprehensive care or recognizing that the care has changed. An important part of the concept of care has been eliminated in practice. Lack of time is the reason that is given most often as an explanation for why nursing practice is becoming detached from nursing theory.

At a theoretical level it's about satisfying all the needs of the person. But now we don't have enough time to be able to provide that kind of care. (P-16)

Patients need to be listened to, taken care of. But today that's not done so much. (P1)

More Technology, Less Care

Changes in the concept of care relate to the transformations in the health system and in nursing work that occurred during the mid-20th century. The introduction of nursing charts and a greater emphasis on biomedical aspects influenced these changes. Other factors include health policies and budget cuts. Patient demand and the increase in the number of patients per nurse lead the field toward the easiest solution to this pressure: the biomedical model.

Today, nursing follows stricter protocols and requires more bureaucratic work, which takes time away from providing comprehensive care. This affects communication between nurses and their patients and patient families.

Before, you used to talk to the patient and he told you what he needed. Now, everything is governed by protocols and techniques. Each case has a protocol or a specific technique. This helps you to work in the same way, but it's more bureaucratic. (P-11)

Now it's all done through technology and you don't have much time for anything. As soon as you start using a computer, you end up spending your whole life looking up data and entering data. It's a shame that closeness with the patient has been lost. (P-5)

The medical process has also changed. Postoperative stays have become shorter, and home care has increased, meaning that patients spend less time in the hospital. This change complicates nursing care, making it harder for nurses to get to know patients and to provide personalized care.

Care has become depersonalized. It's more technical. Caring requires proximity, closeness. It requires knowing the person, knowing who he is, what his name is, what concerns he has. I think when there were fewer of us, this closeness happened. (P-14)

When I started working, there were more patients, but the volume of work was lower. Now the patient has always just come out of surgery and he's going home soon. (P-10)

Furthermore, the participants perceived a generational change, with the older participants perceiving their younger peers as more focused on technology than on care.

Nurses that are coming in now have another vision. They're better prepared to work with computers and give medication in a more automated way. (P-10)

Younger nurses don't spend as much time listening, speaking to family members. These human values are stronger in older people (...). Knowing how to talk, knowing how to address

another person, knowing how to console, knowing how to convince. Older people do these things better. (P-8)

Ultimately, changes in nursing work have become oriented toward technology. This, in turn, has modified the provision of care, which occupies a progressively smaller proportion of nursing activities.

The Fragility of Autonomy

When participants defined their autonomy with respect to doctors, religious nurses, nursing assistants, and colleagues, they drew on the concept of care. Some talked in terms of "the team" or "multidisciplinary work." In all cases, autonomy was related closely to care.

The participants defined autonomy as the ability to make decisions and to act. They recognized that their profession has gained autonomy with respect to medical power and linked this to the recognition of care as an area that is particular to nursing.

When I started in 1979 there were many things that we couldn't do, like, for example, drawing blood without getting a doctor's order. I had to go get the doctor and ask him to write me an order. (…) Before, we didn't even do integral care like we do now along with the nursing assistant. It was different; we had to chase after the doctor more and now we organize our work. (P-6)

Now I think nursing has its own functions, the doctor has his own and then there are a few tasks that are shared and we have to work together. You do your part, you write it down, and the doctor sees what you've done and that's it. I mean, we're not under them. (P-18)

Nursing has become diversified and stratified. Only nurses at the higher echelons such as nursing supervisors and directors achieve real autonomy (P-4, P-7, and P-8). Another variable is the workplace, as nurses hold more autonomy in the realm of special services than in inpatient units (P-3, P-20, and P-18). Finally, nurses with experience have a greater capacity to make decisions than novice nurses (P-9, P-12, P-15, P-16, and P-17).

All of these differences in degree of autonomy indicate the fragility of the autonomous role of care and its embeddedness in power and gender relations. A large portion of nursing work remains dependent on the medical profession, a fact of which our participants were very aware. Some of the participants described autonomy as a sort of concession made by doctors or something that one earns from doctors as a function of experience and trust.

I think that to be autonomous the important thing is for them to let you take the initiative. (P-11)

I organize my work from the moment I get here in the morning. I rely on myself because I'm on my own. I rely on myself for everything. The doctors give me this freedom and I take it and use it. (P-18)

The struggle for autonomy is invariably related to the struggle for the recognition of the value of care. We have seen that nurses claim this autonomous role, but they do not always feel free to confront and challenge doctors when it comes to the care of patients. This insecurity is the result of the lower value that is given to care with respect to medical actions and the fact that nursing professionals feel undervalued.

Today's nurse is much better trained and is better able to make decisions, but we still have to advance (...) I think—and this is a criticism that I make of the nursing profession—that we do not value each other. Respect for knowledge, in medicine, is very clear, but in nursing we have a long way to go. It would improve our autonomy and it would improve the way nursing is judged from outside. (P-14)

The Invisibility of Nursing Work

Some functions of nursing are invisible despite advances in nursing autonomy. This was the case at the HHS. Nurses are unable to document a certain portion of their care activities because the software that is used to create nursing care plans does not include them (P-15).

The following example is significant in that it expresses very clearly a reversal of the definition of the essence of the profession: Providing care is considered a waste of time that threatens what a participant considered to be true nursing work—such as recording care plans.

Now nurses do what they did before and on top of that, they also have to record their care plans. This is very valuable time and we are racing against the clock. The more time you spend with the patient to listen to him, to talk or to be with the family member…. It's time that you're taking away from your work. (P-8)

Discussion

Nursing practice at the HHS bases its conception of care on the needs of life and on care as a human value. The model of Virginia Henderson (1966) has been strongly incorporated into health institutions, where it has been effectively adopted by nurses. Henderson's influence is evidenced by the fact that it was adopted by the International Council of Nurses and that her *Textbook of the Principles and Practice of Nursing* (Harmer & Henderson, 1955) was translated into Spanish, favoring its use in nursing schools and health

centers. This model influences the way that nursing professionals construct the concepts of care and professional autonomy. Care is oriented toward meeting the needs of the patient. Although nursing staff have an independent role while working with other professionals, the daily practice of nursing differs from and limits the concept of care, with many former activities now excluded. These changes in care activities have implications for nursing autonomy.

A greater emphasis on biomedical aspects further modifies the changes in nursing activities and reduces the importance of care. This trend is conditioned by the fact that the nursing profession in Spain was born of the merger of two areas of study: "Practitioner and Midwife" (1857), which was more technical, and "Nurse" (1915), which focused on care. These two areas (one biomedical and one focused on care) are deeply divided in terms of how they define nursing and how they conceptualize autonomy (del Pino Casado & Martínez Riera, 2007). Both profiles are present at HHS, and, although nursing organizational culture is based on the model of care, the development of the profession, especially in the context of increased patient demand, is pressuring the field in the direction of the biomedical model.

Regarding care and autonomy, nursing has gained power in health institutions. This is true in organizational terms and in relation to the medical profession but may not be generalized to nursing as a whole. Nurses in senior positions converge in the institutional leadership with doctors and administrators, and in this context, they compete with other departments for budget allocations, autonomy, and power. This study found the symbolic dimensions to be associated with the value and recognition of certain activities and professions. Whereas medical acts are recognized both socially and within the field, the acts of care that accompany medical acts are undervalued (Fajardo Trasobares & Germán Bes, 2004). In fact, some areas of nursing care are altogether invisible. This asymmetrical value between medical acts and care activities reflects asymmetrical power in terms of profession and gender.

In relation to the invisibility of nursing work, some of the activities that are required of nurses are not recorded in nursing records. These activities relate to communication strategies for the emotional care of patients and their families, creative therapeutic strategies, and care related to comfort, intimacy, relief, pain, support, and the maintenance of trusting relationships (German & Hueso, 2010; Huércanos Esparza, 2010). The fact that these nursing actions are not recorded is because of the low value that these forms of care are accorded by nurses, institutions, other health professionals, and society in general. Their low value relates to the fact that these tasks have historically been classified as feminine, that they are not measurable, and that they do not have social and economic recognition. Conversely, the technical aspects and physical skills that can be protocoled and measured are of interest to professionals and receive social recognition (Fajardo Trasobares & Germán Bes, 2004; Huércanos Esparza, 2010).

Care recedes in the face of work that relates to the bureaucratization of nursing. Furthermore, care recedes with the development of biomedical nursing techniques, which stress diagnosis and medical treatment over care and the promotion of health (Cano-Caballero Gálvez, 2004; del Pino Casado & Martínez Riera, 2007). This trend makes it difficult for the nursing profession to advance in terms of autonomy and professional development. The profession will not advance if the impact of care is not measurable. Furthermore, the impact of the profession will not be evaluated if certain care activities are absent from the nurses' own charts. When care becomes invisible, the autonomy of nursing as a profession is threatened. It is difficult in these conditions to break gender and power-conditioning factors.

Conclusions/Implications for Practice

The changes in the autonomous role of nursing relate to changes in the concept of care. In practice, care has a biomedical orientation despite its theoretical underpinning in the biopsychosocial realm. Moreover, the advent of nursing charts increases bureaucratic work and decreases the time that is available for direct contact with patients.

Furthermore, the concept of autonomy has experienced changes that relate to the changes in care activities. In fact, the struggle for nursing autonomy is based on the recognition of the value of care, in a context in which medical power clearly predominates. Contradictorily, as the nursing profession becomes technologized and bureaucratized, some care functions become invisible. These dynamics show that nursing autonomy relates to the value attributed to care as the essence of the profession. Furthermore, this assignment of value occurs within the framework of power relations, which reflects gender hierarchies and inequality between medicine and nursing.

The implications for practice of this research relate to the need to strengthen the recognition of care. Reappraising the value of care as defining the nursing role may serve to enhance nursing autonomy and improve clinical practice.

Limitations

The main difficulty was to find living witnesses who had worked between 1960 and 1970. For this reason, we interviewed participant P-2. She worked as a nurse at the HHS

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during a period when holding a title of "nurse" was not required to work as a nurse.

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