

## **Abstract**

A Case Study of the Professionalization of Mexican Nursing: 1980 to 2005

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The study of the evolution of a healthcare profession in a developing country context has many implications not only for healthcare human resources policy structuring, but also for health and development outcomes. With the global shortage of nursing personnel, understanding the country-specific factors involved in the recruitment and retention of nurses into the profession becomes critical for ensuring ongoing, quality health care services delivery. Using theories about professions, an examination of the process of the professionalization of nurses is one way to improve understanding about nursing human resources. Professionalization is a developmental process that structures how a group organizes to advance itself socially, politically, and economically in a country. Mexico is an economically high-middle income country with an established but underdeveloped nursing profession. This exploratory case study examined the professionalization of nursing in Mexico between 1980 and 2005 with the aim of improving understanding about Mexican nursing human resources. The twenty-five year period was selected because it represented a period of significant economic and political change in Mexico that would have impacted Mexican nurses both personally and professionally. Methods included semi-structured interviews with 32 Mexican nurses from both rural and urban healthcare settings, an extensive interdisciplinary literature review from the designated period, and a contextual analysis of Mexican federal government and Ministry of Health documents related to nursing human resources. Study findings indicate that eight variables strongly affect the development of the nursing profession: professionalization processes, the workplace, unions, history, economic, political, sociocultural factors, and international influences. The relationships among the variables suggest the presence of a country-level “nursing system” that produces nursing personnel and affects health-system outcomes. To illustrate the relationships and potential effects on these outcomes, a theoretical model was developed. The findings of this study have implications for the production, development, and management of nursing human resources in other developing countries and may also apply to nursing in developed countries.



A Case Study of the Professionalization of Mexican Nursing: 1980 to 2005

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## **Dedication**

*This work is dedicated to my parents:*

*To my mother, Maureen Squires, who taught me how to see the beauty*

*found in the structure of words;*

*To my father, David Squires, who taught me how to listen to them.*

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## CHAPTER ONE

### INTRODUCTION

What is a professional? As a term, it is associated with a variety of groups, including actors, firemen, lawyers, and nurses. “She’s such a professional!” is an expression often heard when associating individuals with specific behaviors such as conscientiousness in work, style of dress, and respectful behavior toward others. Generally, the term implies that a person has associated him or herself with an organized group within a society that is allied with their career and personal interests.

Sociologists describe “true” professions as organized groups whose primary goal is to provide a service to society. They possess institutional mechanisms for self governance and control of work, and have a unique body of knowledge often characterized by intellectual and skill-based content (Abbott, 1988; Cogan, 1955; Freidson, 2001; Hall, 1968; Larson, 1977). There are class groupings among professionals usually based on salary level or the socially ascribed value placed on their services (Abbott, 1988). Once organized, professions strive to maintain their social status within a society in order to preserve their “superior” status or elevate themselves to a higher one (Freidson, 1970, 1986, 2001).

The highly organized societies found in developed countries possess the economic resources to support a variety of professionals (Sullivan, 2005). Professionals can provide key services, such as health care and education, which help foster social stability. Sullivan (2005) contends that due to their participation in market and political processes, the numbers and types of professionals in a society can also be an indicator of the level of democracy present in a country. Therefore, the development of professionals and their services is an important goal for countries seeking to advance to higher levels of social and economic development (Sullivan & Benner, 2005).

In order to study a profession thoroughly, one must first analyze the circumstances in which it functions (Abbott, 1988). These conditions include the country's history, political and economic development, and how sociocultural variables, such as class and gender, influence professional roles. When studying healthcare professions, the design of the health care system (HCS) is a significant variable. Participation by healthcare professionals in the creation of the HCS policies affecting their practice is an important part of sustainable healthcare systems (Ruger, 2003).

Before analyzing the development of professions, however, two core terms need to be distinguished: professionalism and professionalization. *Professionalism* is the philosophy associated with being a professional (Turkoski, 1989, 1995). This organizing philosophy shapes how a profession develops within a society. Professionalism provides specific criteria for a group that wishes to be considered a profession, as well as its behavioral norms and internal group dynamics. It draws heavily upon the internal characteristics of the group, creating specific "traits" used to mark whether a group meets the criteria of a profession (Cogan, 1955; Turkoski, 1989). For example, experienced professionals socialize new members of the group to the core philosophies of the profession through formal (degree-based) and informal (on-the-job learning) education (Benner, 1984). The intra-group dynamics derived from professional socialization shape the nature of the profession and its relationship with society. Professionalism philosophies will vary among professional groups. All professions, however, share some basic characteristics that support the service-driven philosophy: members have a) a professional body representing the professionals to State level entities, b) a code of ethics that guides behavior, and c) a unique body of theoretical and psychomotor skill-based knowledge that requires specialized training at the post-secondary level (Abbott, 1988; Cogan, 1955; Freidson, 1970; Hall, 1968; Larson, 1977; Sullivan, 2005).

“Professionalization is not a simple collective action by a cohesive group” (Abbott, 1988, p. 380). *Professionalization* is a developmental process shaped by variables internal and external to the profession. Social and political elements of a society directly and indirectly impact this process. These might include the political and social context in which professionals organize and their influence on the organizational process (Johnson, 1972); the history of the region or country as it relates to the profession; the availability of economic resources to facilitate development; and the influence of gender on the overall developmental process. The collective interactions of these variables, however, is not well understood.

Johnson (1972) provided the first widely accepted definition of professionalization, but drew his definition largely from how the internal characteristics of the professional group (e.g. class, minimum education level for entry, and earning potential) affect the process of professionalization. His definition does not account for gender dynamics nor a non-Western context. Others, like Forsyth and Danisiewicz (1985), attempted to measure professionalization levels by assessing perceptions of their power in society. Sills (1998) used the term professionalization interchangeably with professionalism when describing the influence of a nurse theorist on the development of the nursing profession in the United States (US). The two terms, however, are not interchangeable and represent separate aspects of the evolution of a profession.

For the purposes of this study, professionalization is defined as a developmental social process that transforms an organized group from an occupation or vocation into a profession in response to the external variables produced by a specific context. Professionalization differs from professionalism in that it focuses on how the place where professionals develop affects their ability to act as a group. One limitation of this definition is that it draws heavily from Western and European social structures. The applicability of this definition of

professionalization to a developing country is unclear.

Nurses adopted the professional model as their organizing philosophy and framework for development well over a century ago (Ashley, 1976; Melosh, 1982; Mortimer & McGann, 2005). With the current global shortage of nurses, identifying the critical variables in the professionalization process is important to understanding how nurses professionalize within their home countries and becomes a critical component in producing nursing human resources. By identifying the barriers to and facilitators of professionalization, the efficiency of nursing human resources production could increase and help alleviate the shortage.

The primary goal of most research about professions is to describe how certain well-known professionals (e.g. lawyers, physicians, architects, engineers) subscribe to the professionalism philosophy in order to ensure their social and economic status within a given society (Larson, 1977). None of the previous research about professions has analyzed how country context influences how groups associated with lower status professions (nursing, teachers, social workers) adopt professionalism or develop through professionalization processes.

The influence of gender on professionalization is not well understood. Gender represents an important variable in the development of a profession because it is well known that women face more difficulty harnessing economic resources and more employment discrimination than their male counterparts (Harrison, 2000; Hite & Viterna, 2005). Harnessing economic resources and developing social prestige are critical for the development of a profession (Freidson, 1970). This proves particularly challenging for women in developing countries in which sociocultural, political, and historical variables hinder women's ability to garner economic resources for advancement within society (Hurtig & Montoya, 2005; Safa, 1995). In such countries, there are few sources of funds and those that exist are generally dominated by men.

Understanding these issues and the interplay of these variables in professionalization is

necessary for enhancing development of nursing human resources. Since nursing is a predominantly female profession, its development will be affected by all of the variables described here.

This study analyzes the professionalization of nurses in Mexico between 1980 and 2005. This research is in line with current World Health Organization (WHO) efforts to refine and expand working knowledge of human resources in health care (Diallo, Zurn, Gupta, dal Poz, 2003; WHO, 2006). Mexico provides an excellent setting for this type of research.

### **Why Mexico?**

Before and after the Mexican Revolution at the beginning of the twentieth century, health policy makers there derived many ideas from counterparts in the United States and Europe (Bliss, 1999; Bliss, 2001; Vaughan, 1977). It is puzzling, then, why nursing did not develop in a fashion more parallel to its other North American counterparts: the US and Canada. Although economic differences between the countries provide an easy answer, the problem is not that simple.

The nursing profession in Mexico was formally organized about 100 years ago and is now at a critical developmental juncture. The modern Mexican health system that developed after the Mexican Revolution in the early twentieth century extensively incorporated nurses in shaping health-services delivery (Birn, 1998; Birn, 1999a; Birn & Solorzano, 1999; Bliss, 2001; Kappelusz-Poppi, 2001a; Kappelusz-Poppi, 2001b). Throughout the twentieth century, Mexican nurses fought for an elevation to professional status, but faced significant resistance from the physician-dominated health ministry. Consequently, they have suffered from stagnation in the growth and evolution of the profession (Nájera, 1992).

Uniform entry-level education at the post-secondary level only became mandatory in

Mexico in 1990 (TINAN, 1996). Few nursing master's degree programs exist in the country and the first doctoral program, established in Monterrey in 2001, is only beginning to produce nurses equipped with doctorates for faculty and research positions in Mexican nursing schools. Moreover, there are few opportunities for professional advancement for nurses in Mexico (Cardenas-Jiménez & Zárate-Grajales, 2001). While there is an extensive body of interdisciplinary research that helps explain exogenous and endogenous factors that influence the development of health-services in Mexico, none of it directly involves nurses (see, for example: Agostoni, 2003; Antunano, 1993; Birn, 1998; Frenk, 1990; Kappelusz-Poppi, 2001; Laurell, 1991).

A significant event occurred in December of 2004, when the Comisión Nacional de Salarios<sup>1</sup> of Mexico elevated nurses with a bachelor's degree or higher to professional status (Boletín de Prensa, 2004). Prior to this time, the Commission categorized nurses of all types, including those with master's degrees, as members of a trade rather than a profession. Consequently, nurses' salaries barely reached middle-class income levels and most nurses worked two or three jobs to subsist.

The Colegio Nacional de Enfermeras (CNE)<sup>2</sup> of Mexico welcomed the policy change as a key step in the development of the nursing profession. Yet even though the status elevation will benefit Mexico's 180,000 professional and auxiliary<sup>3</sup> nurses, US newspaper articles discussing the recruitment of nurses from Mexico are increasing in the face of the US's own nursing shortage (Anonymous, 2004a; Anonymous, 2004b; Gilbert, 2003; Lee, 2004; Patrick, 2002; Smith, 2003; USBHC, 2004; Weick, 2002). All articles describe the pros and cons of

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<sup>1</sup> Federal Salary Commission. This body sets minimum wages for all types of occupations and professions in Mexico.

<sup>2</sup> Mexican Nurses Association

<sup>3</sup> Equivalent to a nurse's aide, patient care assistant, or patient care technician in the US.

Mexico serving as the next target for nurse recruitment.

This change in status prompts several questions. First, why did this elevation in status not occur earlier in Mexico? If it had, could this have spurred the development of the profession? What is it about recent history that led Mexican officials to make this decision in 2004, but not before? By examining how Mexican nurses professionalized, answers to these questions can be found.

With official “professional” status assigned to Mexican nurses, that status could facilitate nurses obtaining trade negotiation visas (TNV) so they could more easily and legally work in the US. This, in turn, would increase the remittances sent back to Mexico from nationals working abroad, which now comprise the single largest source of income for the country. Like other workers, if Mexican nurses chose or were “incentivized” migrate, the remittances benefit nurses, their families, and the country of origin. If this becomes the case, managing the migration of nursing personnel will have significant implications for nursing human-resources policy in Mexico and throughout Latin America.

At first, increased migration of nurses to work abroad appears to be a winning policy from all stakeholders’ perspectives. The receiving country gets skilled labor to fill a shortage while the sending country receives the financial rewards (Buchan, Parkin, & Sochalski, 2003). The migration of nurses, however, takes a sociocultural toll on societies that is not yet well understood. Research shows that nurse migration generates prolonged familial separations which can negatively effect family structures, creates changes in traditional gender roles, and affects the image of nurses from “sending” countries in both positive and negative ways (Buchan, Parkin, & Sochalski, 2003; George, 2000). Part of understanding the issue of nurse migration and the circumstances that generate it includes understanding how the nursing profession develops in the sending country.

Finally, Mexico is a good choice for a case study because the available data about the health care system is of good quality. A large general body of social science and public health literature about all aspects of health care services delivery in Mexico exists for review. Nonetheless, as a topic of academic scholarship Mexican nurses remain understudied by both Mexican and foreign scholars in the health and social sciences. Thus, literature about nursing, nurses, and their place in the healthcare system of Mexico and Mexican society is sparse but growing slowly.

This work will contribute to filling that gap in the literature and add to the existing research about healthcare and health-services delivery in the country. It will answer some of these questions related to how nursing human resources policies evolved and identify variables promoting or hindering the development of the profession. This study does not seek to discuss the merits or problems associated with nurses adopting professionalism as an organizing philosophy. Rather, it aims to study how nurses in Mexico have used the macro-level aspects of professionalization to organize and advance the profession in a developing country. Finally, this work also has the potential to be replicated in other countries throughout Latin America, as Mexico frequently sets trends for health services research in the region.

### **Conclusion**

The study of the evolution of a healthcare profession in a developing country context has many implications not only for nursing human resources policy structuring, but also for health and development outcomes. For developing countries seeking to expand and improve the quality of health-services available to their populations, answers revealing the nature of professionalization of nursing will become critical to streamlining the development process.

Hence, the specific aims of this study were to:

- 1) Identify and describe variables specific to Mexico that influenced the development of the nursing profession in Mexico between 1980 and 2005;
- 2) Analyze the contextual relationship of the variables for the purpose of theoretical framework construction.

This study attempted to answer the following questions:

- 1) How does the interplay of sociocultural, political, economic, gender, and historical variables affect the development of the nursing profession in Mexico?
- 2) How do sociocultural conceptions of gender, women working, and women's roles influence the development of the nursing profession in Mexico?
- 3) How have the economic crises of the 1980s and 1990s affected, and continue to affect, the professionalization of nurses?
- 4) How do current institutional structures in health care and university education influence the professionalization of nurses in Mexico?

This study hypothesized that the ability of nurses to use professionalization as a means of advancement will be strongly associated with how they, as a largely female social group, are willing or able to capitalize on the economic and political resources available to promote the advancement of the profession.

Because some of the terms will be in Spanish, all names of Mexican institutions and their abbreviations will be presented in their Spanish equivalents, with the English equivalent provided in translation in a footnote. An abbreviations index and glossary of terms is available in Appendix A. In addition to the language issues, a certain amount of description, both clinical and historical, will be necessary to ensure understanding and validity of the work across disciplines (Higginbotham, Albrecht, & Connor, 2001). Therefore, when the context of research demands historical or political explanations, brief explanatory footnotes will be included. The

same process will be used when referring to clinical terminology so that concepts can be clear for non-healthcare professionals. A brief chronology of Mexican history in relation to health-services and the nursing profession is also provided in Appendix B.

## **CHAPTER TWO**

### **REVIEW OF THE LITERATURE**

This literature review covers the dependent variable, the professionalization of Mexican nursing, and the independent variables identified in the literature review that may influence that process: economic, historical, political, sociocultural, and gender-based factors. First, it outlines why professionals are integral parts of a healthcare delivery system, and then gives a general review of the literature on professions and on nursing and professionalism. Then, a literature review of each independent variable is presented. As nurses are unionized in Mexico, union dynamics are also briefly discussed. When applicable, information about the Mexican healthcare system and the history of nursing in Mexico is interwoven throughout these sections.

#### **The Importance of Professional Human Resources for Healthcare Services Delivery**

More than most organizations and institutions, a health system's operations rely heavily upon a workforce consisting of various professional and technical staff (Dussault & Dubois, 2003; Gupta, Diallo, Zurn, dal Poz, 2003). Professional and technical "people working in health-services are not exclusively 'instruments' for delivering necessary health care. They are strategic actors, who can act individually or collectively to modify the [health system's] projects" (Rigoli & Dussault, 2003, HRH #9). "Improvement in the working and living conditions of health workers is a precondition for the effective delivery of public health services" (Segall, 2003, S5). Therefore, the success of health-system outcomes, such as improved quality of care, rests heavily on the ability of the system to incorporate professionals into these strategic goals of improving and maintaining the health of the society it serves.

In 2006, the WHO declared the theme of its next working decade to be that of the health-

services worker (WHO, 2006). Recognizing the critical nature of human resources for health, WHO member states made a new commitment to improve working conditions and access to educational development resources for their health-system workers.

WHO's commitment highlights the importance of the healthcare worker for a country's development and the sweeping forces of change that globalization brings. "Health-systems are...neither immune nor divorced from the impact of the new global order" (Biscoe, 2000, p. 160). Since, the healthcare industry can represent anywhere from three to nine percent of the workforce in a country, the majority of budgetary expenses, and a large cadre of professionals (Gupta et al., 2003; Martineau & Buchan, 2000), understanding the variables that effect healthcare human resources production becomes a critical component of developing, managing, and expanding health-services delivery. Unfortunately, the complexity of the relationships among all of the variables affecting healthcare human resources is not well understood (Biscoe, 2000; Dussault, 2006).

The lack of human resources and human capital policies in Latin America affects workforce development (Abramo & Moreno, 2000; Cavalcanti, 2002) and subsequently, the ability to deliver healthcare services to the population. Moreover, due to increased life expectancy, an aging population, epidemiological shifts, and the incidence of HIV/AIDS, the healthcare needs in Latin American and the Caribbean are changing (Arredondo, Zuñiga, & Parada, 2005; Carolina & Gustavo, 2003; Laurell, 2003; PAHO, 2005; Tajer, 2003; Waitzkin, Iriart, Estrada, & Lamadrid, 2001).

According to the Pan American Health Organization (PAHO), the Latin American and Caribbean regions face a critical nursing shortage, which threatens the quality of health care and has the potential to adversely effect health outcomes (PAHO, 2005). The nursing shortage is further exacerbated by the migration of nurses from Latin America and the Caribbean to work in

the United States and Canada (Buchan, Parkin, & Sochalski, 2003). PAHO (2005) stresses the need for improved nursing education, policy planning for nursing services and development, and management for healthcare human resources in order to meet the healthcare delivery needs of the region. A lack of qualified educators, inadequate local university infrastructures, poor representation of nurses at high levels of political office, political interference from a variety of health ministry and non-healthcare sources, the ministry of health regional office conflicts, and an absence of human resource development plans all contribute to the current nursing shortage in the region (Homedes & Ugalde, 2005; Laurell, 2003; PAHO, 2005; Tajer, 2003).

Although human resources comprise the largest critical functional element of a healthcare system, policymakers and researchers know few specifics about their production and management at country levels (Biscoe, 2000; Brito, Padilla, & Rigoli, 2002; Dussault, 2006; WHO, 2002). Healthcare human resources policies targeted toward the development of nurses and the nursing profession could ensure the efficacy and sustainability of not only training programs for nurses in the region, but also address the cited problems.

For example, by precisely defining nursing human resources policies, local and national policymakers can determine the potential impact nurses have on a population's health. The information generated from these policies can also identify opportunities and constraints facing the development of nursing professionals, alert social and political stakeholders to the importance of nurses, address workforce issues, and ultimately place healthcare human resources issues on political and public agendas (Diallo et al., 2003).

Researchers have already identified the obvious macro-level variables affecting production and management of healthcare human resources (Egger, Lipson, & Adams, 2000) and these variables frame the thematic analysis of the data in this study. Most of these variables identified by healthcare human resources researcher draw from studies about physicians. The

analyses assume that the professional behaviors of physicians will also be applicable to nursing. Yet, if healthcare human resources policies are to promote the incorporation of strategic actors like nurses, their design needs to consider how nurses in a specific country have and are developing as a profession. A professionalization framework has the potential to address many variables at once and evaluate their relationships.

### **Professions**

As a social-science research subject, professions and professionals received significant attention during the twentieth century. The notion of professionalism in the early twentieth century was synthesized by Flexner (1910) with his initial treatise on the topic. Flexner described professions as composed of individuals with altruistic tendencies, a service orientation, and a sense of social responsibility. As a result, professionals are socially accountable to societies. He also described professions as having scientific and specialized knowledge that they use to provide a service to society. A professional moves beyond basic education and functions at a high intellectual level within a hierarchical system. Flexner categorized the early professions as medicine, law, and the clergy. He did not include nursing because he considered it as subordinate to medicine. A true professional, according to his theory, could not be subordinate.

Other twentieth-century social scientists added to the initial concepts of professions and professionals by including the presence of a code of ethics, professional organizations, and professional work as playing significant roles in shaping personal identities. Cogan (1955) first asserted the “trait theory” of professionals, which set the criteria for differentiating professions from occupations. Other social scientists characterized attitudes of professionals as biased toward independence, self-regulation, self-determination, and the perpetuation of the economic dominance they hold in a marketplace (Castledine, 1998; Derber, 1982; Jackson, 1970; Larson,

1977; Sills, 1998). Freidson (1970) claimed the medical profession stood as the gold standard for professionalism. His work is discussed below in the section on healthcare professions.

Hall (1967, 1968, 1982) added to the trait theory of Cogan by synthesizing attitudinal characteristics of professionals into five categories: professional organizations as primary support means; belief in public service; autonomy in decision making from external sources (i.e. government legislators and regulators, other professionals); self regulation; and a sense of calling interlaced with a high degree of idealism and commitment to the profession (and the clients whom they serve) that goes beyond economic incentives. Using these categories, Hall created the Professionalism Inventory which has been widely used to measure trait-based professionalism characteristics in nurses (Adams, Miller, Beck, 1996; Adams & Miller, 2001; Castledine, 1998; Fetzer, 2003; Hampton & Hampton, 2000; Liaschenko & Peter, 2004; Miller, Beck, & Adams, 1991; Miller, Adams, & Beck, 1993; Sills, 1998; Yoder, 1995).

Larson (1977) introduced several critical components to the discussion with her research about professions, including the identity of professionals, the effect of markets and monopolies, and the link between knowledge development and professionalization. She explained her theory by describing the link between all these variables in relation to the “larger social structure” in which the process of professionalization occurs.

The structure of a professional market is determined by the larger social structure within which it is situated. The stage of economic development, the volume and distribution of national income, the class structure and ethnic composition, the average standard of living, the nature of the state and its policies, and ideology—including a variety of cultural traditions—define the potential, the characteristics, and the dynamics of a profession’s market (Larson, 1977, p. 50).

With regard to nursing and professionalization, Larson’s work identifies key components of the professional’s social characteristics (such as dominant gender) and the efficacy of leadership in that context. Her work implies that women’s ability to capitalize on the resources available to their profession will influence the professionalization process and their ability to secure their

formal place or monopoly in the market for their services.

Abbott (1988) proposed a synthetic theory that combined four schools of thought surrounding professionalization, known today as the jurisdiction argument. Professions make their jurisdictional claims first in the public domain, then in a legal arena. Claims are based on the power of the profession's abstract knowledge to define and solve a certain set of problems, which may or may not already be under the full jurisdiction of some other professional group. "Ordinarily, claims assert the efficacy of the profession's social organization in applying or further developing its knowledge or in controlling its work. Claims of full jurisdiction must be made by organized groups" (Abbott, 1988, p. 70).

Abbot (1991) continued his theoretical work when he sought to outline and solidify the professionalization process by studying American medicine. The strength of his theory is that it identified a series of significant events that occur at different times during the professionalization of medicine. He does not attempt to describe professionalization as a linear process, rather as one made up of peaks and valleys occurring in time. This work accounts for the deprofessionalization phenomenon, first described by Toren (1975), which is tied to the development of knowledge, technological advances, and the routinization of work.

Overall, most of the authors writing in the 1970s and 1980s had surprisingly consistent views about professions, their nature, and what aspects of them should be explained (Abbott, 1988; Begun, 1986; Cullen, 1985; Forsyth & Daniziewicz, 1985; Klegon, 1978; MacDonald & Ritzer, 1988; Roth, 1974). In the last decade of the twentieth century, researchers began to study the influence of three factors not extensively addressed by prior research: interprofessional relationships, the role of the State, and of the workplace (Jones, 1991; Knowles, 2000; MacDonald, 1995; Perkin, 1996; Schmidt, 2000). Jones (1991) and Knowles (2000) were among the few researchers to examine professionals in a developing country context. Jones studied

professionals in Eastern Europe and Russia while Knowles and colleagues examined health professionals, including nurses, organizing capacity in Jordan. Central to all these studies was how the professions obtained or maintained their “dominance” or authority over a specific subset of knowledge or how their roles were shaped by the historical, political or economic context of their countries.

One way professions maintained their market dominance was through control over the creation and maintenance of a specific body of professional knowledge (Larson, 1977; Toren, 1975). Once the exclusive domain of the professional, some of their knowledge is now accessible to the public via the Internet, thereby minimizing the exclusivity of the knowledge. Public access to professional knowledge increases transparency of professionals and introduces a new level of accountability in professional practice. By removing the “mystery” of once-exclusive professional knowledge, technology like the Internet has the potential to alter the dynamics, hierarchies, and social authority of professions in the twenty-first century (Sullivan & Benner, 2005).

#### *Research on Health Professions*

The seminal work of Freidson (1970, 1973, 1986, 2001) and his protégées has shaped much of the dialogue about medical and health professions. His research leaves much of the idealism of Hall’s work behind and focuses on power elements and dominance of the medical profession over other professions. As Abbot (1988) explained, “Eliot Freidson argued that dominance and autonomy, not collegiality and trust, were the hallmarks of true professionalism” (Abbott, 1988, p. 5).

Freidson’s recent work (2001) described how institutions and social mechanisms sustain the professionalism philosophy by reinforcing control over the nature of professional work. He used a framework to demonstrate how physicians continue to dominate the medical workplace

and why this remains important for medical autonomy in practice. Freidson underscored the importance of this control in maintaining professional autonomy in the face of State and other regulatory mechanisms. Maintenance of hierarchical institutional structures was central to his “third logic of professionalism.” In his overall analysis, however, he failed to address how the behavior of professionals negatively impact professionalism and subsequently undermine their own autonomy and authority. Furthermore, even he acknowledges that his work applies largely to English-speaking nations; its applicability to a non-English speaking, developing country context is debatable.

Early on, Larson (1977) also identified some critical flaws in Freidson’s model. She thought Freidson’s model should be examined closely because it is impossible to duplicate across other fields, lending itself to medical exceptionalism. The key problem with Friedson’s model is that no other profession except medicine controlled the operation of hospitals, which are complex organizations designed to generate new skills and specializations in the healthcare field (Larson, 1977). His model also did not necessarily replicate well in other countries; in Mexico, for instance, the State proved to be a stronger political actor than physicians (Cleaves, 1987).

Guy (1985), in a different analysis of health professionals, found the interactions among healthcare professionals were far more egalitarian than had been theorized by Freidson. She found the sources of inter-professional conflict largely rooted in differences in gender-based communication styles and increasingly blurring lines in the roles of health professionals in healthcare institutions. Her works hints that theories about professions may not play out as expected when they are analyzed in the workplace and indicates that gender is a significant factor when studying professions and professionals.

Nonetheless, Freidson’s physician-based medical dominance model of 1970 described the culture of medicine during the late twentieth century. During this period, medicine emerged

globally as a socially attractive career option for many individuals as it represented power, authority, and independence, and served as a vehicle for class mobility. Consequently, physician oversupply has become a common problem in many middle-income developing countries, including Mexico, because while the practice of medicine offers opportunities for class mobility, market forces do not always ensure the economic rewards promised by the dominance and autonomous practice described by Freidson (Frenk, 1990; Frenk, Duran-Arenas, Vazquez-Segovia, Garcia, & Vazquez, 1995; Nigenda, 1997; Nigenda, Ruiz, & Bejarano, 2005; Vargas-Lagos, 1991).

#### *Studies of Professions in Mexico*

The sociology of work and occupations in the Latin American context emerged as a “new” discipline for study in the last decade of the twentieth century. Researchers working in this field identified two key contextual variables that shaped this field of research: 1) countries experiencing restructuring in the presence of poorly organized actors and dictatorial-like State forces and 2) high degrees of poverty and social exclusion that make the social costs of restructuring higher than usual (Abramo, Carrillo V., de la Garza Toledo, Leite, Novick, Alá Santiago, & Da Silva, 1997). Abramo (1998) identified the priority research needs in the field as centered on studies about gender and labor cultures, relationships between labor and markets, and development processes occurring within organizations.

Nurses in developing countries, like those in Latin American and the Caribbean, remain under-researched by social scientists studying professions and by nurse-researchers in countries with strong research traditions. Some researchers have studied professions in Mexico, but none focused on nursing. This may be from biases of researchers only researching the “traditional” professions (e.g. lawyers, architects, engineers) or because nursing was not considered a “full” profession in Mexico until 2004. Studies of professions in Mexico have examined the influence

of the State (Cleaves, 1987; González-Leandri, 1999; Gurza, Bazant, Staples, Tanck de Estrada, & Zoraida-Vázquez, 1982), physician underemployment and overproduction (Frenk, 1990; Frenk, Duran-Arenas, Vázquez-Segovia, Garcia, & Vázquez, 1995; Rodriguez-Cuba, 1995), and their development in Mexican society (Farell, 1989; González-Leandri, 1999; Gurza et al, 1982; Lorey, 1994).

Hite and Viterna (2005) examined how women in Latin America used professional education to advance their class and social status. They categorized nurses as professionals for their analysis, even though central governments did not always classify them that way. Hite and Viterna demonstrated a 7.8% decline in the number of women professionals in the region between 1980 and 2000. They attributed the decline to regional economic crises and subsequent neoliberal economic reforms. They claimed that employment discrimination resulting from workplace gender biases made female professionals less likely to be hired, therefore decreasing the economic incentives for women to even enter into professional positions.

Hojat et al (2001, 2003) analyzed professional relationships between physicians and nurses in five different countries. Their work in Mexico demonstrated that physician-nurse relationships were reflective of social hierarchies present in the country and that gender shaped the quality of the relationships. For example, female nurses reported more negative relationships with female physicians, whereas male nurses reported generally positive relationships with physicians, regardless of gender.

Finally, Harrison (1994, 1998, 2000) completed some of the few studies about female medical professionals in Mexico. She also was the first to indicate that research about women in the developing world is notably lacking in studies of professional women. Her work demonstrated a concept of being a professional that is intertwined with family life and negatively affected by economic changes, usually in the form of un- or underemployment.

Frenk and colleagues (Frenk, Knaul, Vázquez Segovia, & Nigenda, 1999) along with Knaul, Frenk, and Aguilar's (2000) research supported Harrison's findings and also demonstrated discrimination in employment toward female medical professionals. Significant to their work, however, is that the research indicated "the structure of higher education and healthcare may end up reproducing social inequalities rather than ameliorating them" (Frenk et al, 1999, p. 1058). The findings from these studies are important when analyzing nursing in Mexico because they indicate that class origins and gender of nurses in Mexico may be a significant factor when studying professionalization there. The studies also indicate that institutionally-based hierarchies present in a society, such as those in the university education and healthcare systems, could play a role in how nurses are able to develop as a profession.

### **Nursing and Professionalization**

When studying the professionalization of nurses, two key problems emerge. The first is that as a process, researchers have not extensively studied professionalization in developing countries. As indicated earlier, most studies about professions and professionalization have occurred in the United States, Canada, and Western Europe. Second, research related to gender issues in professions has focused primarily on teaching and social work and does not often extend into the developing world. In addition, most authors assumed that nurses face the same issues everywhere in the world. The common issues include a lack of role-based autonomy and varying degrees of professional subordination. Few, if any researchers have studied how these vary across countries or cultures. Most research on nursing professionalism does not compare or analyze the historical, social, political, and economic variables that may affect professionalism and professionalization.

One of the primary debates among nurses and other scholars about professions is

whether or not nursing meets the criteria of profession. The debate has provoked an interdisciplinary discussion that has lacked consensus over the past 160-year history of modern nursing (Ashley, 1976; Calder, 1997; Castledine, 1998; Daly, 1990; Goodwin, 1990; Kinnear, 1994; Melosh, 1982; Reverby, 1989; Ruddy, 1998; Turkoski, 1989; Turkoski, 1995). Despite the lack of consensus, the research completed highlights several variables that appear to be common across borders in relation to the development of the nursing profession. These include the influence of the class origins of nurses (Ashley, 1976; Goodwin, 1990; Melosh, 1982; Reverby, 1989); race or ethnicity (Cheal, 1999; Shkimba & Flynn, 2005; Sweet & Digby, 2005); the work environment (Melosh, 1982; Reverby, 1989); and power dynamics between nurses and physicians (Ashley, 1976; Lusk & Robertson, 2005; Melosh, 1982; Reverby, 1989). Regardless of the intellectual arguments, the International Labor Organization (ILO) categorizes nursing as a profession divided into two categories: professional nurses (those with post-secondary basic education) and associate professionals (the equivalent to a nurse's aide in scope of practice and responsibilities) (Diallo et al., 2003; ILO, 1993).

The following section discusses the nursing profession in Western nations, where it is highly developed. This literature about the nursing profession and professionalism is largely from US, Canadian, Australian, and European scholars, with questionable applicability to Mexico.

#### *A Complex Picture*

The literature discussing professionalization in nursing reveals a varied and complex picture of a profession shaped by the dynamics of women's lives and their places within a society, which in turn shape the process of nursing's professionalization. Turkoski (1989) stated that traditionally, nursing used a "trait" approach to quantify specific behaviors related to professionalism, generated largely from Hall's work on professions (1968, 1982). The plethora

of studies using this approach address topics related to the image of nurses—mostly workplace attire (Lehna, 1999), the measurement of professional behaviors (Adams, Miller, & Beck, 1996; Adams & Miller, 2001; Brooks & Shepherd, 1992; Fetzer, 2003; Hampton & Hampton, 2000; Miller, Adams, & Beck, 1993; Wynd, 2003), and knowledge of the professional code of ethics (Aiken, Clarke, Sloane, Sochalski, 2001; Miller, Beck, & Adams, 1991). Turkoski (1989) believes that these quantitative approaches lose the multifactorial nature of the process of professionalization and fail to capture other dimensions central to shaping a profession composed largely of women. Qualitative research by MacIntosh (2003) and a dimensional analysis of the bedside nursing role by Squires (2004) supports Turkoski's insights because they capture many of the sociocultural, economic, and gender-based variables not previously considered nor included in the quantitative studies.

Some research has demonstrated a relationship between the personal lives of nurses and their career paths, which consequently shapes the process of professionalization (Apker, Ford, & Fox, 2003; Daly, 1990; Duffield, Pallas, & Aitken, 2004; Glynn, Arndt, Beal, & Bennett, 1996; Goodman, 1991; Yoder, 1995). Nurses in these research studies frequently cite familial factors (e.g. child care, parent care), major life events (e.g. spouse career changes, divorce making the nurse the sole source of income, death of family member, having children), and economic factors (e.g. spousal income, presence of secondary income source, workplace reimbursement for education) as key elements that affect their ability to develop as individual professionals. Ethnicity, race, gender, and class background of nurses also factor significantly into how an individual nurse develops as a professional and how the profession itself evolves (Dombeck, 2003; Duffield, Palls, & Aitken, 2003; Glynn et al., 1996; Goodman, 1991; Jones & Gates, 2004; Magnussen, 1998; Shkimba & Flynn, 2005; Sweet & Digby, 2005; Turkoski, 1989, 1992).

*Autonomy and the Nursing Profession*

Autonomy is a central concept of the professionalism philosophy. Theorists writing about professions regard autonomy in governance (through professional associations and in cooperation with States), education, and the enactment of the professional role as hallmarks of professionalism (Abbott, 1988; Freidson, 2001; Sullivan, 2005). These are key macro-level variables when studying the process of professionalization as they help to establish the institutional mechanisms necessary for sustaining a profession.

In most Western nations, nurses control education with little outside interference. Theorists widely agree professionals should govern the overall education, administration, and entry requirements for their own profession (Abbott, 1988; Cogan, 1955; Freidson, 1970; Freidson, 2001; Hall, 1968; Sullivan, 2005). Autonomous control over the education of nurses is important for the simple reason that it is critically important who has control over the education and governance of the profession: Is it nurses or is it someone else? Variation in professional autonomy over education is also what makes nursing most vulnerable to interdisciplinary poaching (Northrup et al., 2004). Nursing education in the developing world frequently lacks autonomy in governance as physicians often supervise or direct nursing education programs (Pearson & Peels, 2001b).

Governance of nurses is interlaced with a variety of institutional mechanisms from the workplace and the State (Apker, Ford, & Fox, 2003; Fung-kam, 1998; Havens & Vasey, 2003; Shader et al., 2001; Squires, 2004). Governance mechanisms also affect the jurisdiction of nursing practice. This means that when nurses have autonomy in governance, they have the ability to shape professional practice laws and expand practice jurisdiction when a market gap can be filled by their skills (Mason, Leavitt, & Chafee, 2002). Abbott (1988) described how the state has ultimate authority in regulating jurisdiction of professional practice. He explained how

a group meeting the criteria of a profession can autonomously generate changes for their group.

Social science and nursing scholars have yet to examine the extent of educational control and self-governance that nurses possess in developing countries. Therefore, the extent of their professional autonomy and hence, their ability to advance as a group in society is not well understood. In many developing countries, nurses participate in institutional decision-making processes at a level no higher than middle management. These institutions may provide healthcare services (hospitals or clinics) or regulate them (government health divisions). Health ministries often do not employ nurses in high level positions, either because they favor physicians for these posts or because nurses are unable to pursue the advanced education required for these positions due to a lack of political opportunity or socioeconomic constraints.

For most nurses, individual role-based autonomy means they make independent decisions about patient care do not have to ask permission of a superior to perform caregiving tasks (Aiken et al., 2001; Chaboyer, Najman, & Dunn, 2001; Hoffman & Scott, 2003; Squires, 2004; Stordeur, D'hoore, Vandenberghe, 2001; Tonges, 1998; Tummers, Landeweerd, & van Merode, 2002). It means accepting responsibility and accountability for those actions and their consequences.

The level of individual role-based autonomy that nurses possess is often misinterpreted by theorists of professions. Many theorists assume that because nurses implement physician orders, they have no autonomy in their role or that this role does not involve the intellect. Furthermore, the institutionalized practice of nursing<sup>4</sup> historically defined its work and often times established the levels of autonomy the institution deemed appropriate for the bedside

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<sup>4</sup> Nursing practice occurs in a variety of settings, including the community, primary care clinics, schools, and other service delivery points. Most nurses, however, work in institutions like hospitals or nursing homes. When nurses practice in these settings, their practice is often referred to as "institutionally-based" whereas practice outside the hospital is considered community-based.

nursing role (Daly, 1990; Guy, 1985; Liaschenko & Peter, 2004). Institutional mechanisms strongly influencing a professional's role-based autonomy were antithetical to early theorists writing about professions (Cogan, 1955; Hall, 1968; Freidson, 1970). Unlike the independent physician practitioners who set their own rules and controlled their medical practices, physicians and healthcare administrators defined nurses' autonomy. Therefore, nursing theoretically, could not be considered a profession based on the traits established by Cogan (1955) and others (Abbott, 1988; Ashley, 1976; Baer et al, 2003; Melosh, 1982; Reverby, 1989; Turkoski, 1989; Turkoski, 1992).

Many of these studies assume that because nurses are not at the top of the patient care hierarchies, they do not have autonomy in decision-making. These studies demonstrate a poor understanding of the importance of nursing in patient care. They also fail to account for the workplace context as a variable in shaping the professional role and its level of autonomy, a methodological weakness of early research about professions (Abbott, 1988).

### **The Mexican Economy in the Late Twentieth Century**

The influence of the economy on the development of the nursing profession in Mexico—or any other country—is not well understood, yet it is important to understanding professionalization. Nurses' ability to marshal economic resources that support professionalization likely affects the rate at which the process occurs. No literature currently explores the relationship between these variables.

This section briefly describes the origins and consequences of two major economic events in Mexico in the late twentieth century: the 1982 debt crisis and subsequent "lost decade," and the 1995 peso devaluation which resulted in a shorter but equally severe crisis for the Mexican population. This section also discusses the literature about NAFTA, the consequences

of the neoliberal economic reforms, and the actual or potential consequences of these major economic events to healthcare and nursing in Mexico.

*The 1982 Debt Crisis and Its Impact on the Healthcare System*

From the late 1930s through the early 1970s, Mexico experienced sustained economic growth. During this time, investment in medical and nursing services was roughly equal until the 1970s, when changes in educational and university systems reduced class barriers to higher education, resulting in increased student enrollments to medical schools (Frenk, 1990; Lorey, 1993). Physicians embraced the change, assuming greater numbers would help enhance their power within the state-run health-system. The actual consequence, however, was to create significant problems with physician oversupply (Frenk, 1990; Frenk, Duran-Arenas, Vazquez-Segovia, Garcia, & Vazquez, 1995; Harrison, 1998; Harrison, 2001).

In the 1970s, the Mexican economy's rate of growth slowed significantly compared to previous years; in 1982, the economy collapsed from a debt crisis (Davis, 1993; Fehrenbach, 1995; Keen, 1992; Middlebrook & Zepeda, 2003b). This sent the country into a long period of economic crisis known as "the lost decade" and effectively reversed nearly a century of economic growth, poverty reduction, and improvements in public goods and services like healthcare (Davis, 1993; Fleury, Belmartino, & Baris, 2000).

Mexicans experienced an economic downfall similar to the US Great Depression in the 1930s. Runaway inflation occurred while real wages of professionals fell (Davis, 1993; Middlebrook & Zepeda, 2003b). Consequently, the World Bank (WB), US policy makers, and the International Monetary Fund (IMF) forced Mexico to liberalize its economic policies.

This ultimately laid the foundation for the formation of the General Agreement on Trade and Services (GATS) and implementation of NAFTA in 1994. The GATS established minimum trade regulations for goods and services around the world. NAFTA created a "free trade" zone in

North America that minimized or eliminated tariffs on the majority of items traded between the US, Canada, and Mexico. In order to facilitate legal migration, negotiators made provisions for trade-in-services, including healthcare. These neoliberal reforms, however, never “delivered rates of growth equal to those of the 1940s through the 1970s nor guaranteed economic stability” (Middlebrook & Zepeda, 2003b, p. 4). The 1985 earthquake in Mexico City further aggravated the 1980s economic collapse as it destroyed as much as 40% of the health-system infrastructure in a city that provided healthcare to roughly a quarter of the overall Mexican population (Borzutsky, 1991; Soberón, Frenk, & Sepulveda, 1986). Consequently, the healthcare system faced the dual challenge of systemic reconstruction of physical infrastructure in the nation’s healthcare epicenter and changes to health-services administration and organization required by the neoliberal economic reforms.

Both before and after the 1985 earthquake, decentralization guided the health-system reorganization in Mexico. The basic theory behind decentralization posits that the health-system reorganizes from a centralized, federally controlled model to one in which states manage the healthcare needs of their residents. Policymakers theorized that decentralization would improve evidence-based, decision-making processes within a health care system, increase operational efficiency and accountability, reduce operating costs, increase access to primary care, improve quality of health services, and enhance democratic tendencies at the local level (Bossert, 1998; Collins, Omar, & Tarin, 2002; Pappaioanou, Malison, Wilkins, Otto, Goodman, Churchill, White, & Thacker, 2003). During a decentralization process, the federal role changes to funding assistance and technical support. Thus, in the 1980s healthcare services started shifting from a centralized to a decentralized model administered by each of the 31 Mexican states (Frenk, 1990; Soberón, Frenk, & Sepulveda, 1986; Laurell, 1991).

As part of the strict cost-controls imposed upon the country during the 1980s, the

Secretaria de Salud y Asistencia<sup>5</sup> (SSA), instead of cutting jobs suppressed wages and continued to increase the number of healthcare personnel employed within the healthcare system (Middlebrook & Zepeda, 2003b). The SSA data from the period indicate the number of physicians and nurses employed by the healthcare system continued to steadily grow between 1980 and 2005 (Anonymous, 2000; Frenk, Duran-Arenas, Vazquez-Segovia, Garcia, & Vazquez, 1995; INEGI, 2003). In keeping with decentralization goals, the SSA also decreased investment in acute care services and shifted resources to the construction of primary care clinics in rural areas in order to reduce the health effects of the economic crisis in strongly affected rural areas (Soberón, Frenk, & Sepulveda, 1986) and also as a means of ensuring social stability during the prolonged economic crisis (Birn, 1998; Birn, 1999a; Davis, 1993)

For nurses, the 1980s crisis had the effect of freezing wages while also providing a secure means of employment at a time when unemployment rates were soaring. One possible explanation for the consistent growth in the number of nurses during the period is that many women became attracted to nursing training because it offered job security and an additional income when male wages were no longer sufficient to support a single family. It also created opportunities for employment in the newly constructed rural health clinics, where many nurses would remain working for their entire careers. The total effect of the 1980s crises upon nurses, therefore, is unclear and requires further exploration to fully understand its influence upon professionalization.

#### *Neoliberal Reforms and Their Consequences to Healthcare in Mexico*

In general, the neoliberal reforms advocated by the World Bank and similar bodies, like health system decentralization, have not produced the results—increased worker productivity, performance incentives, improved quality of care, and streamlined regulation— theorized by

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<sup>5</sup> Secretary of Health and Public Assistance

reformists (Arredondo, Orozco, De Izcaza, 2005; Arredondo & Parada, 2005; Arredondo, Parada, Orozco, & Garcia, 2004; Birn, 1999a; Collins & Green, 1994; González Block, 1994; Homedes & Ugalde, 2005a; Homedes & Ugalde, 2005b; Laurell, 1991; López Acuña, 1996; Mayer, 2002; Pego & Alday, 2002; Pier, 2005; Soberon-Acevedo, & Martinez-Narvaez, 1996; Ugalde & Homedes, 2005). The type of government present in a country and its degree of democracy appears to affect how decentralization is implemented, but not the quality of healthcare institutions (Khaleghian, 2004). Recent studies indicate that the political culture and technical capacity available in a country affects the degree of success of decentralization (Atkinson & Haran, 2004; Bossert & Beauvais, 2002) and that rural areas may not adapt as well to a decentralized model (Tang & Bloom, 2000).

More frequently, however, studies show that health worker productivity remains unchanged, working conditions are poor, staff motivation is not driven by internal incentive mechanisms, quality of care shows some signs of compromise, and regulation is virtually non-existent (Arredondo, Parada, Orozco, & Garcia, 2004; Fleury, Belmartino, & Baris, 2003; Homedes & Ugalde, 2005a; López Acuña, 1996). Many of these problems can be attributed to a lack of healthcare human resources policies to facilitate these improvements and the inadequate training of managers and other administrators (Homedes & Ugalde, 2005a; Homedes & Ugalde, 2005b; Laurell, 1991; López Acuña, 1996; Ugalde & Homedes, 2005).

Neoliberal reforms required by the World Bank contributed to the problem by promoting high numbers of temporary and contract workers, creating intense competition for institutional contracts which could often only be obtained through personal or political connections and reinforced already corrupt hiring practices (Fleury, Belmartino, & Baris, 2003; Homedes & Ugalde, 2005b). Unionized workers in Mexico managed to stall or delay some of the reforms, but found themselves caught in the abstractions of decentralization in health-services (Bizberg,

1990). Federal health-services expenditures for the uninsured increased as well (Lara, Gomez-Dantes, Urdapilleta, & Bravo, 1997). The reforms also caused increases in infant mortality rates (Frank & Finch, 2004) and reduced the ability of families to provide care to the elderly (Cutler, Knaul, Lozano, Mendez & Zurita, 2002).

Pastor and Wise (1997) suggested that Mexico's problems with social-service provision after the neoliberal reforms came from a combination of sources. The first cause was the structure of social-service policies for public goods that were implemented under the banner of neoliberal reforms. Social-service policies, which primarily benefitted the middle class, remained largely unchanged during the crisis. Since the middle class shrunk by half, the number of persons benefitting from the social-service policies dropped significantly. The second source of problems were deficiencies in the implementation of macroeconomic stabilization policies. Per Pastor and Wise, macroeconomic policies focused entirely on opening markets and ignored microeconomic stressors that would have influenced the overall success of policy implementation, in areas such as investments in education, healthcare, and food distribution. In a major study in 2005, Homedes and Ugalde estimated that the decentralization reforms advocated by the World Bank actually cost Latin American countries more over time than retaining their original systems would have and that systemic efficiency did not improve from the reforms.

#### *The Peso Devaluation Crisis of 1995*

In 1994, shortly after NAFTA was signed into law among its three participating countries, the presidency of Salinas ended and that of Ernesto Zedillo began. His entry into office in the fall of 1994 followed a turbulent year which included the assassination of the leading candidate for the presidency and the declaration of war against the federal government by the Zapatistas in the southern state of Chiapas. As a consequence of the Salinas government's economic policies and the need to comply with the specifications of NAFTA, President Zedillo

devalued the peso in December 1994 (Middlebrook & Zepeda, 2003b). The peso devaluation, combined with the effects of the political events of the past year, plunged the country into an economic crisis in 1995 equivalent to what occurred during the 1980s. The policy change caused massive capital flight, and forced Mexico to borrow billions of dollars from the US to stabilize its economy (Middlebrook & Zepeda, 2003b).

This crisis was far more short-lived than the debt crisis of 1982 through 1989.

Nonetheless, the 1995 crisis negatively effected how Mexican states were able to provide health-services as many could not cope with the loss of resources from the federal system. States were forced to decrease investments in health-system infrastructure and freeze wages again in order to maintain basic services (Nigenda, Orozco, Guzman, Mora, Lockett, & Pacheco, 1998; Rocha, Martinez, Rios, & Elizondo, 2004). The peso devaluation also increased household expenditures on health-services because many Mexicans who had become unemployed were forced to pay out of pocket for private healthcare services (Parker & Wong, 1997). Health-sector reforms also began shifting costs to the consumer due to powerful influences from international financial institutions (Infante, 1997).

#### *NAFTA*

Ramos-Sánchez (1998) examined the North American Free Trade Agreement's (NAFTA) potential to impact the development of professions in Mexico and was the only person to specifically focus on professionals for the analysis. He saw trade agreements as potentially beneficial for professions in Mexico by requiring improved education and practice standards for professionals in order to facilitate international migration, meet international standards, and improve the overall quality of professional services.

The discourse in the other literature about NAFTA is divided into three sections: potential effects to the healthcare system, actual effects to the healthcare system or health-

services delivery, and the migration of nurses. For most researchers, the agreement has not been in effect long enough to evaluate the its actual effects on Mexican healthcare.

**Potential effects.** Early literature about NAFTA and its potential effects covered a range of topics. Hernández-Peña and colleagues (1993) indicated that NAFTA had huge potential to negatively effect the environment. NAFTA, they stated, could introduce new organisms through increased migration, thus challenging health-system capacity. Increased industrialization could alter the environmental landscape and change the epidemiological profile<sup>6</sup> of the country. Juan-Lopez (1994) thought NAFTA had the potential of improving sanitary regulation in Mexico by setting higher standards that were more in line with international regulations, but would challenge the current infrastructure in the health-system because it lacked the technical capacity to meet these regulations. Finally, J.C. Brown (1997) believed that when considering the historical patterns of free trade in Latin America, an increase in coercive labor practices in workplaces associated with the agreements was likely.

**Actual effects.**<sup>7</sup> Trade agreements appear to have mixed effects on the health of a population and these effects are dependent on a country's ability to integrate mechanisms in the agreements that have the potential to improve health-services delivery (Oliveira, Zepeda-Bermudez, Costa-Chaves, & Velásquez, 2004; Sebastián & Hurtig, 2004). McGuinness (2000) demonstrated that worker health in Mexico has had increased levels of protection after NAFTA. However, he also indicated that enforcement of labor laws protecting Mexican workers is

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<sup>6</sup> The epidemiological profile of a country consists of all the diseases and conditions present in a country's population. For example, it would include the incidence of infant mortality, heart disease, diabetes, accidents, and workplace injuries. Epidemiological profiles change as countries develop economically and politically. Countries with higher levels of development have a higher incidence of chronic diseases, like diabetes, and lower incidences of infectious diseases, like pneumonia.

<sup>7</sup> Anecdotally, I have observed over the last ten years that healthcare technology use in Mexico has increased significantly. This could possibly be attributed to easier financing plans for health equipment leasing that were facilitated by trade agreements Mexico has with the US and other countries.

inconsistent due to how inspectors are trained and managed by the federal system. Otherwise, longer term studies are needed to demonstrate the effects of NAFTA on health and healthcare in Mexico. No studies have examined the effects of the agreement on Mexican nursing.

**Nurse migration.** Countries use foreign recruitment as a tool for fixing personnel shortages. Emigration was already a problem for Caribbean nations even before regional free trade agreements such as NAFTA went in to effect (Buchan, Parkin, & Sochalski, 2003; Buchan & Chalman, 2004; Deyal, 2003). The emigration of Mexican nurses to work in the US or Canada was viewed as something with potential by scholars and policymakers alike— though exactly what that potential was for Mexican nurses was not clear.

US nurses, on the other hand, were very clear about their concerns about recruiting Mexican nurses. Despite a long history of overseas recruitment, when NAFTA was implemented in 1994, US nurses speculated Mexican nurses coming to work in their country could profoundly hinder their job opportunities (ANA, 1996). At the time, restructuring of the US healthcare system had cut nursing jobs in hospitals where greater than 60% of nurses were employed. Unlike today, there was no nursing shortage in the US; thus, promoting migration through NAFTA raised concerns about wage depression and decreased opportunities for US educated nurses (ANA, 1996).

Since 2001, the US has experienced a nursing shortage. Hospitals and nursing homes do recruit foreign educated nurses to work in their facilities to alleviate their staffing issues. Some areas, however, are testing alternatives to direct foreign recruitment. For example, nurses in the Chicago area capitalized on Mexican women who had worked as nurses in Mexico and are already living in the US by providing them with skills-refresher programs and a year of training to pass the licensure exam (Smith, 2003). The program provides the women, often working illegally in non-nursing jobs, with the opportunity to significantly increase their earnings and

obtain a legal form of work. Reviews of a variety of media reports suggest that Mexico, due to NAFTA's ability to provide a trade negotiation visa for nurses to work legally in the US and (with training) bilingual workers to care for the growing Hispanic population, will increasingly be viewed as a staffing source for the US healthcare system (Anonymous, 2004a, 2004b; Gilbert, 2004; Lee, 2004; OR Manager, 2004; Patrick, 2002; Shusterman, 2004; Wieck, 2002).

### **Historical and Political Aspects of the Mexican State in Relation to Nursing and Healthcare Services in Mexico**

This section provides an overview of the basic history of nursing in Mexico in order to help establish context for the study. It then summarizes the basic tenets of Latin American Social Medicine and how this philosophy shapes policy in the region. The review then proceeds to a description of the basic structure of the Mexican healthcare system is provided followed by an analysis of the State's historical influence on the profession. It then proceeds to draw from internationally available literature about Mexican nursing to describe what is currently known about the state of Mexican nursing.

#### *Historical Overview of Early Mexican Nursing*<sup>8</sup>

Since medicine and health-services began to formally organize in late nineteenth-century Mexico, the theme of modernity persists as an evolutionary sociocultural concept. Porfirio Diaz ruled Mexico from 1870 through 1910, a period known as the *Porfiriato*. As president, Diaz ruled in a dictatorial fashion, opened the country to foreign investment and exploitation, and

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<sup>8</sup> The following is a list of articles which address various historical aspects of nursing or their roles in health-services delivery in Mexico: Alatorre, 1991; Alatorre, 1992; CNE, 1965; Balderas-Pedrero, 1995; Birn, 1999; Bliss, 2001; Bustamante, 1940; Cardenas-Jimenez & Zarate-Grajales, 2001; CENCAMEX, 1984; Chacón-Alvarez de Castillo et al., 1968; Chávez-Contreras et al., 1970; Fehrenback, 1995; Fisher, 1957; Flores, 1995; Gómez Siegler, 1964; Gonzalez-Rodriguez, 1992; Kappelus-Poppi, 2001; Lartigue & Fernandez, 1998; Lozier, 1953; Martín-Montoro, 2001; Morales, 1984a; Morales, 1984b; Nájera, 1992; Prida & Miranda, 1944; Purves, 1906; Resendez-Fuentes, 1995; Rios-Everardo, 2001; Royer, 1949; Safa, 1977; Sosa de Ramierz et al., 1969; SPM, 1965; Starr, 1918; Stern, 1999; Tapia-Arizmendi, 1986; TINAN, 1996.

increased the physical infrastructure of Mexican society (Keen, 1992).

Basic education for women became fashionable at this time with the construction of normal schools for girls. These schools prepared girls to be teachers or social workers and taught them social graces. The assumption of the time was that an educated woman would better complement her “modern” husband and create “modern” well-educated children (Vaughn, 1977). Female education, thus, did not seek to create independent, self-sufficient women capable of supporting themselves or actively contributing to society.

Fueled by a collective cultural desire to be seen by Europeans and Americans as more modern nation, physicians during the Porfiriato began to establish themselves as social and economic elites in Mexican society. They claimed to represent the latest “modern” thought about social advancement through improved medical care (Agostoni, 2003). These elites shaped much of health and social policy by borrowing from North American and European examples – the ultimate symbols of modernity at the time (Agostoni, 2003; Vaughan, 1977).

This desire for “modernity” persisted after the 1910 Revolution. The Mexican Revolution was a period of armed conflict and social change, though some would argue that nothing really changed. Nonetheless, the energy of the Revolution helped establish the mechanisms for a form of democracy in Mexico (Davis & Brachet-Marquez, 1997; Keen, 1992). Armed internal conflict began in 1910 and persisted until 1920. From 1920 until 1940 the country underwent a period of significant social upheaval and political change, finishing with stability at the end of the very popular Cardenas presidency in 1940. Some historians consider the Revolution from 1910 to 1920, others through 1940 because of the massive changes in social-services infrastructure that began during this period. For health-services, the revolutionary period consisted largely of public health initiatives aimed at modernizing society and elevating the lower classes and “dregs” of society to the social mores of the middle class through public

health education programs and for some, forced medical examinations (Birn, 1999; Bliss, 1999; 2001). The health-system expanded rapidly between 1940 and 1970 as it aimed to placate the needs of the equally rapidly growing Mexican middle class (Frenk, 1990).

#### *Latin American Social Medicine (LASM)*

To understand the modern Mexican healthcare system and its policies, a brief background in Latin American Social Medicine (LASM) is required. Tajer (2003) showed that LASM had its roots in nineteenth century French and German social movements and Marxist philosophies for organized social and political change. The movement evolved as a specialized form of medical study in Latin America in the 1950s. The first formal program of study on the subject began in Mexico in the mid-1970s and continues today.

The primary goals of LASM scholars and policy activists are to effect political and social change through the improvement of population health (Laurell, 2003; Tajer, 2003). The goals guide research priorities and the development of culturally sensitive methodologies for studying population health in the Americas.

The movement shapes much of the research critical of healthcare and social policy in the region. LASM researchers produced some of the first studies demonstrating the effects of State health policies on the health of indigenous people in Latin American countries. The movement's research proved instrumental in illustrating the negative consequences of neoliberal economic reforms on the healthcare sector throughout the region. The LASM movement also linked social and political practices to healthcare outcomes (Tajer, 2003). LASM also frames the academic activist debate about health-services priorities in Latin America. This is important because the research produced by LASM scholars has the potential to influence the roles of nurses in the region, as well as the development of the profession.

LASM-trained researchers currently face new challenges in testing their theories through

policy implementation in the “real world.” Much of their work emerged from the confines of academia and has not had to withstand the political challenges of the governance systems (Laurell, 2003). Nonetheless, work produced by the LASM movement provides strategies for combating corruption and reprioritizing spending to meet community health needs instead of political priorities (Laurell, 2003; Tajer, 2003). LASM scholars, however, have not addressed nursing issues in the region or how nurses can help them to achieve their goals.

### *The Modern Mexican Healthcare System*

The basic organization of the current healthcare system reinforces class divisions within Mexican society (Fleury, Belmartino, & Baris, 2003; Zakus, 1997). The Instituto Mexicano de Seguro Social (IMSS),<sup>9</sup> the Instituto de Seguro y Servicios Sociales para Trabajadores del Estado (ISSSTE)<sup>10</sup>, and the Secretaria de Seguridad y Asistencia (SSA)<sup>11</sup> encompass health-services for the majority of the population (Arboledo-Florez et al., 1999; Fleury, Bemartino, & Baris, 2003; Hulme, 1994; PAHO, 2004). About 5% of the population receives healthcare coverage as employees of the military and the oil industry. IMSS and ISSSTE insure the majority of the middle and upper-middle classes in Mexico; the SSA the lower classes; and the very wealthy obtain their healthcare through large, private hospitals in the major cities of Mexico or go abroad (PAHO, 2004).

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<sup>9</sup> Mexican Social Security Institute - For all persons who are employed by any kind of business. The IMSS covers approximately 35% of the population. Contributions are made monthly out of the paycheck and also by the employer. Historically, the IMSS receives the best resources and personnel and is the preferred choice for insured coverage by most Mexicans (Barranza-Lloréns et al., 2002); however, employees of this institution heavily unionized and strike at least once or more per decade.

<sup>10</sup> Government Worker's Hospital & Healthcare Services - Serves all federal and state employees and their family members. Approximately 10% of the population receives healthcare from this section of the health-system. Insurance contributions are made monthly from the worker's paycheck and comprise less than 1% of the person's annual salary.

<sup>11</sup> Public Assistance Services - Includes primary care and acute care services for all members of Mexican society and provides coverage for 50% of the population. Anyone may obtain healthcare from this division of the healthcare system. However, it primary serves the poorest members of society, has the least amount of resources, and many without any kind of healthcare coverage seek private healthcare services in lieu of using the SSA. Hospital services are of such poor quality that people seek care there only as a last resort.

Rural health-services run by the State began shortly after formal hostilities of the Mexican Revolution ended around 1920. Rural health programs then expanded significantly with the creation of IMSS COPLAMAR in the 1970s and continues to grow and change under different names, with the SSA also sharing the cost burden (Barranza-Lloréns et al., 2002; Canedo, 1970; Sherrard-Sherraden, 1991; Sherrard-Sherraden & Wallace, 1992; Stebbins, 1986c).

The State deliberately integrated school health-services with the rural primary care clinics by constructing primary schools next to clinics (Allensworth & Greene, 1990). Clinic workers are responsible for providing health-services to the community and health education to children and their parents.

Private healthcare services vary significantly throughout the country and receive little to no regulation. It represents free-market healthcare, as fees go as high as the market will bear (Barranza-Lloréns et al., 2002; PAHO, 2004). These facilities tend to be small, ranging from five to 100 beds (average is 15) per facility and are physician-managed. Patients seeking services from these facilities use them for normal deliveries, minor surgeries, and acute episodic events such as pneumonia or severe gastrointestinal disorders (INEGI, 2004). A physician's reputation as a healthcare provider plays a large role in the success of the clinic. With the exception of large facilities found mostly in the major cities, nurses working in small private hospitals do not participate in administration of nursing services nor in institutional governance.

Finally, all classes in Mexico utilize the services provided by traditional healers, such as *curanderos*, *hueseros*, and *parteras*.<sup>12</sup> Due to significant variations in the quality of care in both the public and private sector and popular distrust of practitioners, traditional medicine remains an active part of the healthcare system in Mexico (Sesia, 1996). The services and remedies of

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<sup>12</sup> Respectively: spiritual healer, bone setter, lay midwife.

traditional healers can easily be found in large *mercados*<sup>13</sup> or private homes in cities and towns. Remote rural dwellers rely heavily on traditional providers for healthcare as Western trained providers are inconsistently present in these remote locations. Mexican physicians tend to see the traditional medicine system as contrary to the concept of modern medical care and have systematically tried to eliminate or reduce its influence (DeWalt, 1977; Sesia, 1996).

It is easy to observe how in its modern form, the Mexican health-system is a fractured mix of public and private service delivery mechanisms. It is the product of the rapid industrialization processes and huge population growth Mexico experienced in the mid-twentieth century (Alba & Potter, 1986).<sup>14</sup> Historically, however, Mexico spends a significantly smaller portion of its gross domestic product (GDP) on healthcare than similar middle-income countries throughout Latin America (Anderson & Poullier, 1999; Eckstein, 1982; Fleury, Belmartino, & Baris, 2003; Horn, 1983; Retzlaff-Roberts, Chang, & Rubin, 2004; Zakus, 1998). For example, Mexico spends 5% on healthcare; Argentina spends 9%; and Chile 8%. Health-services policy experts often criticize Mexico for this lack of spending because research has demonstrated that re-prioritized spending could improve healthcare coverage and the epidemiological profile of the country (Barranza-Lloréns et al., 2002; Fleury, Belmartino, & Baris, 2003; Parker & Wong, 1997). This generally reflects the lack of domestic investment policies in Mexico which has contributed to the country's inability to maintain sustained economic growth and repeated financial crises (Cypher, 2001; Lustig, 2001; Middlebrook, 2003; Parker & Wong, 1997; Springer & Molina, 1995; Strehan, 1987).

Finally, statistics indicate that Mexico is better than most Latin American countries in

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<sup>13</sup> Huge central markets for agricultural products, craft goods, and just about anything else imaginable are common throughout Mexico. Traditional cures for a variety of illnesses are often found in these markets.

<sup>14</sup> After World War II, most countries began constructing or rapidly expanding their health-systems. Health-system designs represented national priorities for health-services delivery (Roberts et al., 2004).

delivering rural healthcare to remote locations that serve the rural poor. Childhood immunization rates reached 95% in the 1990s and they eradicated polio early in that same decade (Anderson & Poullier, 1999; Anonymous, 2000; Barranza-Lloréns et al., 2002; PAHO, 2004). Despite these promising numbers, the rural poor of Mexico remain some of the most marginalized members of society.

### *Unions*

In Mexico, unions are present in most industrial sectors. Evolving out of the Revolution in the early twentieth century, they became closely tied to the State in a symbiotic relationship that helped reinforce PRI development policies and union interests (Aguilar Garcia, 2001; Bizberg, 1990; Cadena Vargas, 1996; de la Cruz, 2002; Middlebrook, 1991; Zapata, 1995).

Unionized Mexican women in the industrial sector experience the same gender dynamics within the union as they do in Mexican society. These include sexism, barriers to leadership, and discrimination in pay, to name a few (Solis de Alba, 2002).

Healthcare worker unions formed in Mexico in the late 1960s in response to low wages and poor working conditions (Ravelo Blancas & Sánchez, 2004). The IMSS union, known as the Sindicato Nacional de Trabajadores del Seguro Social (SNTSS) is the largest of all the healthcare worker unions. Nurses working in State-managed facilities in Mexico are unionized along with all other non-administrative hospital employees. Private hospital nurses are not unionized. In contract negotiations, the SNTSS has the most influence over the process. ISSSTE and SSA workers get the same package because of a “me too” clause that is part of all SNTSS negotiations.

Yet literature about healthcare workers unions in Mexico is scarce for reasons that are unclear. Most sources including information about the healthcare workers unions mention it only in passing or as part of the larger labor movement in Mexico. Consequently, the influence of

healthcare unions on nurses and their professionalization process is not well understood.

*The State and Nurses in Mexico*

The State has been the primary entity shaping the development of health-services in Mexico throughout the twentieth century (Frenk, 1990). The Mexican State has used health-services as a means of ensuring its authoritarian rule and placating the demands of the masses (Davis & Brachet-Marquez, 1997; Kappelusz-Poppi, 2001). The State theoretically played a significant role in the development of the nursing profession in Mexico, but the literature fails to describe its specific role in helping– or hindering– the process.

What is known about the Mexican State's role is that historically it has chosen the roles nurses will play in the healthcare system. Hernán Cortéz institutionalized nursing practice along with the new country when he arrived from Spain and in 1524, he established the first hospital in the Americas (Hospital Juarez in Mexico City). Until the 1840s, male religious orders provided health-services to the middle and upper classes while traditional healers provided services to the indigenous and lower classes (Alatorre Wynter, 2003). Nuns and selected women of the Catholic church provided nursing care that did not involve viewing the naked body– due to prohibitions from the church– until the late 19<sup>th</sup> century (Alatorre Wynter, 1991,1992, 2003; Purves, 1906; Cárdenas-Jiménez & Zarate-Grajales, 2001; Colby-Monteith, 1940; Lartigue & Fernandez, 1998). The Sisters of Charity, a religious order that provided nursing care throughout Europe and other parts of the world, did not arrive in Mexico until the 1840s.

The finalization of anticlerical reforms implemented by the Mexican State in the 1850s forced the Sisters of Charity to leave Mexico in the early 1870s (Alatorre Wynter, 2003). These anticlerical reforms began in Mexico in the 1850s with the election of the first president of the country, Benito Juarez. The reforms sought to decrease the power and influence of the Catholic Church in Mexico, especially in affairs of the State. However, the expulsion of the clergy,

including nuns, had a disastrous effect on health-services in Mexico because most of these services were provided by the church.

Eventually, in order to replace the nuns and other individuals associated with the church who provided care to hospitalized patients, the State in the 1870s employed lower-class women with little to no education as nurses. Physicians managed all technical aspects of care while nurses performed tasks acceptable for their educational and class level: cleaning, cooking, laundry, and bathing patients. Physician administrators saw this work as an extension of normal female roles and therefore, nursing became an acceptable form of work for women of low socioeconomic status (Rios-Everardo, 2001). Women of the middle and upper classes in late nineteenth century Mexico were not permitted to perform this kind of work because it was deemed socially unacceptable due to cultural norms regarding women's behavior.

Formal education for nurses in Mexico, requiring at least a junior-high school education, did not begin until 1905. The Revolution slowed the development of nursing education programs until well after 1920. The State did not sanction the formal education of nurses until just after the Revolution began in 1911.

After the Revolution, in cooperation with the State, the Rockefeller Foundation funded nursing training programs for public health in Mexico and contributed to the rise of the nursing profession between 1920 and 1960 (Birn, 1999). Collaborative investment by the post-Revolutionary Mexican state and the physician community contributed to a rapid growth in the number of nurses and an expansion of their roles. This period is considered by many as the golden age of nursing in Mexico, where autonomy, professional growth, and prestige grew apace and practice opportunities peaked in availability (Martinez-Benitez, 1985; Rios-Everardo, 2001), thanks in large part to State investments in the profession.

The 1960s marked the end of the "golden age of nursing" in Mexico (Cardenas-Jimenez

& Zarate-Grajales, 2001). The role they played in disease eradication combined with the educational requirement for nurses elevated nursing's status in the country. Nursing services also had their own division in the national ministry of health to guide policy making for the profession (Gómez Siegler, 1964).

Unfortunately, by the 1970s, public health nursing, once the most prestigious speciality in Mexico, lost its influence as physicians increased in number and they displaced public health nurses in their roles (Alatorre, 2003; Macias-Baez, 1975). Throughout the 1970s, professional nursing roles increasingly shifted to institutions and away from the community, resulting in a decrease in professional autonomy for nurses (Espinosa de los Monteros, 1979; Langarcia Salazar, 1977; Villegas R. & Langarcia S., 1977).

The convergence of two factors caused a shortage of formally prepared nursing personnel in Mexico in the late 1960s and 1970s: the rapid expansion of the healthcare system and that most women in Mexico at this time having low levels of education (below 6<sup>th</sup> grade). Rapid growth of the healthcare system caused high nursing vacancy rates within the system. In response to this problem, the auxiliary nursing<sup>15</sup> role, a worker whose education was completely unregulated, was introduced into the hospital system during the 1960s. The nurse's aide position, requiring only a sixth-grade education level, was created to fill the vacancies in the system and bring more women into the healthcare workforce (Alatorre, 2003). Due to the shortage of formally trained nurses, the aides ended up performing much of the work of educated nurses, often working alongside them as "equal" colleagues even though they had no formal education.

It caused discontent among nurses with formal training. They blamed the rapidly increasing numbers of auxiliary nurses for the growing disunity within the nursing profession

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<sup>15</sup> Equivalent to a nurse's aide in the US.

and for inhibiting their professionalization efforts (Chacón-Alvarez del Castillo, Espinosa-Chiapa, & Navarro-Salazar, 1968). Placing blame on the un-socialized members of the profession, nursing journal articles depicted growing concern over the stagnation of the professionalizing culture and the fracturization of nurses as a group (CNE, 1978a; Diaz Camargo, Martínez Manatou, Farell Cubillas, & Jonguitud Barrios, 1977; Cortés Ramírez, Villareal Guzmán, Martínez Benítez, Guerrero Hernández, & Padilla Hernández, 1979).

Finally, the latter half of the 1970s foreshadowed the impending national economic crisis of the early 1980s. In some ways, the effects on the nursing profession served as a bellwether forecasting the collapse. The forecast emerged from a significant event that occurred at the CNE.

Mexican nurses were producing their own “professional knowledge” since the 1960s in both the CNE’s monthly journal “Enfermeras,” regular contributions by nurses to the national public health journal “Salud Pública de México,” and other articles in materials produced by nurses working at PAHO. Yet between 1976 and 1977, during a brief economic crisis, the CNE journal ceased publication due to lack of financial resources – a first in the journal’s history (CNE, 1977). Nurses could no longer afford to pay their membership dues. Previously, the booming economy of post-Revolutionary Mexico made it easy for nurses to join the national professional organization. Nurses had far greater success harnessing the economic resources needed to support the operations of the CNE during this period than at any other time in the group’s history. With the organization’s dependence on membership dues from nurses for its existence, the CNE experienced a sharp drop in membership revenue because their members could not afford to pay. As a result, the CNE altered its development plan for the remaining years of the decade to one that possessed much more modest professionalization goals as compared to previous years (CNE, 1978b; CNE, 1979).

*The State and Contemporary Nursing in Mexico - 1980 to 2005*

Internationally available literature indicates that Mexican nurses working for the State, both past and present, can find themselves politically challenging positions or situations compromising their personal safety. Because their role generates nearly constant contact with patients in all parts of the Mexican healthcare system, they can become the “face of the state,” representing its positive and negative aspects (Squires, 2005). The negative consequences for nurses representing the State are illustrated by the 1996 deaths of three nurses at the hands of anti-Mexican government forces (Latin American Perspectives, 1996). These nurses were employed by the Mexican government in State-run health clinics in the southern state of Chiapas. As the most visible representatives of the State in this region, they became targets of violent retaliation by anti-government forces that arose from the extreme frustration citizens felt regarding repressive Mexican government policies in the region.

Research by foreigners highlighted the problems related to cultural and class differences faced by nurses and patients in the HCS (Menegoni & Hendershott, 1992). Foreign researchers, decidedly biased toward the patient, tended to view nurses and other HCWs as hostile forces in the HCS that contributed to patient suffering. They did not move out of this narrow lens to view how the State and its management of the system might contribute to HCW treatment of patients. Thus, one may not assume that healthcare workers are neutral figures in the delivery of healthcare services where authoritarian regimes are in power. These workers can be and are used (often without their knowledge (Ramirez-Valles, 1999)) to ensure the enforcement of authoritarian policies.<sup>16</sup> As patient satisfaction studies regarding the services of the government sponsored Mexican healthcare system are relatively new and focus largely on satisfaction with

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<sup>16</sup> Until 2000 when the Partido de Acción Nacional (PAN) [National Action Party] won the presidency, the Partido Revolucionario Institucional (PRI) [Institutional Revolutionary Party] ruled Mexico by authoritarian means, under the guise of a quasi-democracy. The Mexican presidency and his cabinet determined all policies in Mexico and legislative approval was merely a formality (Davis & Brachet-Marquez, 1997; Keen, 1992).

physician care, it is not yet possible to determine whether nurses are positively perceived by health-system clients.

Current research indicates that nurses in Mexico face systemic challenges similar to those of nurses throughout the Western hemisphere. In a study commissioned by PAHO, Guevara and Mendias (2002, 2005) conducted a comparative, narrative analysis of interviews from a purposive sample of 125 nurses from Argentina, Colombia, Brazil, Mexico, and the US. Mexican nurses represented 29% of the nurses interviewed for the study. The nurses reported decentralization and cost-control measures in all countries, with a definite trend toward health-promotion services. These cost-control policies, a consequence of the neoliberal reforms implemented throughout Latin America, have resulted in less nursing staff with more work to do, more paperwork, less direct patient care, more administrative duties, increased demand for technological knowledge without support for training, changes in practice settings, concerns about malpractice (Arroyo de Cordero, 2004), discrepancies between role and job titles, increased institutional migration, and an increase in consumer-savvy clients (Guevara & Mendias, 2002).

The authors reported the specific challenges for Mexican nurses included heavy workloads, low salaries, reduced time for patient care, increased responsibilities, not enough nurses to provide care, increased paperwork, and increased use of technology in the workplace where there previously was none (Guevara & Mendias, 2002). PAHO's research division on the organization of health-services (HSO) conducted a regional survey of nursing and midwifery services in the Americas in 2002. The findings demonstrated that 20 of the countries, including Mexico, had formal plans for the development of the nursing profession. These plans addressed education (basic and graduate level), governance mechanism, increased participation in health-system policy making, and other issues. These two studies illustrate the importance of PAHO in

providing research-based information to nursing and healthcare professionals that can facilitate the development of the field.

Rios-Everardo (2001) studied nursing professors in Mexico and identified many hierarchies and power dynamics within the nursing profession that are related to and in harmony with internalized patriarchal power systems. She identified a vertically structured system that has the potential to detract from the care provided to patients if the nurse is unable to maintain her place within it (Rios-Everardo, 2001).<sup>17</sup> The hierarchical system within which nurses work may be another significant factor in the process of professionalization of Mexican nursing.

Most of the rest of the literature about nursing in Mexico is largely anecdotal but when synthesized it provides useful information about the nursing profession. Morán Peña (2003) described the developing communities of nursing scholarship in twenty-first century Mexico— a key element in the development of a profession —as rife with controversy. She acknowledged that the lack of doctorally- and masters-prepared nurses contributes to the problems in research dissemination and professional recognition. She also cited the inertia of the Mexican political and healthcare system and prejudice resulting from “the hegemonic influence of some professionals use[d] to control the decision-making process” (Morán Peña, 2003, p. 39). Carlson’s (2000) research confirms these statements.

Cardenas-Jimenez and Zarate-Grajales (2001) optimistically characterized the last twenty-five years of Mexican nursing as *un fuerte movimiento*— a powerful movement —toward professionalization with the goal of autonomous control over the governance, education, and performance of nurses, as well as addressing the persistent shortage of nurses in Mexico. Other

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<sup>17</sup> Original quote: En el equipo de enfermería también existen categorías, aunque todas éstas tienen menor poder frente a los de los médicos. Asimismo, se establecen jerarquías y poderes, relacionados de acuerdo con el poder patriarcal internalizado. La enfermería tiene que delimitar su campo y construir los objetos de conocimiento, que le permitan participar activamente en la prevención y atención de salud, y no en su actual y reducido espacio de atención al paciente (Rios-Everardo, 2001, p. 63).

articles demonstrated that Mexican nurses are both independent and collaborative producers of research (Alvidrez-Aguirre & Oderkirk, 2004; Hecker, 2000; Martinez-Rodriguez & Luis, 2004; Muñoz Canche & Salazar Gonzalez, 2005; Nájera, 1992; Nájera, Mandujano, & Sánchez-Pérez, 1999; Ortega-Altamirano, López-Carrillo, & López-Cervantes, 2000; Otero-Miyar, 2004; Rappsilber, Castillo, & Gallegos, 1998; Robinson & Wharrad, 2000; Salmerón-Castro et al., 2002; Villaruel, Gallegos, Loveland-Cherry, & Refugio de Duran, 2003). Finally, another growing body of research indicates three general trends in the profession: a) a general shift in the role of the nurse toward one with more autonomy (Garcia-Peña, Thorogood, Wonderling, & Reyes-Frausto, 2002; Hernández-Garduño & Rosa-Ruiz, 2000; Nájera, Mandujano, & Sánchez-Pérez, 1999; Otero-Miyar, 2004;); b) gender and class influence physician-nurse workplace relationships (Ángeles-Llerenas et al., 2003; Champion, Austin, & Tzeng, 1987; Douglas, Meleis, Eribes, & Kim, 1996; Douglas & Meleis, 1997; Harrison, 1994; Hojat et al, 2001; Hojat et al, 2003; Vargas-Lagos, 1991; Zakus, 1997); and c) a greater assumption of responsibilities previously held by physicians by nurses (Carlson, 2000; Farr, Rivera, & Amatya, 1998; Guiscafere, Martinez, Palafox, Villa, Espinosa, Bojalil, & Gutiérrez, 2001; Guitiérrez, Guiscafere, Verver, Valdés, Clavery, Rivas, & Loyo, 2001; Ortega-Altamirano, López-Carrillo, & López-Cervantes, 2000; Vargas-Lagos, 1991).

### **Sociocultural and Gender-Based Variables and the Development of the Nursing Profession in Mexico**

When studying women in developing countries, one must acknowledge the legacy of colonialism on social, political, and economic structures (Acosta-Belen & Bose, 1990; Deutsch, 1991) as well as the influence of globalization on feminist politics (Bergeron, 2001). These factors affect everything from political participation (Aviel, 1981; Lavrin, 1989; Ong, 1991;

Shaul, 1982; Stephen, 1992), to leadership (Cortina, 1989; Muller & Rowell, 1997), and labor (González-Salazar, 1974; Messias, Im, Page, Regev, Spiers, Yoder, & Meleis, 1997; Ong, 1991; Safa, 1977).

Mexican female workforce participation increased steadily since the 1970s with the greatest leap occurring in the 1980s, after the 1982 economic collapse (García & de Oliveira, 1994). While workforce participation by females in their 20s increased relatively evenly, participation by women between the ages of 30 and 49 increased by nearly 75% between 1982 and 1987 (García & de Oliveira, 1994). Garcia and de Oliveira (1994) attribute this rise, despite the prevailing unemployment in the country, to women obtaining low paying jobs in order to supplement household incomes resulting from their husband's frozen wages and skyrocketing inflation.

Current working conditions for Mexican women present a variety of challenges. Pedrero, Rendón, and Barrón (1997), in a massive national study of Mexican women and their occupations, found that Mexican women work primarily in service sectors in part-time positions that have little job security. Their study, along with that of Guerra Ochoa (2005) and González Marín (1998), found that many Mexican women worked multiple jobs, in addition to managing their household duties.

Guerra Ochoa (2005) studied female workers rights and labor conditions in all sectors, but largely focused on manufacturing. Her analysis of year 2000 Mexican national labor data demonstrated that women were 22% more likely than men to work two jobs, even in the most economically well-off regions of the country. Mexican women were also 10% more likely to be working without pay than their male counterparts. Findings from her study also indicated that education pays for women. Females with university degrees were nearly three times as likely and females with high school education twice as likely to find employment and participate

economically. In comparison, education only made a 10% difference in the likelihood for employment and economic participation for males with high school diplomas or university degrees.

González Marín (1998) evaluated the female labor market in Mexico in the mid-1990s. Her analysis demonstrated that females faced employment discrimination in the sense that they rarely were able to obtain jobs with benefits like health insurance. González Marín found this disturbing because that meant many wives of small business owners—who are not eligible for IMSS coverage—would have difficulty obtaining health insurance coverage for their families. Finally, Frenk et al. (1999) found that female physicians in Mexico—the closest female, health-system counterpart for nurses—faced competing demands on their time and energy from their families and workplace, employment discrimination, and restrictions (largely economic) to obtaining additional education.

#### *Gender and Health-services Delivery*

Gender issues are critical in health-services policymaking, especially for healthcare human resources, but they tend to be ignored in the policy and planning process (Standing, 2000). Yet health-systems are often the largest employers of women in any country, with numbers ranging from 62% to 85% of all healthcare personnel (Gupta et al., 2000; ILO, 2002; Standing, 2000). In high-level decision making processes in health-systems or representation through professional organizations, women are usually under-represented and have difficulty exerting their professional autonomy (Gisbers van Wijk, van Vliet, & Kolk, 1996; Standing, 2000). Accounting for gender bias by enacting measures that reduce inequity and promote equality in employment opportunities, therefore, becomes critical for delivering high quality of care through the healthcare system (Standing & Baume, 2001).

Most studies about gender in healthcare systems have been done in Western nations,

leaving the unique aspects of developing-world context under-researched. For example, Gupta et al. (2003) found that women worked, on average, fewer hours than their male counterparts and also earned less per hour. Their study, however, included only Western nations and the Russian Federation. They did not examine healthcare workers, such as nurses, in the developing world who may work two or three jobs in order to sustain a middle class existence. Gupta et al. (2000) also posit that the extent of gender imbalances in a healthcare workforce may indicate the extent of gender-based equity in career choices better than other fields, as both vertical and horizontal gender imbalances are present in the healthcare industry.

#### *Gender and Mexican Nurses*

The influence of sociocultural variables on the lives of Mexican nurses has received little study. Mexican feminists view nurses and their roles in the health-system as essential and representing the majority of the personnel in the health-system; however, much like their roles as wives and mothers, Mexican feminists view nurses as functioning in an environment that does not value their contributions and in which they are consequently emblematic of the self-sacrificing Mexican woman (Morales, 1984; Lartigue & Fernandez, 1998; Martinez-Benitez et al., 1985; Rios-Everardo, 2001). They associate these characteristics with low salaries, lack of educational opportunities, and medicine's control over nursing— all of which maintain the public's perception of nursing as a vocation, more than a profession (Tapia-Arizmendi, 1986).

Nonetheless, Howell (1993) found that nursing is a viable and attractive career option for young women from poor families in Oaxaca, Mexico. In her qualitative study of 131 females from the state, she found that economic instability and social changes in attitudes toward female education and work opportunities helped make nursing, along with teaching and other professions, a preferred means for socioeconomic mobility and familial economic stability. Furthermore, Howell's study found that the nurses in her study were three times as likely to be

divorced as other women, professional or non-professional. (This was also the case for two out of the three nurses interviewed in the March 2005 pilot study for this project.)

Douglas and colleagues (1997) and Diaz Olivarrieta et al (2001) examined the effects of socioculturally generated, life demands on the health of nurse's aides. Díaz Olivarrieta et al. (2001) examined the incidence of intimate-partner abuse among Mexican nurses and nurses' aides. They found in their sample of 1,150 nursing personnel (n=295, nurses; n=888, nurses aides) in 11 urban hospitals in Mexico City that 39 to 42% reported emotional abuse during adulthood with a higher prevalence reported among younger women. Douglas et al. (1997) demonstrated that work-related stress correlated significantly with physical symptoms of stress ( $r = .30, p < 0.05$ ). Longer working hours correlated positively with increased reports of psychological stress. Nurses with positive relationships with their spouses had higher levels of work satisfaction. Auxiliary nurses with more than three children reported lower overall scores on their perception of their own health. Education level and maternal satisfaction had no significant relationship to health symptoms, physical or psychological. Finally, economic insecurity significantly correlated with higher levels of work-related stress. While the sample size of both studies by Douglas and colleagues is generally small and limited to nurses in Mexico City, it does provide some indication of the relationship between work-related stress on the social and familial aspects of the lives of Mexican auxiliary nurses, and likely Mexican professional nurses as well.

The international comparative studies of Hojat et al.'s (2001, 2003) on nurse-physician relationships highlighted several key issues with regard to Mexican nurses and their status as females. First, the findings from this research confirm that nurse-physician relationships functioning under hierarchical models are less collaborative than models with more equity built into them, despite nurses desiring more collaborative relationships. Mexican nurses reported

more positive relationships with female physicians than their US counterparts (Hojat et al., 2001). Mexican physicians and nurses also perceived less role-based conflict than their counterparts from the US and other developed nations. Culturally-based gender dynamics may also influence this finding as similar results came from the Italian nurses and physicians participating in the survey.

Finally, Rios-Everardo (2001) attributed many of the challenges nurses face when trying to advance within Mexican society to several cultural variables that may be unique to Mexico and Latin America. She suggested that the rigid rules of Catholic conduct and strict sexual norms is “hyper-reinforced” in the socialization processes of Mexican nurses through dress codes, how time is structured, and formalities regarding relationships with physicians and others in the hospital or clinic. She claimed that the white uniform and strict behavioral codes reinforced the virginal image of purity in a forceful attempt to desexualize the image of the nurse as a female figure. The professional norms distinguish her from the maquiladora worker<sup>18</sup> or other women from similar classes. She theorized that nursing in Mexico becomes the ultimate reinforcement of the cult of virginity, while at the same time providing personal and economic independence for women when they reach a certain level of professional development.

### **Conclusion**

The literature reviewed here identified some of the key variables that may influence the development of the nursing profession in Mexico. They are generated from historical, political,

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<sup>18</sup> Maquiladora workers are women who work in factories, usually making clothing. The research on this topic is too extensive to be reviewed here, but these women do represent a significant portion of the research about women in Mexico. To work in the factory, a junior high school level of education is all that is required –sometimes less. Many girls who work there are as young as 12 and are frequently subject to exploitative management practices. They choose factory jobs because their families need financial support and often sacrifice their education as a result. Work in the factory is associated with negative stereotypes, including promiscuity, single motherhood, and other social vices deemed “inappropriate” for women in general.

economic, sociocultural, and gender-based factors present in Mexican society.

Nonetheless, the literature review identified a general gap in the internationally available literature about the nature of Mexican nursing. Other literature gaps related to the understanding of autonomy as a concept in the nursing profession, how the nursing profession's development is affected by a non-Western and developing country setting, and a lack of information about nurses in Mexican healthcare worker unions. Literature deficits in areas related to NAFTA and Mexican nursing along with studies of about professionalization in developing countries were also identified.

Meanwhile, the literature helped to identify several significant variables that may influence the professionalization of nursing in the Mexican context. They include the economic crises of the 1980s and 1990s and medicine's relationship to the nursing profession and women's advancement in Mexican society. Sociocultural constructions of class and gender relationships, along with the historical aspects of the health-system's design, appear to affect the extent to which Mexican nurses autonomously control education, governance mechanisms, and their roles in the healthcare system. Despite the plethora of literature on all of the individual subjects reviewed here, little is known about how these variables synthesize to influence the professionalization of nursing in Mexico. This study addresses these shortfalls.

## CHAPTER 3

### METHODS

A case study approach is the preferred method for conducting country-level healthcare human resources studies (Egger, Lipson, & Adams, 2000; Frenk, 1995; Martineau & Buchan, 2000) because of the method's ability to cope with a greater number of variables than data points, its reliance on multiple sources of evidence to triangulate data, and "benefits from the prior development of theoretical propositions" (Yin, 2002, p. 14). Researchers have frequently chosen case studies for studying other professions in Mexico (Cleaves, 1987; Harrison, 1994, 1998, 2000; Rios-Everardo, 2001).

Case studies are ideal for research situations that will involve several short, intense exposures to a group over a period of time (Sofaer, 1999). Case studies can be empirical inquiries of contemporary phenomena that can help define boundaries between them (Meyer, Spilsbury, & Prieto, 1999; Yin, 2002). An exploratory case study allows the researcher to analyze a phenomenon with multiple variables and to develop a theoretical framework for future analysis.

With the exception of some social policy research, such as Cohen's 2001 study of the politics of child care policy in the US, nurse researchers have mostly used case study approaches to analyze individual patient cases (Bergen & White, 2000) and role changes within health-systems (McDonnell, Jones, & Read, 2000). No country-level case studies to examine the nursing profession or contextual variables affecting its practice have ever been conducted even though it is the preferred method

In addition to case study approaches, qualitative research methods in health-services and policy research are also recommended for studying professions because healthcare workers can express their perspectives in their own words, instead of having categories imposed upon them

(Sofaer, 1999).

Framing a study about professions using naturalistic inquiry is also recommended when what is known about a phenomenon is disparate and unsynthesized or requires knowledge generation (Sandelowski, Davis, & Harris, 1989). This kind of research design has been shown to be a good starting point when investigating phenomena whose multiple variables render them somewhat unclear (Creswell, 1998; Sandelowski, Davis, & Harris, 1989).

A case study approach using qualitative methods shaped by a naturalistic inquiry philosophy, therefore, was used to explore the question of how the nursing profession developed in Mexico between the years of 1980 and 2005. Some quantitative data were gathered for demographic and descriptive purposes.

The study's design was built around the criteria for the ethical conduct of international nursing research, as described by the International Centre for Nursing Ethics (ICNE) (Olsen *et al*, 2003) and advocated by other researchers employing qualitative methods (Boman & Jevne, 2000; Davies & Dodd, 2002; Fossey, Harvey, McDermott, & Davidson, 2002). The researcher attempted to minimize Western bias where possible, incorporate respect for persons, utilize ethical principles of beneficence and justice, and respecting the interests of the Mexican nursing community. The author's previous experience of periodically living and working as a nurse in Mexico over a ten year period provided both linguistic and cultural competence that allowed her to foster collaborative relationships with Mexican nurses during the research process. The collaboration aspect aligns with feminist approaches to research, which address issues of gender and power relationships in societies (Creswell, 1998; Grewal & Kaplan, 2002).

### **Time, Setting, and Sample**

The period of 1980 to 2005 was chosen for several reasons. First, professionalization

processes are shaped by social mechanisms that change over time. Accounting for how time shapes these social mechanisms related to professionalization processes will help to more clearly define them (Pierson, 2004). Second, the chosen twenty-five year period represents a turbulent period in Mexican history, which included two major economic crises (1982 and 1995) that had long-lasting economic effects on the population and the ability of the government to deliver social services such as healthcare. This period has also saw the most significant advances in the nursing profession since the immediate post-revolutionary period in the early part of the twentieth century.

### *Setting*

Two sites were chosen for the study: Mexico City and Oaxaca State. Mexico City is the largest city in the world with a population of 25 million living in city limits that extend from the federal district (population ca. 8 million), to the neighboring state of Mexico. Approximately one-fourth of the Mexican population lives and works in Mexico City.

The majority of all medical research in Mexico takes place in Mexico City. Significant portions of the population have migrated from rural areas around the country to work in Mexico City. Interviewing nurses in this city offered the potential to obtain greater geographic diversity among the subjects, thus making the interviews more representative of nurses in the country as a whole. The city also hosts all the national health archives and current documents collections related to healthcare.

Oaxaca is the largest southern state in the country and one of the poorest economically. It is considered the “capital” of the southern region of the country due to its extensive agricultural and tourism industries. Oaxaca offers a sharp contrast to Mexico City in that is still largely culturally indigenous. The healthcare challenges are vastly different from those in Mexico City because of the differences in resources available for healthcare provision and the

urban-rural contrast of the setting. It offered the opportunity to interview nurses working in rural healthcare clinics and under-funded state run hospitals, whereas Mexico City nurses worked primarily in large, State-managed facilities. Nonetheless, interviews with rural clinic nurses could not be obtained due to time constraints during the data collection process.

### *Sample*

Yin (2004) indicates completing between 20 and 30 interviews for case studies is sufficient because data triangulation with primary and secondary sources will also help to create the picture of the case study. Nurses were recruited to the study through purposive, convenience, and snowball sampling. Potential subjects were practicing nurses, nursing leadership, nurse educators, and nurses who are also health-system administrators. This approach generated a cross section sample of Mexican nurses. All interviews were conducted in Spanish, digitally recorded, and then transcribed by a professional transcription company in the US.

Nurses in Mexico City were interviewed at the Escuela Nacional de Enfermería y Obstetricia<sup>19</sup> (ENEO). Oaxacan nurses were selected from a private hospital, the IMSS hospital, ISSSTE hospital, SSA-Speciality hospital, and the Hospital de la Niñez<sup>20</sup> Oaxaqueña. For all locations, institutional consent to interview nurses working there was obtained and a copy of the consent form faxed back to the Yale School of Nursing (YSN) internal review board (IRB).

### *Accounting for Otherness in Relation to the Sample*

As the author is a Caucasian female from a country with an imperialist history with Mexico, she anticipated encountering some reluctance on the part of subjects to participate in the research. At the same time, “otherness” can often be useful when conducting research as it may remove cultural differences present between researchers and subjects with similar backgrounds,

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<sup>19</sup>National School of Nursing and Obstetrics

<sup>20</sup>Children’s Hospital of Oaxaca

allow for discussion of topics not readily discussed within cultures, and open new areas for research (Adamson & Donovan, 2002).

Two things minimized the problem of otherness in this case. First, the author's own credentials as a practicing nurse generated a professional affinity between herself and the subjects. Her ability to share patient-care stories and other professional challenges created an easy conversation between the researcher and the nurses she interviewed. Furthermore, her experience working and living in Mexico along with language fluency helped overcome many barriers to recruiting research subjects and obtaining access to data. All of these factors combined generated very rich interview content.

### **Data Collection and Management**

Data collection consisted of two parts: semi-structured interviews and primary/secondary source collection. The interview data-collection process will be described first, followed by the document collection and analysis process.

#### *Interviews*

Prior to the study, interview questions were pilot tested with three Mexican nurses in February of 2005. The YSN IRB approved the pilot study along with the appropriate bilingual consent forms (see Appendix B for the interview guide).

Subjects had to meet three criteria in order to participate in the study. First, subjects had to be working or have worked as a nurse at some point between 1980 and 2005. A nurse must have worked for at least one year in any nursing role during that period. Finally, when possible, those with career experience working in other locations in Mexico were given some preference for interviews. Variations in State financing for health-services in Mexico do not create equal levels of service around the country (Lezana Fernandez, Alvarez Lucas, & Leviz Cordero, 1993;

Nigenda et al, 1998; Romero Guerrero, Perham Zellmer, Vázquez Calderón, Díaz Gois, Garcia Martínez, & Gómez Solis, 1992; Sesma Vázquez, Perez-Rico, Martínez Monroy, Lemus Carmona, 2005; Simonelli, 1987; Soberón Acevedo & Martínez Narvaez, 1996; Stebbins, 1986), and therefore, were thought to influence the work experiences of the nurse.

At each location, a potential subject was identified through an introduction from a Mexican nurse or physician. Upon identification of a potential subject, the author introduced herself to the nurse, explained some of her clinical and educational background, and asked him or her to participate in the interview. Approaches varied slightly at each location and are described in more detail below. The interview took place at times that suited the subjects' schedules, in locations convenient to the interviewees, and where the subjects' privacy could best be protected. These locations included university offices or secluded lounges in hospitals that were away from public areas or high levels of pedestrian traffic. Subjects expressed reluctance to be interviewed outside the workplace as they perceived coordinating logistics with the demands of their personal lives as difficult.

Once the nurse agreed to participate in the study, a copy of the consent form was provided to him or her (see Appendix B). The subject's oral consent was recorded at the beginning of the interview. Subjects were not required to answer any question they felt was in conflict with their personal or professional responsibilities. Nurses agreeing to participate in the study received no money for their participation and were offered an electronic copy of the final dissertation (in Spanish).

The semi-structured interview was then digitally recorded. Interviews lasted between 22 minutes and 100 minutes. The average interview length was 50 minutes. Recordings were backed up on the author's personal computer and CD-ROM. All electronic copies of transcribed interviews were protected with a password. Interviews saved on CD-ROM were mailed through

DHL international express mail with signature requirement to a professional transcription service because publicly available internet connections in Mexico proved too slow for secure file transfer. The transcription service's protocols adhered to all US Health Information Privacy and Accountability Act (HIPAA) guidelines for confidentiality. Hard copies of the transcripts were kept in a binder and stored in a locked file cabinet in the author's place of residence.

Once transcription was completed, accuracy was verified by the author as a third check of data quality. In the interview transcripts, subjects were identified by the title "Enfermera" and their interview number. Their place of work was identified by a general description with no identifying characteristics. The overall data management procedures created an auditable trail of research, as advocated by Rodgers and Cowles (1993).

#### *Mexico City Interviews*

In Mexico City, subject recruitment began at a large, public university with an established nursing program. A professor with expertise and research experience in Mexican nursing history (including professionalization issues) served as the initial contact, interviewee liaison, and subsequent "introducer" to the first five interviews for the sample at the Mexico City site. Other interviews emerged from her initial introductions.

Several cultural factors made it difficult for the author to obtain interviews at another Mexico City site. Nurses typically would not agree to participate in the study without an introduction from another Mexican nurse. In Mexican culture, it helps to establish trust between two individuals if a colleague makes the introduction. Potential subjects also were reluctant to set up interviews over the phone, so this limited access to other sites. Mexicans value in-person interactions over telephone contact. Nonetheless, despite being limited to one site in Mexico City, the sample was diverse in that the nurses at the school had worked all over the country and

in different types of settings. These included universities, second- and third-level hospitals<sup>21</sup>, and urban primary care clinics.

### *Oaxaca Interviews*

The Oaxaca subject recruitment process was different because of the author's work experiences in that state over the last ten years. This yielded a greater diversity of contacts and the ability to access more staff nurses than in Mexico City. Despite these contacts, the "introducer" role still proved to be important in subject recruitment in Oaxaca. For Oaxaca, the introducers were two physicians, each working at two hospitals (public and private). The researcher was able to recruit nurses for interviews at all four sites as a combined result of the introductions made by the physicians and her own work experiences in these locations.

### *Primary and Secondary Sources*

Primary sources about the nursing profession in Mexico were obtained from the Archivo Nacional de Salud<sup>22</sup> and the Comisión Interinstitucional de Documentos<sup>23</sup>— a "present day" government documents library—in Mexico City. At both locations, searches began with a simple personal introduction and explanation of the research to the archivist or library staff. An explanatory letter, in Spanish, and signed by the dissertation advisor on university letterhead was available to present to authorities upon request. Primary sources were selected based on themes identified during the literature review and included decentralization, annual ministry of health reports, human resources, and any document categorized in the archival database as related to the nursing profession.

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<sup>22</sup> A second level hospital provides mid-level hospitalization care. This can include normal deliveries, general surgery, or uncomplicated treatment of infectious diseases like pneumonia. A third level hospital performs complex surgeries (i.e. heart bypass or neurosurgery) and cares for the sickest patients. These tend to be the largest hospitals in Mexico.

<sup>22</sup> National Health Archive

<sup>23</sup> Interinstitutional Document Commission

For secondary sources, journal articles, books, monographs, and other documents related to nursing and healthcare in Mexico were obtained from the library at the ENEO (the largest and most extensive nursing library in Mexico), the CNE library, and the PAHO institutional memory collection. The majority of the materials came from Mexican nursing journals. Articles from these sources were selected because they dealt directly with professionalization concepts.

#### *Risks/Benefits*

Possible risks to subjects included spending time away from home, conflict with family obligations, or stating something in an interview that they may categorize as compromising to their work or personal life. A potential indirect benefit through participation in the study was possible new insight for the nurse about her own professional development and the factors that shaped it.

### **Data Analysis**

The case study approach generates data that are “not guided by an explicit or established set of philosophic assumptions” (Caelli, Ray, & Mill, 2003, p. 3) established by traditional qualitative methodologies. Both interviews and documents were coded using general thematic analysis techniques, as is recommended for case studies (McDonnell, Jones, & Read, 2000; Yin, 2002). Initial coding was guided by the initial five themes identified in the literature review: Economic, political, sociocultural, historical, and professionalization. Other codes emerged during the data analysis process and are described in the results section. Coded data was then synthesized from all sources (interviews and documents) to produce the results.

#### *Interview Analysis*

All interviews were transcribed in Spanish and sent to the author in simple line-by-line format. Each interview required formatting after the transcription process. Interview content

was separated into a two-column table, with subject content on the left and the researcher's coding on the right. For confidentiality purposes, the author de-identified as much information about work location as possible to protect subjects' identities when coding the interviews.

The interview analysis evolved from a three-part process. The author began with general coding, followed by an extensive interview summary, and finished with sub-code thematic synthesis. Each major theme was assigned a color to visually distinguish the coding process. Key quotes from subjects were translated during the coding process to facilitate writing the final results. This allowed for a very detailed coding process.

The author opted to code data in English because most of the dissertation committee did not speak Spanish and needed to review the data in order to enhance reliability and validity. When general thematic analysis is used with qualitative methodology, themes transfer across languages without any loss to data quality (Coverston, 2002; Mill & Ogilve, 2003; Temple, 2002; Temple & Young, 2004; Twinn, 1997). The bilingual member of the dissertation committee verified content validity of the translated coding process for accuracy in translating the concepts, themes, and quotes.

#### *Document Analysis*

A context analytic approach was utilized for document analysis, using methods described by Miller and Alvarado (2005). For government document analysis, the researcher adopted a constructionist view of the documents to frame the process. The documents served as actors in the social field, shaping the social reality of nursing practice. Documents produced by nurses, such as journal articles, were analyzed through a "documents as commentary" lens as much of their writing reflect insights into the contextual social reality of nurses during different periods. The second approach to document analysis allowed the author to analyze how nurses responded to State policies outlined in government documents during the period of study.

With these two types of document analysis in mind, the author reviewed each one for relevant content and coded them using the major themes. The author made notes about significant findings on the documents themselves during this process. This part was completed in concert with the interview coding.

Upon completion of the interview coding, a spreadsheet to capture the document-coding content was created. Documents were categorized according to their type (journal article, government document, etc.) and institutional source. The researcher created columns for each major theme used during the interview coding process. The researcher's notes about the document or content were typed into the spreadsheet next to the document's information. Relevant quotes from the documents were also placed in the notes column.

At the end of the document analysis spreadsheet, the author programmed the major theme columns to add up the number of "1"s used to identify the document coding. By totaling the number of codes, the author was able to obtain a crude measure of the quantitative strength of each independent variable in relation to the dependent variable of professionalization. This information proved useful for developing a conceptual model of the relationships among the variables.

## **CHAPTER 4:**

### **RESULTS - PART A:**

#### **DESCRIPTIVE STATISTICS AND DOCUMENT ANALYSIS**

The purpose of this study was to analyze the professionalization of nursing in Mexico between 1980 and 2005. The study had two specific aims. The first was to identify and describe variables specific to Mexico that influenced the development of the nursing profession in Mexico between 1980 and 2005. The second was to analyze the contextual relationship of the variables for the purpose of constructing a theoretical framework.

Professionalization was the dependent variable for the study. Initially, four independent variables were thought to influence professionalization: economic, political, sociocultural (including gender), and historical. This study also hypothesized that the ability of nurses to use professionalization as a means of advancement would be strongly associated with how they, as a largely female social group, are willing or able to capitalize on the economic and political resources available to them to promote the advancement of the profession.

The study sought to answer four research questions. First, how did the interplay of sociocultural, political, economic, gender, and historical variables affect the development of the nursing profession in Mexico? This question is answered through the contextual analysis of primary and secondary source data in this chapter.

The second question sought to address how sociocultural conceptions of gender, women working, and women's roles influence the development of the nursing profession in Mexico. This question is answered through an analysis of the interview data in chapter 5.

Research question three addressed how the economic crises of the 1980s and 1990s affected, and continue to affect, the professionalization of nurses. The answer to this question was found through an combined analysis of document and interview data. Chapter 4 examines

the content of government documents related to health-system management between 1980 and 2005 and synthesizes those materials with secondary sources from Mexican nursing during the same period. Chapter 5 builds on the content of Chapter 4 and explores the economic legacies further by analyzing the impact they have had on the personal and professional lives of Mexican nurses.

The final research question was how current institutional structures in health care and university education influenced the professionalization of nurses in Mexico. Health-system institutional structures were probed through semi-structured interviews with Mexican nurses about their workplace in Chapter 5. Mexican educational system structures relevant to nursing are treated primarily in Chapter 4 during the document analysis.

**Table 1: Document origins and types.**

<b>Institutional Source</b>	<b>%</b>	<b>Type of Document</b>	<b>%</b>
Mexican Health Archives	22%	Books	5%
Library of the ENEO	40%	Conference proceedings	8%
Current Documents Institute	11%	Government reports/monographs	19%
Mexican Nurses Association	18%	Journal articles by Mexican nurses	60%
Pan American Health Organization	4%	Non-government reports/monographs	8%
Other	5%	Other	0.5%

Thus, the professionalization of nursing in Mexico between 1980 and 2005 was examined through a case study that used a combination of document analysis and interviews with 32 Mexican nurses. Between January and March of 2006, a total of 410 primary and secondary sources published between 1974 and 2006 were collected from Mexican archives and libraries. These documents were only available in Mexico and could not be obtained from international

research databases. Ninety percent of the printed sources are of Mexican origin or by Mexican authors. A summary of document statistics is provided in Table 1.

Government documents about nursing personnel policies, decentralization plans, and annual “state of the nation” reports comprise the majority of primary documents. Primary documents produced by the Secretary of Health (SSA), non-nursing institutions, and international organizations shape the period of study by reflecting institutional reactions to the major historical events of that time and how nurses were included or excluded from the policymaking process. The majority of materials written by nurses come from journal articles (60% of all documents) selected because they include content relevant to professionalization.

By analyzing the professionalization of Mexican nursing through a variety of sources, the variables that influence the overall process were identified. These variables helped explain the barriers and facilitators to both professionalizing and producing nurses in Mexico.

Seven themes emerged as independent variables that influence the professionalization (PD) process (the dependent variable) in Mexico. In addition to the initial four independent variables (Economic [E]; Political [P]; Sociocultural [SC]; and Historical [H]), another three emerged from the analysis. These included the Workplace (WP); Unions (U); and International influences (I). Conceptual definitions of each theme are included in Appendix D.

The “sociocultural” theme had three strong sub-themes: gender, healthcare system, and education system. These three sub-themes consistently emerged in both the primary sources, other written materials, and interviews as significant factors affecting the professionalization process. A country designs its education and healthcare systems according to sociocultural beliefs about who should receive healthcare and education. Concepts about gender come from deeply rooted, culturally specific ideas about appropriate roles for males and females in a society. As such, these factors cannot be separated from the sociocultural context that shapes

Mexican society.

The study found that all the identified variables have interactive, complex, and interdependent relationship that influence the professionalization process. The nature of the relationships highlighted in the conceptual model suggest the presence of a Nursing System (NS) within the country. The purpose of the system is to produce and develop nurses and their services, both individually and as a group. The findings from this study suggest that the quality of the country's infrastructure affects the ability of the Nursing System to operate and thus, produce nurses and keep them working in the healthcare system. Beyond the institutional level, no researcher has previously identified the concept or presence of an Nursing System at the country level.

To illustrate the potential relationships of these variables, a conceptual model is provided in Appendix E.<sup>24</sup> This model is a theoretical suggestion of how these variables might interact to influence the professionalization of nurses and the nursing profession in Mexico. The results of this study are presented as a description of their interactions in relation to the professionalization of nursing in Mexico.

The analytic tone of the documentary evidence and the interview data analyses differed greatly and created an extensive set of results. In order to present the results in a way that best represented the findings from the data, the results are divided into two chapters. The current chapter, number four, focuses on documentary evidence. This analysis focuses on the trends that emerged from a synthesis of government health system documents, nursing journal articles, and

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<sup>24</sup> This current representation of the relationship between the variables involved in professionalization is in the earliest stages of theoretical development and represents the fifth rendering of the interactions by the author. It may evolve further with continued work. The model's design draws not only from this study, but from the author's experience and knowledge of international nursing literature. The size of each shape representing a variable should not be interpreted as how great an influence the variable has at this time. The degree of influence each variable has and the strength of the relationship between the variables cannot be determined at this time. Further replication of the study is needed to confirm this arrangement of the relationships.

other documents relevant to the professionalization of Mexican nursing. It establishes the context, both historical and political, under which Mexican nursing implemented professionalization.

This part of the analysis focuses on the written data collected for the study and shows how the independent variables affected professionalization during three significant periods in the professionalization of Mexican nursing. Period I (1980 to 1993) includes an analysis of the effects on the professionalization of Mexican nursing of the economic collapse of the 1980s and initial health-system decentralization efforts. Period II (1994 to 2000) and focuses on the implementation of the North American Free Trade Agreement (NAFTA) and the 1995 peso crisis. The third period (2001 to 2005) includes an analysis of recent national health-system policy changes affecting Mexican nursing. The chapter concludes with an analysis of the historical legacies of the Mexican State's healthcare human resources policy initiatives from the 1970s that subsequently affected the professionalization of nursing during the entire period under study. When appropriate, comments from Mexican nurses interviewed in the study are included to confirm or support findings from the document analysis.

Chapter 5 centers on interview data analysis and reveals the effects of the historical and political context on the Mexican nursing profession and the personal lives of Mexican nurses. The majority of the findings presented in Chapter 5 are derived from the interviews. The presentation of the results begins with a description of the study's sample and includes, when appropriate, descriptions of sample differences found between the two sites. Descriptions of trends and significant findings in nursing human resources production during the 1980 to 2005 period are also included in that section.

### **PERIOD I: 1980 TO 1993 - ECONOMIC COLLAPSE AND ITS CONSEQUENCES**

Period I explores the impact of the economic collapse on Mexican nursing between 1980 and 1993 through a synthesis of Mexican health-system archival documents, conference proceedings, and nursing journal articles. It begins with a description of the effects of the economic collapse and then explores how the health-system decentralization process affected the nursing profession. Analysis of this period highlights the systematic exclusion of nurses from the policy making process. Perspectives of nurses at the time are included through what they wrote about professionalization in nursing journals published during this period.

#### **Consequences of Economic Collapse to the Nursing Profession**

All of Latin America was impacted by the 1982 Mexican economic crisis as the effects of the collapse spread domino fashion throughout other countries in the region. The type and extent of the consequences varied from country to country.

For Mexico, it is difficult to convey the extent of the economic and social devastation the 1982 economic collapse. Simply stated, every Mexican of every class became poor (Cue Mancera, 2004). The middle class disappeared and never regained the numbers it had prior to the collapse. Inflation spiraled out of control, driving up the costs of basic goods. Salaries were frozen for the vast majority of Mexicans, making purchases of food and water difficult. Health-system spending in Mexico hovered around 2% of GNP, down from the 6% average of previous decades (Cue Mancera, 2004). Figure 2 (see page 125), illustrating the fluctuations in Mexico's GDP, reflects the economic volatility of the period.

Nurses working at PAHO described three broad effects of the collapse on nurses in the region. First, there was a decrease in nursing school enrollments as most young women and their families could not afford to pay for formal nursing education. Second, nursing salaries were so

low that women could work in *maquiladoras* (clothing factories) for more money. In the northern region of the country, *maquiladoras* paid their workers salaries nearly three times higher than those of nurses with technical degrees, providing a quick way to increase familial economic security. Finally, there was a significant increase in nurse migration among Latin American countries and to Spain, but what percentage of Mexican nurses migrated is not known (Valdez de Reyes & Garcia Jiménez, 1991).

Contributing to the trends described by PAHO, evidence from three administrations indicates the SSA continued to deliberately pursue a hiring policy biased toward auxiliary nurses in order to save costs (Poder Ejecutivo Federal, 1983; Secretaría de Salud y Asistencia [henceforth SSA], 1989a; SSA, 1989d; Salinas de Gortari, 1991; Subsecretaría de Planeación, 1986c; Valdés Olmedo, 1991). Professional nursing vacancies averaged (per year) around 45,000 places while auxiliary vacancies were double at 90,000 (Balseiro Almario, 1988). Many State hospitals also had a deliberate “no hire” policy for the most highly qualified nurses, despite the high vacancy rates (Rosales Rodríguez & López Andrade, 1987). A 1991 document shows nursing human resources for rural areas included 196 educated nurses (1 year education or higher) and 4,100 auxiliary nurses (de Gortari Gorostiza, 1991). In the acute care system, auxiliary nurses outnumbered educated nurses three to one by 1991 (Poder Ejecutivo Federal, 1991).

Somewhat illogically, the largest growth of healthcare workers (HCW) occurred between 1980 and 1985, right in the midst of the worst of the crisis. The State, seeking to offset the effects of the crisis, hired more auxiliary nurses into the system as a way to add to household incomes and provide jobs for women. Even hospital facilities grew in number during this time, creating more places for nurses of any educational level to work (Kumate Rodríguez, 1992). Occasionally, salary increases occurred to help HCW keep up with rising costs of living due to

inflation (Poder Ejecutivo Federal, 1987; SSA, 1989a). Easing the economic burden of the polis through raises and employment opportunities softened resistance to the State's political agenda and reinforced the appearance of democracy in the single-party dominated Mexican State. It is no surprise that most of these raises were put into effect in 1987, right before a federal election. Thus, despite the economic instability of this period, the HCS continued to expand by adding personnel every year and growing in proportion to the population (Salas Segura, Zárate Grajales, & Rubio Domínguez, 2002; Valdés Olmedo, 1991).

The effects of these policies were devastating to Mexican nursing, contributing significantly to its deprofessionalization.<sup>25</sup> Pérez Roman (1987) wrote that the 1982 crisis effectively diluted any technical authority nurses had previously attained. The State systematically eliminated nursing from the highest levels of operations and leadership within the SSA. By 1987, the number of nurses serving in state or federal administrative levels in the SSA had decreased by a third from 1980 levels (Pérez Roman, 1987). Replicating typical administrative patterns of cost-cutting, nursing leadership positions in government were eliminated as part of the stern fiscal-reform measures imposed in the 1980s. Furthermore, since most Mexican nurses were economically middle or lower-middle class females, higher-class male government officials enforcing these measures likely did not perceive them as primary or complimentary contributors to household incomes. It also contributed to the deprofessionalization of nursing personnel in Mexico during the 1980s. The system continues to pay for this policy today with worker stagnation within the system and poor quality nursing care because of a lack of professional, or even technical, personnel.

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<sup>28</sup> Deprofessionalization occurs when professionals experience a downgrading of skills, status, and economic security in response to changes in their environments and workplaces. The concept is more directly addressed in chapter 2's literature review.

### **Effects of Decentralization of the Mexican Healthcare System on Mexican Nursing**

Decentralization of the healthcare system is a process of government restructuring in which administrative controls redistribute from a centralized, federal level to the decentralized state level. Financing is shared between federal and state levels. Theoretically, decentralization allows states to more directly control and address healthcare problems within their jurisdictions. For decentralization to be successful, however, states must have personnel with high levels of technical and administrative competence to implement the restructuring changes. Even though documentary evidence from this study indicates the Mexican government planned to begin decentralizing the healthcare system before the 1982 crisis (Poder Ejecutivo Federal, 1980; Ruíz de Chávez, 1983), international institutions made the process a mandatory part of the strict economic reforms for the country that were implemented after 1982.

In addition to financial and organizational restructuring, providing continuing education (CE) programs for all healthcare workers and developing healthcare research capacity—critical components of the professionalization process for nurses—were two additional goals added to Mexican decentralization plans (Banco Interamericano de Desarrollo, 1986; Instituto Nacional de Administración Pública, 1987; Sordo Fernández, 1998; Subsecretaría de Investigación y Desarrollo, 1985). The following sections describe the implementation of decentralization and its consequences to Mexican nursing during Period I.

#### *Decentralization Implementation between 1980 and 1993*

The State initially viewed decentralization as a goal that would further the ongoing political agenda of maintaining the power of the ruling PRI party (Sordo Fernández, 1998). Decentralization, in theory, would increase the number of pro-party members working in the “field” and help solidify political support for the PRI. The economic crisis, however, forced the State to restructure the financing plan for the process and implementation began sooner than

initially anticipated, under the supervision of international institutions (Dirección General de Planeación y Presupuesto, 1984). A plan was developed that was extremely hierarchical and, of course, politically beneficial for the PRI. Quite unrealistically, a two year time frame for completion was set (Subsecretaría de Planeación, 1984d). Which of the thirty-one Mexican states became decentralized first reflects the politics of this period. The PRI chose states where their support was strongest, even if economic resources did not match popular support (SSA, 1984b). Eventually, working groups were formed in politically amenable and financially viable Mexican states, like Aguascalientes (CIFRHS, 1986).

Martini (1983), in an early analysis of decentralization policy, described decentralization as an attempt to diffuse the State agenda throughout the country under the guise of furthering democracy. Healthcare workers, according to Martini, were to become vehicles for delivering this message. The author expressed concern about this policy goal because she felt that many workers delivered the message of the State without fully understanding their sociopolitical role in its agenda. She further criticized the design of decentralization programs, which she believed centered on eliminating criticism of federal programs. The author's points are reinforced by a number of State documents about decentralization (Dirección General de Desconcentración y Modernización Administrativa, 1987; Poder Ejecutivo Federal, 1993; SSA, 1990).

Most decentralization guides produced at the federal level failed to account for a lack of administrative and technical capacity for the implementation process (Centro de Capacitación y Desarrollo, 1986b; Subsecretaría de Planeación, 1985a; Subsecretaría de Planeación, 1985b). Healthcare human resources guidelines for hospital management focus almost entirely on physicians (Centro de Capacitación y Desarrollo, 1986b). For the author, guidelines for nursing personnel proved difficult, if not impossible, to find.

Upon further examination of the status of nursing during the early stage of health-system

decentralization, it appears that in many respects the decentralization process of the HCS ironically caused an increase in the centralization of nursing services administration. With the elimination of the Chief Nurse position in the late 1970s (Navarro Salazar, Aoki Maki, Saavedra, & Espinosa, 1978), nursing had no centralized representation in the healthcare system and little to no representation at the State level. The State had to centralize (at the federal level) some aspect of the policy-planning process for nursing's development in order to implement decentralization of nursing personnel and nursing services in the country.

The only positive aspect of decentralization for nurses was the creation of new opportunities in primary care. Policymakers at PAHO touted the new role as opening new doors for nurses to exercise independent practice with increased autonomy and improved social respect (PAHO, 1990; Valdez de Reyes, & Garcia Jiménez, 1991; UANL-Facultad de Medicina, 1984). PAHO researchers also believed that the CE programs required by decentralization would help improve worker quality within an institution (McDermitt, 1984). Few positions for technical or higher level nurses, however, were created in primary care or community health services in Mexico

The fractured nature of experiencing decentralization as a nurse was best captured during the interviews. A nurse with over thirty years of experience working clinically and as a professor described her experiences with the decentralization process— which played out over nearly her entire career —like this:

Decentralization, for me, would imply, or rather, infer that one delegates knowledge, responsibilities, attributes, and resources; that there is support to do so you can build your own basic infrastructure, have a health center in a community that is so good, totally complete, with qualified personnel and everything. But those aren't the conditions. It's like saying, "Of course, we will decentralize! Do this and do that," but there is no support, no workers, nothing. It's absurd!

Her statement confirms what much of the present day literature, as described in the literature review, says about decentralization and neoliberal reforms: That implementation was uneven and

most Mexican states were not ready to handle decentralization because they did not have the financial nor human resources to follow through with the reforms.

Other decentralization documents from throughout the 1980s demonstrate that little changed from the initial decentralization plan and implementation was slow (Kumate Rodríguez, 1992; SSA, 1984b; Sordo Fernández, 1998; Subsecretaría de Planeación, 1988).

Decentralization would be a politically charged process (Soberón Acevedo, 1987; Sordo Fernández, 1998; Subsecretaría de Planeación, 1984a; Subsecretaría de Planeación, 1985c). Healthsystem leaders faced growing public criticism from physicians and nurses and resistance to the avalanche of economic and health-system reforms that were part of the strict economic reforms imposed on the Mexican government (Ravelo & Sánchez, 2001). Assuming political “buy-in” toward decentralization by physician and nursing groups facing severe economic losses proved to be a fallacy. The late 1980s saw numerous public protests organized by unionized physicians and nurses working for the State-run health-system, despite the fact that physicians held most of the power in the decentralization process. Demands included increased pay, improved working conditions, and reforms to the fiscal austerity measures imposed on the HCS that affected patient care (Ravelo & Sánchez, 2001).

In response to increasing physician resistance to decentralization, the 1989 annual activities report of the Secretary of Health quotes President Salinas saying the following about physicians and their role in “modernizing” the healthcare system:

For physicians, modernization will permit them to better realize the benefits of their important labor, to consolidate their responsibilities, and to ensure their position of respect in the community and fortify their ability to socially advance in Mexican society (SSA, 1989a, p. 1).

Salinas emphasizes the economic security that modernizing the HCS would purportedly bring to physicians, an important point to reinforce at the end of a period of economic upheaval. He also weaves class mobility language into the statement, reinforcing the perception that physicians

belong in the highest classes of Mexican society. Nurses were never mentioned and Salinas' statement about physicians highlights the power differences between physicians and nurses within the healthcare system. His failure to include nurses in his political thinking is one representation of how the State repeatedly excluded Mexican nurses from the policymaking process.

### *Invisible Nurses*

Physician roles, reflecting their political and economic power within the ministry of health, are mentioned regularly in decentralization plans (Subsecretaría de Planeación, 1985a). Almost always, a physician's authority and ability to carry out said plans is assumed in the documents. As documents regarding federal-level human resources planning for decentralization reveal, however, Mexican nursing was virtually absent from federal or state level policy planning at any point between 1980 and 1993 (Álvarez Manilla, 1983a; Álvarez Manilla, 1983b; Marin Palma et al, 1992; SSA, 1983; Valdés Olmedo, 1987). In total, 52 primary government documents related to the decentralization of the Mexican healthcare system were obtained. Of these, thirty-four documents dealt directly with the topic of decentralization, while the remaining 18 indirectly referred to decentralization as part of the overall report. For the majority of the primary documents about decentralization, it was difficult to even find the word "enfermera." In all the annual "state of the nation" reports from the executive office, nurses are only mentioned as numbers and never directly referenced as part of the decentralization process (Poder Ejecutivo Federal, 1984, 1985, 1986, 1987, 1988, 1989a, 1990, 1991, 1992, 1993; Salinas de Gortari, 1989; Salinas de Gortari, 1992).

Only five government documents related directly to nursing human resources development during the decentralization process (SSA, 1984a; SSA, 1985). Of the five documents, two were conference proceedings sponsored by the Instituto Nacional de Salud

Pública (INSP)<sup>26</sup> about developing public health nursing (PHN) services in Mexico (INSP, 1986, 1987; Subsecretaría de Regulación Sanitaria y Desarrollo, Dirección General de Enseñanza en Salud, 1987). Nurses presented their plans for developing PHN, including infrastructure requirements for building nursing research capacity, role expansion, and curricular changes (INSP, 1986, 1987).

In one of the few documents related to nursing and the decentralization process, a 1984 report by the SSA highlighted the political, regional, and economic factors that contributed to the state of nursing at that time (SSA, 1984a). Three pages of systemic deficiencies contributing to the poor nursing situation are outlined in the report. This outline provided an agenda for the development of Mexican nursing for the next decade. Nurses were made to appear as if they had been included in SSA policymaking and human resources planning, but this was not the case as the deficiencies in nursing care were not actively addressed until the late 1990s.

Overall, the State's HRH development goals as part of the decentralization process frequently did not align with the professionalization goals of nursing, as described by the leadership of the time (González Elizarrarás, 1987). Only three out of the eleven Mexican States initially targeted for decentralization created offices to address nursing issues during the implementation process (Guerrero Cansino & Capistran Ocampo, 1987). Two nurses captured the prevailing sentiment of the SSA during this period. Railing against the lack of nursing leadership roles and exclusion at the highest levels of government, they wrote, "...the positions, in their majority, are occupied by physicians because they do not believe that we are capable of making high level decisions" (Guerrero Cansino & Capistran Ocampo, 1987, p. 26). Thus, by not actually addressing nursing, the State's policy goals did not enhance the professionalization

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<sup>29</sup> National Institute for Public Health. Equivalent to the U.S. public health services and the public health research branch of the United States' National Institute for Health.

of nursing during this period.

### *Continuing Education*

For professionals, continuing education (CE) programs are necessary to maintain knowledge and keep clinical skills current. Research develops their professional knowledge base and helps justify the services they provide. Both CE and research development (discussed in the following section) were key goals of the decentralization process, but the State did not include nursing in those plans.

In Mexico, CE courses created specialized training for nurses (i.e. pediatrics, ICU), increased the specialized nature of institutional care in Mexico, generated horizontal career paths for nurses, the opportunity to make more money, and became viewed by nurses as a professional responsibility (Balseiro Almario, 1990; Romero Aldana, 1989). The State initially viewed CE for professionals as an added expense and did not invest in those programs early on. It did not consider CE offerings as a mechanism for facilitating institutional cultural change or internal capacity building.

In the context of economic crisis, however, for the Mexican State CE courses provided a low-cost excuse to for ignoring investment in professional education and other parts of the education system that could have contributed to improved healthcare human resources production capacity. What little investment there was in professional development focused on developing graduate education programs for building research capacity (SSA, 1987). Instead, CE programs served as part of the agenda for advancing decentralization goals in the workplace (Rico Avila, 1984; Valdés Olmedo, 1986).

As with the rest of the decentralization process, the SSA did not have the capacity to widely provide CE programs to healthcare workers at the federal or state level. Only one document produced by the State publicly acknowledged this institutional incapacity

(Subsecretaría de Regulación Sanitaria y Desarrollo, Dirección General de Enseñaza en Salud, 1987). Of the programs that existed, most remained concentrated in Mexico City, a finding contrary to the goals of achieving a decentralized health system.

The SSA rarely offered courses relevant to nurses or nursing practice as capacity-building plans from the period demonstrate (SSA, 1992b). On average, only 23% of CE programs were specific to nursing's developmental needs, despite the fact that nurses represented over 60% of employees in the system (IMSS, 2000). No curricula specific to different kinds of human resources or explanation of topic selections were found. Since the implementation of decentralization was uneven at best, documents rarely indicated which Mexican states would be required to implement the selected topics (Departamento de Capacitación y Desarrollo, 1987; Poder Ejecutivo Federal, 1989b; SSA, 1988; SSA, 1992a; Subsecretaría de Planeación, 1984c, 1986d). Program evaluations to determine the efficacy of educational offerings were nowhere to be found. Nurses, through the CNE, were unable to offer CE courses outside of the healthcare system because they did not possess the financial resources to do so.

*Another Decentralization Goal: The Development of Research Capacity, Except in Nursing*

A primary goal of Mexican decentralization was the development of research capacity in the health system. Apparently, however, Mexican nurses were not included in this human capital development plan.

Salazar's (1987) historical review of nursing research in Mexico demonstrated that it was not a new phenomenon of the decentralization movement in the country. The seeds of nursing research were planted during the early 1980s prior to the economic collapse and implementation of decentralization (Ebensperger, 1980), not later on or as part of the decentralization process. Mexican nurses working in academic and administrative roles quickly tied the development of nursing research to capacity building within the nursing profession and improvements in quality

of care (QOC) (Hernández de Sandoval & Balseiro Almario, 1986; Hernández Torres, 1987; Salazar G., 1987).

Only in the early 1990s did nursing research begin to expand and become integrated into many nursing education programs (Contreras Garfias, 1991; González Morquecho, 1989; Medina Rocha, 1993; Meléndez Torres, 1991; Nájera Nájera, 1991; Saporeti, Almeida de Souza, Malgon Salazar, Nájera Nájera, de Escobar, Limarco, Manfredio, & Collado, 1991). Early nursing research topics included the impact of stress-filled work environments on nurses (León Montes, 1993; Piña Pinyero, Romero Pérez, & Flores Falla, 1989), the market for nursing work (Müggenburg R.V., Aldana Alcalá, & Casasa Garcia, 1991), nurse's knowledge about regulatory mechanisms governing their practice (CNE, 1992d), and for formal identification of barriers to development (CNE, 1992e).

The literature from this period indicates that Mexican nurses already had some capacity to conduct research relevant to their profession and patient care. Yet the lack of nurses participating in research capacity-building efforts that were part of decentralization goals was yet another way in which nurses were excluded from decentralization efforts (Interview with Nurse 22). Nonetheless, despite this oversight Mexican nurses took it upon themselves to develop research capacity within their own profession because it contributed to their professionalization efforts.

### **Perspectives of Nurses**

Profession-specific knowledge is one of the criteria that marks a profession. What nurses wrote about professionalization during 1980 through 1993 capture the challenges and their experiences in the system during this time. A synthesis of the proceedings from the two conferences about nursing held during that period and the 81 nursing journal articles relating to

professionalization and published between 1980 and 1993 illustrates their perspectives. Of note, 46 of the journal articles were published between 1990 and 1993. Documents from PAHO are also included.

Literature from the start of this period reflects a tone of optimism regarding the growth and development potential for Mexican nursing during the next decade. Their goals centered on improving professional infrastructure to foster advancement within the profession, integrating market-based structures to increase economic opportunity, improve the public image of nurses, and change nursing's focus to a more patient-centered approach to care delivery (Arango de Bedoya, 1980; Avila Jiménez, 1981; Cortés Ramírez, Villareal Guzmán, Martínez Benítez, Guerrero Hernández, & Padilla Hernández, 1981; Nájera, 1981; PAHO, 1980; Roberts, 1980; Sosa Vázquez, 1981). Improving the professional infrastructure of the group was one solution posited to help resolve those problems.

Aspects of Mexican culture related to female education, women working, and female roles in society in a context of economic crisis altered the development of the profession by changing the social concepts about women of most classes in these situations (Avila Jiménez, 1984; Balseiro Almario, 1988; Piña Osorio, 1984). The crisis forced nurses to recognize the inescapable connection of their service to society and the effects of the economic and political conditions on the development of the profession (Antiga Trujillo, 1982; Avila Jiménez, 1984; Balseiro Almario, 1988; Hernández de Sandoval & Balseiro Almario, 1986; Hernández de Sandoval, Rivadeneyra Hernández, Ramírez Sánchez, & Zambrana Castañeda, 1987). It also spurred the first wave of nurse migration from Mexico to other Spanish speaking countries (Balseiro Almario, 1988) and decreased knowledge production by nurses during this time (Chacón, 1990).

Despite the economic upheaval, nurses continued the professionalization process albeit

at a slower rate than before. Barriers to professionalization from outside the profession included a lack of representation at high levels in the HCS, struggles to improve autonomy in governance, low salaries, heavily imbalanced skill mix with a bias toward non-professional personnel, and the need for reorganization of nursing roles throughout the entire system (Antiga Trujillo, 1982; Arellano Díaz, Bautista de Patiño, Campillo Hernández, Cervantes Mota, Domínguez Hernández, Durán, Granados Frías, Gutiérrez Raygoza, Herrera Martínez, Holguín Calzada, Martínez Sandoval, Ortiz Vázquez, & Vargas Garcés, 1987; Avila Jiménez, 1983; Balseiro Almario, 1988; de la Torre, 1985; Maldonado Escamilla & Badillo Sánchez, 1987). As the economic crisis shifted many Mexican households from single to dual incomes, Mexican nurses sought to upgrade their skills through the creation of new executive roles, specialized practice, and career paths (Balseiro Almario, 1987; de la Fuente Rocha, 1987; INSP, 1987; Martínez, 1985; Morales Valdez & Chavez Villanueva, 1987; Ortega Velázquez, 1987; Ortega Velázquez & Garcia Durán, 1987; Rosales Rodríguez & López Andrade, 1987). Leadership development in the profession suffered because the economic demands of the crisis curtailed the time nurses might otherwise have used to develop these skills (INSP, 1986; Mayer Celis, 1987).

By the end of the 1980s, the country began slowly evolving from a state of economic crisis to one of greater stability. Many of the nursing journal articles of the late 1980s and early 1990s contained a pro-State tone that was supportive of decentralization and its goals, even if they did not include nursing's participation in the process beyond working in primary care (Alvarado Ramírez, Campos Bravo, Casimiro González, Tobias Garcia, Diaz Jiménez, Hernández Arrendondo, & Mora Zarate, 1991; Aoki Maki, 1990; Medina Rocha, 1993; Sánchez & Maya Morales, 1990). Others began seeing the root of many of nursing's problems as the State itself (Mejia Zepeda, 1990). This contrast highlights the sometimes precarious position of nurses who were working as employees of State run institutions while trying to maintain their

individual professional identities.

With a sense of economic stability returning, nurses increasingly wrote about professionalization concepts in their professional journal publications starting in the early 1990s. Articles focused on how professionalization could be used to build capacity within nursing and address some of its problems (Arroyo de Cordero, 1991a; Arroyo de Cordero, 1991b; Babb Stanley, 1989, 1991). Membership in the Colegio Nacional de Enfermeras (CNE) was stressed as an important part of professionalization. Increased economic stability allowed more nurses to join (CNE, 1992a; de la Fuente Rocha, 1991a). The concept of autonomous, private nursing practice was brought up for discussion in the Mexican nursing discourse for the first time (Gutiérrez Raigosa, 1993).

#### *Nursing Education in the Midst of an Economic Crisis*

Commentary by nurses about nursing education indicated they faced several key educational challenges relevant to professionalization between 1980 and 1993. These included autonomy in educational governance, issues with the socialization process, and new challenges for educating in an international environment.

Autonomy in the governance of nursing education had increased as 63% of nursing schools in Mexico during this period were run by nurses, but only 46% of faculty were nurses (Avila Jiménez, 1984). The rest of the faculty could be a mix of physicians or other individuals with bachelors or graduate degrees in any discipline. Faculty shortages caused by nurses lacking funds to return for BSN-level education or higher also complicated the educational process at this time (Alvarado Cardona, 1985; McDermit, 1987).

Nurses also acknowledged that their socialization process created workers embedded with traditional Mexican social values about women, which meant that they focused on the completion of tasks and following orders without question (Bautista & Rodriguez, 1986; Ocaña

C., 1985; Soberanes Velázquez & Martínez Martínez, 1987; Villela Rodríguez, Cruz Colunga, Saucedo Ramos, & Meléndez Torres, 1987). Working within a rigid educational model, their own faculty reinforced these social values, contributing to high attrition rates and entry-level programs not designed to facilitate the technical or professional education of auxiliary nurses (Avila Jiménez, 1983; Avila Jiménez, 1984; McDermit, 1987; Piña Osorio, 1984).

Mexican nurses responded to these issues by developing empowerment plans for the profession. Educators added gender theory<sup>27</sup> into technical- and bachelors-level nursing curricula. Nursing professors viewed the theory as a potential framework for overcoming the gender dynamic challenges that were complicating the professionalization process (Hierro, 1990; Pérez-Gil Romo, 1993). Educational programs, with comparisons coming in from other countries, also improved their overall organization and faculty quality (Alatorre Wynter, 1993b; Cruz López, de la Cruz López, Mozquera López, 1992; Estudiantes de la Escuela de Enfermería y Obstetricia de Chihuahua, 1991; Garcia Contreras, 1991; Morán Peña & Espinosa Olivares, 1991; Muñoz Jimenez, Blanco Monje, & Arroyo Cabrera, 1991).

#### *International Influences*

International collaborations, long a part of Mexican nursing history, helped maintain professional infrastructure for Mexican nursing during the economic crisis. These collaborations came from many sources. Work to develop nursing regulatory mechanisms in the region came not only from joint efforts with PAHO, but also from the Kellogg Foundation (CNE, 1989, 1992b, 1993; Gomez Flores, 1991; León Gomez, 1990; Reyes Camacho, 1989; Sanchez Bringas, 1991). The effort attempted to help nursing in the region meet the “trait” characteristics of

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<sup>30</sup> Gender theory was not newly introduced at this time. High level professors in the best nursing programs in the country studied gender theory in relation to nursing starting in the 1970s and in concert with the Mexican women’s movement. The delay of formal integration of gender theory into nursing education probably resulted from the economic crisis.

professions, like licensure and improving regulation of the profession.

The coming of NAFTA generated a new level of international consciousness among Mexican nurse leaders. Comparisons with nursing in other countries became common (Garzón Alarcón, 1990; McDermit, 1991; Saporeti et al, 1991) and provided the impetus for nurses to create their own national development plans independent of the State (Hernández Guerrero, 1990). Mexican nurses, drawing on trends in Western nations, also introduced the language of quality of care (QOC) in the literature of this time (CNEES, 1993; Escoriza Juárez, 1993; Navarro Salazar, 1992)

### **Summary of Findings from Period I: 1980-1993**

The content and context synthesis of primary documents and other materials from this study demonstrate several important findings. First, economic collapse hinders the rate of professionalization in female-dominated Mexican nursing because it is tied to women's ability to harness economic resources to promote the growth and development of their profession.

Second, State economic and health-system restructuring policies in response to economic collapse contributed to the deprofessionalization of Mexican nursing. Nurses, despite representing 60% of the health-system workforce in Mexico between 1980 and 1993, were marginalized during the planning and implementation of the decentralization of the HCS in Mexico. This exclusionary trend results from physician dominance within the system, but is also rooted in the social, class, and gender characteristics of Mexican nurses. Yet Mexican nurses felt that the State's support for their professional development goals played a key role in the success of the profession (Soberanes Velázquez & Martínez Martínez, 1987).

The results from this period demonstrated that nurses recognized some factors in their development as beyond their control. The developmental factors within their control— the

education and socialization of new nurses obtaining formal education –became the focus at this time.

## **PERIOD II: 1994 TO 2000**

### **NAFTA, THE PESO CRISIS, AND JUMP-STARTING PROFESSIONALIZATION**

With the turmoil of the 1980s behind them, the mid- and late 1990s proved to be a transformative decade for Mexican nursing. This section illustrates what happened when the State was forced to examine the status of nursing in response to the development of trade agreements. It shows how this new level of attention allowed Mexican nursing to ride out the latest economic shock wave, instead of drowning in it. It will also describe key trends influencing nursing during this seven year period.

#### **The North American Free Trade Agreement (NAFTA) and Mexican Nursing**

Policymakers in Canada, the U.S., and Mexico established NAFTA to reduce or eliminate trade barriers among the three countries (Arboleda Florez et al., 1995; Frenk et al, 1994; Gómez Dantes, Frenk, & Crus, 1997; Sebastian & Hurtig, 2004). Part of the agreement includes trade in services where there are provisions for nurses to obtain trade negotiation visas to work in one of the three countries. After two decades of exclusion, Mexican nurses, along with their other North American counterparts, were included in the process for creating the trade-in-services sections of NAFTA (Alatorre Wynter, 1995; TINAN, 1996) — a first for Mexican nurses.

Primary sources and nursing materials confirm that NAFTA and its implementation generated a federal-level incentive to evaluate the state of nursing in Mexico. With NAFTA's implementation, the State increasingly crafted policies that supported the professionalization

process for nurses as a way to increase Mexico's international competitiveness in trade-for-services (Frenk, Gómez Dantés, Cruz, Chacón, Hernández, & Freeman, 1994; Gómez Dantés, Frenk, & Cruz, 1997; SSA, 1996, 1997; Sociedad Mexicana de Salud Pública, 1997). The new technologies for health services delivery—like laparoscopic surgical equipment—promised by NAFTA added additional incentives for the State to professionalize nursing services as the operations of these new technologies were believed to require a higher level or quality of education than many healthcare professionals possessed at the time (Frenk et al., 1994; Gómez Dantés, Frenk, & Cruz, 1997; IMSS, 1996).

NAFTA also facilitated the reintegration of the nursing profession into State policy making processes. These policies included improving standards for entry-level education, increased support for continuing education, the creation of new financial and other incentives for nurses to pursue vertical education moves instead of lateral ones, and the promotion of licensure and certification for nurses (Anonymous, 1995; Arroyo de Cordero & Rubio Domínguez, 1994; de la Fuente Rocha, 1994b; M. Delgado Choreño, 1999; B. Delgado Choreño & Camacho, 2000; Moriel & Gallegos, 1994; Rubio Dominguez, 1994; Zárate Grajales, 1994). The professionalization process, however, remained a gender-infused fight for nurses as they constantly faced challenges from the male physicians and administrators dominating the system (Alatorre Wynter, 1997; Arroyo de Cordero, 2000).

An important contribution of NAFTA to the professionalization of nursing was the effect it had on increasing the number of nursing programs in the country. A three-country analysis comparing basic nursing educational programs revealed serious deficits in Mexican nursing education (TINAN, 1996). This spurred changes in educational standards for Mexican nursing and increased the number of programs in the country. Figures 4 (see page 127) and 5 (see page 128) provide the evidence for this trend as prior to 1994, there were approximately 253 nursing

programs in the country (SSA, 1994A). Yet by 2005, there were 503 with 100 of those providing BSN-level education (Arroyo de Cordero, 2005). Growth in nursing education programs, however, did occur without the presence of educational standards or accreditation programs; therefore, the quality of these programs varied widely.

### **The 1995 Peso Crisis: Surviving the Shockwave**

The peso crisis was far more short-lived than the crash of 1982. A pediatric nurse in the study with fifteen years experience, who was pursuing a master's degree at the time of the study, described the 1995 peso crisis as "...the moment when everything stopped."

From 1994 to 1995, due to the peso crisis, healthcare financing within the Instituto Mexicano de Seguro Social (IMSS) was reduced by 89.5% (Poder Ejecutivo Federal, 1996). These cuts were echoed in the other parts of the healthcare system, which effectively froze its operations. Its effects on nurses proved dramatic as enrollments in nursing schools dropped by 50% or more (Müggenburg, R. V., Castañeda Sánchez, & Franco Paredes, 2000; Vargas Daza & Solis Guzmán, 1997). Again, nursing salaries froze while inflation soared.

Nonetheless, the professional development impetus created by NAFTA in the early 1990s provided a bulwark against the economic shockwave. The infrastructure investment (prior to the 1995 crisis) by nurses and Mexican authorities in the profession, in the form of strengthening the CNE and increasing technical-level and graduate education, proved beneficial in that respect.

### **Important Development Trends**

After the peso crisis, development of the nursing profession in Mexico continued to accelerate for the remainder of the twentieth century. The following sections highlight the

effects of international exchanges on the development of Mexican nursing, changes to nursing education, efforts to combat issues related to the public image of the profession, and the influence of a variety of political actors on professionalization during this period.

### *International Exchanges*

Historically, international exchanges were always used to help build internal capacity and leadership for Mexican nursing (Álvarez Gutiérrez, Bojalil, Fajardo Ortiz, Fujigaki Lechuga, Guerra de Macedo, & Pérez Loredó Díaz, 1995; Pérez Loredó Díaz, 1995). Mexican nurses capitalized on the increased international exchanges generated by NAFTA and new-found institutional support by implementing new models of care at the institutional level (Cuevas Nuñez & Castelazo Ayala, 1995; Espino Villafuerte, 1994; Ibarra Castañeda & Yarza Solórzano, 1999; Morán Aguilar & Mendoza Robles, 1994). The diffusion and integration of quality-of-care (QOC) processes into institutions and nursing culture also became part of the dialogue that nurses did as part of NAFTA's development (Castro Meza Amada, Alvarez Estrella, Arias Vázquez, Botello Zuñiga, Niehus Verdugo, & Vázquez Armendariz, 1998; Garcia Jiménez, 1994; Ibarra Castañeda, 1994a; Ibarra Castañeda, 1994b; Ibarra Castañeda, 1994c; Valencia Pérez, 1997). A cultural coalescence<sup>28</sup> of knowledge transfer and adaptation of nursing theories developed in the U.S. and United Kingdom to Mexican nursing exploded during this period (Antiga Trujillo, 1996; Castillo, 1998; Collado Soto, 2000; Garrido Abejar & Serrano Parra, 1994; Martínez de Dávila, 1999; Mora Carrasco, 1994; Nava Ramírez & Cabello Bonilla, 2000; Sánchez Piña, 2000).

Effectively, comparative analysis of nursing's status domestically and in other countries

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<sup>31</sup> The concept of cultural coalescence in knowledge transfer was first described by Hodgdon (2000) when examining how Mexican feminists adapted feminist theories produced by Western feminist philosophers to women's issues in Mexico. He defines "cultural coalescence" as the process whereby a group takes knowledge gained from another location and adapts it to its own social norms. For knowledge transfer of Western nurse theories, concepts, and models of care, it works very well.

became “normal” in Mexican nursing. Many Mexican nurses used the period to reflect critically on the process of professionalization and how it should take place in Mexico (Arroyo de Cordero, 2000; Durán López, 1999; Martínez, 2000). The work of PAHO, WHO, and ICN during this time also supported this new dynamic and would serve as a standardizing, neutral voice to clarify various aspects of nursing and its roles (Capistran Ocampo, 1997; Comité de Expertos de la OMS, 1996; CNE, 2000c; Gutiérrez Raigosa, 2000).

### *Education*

Mexican nurses began discussing increasing nurse autonomy through elevated entry-level educational requirements, the concept of independent practice, primary nursing roles, and the reclaiming of public health nursing as part of the professionalization dialogue that started during the mid-1990s (Arroyo de Cordero & Rubio Domínguez, 1994; Castrejón Huico, 1995; Ibarra Castañeda, 1995; Marín Chagoya, 2000; Morales Rodríguez, 2000; Rodríguez Romero, 1997; Thompson, 1997). To facilitate the transition from technical degree programs to BSN programs, nursing schools began sharing their curricula in the literature to help other schools with the process (Castro Ceja, 1994; Espino Villafuerte, 1999; Marrufo Valles, 2000; Nájera Nájera, 1994; Paredes Breña, 2000; Pérez Camargo, Pérez Luna, Sánchez Arroyo, Cruz Granados, Pérez Estrada, & Ruiz Samorano, 1996; Ponce Cortes & Quesada Fox, 1994; Rosales Rodríguez & Palazuelos Lacaille, 1997). Mexican nurses began to realize that becoming a “true profession” —which they defined as universal entry at the BSN level—was a reality they could aspire to for the future (Silva Luna, 1998).

Nurses also began to examine where nurses worked after graduation and reasons for the high attrition rates in their programs. Demonstrating acute insight into her profession and the constraints it faces in Mexico, Cabello Bonilla (1998) attributed high attrition rates and failure to complete continuing education programs to a variety of sources all affected by the same

institutional dynamics of change that evolved from the economic reforms of the 1980s. She wrote:

...the extent to which maintaining qualifications for practice is less and less a responsibility of the employer...costs and requirements for practice that have been passed on to the employee...[In order to] to compete in a modern work environment that requires continuous training/work/ certification, this results in an increasingly complex system for professionals to access education and requires that institutions adapt to these new demands (p. 5-6).

According to studies conducted by Mexican nurse researchers, family demands and financial difficulties were the top two reasons for dropping out of technical or BSN programs (Sánchez de León & Castro Ibarra, 1996; Uribe Calderón, 1997; Vargas Daza & Solis Guzmán, 1997). Additional research by Müggenburg R.V., Castañeda Sánchez, and Franco Paredes (2000), who examined the nature of nursing work and the barriers and facilitators to achieving higher levels of education, helped to further explain the high attrition rates from Mexican nursing programs during the 1990s.

In concert with Cabello Bonilla's (1998) insights into the institutional barriers facing nursing's development, discussions about increasing graduate-education options for nurses also entered the professional dialogue of the time. Nurses agreed that the promotion of graduate education for nurses had to be tied to a flexible education process that took into account the variety of educational levels Mexican nurses possessed (Castillo, 1998; CNE, 2000b; Morán Peña & Piña Jiménez, 1997). Mexican nurses' research also demonstrated that graduate education benefitted patients and the profession because these nurses conducted more research as part of their roles, served as educational resources for less experienced or educated nursing staff, and further developed specialized clinical practice (Martínez Márquez & Salazar González, 1999).

### *Research*

Since the production of research is part of knowledge created by professionals, nurses began to examine barriers and facilitators to the conduct of research by nurses (Cabrero Garcia,

2000; Méndez Villa & Quintero Crispin, 1999; Morán Peña, 1997; Rodríguez Domínguez, 1997). Their work demonstrated that research production in nursing coincided with economic fluctuations and that financial support for this kind of work was limited (Meigarejo Silva, Hernández Tapia, & Palazuelos Lacaille, 1996; Müggenburg R.V. & Aldana Alcalá, 1996). Non-nurse researchers also began integrating nurses into the research process, usually in data collection roles as in the 1996 study by Waitzkin, Cabrera, Arroyo de Cabrera, Radlow, and Rodriguez about trends in Mexican patient-physician communication.

For Mexican nurses, linking research with the decentralization process became a politically viable way to advocate for research specific to their profession. With the advent of NAFTA, Mexican nurses also tied increasing their knowledge base to staying competitive because their North American counterparts had greater levels of professional autonomy (Arroyo de Cordero & Rubio Domínguez, 1994).

### *Image of Nurses*

In their nursing journals, Mexican nurses first tied their developmental challenges to their public image in the late 1980s. Initial reflections showed how the economic crisis affected nursing's public image and began spurring a migration of professionals, as this quote from Balseiro Almario (1988) demonstrates:

...the economic crisis in which we live along with the mass unemployment transfers to professionals, too, and generates what could be considered a necessary migration of Mexican nurses to other countries...This circular chaos diminishes our professional identity and is demonstrated by student and nurse dissatisfaction in the workplace (p. 22).

Clearly, Mexican nurses saw a connection between professionalization and an improvement in their public and internal group images. The first article about the concept of professionalization appeared in the Mexican nursing literature in 1989 and was written by a nurse working for PAHO (Babb Stanley, 1989). The author wrote that the breaking of routines, critical thinking,

and constant evaluation of performance were fundamental to professionalization. These changes to clinical practice would help improve the public image of nurses.

After the PAHO nurse's article, there was a shift in the nursing literature. Mexican nurses started to link the public image of nurses to professional traits and this trend continued throughout the 1990s. Unity within the profession, increased standards for education and care delivery, higher salaries, a single level for entry into the profession, and increasing economic security were the consistent aims that nurses saw as key to improving the public image of nursing in Mexico (Guevara & Mendias, 2001; Hernández Guerrero, 1990; Hierro, 1990; Medina Rocha, 1994; Ostiguin Meléndez, Velázquez Hernández, & Gómez López, 2001; Paredes Breña, 2000; Pérez Camargo et al, 1996; Pérez-Gil Romo, 1993; Ramírez Díaz, 2005; Rojas Ortíz, Mandujano Garrido, & Villegas Romero, 2001; Valdez de Reyes & Garcia Jiménez, 1991). Focusing on these factors, nurses thought, would also increase their autonomy in practice and as a professional group (Comité de Expertos de la OMS, 1996; Ibarra Castañeda, 1995). All of these public-image issues described by the nurses in their journal publications, however, were connected to the challenges of being female in Mexico and factored into how nurses thought the image could be positively changed within Mexican society (Casique Casique, 2000; Martínez, 2000; Ramírez Díaz, 2005; Ostiguin Meléndez, Velázquez Hernández, & Gómez López, 2001).

Also during the post-NAFTA period, researchers found that nurses working in hospitals reported an increase in positive perceptions on the part of nurses about their profession (Cárdenas Maldonado, 2001), indicating that a shift had begun within the profession itself, if not in society. Another study about one cardinal nursing symbol, the white cap, further explored nurses' attachment to this traditional piece of their public image. Cárdenas Becerril et al (2000) studied 252 Mexican nurses and the use of the traditional nurse's cap as part of the uniform. They found most nurses wanted to get rid of this traditional element of the uniform, mostly

because it interfered with their ability to work. The technology influx into the acute care work environment, facilitated by NAFTA, changed the nature of the work environment and contributed to the nurses' willingness to remove this traditional symbol for the sake of facilitating their work on a practical level.

Finally, an improved group image became central to Mexican nurses' ability to increase their political power (CNE, 1992a; Comité de Expertos de la OMS, 1996; Guevara & Mendias, 2001). Even the Mexican State recognized that the poor public image of nurses contributed to deterring people from choosing the profession as a career (SSA, 1994c). It is not surprising that this recognition came with the implementation of NAFTA because the State now had an incentive to examine the nursing profession within its own borders.

#### *Activities of the CNE*

The professional nursing organization serves as a political representative and formal organizing entity for the group. In effect, it provides centralized administrative services for managing the profession.

The CNE lost membership and influence during the 1970s due to economic crises. The early 1980s, before the late 1982 crisis, allowed them to regain some influence with a reorganization that created five hierarchical levels in the chain of command. The CNE moved toward unifying nursing with a single agenda of inclusiveness and the goal of increasing the visibility of nursing and its role in Mexico (Navarro Salazar, 1981). They continued transmitting the policy priorities of the International Council of Nurses and showed how they could be adapted to the Mexican context (CNE, 1980). The strength of state level chapters of the CNE would vary throughout this period based on their organizational and local nursing history (CNE, 2002; Saldaña Rivera, 1988).

Nurses participating in the interviews who practiced during the 1994 to 2000 period

unanimously agreed that the CNE was highly effective as an organization during this period. Strong leadership in the professional organization was the single attribute they all named that made this such a productive period. The literature supports their statements.

During the 1990s, the CNE outlined clear development plans for the profession by focusing on developing the traits associated with professional infrastructure, specifically focusing on standards, licensure/credentialing, and the development of state-level chapters of the organization (Camacho Solis, Barcena Nárvaez, & de la Fuente Rocha, 1994; CNE, 1998b, 2002; de la Fuente Rocha, 1994a; Gutiérrez Raigosa, 2000; Navarro Salazar, Cárdenas Becerril, & Vázquez Domínguez, 2002). It continued its central role in disseminating the ICN's policy recommendations in Mexico, including the first notices about the global nursing shortage and the implications for nurse migration (CNE, 2001; Gutiérrez Raigosa, 2000).

The CNE also increased their collaboration with federal entities that focused on the development of professions in Mexico (CIE, 2001b; CNE, 1998a, 2002). Early on, Zarate Grajales (1994) differentiated the roles of the State and the CNE in the professionalization process. As a result and consistent with their decentralization policies, the Mexican State opted not to manage the national nursing licensure and credentialing system and placed that responsibility on the CNE (CIE, 2001b; CNE, 2002). Organizing the system this way benefits both the State and the profession. It provides the State with a decentralized management approach in the hands of professional experts. The CNE then has a mechanism by which it can generate revenue to support its professionalization and political activities. The Internet made this possible because the entire process is designed around Internet-accessible entry into the CNE's licensure management system, thus eliminating the centralized access issues most nurses faced for credentialing.

Yet despite the efforts in the 1990s, the CNE of the twenty-first century remained

plagued by low membership rates and perceived inefficacy among Mexican nurses (Martínez de Dávila, 1999; Navarro Salazar, Cárdenas Becerril, & Vázquez Domínguez, 2002). These problems became complicated by internal political divisions within the CNE itself during the early twenty-first century as yet again, the CNE suspended publication of its journal due to financial and political difficulties within the organization. With the implementation of the new credentialing system in 2006, however, it will be worthwhile to study how the CNE fares as an organizing entity.

*The State & Professionalization between 1994 and 2000*

NAFTA put the professionalization of nursing on the State's political radar and continued its strong role in shaping the professionalization process in nursing (Cabello Bonilla, 1998; de la Fuente Rocha, 1994b). This was part of a larger policy initiative to professionalize State workers in Mexico during the Zedillo administration.

Professionalization language was found more frequently in national state-of-the-union reports after the implementation of NAFTA. The Zedillo administration used the term "professionalizing" or "professionalization" of government employees in every annual report published during his term (Poder Ejecutivo Federal, 1995a, 1995b, 1996, 1997, 1998, 1999, 2000a, 2000b). By 1997, the State viewed professionalization as a means for reducing corruption in the country (Poder Ejecutivo Federal, 1997). PAHO also supported professionalization efforts as a way to better distinguish service delivery roles in healthcare systems (Informe de un Grupo de Estudio de la OMS, 1996).

One key trait of professions is the presence of an ethical mindset, at least when a written code of ethics is not present. With the integration of professionalization language into State documents came an increased discussion of ethics and human rights in the healthcare arena. The Comisión Nacional de Derechos Humanos (CNDH) compiled a document outlining the failures

of the State in the delivery of healthcare to the population and concluded that the State had violated the average Mexican's basic human rights (Garcia Romero, Cano Valle, Cordera, Hernández, Moreno, Ponce de León, & Vargas, 1996). The document highlighted, for example, nurses' lack of the supplies they needed to perform their work as one of many examples of these violations.

In turn, the support for professionalization from multiple analyses from various State entities benefitted Mexican nursing in a variety of ways. The State solidified the development of the national nursing human resources database in the SSA, known as the Sistema de Información Administrativa de Recursos Humanos en Enfermería (SIARHE)<sup>29</sup> (SSA, 1994c, 1999). Salaries began to increase in 1998, by as much as 54% per year,<sup>30</sup> and both national and state level commissions were developed to address nursing issues at their respective levels (Poder Ejecutivo Federal, 1999; SSA, 1997).

From a leadership perspective, Zedillo, like his predecessor, also addressed healthcare workers and the topic of healthcare in a series of speeches. Unlike his predecessor, however, Zedillo regularly mentioned nurses in his speeches to healthcare workers and recognized the value of international exchanges to promote development of the professions (Zedillo Ponce de León, 1996). The document analysis results indicate that support from the State— through public recognition, diversion of resources, etc.— for professionalization promoted a culture among professionals to reach for higher levels of development.

At the same time, the State continued its policies of recruiting low-level healthcare workers into the HCS. In a policy shift, however, the State moved away from recruiting

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<sup>29</sup> System for Administrative Information about Nursing Human Resources.

<sup>33</sup> The document broadly references a 54% salary increase for healthcare workers. How much nurses actually benefitted from this increase is unclear in the annual federal report or in the literature elsewhere.

auxiliaries into the acute care setting and focused on the recruitment of auxiliaries to work in the IMSS Solidaridad rural health services delivery system (SSA, 1994b; IMSS, 2000; Poder Ejecutivo Federal, 2000b). In eight years, Solidaridad recruited and trained 5,300 women to work in these positions (IMSS, 2000) while the Zedillo sexenio would add 51,000 healthcare workers to the system (Poder Ejecutivo Federal, 2000b). By providing jobs to females with low levels of education in rural areas, the State could orchestrate a cultural change with regard to females and work outside the home, along with fostering loyalty to the State and its policy initiatives. It did attempt to mediate, to some degree, the lack of education among rural healthcare providers by developing a rural social-service<sup>31</sup> rotation for nurses after graduation (SSA, 1996). Among their many responsibilities, the nurses working their social-service year helped to train rural healthcare providers.

Finally, when Mexican nurses wrote about their experiences as State employees, they were ever mindful of their position in the political arena. The tone of their articles, therefore, tends to be positive or supportive of the State's development agenda (Arroyo de Cordero, 2000; Cuevas Nuñez & Castelazo Ayala, 1995; Delgado Choreño & Camacho, 2000; Morán Peña & Piña Jiménez, 1997). This implies that nurses at the time had—and may still have—a complex relationship with the State. Since they often relied on the State for employment, nurses employed by State institutions might have been reluctant to publicly criticize due to fears of political retribution or exclusion from the policymaking process.

### **Summary of Findings from Period II: 1994-2000**

Key findings from this period are as follows. First, NAFTA proved to be a positive force

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<sup>34</sup> All Mexican healthcare professionals are required to complete one year of social service in an under-served area in their home state in Mexico. Many nurses are sent to rural areas and often experience more autonomy and responsibility in their first year out of school than they will in the institutional setting.

for the professionalization of Mexican nursing. The in-depth analysis of the status of Mexican nursing in comparison to its other North American counterparts spurred investment from the State into the profession. NAFTA reversed the exclusionary trend of previous decades by strengthening the role of nurses in the policymaking dialogue. With increasing economic stability after 1996, Mexican nursing began analyzing its own educational processes and public image in order to work on the internal aspects of professionalization. Finally, the CNE's strong leadership during this period facilitated the overall growth of the profession.

The findings from this section suggest that the State's role in incorporating nurses into the policy-making process serves as a positive developmental force. Strong leadership by the CNE facilitates professional growth by acting as an intermediary between the State and international entities.

### **PERIOD III: 2001 TO 2005 - POLITICAL EXCLUSION TO INCLUSION, CORRUPTION, AND THE EFFECTS ON PROFESSIONALIZATION**

Politics internal and external to the Mexican nursing profession affect the professionalization process. Previous sections demonstrated a systematic exclusion of nurses by the State from the policymaking process within the health-system. Using data from the interviews and documentary evidence where appropriate, this section highlights the present-day internal and external consequences of this exclusionary tendency to the professionalization process. It also describes the effects of Mexico's persistent corruption problems—a product of historical and political dynamics of Mexico—on the healthcare system. The final section discusses the development of regulations and formal credentials for Mexican nurses.

### **Health System Policymaking - Moving Toward Increased Inclusion of Nurses**

Because of the State's progressive elimination of nurses at high level government positions, it is not surprising that political approaches to resolving issues relevant to nursing were rarely mentioned by staff nurses or faculty during the interviews. The elimination of the Chief Nurse position in the late 1970s removed any political influence, however small, that nurses had in the larger decision-making process in the healthcare system. Subsequently, for more than two decades nurses had little or no opportunity for participation in the political process due to deliberate marginalization by political actors in the system (Marin Palma, Semano Sánchez, Morales Merino, Gómez Corona, & Alvarado, 1992). This generated a degree of political apathy among Mexican nurses.

Another possible cause of political apathy may be the electoral structures of Mexico. Voting fraud is an obvious cause of political apathy. At the same time, however, most elected officials in Mexico are limited to one three-year term. While the intent of the law is to reduce corruption by decreasing the risk of incestuous, long-term relationships forming among elected officials and powerful entities, it also does not allow for the development of constituent relationships.

One way nurses began to mediate their own political apathy was through research. According to Mexican nurses, research highlights knowledge deficits and makes knowledge tangible and usable by others, particularly government policymakers (Guillén Cadena, 2001; Meléndez Torres, 1991). Mexican nurses believed research as critical for fostering professional and role-based autonomy (Garzón Alarcón, 1990; Medina Rocha, 1993). Nájera Nájera (1991) boldly described the conduct of research as a political act because it produces evidence that can hold the State accountable for inaction around problems like poor quality of care. At the same time, González Morquecho (1989) believed research should be a part of basic nursing education

so that nurses could help the State to meet its goals for development. The contrasting views between the two authors reflect a repetitive theme throughout the study: The desire by Mexican nurses for greater accountability from the State for health services delivery and their own willingness to be a part of its political agenda.

The duality of views emerged in reality when policymakers integrated professionalization language into the State's national development policies. Nurses, on their own professionalization course, alerted policymakers to their own efforts and this helped improve the participation of nurses at the Federal level. With this new, mutually beneficial level of inclusion, Mexican nurses increased their work at the federal level of the SSA; politically, that became a better option for nurses wanting to create longer term change for the profession.

As an illustration, of the effectiveness of this approach, during the Fox administration, the Mexican minister of health Julio Frenk worked with nurse leaders to develop federal policies and documents that supported professionalization. Some of these included a written code of ethics, the licensure system that begins in 2007 and will be managed by the CNE, and the status elevation to "professional" pay category for BSN and higher prepared nurses (Boletín de Prensa, 2004). Since Frenk received his Ph.D. in health-systems administration from the University of Michigan and worked internationally, it is likely these experiences helped to shape his views of nurses and the potential professionalization had for developing their roles in the healthcare system.

Despite these new levels of inclusion and awareness of the importance of nurses in the SSA, it remains difficult for nurses to organize as a profession or to participate politically because of the competing demands experienced by Mexican nurses. On one side, it appears that statements—or the absence thereof—made by nurses in the interviews support Cleaves' (1987) findings that Mexican healthcare professionals tend to be politically apathetic. Yet the issue of

the multiple demands on nurse's personal lives may be the real cause inhibiting political participation. In addition, nurses made it clear in the interviews that they have few resources available to help them defend their rights in the workplace or in society. Many nurses also view political activism as a form of feminism that is contrary to their nursing role (Ravelo Blancas & Sánchez, 2004). All these factors, coupled with economic insecurity, contribute to their political apathy. Few are willing to risk their jobs—especially ones with a good salary who tend to be employed in State run institutions— to speak out politically because of the dependence of their families on their income.

### **Corruption**

One cannot refer to Mexican politics without discussing corruption. The corruption culture in Mexico grew from colonialist dynamics, a powerful elite that did and does whatever is necessary to maintain their economic and political dominance, weak institutional infrastructures, and a lack of popular or business incentives to combat corruption. Global Integrity (GI)<sup>32</sup>, an international anti-corruption monitoring group, rated Mexico overall as “weak” when it came to managing corruption in the country (Global Integrity, 2006). The GI also rated Mexico as the most corrupt of all Latin American countries at similar levels of development. Widespread corruption is an unfortunate part of Mexican history and is well documented in the literature.

The effects of health-system corruption on Mexican nursing practice is not as well understood and is subsequently not well documented in the literature. Corruption can affect professionalization by acting as a deterrent to entering in or staying in the nursing profession. As ground workers for the HCS, Mexican nurses frequently observe the problems with corruption in

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<sup>35</sup> GI provides unbiased information to the international community about governance and corruption trends in countries around the globe. Using well-tested research methods for assessing corruption at the country level, their ratings index is considered a solid indicator of corruption levels in a country.

the HCS. It pervades every aspect of a nurse's life, from the State to unions to the HCS (Gomezjara, 1984; Nájera, 1981). Nurses participating in the study frequently discussed corruption as a complicating factor in their ability to provide patient care. Frustration with system corruption, nurses reported, drove many of their colleagues out of the profession.

In the interviews, nurses described examples of corruption in the HCS through the hiring of unqualified bosses through political connections. They expressed frustration with the lack of law enforcement and reported abstaining from voting because of beliefs that the voting system is fixed for specific candidates. Nurses readily associated economic instability with a rise in corrupt practices in greater Mexican society. They attributed corruption to economic instability because it increases an individual's sense of desperation to meet the basic needs of their families and as a result, makes people more likely to adopt corrupt practices.

A male nurse with thirty years experience in administration and teaching, including two masters degrees, described how corruption happens among nurses in the HCS.

With the lack of supplies and resources, we become very savvy at getting what we need for our practice. We work at ISSSTE, we work at IMSS, we work at SSA, and we see the differences in supplies between each place. So, people take from one place of work and bring it with them to the next place of work so the patients at that job get what they need. This leaves one place with fewer supplies and having to compensate for these practices. It's a vicious cycle.

What is interesting about his statement is that nurses engage in corrupt practices to get patients what they need, yet the root of the problem is supply and financial mismanagement within the system.

On a larger scale, because of the pervasiveness of corruption throughout Mexican society, one goal of the decentralization process was to reduce corruption in the HCS (SSA, 1989a). Since the 1990s, the State made a variety of attempts to reduce the problem. For example, in the Zedillo administration, professionalization of government workers was viewed as one solution to reducing corruption among civil servants because professionalism requires a set

of behaviors grounded in ethical traits being a professional (Poder Ejecutivo Federal, 1997).

Nonetheless, the annual State of the Nation reports did not formally mention health-system corruption in any of the annual reports from the executive branch until 2001. The newly elected Fox administration emphasized transparency in government and tied this to the SSA's democratization theme for advancing healthcare in Mexico (SSA, 2001b, 2001c). Seeing ethics as a core component of reducing corruption and improving quality of care (QOC), the SSA used professionalization principles as a model for health-system decision-making and required the creation of codes of ethics for all divisions of healthcare workers (SSA, 2002, 2003). The SSA tied ethical practice to its goals for improving QOC delivered by the HCS (SSA, 2003).

Ahead of the SSA's goals, nurses in the Comisión Interinstitucional de Enfermería (CIE)<sup>33</sup> developed a code of ethics for nurses in 2001 a full year before the State made it a formal policy goal (CIE, 2001a). The capacity for its development came from the foundation provided by the ICN when it produced its international code of ethics for nurses in 2000, along with a textbook to provide an educational foundation for nurses (CNE, 2000a; Fry & Johnstone, 2002). Mexican nurses, in their own literature, consistently recognized ethical principles to guide behavior as a potential solution to corruption (Chamoro Juárez, 1990; Collado Soto, 2003; Hernández Velázquez, 1994; Nájera, 1981; Ontiveros Cerón, 2004).

Throughout the period of study, nurses considered one solution to HCS corruption— one in which many nurses participated—was the integration of humanistic philosophies into nursing education, care delivery, and health-system administration (Babb Stanley, 1994; de la Torre, 1985; Guzmán Vollalva & Tonis Mayen, 2001; Malvárez, 2002; Navarro Juárez, 1993; Suárez

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<sup>36</sup> Interinstitutional Commission for Nursing - Organized in 1996 by the Mexican State, it was unable to begin seriously working until economic stability returned to the country in the late 1990s. Since then, it receives support as a division of the SSA, thus reintegrating nursing into governance, policy, and decision making processes in the State. The CIE functions as a symbiotic but autonomous entity within the Ministry of Health.

Briseño, 1999; Valdivia Moreno, 2003). One OR nurse, after discussing politics and corruption during an interview, she began talking about humanism in medicine as an operating philosophy for Mexican nurses. Humanism possesses strong ethical components as its core tenets. The OR nurse described the importance of this philosophy to nursing when she was talking about her frustration with corruption in Mexico and how it effects nursing practice.

Our focus of work is the man and the woman, or the human being. If there were no human beings, we would have no work and no reason to develop the profession...Humanism is important for nursing, very important these days with all the problems in the world. We have to take it back, as human beings, as thinking beings, as beings capable of transforming society.

Her focus on the transformative nature of humanistic philosophy highlights the fact that to change the nature of corruption in Mexico, a social and political transformation by the people will be required. This nurse believed that humanistic approaches to care could help provoke change within nursing and in Mexican society.

### **Regulation & Licensure**

According to the trait theory of professions, two markers of professions include the presence of laws governing the scope of professional practice in a society and a licensure system. When done well, they can help monitor quality levels of professionals practicing in a society.

Mexican nurses' scope of practice is governed by an extensive series of laws that determine what each level of nursing role is allowed to do (Calderón Magaña, Garcia Ramírez, & Acosta Bernal, 2002; Cervantes Mota, 1978; de la Fuente Rocha, 1991b; Guevara & Mendias, 2001; Nájera, 1968, 1992; Sánchez Bringas, 1991; Valdéz M., 2001; Zárate Grajales, 1994). The enforcement of these laws at the institutional level, however, varies significantly. The CNA added another, much needed layer of regulation for all healthcare professions in Mexico in 2002.

For many years, Mexican nurses sought to create a licensure system for themselves. This

struggle began in the late 1960s (CNE, 2002; Nájera, 1968). Journal articles chronicle the struggle for developing a licensure system for Mexican nurses during the entire period of this study (Cervantes Mota, 1978; CNE, 1998a; Valdéz M, 2001). Only when the State had the political will to support the idea and provided technical support for its development did the Mexican nursing license become a reality (CNE, 2002).

Adhering to its decentralization philosophy, the non-mandatory nursing licensure system in Mexico began in 2007 and is managed by the CNE (CNE, 2002). It requires nurses to present their educational credentials, pay a fee, and take a test. The State and CNE maintain records of all nurses with licenses and the CNE keeps the fees. This will help the CNE to remain financially viable and less dependent on membership dues. While the overall structure is centralized, the CNE state nursing associations do not yet have the infrastructure capacity to manage the licensure system at the state level.

### **Summary of Politics and Its Effects on Professionalization**

Nurses in the study saw the potential professionalization infrastructure produces for supporting a political transformation within the profession. A technical-level staff nurse working for a government hospital for over fifteen years provided the following inspirational and insightful statement about political participation and its importance to Mexican nursing. Her acute insight into the inefficacy of political protests, a long standing form of political activism in Latin America, along with inclusion at the negotiating table with key HCS actors summarizes the importance of smart, strategic political participation and inclusion for Mexican nurses in the policy making process.

We are part of the political process. We are workers within a social group. We belong to the political process in the country. We have to participate in the political process in our country. Yes, yes! This is something in which nursing, in a place like this, is lacking: political participation. We must bring our coworkers to the legislature to see

what it is like. We must bring our coworkers in front of the congress, in front of government representatives, to lobby for resources for our profession, to lobby for resources for the hospitals. Just now they are starting this...But, we have to participate with understanding, with intelligence, and using strategy. We can't just be another group protesting, no. That is not political participation. We need to participate in the politics of work, of government; we need to involve everyone —patients, nurses, doctors, administrators, the state, and nation.

### **POLICY LEGACIES OF THE MEXICAN STATE**

Nurses consistently identified the State as an important factor in the history and development of nursing (Cerezo, Jones, & Gibbons, 1980; Meyer, 1980; Verderese, 1980). During the data-collection process for this study, two key State policy decisions during the 1970s were found to be significant contributors to starting the deprofessionalization of Mexican nursing which, as noted above, began in the 1980s and lasted until the early 1990s. Deprofessionalization occurs when a profession's growth is slowed or changed due to external circumstances. It assumes that professionalization is a non-linear developmental process, filled with peaks and valley. Abbott (1991) theorized that it is a normal part of the development of a profession. Documents analyzed for this study indicate that the deprofessionalization of Mexican nursing began in the 1970s and had two causes: policy shifts in public university admissions processes and health-system hiring practices.

The massive student movement of the late 1960s generated a federal policy shift in the rules regarding the public university admissions process. This, in turn, led to a rapid increase in the number of medical school graduates during the 1970s and succeeding decades (Frenk et al., 1995; Lorey, 1993). The student movement forced the federal government to create a more open admissions policy in all of Mexico's public universities (Lorey, 1993). Until then, education served as a demarcation line between the elite and upper classes of Mexico and everyone else. As long as a Mexican citizen could find a way to complete, or at least enroll in a university

degree program, he or she had the chance to move up a class level because of how Mexican society values education (Lorey, 1993).

The educational requirement for physician training, the high social status physician's held in Mexican society, and their earnings potential made the medical profession an attractive option for Mexicans of all social classes. Eventually, Mexico began to produce more physicians than it could employ (Frenk, Duran Arenas, Vázquez Segovia, Garcia, & Vázquez, 1995; SSA, 2002).

The university admissions policy change also increased educational opportunities for women. Mexican women in the 1970s made up 15% of the economically active population and only 40% of all Mexican women met the minimum educational requirements for nursing school: successful completion of junior high school (INEGI, 1999). Since the new university admissions policy created new educational opportunities for women, this decreased the overall pool of candidates who would attend nursing school. Women began to study other disciplines because they had more choices and female education became increasingly acceptable across all classes in Mexican society. Reflecting this trend, technical-level training programs for nursing –sometimes found in universities– increased minimally during the 1970s (SSA, 1974b; Verderese & Garcia, 1974) and problems with student retention began to increase (Trujillo Moreno, Gómez Espinosa, & Merlin Pichardo, 1978).

The second cause of deprofessionalization came from the Echevarria administration's policy goal of hiring up to four times as many nursing auxiliaries as formally educated nurses (SSA, 1974a, 1974b). The Echevarria administration of the mid-1970s faced increasing economic stress and rising unemployment. To mediate growing public discontent with his administration and the escalating economic difficulties of the country, Echevarria developed an ambitious job-creation plan (SSA, 1974a; SSA, 1974b). This included training for 8,000

auxiliary nurses and 4,500 technical-level and higher nurses to staff the healthcare system. As the ruling Partido Revolucionario Institucional (PRI) maintained its policies from one presidential administration to another, the overall nursing human resources production goal was set at an increase of 7,500 between 1974 and 1983. Therefore, regardless of which kind of nurse was produced, the State could say it had met its goal. These policies allowed the administration to continue expanding health services delivery to the masses and add more women to the workforce. Since auxiliary nurses required as little as a month of training and could be hired into any kind of position in any healthcare facility, the State had no incentive to invest in higher education for nurses.

As a result, the Mexican healthcare system found the majority of its institutional nursing care provided at the hands of nursing personnel with minimal or no training until well into the mid-1990s. The image of a nurse shifted toward the negative because auxiliary nurses were only required to have a sixth-grade education and due to their educational level, it limited the type and quality of care they could provide. For the next two decades, auxiliary nurses dominated (in numbers) in the healthcare system, affecting the quality of care<sup>34</sup> provided in the institutions and the community.

A further blow to Mexican nursing in the late 1970s resulted from a small economic crisis in the late 1970s. Since the mid-1950s, the Mexican government had a “chief nurse” who worked in the SSA to advise the government on issues relevant to nursing (Navarro Salazar et al., 1978; SSA-Dirección de Enfermería, 1977). As mentioned previously, the effort to cut government expenditures during the economic crisis included the elimination of the chief nurse position from the SSA hierarchy (Navarro Salazar et al., 1978) and no equivalent would be

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<sup>37</sup> The concept of evaluating quality of care began to emerge in health services research the U.S. and Europe in the 1980s (IOM, 1999).

reinstated for thirty years.

Resource constraints imposed on the health-system due to the mini-crisis of the 1970s also effected health-system operations. The economic crisis generated poorly considered cost-cutting measures in the health-system. In writing about managing nursing practice in the institutional setting, Cervantes Mota (1978) wrote:

Health-system administrators have a tendency to save wherever possible with regard to qualified nursing human resources. These factors influence the management environment of the workplace, fatigue, emotional stress, the indiscriminate hiring of unqualified personnel, and the use of nursing students as cheap labor. This diminishes the service provided by the organization and the quality of care (p. 27).<sup>35</sup>

Put simply, auxiliary nurses were less expensive to hire than better educated nurses with more formal training. In the face of economic constraints, health-system administrators opted for the cheapest solution to solve their financial woes and as a result, sacrificed the quality of care patients received.

Nurses, however, consistently identified poor education and training of nursing personnel as a serious detriment to the quality of care provided by the healthcare system, contributing to a stressful work environment, and management's view of nursing human resources as an expense, not a benefit, to the system (Cortés Ramírez, Villareal Guzmán, Martínez Benítez, Guerrero Hernández, & Padilla Hernández, 1981; Diaz Camargo et al, 1977). In fact, the poor quality of care delivered by auxiliaries and others in the system was so apparent to the CNE that they felt compelled to publish articles on basic nursing process skills in order to provide nursing auxiliaries or their supervisors with some kind of professionally derived knowledge to guide their practice (Avila de Castellanos, Aguirre Sanchez, Burgos Jara, &

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<sup>38</sup> Original quote: "La tendencia que tienen los administradores del sector salud de ahorrar hasta donde sea posible en recursos de personal de enfermería sobre todo el personal calificado, son factores que influyen definitivamente en la legislación laboral existente, la fatiga, el stress emocional, la indiscriminada dotación de personal no calificado, la utilización de estudiantes de enfermería como fuerza de trabajo menoscaba la organización del trabajo prestado y su calidad" (Cervantes Mota, 1978, p. 27)

Encinas, 1978). Mexican nurses intuitively knew the HCS reliance on auxiliary nurses was bad for patient care, but they did not have the capacity to empirically capture the consequences through research. They could only describe the problems through anecdotal stories in their professional literature.

The events in the 1970s set the tone for the next several decades of Mexican nursing's professional evolution. These decades would be shaped by a lack of monetary resources, constraints conferred upon the profession due to economic crises and health-system management issues.

### CONCLUSION

The data from the periods described in this section demonstrated that the historical legacies of the State's economic and health-system policies affected the professionalization of nursing in Mexico. It provided support for the study's hypothesis that professionalization is affected by nurses' ability to harness economic and political resources in order to advance.

This chapter showed how over a period of thirty years, the State progressively moved from a policy of excluding nurses from the policymaking process related to their own profession, to one of inclusion. During the period of exclusion, the State contributed significantly to the deprofessionalization of nursing in Mexico through policies that promoted hiring poorly trained nursing personnel and less-than-competent nursing staff.

The economic crises, coupled with the exclusionary practices of the State, rendered Mexican nurses unable to harness the economic resources they needed to mediate the effects of the State's exclusion. As a result, knowledge production by nurses decreased, nursing research did not have the resources to develop, and the new economic constraints nurses experienced did not allow them to financially support their profession or their own individual professional

development.

Once the State began to include nurses in the policymaking process—an incentive generated by the creation of NAFTA—the State aided development of professional infrastructure helped nurses survive the economic crises of the 1990s with fewer detrimental effects than previous decades. Nurses taking charge of their own profession through increasing entry levels of education and research production helped create the information the State needed to support professionalization. The new political will of the Mexican State in the 1990s to professionalize public servants and government employees also helped to generate additional support for the professionalization of Mexican nursing. For the first time, the overall numbers of professional personnel began to increase while the number of auxiliary personnel remained steady or decreased.

From the Nursing System model, Chapter 4 illustrated the intersecting influences of economic, political, historical, and some of the international factors influencing the professionalization of Mexican nursing between 1980 and 2005. The following chapter describes how the policy patterns and historical legacies identified in this chapter shaped the personal and professional lives of Mexican nursing in early twenty-first century Mexico, as captured through the interviews with thirty-two currently practicing Mexican nurses.

**CHAPTER 5**  
**RESULTS - PART B:**  
**INTERVIEW ANALYSIS**

Previous sections explored the professionalization process largely from a historical perspective using document data as evidence. This chapter explores the consequences of the twentieth-century economic and health-system policies in relation to Mexican nursing in the twenty-first century. A general thematic analysis of the interviews from the study provided the majority of data for this chapter. When appropriate, document evidence was included to provide further support for the nurse's statements.

Nurses in early twenty-first century Mexico manage multiple complexities in their personal and professional lives. Gender dynamics within the profession, society, and the workplace contribute to these complexities. The dynamics shape nurses' reasons for choosing to be a nurse and the sense of autonomy in nurses develop for their role. Domestic and international factors influence workplace dynamics. Nurses participate in unions that strongly influence the workplace and are a political force enmeshed with the State in Mexico. Due to the economic crises of the last twenty years, economic instability has become a part of nurses daily lives. The confluence of these factors shape how nurses exercise their political economy at all levels of Mexican society.

Chapter 4 described how Mexican nurses were unable to advance the profession due a lack of inclusion in the policymaking process and the lack of capital that resulted from economic crises. This chapter adds to these results by providing additional support for the association between resource harnessing and professionalization by highlighting how gender dynamics in Mexico create competing demands in nurses' personal lives that influence their ability to harness funds and power, thus hindering professionalization.

To further explore the components highlighted in the Nursing System model (NS) found in Appendix E, this chapter is organized around the variables important to professionalization that were identified in the previous chapter. This chapter addresses the factors related to the sociocultural, unions, and workplace themes that Chapter 4 did not discuss. Variables addressed in Chapter 4 (economic, political, historical, international) are interwoven throughout the results presented in this chapter and explained in further detail when appropriate. Since Chapter 4 already demonstrated the influence of history on Mexican nursing's professionalization during the period of study, that content is not included in this chapter.

To start the interview descriptions, sample demographics are provided. The analysis then begins by exploring parts of two variables that pervaded every aspect of professionalization for Mexican nurses: present-day legacies of economic instability and the sociocultural dynamics of gender. Gender is one of the strongest sociocultural influences affecting Mexican nursing and influences all aspects of this study. Other sociocultural factors identified as influencing Mexican nursing's professionalization (the education and healthcare systems) were analyzed in Chapter 4.

The chapter then proceeds with an in-depth exploration of some of the significant internal factors influencing professionalization. It then progresses to how workplace factors affect the professionalization of Mexican nursing and studies the effects of unions, an element strongly tied to the Mexican nursing workplace. That section is followed with an exploration of the new political dynamics of the twenty-first century that influence Mexican nurses' participation in policymaking. Perspectives from nurses about the effects of globalization, another important international influence on professionalization, are then described. The chapter concludes with a description of the visions for the future of Mexican nursing stated by nurses participating in this study.

### **Interview Sample**

Thirty-two Mexican nurses – 16 from Oaxaca, 16 from Mexico City – were interviewed for the study. A summary of sample demographics is provided in Table 2. Of the interviewees, 29 were female and 3 were male. Equal sample sizes between the two sites was a random occurrence. Nurses worked in all divisions and institutions within the Mexican healthcare system, from public to private. The majority of nurses worked or had worked for the SSA system in either public (free care) institutions or specialty hospitals. Sixty-six percent of nurses in the sample also taught in universities, mostly to supplement their incomes. The average age of nurses in this study was 39 years, with subjects ranging in age from 24 to 60. Novice through expert nurses participated in the study. Subjects averaged 18 years of experience in nursing with that range covering 1 to 42 years working as a nurse or in a nursing role.

Most of the participants from Oaxaca had primary jobs as staff nurses or administrators in hospitals. The majority of Mexico City nurses worked in education while others worked in clinical nursing positions as their second job.

Sixty six percent (21) of nurses in the study had children. One male in the study had a child. Of the women, 34% (11) were single mothers, most of whom never married the fathers of their children. A startling 44% (14) of nurses in the study were single, having never married.

Overall, the sample was a highly professionalized group with 81% of participants possessing a bachelors degree in nursing (BSN) and 34% (11) having masters degrees in nursing or other fields. Most nurses obtained masters degrees in other disciplines because when they were ready to study for a masters degree, one specific to nursing was not available or they had an interest in studying another discipline with content related to nursing, such as bioethics. Eleven of the nurses in the study went directly to the university BSN program after high school. All of these nurses were under the age of 35, reflecting a generational shift in nursing education trends

**TABLE 2:** Demographic Data of Sample (n=32, 29 Female, 3 Male)

<b>Age</b> Mean Range	<b>Years</b> 39.8 24 to 60	<b>Speciality*</b> Medical-Surgical  Operating Room OB/GYN/Women's Health Intensive Care (ICU) Pediatrics  Public Health Administration Education Other	<b>% of Sample with Experience Working in the Speciality</b>  53%  19% 19% 16% 28%  6% 34% 9% 3%
<b>Years of Experience</b> Mean Range	<b>Years</b> 18.2 1 to 42		
<b>Civil Status &amp; Children</b> Single, never married Single mother <sup>▼</sup> Married Divorced % with children <sup>°</sup> % with children @ home	<b>% of Sample</b> 44% 34% 38% 22% 66% 56%		
<b>Education</b> Technical BSN Masters or higher # of Direct Entry BSN nurses Average age of DE-BSN	<b>% of Sample with this Degree*</b> 63% 81% 34% <hr/> 11 35 years	<b>Institutional Work Experience</b> IMSS ISSSTE SSA-Federal/State Private Hospital Teaching/University	<b>% of Sample with Experience Working in this Kind of Institution</b>  28% 19% 60% 22% 66%

\* Reflecting the multiple education entry system present in Mexican nursing, many nurses will have multiple degrees; therefore, numbers will not add up to 100%

▼ % of nurses in sample who are single mothers either because they had children out of wedlock or have children but are divorced.

◆ Specialty numbers will not add up to 100% because of Mexican nurses tendencies to work multiple jobs or it is a reflection of career fluidity.

° This number represents all nurses in the study who had children during their career.

that began in the early 1990s. This sample is atypical of Mexican nursing overall, where the majority of Mexican nurses possess the equivalent training to a U.S. licensed practical nurse (LPN). Finally, illustrating the fluidity of nursing careers and the tendency of Mexican nurses to work multiple jobs, many of the participants indicated they had worked in a variety of specialized practice areas during their careers. For this reason, specialty practice statistics will not add up to 100%.

From the interviews, nurses reported a wide range of salaries, depending on his or her type of workplace. Table 3 outlines the salary ranges described by nurses in the study, based on institution of work. As the table indicates, nurses can make as little as \$250/month or as much as \$2500. The numbers reported by the nurses in this study are consistent with the salary findings from Salas Segura, Zárata Grajales, and Rubio Domínguez (2002).

**Table 3: Salaries by institution as described by nurses in the study**

Institution of Work	Monthly Salary Range*
Private Hospital	\$240 to \$500 <sup>^</sup>
IMSS	\$500 to \$2400
ISSSTE	\$500 to \$1900
SSA-Civil	\$350 to \$1400
SSA-Speciality	\$1000 to \$2500
State managed facility	\$260 to \$1000

\*All numbers are presented in US dollars at a conversion rate from the peso at 10MP per US\$1. Actual monthly salaries may vary due to fluctuating exchange rates.

<sup>^</sup>Higher end of the salary ranges almost exclusively represent numbers from nurses living in Mexico City.

Most staff nurses in the study fell somewhere in the middle ranges of the salary reports. Professors reported the highest salaries and 85% (27) of the nurses in the study worked at least two jobs. Professor salaries were often complemented by healthcare system pensions that would

place their income even more solidly in the middle to upper-middle class of Mexico.

Demographic descriptions about population differences between Mexico City (Federal District only<sup>36</sup>) and Oaxaca are illustrated in Table 4. Information about persons with or without health insurance<sup>37</sup> is included in the site description as an illustration of the resource disparities between the two sites.

**Table 4: Site Data for Mexico City (Federal District only) and Oaxaca\***

	2005 Population	# of Females	# of Males	Total Population w/ Health Insurance**	Total Population w/o Health Insurance**
<b>National</b>	106,451,679	53,522,389	52,929,290	47,772,541	57,577,296
<b>Mexico City</b>	8,814,797	4,522,179	4,292,618	5,055,226	3,758,897
<b>Oaxaca</b>	3,716,837	1,890,208	1,826,629	909,681	2,783,816

Source: <http://www.salud.gob.mx>, downloaded May 5, 2007;

\* All data is from 2005 unless otherwise noted. \*\* Data from 2004

An important component of professionalization is education. Table 5 provides a description of the 2005 educational system enrollments of the Mexican population at the two study sites and illustrates the potential pool from which to recruit nurses, both nationally and at each site.

<sup>25</sup> The borders of Mexico City include the Federal District and part of the adjacent the State of Mexico. The estimated population residing within the overall city limits hovers around 25 million people. Because the total population only includes a portion of the State of Mexico, for comparative purposes in this study only Federal District numbers are provided.

<sup>37</sup> How Mexicans are insured is reviewed in Chapter 2.

**Table 5: 2005 Mexican Education System Enrollments with Gender Breakdown**

	Elementary Education			Secondary Education		College/ University Education			
	Pre-School	Primary School	Junior High School	Vo-Tech High School	General High School	Teaching/ Social Work Degree	Specialty Certification	Bachelor's Degree	Graduate Level
<b>National</b>	4,086,828	14,652,879	5,894,358	362,835	3,185,089	146,308	77,510	2,010,188	150,852
Men (%)	50.5	51.2	50.3	51.1	48.5	30.2	57.7	50.6	52.9
Women (%)	49.5	48.8	49.7	48.9	51.5	69.8	42.3	49.4	47.1
<b>Mexico City</b>	316,435	969,140	488,742	51,604	356,757	8,735	1,403	340,795	44,197
Men (%)	50.8	50.8	50.8	50.3	50.6	22.5	45	50.6	55.3
Women (%)	49.2	49.2	49.2	49.7	49.4	77.5	55	49.4	44.7
<b>Oaxaca</b>	162,967	622,862	223,085	6,473	122,080	6,562	ND	48,920	998
Men (%)	50.2	51.3	50.9	50.6	48.8	42.6	ND	50.7	52.1
Women (%)	49.8	48.7	49.1	49.4	51.2	57.4	ND	49.3	47.9

ND=No data

Source: <http://www.inegi.gob.mx/est/tmp/c200754143544906.xls>, downloaded May 5, 2007

The minimum education level required to enter a general nursing program is the completion of junior high school, known as *secundaria* in Mexico. A technical degree is the minimum education level required to become a teacher of nursing in private universities, while a bachelor's degree is the minimum for teaching at public universities. The data in Table 5 shows an extremely small pool of individuals studying for bachelors or graduate degrees, indicating the potential for a nursing faculty shortage in Mexico. Also reflecting the poverty of Oaxaca, proportionally fewer numbers of the population there are enrolled in educational programs overall when compared to the Federal District. This means that proportionally, Oaxaca has a smaller pool of potential nurses from which to recruit than the Federal District. This reflects geographic disparities in education between urban and rural areas in Mexico.

**Table 6: Comparative Human Resources Data: Mexico City & Oaxaca\***

	# of MDs	Total # of Nurses	Nurses: Public Hosps.	Aides	General	Specialty	Social Service Year	Nurses: Private Hosps.	Other ^^
<b>National</b>	157385	196675	78279	24,221	39099	6,059	8,900	35477	82919
<b>Mexico City</b>	30115	n/a	9533	1703	5,900	1,517	413	6,803	n/a
<b>Oaxaca</b>	4120	n/a	2,087	619	1013	161	294	524	n/a

Source: <http://www.salud.gob.mx>, downloaded May 5, 2007

\* All data is from 2005 unless otherwise noted.

\*\* Data from 2004

n/a = no data available

^^ These nurses may be working in faculty, public health, other positions not in direct contact with patients or not at all. No distinguishing data is available.

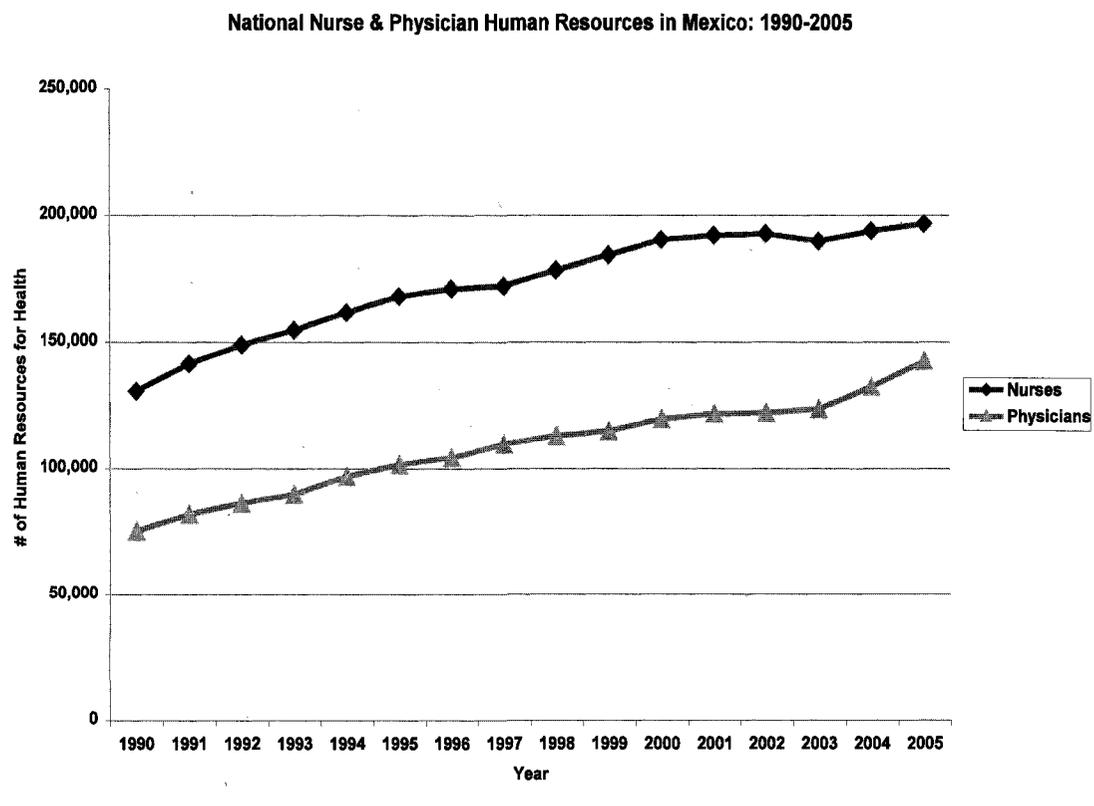
For human resources for health, Table 6 illustrates the large differences between healthcare human resources (physicians and nurses<sup>38</sup>) in the Federal District (part of Mexico

<sup>27</sup> Nursing numbers in Table 7 represent nurses in direct contact with patients. These numbers do not include nursing faculty or individuals with nursing training who are not practicing.

City) and in Oaxaca. The majority of the nursing group are generalist nurses. Specialist nurses are technical or BSN level nurses with specialized training like hemodialysis, cardiology, or obstetrics. Like many rural areas, Oaxaca possesses a lower nurse-to-population ratio than Mexico City. These differences are important because the numbers indicate that while there is a nursing shortage in both areas, there is a trend toward urban migration from rural areas.

In another example of human resources trends that occurred during the study, Figure 1 illustrates the growth in numbers of physicians and nurses between 1990 to 2005. Growth in these two professions occurred in proportion to population growth and progressed despite the economic shocks that occurred in 1995. As the graph illustrates, growth rates in both professions appear steady throughout the fifteen-year period.

**Figure 1: Growth of physician and nursing human resources in Mexico between 1990 and 2005. All nurses of all educational level are included in the numbers.**



Nonetheless, as Chapter 4 highlighted the volatility of the Mexican economy during the period of study, 1980 to 2005, as illustrated by Figure 2.<sup>39</sup> The appearance of steady growth rates in the number of nurses, however, suggest that nursing human resources production is not affected by economic shocks.

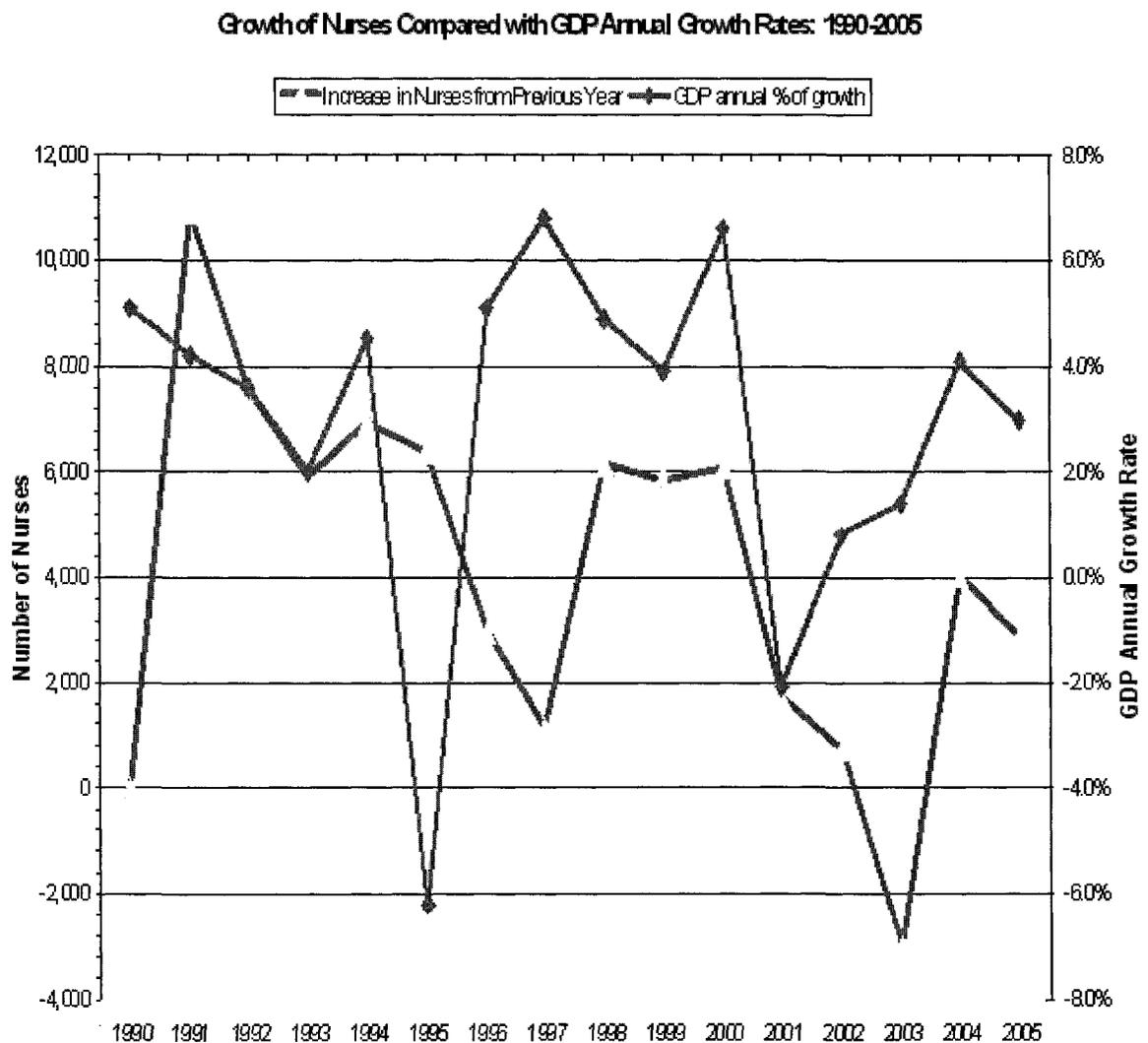
**Figure 1: Mexican GDP annual rate of growth (%/year)**



<sup>39</sup>\*This is a crude rendering of macro-economic trends for the period of study. It was purposefully kept simple to illustrate the volatility of the Mexican economy for an audience that is largely unfamiliar with reading trends in economic data.

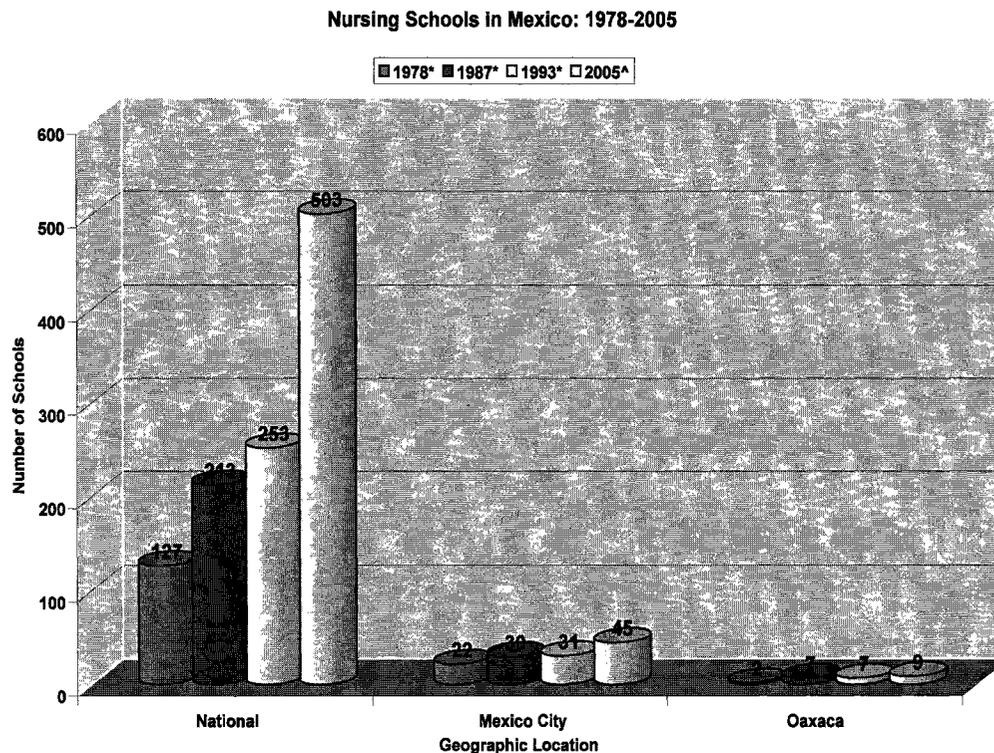
Yet, if one compares the economic growth with the actual increase in nursing human resource numbers each year, a different trend appears (see Figure 3). This graph suggests that decreases in the production of nursing human resources occur for several years after decreases in the GDP. Further quantitative analysis of the growth patterns in relation to the GDP is warranted, but that is beyond the scope of this study.

**Figure 3: Annual growth in number of nurses compared with GDP annual % of growth rates: 1990 to 2005**



Finally, Figures 4 and 5 shows the growth of nursing programs in Mexico 1978 and 2005. Figure 4 shows a large spike in the overall nursing educational program growth after 1993. The spike coincides with the implementation of NAFTA. When educational programs are divided between technical and bachelors degrees, Figure 5 depicts a three-fold growth in

**Figure 4: Nursing Schools in Mexico: 1978-2005**



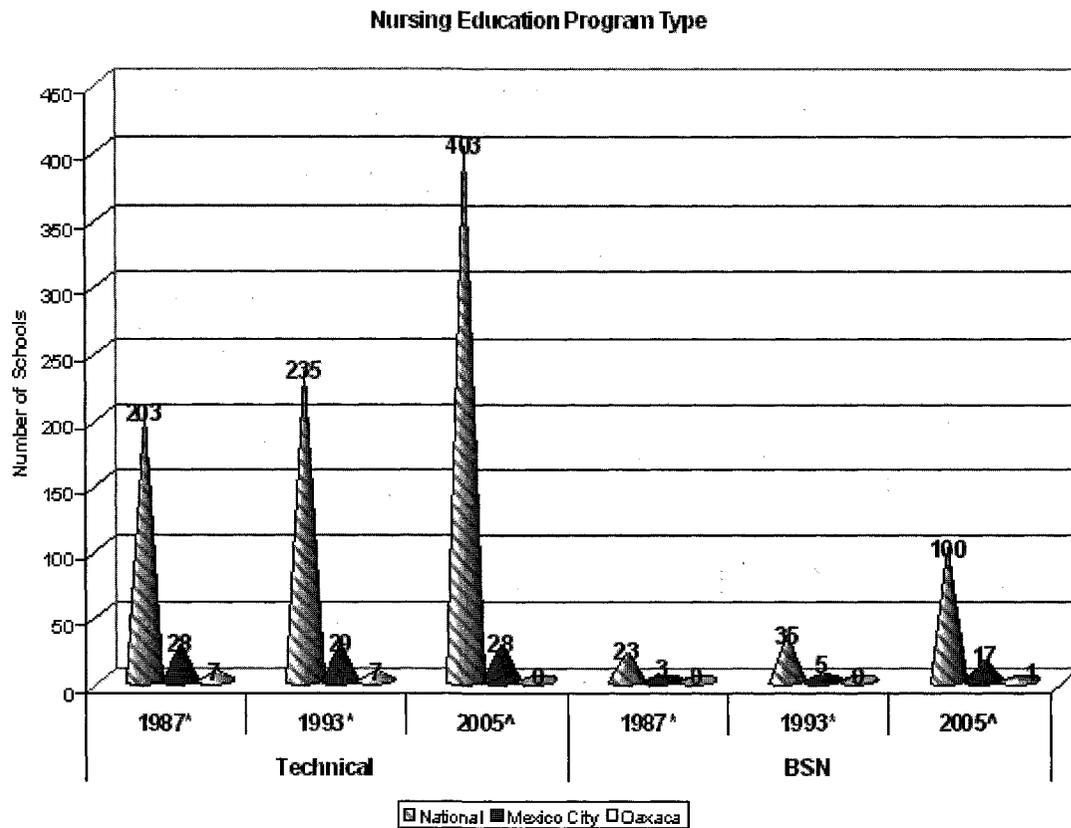
^Source: Arroyo de Cordero, G. (2005). Sistema educativo de enfermería. Mexico D.F.: Comision Interinstitucional de Enfermería. Powerpoint presentation downloaded May 5, 2007 from [http://www.salud.gob.mx/unidades/dgces/foro\\_enf/descargas/06.ppt](http://www.salud.gob.mx/unidades/dgces/foro_enf/descargas/06.ppt)

\*Source: SSA. (1994). Directorio de facultades y escuela de enfermería por entidad federativa.

Mexican BSN programs and that technical degree programs nearly doubled in number. All 31

Mexican states now have BSN level education available to nurses.

**Figure 5: Number of nursing education programs in all of Mexico between 1987 and 2005, by degree offered.**



<sup>^</sup>Source: Arroyo de Cordero, G. (2005). Sistema educativo de enfermería. Mexico D.F.: Comision Interinstitucional de Enfermería. Powerpoint presentation downloaded May 5, 2007 from [http://www.salud.gob.mx/unidades/dgces/foro\\_enf/descargas/06.ppt](http://www.salud.gob.mx/unidades/dgces/foro_enf/descargas/06.ppt)

\*Source: SSA. (1994). Directorio de facultades y escuela de enfermería por entidad federativa.

Today, Mexican nursing programs produce an annual average of 13,000 nurses (Arroyo de Cordero, 2005). Of these graduates, approximately 3,000 are BSN graduates and 10,000 are technical-level graduates (Arroyo de Cordero, 2005). The number of auxiliary nurses produced annually could not be determined.

### PRESENT-DAY LEGACIES OF ECONOMIC INSTABILITY

Despite some increased stability in the Mexican economy, economic instability—or the threat of it—continues to affect every aspect of a nurse’s life, from the personal to the professional. Chapter 4 illustrated how the State’s economic policies translated into the healthcare system and nursing profession overall. This section draws from the interviews to describe the lasting effects of the economic instability of the 1980s and part of the 1990s on nurses as individuals and professionals. Documentary evidence to support the nurses’ statement is included when necessary.

In an apt description of the effects of economic instability on nurses Nurse 13, a woman in her mid-thirties with a master’s degree, specialization, and fifteen years experience, illustrated the personal toll on nurses’ work life and their struggles for class advancement within Mexican society.

The economic situations hit us hard...we have nurses working double shifts, we have nurses working for very low salaries with a very high patient load, whether your part time or full time, and sometimes working in places where the quality of care is questionable...You can end up leaving your job in the private sector with no seniority, no retirement. As a result, you are left unprotected in that sense...So the crises hit us hard, more so because...we are first, mostly women and men who come from lower and middle classes who are trying to move up, but left unable to cover even our basic needs...

Most nurses in Mexico come from socioeconomic circumstances that are described universally by nurses in the study as “humble.” The education that nursing offers a Mexican from that class level is a vehicle for economic advancement and can offer some stability in the long term of a career life. For many, this represents an escape from the insecurity of poverty they experienced as children. For their families, it means additional financial security as 40% of the nurses in the study were supporting extended family members—not just children—with their salaries. Nonetheless, economic instability decreases the sense of security a professional education provides. Personal financial demands on nurses, consequently, increase and inhibit

individual professional growth. This can be because of inflation, the number of people one nurse supports financially, and frozen salaries (Cuevas Nuñez, 1995).

Prior to the 1982 economic collapse, a Mexican nurse's salary offered some level of economic security (Verderese & Garcia, 1974) and a nurse could expect a salary increase as she advanced in her career (Balseiro Almario, 1987). In twenty-first century Mexico, all Mexican nurses are salaried workers, paid biweekly or monthly. The State sets minimum salary levels and incentive programs in the HCS, based on type of position in which the nurse works (Comité de Estimulos a la Calidad de Desempeño del Personal de Salud, 2005; SSA, 1997). They do not receive hourly wages, regardless of institution. Nurses working in State-managed facilities can receive overtime pay. Private hospital nurses do not.

When necessary and usually not without cajoling, the Mexican State will raise salaries in response to economic instability. For example, in the mid-1990s the State did raise healthcare worker salaries by an average of 54% in 1998 (Poder Ejecutivo Federal, 1999). The percentage received by nurses could not be determined from this source. These raises did not create salaries equivalent to what professional nurses made prior to the 1982 economic collapse.

Nurses in this study, however, were highly vocal about their salaries. Their comments reflect concerns not only about achieving a salary that reflects their level of workplace responsibility, but also about their buying power as middle-class consumers. This study also found that in a decentralized, State-managed facility<sup>40</sup> salaries do not appear to be much better than those found in private hospitals. This becomes of particular concern for the decentralization process as it may be an indicator of poor resource management in State-run facilities and that the State was not prepared to independently manage its decentralized facilities.

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<sup>39</sup> A "state managed facility", in this section, refers to acute care facilities managed by the state government, not the federal one.

The retirement pension system for healthcare workers underwent a number of reforms during the 1990s, largely due to the economic instability experienced by Mexico (Cantón y Mena, 2004; Osorio Martínez, 2004; Ravelo & Sánchez, 2001). Healthcare workers unions participated fully in these pension reform negotiations (Osorio Martínez, 2006; Quiróz Trejo, 2004; Ravelo & Sánchez, 2001).

One nurse in the study, however, expressed concern about changes to the pension system, which now requires individuals to save for their retirement in individual accounts. “How am I supposed to save when I only make \$400 a month? In other places...I believe the salary is like \$1200 a month...with that you can save!”said Nurse 37. If the Mexican State expects its employees to begin saving for retirement instead of relying on pensions, salaries must increase to allow the worker to do so. Nurse 37's statement shows that a monthly salary of US\$400 is not enough to save for retirement, let alone maintain a middle-class existence. Her marker of earning over US\$1,000 per month suggests that the ability to save becomes a possibility with that level of salary. In confirmation of Nurse 37's statement about minimum monthly salaries, in this study nurses making more than US\$1000 per month in Oaxaca and US\$1500 per month in Mexico City were far less likely to complain about their salaries. They also commented less about economic stressors than their counterparts making less than those amounts.

The remarks nurses made about salaries beget the question of how do their salaries compare to women working in other female-dominated occupations? For comparative purposes, 1998 minimum salary data for female-dominated occupations is provided in Table 7. The data shows that among women working in similar job categories, nurses are the best paid of the group. In 2005, minimum salaries hovered around US\$250 per month for formally educated nurses. Wage differences between nurses and other female-dominated occupations remained steady.

In contrast to unionized State-managed hospitals and clinics, private healthcare facilities

**Table 6: 1998 Comparative Salary Data - Nurses vs. Other Female Dominated Occupations (INEGI, 1999).**

<b>MEXICO CITY</b>	<b>Nurse with Formal Training</b>	<b>Auxiliary Nurse</b>	<b>Teacher</b>	<b>Secretary</b>	<b>Beautician</b>
Minimum Daily Salary*	\$49.80	\$41.00	\$46.55	\$39.35	\$41.00
Est. Monthly Salary (in pesos)**	\$1,494.00	\$1,230.00	\$1,396.50	\$1,180.50	\$1,230.00
US\$ monthly equivalent	\$149.40	\$123.00	\$139.65	\$118.05	\$123.00
<b>OAXACA</b>					
Minimum Daily Salary*	\$42.90	\$35.30	\$40.10	\$33.85	\$35.30
Est. Monthly Salary (in pesos)**	\$1,287.00	\$1,059.00	\$1,203.00	\$1,015.50	\$1,059.00
US\$ monthly equivalent	\$128.70	\$105.90	\$120.30	\$101.55	\$105.90

\*Minimum amount a person with this qualification must be paid (in Mexican pesos) on a daily basis, regardless of hours worked

\*\*An average conversion rate of 10 pesos per US\$1 was used for currency conversion.

rarely pay nurses above the State-mandated minimum wage, US\$5 per day. Nurses in the study universally agreed that private hospitals, whether in Mexico City or Oaxaca, exploit nursing personnel through sixty hour or more work weeks and low rates of pay. This finding is atypical of salary findings in most countries where the private sector tends to pay nurses better, regardless of the presence of a union.

The exploitation of nurses by private hospitals especially affects new graduate nurses in Mexico. In several studies of recent new graduate nurses, the researchers found that the majority of their graduates worked in private hospital facilities in Mexico City because they had difficulty

obtaining positions in State facilities (Müggenburg, 2004; Müggenburg, Barreto Plácido, & Garcia Ortíz, 2006; Müggenburg, Castañeda Sánchez, & Franco Paredes, 2000). This suggests that a similar trend may be occurring throughout the rest of the country and that private hospitals are not only paying the least, they are hiring the least experienced staff. As hiring practices of the State-run system are biased toward experienced staff, new graduate nurses have few options outside the private hospital for work.

The findings here clearly suggest that government institutions pay unionized nurses salaries that place them solidly in the middle-class in Mexico. Contract workers hover precariously at the edge of the middle-class due to lower pay rates and a lack of benefits. Private hospitals keep nursing salaries at the lowest possible level.

Nurse 3 described the impact that low salaries coupled with economic instability can have on career advancement for a nurse. Obtaining a specialty practice certificate is almost always a guaranteed way to make more money and increase economic security for Mexican nurses. Specialized positions, like ICU, OR, or dialysis<sup>41</sup> are coded for higher salary rates than generalist positions. Universities provide and administer the certificate training programs. As additional education can cost up to half of a nurse's monthly salary (INSP, 1992), the challenge, as Nurse 3 notes, comes from finding the financial resources to obtain that training. She said:

The economic factor is important for the nursing profession because if you want to do a speciality certification, a continuing education course, or whatever academic activity you can think of, you have to pay for it yourself. The university charges you to enroll, charges you for some monthly fees, charges you for many things to keep them running. Where are you going to get the money for all that? From your nursing job of course. But they are only going to pay a little part of that, you still need to pay for life's basics like food, clothes, housing. So, many times if you cannot cover the basic things, you're not going to be able to pay for the academic ones, no matter how much you want to do it. There are lots of people who want to advance in their careers, but their economic level doesn't allow them to pursue advancement because they don't have the money for a university education.

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<sup>41</sup> Nurses receive the same rate of pay for performing hemodialysis and peritoneal dialysis.

Since no other vehicle to support additional education is available to nurses other than money out of their own pockets, economic instability effectively slows the rate of individual professional development. Subsequently, the rate of professionalization for nurses as a whole is slowed down by an absence of economic resources.

#### **THE SOCIOCULTURAL ASPECTS OF GENDER AND THEIR EFFECTS ON MEXICAN NURSING**

As described in the literature review, the effect of gender on professionalization and in the production of human resources for health is recognized as a factor in the production, development, and retention of personnel. Researchers and policymakers, however, universally agreed that the specific effects are not well understood (Dussault, 2006). From this study, it is clear that the dynamics of gender infuse every aspect of being a nurse in Mexico, especially since Mexican nursing is dominated by women. Thematically, this section explores aspects of gender through analyzing the nature of “being female” in Mexico, single motherhood, male nurses, work-family balancing, female access to education at all levels, personal relationships, and generational differences. The combination of all these aspects of Mexican culture influence the professionalization process.

#### **Being Female**

Understanding the experience of being a female professional in Mexico is critical to understanding the factors that facilitate and inhibit professionalization. Separating the place of women in Mexican society from the nature of nursing is nearly impossible. A nursing professor with extensive education in gender studies and human rights astutely captured the situation of women in Mexico when she described the social dynamic Mexican women encounter, whether or not they are nurses:

We say here in Mexico, ‘things like [genital mutilation or being required to wear a burka] don’t happen here, and for sure, not in the United States’ but there are many other forms of mistreatment, discrimination, and exclusion [here]...In every aspect, when a woman lives with the violations of her rights, her education, her dignity, her ability to receive justice...all are the same violations, the same ones lived by nurses.

Her words describe what could be construed as a more subtle form of gender-based discrimination in Mexican society. The obvious markers of female control, like ritual physical mutilation or dress codes, are not present in Mexico. She alludes to a culture where women perceive themselves as having it “better” than women in more restrictive societies and rationalize the injustices they experience through comparisons. Consequently, a culture of denial develops when facing the social injustices directed toward women in Mexican society. For nurses, these injustices morph into other forms that inhibit an individual woman’s ability to professionalize. Subsequently, the professionalization of nursing as a group is slowed.

The professor believed that the resulting female gender-influenced socialization process that occurs within Mexican nursing creates a conflicting message. She reported that in one way, Mexican nursing socialization to the role counters many of the injustices women were taught to accept prior to their professional education. That breeds a fierce independent streak that is atypical of most women from the social classes where nurses come from in Mexico.

At the same time, however, nurses still receive some of the traditional socialization that values obedience and following orders without thinking. Many nurses in their institutional roles behave in a submissive way in order to function politically within the hierarchy, but at home, her salary is frequently the one that supports the family. The power the nurse may lack at work shifts to increased power at home because of her earning capacity. Thus, “the nurse is a bit ambiguous, no? On the one hand, she is submissive, but at the same time she is the one who supports the household,” said Nurse 30, a nursing supervisor in a government hospital with a masters degree in sociology. Her astute statement confirmed the professor’s ideas and recognized the

socialization conflict.

Becoming a nurse also creates a fundamental shift in a common social dynamic in Mexico: the ability to be alone. The concept of spending time alone, out of the presence of friends or family, is uncommon in Mexico. For most Mexicans, because of extended-family living situations spending time by oneself out of the presence of friends or family is uncommon and may even be considered strange. Yet many nurses in the study described how their education gave them the capacity to spend time alone, to support themselves independently, and to rely less on others to survive. As a new graduate nurse stated: "If you are alone and you know you can do things on your own, you're going to grow as an individual." The social interaction that they would normally achieve through familial relationships changes to relationship rewards coming from patients and colleagues instead of family members. Nurses in the study unanimously agreed that becoming a professional nurse teaches independence and healthier reliance on others.

#### *Single Motherhood*

Another common theme about being female in Mexico was the issue of single motherhood, a persistent problem throughout Mexico due to high teen and young adult pregnancy rates. In this study, 34% of the sample were single mothers and the majority of single mothers never married the fathers of their children.

For Mexican nurses, single motherhood has mixed social consequences. The story of Nurse 41 exemplifies this phenomenon. She became pregnant during nursing school and described being stigmatized for becoming pregnant because the knowledge she had obtained in nursing school should have given her the skills to prevent that from happening. Conveying a note of irritation at society's assumptions and expectations, she said:

I think, if you say that you are a nurse, that you are studying nursing, people think 'how is it possible that you got yourself pregnant and didn't take precautions?' They say things

like 'you should have known better'.

Despite her own irritation, Nurse 41's body language indicated a lingering sense of shame that she did actually get pregnant. Her words illustrate how obtaining professional knowledge separates the female from the "average" woman in society. Access to "specialized" knowledge received during a nursing education creates a different set of social expectations for females, a set that implies a higher level of responsibility for one's person.

At the same time, nursing provides single mothers with a solid income to support themselves and their child or children. Many single mothers in this study indicated that they lived with their parents; thus, they did not have to pay rent. They described how their mothers helped them with child care while their salaries benefitted everyone living in the household.

Divorced single mothers frequently described themselves as having married too young and to men who could not handle their wives' career advancement. Educational disparities between spouses and nurses were often cited as reasons for divorce. Their former husbands could not accept their wives advancing beyond themselves. The variety of work opportunities for these nurses allowed them to support themselves and their children. Spousal or child support from ex-husbands were rarely expected and are not required under Mexican law.

Without question, however, nurses who are single mothers face more difficult circumstances than their colleagues without children or those who are married. All single mothers in this study described working multiple jobs to support themselves and their families. Married or single nurses in the study could easily name single-mother co-workers who had to work multiple jobs to sustain their families. Typically, these nurses supported not only themselves and their children, but also extended family members.

### **Men in Mexican Nursing**

The issue of male Mexican nurses proved to be a consistent theme for discussion. This new wrinkle for the traditionally female profession brought a decidedly mixed reaction from the female interviewees in the study. This section begins by describing the perspectives of the three male nurses from the study and follows with perspectives about men in nursing from the female nurses.

All three of the male Mexican nurses, consciously or not, conveyed some conflict over being male and a nurse. The men genuinely found their experiences as nurses to be rewarding, but expressed frustration with the institutional challenges imposed on the nursing role because of its feminine associations and public image. This translated into frustration with administrative structures, the nature of workplace relationships, and variety of other experiences.

Illustrating the social challenges of being male and a nurse, Nurse 14 (married, one child) chose to enter nursing straight out of high school. He described the social challenges he faced, especially when it came to dating.

To be a male nurse in this society, it does not accept you. Now it's better, but before (like ten years ago), a male nurse wasn't looked upon favorably. I felt uncomfortable. Imagine it: I had girlfriends but they felt uncomfortable with me because I was a male nurse and they'd say things like 'Hey, why don't you pursue some other career?'

His words describe a Mexican social construct of gender associations with certain kinds of work. Mexican women appear just as guilty in perpetuating these stereotypical associations as men.

Mexican men who enter nursing also face the persistent stereotype of being homosexual or being a sexual deviant. One nurse, showing a keen awareness of the hypocrisy of the stereotype, countered conventional thinking when she, speaking of men in nursing, said "You know, women can be sexual deviants too...sexual problems are not just a male problem."

Nursing professors interviewed in the study did report that the 2004 status elevation of the bachelor's degree in nursing qualification to "professional" status in the national salary

indicators has brought more males willingly into the profession. Research by Mexican nurses also suggested an increase in male student enrollments (González Velázquez, Salazar Hernández, Crespo Knopfler, López Gudiño, & Carmona Mejia, 2001; Müggenburg, 2004; Müggenburg, Barreto Plácido, & Garcia Ortiz, 2006; Salas Segura, Zárate Grajales, & Rubio Domínguez, 2002).

With the changing enrollment demographics, one faculty member conveyed a series of mixed emotions about increased male enrollments in the traditionally all-female school. Overall, her thoughts and feelings ranged from excitement about the new possibilities increased male enrollments meant for the profession to concern about replicating external intergender social dynamics in places where, historically, girls were allowed to excel free of the traditional norms that the professor perceived as barrier to their individual development. With thirty years of teaching experience and a Ph.D. in education nearly completed, her depth of knowledge about the issue and experiences brought her to reflect on the situation this way:

...what we have seen during the educational process is...that we end up replicating the same stereotypes that we have in the home, right? ... for example...when they have to choose a group leader, it ends up being the boy. When there are opportunities to go to a conference or some other activity outside of school, it is the boys who end up going. The dynamic starts to replicate itself here even though the boys are not the best students and not the best prepared. They get elected to represent us because [the girls] have been socialized to give preferred treatment to males. I think it is a very serious problem because the students all bring these ideas with them from their families. First, it replicates in the school and then the workplace.

Her words illustrate the persistent challenge that nurse educators face in preparing students. The nursing role requires a socialization process that frees the female student from what they were taught to believe about men and women growing up. This nursing socialization process, confirmed by statements from the majority of interviewees in the study, creates young women who are very independent. In learning to care for others, they learn how to care for themselves without requiring the support of a man to do so — unless she chooses that kind of support.

Therefore, the concern about males shifting the socialization dynamic within the educational environment is a legitimate one.

Finally, the increase in male nurses —simply for their gender— appears to be helping to improve the public image of nursing by identifying it more as a profession. This suggests that the concept of a “profession” is ascribed to inherently male characteristics, normally assigned a greater social value in Mexican society.

### **The Work-Family Balancing Act**

Like working women everywhere around the world, Mexican nurses face persistent challenges about balancing work, family issues, and child care. For female nurses, whether married or single, balancing work and family demands was a consistent theme for female nurses throughout the interviews regardless of the participant’s age.

Nurse 2 provided an excellent example of balancing the numerous challenges of working Mexican women. She is married with two children and received two graduate degrees while raising her family and taking care of her home. She described the challenge of balancing work-family demands by using the phrase “*es difícil*” —“it’s difficult”—ten times when referring to the juggling act between work and family.

It’s difficult....This thing about combining roles of housewife, wife, career woman, and everything, it’s very tiring, terribly complicated....I think that we as nurses are people who sacrifice everything, not just in the workplace, eh? Not just here, but also in the home.

Analysis of Nurse 2’s interview also revealed how female education changes conceptions about personal relationships and traditional gender roles that relate to the balancing act. Nurse 2 conveyed that the years she spent pursuing more education changed her perception of how much responsibility she should have for housework. Since her schooling is equivalent to her husband’s, she believes the housework responsibilities should be shared equally.

Meanwhile, from a managerial perspective, a nurse who worked as an administrator in an ISSSTE hospital described trying to change institutional policies about child-care services in order to support nurses working evening or night shifts. She surveyed nurses working those shifts and found that:

...they told us that their biggest worry was what would happen to their daughters. Or to their small children, because they all knew of some man or woman who had some sort of violence happen to their families, so they go to work with this fear. If we had a night childcare service, this would be a great benefit. Now it's just for the morning, so yes, we have something but it's insufficient.

At present, childcare services in Mexico are only available to women working daytime hours. For nurses working night shifts, they must rely entirely on family members or friends. Some nurses even described stories of former employees locking their children in their homes alone because they had no other option. With the threat of violence in some Mexican cities, the concern for their children may compromise their ability to perform well on the job.

In another illustration of social changes related to traditional relationship norms of Mexican society, Nurse 41's reaction to work-family balancing and some aspects of male-female relationships in Mexico brings yet another dimension into the picture. A young, unmarried, single mother with only a few years of nursing experience, she supports her daughter and parents with her nursing salary. Her mother lives at home with her to provide child care while her father travels back and forth between their rural village home and the city. Recognizing the "extra" demands a marriage places on a career and describing her own experience as a single mother, she stated:

You're always tired...I imagine more so for my co-workers who have husbands, who have to wash their clothes, iron them, and no one to help them, doing everything in the house, or also, doing everything else you need to do as a woman, a mother, and all that. It has to be worse...

Like many younger nurses, during her interview she conveyed a sense of resisting traditional expectations of male-female relationships in her personal life. All of the nurses under age 35

interviewed for the study conveyed a greater sense of egalitarian ideas and expectations in their male-female relationships than their more experienced counterparts from a different generation. Her statement also suggested that female Mexican nurses, unlike their female physician counterparts, may not be able to afford to pay for help in the home to offset some of their domestic responsibilities.

### **Female Education - Barriers and Facilitators**

Absolutely critical to the professionalization process is the access females have to education at all levels and ages. How women obtain an education, along with factors that facilitate or block access, is linked to a country's ability to produce nurses. The professional level of education—defined by nurses in this study as the BSN—is an important distinguishing factor because the nurses all described how the process of attaining this degree, not the technical or auxiliary level of training they may have previously received, was what “woke them up” and “opened their eyes” to who they could be as individuals. The educational process affects the quality of nurses produced and the health-system's ability to improve its functional capacity.

Despite this, there are numerous barriers to Mexican women achieving education at any level. They can come from family members, spouses, institutional biases, and many other sources.

Nurse 37 opted to return for graduate study for herself and to benefit her family through the expanded career options. She described not only the example she feels she sets for her children, but also the supportive culture she found in her graduate nursing programs:

The majority of my classmates...bring the kids to school ...It's not an inhibitor for us. And aside from that, I think you are teaching the kid that mom is going to school to be better educated, no?... Instead of sitting in front of the TV watching *novelas* all afternoon.

That Mexican nurses can bring young children to class demonstrated two points. First, it shows

that there is a lack of affordable childcare for women who want to pursue education beyond the traditional university years. Second, it reflects how the nursing profession compensates for this lack of services by creating a supportive culture for childcare for those who can afford to pursue graduate education. Flexibility in the educational process, therefore, becomes an important theme for the professionalization of female-dominated occupations and could prove important for the growth of human capital in Mexico.

Most of the time, however, for most Mexican women attaining a professional education requires a lot of sacrifices. The following statement by Nurse 41 highlights the struggle many young women face in pursuing a university education:

I suffered a lot of things...so much because I had to work and study. My parents could not afford to give me anything when I was in school...my brother and I...came to the city with nothing and started working for the very little that I got paid...I endured a lot of suffering to finish my studies...because I could not eat. I'd go to school and have eaten nothing...It would make me so sad because...well, when you want to eat and there is nothing, it becomes nothing but suffering.

Nurse 41's story of her struggles highlights the financial barriers many young women face in achieving a professional education. As this interview progressed, she articulated a fierce desire to reject the circumstances she started from, that the power to change her life was in her hands, and that education was a key component in her ability to do those things on her own.

Nurse 13, a professor and diabetes educator, described another common barrier for some Mexican women: their husbands preventing them from studying more.

Here we've had cases of students that tell me, 'I'm leaving school because my husband doesn't want me to study more; I'm leaving school because my husband won't watch the kids.' So they've lost the possibility for personal growth and for others, because of a situation where a macho, a spouse, or a family situation doesn't allow them to continue.

Another professor interviewed in this study described the unanticipated effects of a distance education program designed to develop auxiliary nurses obtain technical and bachelor's degrees in nursing.

...in one state, Baja California...when the open university system came there, there were many nurses aides that entered the system and it changed their vision of the world. Their whole world vision is totally different! They see all the power they have as people, as humans, that they have the same potential, or more than the men that are dominating them. They not only changed as nurses, but also as persons. Then they started to have big fights with their husbands. It created a special situation because the majority of women finished their studies divorced. They ended up divorced because they had so many problems with their husbands because their eyes opened to the world.

The professor's description of a rather dramatic social change that occurred through nurses professionalizing demonstrated how women's lives are changed through education. She believed the change to be positive because it increased the self awareness of many nurses and helped a number of them escape from abusive situations.

These findings demonstrated that spousal dynamics can be a significant influence on the success of nurses who choose to professionalize. This is further illustrated by the fact that all of the married women in the study had very supportive spouses who were not threatened by their quest for more education and greater self-actualization.

### **Evolving Women: Generational Differences and Intergender Dynamics**

Evidence of a generational social change regarding typical gender roles emerges from this research. There was a distinct generational difference in responses about gender between nurses under 40 and those over the age of 40.

Younger nurses spoke of relationships between the sexes and expectations of the opposite sex as much more egalitarian and articulated, quite clearly, that they expected to be treated with respect because of their level of education. Nurses under the age of 35 also universally described working with male nurses, for example, as a "positive" experience. One of them captured the general sentiment of the group when she said, "They think totally differently...from female nurses and this also helps us to grow because we are seeing things from another point of view."

Younger female nurses did acknowledge that they continue to face obstacles related to their gender and having a career, but did not see the obstacles as insurmountable in their lifetimes. Finally, for many, their concept of gender issues in nursing related only to an increase in the number of men in nursing. It did not transfer to what it is to be female, how that affects nursing's development, nor how it affects their own lives and choices available to them.

Nurses over 40 had a much more polarized view of male and female roles, relationships, and limitations. They demonstrated a deeper gender consciousness in terms of injustice faced by Mexican women, especially when it came to access to education and having a career. Sophisticated concepts of gender in relation to nursing belonged almost exclusively to nursing faculty or those with graduate degrees.

Older nurses expressed a series of mixed views about working with men, mostly in the form of finding them useful for assisting with the "heavy lifting" work of the bedside nursing role. In a reflection about stylistic differences in role enactment between male and female nurses, a middle-aged nurse stated:

I think sometimes men don't like our kind of work, that's my opinion. Because you need to do things that require a delicate approach and lots of patience to do them and many times, the men don't have the patience to do those kinds of things.

The generational differences in concepts about gender are clear from the interviewees. Change is occurring in the most recent generation. It also supports the finding that a generational shift about gender concepts is occurring among females and males in Mexico, but remains deeply rooted in social norms that are slow to change.

#### **PROFESSIONALIZATION: THE INFLUENCE OF INTERNAL DYNAMICS**

To this point, this study has shown how variables external to the Mexican nursing profession affected its development. The internal dynamics of the profession, however, add

another layer of complexity to the professionalization process. Previous sections touched on a few aspects of the internal dynamics of the profession between 1980 and 2000. This section captures the current nature of these dynamics and how they are affecting the development of nursing in Mexico.

This section starts with an examination of the reasons why young men and women in Mexico choose to become nurses. This information is especially important to professional recruitment. Autonomy, leadership, and the importance of profession-specific knowledge are also explored as critical internal factors in the professionalization process.

### **Reasons for Becoming a Nurse**

In the face of so many expanded career opportunities for women in Mexico, it is important to understand why women choose to enter the nursing profession and remain in it. *Ayudando a los demas*—helping others in need and the personal satisfaction it creates—was a universally cited by nurses in this study as among the reasons for entering into the nursing profession and staying in it. Thematically, economics, familial influences, and destiny were the three main reasons cited by nurses for entering the profession. The following section further explores each of these elements in relation to nursing as a career choice.

#### *Economics*

Since after the Revolution ended in the 1920s, many Mexican women chose to study nursing because of the economic security provided by a job within the profession (Cortés Ramírez, Villareal Guzmán, Martínez Benítez, Guerrero Hernández, & Padilla Hernández, 1981; González Velázquez et al, 2001; Pérez Roman, 1987; Ramírez Díaz, 2005; Verde Flota, Ortíz Hernández, Monroy Rojas, & Valle Arcos, 2004; Verderese & Garcia, 1974). The economic stability or instability experienced by each generation of nurses informed their career choice.

A clear distinction in economic reasons for choosing nursing emerged between nurses over the age of 40 and those under the age of 40, suggesting a generational difference related to economics. Many nurses over the age of 40 came from families of lower income backgrounds that did not fit into the economic middle-class. While low-income women in Mexico have historically worked outside the home to contribute monetarily to the family, the economic crises of the 1980s and 1990s made this a necessity for middle-class families too.

Nurses of all ages in the study frequently described the economic circumstances of their families as the primary reason driving them into nursing because it was a “quick career” that did not require a long period of study. Wages paid to nurses, prior to the economic crises of the 1980s, allowed them to sustain a steady middle-class existence and contribute to the family’s household income; thus, easing a family’s financial burdens. A nurse’s financial contributions to the household helped her to fulfill social expectations about female roles in families of lower income status. In the 1980s, however, their income changed from “added” household income to necessary income required for the family’s survival.

A few nurses in the study also reported opting to study nursing first so they could pay for medical school in the future. Nurse 5 relayed advice her mother gave her when she was instructed to “‘Study nursing now so you can support yourself when you want to go study medicine’.” Nurse 2, a hospital administrator, reported that many male students now opt to study nursing at the vocational high- school level as a pre-medicine course of study. She stated that many of these male students go on to work as nurses to support themselves during medical- school studies. “It will make them better doctors down the road,” she said, “so I think it is a good thing.”

Of the nurses who indicated nursing as a second career choice because they could not afford medical school, none went on to study medicine. They described becoming intrigued by

the nature of nursing work along with the career opportunities afforded by the profession. These nurses expressed a strong loyalty to nursing and a deep commitment to developing its service potential to Mexican society.

#### *Family Influences - Positive & Negative*

Families influence career choices in both positive and negative ways. For some, a career choice is made because of positive encouragement from siblings or strong role models. For others, it is a reaction against parental wishes. Negative family influences may push nurses into the profession, but research by Mexican nurses also suggests that family dynamics affect the likelihood that a student nurse will complete his or her studies (Avila Jiménez, 1984; Vargas Daza & Solís Guzmán, 1997).

To start with, many nurses in the study indicated that their siblings were the ones who most often provided positive support for choosing nursing as a profession. For example, Nurse 1 wanted to get an education and have a job that would allow her to support herself, but her father did not believe that women should study or work outside the home. Her older brother, however, said he would pay for her schooling as long as she chose something that did not require many years of study. She chose vocational-technical nursing program that only required three years of study. Her academic success during the program encouraged her younger sisters to attend both high school and university. Nurse 1's academic success actually changed her father's perspective about female education and, she reported, paved the way for her younger female siblings to obtain higher education. Many nurses were very conscious of the example they set for siblings and other female relatives by choosing a professional education.

Male nurses interviewed for the study, not surprisingly, found all kinds of familial resistance to becoming a nurse. One male nurse stated with a touch of sarcasm, "I didn't want to do this just to dress in white and so they'd pay me well...In my house, they almost ran me off."

On the other hand, Nurse 29, a male nurse in his 20s, talked about the support he received from his brother for choosing the profession. Wrestling with the common stereotypes of homosexuality and sexual deviance associated with male nurses, his mother was adamantly against him studying nursing as she did not believe it was appropriate work for men. For support, Nurse 29 sought out his brother and described his reasons for studying nursing to him. After reflecting on the discussion, his brother said to him, “if you’re going to be a nurse, be a *good* nurse, and not just one of the ordinary ones.” The brother’s statement implied significant support for his choice that mediated Nurse 29’s mother’s reaction. Yet it also suggests that the negative public image of nurses was something he expected his sibling to overcome by performing exceptionally on the job.

Some nurses in the study identified other family members who were nurses, usually aunts or grandmothers, as role models. One nurse, the only sister among five brothers, described herself as fated to enter nursing because every female in her family was a nurse for as long as she could remember. Others described physician relatives who were supportive of their choice to study nursing. Many of these nurses accompanied these relatives while they practiced. This provided them with the opportunity to observe the role of the nurse in action and was a strong influence in their decision to study nursing. Nurse 29’s exposure to nursing in the hospital setting as a patient also illustrates the effect that observing the nursing role in action can have on young people considering careers in healthcare.

The social class level of families also appears to influence career choice. In this study, some female nurses from middle- and upper-middle-class families dominated by other professionals experienced greater resistance to their career choice from family members of all kinds compared to nurses coming from families of lower socioeconomic status. Nurses from middle-classes felt compelled to prove to their family members that nursing was more than what

its poor public image portrayed. In contrast, nurses from poor or lower-middle-class families often reported they were the first professionals in their families, a status that served as a point of pride for their parents who frequently attained little more than a junior-high level education. These findings suggests that social-class backgrounds of nurses will influence the choice to become a nurse.

#### *A Sense of Destiny*

Early formal caregiving roles in Mexico evolved out of the Catholic Church (Alatorre Wynter, 2003). The religious caregiver role never disappeared completely from Mexican society and many nuns continue to work as nurses in the HCS (INSP, 1987; Pérez Roman, 1987; Suárez Vázquez, 1997). The mystical aspect of a religious-like calling to the profession manifests itself through many nurses' statements about their decisions to become nurses, but most strongly in Nurse 15's description of how nursing "found" her. She used the word "destiny" to describe her career choice no less than twelve times during that part of the interview. As her quote below demonstrates, the "calling" aspect also translates into her interactions with students.

...for me, nursing is something mystical, no? Something more than a profession is what I tell my students...more than a profession or a vocation, I believe it is a mission. They could be whatever they want...but something told them to be nurses...they do not have to be here, but even in their last semesters, I see them identifying well with the career, working well and very happy. I tell my students ...I believe God has assigned us to [nursing], and not just anyone is selected. You were all chosen...and it is a privilege and a pride... .

Her words emphasize the exclusive nature of having a calling for a career.

Other nurses interviewed for the study also recognized the same aspect of choosing to be a nurse. "So, not everyone has this service vocation, right? This vocation to take care of patients" said Nurse 32 when she talked about her own reasons for becoming a nurse. For Nurse 7, a women's health nurse from Mexico City, the nature of nursing work is a fundamental part of her concept of what it is to be human. Again, using the language of destiny, she said, "I believe

it's part of you if you have a calling to help, to be useful, to care. It's everything that is my idea of being a human being.”

Finally, for some nurses in the study a recognition of destiny in reference to their career choice came later in their careers. Nurse 11, for example, described how she did not like nursing while in school. She reported that only later on in her career as she advanced in the profession did she realize that nursing was her true destiny in life. Through her work she found a sense of what could be described as a spiritual fulfillment.

### **Autonomy**

Autonomy is an important concept in the professionalization process. For nursing, it affects the profession and the workplace in a constant, dynamic interaction. It shapes their political participation in Mexican society and their ability to withstand economic fluctuations. Thematically Mexican nurses indicated that autonomy is most important in three key professional areas: governance, education and role enactment. Repeatedly, Mexican nurses in the study interviews emphasized the importance of autonomy. Support for their statements is echoed in nursing journal articles, government documents, and policy statements by PAHO and WHO on the subject.

Nursing journal articles written between 1980 and 2005 repeatedly state that nursing experienced a decrease in autonomy in the governance of its own profession during the twentieth-century (Antiga Trujillo, 1982; Mejia Zepeda, 1990; Navarro Salazar et al, 1978; Ostiguin Meléndez, 2002; Rodríguez Domínguez, 1997). Mexican nursing leaders constantly reiterated the need for increased autonomy in the governance and education of the profession so that it could adequately respond to the changing needs of society (Aranda Flores, 2002; Babb Stanley, 1994; Balseiro Almarío, 1988; Cárdenas Maldonado, 2001; CIE, 2001a; Ibarra

Castañeda, 1995; Marín Chagoya, 2000; Martínez de Dávila, 1999; Medina Rocha, 1994; Morales Rodríguez, 2000; Nájera, 1981; Nava Ramírez & Cabello Bonilla, 2000; Rodríguez Domínguez, 1997; SSA, 1994c; Silva Luna, 1998; Sosa Vázquez, 1981; Villela Rodríguez, Cruz Colunga, Saucedo Ramos, & Meléndez Torres, 1987).

Often times, increasing professional autonomy meant nurses freeing themselves from patriarchal controls, like simply being able to choose to wear pants to work instead of a dress (Balseiro Almario, 2004). A lack of professional autonomy was also attributed to the poor public image of Mexican nursing (Comité de Expertos de la OMS, 1996; Ibarra Castañeda, 1995; Medina Rocha, 1994). If nurses were not even allowed to choose their uniforms, it is not a surprise that their public image fared poorly as a result. Frequently, however, documentary evidence suggests that Mexican physicians still played a large role in defining nursing roles in institutional settings, thus limiting nursing's autonomy (Cabral Soto, 1997; Perez Loredo Diaz, Lugo Botello, Rodríguez Andrade, Martínez Salazar, Ibarra Gutiérrez, & Medina Hernández, 1999; Rojo Padilla, 1997). The educational level of physicians was frequently used to justify this professional dominance.

Nonetheless, from the literature analysis an interesting trend emerged: The discourse about professional autonomy exploded after the implementation of NAFTA. Mexican nurses wrote a total of 19 articles dealing with this subject between 1994 and 2005, compared to just four between 1980 and 1993. In studies of Mexican nurses, they began to report increased levels of role-based autonomy in some institutions in the early twenty-first century (Cárdenas Maldonado, 2001). The State also made nurses responsible for a national monitoring project of three key indicators of quality nursing care (CIE, 2003a). This further supports the argument that NAFTA was a positive force for the development of the nursing profession in Mexico. The following sections describe key areas where the discourse about professional autonomy emerged

in Mexican nursing.

### *Autonomy in Educational Governance*

For the education of nurses, autonomy is most important when it comes to directing the nursing school. Today in Mexico, of the 100 BSN programs in Mexico, 92% are directed by nurses (Arroyo de Cordero, 2005). For the 403 technical degree programs, only 28.4% are directed by nurses with over half of the remaining programs directed by individuals who are not even nurses or healthcare professionals (Arroyo de Cordero, 2005). The literature shows a wide range of numbers for nurses directing nursing schools, fluctuating between the low and high provided by Arroyo de Cordero (2005), but historically averaging around 60% (Arroyo de Cordero & Jiménez Sánchez, 2005; Avila Jiménez, 1984; Pérez Loredo Diaz et al, 1999).

A quote from a former nursing school director illustrates what happens when nurses do not have autonomous governance over their own educational programs. Nurse 32, in her mid-thirties with a masters degree in sociology, described why she had to leave her former position as a nursing school director for a BSN program, despite loving the job. During the interview, she revealed that the director over her section of the university was a graphic designer without any experience managing professional education programs. He received the job as a political appointment because he knew someone in the newly elected state government. He refused to allow her to manage the school the way that she knew was correct for nursing as he believed all professional curricula should follow the same pattern. Her indignation at being forced to follow the direction of someone without any qualifications in the healthcare field was clear in the interview:

They asked me not to, that I would not give up my position as director of the nursing school, but it would have been the worst thing I could have done for my career [if I had stayed]. Why? Because I would be leaving my career choices in the hands of a graphic designer, which would be stupid. But I couldn't bear it any longer, and I decided to leave, to resign the position. Now, I know they are having lots of problems, that the students are complaining a lot, no? They complain that don't have classes, teachers,

library resources, nothing in the computer centers, everything less in nursing, no? So now, [without a nurse to run the nursing program], there are lots of problems in the university.

Her statement highlights two key points about autonomy and professionalization. First, having professionals managing the entry-level programs of their future colleagues is important for producing qualified graduates that are ready to practice. The second important point is that the governance of nursing schools is also tied into political alliances, gender dynamics, and university organizational structures. If the minimum requirement for serving as a director of an educational program at a university is a bachelor's degree, the lack of nurses with BSN-level education makes it difficult to have nurses governing their own professional education. Since nearly half of all nursing programs in Mexico are managed by non-nurses, this may prove to be a greater problem than many realize.

#### *Education and Autonomy*

The second important aspect of autonomy relates to the quality of role enactment of nurses. Frequently, nurses must be able to make decisions about patient care without a physician's order. To create new roles for nurses, they must be able to demonstrate that they can make these decisions on their own through a solid educational foundation.

In the interviews, nurses universally linked education (technical or higher) with their ability to act autonomously and correctly at the bedside. For example, Nurse 15, a former career auxiliary nurse now pursuing her masters degree, described the effect of higher education on her concept of nursing when she referred to her initial pursuit of a bachelor's degree at the ENEO. She said, "here is where my idea of what is was to be a nurse was broken, in a good way." Like many of her nursing colleagues interviewed in this study, professional education fostered a new sense of autonomy and security in their ability to deliver care to patients.

A nursing director in a hospital perfectly described the link between education,

knowledge, and the ability to act with confidence about one's decisions when taking care of patients.

If you don't know, you cannot act, and all the time you will be submissive, waiting for someone to tell you what to do...So you must continue getting education, that you keep awakening to new knowledge; that you keep learning about other perspectives, so that you *really* know what you need to do to take care of a patient. But if you have never read, or attended a conference, or gotten a certificate, or completed a university degree, only what you hear is what you're going to be able to do... .

Her perceptive comment on the problems with experiential knowledge versus formally acquired knowledge highlights an ongoing battle within the nursing profession in Mexico between experienced nurses with little or no formal education and those newly entering the profession with higher levels of education.

Several nurses in the study commented on how this dynamic manifests itself in practice in a phenomenon that could be described as “the importance of knowing why” versus experiential knowledge. One professor described how her adult-learner students frequently comment, “I always knew *how* to do this procedure. I knew it perfectly, but I never knew *why* I was doing it.” An experienced staff nurse described it as learning by doing, where they had “five or six nurses working on the service and if one didn't know how to work a piece of equipment, there was always someone who had been there long enough before you that they taught you on the job.”

As younger nurses increasingly pursue technical or BSN-level educations, the educational disparities between older and younger nurses will continue to increase. A new graduate nurse's comment about the educational tensions within parts of Mexican nursing illustrates this evolutionary challenge. She said, “sometimes there is something I don't know...and if you have a higher educational level than your co-worker, then they say ‘you studied, so you ought to know.’” A nursing professor and veteran hospital administrator further explained the phenomenon, attributing it to the fact that “most have practiced based on empiric

observation of others and just to do the task, but not think about what they're doing." Time may resolve this issue but meanwhile it will affect the work environments of nurses by increasing co-worker tensions and decreasing teamwork.

### *Role-Based Autonomy*

New roles for professionals are part of the evolution of a profession. Role-based autonomy becomes most significant in the face of malpractice and legal issues nurses confront in their practice. Mexican nurses interviewed for the study frequently used emergency situations to highlight the importance of role-based autonomy. A pediatric nurse described role-based autonomy as "that one, in the moment, can act and not that you have to call the doctor first [in order to act] when he is not there. Then you wait and wait while the patient dies." A medical-surgical nurse reflected a humanistic perspective about caring for people in a technology-laden environment when she said, "At best, if you screw up something with a machine it will break and a technician will fix it. But to a patient, if you do something bad, your putting the patient's life at risk...and who's going to fix that?" Both of their statements highlight the importance of having the knowledge to act in a timely manner in order to prevent something worse from happening to a patient.

With the increased responsibility and risk that goes along with role-based autonomy, however, comes the assumption of increased protection from the State on the part of Mexican nurses (Aranda Flores, 2002; Cabello Bonilla, 1998) and a form of self protection that acts in the best interest of patients (Aranda Flores, 2002; Navarro Salazar, 1992). These factors link back to the "importance of knowing why" phenomenon described in the previous section. The knowledge-autonomy link is also frequently cited by nurses when they describe protecting themselves from errors their colleagues or physicians might make when caring for patients. A staff nurse with over fifteen years experienced described the importance of having enough

knowledge to foster autonomous decision-making as a form of self protection:

...sometimes doctors make mistakes, so a nurse needs to read, and read, and know as much as she can so she does not make a mistake. Because sometimes the doctors write an order...like an overdose of a medication, then you can have adverse reactions happen in children, or poison them. So a person has to read, more than anything.

Thus, autonomy for Mexican nurses comes from their ability to acquire knowledge and apply it to practice. The quality of that knowledge directly translates to the quality of care they are able to provide and the timeliness of their responses to fluctuating patient conditions.

Nurse 30 commented, “Knowledge gives you autonomy and that gives you power.” The power element of autonomy for nursing is, perhaps, the most threatening piece of the professionalization process. When nurses attain increased power through more autonomous practice, the traditional patriarchal elements of Mexican society that rest on maintaining control of females can feel threatened.

### **Professional Knowledge: Education, Generation, and Dissemination**

One of the traditional “traits” of a profession is the existence of a specific body of knowledge representative of the work of the profession. Aguilar Hernández (2004), a Mexican nurse educator, aptly described knowledge formalization as the transition from just knowing “what to do,” to also knowing the “why” behind a nursing action. Mexican nurses produce their own knowledge through anecdotal, educational, and research methods (Alvaro de Silva, 2002; Andrade Cepeda, 2001; Antiga Trujillo, 1996; Babb Stanley, 1991; Balseiro Almario, 1987; Calderón Magaña, Garcia Ramírez, & Acosta Bernal, 2002; Casique Casique, 2000; Castrejón Huico, 1995; Centro Interamericano de Estudios en Seguridad Social, 1992; CNE, 1992d; Collado Soto, 2000, 2003; Espino Villafuerte, 1994; Cruz Quevado & Salazar González, 2004; Garcia Garcia, 2003; Garrido Abejar & Serrano Parra, 1994; Hernández de Sandoval, Rivadeneyra Hernández, Ramírez Sánchez, & Zambrana Castañeda, 1987; Ibarra Castañeda,

1994b; López Cisneros & Jordán Jinez, 2003; Malvárez, 2002; Medina Rocha, 1993a; Monroy Rojas, Verde Flora, & Garcia Jiménez, 2002; Mora Carrasco, 1994; Morán Aguilar & Mendoza Robles, 1994; Ostiguín Meléndez, 2002; Pérez-Gil Romo, 1993; Quesada Gudiño & Cuevas Cancino, 2003; SSA, 1994c; Tena Tamayo, Manuell Lec, & Sánchez González, 2003; Valdivia Moreno, 2003).

Professional knowledge constantly evolves; therefore, professionals must constantly update their knowledge base to keep their practice current. The study participants also stressed that this knowledge, which helps to foster autonomous decision-making as a nurse, should be generated from within the profession even if it was adapted from other disciplines.

Drawing from the materials produced by Mexican nurses, this section describes the pattern of knowledge production by Mexican nurses between 1980 and 2005, highlights the factors that affect dissemination and production, and identifies additional barriers Mexican nurses encounter when creating or seeking out nursing knowledge produced outside of Mexico.

The majority of knowledge initially produced by Mexican nurses in their journals was anecdotal in nature and gradually moved toward research-based knowledge as the research culture developed in the country. During the period of study, Mexican nurses produced professional knowledge through journals, conference proceedings, and books. The subjects they chose to disseminate are tied to professionalization topics, in addition to clinical ones. They included new educational models for technical and bachelors-level nursing degrees (Alvarez Vázquez & Murillo Pacheco, 2004; Antiga Trujillo, 1982; Arroyo de Cordero, 1991a; Avila Jiménez, 1983, 1984; Castro Ceja, 1994; Comisión Ad Hoc para el Diseño de Plan de Estudios de la ENEO, 2005; Espinosa de los Monteros, 1979; Estudiantes de la Escuela de Enfermería y Obstetricia de Chihuahua, 1991; McDermit, 1984; McDermit, 1987; Morán Peña & Espino Olivares, 1991; Muñoz Jiménez, Blanco Monje, & Arroyo Cabrera, 1991; Nájera Nájera, 1994;

Nicolas Cisneros, Martínez Castro, & Pérez Maya, 2006; Pina Osorio, 1984; Ponce Cortes & Quesada Fox, 1994; Ponce Gómez, González Judrez, & Bernal Becerril, 2006; Reiss, 2005; Soberanes Velázquez & Martínez Martínez, 1987; Trujillo Moreno, Gómez Espinosa, & Merlin Pichardo, 1978; Villela Rodríguez, Cruz Colunga, Saucedo Ramos, & Meléndez Torres, 1987), the challenges Mexican nurses faced for completing CE courses (Ballinas Aguilar & Gómez Mejia, 2004; Herrera Molina, Mancera Sánchez, & Garcia Campos, 2004), and the few courses targeted specifically toward nursing practice (Departamento de Capacitación y Desarrollo, 1987; INSP, 1992; SSA, 1990, 1992b; Subsecretaría de Planeación, 1986d; Valdés Olmedo, 1986). Mexican nurses' ability to produce nursing journals formalized experiential knowledge by providing a standardized mechanism to disseminate knowledge.

Cabrero Garcia (2000) noted that the dissemination of nursing knowledge is useless if nurses do not possess the financial resources to access it. Economic instability has had a profound effect on Mexican nurses' knowledge production. Through the 1970s, only one nursing journal specific to Mexico existed, published by the CNE. The publication pattern of the journal *Enfermeras* was repeatedly interrupted by the economic crises that occurred in the country. The CNE ceased publishing the journal for nearly two years between 1976 and 1978 due to lack of funds to pay for publication costs. They were unable to produce the journal at all between 1982 and 1989 because, from a financial perspective, the national economic crisis nearly crushed the organization's ability to function. The journal *Enfermería Hoy* was a short-lived production by Mexican academic nurses that began in 1981 and ended in 1985. The editors cancelled publication of the journal due to lack of financial resources for production. Only the journal *Enfermera al Dia* survived the crisis of the 1980s, leaving Mexican nurses with one vehicle for professional knowledge dissemination for most of the decade.

Mexican nurses also recognized that economic instability, among other factors associated

with being female in Mexico, makes the production of knowledge through nursing research very difficult (Méndez Villa & Quintero Crispin, 1999; Morán Peña, 2002; Müggensburg R.V. & Aldana Alcalá, 1996; Saporeti et al., 1991). For example, a study by Melgarejo Silva, Hernández Tapia, and Palazuelos Lacaille (1996) showed a downturn in nursing research production between 1992 and 1995. During this three-year period, NAFTA was implemented, the Mexican GNP had little growth, the Zapatistas went to war against the Mexican State, and the second peso crisis occurred. The combination of these external factors likely contributed to nurses' inability to increase research production during this time.

Nonetheless, with increased economic stability present for at least part of the 1990s, nursing journals began to flourish. Even with the economic shocks of the mid-1990s, most nursing journals produced at least one complete publication per year; thus, knowledge creation fluctuated but developed the ability to sustain itself through economic instability. The CNE resumed publishing *Enfermeras* in 1990 and began to favor the publication of nursing research articles over anecdotal works. Recently, however, due to internal politics and divisions in the CNE, the organization has not published the journal since late 2004.

Eventually, the State realized the importance of supporting nursing-specific knowledge production when it began producing nursing journals for two out of three parts of the HCS. The IMSS system began publishing its own nursing journal in 1992 and regularly published nursing research articles for nearly fifteen years. In addition, the IMSS system developed formal plans to support research projects by nurses (IMSS, 1996). The ISSSTE system also has a nursing journal but publication has been much less regular. The SSA system does not produce a nursing specific journal. The State publishing support for nursing journals within its healthcare system mirrors the class and resource biases within the Mexican healthcare system: IMSS gets the most support and resources while SSA gets the least.

The State's sponsorship of institutionally specific journals solidified its role in one aspect of Mexican nursing's knowledge production process. Other Mexican institutions, however, play roles that influence the production of nursing research in Mexico. Hernández Torres (1987) found that nursing faculty in Mexico faced political barriers to conducting research from various forces in the university system. A study by Monroy Rojas, Verde Flota, and Garcia Jiménez (2003) confirmed her findings when they too found that institutional culture (referring to hospitals) determines support for nursing research projects. Nurses in the study reported that institutional barriers to conducting research are decreasing but still prevalent.

Outside of the public sector, with one exception, *Desarrollo Científico de Enfermería* (DCE), the private sector in Mexico does not contribute to knowledge production for the nursing profession nor does it support nursing research. DCE is a journal started by a large private hospital group in Mexico City in 1993 and is the only one financially supported from sources external to the nursing profession. To underscore how difficult it can be for a nursing journal to publish regularly, the editors of DCE wrote a happy editorial in 2002 celebrating ten years of uninterrupted publication (Medina Rocha & Medina Rocha, 2002).

Institutional politics and a lack of financial resources were already cited as a barrier to knowledge production by Mexican nurses. Other barriers included lack of Internet access, inability to use a computer, and lack of English-language skills. Cabrero Garcia (2000) expressed great hope at the possibilities the Internet presents for increasing nurses access to their own collective knowledge. While researchers have yet to study how Internet access influences Mexican nurses ability to access professional knowledge, its effect in this area cannot be discounted. Since the average Mexican usually cannot afford a computer in their home, Internet cafés proliferate throughout Mexico, even in the most remote villages. At these cafés, access to the internet can be purchased for as little as forty cents per hour. Nursing professors in the study

reported that all of their students knew the basics of how to use a computer and email served as the primary vehicle for school related communications. Nurses under the age of 45 cited computer and Internet use as a normal part of their everyday lives while those over 46 expressed some reluctance at further integrating computers into their work or personal lives. All nurses expressed frustration at their lack of fluency in English as a barrier to accessing a wider breadth of knowledge online from international nursing journals, the majority of which are published in English.

#### *Cultural Coalescence of Knowledge*

Cultural coalescence is a process that occurs when one group selects relevant knowledge from one place and adapts it to a new cultural form in another (Ruiz, 1991). Hodgdon (2000) demonstrated how this phenomenon occurred with Mexican feminists during a similar period as this study. He reviewed articles published between 1970 and 1990 in the Mexican feminist journal *FEM*. Hodgdon's analysis demonstrated that Mexican feminists adapted Western feminist theories to their own struggles in a cultural coalescence of knowledge. Basic tenets of the theories remained the same while Mexican feminists adjusted them to their own cultural beliefs.

The same phenomenon occurred and continues to occur with Mexican nurses as they adapt knowledge and ideas produced abroad to their own practice, education, and philosophical development. Generally, in their professional journals nurses communicate the basic tenets of the knowledge and then describe ideas for adapting it to the Mexican context. Every nursing journal article in this study contains at least one bibliographic reference to nursing knowledge produced outside of Mexico. The external sources come primarily from the U.S. and other Spanish-speaking countries.

Aside from journal references, two specific examples of knowledge coalescence emerge

from the contextual analysis of the literature. These include the integration of theories about the nature of nursing and its services and the application of nursing-service delivery models developed in the United States to the Mexican context.

Nursing journal articles analyzed for this study show that nursing theories by Henderson<sup>42</sup> (Marriner-Tomey, 1994) and Orem<sup>43</sup> (Marriner-Tomey, 1994) are the most widely cited in Mexican nursing journals, especially when referring to the professionalization process. These two theorists were also the most frequently mentioned in the interviews. The second example of knowledge coalescence started in 1994. Reflecting increased interaction and collaboration with nurses from other countries, Mexican nurses began describing the successful testing of operational models for the delivery of nursing care in their workplaces (Alemán Escobar & Molina Rodríguez, 2004; Aranda Flores, 2002; Espino Villafuerte, 1994; Garcia Jiménez, Monroy Rojas, & Verde Flota, 2002; Garcia Jiménez, Moreno Farias, & Monroy Rojas, 2001; Garrido Abejar & Serrano Parra, 1994; Ibarra Castañeda & Yarza Solórzano, 1999; Morán Aguilar & Mendoza Robles, 1994; Torres Lagunas, 2006). Most of these models were developed in US hospitals or out-patient settings.

Overall, findings from this section along with those of Chapter 4 suggest that economic instability affected Mexican nurse's ability to produce knowledge by decreasing its rate and the vehicles available to disseminate it. The Internet has the potential to mediate many of the

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<sup>40</sup> Henderson provided the most internationally accepted definition of nursing and laid the academic foundation for much of modern nursing practice and education. Her work is accepted and adapted by nurses around the globe.

<sup>41</sup> Orem developed the theory of promoting "self care" in patients. She viewed the nursing role as central to helping patients develop the ability to care for themselves during an episodic or chronic illness. By promoting self care in the patient, the nurse reduces the patient's dependence upon the nurse for her caregiving services and learns when and how to ask for help. The patient's confidence in their ability to care for themselves also increases. The striking thing about Orem's popularity among Mexican nurses is that it occurs in such a strongly family oriented society. Anecdotally, when I asked several gender-astute professors about this phenomenon, they replied that Orem's theory helped combat against the negative aspects of family dynamics in Mexico, i.e. those that promote dependence on female family members. The professors believe that Orem's theory can help Mexican women fulfill their traditional social roles in a more productive way, one that does not promote negative dependence on women. Their ideas about Orem's theory merit further testing through a directed nursing intervention study with Mexican families.

knowledge-production issues identified in this study. The findings here also confirm that Mexican nurses possess their own unique body of knowledge created through a process of cultural coalescence of knowledge. “We’ve really come to think that knowledge will open our eyes, not only as nurses but as women in general,” said Nurse 5.

### **Leadership**

The WHO (1996) produced a document to explain nursing roles, encourage investment in nursing leadership development by States, advocate for nurses’ inclusion in the policymaking process, and create a chief nurse for the nation. It concluded that the nursing profession in developing countries often lacked leadership. This finding was reinforced by a regional analysis conducted by Latin American nurse leaders (the *Federación Panamericana de Profesionales de Enfermería*, or FEPPEN<sup>44</sup>) which illustrated the consequences of decades poor nursing leadership in the region. Describing a confluence of factors related to ineffective nursing leadership in the region, the study’s authors wrote:

These variables, associated with a history of subordination to the physician’s work, little participation in the spheres of power, and living at the juncture of political and economic crises has brought a series of consequences to the workplace: unemployment, underemployment, low salaries, long shifts, mass exodus from the profession, unhealthy work environments, and other related problems...(FEPPEN, 2002, p. 17).

Nurses need leaders within the profession and advocates in their workplaces if they are going to remain working in the profession in their country. In the absence of such leadership within the profession, nurses leave the workplace and retention rates are affected. This section aims to show how leadership issues within the nursing profession affect the professionalization process. It draws from the interviews with nurses in the study and materials produced by Mexican nurses about leadership within the profession. The section shows how Mexican nursing

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<sup>44</sup> Panamerican Federation of Nursing Professionals.

leadership dynamics are tied to nursing and women's history in the country, gender, and economics. It begins by describing the leadership challenges internal to Mexican nursing and illustrates some of the positive and negative consequences of how nursing leadership exercises their power at the institutional level.

#### *Leadership Challenges within Mexican Nursing*

Mexican nursing faces a constant challenge of developing new leadership within the profession. As highlighted previously, many Mexican nurses manage multiple demands on their time, including family and a second job for additional income. These external demands appear to inhibit many Mexican nurses' ability to serve as leaders within the profession.

When leaders do emerge in Mexican nursing, however, they tend to have significant impacts on the profession. Twentieth-century Mexican nursing leadership was strongly affected by the death of two key leaders at critical developmental junctures. Maria Elena Maza Brito was a mid-twentieth-century nursing leader whom many Mexican nurses considered the Florence Nightingale of Mexican nursing. They felt she shared many of Nightingale's personal characteristics, including similar class backgrounds, reasons for choosing nursing over other careers, and the fact that she never married (Chávez Contreras, Rodríguez Gómez, Guevara, & Sánchez-Silencio, 1970). She and several other nursing leaders conducted some of the first nursing workforce studies in Mexico that highlighted, through research, the lack of professionally prepared personnel (Maza Brito, Pérez Loredo, & Trujillo Moreno, 1969; Sosa de Ramírez, Rodríguez Velázquez, Ponce de León de García, & Maza Brito, 1969). Her early death at age 40 in 1970, from cancer, was a blow to the profession as it struggled with growing numbers of auxiliary nurses and increasing physician dominance (Pérez Loredo Díaz, 1970).

For late twentieth-century Mexican nursing, a dynamic leader, Graciela Arroyo de Cordero, emerged as an individual instrumental in advancing Mexican nursing throughout her

career which began in the late 1960s. She was a key person involved in the creation of the Comisión Interinstitucional de Enfermería (CIE), a body that created a national network of nurses responsible for developing federal and state level human resources policies for Mexican nurses (SSA, 1994c). Arroyo de Cordero also helped ensure the development of the nursing human resources information system to improve the quality of data available about the kinds of nurses working in Mexico (SSA, 1994c). She participated in the development of NAFTA's trade in nursing services (Arroyo de Cordero & Rubio Domínguez, 1994). Arroyo de Cordero came to believe that nursing had a professional pact with society. She emphasized the need for nursing's professionalization because it would make nurses more capable of responding to the healthcare needs of society (Arroyo de Cordero, 2000).

Nurses from Mexico City, interviewed for the study, described her as a force of nature who possessed a gift for navigating the complex political waters of the SSA to advocate for the professionalization of Mexican nurses. She was described as bold enough to criticize the State while also working with it for the benefit of nursing. Two Mexico City nurses interviewed for the study referred to her specifically as the reason why they chose to obtain graduate degrees and remain in the profession. Unfortunately, like her predecessor Maza Brito, Arroyo de Cordero also passed away from cancer in late 2005. Her death left a leadership vacuum yet to be filled and much of the work she led in the SSA has slowed down. After her death, Bernal de Phelis (2006) called on all Mexican nursing leaders to fill the leadership gaps as part of their professional responsibility to grow the profession.

The work and influence of Arroyo de Cordero illustrates the importance of strong leadership to develop the nursing profession. Her death shows how fragile the professionalization process can be without a leader to promote it. In the literature from the 1970s through the 1990s, nurses repeatedly identified a lack of nursing leadership as contributing to

deprofessionalization and other problems faced by the profession (Castillo, 1998; Guerrero Cansino & Capistran Ocampo, 1987; INSP, 1986; Mayer Celis, 1987; SSA, 1994c). In addition, Mexican nurses recognized that the nature of “being female” in Mexico (as described in the gender dynamics section of this document) contributed to the problems of developing nurse leaders because nurses face multiple, competing social and familial demands outside of their careers (Balseiro Almario, 1988; Castillo, 1998).

The State contributed further to the deficit of nursing leadership at the national level by systematically eliminating a third of nursing leadership in the system between 1970 and 1987 (Pérez Roman, 1987). Work between the CNE and the SSA in the 1990s, however, reversed the trend of the previous two decades—even with the mid-1990s economic crisis (Camacho Solis, Barcena Nárvaez, & de la Fuente Rocha, 1994; CNE, 1992b, 1992e, 1998a, 1998b; de la Fuente Rocha, 1994a; Garcia Jiménez & Garcia Lendeck, 1994; ). Collaboration between the two entities reintegrated nurses into leadership roles within the SSA at both the federal and state levels and restructured nursing roles in hospitals (CIE, 2003c). The CNE’s leadership during the 1990s viewed strengthening the professionalization of Mexican nursing as part of its role (de la Fuente Rocha, 1991) resulted in highly effective leadership from that organization during the 1990s.

#### *Nursing Leadership at the Institutional Level*

Institutionally, nurse leaders are the advocates for nurses working at the bedside. When these leaders exercise their skills in a proactive way, both nurses and patients benefit. This section highlights how institutional nursing leadership affects nursing education levels within an institution.

Institutions that support auxiliary and technical-level nurses returning for higher degrees would be considered “professionalization friendly” places to work. The interview with Nurse 18

illustrated the importance of nurse leaders creating an institutional culture that supports professionalization. She worked at a children's hospital with strong nursing leadership. The director of nursing was a forceful proponent of nurses obtaining BSN- or graduate-level education. She managed to find a way to get upper-level hospital administrators to pay for BSN- and graduate-level education for the nurses. Physicians supported her professionalization efforts because, as Nurse 18 noted, they saw benefits for their patients. She said that the pediatricians reported that the quality of care and type of interactions that they and their patients experienced with nurses with BSN-level education was better than with of nurses with less education.

Nurse 18 provides a clear example of how powerful an influence nursing leadership can be for retaining nurses and creating supportive work environment for them. She left her job at the hospital for a period of time to work at a job that paid more money. The work environment at the other hospital, however, was not supportive of her goals for personal growth nor did it have strong nursing leadership. Consequently, she returned to the children's hospital to work for less money because the institutional support for her individual professionalization was so much stronger.

A similar story came from Nurse 39, except from the nurse administrator side. With over forty years experience in a variety of roles in the Mexican HCS, Nurse 39 deeply understands the importance of effective institutional leadership for nursing personnel. Even though she only obtained a technical degree level of education, and even though she knows they might not return to work at her facility, she pushes her staff to pursue further education. When describing her pro-professionalization philosophy, she said:

I can support them...so that they can go do their clinicals in Mexico City or wherever. I tell them, 'Listen, we'll help you during this time. Go and get your education and don't worry about it, your salary will continue.' ...there is no need to block them, right? Or destroy their dreams about getting ahead, yes? They always need to be getting ahead because if they don't, they stagnate...And if they go work elsewhere, that's OK too because it is about strengthening the profession at the state level...I've always tried to

support them a lot, as much as I can, and I take pride in the fact that so many of them choose to stay when they finish.

Key to Nurse 39's statement is that she can support her staff's desires to advance because she, in turn, has support from higher levels of hospital management, as well as her own desire to do so. Ultimately, this combination benefits her facility through high retention rates, reduced institutional recruitment costs, and improved quality of care. She reported that over 70% of the nurses in her facility had a BSN or specialty certification. Nurse 39 also demonstrated the ability to think beyond the institution to the greater benefit of the profession: more nurses with better education strengthens all members of the profession.

The stories of Nurses 18 and 39, however, were some of the few stories the author heard about effective hospital nursing leaders. When asked about the nursing work environment at their institution or previous institutions where they worked, nurses in the study rarely told positive stories. It was the absence of these kinds of experiences from most nurses interviews that is most striking finding.

The absence of commentary by nurses about supportive nursing leaders underscores the great need for strong institutional nursing leadership. How a Mexican nurse leader exercises her power within a healthcare institution affects a staff nurse's sense of autonomy, her ability to act during an emergency, and the quality of care provided by nursing staff (Navarro Salazar, 1992). Also, many Mexican nursing administrators were found to be resistant to integrating research into their practice (Escoriza Juárez, 1993). Nursing leaders, therefore, contribute to the tone of the organizational culture and can be instruments of or barriers to institutional changes desired by the State. Yet as employees of the State institutional nurse leaders may find themselves caught in the middle between State interests and the interests of staff nurses or the profession.

Nonetheless, Rigoli, Famer Rocha, and Foster (2005) stressed the importance of the State's role in supporting the development of nursing leaders within the country and the

institution. The authors believed that an investment by the State in developing institutional nursing leadership would help advance its goals for providing health services to its society.

Finally, the study hinted that an education gap between Mexican staff nurses and current institutional nursing leadership is emerging because more nurses are obtaining their BSNs as their entry-level degree. This presented a problem for several nurses in the study. Many younger nurses with BSNs expressed frustration with working under managers with less education than themselves. They provided examples of unskilled nursing leadership or the “disappearing manager” phenomenon that leaves patient care units without leadership support when conflicts arise between staff or with patient’s family members. The education gap between staff and institutional leadership is likely to characterize this transitional phase in the profession. Investment by the State in leadership training for these nurses could help mediate some of these tensions.

The education gap also emerged in leadership skills. Nurses often described nurse administrators or supervisors who received their positions for political reasons, not based on skills, merit, or abilities. They also indicated that government health system administration does offer leadership and administrative skills training to health system workers, these sessions rarely focus on content specific to the nursing profession. As a result, the nurses reported that not enough of their colleagues had real leadership or management skills. This deficit affected the nurses’ workplace.

### **THE WORKPLACE**

A Mexican nurse’s workplace is a complex compilation of relationships reflecting the gender dynamics in Mexican society fused with long-term issues related to the management of the HCS. Without a doubt, Mexican nurses interviewed in this study recognize the value of their

contributions to places where they work. An obstetrical specialty nurse put it best when she said, “There could be no doctors, no laboratory technicians, no people who do intakes, but if the hospital had no nurses, it could not function...” The nursing workplace is tied to professionalization because it will influence recruitment and retention of nurses. Workplaces can provide mere jobs or offer career advancement opportunities for nurses.

The data already presented about gender, professionalization, autonomy, knowledge, and leadership all influence the workplace of a nurse in both subtle and overt ways. This section emphasizes variables specific to the internal workplaces of nurses, with the assumption that gender dynamics infuse every aspect of the workplace. A combined analysis of interview data and content from Mexican nursing journal articles about the workplace suggests that themes divide into two areas: the work environment and workplace relationships.

### **The Work Environment**

Few, if any nurses, want to work under poor conditions. Buchan, Parkin, and Sochalski (2003) identified poor working conditions as a significant driver of international migration of nurses. U.S. nursing research demonstrates over and over that the nurse’s work environment plays a key role in job satisfaction and retention of nursing staff.

For Mexican nurses, it is no different. Issues with institutional management, supplies, and workplace dynamics all appeared repeatedly in both the interviews and the nursing literature. The core areas that emerged from this study are analyzed in the following paragraphs. They include hiring practices, staffing, supply management, burnout experiences resulting from problems with these three components of the workplaces, and teaching physicians.

#### *Hiring Practices*

Nurses interviewed for this study reported that hiring practices of State-run healthcare

institutions are rife with politics complicated by unions, physicians, and the Ministry of Health. Nurses in the study reported that one reason for this is that unions and the hospital administrators share control over vacancies. This creates a fractured hiring process that often places overqualified workers into positions that do not match their education level or skill set.

For example, if a BSN-prepared nurse is seeking work right out of school may find that the only vacancy available in a State hospital is for an auxiliary nurse position, and she will get hired into that position and be paid at that rate. There may be experienced auxiliary nurses working as regular staff nurses, administering medications and performing other procedures for which they have had no formal training, while newer, better-educated nurses are relegated to lower-level jobs. Issues of seniority and poor institutional management produce this problem within the system. All nurses in this study with less than ten years of experience described enormous difficulties trying to obtain a full-time position with benefits in State hospitals, but contract work was usually readily available.

Contract work is another element factoring into the hiring practices of the Mexican healthcare system. The contract hiring system emerged from the neoliberal reforms imposed on Mexico during the debt crisis of the 1980s. In this system, personnel are hired for short periods of time, usually three to five months, and it allows for renewal of the contract at the end of the period. In some ways, Mexican nurses working contracts can be considered equivalent to U.S. nurses who work in per diem positions in hospitals. Contract personnel are paid about 25% less than unionized personnel working in the State-run healthcare system. The contract system provides administrators with the ability to easily fire poorly performing or politically incompatible individuals or to cut personnel when resources become scarce. Longer contracts of six months to a year are available, but nurses in this study reported that they are rarely offered because under those types of contracts, the worker can petition to obtain a full time, union

protected position with benefits and a higher salary.

In the synthesis of interview data and materials obtained for this study, it appears that the Mexican government might be using the contract system as a means to decrease the power and influence of the healthcare workers union. The contracting system allows administrators to quickly get rid of underperforming or troublesome personnel. It also provides no job security beyond the individual performance of the nurse, who has no protection in case she receives a poor performance review. The system also leaves a generation of young women in their childbearing years without health insurance, since nurses' salaries are not high enough for them to be able to purchase the new forms of private health insurance in available in Mexico that might cover their medical expenses or those of their family members.

Also important to this section is that nurses interviewed in this study under the age of 35 worked almost exclusively under contracts and found it extremely difficult to obtain full-time, union-protected positions with benefits. The staff nurses also described conflicts between contract personnel and union personnel in the workplace. This frequently came in the form of how patient-care assignments were allocated during a shift, with union nurses receiving lighter workloads than contract personnel. Study participants reported that "regular" staff perceive contract personnel as providing them with a break from the usual patient loads and that nurses making assignments will often given a contract nurse a heavier assignment compared to the co-workers.

#### *Staffing*<sup>45</sup>

Having the right number of nurses to care for hospitalized patients is a key component of

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<sup>43</sup> "Staffing," for nurses working in hospitals, refers to the number of nurses working to care for a group of patients during a shift (eight or twelve hours in the US). Staffing numbers, often referred to as nurse-patient ratios, vary based on the age of the patient, the acuity of their illness or condition, the shift worked by the nurse, and institutional resources. Common daytime nurse patient ratios include: 1:5-7 for adult health units; 1:2 for ICUs; 1:3-4 for pediatric units; and 1:2-3 for labor and delivery. Adequate staffing can significantly reduce workplace stressors experienced by nurses when providing patient care.

good patient outcomes and the quality of care provided to health-system consumers. Adequate staffing creates a sense of institutional support for nurses providing care and reduces workplace stress. Both the Mexican nursing literature reviewed for this study and the interviews confirm that staffing levels are also important to Mexican nurses and their workplaces.

In one of the earliest research studies by Mexican nurses, Piña Pinyero, Romero Pérez, and Flores Falla (1989) identified poor staffing as a source of workplace stress that contributed to high rates of absenteeism and poor unit-level retention rates. The authors defined poor staffing not only as having not only enough nurses, but not enough of the right kind of nurses. The research subjects, a group of technical-level ICU nurses in a large urban hospital, reported frequently having to work with auxiliary nurses with no formal training who were assigned to care for ICU patients. Furthermore, the study found that while institutions may have policies that dictate what staffing levels should be, this does not mean they are enforced—especially when the institution is under pressure to save costs. This research demonstrated some of the first workplace consequences of the State's auxiliary hiring preference policy.

One of the staffing (or human resources) policy consequences Mexico wrestles with today is the large number of auxiliary nurses working in union-protected positions. The healthcare workers unions<sup>46</sup> and the Mexican State, despite public appearances of contentious relationships, always come to mutual agreements about nurse staffing in hospital facilities (Garmendia & Nava, 2002; Ravelo & Sánchez, 2001). Unions supported the previously described State health-system policy of the 1980s that called for 60% of hospital nursing personnel to be auxiliary nurses, providing further evidence that the State deliberately favored the hiring of non-professional nursing personnel (Departamento de Normas de Actividades

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<sup>44</sup> The issue of unions in healthcare institutions in Mexico will be explored further in a separate section. Their influence spreads beyond the workplace and strongly tied to the politics of the State.

Paramedicas de Hospitalización, 1985). This contributes to the present-day staffing issues faced by Mexican nurses and indicates that one cannot assume that Mexican healthcare worker unions will support appropriate institutional staffing levels for nurses.

Only with the creation of the Comisión Interinstitucional de Enfermería (CIE) in 2003 did national policies for nurse staffing patterns in State-managed institutions begin to change. The CIE recommended basing nurse staffing patterns on the number of beds and type of patients cared for in an acute care facility (CIE, 2003b, 2003c). Another recommendation was increased support for the development of specialty practice nurses.

Confirming the findings published in government documents and nursing journal articles, nurses in this study reported a wide range of nurse-to-patient ratios experienced by themselves or their students when working in institutions. Nurses frequently described daytime ratios for medical-surgical units as high as one nurse to care for twenty patients; pediatric nurses 1:5 to 10 for general units and 1:2 to 3 for pediatric ICU; and oncology nurses 1:5 to 8 patients with up to half of those patients receiving chemotherapy. All of these ratios were reported by nurses working in State run facilities.

Private hospital staffing report varied the most as the majority of private hospitals in Mexico possess less than fifty beds. No nurses who had worked in large private hospital facilities were interviewed in this study. Nonetheless, nurses participating in this study who had worked in small private facilities often described being the only formally educated nurse in the facility, with the rest of the care provided by auxiliary nurses.

Nurse 32 summarized the effects of poor staffing on a nurse's morale when she said, "You can come in to work with all the desire to do a good job, but you don't get all the support that you need in order to provide the care that patients need." She further described in the interview how workplace support is tied to staffing patterns because nurses, especially new ones,

rely on co-workers for support when they have challenging patients. A co-worker provides practice-based knowledge and another pair of hands for assistance with the physical aspects of the job. These seemingly intangible resources can mediate systemic workplace problems, such as poor supply management.

### *Supplies*

The lack of supplies for nurses to perform their roles is a persistent theme that first emerged in 1984 –after the first economic crisis– when Gomezjara (1984) described working conditions of nurses in which, among other things, as perpetually short of supplies. In the mid-1990s, faulty supply management in the healthcare system became came to be viewed by some Mexican scholars as a human rights failure by the State to provide healthcare for the population (Garcia Romero, Cano Valle, Cordera, Hernández, Moreno, Ponce de León, & Vargas, 1996).

Many staff nurses in the study commented about the supply situation in Mexican hospitals. Professors or those not working directly with patient care were less likely to discuss the current state of supply management in Mexican hospitals, but they occasionally provided stories from their staff nursing experiences. It was clear from the study that supply management in State managed facilities varied widely. They told, for example, of a lack of clean sheets for obstetrical services, a lack of curtains to help provide privacy for patients sharing rooms, and procedural performance alteration because of a lack of supplies. Nurses universally agreed that private hospitals were usually well supplied with the tools needed to provide nursing care.

Two accounts from nurses in this study beautifully illustrate how supply management problems translate into increased risks for patients and nurses in the workplace. The first story comes from a new nurse, Nurse 41. This nurse, with about a year of working experience, described a situation where a lack of supplies inhibited her ability to respond to emergency situations. She spoke of times when her responses to critical situations were delayed because she

had to run around the institution looking for what she needed, which was not readily available.

Sometimes we get critical patients, we need oxygen so that...so that they can stabilize, right? But sometimes we don't have it, and so you go running around and then maintenance has to install an oxygen tank...but there is no oxygen for the whole service.

A patient with a low blood-oxygen level can compensate for a short period of time, but every second of delay increases the risk for complications. The more complex the patient case, the less likely the patient can compensate.

A second story illustrates the consequences of supply management issues Nurse 14, a married male nurse in his mid-thirties, described how poor hospital management practices can affect the availability (or lack thereof) of supplies. His story demonstrated how hospital administrators in Mexico attempt to save money by not providing "modern" equipment. This practice affects the quality of care provided to patients and increases the risk for worker injuries. His story also reflects the consequences to nurses when they speak out about not having the right kind or amount of supplies to provide care.

I went to work in Nephrology where we took care of all kinds of patients with kidney problems. We did peritoneal dialysis<sup>47</sup>, the old style with only one bag because they weren't buying the double bag system. So you worked with the bag with only one connection and we had to measure the peritoneal fluid by cutting the tube with a razor blade and pouring it into a cylinder. It was very risky because we could have gotten cut. The bosses kept insisting we do it this way, without gloves and even though so many of those patients are likely to be infected with hepatitis. I spoke out about this poor practice and that's when I started to have problems.

The nurse's story concluded with him voluntarily quitting that particular job and in fact, being "encouraged to leave" by the administration. He attributed leaving the job to speaking out to management about the poor working conditions and the lack of supplies.

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<sup>45</sup> Peritoneal dialysis is provided to patients with early stages of kidney failure. As it should be performed today, the procedure requires a two-bag system. One bag drains the fluid from the patient, the other infuses the dialysate fluid that removes the toxins a kidney would normally remove from the body. The procedure should be as sterile as possible when performed outside a patient's home because infection is an extremely common occurrence with these patients. It requires a nurse to wear a mask and gloves to protect the patient and himself from obtaining an infection. The two bag system does not require the use of sharp objects to obtain fluid samples, unlike in the description provided by Nurse 14. It decreases the risk for injury or illness in both the provider and the patient.

Finally, a lack of supplies also increases workplace stress on nurses. A young nurse a few years out of school said, “This stresses you out, when you don’t have medicines, when you don’t have the supplies you need. Or if you have to ask a family member [to get something], and the family member gets upset.” Her statement highlights how some Mexican healthcare institutions require family members to go and purchase medicines or supplies for their loved ones while they are in the hospital. This phenomenon occurs when a medicine or supply material is not on the hospital’s standard list or they simply run out of it. This increases the financial burden on families and adds to the stress they experience when a loved one is hospitalized.

For nurses, the lack of supplies complicates the relational dynamic they have with the family. When families must spend extra money to buy supplies for already expensive medical care (relative to their income), it adds to the stress of the whole hospitalization process. Furthermore, if the family cannot purchase the supply or medication, the patient usually does not get the treatment. The lack of supplies is not the nurse’s problem, but they bear the brunt of familial frustration and perceptions about quality of care provided by the institution.

Mexican nurses, effectively, are caught in the middle between the patient, the family, the administrator, and often, the physician as well. Supply management issues are just one area where that could occur, but it is the most frequent. When nurses do not have the supplies they need within a healthcare system, it can potentially translate into longer length of stay, more procedures, lower patient satisfaction, increased patient morbidity, and more costs to the system.

#### *Desgaste Emocional, a.k.a. Burnout*

Burnout forces nurses to leave their jobs and the profession. It is important to professionalization because it affects both the nursing profession and the workplace in areas of recruitment and retention. Despite the fact that Western medical literature recognized burnout as a risk for nurses in the 1970s, the concept did not enter into the Mexican nursing discourse until

1997—a significant finding given the working conditions described by some of the nurses in this study.

Garcia Figueras (1997), a military nurse in the Mexican army, was the first to publish a study about burnout in Mexican nurses. Among the institutional variables of poor staffing and inadequate supplies found to contribute to the phenomenon, she found that nurses with less education were more likely to experience burnout. López Cisneros and Jordán Jinez (2003) reached similar conclusions and used more international literature sources to guide their work.

Balseiro Almarío's (2004, 2005) research on burnout drew from international literature on the topic to describe its consequences to nurses and the quality of care they provide. Her article aligned itself politically with the quality initiatives of the State, while it also demonstrated the implications of the State's poor institutional-management practices to nurses' ability to provide quality care to patients. Some of her Mexico-specific findings suggested that unmarried nurses had higher levels of burnout, suggesting that the home environment contributes to nurses workplace stress. The research also further supported the idea that workplace factors contribute significantly to burnout rates among Mexican nurses and adds that working multiple jobs is another factor contributing to these rates.

Generally, in the current study, nursing professors over 45, in tune with current research literature, were more aware of burnout and its effects than their younger counterparts. A comment by Nurse 20, a former OR and oncology nurse who now works as a professor, confirmed the presence of burnout among Mexican nurses. She described recognizing the symptoms of burnout in herself years later after attending a conference where a Mexican nurse researcher presented information on the topic. Her main reason for leaving a staff nursing position, she realized, was because she could no longer physically or mentally tolerate her working environment. At the time, she said she thought, "My hospital work experiences have

been enough. I don't want to suffer anymore.”

### *Teaching Physicians*

Many nurses in the study discussed something that few Mexican physicians are willing to acknowledge: nurses are their teachers when they are medical students, interns, and residents. Nurse 30 provided her own reflections on nurses teaching physicians, based on her ten years of clinical experience.

This is what I have observed...in most hospitals... all doctors learn from nurses, no? How to take blood samples, put in catheters, whatever; the nurse is the one who teaches them. When you are teaching the doctor, he is your friend, but once he has learned, he doesn't need you anymore, right?

Nurse 30's words might explain some of the quality of care issues found in the Mexican HCS. If the majority of Mexican nurses possess only an auxiliary or general nursing education, then one would assume that these are mostly the kinds of nurses that physicians work with as students and residents in hospitals. That means that physicians are learning skills from individuals with little to no formal education. The professionalization of nurses, therefore, would also benefit the basic training of physicians. Nurses with better education would enhance the quality of care provided by physicians not only in how physician orders are managed, but also with the quality of information provided to physicians learning their skills.

### **Workplace Relationships**

Intergender dynamics pervade all aspects of a nurse's workplace relationships (Verde Flota, Monroy Rojas, & Garcia Jiménez, 2003). These relationships make a significant difference in the quality of the work environment and stress levels experienced by staff nurses on the job. Three types of relationships nurses have in the workplace affect her sense of autonomy and her ability to perform her job: the immediate nursing supervisor, the physician, and other nurses. As the effective of supervisory relationships were discussed in the “Leadership” section

of this document, the following sections will focus on working relationships with physicians and other nurses.

### *Nurse-Physician Relationships*

The nurse's relationship with physicians in Mexico emerges from a complex history of role-based and gender oppression (Alatorre Wynter, 1991, 1992, 2003; Martínez Benitez et al, 1985) laced with bursts of support for professionalization (Suarez Vázquez, 1994). Early twentieth-century physicians championed the development of nursing and nurses –to a point. In reality, most physicians writing about healthcare in Mexico during the early decentralization period (1980s) rarely mention nurses. Those physicians who did write about nurses at this time used language that reflected the power differentials between the two professional groups. Some physicians writing about the physician-nurse relationship acknowledged that Mexican nurses were marginalized within the HCS and that this marginalization might contribute to poor role performance and low quality nursing care (Castillega Mendieta, 1988; Gardino & Torres, 1981).

One physician, in support of expanding public health nursing roles and recapturing the status held by these nurses in the mid-twentieth-century, wrote about the first public health nurse in Mexico and her critical role in early smallpox vaccination campaigns (Bustamante, 1981). He wrote about the value of her intelligence and contributions to organizing the campaign. Focusing on the ideal behavioral characteristics of this nurse, he stressed the need for more nurses to assume these professional behaviors.

Others believed that nursing roles should be designed by physicians to best meet their practice needs (INSP, 1987). The contrast in dialogue between physicians about nurses illustrates how physicians expected nurses to behave more professionally than their education warranted, but keep their roles under physician control.

Operationally, however, most nurses found themselves expected to follow physician

orders without question or thought. Class differences between physicians and nurses fueled some of these relational dynamics (Birn, 1999b). Specialization influences working relationships. Regardless of geographic location, pediatric nurses reported the most positive working relationships between physicians and themselves of any nurses in the sample.<sup>48</sup>

The SSA did not acknowledge the tensions between providers in any annual report or human resources policy document until 2003. In the SSA's annual report for 2003, it called for greater collaboration between all types of health-system workers to improve quality of care in the system (SSA, 2003). Yet in contrast to the SSA's intentions, in an extensive exploration of communication issues related to patient care, physicians from the Hospital General in Mexico City never once identified communication problems between physicians and nurses as contributing to quality of care issues in the healthcare system (Tena Tamayo, González Martínez, & Sánchez González, 2003).

A young staff nurse with only two years of acute care experience, however, clarified what it is usually like today for nurses to work with physicians. In the following statement, her words indicate that education helps create better working dynamics with physicians and mediates some of the class issues identified above, as individual educational differences in Mexico are frequently markers of class divisions.

Some doctors are very 'special.' [*How, like very picky about certain things?*] Yes, or they look at you like you are less than they are...But some are very nice and they treat you well, as a professional equal to them because you studied for a career.

All of the issues identified above have contributed and continue to contribute to workplace relationship dynamics between physicians and nurses.

Generational differences also affect workplace roles and relationships of nurses and

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<sup>46</sup> Of note, two members of the dissertation committee are US pediatric nurses. They both reported experiencing the same positive kinds of relationships between pediatric nurses and pediatricians. An interesting study would be to compare these perceptions across countries with providers who work with children.

physicians. A 32 year-old nurse described a common dynamic between younger nurses and older physicians when she talked about working with them and said, “and most of the time I think, those guys are old, and have no sense of humor.”

Traditional intergender dynamics proved difficult for many nurses to escape in the workplace. Nurse 29 described how he tried to teach his female colleagues to act differently around physicians. For him, the issue was not as much a matter of gender, but of generating respect for the nursing role from physicians and fostering a greater sense of equity between the two. He described how treating physicians as colleagues and not superiors was difficult for many nurses. It involved overcoming what he saw as female methods for ingratiating themselves with males and sacrificing their own needs. He described this gender dynamic when he said:

...sometimes nurses, to get on the good side of physicians, will make them coffee and bring them a snack. I try to tell my co-workers, if you're going to do that from the beginning, make sure you're not doing it when you have a lot of work to do. Because the docs get used to it, really quickly. I try to tell them to make it more balanced, like you go get the coffee and I'll get the cookies.

His words identified the traditional dynamic occurring between physicians and nurses and provided a solution that fostered more equity between the sexes. This, he believed, would help improve the quality of working relationships.

Nurse 29's efforts were supported with statements from Nurse 12 who believed that increased professionalism in nursing behaviors when interacting with physicians will help to improve relationships and mediate the effects of gender socialization. Other nurses in the study indicated that behaviorally-based professionalism promotes equity between nurses and physicians. These nurses attributed professional behaviors in nurses to the quality of information provided to physicians when reporting about a patient's status, asking appropriate questions, contributing opinions that help formulate the plan of care, seeking assistance when necessary, and acting in a non-submissive way that shows the physician that respect is expected. Nurse 12,

however, attributed this level of professionalism exclusively to BSN-levels of education.

*Intraprofessional Relationships or the Culture of Nursing*

Nurse's ability to work together affects the overall working environment. Mexican nursing journal articles indicate that intraprofessional relationships in the Mexican nurses' workplace have always proved complex and are not necessarily positive (CNE, 1989). Negative relationships between nurses effect the work environment, the ability of the profession to advance, and public image of nurses (Navarro Salazar, 1992). In general, Mexican nurses (both in the study and journal articles) recognized the negative effects of poor workplace relationships within their own profession and the complications created from multiple entry levels into the profession. Integrating humanistic philosophies into the institutional culture was identified as one solution to improve working relationships between Mexican nurses (Babb Stanley, 1994).

Müggenburg R.V., Castañeda Sánchez, and Franco Paredes (2000) found that most relational conflicts between Mexican nurses occurred between those returning to school and those who cannot or have no desire to professionalize their level of education. Nurse 36 expressed frustration with this dynamic in her own workplace. She described what it was like to work with nurses with significantly less education and how it affects her ability to do her job.

When there is a lot of work to do, it's really hard to keep telling them 'listen, do it this way or don't do it that way.' And many...are reluctant to learn more, and so they get stuck in their way of doing things, saying 'in my day I learned to do it this way so I'm going to keep doing it that way'.

Nurse 36's statement indicates that concern over the quality of care provided by nurses with less education or by those who refuse to learn more to improve the quality of their work. This appears to add to her level of workplace stress. The description also highlights a faction of Mexican nursing that is very resistant to change. Other nurses made similar comments about this dynamic from their own work experiences throughout the healthcare system.

Meanwhile, generational differences between nurses arise again as nurses under age 35

demonstrated a stronger sense of teamwork when describing working relationships with their coworkers. They viewed the healthcare team as central to the functioning of the institution and necessary for delivering quality care. This may be the product of more group interaction during basic education, promotion of teamwork during their entry level education, or possibly, increased participation in sports or other team-oriented extra-curricular activities. Nurse 41 captured this teamwork sentiment best when she enthusiastically described working with coworkers who were all her own age, a twenty-something group.

There is this chemistry between all of us, this companionship, everybody helps each other, everyone! Our shift ends at 8:30, but sometimes we leave a little later...we try to end on time with everything we have to do, because we want to make sure we've done it right. A lot of the time we end up leaving at 9:30, an hour after the shift ends, but everybody waits for everyone else to finish...That's how it is, we're not going to abandon each other.

## UNIONS

All Mexican healthcare workers are represented under a single union that was initially organized to ensure better salaries for HCWs and improve working conditions (Gomezjara, 1984; Mercado Calderón, 1982; Quiróz Trejo, 2004). Few documents, however, were found about HCW unions in Mexico from either international or domestic resources but they do indicate that HCW unions participate in every aspect of health-system management, especially pension reform and quality of healthcare services initiatives (Garmendia & Nava, 2002; Ravelo & Sánchez, 2001; Ravelo Blancas & Sánchez, 2004). Only one article, by Ravelo Blancas and Sánchez (2004) specifically explored female participation in Mexican unions. Overall, the work focused on nurses and their level of participation in union activities. The results indicated that healthcare workers unions have mixed effects on nurses. Their most significant finding was that nurses frequently associated union activism with feminism, something that was reported by nurses in their study as contrary to their nursing role as formal caregivers.

For nurses in this study, unions had a mixed effect on the professionalization process, benefits, and their institutional role enactment. They are an important factor in the workplace, but are a strong enough political force in Mexico that their effects on professionalization are analyzed outside the workplace context. Findings from this study support those of Ravelo Blancas and Sánchez with interviewees reporting a series of mixed effects and feelings about healthcare workers unions. The next sections illustrate how the Sindicato Nacional de Trabajadores de Seguro Social (SNTSS) and other similar healthcare workers unions affect Mexican nurses and the professionalization process.

### **Nurses' Perspectives about Mexican Healthcare Worker Unions**

The greatest benefit of unions to Mexican nurses is their ability to secure benefits such as health insurance, retirement, paid time off, financial support for continuing education, and scheduling. They also provide a vehicle for addressing complaints and grievances related to institutional politics and related problems. An important finding from this study, however, is that over 50% of the nurses —most under the age of 40— had never worked in a union position in the HCS. The nurses expressed a sense of increased vulnerability without the presence of a union, regardless of how little protection it may actually provide them.

When there is unskilled management present, a union also provides the structure that guides administrator behaviors during grievances. According to the nurses with union experience in this study, there is always a nurse representative within the union. That individual's efficacy in the role depends on his or her ability to navigate complex political waters involving the union leader and his or her relationship with the national union and the State.

Nurses frequently expressed frustration with how unions choose to address personnel problems or other workplace issues that affect a nurse's ability to do her job. Those with union

experience unanimously agreed that union leadership colluded with the State in corrupt ways that ended with no benefit to the worker, regardless of job category. Nurses in the study also cited a lack of attention by unions to gender-specific issues, such as equity, discrimination, and wage differences between male and female workers in the same job category. A few nurses described situations in which they had no say over what kind of uniforms they were allowed to wear as non-nurses chose them for the group.

A few exasperated nurses participating in the study also stated that unions do little to address nursing-specific problems, such as short-staffing, and often blindly advocate for their membership even in the face of blatant malpractice. One major reason for this is that, according to nurses in the study, nurses rarely serve as union leaders and infrequently have the opportunity to do so because of their competing demands for their time outside the workplace. All the nurses in the study agreed that physicians or lab workers with university education were most likely to serve as the heads of the union. At the same time, however, the nurses also indicated that janitors, kitchen workers, and other non-professional personnel were more likely to assume a union leadership role than nurses.

In appearance, union structures seem very egalitarian and democratic but in reality, they are not. This structure results in a replication of the male-biased intergender dynamics present in Mexican society, most obviously in the form of a lack of protection for females. The lack of female protection is best illustrated by how malpractice issues are addressed in Mexico. Newly restructured during the last *sexenio*<sup>49</sup>, malpractice is now formally handled through a medical arbitration commission centrally organized through the SSA with branch locations throughout the country (Tena Tamayo & Sotelo, 2005). Unions, when present, are supposed to support their nursing members in these situations. To clarify nurses' rights during malpractice cases, in 2005,

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<sup>49</sup> Sexenio is the term used to describe the six-year presidential term in office.

the *Comisión Nacional de Arbitraje Médica*<sup>50</sup> formally outlined the rights of nurses in these situations (CNAM, 2003). Like many State policy dictates in Mexico, however, the dissemination of this information to nurses and its proper enforcement is likely to be inconsistent.

The arbitration process, moreover, is class and gender biased. Healthcare personnel can be arrested for serious malpractice complaints before the problem is brought before the arbitration commission. In Mexico, one is guilty before proven innocent. An individual can be bailed out of jail— if the family has the financial resources and often times, political connections to do so.

Mexican nurses facing malpractice complaints are frequently abandoned by their unions. When describing a case for which she was asked to consult on quality of nursing care practices, a professor beautifully illustrated the class bias within the arbitration system, union abandonment of the worker, and the challenges nurses face in the legal system due to their inability to harness the socioeconomic resources necessary for a legal defense.

I was involved in a case of...a little girl who went to the OR, and the doctor asked that someone put...a warming blanket on her because she was hypothermic. They put one on her...with no protection. The child ended up with burns on her body [from the blanket]. When the staff told the parents, they went directly to ‘patient rights [department]’ ...and without anyone there asking or even investigating the case, they took the whole medical team to jail... The medical students, because of their [economic] status, could call their daddies and get themselves a lawyer to get out of jail, same with the doctor, and the nurse was the only one left in jail. The union did not help her, neither did the [hospital] authorities. She was left totally unprotected, totally unprotected! It was eventually resolved but the nurse had to stay in jail the whole time because [as a nurse], you’re the only one who can help yourself –you and your family members– to get a lawyer and get the money to get out of jail. But if you are a single mother, who is going to come get you out of jail because you only have kids in your house? That happens a lot, when you need the union the most, they are not there.

The findings here suggest that while union mechanisms may be necessary to ensure

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<sup>50</sup> National Arbitration Commission.

benefits, unless they are structured to ensure that nurses' needs as workers are addressed separately from those of other personnel in the union, nursing-specific issues in the workplace are unlikely to be addressed through a union. Unions, therefore, do not appear to facilitate the professionalization of nurses for two reasons. First, the type of educational programs supported by unions promote horizontal career moves for nurses, not vertical ones. This limits the amount of power and economic resources nurses can harness as a group and individually. The second reason relates to regulation. If one of the purposes of a union is to protect a worker when accusations of violating professional regulations are made, then Mexican healthcare worker unions appear to be inconsistent in their support.

### **Union Repression**

A contentious, incestuous relationship between unions and the State has long existed in Mexico (Quiróz Trejo, 2004). Healthcare workers unions are no different. On the one hand, during the economic crisis of the 1980s, unions were instrumental in obtaining wage increases from the State for HCW to offset the price increases related to inflation (Secretaría de Programación y Presupuesto, 1985). Documents from the 1980s indicate that unions consistently tied quality of care delivered by HCWs with salaries and the availability of supplies (Gomezjara, 1984; Mercado Calderón, 1982; Secretaría de Programación y Presupuesto, 1985).

At the same time, Brachet de Marquéz (1981) found that workplace reorganizations produced conflicts between unions and the State. Her findings indicate that in the Latin American context, the State uses reorganization as a vehicle to challenge the power of unions and theorized that reorganizations could be used for union busting. Twenty years later, research by Maceira and Murillo (2001) found Brachet de Marquéz's early work remained true in the Latin American context and that for a union to succeed, it had to align itself politically with the State.

The annual Mexican State of the Nation report of 1997 is an example that supports both these works (Poder Ejecutivo Federal, 1997). The report outlines the agreement between the State and the HCW unions about the decentralization process, which included a massive restructuring of the pension system in Mexico and the creation of the contract system. By aligning themselves with the State, unions gained the power to limit the extent and pace of the decentralization process (Nigenda & Ruiz, 1999).

Political alignment, however, does not stop the State from repressing unions. The State's primary vehicle for union repression has been leadership collusion to water down worker demands, but it can often involve intimidation strategies.

Nurses are not invulnerable to these tactics. Nurse 9, a nursing professor in the study who was an administrator at a northern ISSSTE hospital vividly describes a story of State-sponsored union repression during the late 1970s and early 1980s—something that was not unusual for any union at this time (Gomezjara, 1984; Ravelo Blancas & Sánchez, 2004). She told how nurses, dissatisfied with the working conditions and salaries in their institution, began to organize their own union separate from the healthcare workers union that was already representing them. The movement gained strength and spread to other facilities in their branch of the HCS. As a supervisor, she maintained a neutral public appearance but secretly supported the nurses' efforts. Her tactic worked as nurses confided stories about the union movement to her. She recalled one story about how government union busters used repressive tactics against the nurses organizing the union.

...these security people from the government infiltrated everything, they identified the leaders, and when one was leaving the hospital, they grabbed her and took her away. They told her they knew everything about her family and if she didn't stop what she was doing, they would harm her family. So, that person quit the movement. Then there were two male nurses...them too, they took away, and one, they...beat him up, and took away his job. The other they just took away his job. That guy could never work in another government institution again. And the union there...they did nothing...the nurses were against the authorities and no support came from the union. So they did all this and

ended up with worse conditions....It was a critical and delicate situation because [the government] tracked the leaders down, bugged their phones, and did whatever they had to do to make them feel...accosted. Consequently, in one way or another, they all left...and with that example, the whole movement died and they were left with nothing.

The story Nurse 9 told illustrates two key points. As stated previously, Mexican unions all have close political ties to the State. Nurses organizing a new union entity for themselves threatened both the union and the State because it would have been outside both their controls. This example also shows the vulnerability of not only the organizing staff nurses, but their institutional nursing leaders. Nurse 9 found herself in a precarious position of balancing what was happening to the personnel in her charge with her role as an administrator. Given the tactics used in the repression of union leaders, her words show how her own safety and that of her family was always in the forefront of her mind.

One might think that this is a phenomenon of the past or a unique case because the government appears to have shifted its union busting tactics to the contract system, but it is not. A few nurses in this study described trying to organize a union at a State-managed facility in order to get benefits, but the effort was quashed by hospital administrators and government authorities.

The combination of well known State-sponsored repression tactics against “rebellious” workers and the economic security that a nursing position offers women in the country explains, in part, why nurses do not, cannot, or will not advocate for their colleagues in workplace confrontations. To illustrate this point, Nurse 5 described a situation at a children’s hospital she had read about in a newspaper article as recently as 2002. According to the newspaper, several nurses at a children’s hospital spoke to the Secretary of Health during a site visit. The professor said the nurses, very distressed at their working situation, informed the Secretary that they lacked medicines and supplies to care for the children. Nurse 5, a professor then described the reaction of the institution’s administrator to the nurses mentioning the quality of care issues to the

Secretary of Health.

...rapidly, the hospital director told the Secretary that this wasn't the case, that [one of] the nurse's was a mental case and that's why she said those kinds of things...it turned out they reneged on her contract; or they just fired her. And there was no group of nurses to back her claims up.

A union was present at the hospital but the nurse worked on a contract basis, so she had no workplace protections. Other nurses, fearing for their own jobs, remained silent and as Nurse 5 concluded, "a great injustice occurred."

The findings from this section describe how nurses, effectively, fall into the middle of two potentially hostile forces: Unions by their absence of action and the State through its repressive tactics. This adds an additional political dynamic to what nurses must already contend with in the workplace and decreases their overall security as workers. Nurses may be some of the least secure workers in the Mexican healthcare system even though they represent 60% of the total healthcare workforce in the country.

#### **INTERNATIONAL INFLUENCES: GLOBALIZATION & MEXICAN NURSING**

Throughout this study, the policies of international institutions and their effects on Mexican nursing have been discussed. International institutions play a mixed role in the professionalization of nursing, with some providing technical assistance for development while others create policy structures that inhibit professionalization. Yet to be discussed is globalization and its perceived effects on Mexican nurses. Globalization emerged as a topic of discussion in all of the interviews. It has also emerged as a theme in Mexican nursing journals.

Not surprisingly, globalization language entered the nursing literature when NAFTA was implemented in 1994. For Mexican nurses, globalization is a force that is affecting their lives through changes in the marketplace, education systems, their work, and the policies of international institutions (Cabello Bonilla, 1998; Crespo Knopfler & González Velázquez, 2003;

de la Fuente Rocha, 1994a; Guevara & Mendias, 2001; Muggenburg R.V., 2004; Quesada Gudiño & Cuevas Cancino, 2003; Salas Segura, 2004). According to the SSA, globalization requires a more responsive economy so that the benefits of trade agreements can be fully realized for the healthcare system (SSA, 2002b). Many nurses believed that increased competition brought by globalization would help improve quality of care (Ibarra Castañeda, 1994b; Marín Chagoya, 2000; Martínez Martínez, Avalos Olguin, & Quintero Crispin, 2001) and facilitate the development of licensure and accreditation systems that meet international standards (Andrade Cepeda & Martínez Rosas, 2004; M.A.B. Delgado Choreño, 1999; Martínez Martínez et al., 2001; Pérez Rodríguez, 2002). Quintero Crispin (2001) wrote that the professionalization of nursing in Mexico would be shaped by globalization in ways that would make it both easier and harder to be a nurse in Mexico.

Generally, the nurses participating in the study views about globalization were consistent, but also cautious about its effects. They understood globalization as a force beyond their control. For them, globalization meant workers had to be better prepared with more skills if they were going to survive, but they felt it might also exacerbate internal divisions in a profession not quite ready to compete (Cabello Bonilla, 1998). Mexican nurses perceived professionalization, with its formal skill set and education, as providing them with the tools needed to compete and feel in greater control of their lives.

One nurse stated that to survive in a globalizing world, professionalization provides benefits that “are necessary. If not, we stay behind with folded hands because we don’t participate in it. Even more, with the changes that come from the World Bank, they say that nurses, effectively, are going to be the ones shaping healthcare. Obviously, we need to be prepared for this.” The theme of professionalization providing nurses with the ability to compete and be prepared for the increasing pace of change brought by globalizing forces was a common

one for nurses discussing globalization during the interviews.

Whether globalization will spur the migration of Mexican nurses to English-speaking or other countries is an unanswered debate within the profession itself. Salas Segura (2004) acknowledged that globalization would make migration more possible for nurses. Arroyo de Cordero and Jiménez Sánchez (2005) agreed with her but felt the educational and language differences between Mexico and other countries would take years to overcome before migration would begin on a large scale. A nursing professor with significant experience working internationally believed that the resistance to learning English, which she saw as prevalent among Mexican nurses, was a force greater than globalization and one that would prevent nurse migration on a large scale.

Finally, a public health nurse in the study described the combination of professionalization and globalization as a reality check about “the globalization and neoliberalism in which we find ourselves, that is permeating our country from our neighbors...they are asking us is to compete as...equals, even though we know we are not equals.” Globalization, along with neoliberal policies, does appear to increase competition, but in a way that Mexican nurses perceive as unequal.

#### **FUTURE VISIONS: THE HOPES AND DREAMS OF MEXICAN NURSES FOR THEIR PROFESSION**

To develop, one must be able to envision ideas for the future and to set goals. Only recently have Mexican nurses considered this kind of exercise. They are now able to do so because there is enough infrastructure and economic stability behind them.

Nurses began expressing their visions for the future of the profession in the literature of the late 1990s. A BSN-level for entry, better salaries, increased support from the State for professionalization, and increased research conducted by nurses were the common themes

present in the literature (Arroyo de Cordero, 2000; Marín Chagoya, 2000; Silva Luna, 1998) and unanimously agreed upon as key professionalization goals by nurses interviewed for the study. Nurses also began using future tense in their publications starting with the twenty-first century.

Common themes, cautious hope, and proud statements about the future of Mexican nursing emerged in the interviews. One nursing professor said, “We are a group who fights with a lot of moxie... Yes, I have many visions [for the profession], but at best, I think they are just dreams.” This was a frequent reaction by the nurses when asked to describe their visions for the future. They took great pride in the advancement that had already taken place. At the same time, the nurses almost always followed those statements with others describing their ideas for the profession as dreams far removed from reality and as utopian visions, and expressing caution toward the idea of thinking about the future.

Nonetheless, all the nurses interviewed had clear visions of what they wanted for the future of their profession. Many expressed the desire for more specialized areas of practice tied to graduate levels of education. Others desired a more humanistic philosophy to guide not only nursing education, but institutional cultures. Nurses strongly believed that every nurse in contact with patients should know why they are doing any task or procedure. All wanted to see the public image of nurses improve while recognizing that the darker sides of their own group dynamics contributed to the poor image and slow development of the profession.

A nursing professor near retirement captured the current state of the profession and the challenges it faces for development. She said:

We are thinking of a paradigm shift where our profession is on the rise... that we now know could serve as change agents, as people who are very well prepared to do this. But there will continue to be people who do this just for work, who will still be just “doers” and obedient in the hospitals.

Her statement indicates the profession is in a period of ascension, like that described in Abbott’s (1991) professionalization cycle. It demonstrates awareness of the potential for the profession as

a group to create change in society.

Her insight, however, also reflects the history of the group and the State's action have left many submissive nurses in the HCS who are not interested in advancing the nursing profession, only in keeping their jobs. The mixture of nursing preparation levels adds to the complexity and is well described by a public health nurse's statement about the present and future of Mexican nursing:

It's very complex, this reality of our profession. It's complex because we're in a process of ...transition and it is not really clear where we are going. And the times when we do have a clear idea of where we are going, the only thing we know for sure is where we have come from. We just don't know about the future...

Her statement indicates the need to develop leaders with a clear vision for the profession. This may mediate some of the concerns she expressed about the certainty of the past and the uncertainty of the future. Certainly, the instability of the past may contribute to a reluctance to have visions for the future.

In many ways, the nurses' visions for the profession also tied into their visions for themselves as Mexican women. They viewed professionalization as providing an autonomy-fostering infrastructure for a kind of self actualization process that would make them better nurses, mothers, wives, sisters, and daughters.

In the end, an OR nurse captured the development process as a labor in which the profession was immersed, one that is "helping future generations to become injected with a love of learning, participation, and professional advancement." She concluded her vision statements optimistically when she said, "...I believe that if each person contributes to teaching others what we know and participates [in our profession], we could be an amazing group."

## CONCLUSION

The interview data demonstrate that the experience of being a nurse is tied with gender

and its dynamics within the Mexican context. Male nurses face discrimination for their career choice rooted in social stereotypes about sexuality and acceptable forms of work for men. Female nurses face educational barriers to studying nursing and difficulty balancing work and family issues. For both sexes, gender socialization contributes to Mexican nursing's autonomy (or lack thereof), both in governance of the profession and in the role enactment process in the workplace. The interviews also suggest that changes are occurring across generations in Mexico that influence gender and workplace dynamics.

Findings from this chapter also indicate that economic instability inhibits the rate of professionalization processes, including knowledge production. In order to grow, professionals need access to higher levels of education and different career opportunities. They also need to be able to produce context-specific knowledge that justifies the value of their work in society and, as Larson (1977) identified, secures their place in the services market. Economic instability contributes to nurses being unable to unite as a group in defense of their rights, thus making securing a place in the market more difficult. Without the ability to secure capital (through salaries) to obtain additional education, pay professional membership dues, or support knowledge production and dissemination, a profession's growth and evolution slows. Globalization is an economic force directly and indirectly influencing the professionalization of Mexican nursing in ways that affect both its internal and external dynamics.

In addition, this section highlighted three key points for the development of nursing leadership. The first and most important part is comes from the collaboration between the State and the nursing profession. When the two work together, professionalization advances more rapidly. The quality of nursing leadership makes a difference in the rate of individual professionalization (via education) for nurses working in institutions and in the ability for institutions to enact changes benefitting patient care.

Finally, the leadership examples of Maza Brito and Arroyo de Cordero indicated that dynamic leaders capable of navigating through multiple layers of Mexican politics and institutions facilitate major advancements within the profession. Their absence leaves gaps that are difficult to fill, as evidenced by a statement from Nurse 3: “We lack leaders in nursing, real leaders, and real leadership...We need leaders who will take away our ignorance and the apathy that we possess.” Leadership for Mexican nursing, both from within and from outside in the form of “champions,” will be critical for realizing the future visions described by nurses interviewed in this study.

## CHAPTER 6

### DISCUSSION

The study's hypothesis was that the ability of nurses to use professionalization as a means of advancement will be strongly associated with how they, as a largely female social group, are able to capitalize upon the economic and political resources available to them. The results strongly conclude the hypothesis to be true, with the caveat that professionalization also depends strongly on the role that the State — a dominant force in the case of Mexican nursing's professionalization— plays in the process.

This study also demonstrated that economic and sociocultural factors related to gender are the most significant variables in the professionalization process. In terms of studies of professions, this is a significant finding as historically, the dominant gender of the profession was not considered to be a factor in how a professional group created and sustained its control over its portion of the market for their services.

Overall, the results of this case study of the development of Mexican nursing between 1980 and 2005 highlighted the challenges of professionalization in a developing country context, demonstrate the effects of gender on the process, and show the consequences of State policies on the production of nursing human resources over a twenty-five year period. History served as the foundation for and indirectly influenced every aspect of professionalization. International forces and institutions influence the professionalization only indirectly, but the consequences of their policies directly affect Mexican nurses' personal and professional lives. All these variables highlighted in this study affect the recruitment, production, and management of nursing human resources and likely, other professional human resources.

The following sections highlight the significant findings of the study by structuring their presentation around a conceptual model of the Nursing System theory first introduced in Chapter

4. It then reviews the limitations of the findings followed by potential areas for future research. The final discussion sections review the pros and cons of professionalization and the policy implications of the findings for Mexican nurses, nursing human resources as a whole, and other disciplines.

### **The Nursing System**

A system can be generally defined as “a group of independent but interrelated elements comprising a unified whole, a complex of methods or rules governing behavior, a procedure or process for obtaining an objective, [or] an organized structure for arranging or classifying” (Downloaded from <http://wordnet.princeton.edu/perl/webwn?s=system>, July 20, 2007). Abbott (1988) was the first person to introduce the concept of a system and associate it with professions and how they operate as a group. His work, however, was entirely with male-dominated professions in the United State and Europe. Gender factored in only tacitly in his analysis and the unique challenges present in a developing country context were not considered. It also did not consider how the system of professions had the potential to influence the service-based outcomes of professionals.

As stated previously, one of the major findings of this study is the presence of a Nursing System (NS). It is called a “system” because the study identified a group of independent but interrelated elements that make up a whole, guided by the theories about professions. Professionalism generates the rules of behavior for the system. Professionalization is used for obtaining social and political objectives that advance the nursing profession in Mexican society and provides the structure for arranging and classifying Mexican nurses. The purpose of the NS is to produce and develop nurses and their services, both individually and as a group. The system, using professionalization process, produces nursing professionals and affects healthcare

system outcomes. How well the NS functions and the quality of its products relates to the overall quality of infrastructure in the country.

This section describes each part of the theoretical Nursing System (NS) model, as presented in Appendix E, and integrates the significant findings of the study to explain the relationships within the NS. Conceptual definitions of each variable are found in Appendix D. The conceptual model focuses on what each variable is composed of and how each one relates to professionalization. The design was derived from the overall analysis of the variables in the study and will likely continue to evolve. The model shows that all variables are linked, but it is premature to determine the directionality or strength of the relationships between the variables. Research about health, development, and economics does, however, suggest a bidirectional link between economics and professionalization of nurses due to the ties between economic development and health (Ruger, 2003). The size of the visual representation of each variable does not reflect its overall influence. Results are discussed using the model as a guide, starting from the bottom of the conceptual model and working its way up through all the variables.

### *History*

In reviewing the structure of the conceptual model of the NS, History serves as the foundation for the development of all the variables. The historical legacies of the development of the country, the healthcare system, and the nursing profession all influence the current state of the NS within Mexico. Women's history in the country, especially of those who enter the profession, is also an important part of the historical variables influencing every aspect of the NS. Determining their exact effects, however, requires a greater level of historical analysis than could be achieved in this study.

History proved to be the hardest variable to represent in the model because it infuses every other part of the model in some way. The historical aspects of each variable help explain

their present state. What this study helped identify was the key parts of Mexican history that most strongly influenced the development of the nursing profession there. The factors might also apply to other countries in the region.

### *Professionalization*

Professionalization (PD), the dependent variable for this study, and the professional's Workplace (WP) are the two most significant variables within the system. Circles of equal size placed in the center of the model to reflect this fact. They are joined by a "rotating" circle that represents their constant interaction. Professionalization, to be discussed first accounts for variables most likely influencing recruitment into the profession, while the WP most likely influences retention and will be discussed in the section following this one.

Nurse 13 captured the essence of the professionalization theme of the study with her metaphoric quote describing professionalization as a constant process that can be as variable and, at least in Mexico, as unpredictable as surfing waves in an ocean.

I tell my students, that [professionalization] is like the waves in the sea...The waves hit the shore, do something, and then go back into the sea. They arrive again and something different happens. By the end of it all, you don't really see the effect on the sand or rocks until after a long time has passed, when you happen to notice that the rock has changed its shape because of how the waves hit it.

These waves are generated by forces external to the profession and include economic, political, historical, sociocultural, workplace dynamics, unions, and international influences. The ability of nurses to stay on the "professionalization" surfboard depends on their own internal developmental dynamics.

Using case study methodology that included a content and contextual synthesis of the 410 documents and 32 interviews, this study identified when conditions for surfing were impossible and Mexican nurses had to wait on the beach until the sea calmed down.

Previous research stated that for an occupation to be considered a "profession" one had

to possess the identified traits.<sup>51</sup> This study adds to that body of literature a more fluid, developmentally structured concept of professional traits that are delineated by the level of access to education of the dominant gender of the profession. Furthermore, the findings from this study indicate that the “traits” of professions described by many Western twentieth-century researchers do carry over into developing countries.

The wave metaphor about the process of professionalization also supports Abbott’s (1991) theory that it is a process characterized by peaks and valleys during the profession’s development. His theory relied heavily on context as the strongest influence in the professionalization process. Absent from Abbott’s 1991 analysis, however, were the effects of gender and economic instability on the professionalization process. These factors might explain some of the peaks and valleys.

This study also supports the jurisdiction argument that Abbott put forward in his initial work (1988) on the system of professions. The core of his theory was that the system of professions is designed to preserve the jurisdiction over the profession’s area of service in society. This system establishes market controls and determines the power of the profession in society, among other things. The jurisdiction argument emerges in nursing when their roles begin to change and expand. For Mexican nursing, these role-based changes come from increased use of technology at the bedside and the use of nurses for procedures once dominated by physicians. One source of increased technology at the bedside in turn resulted from trade agreements like NAFTA that made it easier to import the technology.

In addition, for both men and women, family influence proved a strong factor in their choice to become a nurse. This finding is consistent with results from Western nursing studies, cited in the literature review of Chapter 2, which examined factors influencing individual

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<sup>51</sup> See chapter 2, “professions” section for a description of the common traits of a profession.

decisions to study nursing. Evidence from this study also indicates that familial influence remained a constant factor in the decision-making process for Mexicans choosing to study nursing throughout the latter part of the twentieth century. The influence of familial factors shifted to a new dynamic once a nurse married and had children. The presence of children factored in to when and if nurses chose to obtain additional education. Spouses could be a positive or negative component of the decision to attain more education.

The class origins of the nurses in the study proved to be a significant factor in how quickly nurses progressed in their careers. Nurses from solidly middle class or professional families tended to enter administrative or teaching roles or return to school within five years of graduation from their BSN program. A career path option within the profession also made nursing more attractive for nurses from middle class or professional families. In contrast, nurses who were the first professionals in their families or the first with a high school or university education were more likely to stay in direct patient care roles for longer than five years. This finding suggests that the class origins of nurses may determine how long a nurse will stay working in direct patient care. It may also affect leadership dynamics within the profession and who is selected for nursing leadership positions within the healthcare system.

Gaining a deeper understanding of class dynamics and professionalization may facilitate policymakers abilities to develop plans for increasing the number of nursing human resources. The findings about class origins also suggest that in highly class stratified societies like that of Mexico that there is the potential for class discrimination behaviors to replicate themselves within the profession.

In addition to the external factors just discussed, factors internal to Mexican nursing also influence professionalization. Socialization processes within Mexican nursing appear to create a change in how nurses individually conceive themselves. Research by Douglas et al (1997)

indicated that auxiliary nurses had poor self concepts and difficulty managing the multiple demands on their lives. They attributed these findings, in part, to the status of gender in Mexico and nursing's socialization process. Their study only surveyed auxiliary nurses with little to no formal education.

This study suggests that professional education changes the socialization process and improves the self concept of nurses. Even though Mexican nurses may appear submissive or accommodating to males and physicians in the workplace, many nurses actually become more independent individuals who are freer from traditional forms of gendered social control than many of their peers. Nurses in this study with more education described a more positive self concept than those with less education. Many nurses also described how education transformed their individual identities and how they viewed themselves. These findings indicate that the socialization process that occurs through a professional education may positively affect a nurse's perception of him or herself.

This individual change, however, does not necessarily carry over into the collective identity of the group possibly because the education level of among Mexican nurses varies so greatly. This implies that professionalization could be a positive force for overcoming culturally ingrained ideas about gender and men and women's roles in society.

### *Workplace*

A nurse's place of work is the second major component of the Nursing System model. The effects of the workplace's structure and organization have the potential to influence health-system outcomes related to retention of nurses in the system and its associated cost effectiveness and benefits, the closely related nurse's job satisfaction, patient satisfaction, and most importantly, quality of nursing care.

The workplace dynamics described by the nurses in this study suggest that something

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about the institutional characteristics of acute care services crosses borders and makes the experience of being a staff nurse very similar, regardless of country. One reason for this may be an inherent cultural assumption of healthcare service delivery: that human beings are very physically similar. Under that assumption, care delivery and treatment can be structured in very similar ways, regardless of location. For example, a surgeon removes the gall bladder from the same place in 99.9% of cholecystectomy surgical cases. A nurse helps the patient recover from the surgery the same way by managing the surgical wounds and post-operative side effects (i.e. nausea, pain, mobility issues). How a patient responds to the surgery and how the nurse manages those responses is shaped by culture.

What differentiates the nursing experience in each country relates to two factors: the internal operational processes of the workplace that influence the institutional politics and relationship dynamics between nurses, their co-workers, and administrators. These two factors are specific to the dominant culture of the country or region where the nurse lives. The cultural variations account for the differences in approaches to nursing care and professional development processes.

Research by Guevara and Mendias (2002, 2005) lend credence to this theory as their regional comparison of nursing in the Americas found nurses facing similar challenges in every country. What few differences were found related largely to resource distribution. The findings from this study also support their research conclusions.

The structure of the contract system, another workplace and economic variable for the Mexican nurse, presented several, perhaps unintended, consequences to Mexican nursing. First, a significant number of new graduate nurses are working in places (both public and private) that do not provide health insurance. While private insurance is available and being pushed by the government, the salaries nurses receive at private hospitals may not allow them enough extra

income to purchase health insurance. This leaves a generation of young women in their childbearing years without health-insurance coverage. Since many of these young women contribute financially to their households or are the primary breadwinners, better salaries would allow them to purchase insurance coverage not only for themselves, but for their children and extended family members.

The second implication of the contract system relates to quality of care. New nurses are more likely to make mistakes or miss critical changes in patient condition, regardless of level of education, simply because they do not have enough experience and the novice-to-expert transition can take up to five years. Consistent work in the nursing role is required for the nurse to achieve an expert level of practice. If a private facility does not have a lot of experienced or technically trained nurses for new nurses to draw from as resources, the potential for providing poor quality of care increases. Furthermore, auxiliary nurses may be “task” experts at nursing care but data from this study indicates that many of them do not know “why” they are performing the work that they do.

The contract system may make sense from a financial or administrative perspective if HCS's are trying to reduce costs or reduce the influence of unions. A price, however, may be paid when it comes to quality of care and workforce development.

Benner's (1984) research demonstrated that it can take up to five years for nurses to develop expertise in their nursing care, let alone in a specialty area of practice. Her “novice-to-expert” theory of how nurses develop clinical practice expertise is a five stage developmental theory that measures the professional growth and development of an individual nurse. Her research demonstrated that by the fifth year of full-time clinical practice in one speciality area, nurses reach an “expert” level of practice. Critical to achieving this level of expertise, however, is providing a solid foundation for skill development during the first two to three years of work

as a nurse.

The first year of nursing practice requires consistency of work environment location so that new nurses may solidify their skills and synthesize their school knowledge with workplace-acquired knowledge. Nurses, regardless of how many years experience they possess, temporarily downshift in Benner's novice-to-expert practice paradigm when they change institutions. Because they possess a combined experiential and knowledge-base of practice expertise, this reduces their overall institutional adjustment time when starting a new staff nursing job. This learning curve, in both cases, increases the likelihood for mistakes or problems with quality of care.

Contract work, because of how it is currently administered in Mexico, does not guarantee a long enough period of employment for nurses to be able to deliver a high quality of care. It also makes it more difficult for institutions in Mexico to carry out the initiatives from the Cruzada de Calidad.<sup>52</sup>

Finally, important to managing the workplace is ensuring the correct skill mix of nursing professionals. There is some debate as to whether nursing personnel should be distinguished by skill level in national health reports, in part because the definition and roles of nurses at different levels varies significantly throughout the world. This research shows the importance of reporting resources by skill mix when a country historically has multiple levels of entry. In a case like Mexico's, where the profession is transitioning to a base of professionals that are better educated and trained than previous generations, countries should be required to distinguish between nurses aides and technical or higher- degree nurses. When reporting workforce data to various international institutions, however, countries with a majority of auxiliary nurses or equivalent

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<sup>50</sup> Quality Crusade: A national health services quality improvement initiative undertaken in by the SSA starting with Frenk's administration. It includes the creation of a complaint system, personnel recognition, and targeting quality improvement initiatives for each type of healthcare professional.

may be considered under-resourced in terms of nursing personnel because this study clearly demonstrates that even the experience of auxiliary nurses does not compensate for formal professional education.

This is not to say that auxiliary level nursing personnel do not provide valuable services to a country's healthcare system. For many women, an auxiliary nursing position can provide entrée into the healthcare system and its multiple roles. What needs to be present, however, are formal mechanisms to promote the individual career growth of people working in these positions. A professionalization model is one way to create the infrastructure necessary to promote this kind of growth.

#### *Sociocultural Factors*

Culture and society represent important explanatory parts of the model. The subvariables contained within the "sociocultural" part of the model explain many of the internal dynamics present within PD and WP. These subvariables explain the majority of findings related to gender, the education system, and the overall design and operations of the healthcare system. Both the education and healthcare systems are products of a society's values. Their designs both facilitate and hinder the professionalization of nursing in Mexico. Their presence is highlighted in the model because they are critical to any analysis of the NS.

The study suggests that Mexican nurses had multiple opportunities to respond to open policy windows that could have benefitted the profession. Despite these opportunities, sociocultural factors complicated Mexican nurses' ability to organize and act during these policy windows. This finding adds to Kingdon's (2002) factors that complicate the policymaking process, such as the budget and political culture. Among others, the two sociocultural factors that primarily complicated the professionalization of Mexican nurses' were gender and the structure of the education system.

**Gender.** Standing (2000) and alter Standing and Baum (2001) first identified gender as a significant factor in the management and production of healthcare human resources. This study supports her findings and showed that gender shapes access to education, a critical component of recruiting and developing professionals.

For men, the social acceptance of certain kinds of work normally considered as gendered female influenced the recruitment and retention of male nurses in the profession. Friend and family members usually discouraged males from entering the profession due to stereotypes about homosexuality, sexual deviance, or the nature of the work as gendered female. Male nurses reported an easier time advancing in their careers because they could capitalize on the gender-bias within the system that encourages males entering administrative positions. They also indicated that social mores about child care and spousal expectations did not hinder their ability to advance in their nursing careers.

Findings from this study support Harrison's (1998, 2000) work about female physicians in Mexico in that their career are intertwined with family life and negatively effected by economic changes. In contrast to Harrison's work—which demonstrated that female physicians faced underemployment in response to economic upheaval—Mexican nurses responded to the same situation by obtaining two or more jobs in order to maintain their income levels.

Further consistent with Harrison's findings, this research demonstrated a relationship between an individual nurses' career path and personal lives. The initial research cited in the literature review about the relationship between those two variables came entirely from US and Canadian sources. The findings here show the same kind of relational dynamics in the Mexican context: that the career path of a nurse is intertwined with the demands she faces in her personal life. Because the studies cited in the literature review were not from Mexico, this finding suggests that the personal life-career path dynamic of nurses transcends context and borders.

The study also showed that class differences create a different set of challenges for the professionalization of nurses in contrast to female physicians who, through the course of studying to become a physician, immediately increase their social status by completing a medical education. The historical deficit of university education and training for Mexican nurses make transcending class barriers more difficult for nurses since formal education was not historically associated with a nursing career. As nursing leaders continue the shift of basic nursing education to the university level, it will be useful to study its impact on the public image of nursing; a positive public image is, in turn, associated with improved recruitment into the profession.

Finally, the degree of success associated with achieving a professional nursing degree varied by the class of the study's participants. Success was more pronounced and of greater benefit to the family if the nurse came from a low socioeconomic background. In contrast, nurses from families with large numbers of professionals (usually already solidly middle class) often struggled with convincing their relatives that nursing was a profession.

**Education.** The social acceptance of female education is a prominent force influencing educational access for women. How this dynamic plays out in society influences female recruitment and development for the nursing profession. Currently, Mexican nurse educators have to mediate gender dynamics in order to have a more balanced intergender dynamic transfer into the workplace and counter the effects of traditional female socialization.

Professionalization also depends on the presence of an educational system's infrastructure. A nurse's ability to pursue education and pay for it herself highlights the importance of education policies that are structured to promote life-long learning and access at any age. One must remember, however, that this study showed that the educational opportunities for nurses evolved in concert with social and political beliefs about women's need for and access to education at any level. Addressing these concerns along through policies structured on a

developmental continuum can mediate the effects of generational differences in educational levels between nurses and facilitate the professionalization of nurses at any age.

Technical or university-level training for nurses serves another developmental purpose. All the faculty interviewed in the study reported that nurses who practiced for years without the theoretical knowledge—the “why” of their practice—expressed deep concern about the quality of practice of their colleagues with low levels of education. Many of these women began working at age 18 or younger, like Nurse 15 in the study. From a human development perspective, an eighteen-year-old nurse has fewer life experiences to draw from than a twenty-two-year old nurse. Nursing professors participating in the study who started working as staff nurses at age 18 or younger came to believe that the younger the age of the nursing graduate, the more likely she is to become oppressed in the workplace. They stressed that when these young nurses must combat the oppressive forces of gender-biased individuals or institutions, they have fewer resources to draw from. The current result is that the Mexican nursing workforce is strongly affected by institutional gender-based oppression, likely because of the age that many nurses started working in the system. With these tendencies socialized into them at young ages, oppressed nurses will not speak out about the poor working conditions that increase their risk for making a mistake. For the patient, this means an increased risk for encountering poor quality of nursing care. Age, therefore, combined with education increases the likelihood that the young nurse will be able to advocate for herself in the workplace.

For twenty-first century Mexican nurses, creating policies that encourage enrollment and completion of post-high-school technical or university-level programs benefits both the nursing profession and the healthcare system. Facilitating entry into the educational system as an adult learner will also permit women who were unable to study nursing at younger ages or who were trained as community health workers to pursue nursing as a career option.

Another age-related challenge is that for a time, there will be a transition period during which students will end up with higher levels of education than the faculty who are teaching them. The gap exists because nursing faculty, who are mostly women, will face numerous systemic, financial, and cultural barriers to pursuing advanced education. Experience can compensate for this educational difference in the short term. Policy goals structured toward acknowledging this difference but only tolerating it for a specific period of time until projections can show that there will be enough students with the higher degrees to replace the faculty might prove helpful in mediating this transition.

The final part of fine-tuning nursing's professional education process is the development of standards. Uniform basic standards for nursing education would provide a more consistent product from Mexican nursing schools. The curriculum could then be adapted to reflect regional differences in disease epidemiology and make nurses more prepared to handle the patient populations in their regions. Nurses choosing to migrate to other parts of the country would still possess a basic skill set and have the intellectual capacity to adapt that skill set to the epidemiological profile of the new region where she obtained work.

This is not a new concept in Mexican nursing as work with the Trilateral Initiative on North American Nursing (TINAN, 1996) in the early 1990s highlighted the need for educational standards in the country in order to create nurses that could cross borders and work in US and Canadian institutions. Yet the fact that faculty in the study described a lack of standards for nursing education in Mexico, even though the country has an accrediting body for nursing schools, suggests that the impact of the organization or process itself is not fully embedded. Investment in FEPPEN by the State or private sector to support the accreditation system already in place in Mexico would benefit not only the profession, but also quality of care and female education in the country.

Also critical to educational standards is ensuring that distance-learning programs for nurses possess a certain level of quality. The risk for exploitation of nurses by opportunistic forces taking advantage of the current education boom in the country is significant. Quality of care in the healthcare system could also be compromised by poor quality educational programs. One way to mediate this problem would be for the CIE to publish annually a list of acceptable, CNE-endorsed list of nursing schools in the country. As unscrupulous individuals seeking to capitalize on training professional nurses will no doubtedly emerge, the publication process would be wise to include anti-corruption mechanisms.

### *Unions*

Moving to the center of the model, Unions (U) proved to be a significant factor in the professionalization process in Mexico; thus, it is included as a separate variable, not as a part of healthcare system or political elements as originally conceptualized. While unions are related to the workplace, they are strongly influenced by politics external to both the workplace and the union itself.

For nurses in this study, unions presented a very mixed set of effects for professionalization. While benefits and solidly middle-class salaries were a positive effect, the internal politics of Mexican HCW unions and their relationship with the State do little to directly benefit the professionalization process. Most of the time, the Mexican HCW unions created career structures that maintain nurses in a horizontal career path. They ensure that men hold the majority of leadership and power positions in the organization, leaving nursing with little to no voice. Nurses in this study might be better off if they could organize their own union representing their own interests. The repressive tactics used by the State to quash any new union-organizing activity, however, makes a nursing-specific union in Mexico highly unlikely.

The contentious retirement package negotiation between the HCW unions and the State

did, however, have a silver lining that enhanced professionalization. Many nurses interviewed in this study had officially retired, with their full salaries, from working as staff nurses or administrators in State run hospitals. These nurses were now pursuing BSN or graduate degrees because they finally had the time and financial resources to do so. Frequently, they described many colleagues pursuing similar paths. For all of them, their retirement pensions provided the individual financial resources to do so. All the nurses planned to work in faculty roles when they finish their studies, helping to alleviate the faculty shortage and providing students with an incredible resource of clinical expertise.

This study also appears to support the findings from de la Cruz's (2002) research about the negative effects of Mexican unions. The internal political dynamics of the healthcare worker's union contributes to nurses' difficulties with autonomous governance within Mexican healthcare institutions. Contrary to de la Cruz's findings, however, unions do benefit nurses with higher wages and benefits that they cannot find with work in the private healthcare sector of Mexico.

#### *Economic*

As many of the Mexican nurses wrote or said in the interviews and nursing journal articles, it is impossible to separate the nurse from the political and economic context of Mexico. From the results, it was very clear that the economic instability of late twentieth-century Mexico has had a profound effect on the development of Mexican nursing and where they worked. Therefore, circles representing both Political (P) and Economic (E) variables are placed above the other variables in the model to symbolize their overarching influence on all parts of the NS. Significant findings about economic variables are presented first, followed by those from the political analysis.

Economics, in addition to gender, is the other variable that permeates every aspect of the

professionalization process. Economic instability inhibits the rate at which professionalization occurs and generates reasons for migration. Economic security draws nurses into the profession. Trade agreements created new incentives for the State to invest in developing nursing services.

As a capital-dependent process, professionalization requires financial resources to facilitate education, lobbying, and knowledge production. For Mexican nurses, these financial resources are tied into the State's economic policies. When economic crises occur, wages are frozen, resources are shifted, and health system administrators view professional nurses as costs instead of resources in the healthcare system. In order to grow, professionals need access to higher levels of education and different career opportunities. To do so, they need to have the ability to produce context specific knowledge that justifies the value of their work in society and, as Larson (1977) identified, secures their place in the services market. Economic instability, therefore, contributes to nurses being unable to unite as a group in defense of their rights, thus making securing a place in the market more difficult. Without the ability to secure capital (through salaries) to obtain additional education, pay professional membership dues, or support knowledge production and dissemination, a profession's growth and evolution slows.

In another aspect of the influence of economic factors on professionalization, Mexican nurses in this study saw their professional education as a form of insurance against potential economic shocks. The knowledge that there is always work provides a measure of psychological comfort not commonly found in other professional work in Mexico. Findings from this study support Howell's (1993) work that analyzed career choices among rural Oaxacan women and demonstrate that nursing, even fifteen years later, remains a "preferred" career choice. This study expands on this finding by highlighting the career mobility, ability to help others in need, and economic security nursing offers as the reasons for the career choice. The low salaries of Mexican nurses, however, add to feelings of economic instability. Most nurses work multiple

jobs to maintain that middle-class existence and sense of economic security. The point to stress from the findings is that economic instability does not stop professionalization, it merely slows its pace.

Another significant finding from the economic part of the study is that trade agreements benefit the professionalization process for nurses. The international comparative process required for writing the agreements highlight the disparities between nursing in different countries. Even when the countries involved had vastly different economic resources, the potential for trade-in-services generated the incentive for the Mexican state to begin investing in the development of nursing as a profession. When NAFTA required that the BSN be the minimum educational preparation for obtaining a visa (pending successful passage of the licensure exam), it indicated that educational equivalence across professions would serve as a standard for directing development.

Trade agreements also appear to provide incentive for improving the quality of nursing human- resources monitoring at the country level and for improving the infrastructure needed to develop professionals. The findings from the study suggest, however, that the success of the incentives trade agreements provide to the State to upgrade or create infrastructure related to developing professionals is tied to economic stability. For example, the development of SIARHE, the nursing human resources database, during the mid-1990s emerged after NAFTA was implemented, but it was not fully put in to operation until after the country had recovered from the 1995 economic crisis. The increased flexibility in nursing education that evolved after NAFTA's implementation removed previously rigid barriers to educational access for many nurses. Increased access to education creates career paths for nurses. It allows nurses to become mobile in their careers and has the potential to solve problems like institutional stagnation or costs related to long-term bedside staff seniority.

*Political*

The results from this study demonstrate that when the State includes nurses in the policymaking process and in the governance of the healthcare system, professionalization advances more rapidly than when they are excluded from the process. The results also support Cleaves' (1987) findings that the Mexican State strongly influenced professions in the country and suggests that the State's influence on paraprofessionals may be as great.

In the 1970s, the State gained politically in two ways from its nursing human-resources production policy. First, it provided jobs for women of low socioeconomic status and thus, increased public support for its policies. Second, from an international perspective, international development indices used to direct financial assistance to countries focused only quantitatively on the number of women in the workforce as a signal of gender equity. At the time, international development indices did not consider the quality of the overall female workforce in terms of educational achievements. Thus, the fact that more women with primary-level education who formally participated in the workforce quantitatively improved Mexico's rating in international indices.

The findings from this study also support Ruger's (2003) work that ties "health improvement and economic development...to individual's opportunities to exercise their agency and participate in political and social decision making." When Mexican nurses were incorporated into the policy making process for their own profession, the rate of professionalization increased significantly. The health-system began to benefit from a higher level of technical capacity among their nursing personnel. In contrast, when nurses were not incorporated into the policy making process, professionalization slowed significantly. Contextual analysis of the documents showed how the politics of health-system decentralization did not include nurses and reflected the group's own internal weaknesses, both politically and

economically, to mobilize and call for inclusion in the decentralization policymaking process.

### *International Influences*

The final variable, International Influences (I), reflects the state of the world in which nurses find themselves. Nurses interviewed in the study recognized that forces of globalization were changing where they live and work, requiring them to compete at new levels. International institutions creating health and economic policies (e.g. WHO, PAHO, ICN, IMF, World Bank, IAB, etc.) are likely to indirectly influence the professionalization process as their policies trickle down into a country. Global health organizations generate much needed resources that can facilitate the development of nursing in a country. Due to this combination of factors, a circle representing International Influences is placed at the top point of the model to illustrate its ability to influence all parts of the NS.

Globalization is an international force to which nurses are sensitive in that they see it affecting their personal and professional lives. The analysis of their comments indicated that they do not perceive it to be an “equalizing” force. The source of the inequity globalization brings to their lives may come from the trickle-down effects of international institution’s economic policies.

It is well known that IMF, World Bank, and other large international financial institutions strongly influence resource allocation in Mexico through their policies. The effects of these economic policies on resource allocation in the health sector of Mexico affect nursing most often at the institutional level where unskilled administrators frequently cut nursing staff and the tools they need for safe job performance as part of cost saving measures. Quality of patient care becomes affected through these policies because nurses do not have the supplies to perform their jobs safely and using the correct techniques.

Global health institutions are responsible for providing technical assistance, institutional

coordination, knowledge development and dissemination, and the empowerment of groups and individuals (Ruger, 2006). Since the policies of these institutions affect the professionalization of nursing and subsequently the impact nurses have on the health of nations, global health institutions, like the World Bank and World Health Organization, become obligated to strengthen the institutional capacity to respond to the development needs of nursing human resources. Fostering the professionalization of nurses is one way to do this.

### **Professionalization: The Pros and Cons**

After analyzing the nature of professionalization in the Mexican context, one might ask the question: is it worth it? Is professionalization the best vehicle for health professionals to pursue as an organizing mechanism? Furthermore, in light of the great need for healthcare human resources and given the time it takes to prepare professionals, are more healthcare workers with less training a suitable alternative? This section explores the positive and negative aspects of professionalization in reference to the questions posed above. While some of the content may apply to developed countries, the resource differences between the two settings significantly change the tone of the discourse.

The general discussion centers on possibilities for professionalization in the developing country context. It utilizes Mexican nursing's definition of a professional as a nurse with a BSN degree as a reference point. This educational demarcation serves as an important indicator. In previous discussions about professions, one core assumption is that there is a standard degree for entry into the profession. These assumptions, however, were based on Western male models of education and class structures. Based on the findings of this study, the argument can be made that a four-year, bachelor's degree university education serves as the professional title marker for the nursing profession in Mexico and, possibly, other developing countries.

Important to this discussion is not that every professional obtain that title, but simply that it is an educational option available in the country. This perspective incorporates development ideas into the thinking and allows for a more fluid concept about professionalization than the rigid “trait theories” of chapter 2. The BSN educational option is also a good professional indicator because most universities and technical schools require at least a bachelor’s degree to teach classes or to direct education programs. A BSN education option, therefore, becomes an important part of nurses participating in institutionalized educational systems and building professional infrastructure.

The following sections discuss some of the core pros and cons of professionalization that emerged from this study. It does not provide a lengthy list, but instead focuses on describing professionalization pros and cons most relevant to the overall development of a country.

#### *Pros*

The first argument in favor of professionalization centers around institutional infrastructure, particularly in education. The infrastructure argument operates from a foundation that focuses primarily on females and the institutional barriers they might face when attempting to individually professionalize. Put simply, professionals require a certain level of education. This necessitates high school (post-secondary) and university educational infrastructure within a country and more importantly, the ability for females to access the system it creates. It is not to say that males, especially those of low socioeconomic status, do not need access to the country’s professional education system. Simply said, most educational systems around the world are biased toward male education. Providing that it is culturally acceptable for males to become nurses, this argument assumes that males will be able to access nursing education at all levels if they choose the profession.

In order to produce nurses, therefore, females need to be able to obtain a specialized

education. This may initially come in the form of vocational education and evolve into university-level education. Countries seeking to produce nurses first need to determine if they possess the necessary infrastructure to produce nurses of any skill level. It is in their interest, however, to develop nursing professionals because the educational requirements for most nurses will help to improve the overall picture of women in the country.

Another benefit to professionalization is the code of ethics that guides behaviors of professionals. Theoretically, those guided by codes of ethics will be more likely to eschew corrupt practices. This is one reason why the Fox government (2000-2006) emphasized the development of a code of ethics for each kind of healthcare professional in Mexico. A code of ethics also adds to the legal infrastructure of a country as it provides “outsiders” a way to evaluate the conduct and performance of the professional, as well as guide legal interpretation of laws and regulations for professionals. An emphasis on professional behavior grounded in ethics has the potential to reduce corruption and health system costs.

The last benefit of professionalization reflects as much the current era in history. Professionals produce their own knowledge. Said knowledge can be used by the profession itself and by policymakers to help create policies, laws, and regulations that are appropriate for the profession. Professionals also use knowledge production processes to justify their jurisdiction over their service market and how other professionals encroach upon it. In the increasingly competitive world the Mexican nurses in this study described for themselves, knowledge production becomes critical for securing their place in the health services market.

#### *Cons*

The main problem with professionalization is that it requires a lot of different kinds of capital. Physical infrastructure, paying for an education, and health system financing all require that a country has steady access to financial capital.

Nurses require access to this kind of capital to pay for their education (at every level), maintain or develop their professional organization, and to be a politically viable group.

Institutionally, nurses need to be able to develop political capital in order to effectively get the resources they need to provide care to their patients and advocate for themselves as a group.

Another difficulty with the organizational model of professions is that it requires infrastructure that allows for access to education at any age. For example, for many years in Mexico, access to university education was biased toward those under the age of 35. Individuals older than 35 could not return to school for any level of study at public universities –the least expensive educational option in Mexico. Mexican nursing began changing this philosophy within its own schools in the 1990s when they developed distance learning programs to reach nurses who did not have access to university education in their home states. Educational leaders in Mexican nursing knew, due to the overall status of women in the country, they could not force or even encourage auxiliary or general nurses back to school if they did not have local access to education.

Knowledge production also requires financial capital, though significantly less since the advent of the internet. This study showed that Mexican nurses have difficulty getting their research projects funded, thus inhibiting their ability to produce knowledge specific to the profession. Nonetheless, positive support for nursing from the State in recent years resulted in a veritable explosion in Mexican nursing knowledge production.

The final con of professionalization is the level of commitment required to support nursing services from government entities. This study demonstrated that the development of nursing and its services benefits when government entities pay attention to and incorporate nurses into the policymaking process. It also clearly demonstrated that the State's failure to incorporate nurses into health system policymaking was one of many factors contributing to

deprofessionalization within the profession during the 1970s and 1980s. If States have no interest in supporting nursing personnel within their health care system, the production and retention of professional level nurses within the nursing system will suffer.

### **Limitations**

The study has several limitations. First, case studies are limited by the quality of the data obtained (Yin, 2003). While Mexico has some of the best health-system data available for conducting research in Latin America, the nursing data were sparse. In one way, this is a significant finding that supports the need for documentation about nursing human resources in areas such as staffing levels, their enforcement, and numbers of nursing personnel by education level.

Since the purpose of this study was only to identify the variables that influence Mexican nursing's professionalization, the relative effects these variables had were not analyzed in-depth. As a result, some of the analysis may appear superficial to non-nursing experts.

The demographics of the sample presented other limitations. The majority of nurses in the study had achieved a BSN degree or higher. While over half the nurses in the study obtained their initial nursing education through a technical degree program before proceeding to study for their BSN, few technical degree nurses were interviewed and no nurses working in primary care settings took part in the interviews. This may bias the results toward nurses concerned about their own professionalization and not adequately include views of other nurses.

Furthermore, limiting the sites to Mexico City and Oaxaca may not account for variations in the professionalization process related to geography. For example, the northern Mexican states experience significantly more interaction with US universities; therefore, international influences may be stronger and nurse migration issues of greater concern. In

another example, the state of Jalisco, where the city of Guadalajara is located, is one of the most strongly Catholic regions of Mexico and this variation might add additional sociocultural influences to the overall professionalization of nursing in Mexico. Limiting the study to Mexico City and Oaxaca could influence the generalizability of the findings to the rest of the country.

It was also difficult to separate the specific influence of history on various parts of Mexican nursing's professional evolution. History infuses every aspect of the process, but since the history of Mexican nursing has yet to be extensively studied greater specificity about history's effects could not be determined in this study.

Several challenges related to translation emerged during the data coding process related to the researcher's attempts to ensure the linguistic validity of the interview data. Because only one member of the committee was bilingual, like the researcher herself, the interview transcript coding process was conducted in English even though the interviews were in Spanish. While the bilingual committee member verified the conceptual validity of the translations for accuracy, the process resulted in a somewhat reductionistic analysis in her attempts to synthesize all the data.

As a result, merging the findings from the documentary evidence and the interviews proved challenging at times. Usually, only nurses with graduate degrees who were cognizant of the profession's history and its relationship with various historical dynamics in Mexico were able to provide salient comments that related to events of the past captured in the documents. This created two distinct sets of data: one that focused on the past and the other that captured the nursing experience of the present.

The actual effects of professionalization on individual nurses as compared to the group were also unclear at times. Future research about the professionalization of Mexican nurses may find it useful to study individual factors or microlevel variables, such as workplace characteristics that promote the individual nurse's professional development. Determining the

differences between individual and collective experiences would also be useful.

Finally, the researcher herself had her own biases while conducting the study as she was both an insider and an outsider to the Mexican nursing experience. Her experiences working as a nurse in the United States influenced how she viewed Mexican nurse's relationship with the healthcare system and the surrounding context. The researcher had worked in Mexico in the healthcare system, but only in an informal capacity or as a volunteer. Her work caring for patients in the nursing role did allow her to empathize with the patient care stories and similar system dynamics the Mexican nurses described in the interviews. This helped establish trust between herself and the interviewees. At the same time, since the researcher is not Mexican, this may also have influenced how nurses responded to the questions. Her position as an "outsider," however, proved beneficial in establishing a certain level of neutrality as she was neither an agent of the State nor deeply networked into the Mexican nursing community. Revealing personal opinions and other responses to an outsider with "insider" perspectives about the nursing role and Mexico itself hopefully enhanced interviewee willingness to speak openly with the researcher.

### **Potential Implications of the Study**

Implications of the results of this study fall into three categories: the professionalization of nursing overall, the Mexican nursing profession, and healthcare human resources production. The findings have the potential to influence policymaking in all three areas and may inform the work of other social science and public health professionals.

First, identifying the variables that affect the development of the nursing profession in Mexico, enhances understanding of that development, especially the role gender plays in it. Identification of the common barriers and facilitators to producing more nurses in Mexico

becomes critical for facilitating the creation of nursing human resources for the country. While more nurses for a country does not solve all health system problems related to a shortage of nursing personnel, this study demonstrated the influences of these variables on nursing human resources in the Mexican context.

Nurses in other Latin American countries may collectively benefit from this research for many reasons. The study highlighted the challenges faced by professional women in Mexico and men in nursing, both understudied groups in the region. The research indicated that professional women face persistent challenges to balancing career development and their personal lives. These challenges are different from the ones faced by the more common research subjects, women working in maquiladoras. The study also identified barriers women face when trying to obtain a higher level of education or transcend the rigid class barriers present in Latin American societies. Education, clearly, is a vehicle to transcend economic class barriers. The study suggests that when the public image of Mexican nurses improves, conquering social class barriers will also become easier.

This work has the potential to be replicated in other Latin American countries at similar levels of economic development, such as Argentina, Chile, and Colombia. The Nursing System model may help streamline human resources for health planning in the region because the key variables that influence the development of nursing human resources were identified. Health system policies and group development plans for nurses that are structured around mediating some of the variables identified by this study and their effects may help address some systemic deficiencies related to nursing human resources in the Latin American region.

The research adds to the growing body of literature about healthcare human resources around the globe. What is unique about this study is it identifies and clarifies many of the core variables thought to factor in to human resources production at the country level because it

shows how gender impacts nursing human resources production and the findings may apply to other female-dominated health professions, such as physical or occupational therapy.

The class dynamics within Mexican nursing shed new light on a factor not usually considered by human resources for health policy analysts. Most researchers studying healthcare human resources rarely consider how class origins of nurses factor in to decisions to study nursing or stay within the profession. They also do not consider how class differences between nurses and physicians affect workplace dynamics. It appears that the title of “professional” confers, at least on paper, a perception of class equity when in reality, this may not be the case. Further examination of class origins of healthcare workers would provide valuable contributions to the study of healthcare human resources.

The effects of a multitude of international influences on the professionalization process in nursing are also highlighted in this study both in historical and contemporary perspective. International influences are another variable not previously included in other human resources for health production models.

For social scientists this research opens up many new topics for study. Historians interested in studying healthcare systems, for example, might find the study useful for understanding the role of the nurse in State-run health systems. Studying the evolution of the nursing role in historical context will help to explain many reasons for the state of nursing in a country and its capacity (or lack thereof) to respond to the health problems of society.

Political scientists who specialize in the political economy of gender may be interested in nurses because they represent a group with socioeconomic class mobility and greater job security than most females in developing countries. How the State incorporates nurses into the policymaking process and how nurses are able to gain through political participation are also welcome areas for study.

In sociology, this study could revitalize and recontextualize the study of professions. Long out of fashion for study in sociology, this study shows how the professions literature could be used to understand the causes of professional healthcare human resources shortages. It also explains the influence of gender on professions and provides structure for identifying and analyzing infrastructure deficiencies that affect professionalization.

Finally, economists interested in female workforce issues may find nurses as a useful topic of study. This study showed a clear qualitative association between economic instability and the production of nurses, but quantitative analysis will be able to measure the degree of this association.

### **Suggestions for Future Research**

The results of this study open many avenues for additional research across a variety of disciplines. As a start, to further solidify the Nursing System theory, replication of this study in other Latin American countries would be of top priority. This kind of research would show whether that the conceptual model can be applied to other countries in the region. A regional comparison would control for larger cultural and historical differences that would be found if the study were to be replicated and compared with other regions. At present, these variables and relationships are specific to Mexico. With further replication, they may translate to other sites in Latin America which have similar cultural tendencies and regional histories. The model does have the possibility for replication in non-Latin American countries and even domestically within the United States.

Based on findings from the Workplace section of Chapter 5, one could conclude that women, regardless of profession type, class, or education level, end up doing the domestic work of the Mexican healthcare system. The roles women have in the Mexican healthcare system

largely involve what could be described as its daily operations and maintenance. This gives rise to a number of questions: Has the nurse's workplace become an extension of the domestic space? Does replicating the historical prestige of working outside the home in someone else's domestic space apply to nurses? Are they free from traditional male domestic controls or is this merely replicated by the nurse-physician relationship? These are questions to be explored through further research.

Given the amount of institutional variation between public and private healthcare facilities described by nurses in the study, it would also be worthwhile to further investigate what institutional characteristics of Mexican healthcare facilities promote professionalization, and which ones inhibit it. For nursing, this could be accomplished by using a Spanish-language version of Aiken and Patrician's (2000) Nursing Work Index scale. While some questions would need to be adjusted to account for context, given the workplace similarities to U.S. institutions that Mexican nurses described it could be a worthwhile endeavor.

Another important area of inquiry to investigate is the relationships between professionalization levels, quality of nursing care, and patient outcomes. Findings from this research imply that professionalization, or a lack thereof, affects the quality of healthcare because professionalized nurses have more formal education. Nursing sensitive outcome variables have already been identified in Western nursing research. Testing their sensitivity to nursing care in the developing world would be a valuable study.

In another area related to workforce research, examining the effects of the status elevation of Mexican BSN nurses to "professional" levels—including if the raises were implemented and how it affected nurses lives—will help determine if this is a policy move other countries might want to replicate. Using BSN level nurses as a human capital resource to study in relation to other country-level characteristics would also provide useful data that would help

develop nursing human resources and clarify the costs or cost-savings better educated nurses provide to a healthcare system.

A study examining post-retirement activities of Mexican nurses would be beneficial to determine if nurses returning to school to become faculty is a larger trend or an isolated phenomenon. The State or unions may want to consider encouraging these nurses to return to school and continue working in faculty positions. Financial incentives to spur this movement among experienced nurses could be worked into the next round of pension negotiations between the State and healthcare workers unions. If females face multiple social, economic, and institutional barriers to accessing university-level education, then the professionalization process will take decades because professionalizing nursing is part of a larger social change for females of certain classes in a country. Further comparative research will be needed to determine if these phenomena are products of healthcare system structures or simply the nature of being a working female.

Additional lines of research that explore the reasons why Mexicans choose to become nurses are also warranted. Priority areas would include male nurse's reasons for choosing the profession and in-depth analysis of reasons for high attrition rates in Mexican nursing schools. Exploring attrition rates might help target recruitment initiatives that improve retention rates for both sexes. In another area related to recruitment, a more in-depth analysis of the socialization of nurses and its effects on their self-concept would be beneficial for improving understanding of the internal group dynamics of the profession. That study would also provide strategies for improving the public image of Mexican nursing.

This study also suggests that an increase in the number of male nurses may help to improve the public image of nursing. If Mexican nursing's new professional status allows men to meet the socially ascribed economic demands of serving as the "provider" of a family, this

could change the public's perceptions about the profession. Economic security provided by one's chosen profession associates positively with its image. Oversupply problems in traditionally the traditionally male professional fields of law and medicine have decreased security associated with them because of the tight competition, lack of jobs, and underemployment.

Reflecting on the findings from this study about nurses and their tendency to work multiple jobs provokes several questions. First, if this is the norm for most Mexican nurses, then exactly how great is the nursing vacancy rate in Mexico? Second, if nurses worked only one job that paid them a solid, middle-class salary, would the resulting reduction in fatigue improve the quality of care in Mexican healthcare institutions? Furthermore, because large numbers of nurses are required to provide healthcare to a country, would paying nurses a middle-class salary help stabilize the Mexican middle class? Finally, if one considers the role of State policymaking as fostering the capability and participation of its population in the process (Ruger, 2004a, 2004b), then support for the professionalization of nurses helps the State to fulfill its role in a way that fosters ethics and social justice. These are questions that could be answered through further research.

Finally, state-level comparisons of nursing human resources are warranted in order to determine the relationship between level of professionalization and economic development. This kind of study would be useful to further illustrate the association between economics and professionalization. Additional quantitative comparisons to basic health indicators would also make for a valuable study in that it could determine if nursing human resources influence these indicators in any way.

## CONCLUSION

Professionalization benefits nurses, their patients, and health care systems. The nursing role needs to become professionalized when everyday knowledge is not sufficient to provide care for a sick person.

This study showed how professionalization can be used to develop nursing human resources in a Latin American developing country. It demonstrated how a professionalization model can be used for infrastructure development. It is noteworthy that no single discipline will be able to completely explain the complexities involved with professionalization and nursing human resources, nor make policies about them. The right kind of nursing human resources policies that promote professionalization require an interdisciplinary effort.

The results also support previous research about professions which indicates that their development is marked by significant events, such as the creation of university-level education programs, the formation of specialized areas of practice, and the development of credentialing systems. This study differs from previous research in that the point at which professionalization markers happen is different for the nursing profession and the appearance of the common traits that define a profession is strongly affected when female gender dominates.

No matter what, in a female dominated profession like nursing, this study shows that professionalization benefits women in significant ways and could do the same for men. In a female-dominated profession like nursing, females gain increased economic security, which in turn is a vehicle for vertical career advancement. They also increase the human capital in a country overall by creating a flexible and adaptable healthcare delivery resource. The study also showed, however, that socially embedded gender biases will affect how women and men are able to advance the profession as a whole.

Ruger (2007) suggests that society's internalization social and political norms reduces

variation in policymaking. This study's findings suggest that if professionalization is fostered as a social and political norm for the organization of nurses, the development of the profession can be made more efficient thereby improving a society's capacity to respond to its health problems. Professionalization requires investments in women and the educational system at all levels, but the return to the country through the services provided by the professional nurses is well worth the effort.

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## APPENDIX A

## LIST OF ACRONYMS &amp; ABBREVIATIONS

Acronym/ Abbreviation	Full Name	English Translation or Equivalent
ANA	American Nurses Association	
BID	Banco Interamericano de Desarrollo	Interamerican Development Bank
BSN	Bachelor of Science in Nursing	Licenciatura in Latin America
CE	Continuing education	
CENEES	Centro Nacional de Evaluación de la Educación Superior	National Higher Education Evaluation Center
CIE	Comisión Internstitucional de Enfermería	Interinstitutional Nursing Commission
CIFRHS	Comisión Interinstitucional para la Formación de Recursos Humanos	Interinstitutional Commission for the Formation of Human Resources
CNDH	Comisión Nacional de Derechos Humanos	National Human Rights Commission
CNAM	Comisión Nacional de Arbitraje Medica	National Medical Arbitration Commission
CNE	Colegio Nacional de Enfermeras	Mexican Nurses Association
COPLAMAR	Coordinación General del Plan Nacional de Zonas Deprimidas y Grupos Marginales	National Coordinating Group for Economically Depressed Areas and Marginalized Groups
DCE	Desarrollo Científico de Enfermería	Scientific Developments in Nursing
ENEO	Escuela Nacional de Enfermería y Obstetricia	National School of Nursing and Midwifery
FEPPEN	Federación de Educadoras Panamericanas & Profesionales de Enfermería	Panamerican Federation of Nursing Educators and Professionals
GATS	General Agreement on Trade and Services	
GDP	Gross Domestic Product	
GNP	Gross National Product	
HCS	Healthcare system	
HIPPA	Health Information Privacy and Accountability Act	
HCW	Healthcare Workers	

<b>Acronym/ Abbreviation</b>	<b>Full Name</b>	<b>English Translation or Equivalent</b>
HRH	Human Resources for Health	
IAB	Interamerican Development Bank	
ICN	International Council of Nurses	
ICNE	International Centre for Nursing Ethics	
ICU	Intensive Care Unit	
ILO	International Labor Organization	
IMF	International Monetary Fund	
IMSS	Instituto Mexicano de Seguro Social	Mexican Social Security Institute
INSP	Instituto Nacional de Salud Pública	National Institute of Public Health
ISSSTE	Instituto de Salud y Seguro Social para Trabajadores del Estado	Institute for Health and Social Services for Mexican Government Employees
IV	Intravenous	
LASM	Latin American Social Medicine	
LPN	Licensed Practical Nurse	Enfermera General in Latin America
MSN	Master of Science in Nursing	Maestria en enfermería in Latin America
NAFTA	North American Free Trade Agreement	
OB/GYN	Obstetrics & Gynecology	
OIT	Organización Internacional de Trabajo	International Labor Organization
OMS	Organización Mundial de Salud	World Health Organization
OPS	Organización Panamericana de Salud	Pan American Health Organization
QOC	Quality of Care	
PAHO	Pan American Health Organization	
PAN	Partido de Acción Nacional	National Action Party (conservative)
PD	Professional Development	
PEF	Poder Ejecutivo Federal	Executive Offices of the Mexican government
PHN	Public Health Nursing	
PRD	Partido de la Revolucion Democratica	National Democratic Party (liberal)
PRI	Partido Revolucionario Institucional	Institutional Revolutionary Party (middle)

<b>Acronym/ Abbreviation</b>	<b>Full Name</b>	<b>English Translation or Equivalent</b>
SIARHE	Sistema de Información Administrativa de Recursos Humanos en Enfermería	Administrative Information System for Nursing Human Resources
SSA	Secretaría de Salud y Asistencia	Secretary of Health and Social Assistance
TINAN	Trilateral Initiative on North American Nursing	
TNV	Trade Negotiation Visa	
UCI	Unidad de Cuidados Intensivos	Intensive Care Unit
US	United States	
WB	World Bank	
WHO	World Health Organization	
WP	Workplace	

## APPENDIX B

**CHRONOLOGY OF HEALTHCARE AND THE NURSING PROFESSION IN MEXICO**  
**Adapted in part from Pérez Loredo Díaz (1983)**

1524	Cortez founds first hospital in the Americas. Staffed by religious orders until the mid 19 <sup>th</sup> century. Women forbidden to perform “body care” on ill patients due to religious prohibitions; thus, they performed tasks reflecting household chores (cooking, cleaning, laundry) in order to take care of the sick. Monks and priests performed body care.
1840s	Sisters of Charity arrive into Mexico and being assuming nursing roles in church run hospitals.
1850s	Benito Juarez, first president of Mexico, begins expulsion of church and church officials from Mexico in order to decrease power of the church and separate it from the Mexican State. This includes Sisters of Charity and results in shift of who is providing care to patients in institutions: Uneducated, illiterate women with no formal training.
1860	Nursing education and Nightingale Schools begin to form in Europe, US, and Canada and initiate the movement toward professionalization of modern nursing.
1870s - 1910	Porfirian era in Mexican History. Considered as the era that attempted to modernize Mexico as a country. By its end, 80% of the population was left unaffected by the modernization efforts and most of it could be seen in industrial cities such as Mexico City or Monterrey. Public health movement, dominated by physicians, begins to develop in Mexico and is considered one of the hallmarks of “modernity” in Mexico at the time.
1876	Expulsion of the Sisters of Charity from Mexico is complete. No formally trained nurses are available in Mexico anymore nor is formalization of nursing education considered as part of “modernization” of health-services in Mexico.
1870s-1900	American , British, and French Hospitals established in Mexico City. Staffed by foreign trained nurses –likely from Nightingale Schools– from all over Europe.  Vocational and normal schools, designed to educate Mexican women for the first time, planted the seed of the feminist movement in Mexico and lead to the fairly extensive participation of women in the Mexican Revolution of the following century. The academic development of women during this time added the intellectual dimension to the participation of women in political life in the next century. However, “nursing” as formal education was not considered appropriate for Mexican women of a certain class.
1905	Believed to be the year when the first training program for nurses was started in Mexico at the General Hospital (dates fluctuate between 1905 and 1907).  Compulsory physical examinations for venereal disease are made law for all prostitutes.
1906	Red Cross founds a hospital in Mexico City.

- 1910-20 Mexican revolution occurs. Rural and urban lower classes caught up in struggle and had no choice but to become involved, especially, in military aspects. Women primarily of middle and upper-class status, due to their identification with and support of the church, became enemies of the anti-clerical nature of the Revolution. Women of every class were victims and casualties of the violence of the revolution. Nurses and nursing roles, both formal and informal, were considered essential.
- 1911 First formal nurse training program started at UNAM.
- 1915 First feminist conference held in Mexico. Middle and upper class women, “gente decente”, were invited to participate.
- Divorce made legal in Mexico, but biased against women.
- 1918 First organized public health service created in Mexico.
- 1921-51 Rockefeller Foundation operates public health programs in Mexico, based on disease elimination. Some of the programs identified the first anthropological observations about health and health beliefs in Mexico because of the activities in the communities.
- 1924 Mexican School of Public Health opens, sponsored by the Health Ministry.
- Board of education implements specialized courses for school nurses.
- 1927 Red Cross starts a school of nursing in Mexico City.
- First specialized women’s health clinic, staffed entirely by women (including physicians) opens in Mexico City to treat women with venereal disease. Staffed by nurses and social workers as well.
- 1929 Child protection programs are started by the president’s wife. Creates nursery schools, women’s hospitals for birthing, milk stations, and opening school based health clinics staffed by nurses.
- First public health nurses to work outside of Mexico City begin work in Veracruz.
- 1931 Twelve mother and child health centers were operating in Mexico City with daily attendance of 150 mothers and children at the center. Specially trained nurses and midwives were placed in charge of the centers.
- Public Health department starts expanding its efforts throughout the country.
- 1935 First public health nursing training program created, sponsored by the Rockefeller Foundation.
- 1936 Central Office for Public Health Nursing created in the Department of Health. Main goal was to provide one nurse for every 10,000 population. Office was headed by a female physician.
- Six month social service requirement of physicians after medical school and residency enacted in order to improve health-services in rural areas and attract physicians to practice in these communities.

- 1937            Rockefeller Foundation sends 5 middle class nurses to study in the US.
- Red Cross training program for nurses is accepted for equivalency by the UNAM.
- Foster home system established to help manage problem of orphans or displaced children. These children were supervised by nurses.
- 1934-40        El Cardenismo Era.
- Sex education first introduced into public schools.
- 1934            Minimum entry requirements for nursing raised to the completion of junior high school or three years of secondary school.
- First nursing convention held under the National Academy of Surgeons.
- 1937            Public health nursing becomes first certified nursing specialty.
- 1939            Division of nursing is created in the health ministry.
- Second nursing convention held, organized by physicians.
- 1940            Nursing still done by women of the Catholic church, according to Monteith.
- Nurses outnumber doctors 2:1.
- Compulsory examinations for women considered carriers or potential carriers of venereal disease are no longer mandatory and the law is repealed.
- 1941            Pediatric nursing becomes second nursing specialty.
- 1942            Alumnae Association of the Red Cross School of Nursing created. Considered the first step toward the creation of a national nurses association for Mexico.
- Third nursing convention held, organized by physicians.
- Nurse anesthesia becomes a certified speciality.
- 1943            First children's hospital opens in Mexico with a staff of 200 nurses, three supervisors, one assistant head nurse, and a head nurse. First hospital with significant administrative structure that was nursing, not medicine.
- Surgical nursing becomes certified speciality.
- 1947            Mexican Nurses Association started.
- 1949            Community health nursing becomes official speciality.
- 1952            First nursing instructors trained by PAHO graduate from short training programs. Graduates are fairly young, ranging in age from 19 to 30.
- Nursing education becomes official specialty as a result.
- 1953            Psychiatric & hematology nursing become official specialties.

1954	Women's suffrage occurs.
1955	Nursing administration becomes official specialty.
1940-1982	Huge growth in hospital construction throughout the country. Not enough nursing schools to keep up with growth, but huge numbers of them are constructed.
1964	Urologic nursing is recognized as official specialty (includes dialysis nursing).
1966	Colegio Nacional de Enfermeria replaces the Mexican Nurses Association as the formal representative and organization for Mexican nurses.  Cardiac nursing becomes official speciality.
1967	National Association of Schools of Nursing in Mexico (ANEE) formed.
1973	Plastic surgery becomes recognized speciality.
1976-77	Brief economic crisis; forces CNE to cease publication of its nursing journal for the first time since it began publication.
1980	ANEE converts to the National Federation of Nursing Schools (FENAFEE).
1982-89	CNE cannot publish its nursing journal because no financial resources are available to support publication. CNE receives financial and development support from the Canadian Nurses Association during this period to maintain its existence.
1983	Interinstitutional Commission for the Training of Healthcare Human Resources is created to upgrade the training of personnel to accommodate the shifting needs of the health-system due to increased rural to urban migration. The nursing work group develops new standards but they are never implemented due to a lack of health ministry endorsement.  Major economic crisis forces massive healthcare restructuring and plunges the country into economic chaos.
1985	Mexico City earthquake occurs. Destroys majority of healthcare infrastructure in Mexico City and affects service delivery to one fourth of the population.
1988-1994	Mexico has representative on ICN commission for the worldwide recognition of the nursing profession.  AIDS begins to emerge in Mexico.
1990	All nursing education programs are moved to university-based, three year technical degree programs. Nursing "high school" training programs are still prevalent.
1994	NAFTA ratified.  Colosio, a reform candidate for presidency from the PRI, is assassinated.  Zapatista rebels begin a war with the Mexican State in Chiapas.
1995	Peso is devalued setting off another economic crisis, but far more short lived than 1982.

- 1996            Nursing human resources information system created. Would not be fully operational until 2003.
- 2001            First doctoral program in nursing opens in Monterrey, Mexico.
- 2004            Nursing certified as a profession by the National Salary Commission of Mexico.
- 2006            First nursing licensure exam made available in Mexico. Administered by the CNE.

**APPENDIX C**

**INTERVIEW QUESTIONS - ENGLISH & SPANISH**

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**Yale University School of Nursing  
Doctoral Dissertation  
INTERVIEW GUIDE - ENGLISH**

1. I need some basic demographic information from you. For my records, please tell me your name, clinical speciality, position, place of work, your marital status, and if you have children.
  
2. Please describe to me what it is like to be a nurse in Mexico.  
Probes: Working conditions.  
Salaries  
Unions  
Effect of the economy on nursing and personal life  
Gender and nursing  
Politics in Mexico and their influence on the profession  
Relationships of physicians and nurses  
Career advancement  
Recent changes in status of nursing (professional status)  
Changes in minimum education of nurses and the new open university system,  
good or bad?
  
3. Is there anything else that you think I should know about the nursing profession in Mexico that would be important for this research? Any comments in general?

**Escuela de Enfermería de la Universidad de Yale**  
**Tesis de Doctorado en Enfermería**  
**GUIA DE ENTREVISTA**

1. Necesito información demográfica de Ud. Por favor, dígame su nombre, especialidad de trabajo, en donde trabaja, su posición de empleo, estatus social, y si Ud. tiene hijos.
  
  2. Cuénteme algo de lo que es ser enfermera en México.  
Apuntar: Condiciones de trabajo  
Salarios  
Sindicatos  
El efecto de la economía en enfermería y su vida personal  
Género y enfermería  
La política de México y su influencia en enfermería  
Relaciones entre médicos y enfermeras  
Posibilidades para avanzamiento en la carrera de enfermería  
Los cambios recientes en el estatus de enfermería, a nivel profesional  
Los cambios en educación básica de enfermería y la nueva universidad abierta, son buenos o malos para enfermería y enfermeras?
  
  3. ¿Hay algo más que yo deba saber de la profesión de enfermería en México que sea importante para esta investigación? ¿Tiene Ud. comentarios en general?
-

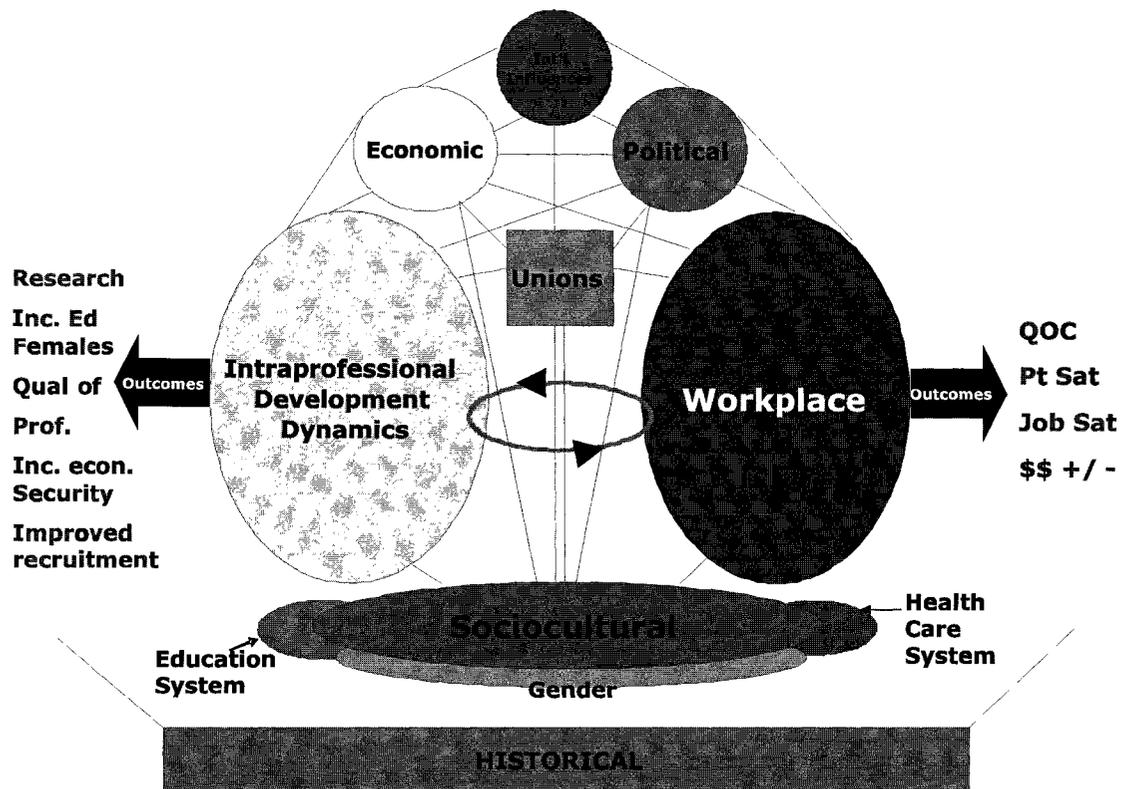
## APPENDIX D

### Conceptual Definitions of the Major Themes Affecting Professionalization

Major Theme	Definition	May include dynamics or factors related to...
Professionalization	All themes relating to the internal development of the nursing profession in Mexico. They refer to professionalization processes, variables that correlate with the literature on professions, and themes specific to Mexico.	Autonomy; career path/ advancement; culture of nursing; development processes; professional education; ethics; visions for the future of the profession; image of the professionals (internal and public); professional knowledge development and dissemination; leadership; licensure/ credentialing; the professional organization; reasons for becoming a nurse; research; rewards for being a nurse; nursing roles; shortage; socialization processes; specialized practice; standards (for education and practice).
Workplace	Aspects of the workplaces of nurses that effect the professionalization in the Mexican context.	Administration/Management of workplace; benefits; contract system; decentralization; institutional variation (public or private facilities); working multiple jobs; institutional nursing roles; quality of healthcare services; health system reforms; professional relationships; salaries; supply management; work environment.
History	Serves as a foundation for professionalization processes because aspects of Mexican history will directly or indirectly influence all variables significant to the professionalization process.	Legacies of the public image of the nurses; other historical legacies (i.e. colonialism, initial design of the healthcare system); history of women.
Sociocultural Factors	Factors from Mexican society and culture that influence the professionalization process.	Being female in Mexico; class; social change & adaptation; discrimination; education system; healthcare system design; the influence of female role models; influence of family; machismo; culturally defined male-female dynamics; men in nursing; the nature of nurses' personal relationships; religion; self-actualization; single motherhood; balancing work and family.

<b>Major Theme</b>	<b>Definition</b>	<b>May include dynamics or factors related to...</b>
Unions	The influence of unions on the professionalization process.	Positive aspects; negative aspects; union repression tactics utilized by the State.
Economic	Factors related to the economy that influence the professionalization process.	Economic security provided by studying to be a nurse; economic instability; economic reasons that encourage or inhibit migration within the country or outside of it; the effects of trade agreements.
Political	Political factors at the federal, state, or local level that influence professionalization processes.	Influence of the State; political participation of nurses; corruption; legislation/regulation of the profession.
International Factors	International forces or bodies that influence the process of professionalization.	Globalization; the policies of international institutions; English language hegemony; intercountry comparisons by Mexican nurses of the state of nursing elsewhere; the influence of international exchanges with non-Mexican nurses or for advanced education.

### Appendix E: Theoretical Conceptual Model of the Nursing System



This drawing provides a possible rendering of the relationship between the variables involved in professionalization and the potential outcomes from the nursing system. It is in the earliest stages of theoretical development and represents the fifth rendering of the interactions by the author. It may evolve further with continued work. The model's design draws not only from this study, but from the author's experience and knowledge of international nursing literature. The size of each shape representing a variable should not be interpreted as how great an influence the variable has at this time. The degree of influence each variable has and the strength of the relationship between the variables cannot be determined at this time. Further replication of the study is needed to confirm this arrangement of the relationships.