Taking Charge: How to Make a Difference

The Role of the University

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Synopsis

The role of the university, and particularly the health sciences university, in promoting positive health for women is twofold. First, the dissemination of existing knowledge raises awareness of special health needs and identifies gaps in the present research and literature base. Second, universities must project future needs of women in a rapidly changing society where such things as space travel may become commonplace. Reduction of the risk of debilitating disease and promotion of positive attitudes will enhance the quality of life for women. A logotherapeutic approach to choosing one's own attitudes toward life's challenges promotes successful coping in a dynamic society.

THIS PAPER WILL FOCUS on the role of the university in the area of women's health care, describing a new Master of Science degree program, discussing societal issues of women's health, the conceptual framework for women's health, and quality of life issues, and finally, offering recommendations for the future role of the university.

Role of the University

The traditional role of any university is education, service, and research. These are not separate entities, but rather are intertwined, that is, a professor has an inherent need to discover new knowledge in a chosen field, which makes teaching more current and relevant. Service to the community follows as knowledge is shared and put into practice.

The role of the health sciences university goes one step further, by providing patient care services. Here, too, is a natural blend of roles, in that patient care generates research questions, patient populations provide the research arena, findings are applied to improve patient care, and students learn.

Master of Science in Nursing Degree Program

The University of Texas Health Science Center at Houston in the fall of 1985 initiated a new Master of Science in Nursing degree Program in Women's Health Care, one of about six in the nation. The program focuses on the holistic needs of women throughout the lifespan and prepares graduates to manage well women, and women with minor, major, and chronic health deviations. Both physiological and psychosocial aspects of women's health are considered. Emphasis is placed on health promotion, health maintenance, and health restoration. Content focuses not only on reproductive problems and needs, but on mental health, including depression, and on major health problems such as cancer and cardiovascular diseases. Clinical experiences take place in a variety of health care and community settings in collaboration with other health care professionals.

The developmental stages of a woman's life are part of the curriculum, and the approach to health problems is interdisciplinary. Outcomes are directed at education, service, and research in the area of women's health.

Women's Health as a Societal Issue

The initiation of the new master's program has raised many questions throughout the health science university. Why not call it the traditional "ob-gyn nurse" or the "maternity nurse" program? Is it prejudicial to have a women's health care program without also having a men's health care program? As a matter of fact, having the women's program has identified gaps in men's health, such as the observation that there are educational programs on breast self-examination, but nothing comparable for male-related cancers. And everyone is concerned with a woman's body image and self-concept after mastectomy or hysterectomy, but nobody speaks of a man's difficulty after urological surgery.

Although the study of women's health may serendipitously raise awareness and improve care for men as well, there are at least three good reasons why the study of women as a separate issue is warranted.

First, women are the largest group of consumers of health care. That women avail themselves of health care services more than men has been documented. Furthermore, elderly women outnumber men and take a proportionately larger share of health resources. Women have ongoing health care needs centered around their reproductive systems, whereas men often seek services only when they are ill. Women often enter the health care system when well to gain control over their reproductive processes.

Second, women are the main care givers within the family. Women traditionally have assumed the role of giving care to family members to maintain health as well as to restore health. Furthermore, women determine the health of their offspring by their antepartal behavior. Women often care for elderly parents, and this practice is predicted to increase.

With the prospective payment system for hospital care, patients are being dismissed "quicker and sicker" to the home setting. Thus, the care giver role for women is likely to escalate in the foreseeable future.

Third, women are the largest group providing professional health care services. Nurses, most of whom are women, now number more than 1.8 million, the largest of the provider groups. Women in medical schools often comprise one-fourth to one-third or more of the class. Likewise, pharmacy schools report classes of which one-half are women. Unfortunately, nursing has not been able to attract the men who are displaced as women move into traditionally male-dominated professions. This is our goal. In the Houston area, where we have 10 percent unemployment due to the oil crisis, we are trying to attract people into nursing as a second career at the University of Texas Health Science Center.

Contextual Framework for Women's Health

Perceptions of women influence the questions that are asked, and therefore the answers that are generated. For example, if women are viewed as "damsels in distress," questions are likely to be asked about women as victims, and answers are likely to be defensive. However, if women are viewed as a part of society as a whole, a systems analysis approach can be used; that is, women as a subsystem can be studied in order to make the entire system function more effectively. The result is that the whole is greater than the sum of its parts.

Societal pressures and expectations can be clearly seen in the study of art forms of the ideal woman as they have changed through the ages. Womanhood characterized as the Madonna and the puritan was at one time the norm. Women as nurturers and supplicators are depicted in art. The Renaissance woman was voluptuous as illustrated in the famous painting, The Three Graces, a sharp contrast to today's "thin is in" ideal. The *femme fatale* must remember that "nothing tastes as good as being thin feels", a popular slogan used by a weight maintenance program. Women have gone from this *femme fatale* look to the unisex look, where gender cannot be distinguished by dress, appearance, or activity. At one time work outside the home was characterized by determination; dress was drab. Today's executive woman feels comfortable and relaxed in the corporate world. She may wear high-fashion clothes, but gives the appearance that she does not have time to fuss with her hair. A woman's ability to serve her country in time of war was above and beyond the call of duty at one time; today we talk about conscripting women for military service. Women are changing from ladylike sports to playing with the boys. Women are training for careers in space. The dread middlescence period for women has been refocused as a time of freedom to pursue the female Renaissance—the "empty nest" myth is gone. Now we can even look forward to post-menopausal zest. Universities must track the changing societal expectations and norms of women to keep pace with needed changes in health care.

Since women are malleable to the demands of society, including expectations of behavior and appearance, it is challenging to visualize consequences of the new era on health. For example, will there be unique concerns resulting from the aerobics craze, plastic surgery for every cosmetic need, test tube babies, dual career parents, and coed living arrangements? What will happen when today's executive superwoman retires and faces the next 40 years of leisure activities? Will nursing homes need spas and health boutiques? Will we all be taking vacations in space, perhaps as therapy for arthritic joints or for the euphoria of weightlessness? A graduate student at the University of Texas Health Science Center at Houston is working under a NASA contract to study feminine hygiene during menstruation as baseline data for space travel planning.

Quality of Life Issues

Health professionals are also challenged to improve the quality of life for women at all socioeco-

nomic levels and for all ethnic groups. The prevention of debilitating disease, both in terms of degree and age of onset, is important. For example, if there is a strong genetic tendency for adult onset diabetes coupled with environmental influences which increase the risk, the goal can focus on delaying the onset as long as possible by preventive and health promotion measures. If successful in delaying diabetes, the disease may not manifest itself until the last one or two years of life as opposed to an earlier age of onset with diabetic complications such as blindness and necrosis requiring amputation, which interfere with the quality of life.

The handicapped woman is an often neglected element of society. In my studies with spinal cord-injured clients, I learned that many women are afraid that having a wheelchair ramp at the house entrance will call attention to the fact that a handicapped person is in the house and defenseless (*1*). We need to know much more about the concerns of handicapped women.

Another challenge for universities lies in the vast gap in knowledge about various developmental stages of women. Health care agencies are not responsive to differing needs of women, or for that matter, of men. There is a strong movement toward "normalization" in pediatrics for children who are hospitalized. Part of it is a bright and cheery environment with bean bag chairs and plenty of toys. Teachers and other educational aides are available; recreational activities are a regular part of the hospital routine, including visits from clowns, famous entertainers, and sports heroes. There are provisions for family to be with the patient to lend support. However, there are no such "normalization" attempts on patient units for adults. Perhaps as hospitals become more competitive we shall see exercise rooms, video movies, fashion shows, mini-offices with dictaphones, and other responses to normalization of lifestyle.

Quality of life discussions would not be complete without recognition that life presents challenges often in the form of suffering and anguish which must be confronted. How can women be helped to cope with devastating personal loss and disappointments? One useful approach is logotherapy, a treatment modality geared to helping individuals find meaning and purpose in life events. In the words of Viktor Frankl, everything can be lost but one thing: the freedom to choose one's own attitude toward a fate which cannot be changed (*2*). Treatment is focused on self-transcendance, as opposed to self-actualization, to get outside the self for a cause in the world rather than to hyper-reflect in a vicious cycle. There are

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many examples of logotherapy, where a tragedy has motivated persons to become active in a project to correct a long neglected social problem. Mothers Against Drunk Driving is a good example.

I would like to propose recommendations as to how universities can continue to make a difference in women's health. I strongly recommend that the study of women's health care continue to be interdisciplinary and that there be adequate numbers of needed professionals. National data already lead to predicting another nurse shortage in hospitals in four States, including Texas (National League for Nursing Executive Director, personal communication, June 1986). This phenomenon is thought to be related to the recruitment of hospital critical care nurses by home health agencies, which are rapidly increasing. A drop in baccalaureate nursing enrollment is also occurring. I strongly recommend that national attention be given to graduate education in nursing, particularly at the doctoral level, based on a recent report on personnel needs (*3*). Essentially, there are now two approaches to doctorates in nursing—the PhD and the DSN (also referred to as DNSc). Schools which have both degrees distinguish them by describing the PhD as the academic, theoretical research degree, and the DSN as the advanced professional degree for clinical practice. Graduates of the DSN degree programs are prepared to contribute to direct patient care as well as to clinical research. There are only nine such programs in the United States (two opened in September 1985 and thus have had no graduates). There are approximately 25 PhD programs. Only 0.2 percent of nurses have a doctorate. This figure is predicted to be 0.3 percent by 1990. In initiating the clinical doctorate at the Texas Medical Center, we have had overwhelming support from the medical school faculty. It is not surprising when one considers that a self-confident physician is not threatened by a well-educated nurse, but rather knows the value of collaborative practice and research. Patients receive better care when both nurse and physician have a high level of basic clinical science knowledge. No-

where is this collaboration more important than in the area of women's health care.

Nursing research has come into its own with the creation of the new Center for Nursing Research within the National Institutes of Health. Studies in the area of women's health which contribute to quality of care as well as to cost effectiveness should be very appropriate for the new Center.

I recommend that consideration be given to establishing women's institutes on a regional basis which could become centers of excellence. The institutes would provide educational opportunities, establish model health care service delivery, and conduct research to fill in the knowledge gaps and to keep pace with changing societal roles.

Educational programs would develop learning materials which could be marketed to all other health care agencies. Programs would serve to resocialize women toward self-care management and control. It has been stated that self-care is an American ideal arising from the desire for independence and self-sufficiency. Many other cultural groups value dependency when sick, providing an opportunity for others to express love through caring. Nevertheless, since
women are the largest consumers as well as givers of health care, it seems essential that women be educated to improve care for themselves and others if prevention and health promotion are to be achieved.

Universities must be cognizant of cultural diversity in terms of student's experiences with patients as well as recruitment of students. Health care professionals report that ethnic minority patients often respond to a nurse of similar background. I am told by administrators that a Caucasian nurse who is bilingual will still not be as effective as a Hispanic nurse who knows the cultural preferences of Hispanic patients. It is distressing to note that only 1.4 percent of nurses are Hispanic (*4*) although the current U.S. Hispanic population is 6.4 percent and rising rapidly (*5*). Hispanic nurses are needed in graduate as well as undergraduate programs.

Model health care centers within universities should promote quality of care. Model centers where patient and professional are partners will promote decision making and responsibility for compliance with mutually set goals. Such models would reduce the alienation often present in traditional services. Patients in our free enterprise system most often choose their physicians. Why not let patients and families choose their nurses too? If nurses had to present their credentials and records of performance in quality of care and cost effectiveness, I believe there would be an impetus for the art of caring in nursing to be refined and its relationship to healing documented.

Finally, the university must generate new knowledge in research in order to make a difference. We currently lack baseline data, as our students in the Women's Health Care program are discovering. Centers of excellence could track changes in data among the various generations. Regional centers could identify areas for high priority for future clinical research.

Research which was originally conducted on men needs to be replicated with women. Areas of research need to be expanded beyond reproductive concerns. For example, teenage pregnancy now overshadows other health concerns for teens. Support mechanisms for women who are likely to continue to experience role overload and role strain from multiple demands need to be explored. More research needs to be done on hazards of the workplace. Much of the research done to date on employment of women centers around its effects on the spouse and children.

In conclusion, universities play a large role in improving the health of women, but the work is only in its beginning stages. The optimistic viewpoint is that by focusing on women, health care for all will be improved.

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