Chapter 10: Research Methods and Analysis of Empirical Results within a Technical-Interested Framework

10.0 Introduction

This chapter will be organised around the four sets of O.E. measures which have been developed: (a) individual measures of the decision to participate (turnover and absence among learners), (b) individual measure of the decision to produce (PROFORN), (c) systemic measure of the decision to produce (PROBS), and (d) systemic measures of systems adaptic capacity (ADAP1, FLEX1, INNOW1). Each set of "dependent" variables or processes to be explained will be examined in turn. This necessitates some small degree of redundancy in the discussion of results as clearly certain kinds of information could explain more than one process; efforts will be made, however, to minimise tedious repetition.

10.1 The Individual Decision to Participate: An examination of Termination Behaviour in Learner Nurses

As argued in Chapter 9, leaving behaviour amongst learners was considered by participants to be a significant indication of the long-run propensity of the system to survive. In order to better understand the kinds of leaving behaviour prevalent in the nurse training system, a detailed archival search was made of all leavers who had been trained by the area school from its inception in 1975. Appendix 10.1a and 10.1b show the results of this research. 10.1a gives the details of all SRN learners who terminated their training prematurely in the period concerned; the data begins with the cohort of 21st April, 1975 and ends with the cohort of 10th November, 1980. The data given is correct as at 1st March, 1981.

The data is divided into nurses from the N and S Districts of the Area Training School. All tests of statistical significance are conducted at the 95% confidence level, ($p \leq 0.05$). Where required two-tailed or one-tailed significance tests were conducted using a Z - statistic to test for differences in proportions of nurses leaving. The Z - statistic was chosen because the number of learners taken into consideration for significance testing numbered more than 30. The data clearly shows that up till the period 1977-78, both districts experienced, on average, a leaving % of 22%. That is approximately 1 in 5 of all learners who began training did not complete it. A one-tailed test of significance showed that the leaving % 22.4 (N District) and 22.6 (S District) were not statistically different from each other. However, after the period 1978, both districts experienced a statistically significant decline in the numbers of learners terminating their contracts. The SRN cohorts which began training in 1978 and 1979 experienced an average leaving ratio of only 12.3% (N) and 14.5% (S); both ratios were statistically smaller than the previous respective ratios of 22.4% and 22.6% at the 95% level of confidence. Indeed the leaving ratio for N District had declined by 45% and for the S District by 35.6%. This decline in leaving was most significant during the first year of training for learners in the N and during the second and third years for learners in the S District. Although both districts experienced a decline in leaving there was no statistical difference in aggregate leaving behaviour between the two districts. As before statistical tests on the means of 12.3% (N) and 14.5% (S) failed to display any difference. However, although both districts experienced essentially similar leaving ratios in aggregate there

are differences in the timing of leaving. As pointed out above, the decline in leaving behaviour was most significant amongst first-year students in the North and amongst second and third year students in the South. This indicates that causal factors influencing leaving behaviour affect the two districts, the sub-systems of the overall systems under analysis, differently. This difference becomes clearer when we later examine the data for SRN leaving.

Averaging over the period 1975-1979 gives both districts a SRN leaving ratio of approximately 19%, a figure similar to that of 20% (for teaching hospitals) which was reported by the General Nursing Council for England and Wales in their major study on student nurse wastage in 1966. However, what was to prove significant in our study was to explain not just the amount of leaving behaviour and the pattern of leaving behaviour but the underlying decline in the number of student nurses terminating training. Based on our technical definition of effectiveness as the propensity of a system to survive in the long-run, and our use of participant leaving behaviour to measure this propensity, it would appear from the data presented on student nurses, that the system had become more effective and was more likely to continue in the future.

Appendix 10.1b reinforces the message given in 10.1a. This data begins with the SEN cohort of May 1975 and finishes with the cohort of 6th October, 1980. It shows that up till the period of 1977-78, the N District displayed a leaving % of 30.8%, which was statistically significantly higher than that of 22.6% experienced by the S District. Pupil leaving was thus a more noticeable phenomena during this period than student leaving behaviour, at

least in the N District. The decline in leaving behaviour, in the N was, however, dramatic. The four cohorts who began training in 1978 and 1979 experienced a leaving percentage of a mere 9.1% whilst the S displayed an increase in leaving behaviour, which was, however, nor significant statistically. Thus, whilst the N District showed a highly significant decline in pupil nurse leaving which parallels the decline in student nurse leaving behaviour, the S District appears to have maintained its percentage of pupil leaving in the period up to 1979-1980. However, there are indications that even the S District is now experiencing significantly smaller percentages in the numbers of pupil nurses leaving. The tentative figures for the 2 1980 cohorts indicate an average learning ratio of only 10%, a figure significantly smaller than before, though, still significantly higher than comparative statistics (3.5%) from the N District. The aggregated, average ratios of leaving between the 2 Districts show no statistical difference. Ignoring the 1980 cohorts, the N shows an average leaving ratio of 23.5% whilst the S shows a ratio of 23.9%. However, as pointed out above, there are significant differences which are masked by these aggregate figures, viz, the decline in the S lags behind that in the N.

Taking the composite figures for both SRN and SEN leaving, it appears that the N district is more sensitive to causal factors which influence leaving behaviour. In both SRN and SEN leaving, the S appears buffeted and exhibits a time lag before following trends in the N. This is clearly exhibited by the picture of SEN leaving and is also indicated by the SRN figures. SRN leaving in the N in the 1978/79 cohorts declined significantly amongst first years whilst similar cohorts in the S only exhibited

a significant decline when they entered 2nd and 3rd years. This observation will be further discussed later. It is sufficient for the moment to note that the N has traditionally served a population which was poorer economically and until centralised recruitment was implemented in the Area Training System in 1980, it partially recruited nurses from within this catchment area.

Some indications of a difference between the proportion of SRN leavers and that of SEN leavers were also noted. In the period 1975-78 the proportion of SEN leavers in the N District was significantly higher than the proportion of SRN leavers. There was, however, no significant difference between SRN and SEN leaving rates in the S District in the same period. In the period after 1978, the N District showed no significant statistical difference between SRN and SEN leaving rates, primarily due to a larger decline in SEN leaving rates when compared with the decline in SRN leaving rates. The S District, however, displayed a significantly higher proportion of SEN leavers. This was due primarily to a maintenance of past SEN leaving rates and a decline in SRN leaving, particularly amongst SRN's in their 2nd and 3rd years of training. These results may be interpreted as suggesting that the SEN learner in the S District at least has become and is more likely to discontinue than a SRN learner in the S whereas in the N both SRN and SEN leaving rates are similarly low. This difference between SRN and SEN leaving rates is, however, tentative. For although SEN leaving ratios in the S for 1980 cohorts appear to be consistent with this hypothesis the statistics are not conclusive primarily because the 1980 cohorts, by definition, can only be incompletely analysed. Nevertheless, there is a suggestion that the

SEN learner is more likely to discontinue than the SRN learner, especially if one speaks of SEN learners in the S. Aggregate leaving ratios for the complete period 1975-1980 in the N District do not distinguish between SRN and SEN leaving. However, aggregate leaving ratios for the same period for the S District show a higher degree of SEN leaving. Similarly, when the two districts are combined for the complete period 1975-80 SEN leaving ratios are significantly higher than SRN leaving.

It was felt that this difference between SRN and SEN leaving is due, in part, to the intrinsic differences between the two courses of training and the type of learner most likely to be recruited from each. As reported earlier the SEN course of training is shorter, has no expanded career structure, requires fewer formal educational qualifications from the recruit and also demands less from the learner in terms of responsibilities assumed. Indeed, it is for these reasons that the SEN is sometimes perceived by nurses to be a "second-grade" nurse, not quite as 'important' or as prestigious as the SRN. Given these characteristics it is likely that the SRN is more committed to nurse training and to nursing as an occupation. In addition, the mature SEN learner may have more family responsibilities which could form a feasible alternative form of time-usage or time-demand, thus creating a reason for discontinuation. Later data confirms that more SEN's cite family/domestic problems as a reason for withdrawal and this does support the second reason given above. There is, however, little evidence to suggest that SRN's are more committed to nursing and nurse training than SEN's. On our sample of 309 learners, there were no significant correlations between course of training and levels of satisfaction and commitment to both job and training. However, our sample consisted exclusively of stayers, that is,

learners who have stayed for more than 1 year of training and is thus irrelevant for use in confirming this hypothesis. As such, we cannot discount the proposition that differences in SRN and SEN leaving could be due to differences in levels of commitment and satisfaction.

The two appendices further show that most learners leave within their first year of training. In the N District 70% of student leavers who began in the period 1975-1979 left within their first year. The comparative figure in the S District is 62.8%. The figures for pupil leavers are 63.2% for the N District and 76.8% for the S District. This clearly shows that were we to take nurse leavers as our population of interest, at least two-thirds of all potential leavers would leave within their first year of training. A detailed study of all available files on nurse leavers in the period 1975-1979 showed the following results (see Table 10.1).

Of all the 292 leavers studied over the 5 year period the number of leavers who left with less than 6 months of training ranged from 32.2% (SRN) to 39.2% (SEN), averaging at 36.3% (SRN + SEN). Nurse leavers who left after 6 months but before 12 months varied from 44.3% (SRN) to 38.5% (SEN). This class of leavers, on average, accounted for 41.4% of all leavers. A χ^2 statistic was significant at the 95% level of significance and showed there were differences in leaving behaviour between learners at different stages in their training. From this simple contingency table analysis, it could be clearly seen that tenure or length of time spent in training is a significant predictor of leaving behaviour. This phenomena is well-documented in the nursing literature (see Macguire, 1966; Moores, 1979a, 1979b; Birch, 1975) and in the

Table 10.1 Summary Statistics of Learners' Leaving Behaviour 1975-1979

SRN	Nurse Leavers who left after < 6 months of training	Nurse Leavers who left after < 6 < 12 months of training	Nurse Leavers who left after > 12 months of training	Total
N District	20	25	11	56
S District	28	41	24	93
	48	66	35	149
SEN				
N District	17	23	19	59
S District	41	32	11	84
	58	56	30	143
SRN and SEN from N and S Districts	106	121	65	292

"turnover" literature (see Schmittlein and Morrison, 1981). It is not difficult to understand this phenomena. A nurse who spends or invests more of her time and effort in training will find it relatively less worthwhile to search for an alternative use of her time. Upon qualification, a trainee nurse, can expect a reasonably secure job, geographical mobility and possibly social and economic status.

Thus far the historical information on learner nurse leaving behaviour within the Mayfield Training System has revealed that from 1978-onwards, there has been a statistically significant decline in leaving behaviour. Such a decline being more pronounced amongst student nurses and pupil nurses in the N District and registered a reduction of (45.1% (SRN) and 70.5% (SEN)). Cohorts who began in the period 1975-January 1978, had experienced an average leaving ratio of 24.2% (SRN and SEN). After January 1978, the ratios for cohorts varied from 9% through to 13% to 27%. The average for all SRN and SEN cohorts who began in the period 1978-1979 was 15.8%. Available information on leaving behaviour amongst 1980 cohorts showed a persistence of this decline in leaving behaviour. Further information showed that over two-thirds of leavers normally left after 6 months of training and that tenure was an important predictor of leaving behaviour. The course studied did not appear to influence leaving behaviour in the aggregate or in its timing. However, there were found to be differences between the two health districts studied, with the N appearing more sensitive to causal factors.

In order to gain more information on the determinants of leaving behaviour, prior to an analysis within the theoretical

framework outlined in Chapter 8, an attempt was made to categorise all the 292 nurses who had begun training in 1975 and who subsequently discontinued according to the reasons given for a termination of training. A summary of these results is shown in Appendix 10.2. A total of 290 cases were categorised as 2 out of the 292 files were unobtainable at the time of collection of this particular set of data. Ten categories of reasons were derived, after an inspection of the file information. These ten categories are as follows:

Categories of Leaving Behaviour

1. Medical/Health Problems of a Physical Nature.
2. Marriage/Pregnancy.
3. Transfer to a different School of Nursing.
4. Home-sickness.
5A. Family difficulties; non-nursing related.
5B. Family difficulties; nursing related.
6. Psychological stress and anxiety.
7. Academic unsuitability.
8. Disillusionment, dissatisfaction.
9. Disciplinary problems/Dismissal.
10. Lack of information/Do not know.

As is common with all forms of categorisation, this method of data analysis reduces the amount of information but it also enables the identification of regularities. Accordingly, after categorisation, contingency table analysis was performed on the data in order to reveal differences between sub-samples. Using the χ^2

statistic appeared to reveal no difference between the N and S districts. However, more than 26% of the expected frequencies were less than 5. Under such conditions the χ^2 - test becomes unreliable, but this was unavoidable given the period under consideration and the size of the numbers in each cell, but there were significant differences between SEN's and SRN's. Student leavers registered higher in the categories of 3 (transfers to different nursing schools) and 6 (psychological stress) when compared with pupil nurses. These results suggest that student nurses have greater geographical mobility, are more willing to continue nurse training despite geographical obstacles and also that the SRN course of training is possibly psychologically more demanding than the SEN. The SRN is a longer course with more theoretical and practical demands and examinations. In addition SRN's are also trained and expected, to manage an entire ward; such an administrative and managerial function is their role prerogative and one which does not enter into the demands on a pupil nurse. More SEN's, on the other hand left training due to family difficulties. This result is due, in part, to the higher probability of married and older female trainees being taken in for training. A phenomena which in turn is correlated with the entry requirements for SEN training. SEN's do not need to possess any formal general educational qualification and are only mandatorily required to sit for a GNC examination. Despite statistical difficulties, SEN's and SRN's are clearly differentiated by their average level of educational attainment and by the level of difficulty inherent in each type of training. Although we cannot establish the hypothesis that SRN's and SEN's may be differentiated by an ability

to withstand stress, it is, however, conclusive that an ability to tolerate psychological stress is required in order that a learner stays in training. Hence we may conclude that in addition to our initial predictors of tenure and district which influence the aggregate proportions of leavers and their timing, there is a 3rd factor of 'course studied' which affects the reasons given for leaving. Whilst no discernable effects of being a SRN and SEN trainee were discovered on the proportion and timing of leaving there is a significant effect on the reasons for leaving. In addition, Appendix 10.2 also revealed that in total (both SRN and SEN combined) the largest proportion of learners reported that they discontinued training because they were dissatisfied and disillusioned with their experience. Leavers categorised under this category accounted for 29.0% of all 290 leavers. The next highest category of leavers were these who found nursing a psychologically stressful occupation, they accounted for 15.2% of all leavers. Transfers to nursing schools (10%) and nurses who had medical problems (9.3%) were the third and fourth highest categories of leaving. These four categories accounted for 63.5% of all leaving.

Appendix 10.2 also classifies SEN and SRN leavers from both districts into specific absence categories. The matrix under the heading "Frequency Inception" gives the number of leavers under each withdrawal category who incurred 1 or more spells of absence. The sample of leavers was, in fact, more or less identical to the sample of leavers who took absence spells and hence a contingency table analysis on the latter revealed similar results. Leavers who did incur absence spells exhibited the

following leaving pattern: SEN leavers tended to cite family problems more while SRN leavers tended to cite psychological stress and 'transfer' more. The matrix under 'S-T spells' shows the number of leavers classified into withdrawal categories who took 1 or more short-term spells of absence (< 3 days). A contingency table analysis at the 95% significance level showed that SEN leavers who did take short-term spells tended to discontinue more because of family difficulties, medical problems and the occurrence of marriage or pregnancy. Similar but not identical results were obtained when the sample of leavers was classified into leavers who took 1 or more long-term spells of absence ($\geq$ 3 days). SEN leavers who did incur such spells of absence tended to cite more the reasons of medical problems, marriage/pregnancy and family problems. However, there is a difference between those results and these obtained for short-term spells of absence. For now, long-term spells of absence appear more associated with medical problems and marriage/pregnancy concerns; whilst short-term spells of absence appear to be more associated with family problems. The association of marriage/pregnancy issues with long-term absence could be due to pregnancy problems of a medical nature. However, it is more difficult to explain why SEN's should tend to discontinue more for reasons of pregnancy/marriage. It could be that the SEN views her training more as a job and less as a long-term career and is thus more willing to discontinue once marriage occurs and a more sufficient income ensues.

The linkage between SEN leavers and a relatively higher incidence of pregnancy being given as a reason for discontinuation could also be linked to the SEN's class, social and educational

background. In general, the SEN has fewer educational qualifications and is more likely to come from the lower social classes. (Our sample of 309 learners showed that there was a negative correlation between course studied and number of 'O' levels obtained of 0.71; SRN being coded as 1 and SEN as 2. It also showed a positive correlation between social class (as represented by father's occupation) and course studied of 0. 38 ; thus indicating that more SEN's are drawn from social classes 4 and 5 and have fathers who have unskilled, manual or semi-skilled jobs.) This educational and class background could help account for the higher incidence of pregnancies as a majority of these were illegitimate and occurred outside the social institution of marriage. These are, however, hypotheses which require further research and investigation.

What is interesting for us is the association between specific types of absence behaviour with specific types of discontinuation rationales. When family problems are cited as the primary reason for discontinuation by SEN's, there is a tendency to incur S-T spells of absence. And not unexpectedly, when medical/health problems are cited as the main reason for dicontinuation by relatively more SEN's, there is a tendency to incur long-term spells of absence.

These association relations between absence and withdrawal appear to give some support to the argument that absence and turnover are related forms of behaviour which lie on a continuum. The decision to be absent tends to predict a decision to leave and absence is not a short-term attempt to reduce the inducement-contribution balance. When the short-term attempts fail to correct

for a perception of inequilibrium the learner leaves. When a learner faces problems coping with family concerns and a part-study job, our data suggests that absence spells of < 3 days are used in the short-run to attempt to right the balance. When medical/health problems or marriage/pregnancy matters are concerned absence spells of > 3 days are more common stabilizers in the short-run. These results are, however, tentative for more rigorous timing of spells of absence would be required to ascertain the manner in which absence behaviour predicts the act of withdrawal. But there are strong suggestions here for a 'continuum' argument. This is in contradiction to those researchers who suggest that turnover and absence are not related in a consistent fashion and to Hill and Trist's (1955) argument that absence is an alternative to withdrawal. Our results are thus more in line with those of Nelson's (1975).

Where do all these implications leave us in terms of our formalised model? It is clear that sections of the theoretical argument were valid. The personal characteristics which were hypothesised to be important predictors and their correspondence to empirical data analysed so far is shown below:

Hypothesised Personal Characteristics	Status
1. Tenure	Influences the probability and timing of leaving.
2. Educational qualifications (partly measured by difference between SRN and SEN)	Influences the type of leaving reported and the probability of leaving
3. Personality (as measured by ability to stand work stress)	Influences the type of leaving and probably the probability of leaving
4. Expectations	Unclear.
5. Perceived employment opportunities (partly measured by differences between SRN and SEN; and by differences between the N and S recruitment area) This variable is somewhat related to tenure, educational qualifications and personality, although their linkages are left unexplored by our model.	Influences the probability, timing and type of leaving.

In addition, there is a strong indication that participant satisfaction and commitment is associated with leaving behaviour. As shown above, a majority of leavers report that they wish to discontinue nursing because they are dissatisfied and disillusioned with their experiences.

In summary then, we would argue that our initial historical analysis into patterns of leaving behaviour lead us to believe that our theoretical framework is a feasible model. Additional retrospective data collected during the second research year of 1980 showed that the distribution of leavers in each category was stable. There were no statistically significant differences (using the χ^2 statistic) between all the 50 nurse leavers studied in 1980 and the 290 who had left before. This data strongly implies that behind these reported reasons and categories there is a generally stable explanatory model of the phenomena. This validation is particularly

strong because the contingency table analysis conducted would have shown a statistical difference if there had been at least one difference in the cell frequencies between the 2 distributions. This evidence thus further lends support to our hypothesis that a generalised model of nurse leaver behaviour exists.

In the light of this historical data, we decided to use the theoretical framework shown in Diagram 8.13 chapter 8 as a model for predicting the individual decision to leave. Four 1980 cohorts were chosen randomly and they formed our primary sample of nurse learners (sample - as outlined in chapter 9). These 4 cohorts and their class sizes are shown below:

SRN	February	1980	53
SRN	May	1980	57
SEN	January	1980	40
SEN	July	1980	45
Maximum size of sample of 1980 learners			195

This sample, henceforth denoted the 1980 sample were to be administered 4 questionnaires (Appendices 9.4, 9.5, 9.9 and 9.10) within the first week of their training. These questionnaires essentially measured their personal characteristics such as age, family background, expectations of nursing, certain personality characteristics, etc. After two ward-based stints, each lasting 13 weeks the sample would be administered the primary nursing questionnaire (Appendix 9.1) which would measure systemic and environmental characteristics. All their responses would then have been used to predict the probability of an individual nurse

terminating his/her contract 12 months after the beginning of his/her training.

Besides the use of questionnaires to gain an explanation of nurse leaving behaviour within the system, the researcher also adopted the research strategy of interviewing every learner from the 1980 sample who discontinued training during the first 12 months of training and all other leavers from other cohorts during the year 1st January, 1980 to 31st December, 1980. This strategy was adopted because it was realised that the questionnaire method of data collection partially limited our study of nurse leaving behaviour.

The full usefulness of these interviews were only to be realised later. For the questionnaire approach to the study of leaving behaviour failed unexpectedly as a viable research strategy. The total number of learners from our 1980 sample cohorts who discontinued training within 12 months fell by more than 50% from our expected figure of 35 to a mere 15. Of this number 8 leavers terminated their training in the period 6 - 12 months from the date of starting. Unfortunately, only 3 leavers amongst this set of 8 were administered both sets of questionnaires. The rest completed only one set of questionnaires. Their failure to do so resulted from a variety of causes: 2 of the 5 leavers took prolonged periods of sick leave immediately prior to their official leaving date and therefore were not present at the date of administration of the second questionnaire; 2 were instructed to substitute a period of ward employment for a period of "school block" when their intention to resign was officially announced and 1 learner was absent from the administration of the second questionnaire because her statutory holidays and annual leave

enabled her to officially end her period of employment prior to the administration date.

The failure of this aspect of the empirical research was, with hindsight, due to several factors. The primary cause was the sharp decline in learner leaving behaviour which was associated with post - 2nd World War highs in levels of youth unemployment. This phenomenon already in evidence in 1978 was compounded in 1979-1981 by macro-societal changes in state policy which were occasioned by a change in ruling interests (The Conservatives took over from Labour in late 1979). This low level of leaving had a sizeable impact on our research. For it meant we had to abandon our original plan of using questionnaires in a two-staged study of leaving behaviour. A contributory cause was a failure on the part of the researchers to accurately predict both the trend of leaving behaviour and the risk of using only four 1980 sample cohorts. A risk had been taken when we decided to choose these particular cohorts as we estimated that the number of leavers who would be able to complete both sets of questionnaires would only number 14; a sample size which would have excluded advanced statistical inference and multivariate modes of analysis but which was judged to be adequate for this section of the research. However, only 3 sets of usable questionnaires were obtained and we could not proceed with our original research strategy.

Despite the failure of this initial strategy, important qualitative research evidence was collected via the interview approach and is collated in Appendix 10.3. This information cannot be used in an obvious statistical manner but as we shall demonstrate later is of vital importance in validating to some degree the formal theoretical model set out in chapter 8.

The appendix records the existence of every general nurse learner who discontinued his/her training during the period January 1980 - December 1980. In addition it records the existence of leavers from our 1980 sample who discontinued training after December 1980 but who were still within their first 12 months of training. The total number of leavers thus amounted to 53 but detailed information was only available on 50 of these leavers. These 50 general nurse leavers may be broken down as follows:

(a) Type of Training — Year of Training

	1st Year	2nd Year	3rd Year	Totals
SRN	18	5	2	25
SEN	16	9		25
Totals* (Per cent)	34(68%)	14(28%)	2(4%)	50

(b) Types of Leaving Rationales

Type of Training	Reason Given										
	1	2	3	4	5A	5B	6	7	8	9	10
SRN	3	0	4	2	1	2	2	1	10	0	0
SEN	1	1	2	0	3	2	4	3	8	1	0
SRN + SEN	4	1	6	2	4	4	6	4	18	1	0

(c) Type of Training — Year of Training

	1st Year	2nd Year	3rd Year	Totals
SRN	114	26	9	149
SEN	113	30		143
	227(77%)	56(19.2%)	9(3.1%)	292

* brackets show the proportion of leavers as a part of the total number of leavers.

From the table (a) it can be seen that 1st year leavers account for 68% of all leavers in our 1980 sample, 2nd years for 28% and 3rd years for 4%. The 1st year leavers figures may be compared with those in table (c) which gives statistics for leavers from cohorts who began training in 1975. 1st year leaving accounts for 77.7% of all leaving. In 1980 2nd year leaving accounted for 19.2% and 3rd year leaving for 3.1%. Tests of significance using the 95% confidence level show that the proportion of leavers in 1st, 2nd and 3rd year do not differ significantly between the 1980 sample and the 1975-79 sample. The number of leavers has, however, declined. On average, during 1980, the Area Training System had 629 general nurses employed. A leaving rate of 53 (including the "file-unavailable" learners) gives a leaving rate of only 8.4%. This may be compared with the 1975-79 average of 21.2% (324 leavers divided by 1666 starters). A result which is both expected (due to our historical analysis of time series data) and unexpected (due to the size of the reduction in leaving rates).

As shown in the table (d) below, the distribution of leaving rationales reported by the 1980 sample is similar to that given by the 1975-79 sample of 290 leavers. Then as now category 8 accounts for the highest number of leavers: 36%(1980), 29.0% (1975-79). Category 6 is the next highest accounting for 12% (1980) and 15% (1975-79). Category 3 accounted for 12% (1980) and 10% (1975-79) respectively. Thus, in aggregate it can be seen that there is little difference between the types of leaving behaviour reported in 1980 and those in the period 1975-79. A χ^2- test conducted at the 95% level of confidence indicated that there was no statistical significance in the aggregate (SRN and SEN) distributions of 1980 and 1975-79. However, it is difficult to confirm this indication adequately because there were expected frequencies of a value smaller than 5 in 10 of the 22 cells of the relevant contingency table. As this is more than 20% of the cell frequencies, the χ^2- statistic no longer

becomes a reliable measure of association. A χ^2 - statistic was also used to compare the distributions of leaving rationales for SRNs who discontinued in 1980 and those who left between 1975-79. As expected no conclusive results were obtained as 12 out of the 22 cells had expected frequencies < than 5. A similar outcome was obtained when the χ^2 test was performed on the SEN distributions for 1980 and 1975-79. Thus, although there appears to be no statistical differences between the distribution of 1980 and 1975-79 leaving rationales the evidence is not clear. Through inspection some slight differences were observed when the SRN (1980) and SEN (1980) distributions of leaving rationales were compared with those of the SRN (1975-79) and SEN (1975-79) distributions.

(d) Types of Leaving Rationales

Type of Training	Reasons given										
	1	2	3	4	5A	5B	6	7	8	9	10
SRN (1980)	3	0	4	2	1	2	2	1	10	0	0
SEN (1980)	1	1	2	0	3	2	4	3	8	1	0
Totals	4	1	6	2	4	4	6	4	18	1	0
SRN (75-79)	12	6	23	6	10	10	27	8	44	1	2
SEN (75-79)	15	9	6	4	15	12	17	11	40	3	9
Totals	27	15	29	10	25	22	44	19	84	4	11

As table (d) shows, in the period 1975-79 more SEN leavers reported 5A and 5B as reasons for leaving whilst more SRN leavers gave 3 and 6 as reasons for leaving. During 1980 there was still a higher number of SEN's who gave 5A (family problems unrelated to nursing) and a higher number of SRNs who cited 3 (transfer to a different school of nursing). However, there was no clear difference in category 5B and category 6 saw somewhat of a reversal as more SENs complained of unbearable stress at work. The data is, however, insufficient to indicate whether these slight observable differences are but temporary phenomena. It therefore seems more prudent to base further discussion on the reasons for learner discontinuation on the 1975-79 data,

rather than infer from comparisons between the 1980 and 1975-79 distributions.

We would thus suggest that the 1980 sample of leavers does not differ statistically from the 1975-79 sample of leavers and may validly be used to represent the underlying hypothetical population of nurse leavers. The sample confirms our initial identification of tenure and type of training as important predictions of certain aspects of leaving. Tenure being related to the timing of leaving and type of training being related to the rationale for leaving. It was further suggested that type of training was perhaps associated with educational qualifications, age and family background. The SEN trainer on average being more likely to possess fewer formal qualifications, be married and be older than 18 years of age. The district within which the learner was trained also appeared to be important, the S District learner being more likely to discontinue. However, this last variable could no longer be analysed within our 1980 leaver sample. This was because all 1980 intakes within the Area Training System were divided up into learners who studied and worked clinically within one District and those studied in one and worked in another. As such it no longer became possible to positively identify every learner/leaver as N- or S- trained since both districts participated in training. To create greater confusion, one 1980 cohort was transferred between districts and it became even more difficult to decide whether a learner was a S- or N- one. As such the researchers decided to ignore the variable of "district" from an analysis of the 1980 leaver sample. This does not mean, however, that it will be completely ignored from now on and will be returned to when an attempt is made to account for the sharp decline in leaving rates. We shall now begin to analyse the factors which increase/decrease the probability that a learner may discontinue by analysing Appendix 10.3.

An examination of Appendix 10.3 immediately reveals the point made before that although one attempts to categorise the primary reason for an individual withdrawing from training there are often secondary and contributory reasons.

For example, leaver 1 states that she discontinued primarily because she was dissatisfied with her clinical experiences but she also experienced pressure from school staff and had to cope with severe personal problems. Similarly leaver 4 reports that she experienced domestic problems and could not tolerate the psychological stress of being continually in the presence of sick and dying patients. We shall use all these statements of contributory causes to assess the appropriateness of the formal model set out in Ch. 8.

The reader should also note that Appendix 10.3 was compiled from three different kinds of information: interview data collected during an exit interview, (Appendix 9.7), data collected via the postal instrument set out in Appendix 9.7 and file information recorded by members of the educational subsystem. Exactly half of the information recorded was file information, that is, 25 leavers' reasons for leaving were as documented in their personal files. 25 other leavers were either interviewed personally by the researchers or they posted in a confidential statement of their rationale for discontinuing training. Information which is collected from learner files is marked with the letter F; such information usually being compiled by members of the teaching staff. As is apparent from Appendix 10.3, such information is usually and necessarily brief and less than that obtained via the exit interview schedule or the postal questionnaire. It is also clear that at times the leaver was unwilling to discuss with the "authorities" the reason for her discontinuation of training; they are simply left with a record of high absenteeism and declining clinical performance (e.g. leaver 7, 15, 16, 19 and 29). In other instances, learners with poor ward reports who were classified as displaying a lack of "professionalism" which was partly synonymous with a staff-definition of "impudence", "cockiness" or "over confidence" were given little support. Such learners were also labelled as showing a "lack of motivation in nursing". However, it is highly likely that from the learner's point of view, she was dissatisfied with nursing as a career whether it be dissatisfied with staff-

learner relationships or with the conditions of work. Hence, in cases where such dissatisfaction could be detected from the biased file accounts of discontinuation a count was made for dissatisfaction as well as for demotivation (e.g. learner 7,15). This was to prevent an exclusive reliance on the filtered statements entered on learner files.

This sample of 50 qualitative leaver accounts was then classified into positive or negative statements about a particular data measure. For example, when 3 leavers reported that the educational sub-system experienced resource scarcity, whilst 2 leavers reported it did not, this was scored RSS (3)(2-). Similarly, when 18 leavers reported that they discontinued training because they were dissatisfied whilst 10 leavers explicitly expressed satisfaction with their nursing experiences, this was scored JOBSAT (10) (18-).

The scores for the composite scales of JOBSAT, TRAISAT, NTCO and NCO were compiled by a subjective evaluation of the overall level of satisfaction and commitment expressed by the learner. Unlike the questionnaire measure of these variables, no attempt was made to average the learners' response to a range of job and training facets purely because the interview data was not amenable to such manipulation. Instead, an overall "feeling" of satisfaction and commitment was recorded. The scores for the factor generated scales of IPHS, CENS and LIBS were again constructed by counting the general impression gained from the interview data. A positive score for IPHS was made when there was evidence of interpersonal rivalry, a lack of trust and of management psychological distance; as for example when a learner (see learner 1, 2, 14) complained of unsympathetic staff who colluded with each other. CENS was scored positively when a learner reported that work was done well and negatively when there was report of poor standards of care and a lack of task involvement. Finally, LIBS was scored positively when a leaver reported that she/he could approach staff with questions and there was management involvement and support during times of stress.

The sample of 50 leaver accounts was then compared with the accounts of their training experiences of a random sample of 50 stayers. This consisted of 25 SRN and 25 SEN learners from the 1980 sample who had stayed in training for at least a year. Positive and negative statements are counted in a similar way. A positive statement was coded whenever a stayer scored > 3 on a five-point Likert scale for each data measure. A negative statement was coded for scores of 1 and 2 on the same Likert-scale type measures. The mid-point of the Likert scale was regarded as a point of indifference, registering neither a positive or negative stance. As such it was not counted in the analysis. Any value not equal to 3 was included; specifically any value less than 3.00 was included as a negative statement and any value greater than 3.00 was included as a positive statement. Variable E33 which represented scores on Taylor's Manifest Anxiety scale was coded such that learners who scored ≥ 30% were coded positive while those who scored less were coded negative. 30% was chosen as this was the mean score found by Taylor (1953) in her large samples which were found to display a normal distribution of scores on the Manifest Anxiety scale. PERAEO was a dichotomous variable and was recoded accordingly, nurses who reported that they could follow an alternative career apart from nursing were coded positive while those who could not were coded negative. The counts for the factor generated scales of IPHS, CENS and LIBS were approximated to by averaging the scores only on the scales with the highest factor loadings. Thus in effect we produced factor-based scales rather than strict factor scales. The positive count for IPHS was obtained by counting the number of people who scored > 3 on the scales INDAGGSC, INDAGGW, LPDSCH, LPDW and < 3 on the scales EGALSCH and EGALW and then averaging across the six sub-scales. Similarly, the positive count for CENS was obtained by counting scores >3 on the Likert-type sub-scales of TASISCH, TASIW, RUORSCH and RUORW and then averaging. The

score for LIBS was obtained by an average of the positive scores on QASCH, QAW, MISCH, MIW and the negative scores on EMEXSCH and EMEXW.

The reason for creating factor-based surrogates rather than factor scales was the case of comparison between positive and negative statements. It was easier to devise a demarcation coding for raw data based on Likert-type sub-scales than for coding factor-generated scales. Since the counts for leaver scores on these variables were themselves made from qualitative data which was interpreted within the general tenet of the same underlying sub-scales, it was felt justified in using factor-based counts rather than factor scale counts. All missing data was then deleted. That is, all leavers or stayers who did not register a positive or negative opinion on a phenomena were excluded from any comparative analysis. However, this does not circumvent the problem of data being available for stayers but not for leavers. For example, no leaver complained of frequent ward changes (CW = 0) whilst 22 stayers made positive statements on that variable with 28 stayers disagreeing. In essence, this does not really present an analytical problem in that since the research is seeking to discover the causal factors for learner leaving, one could safely argue that since no leaver discussed that phenomena, then it was probably not a significant factor in the withdrawal decision. In essence, the leading indicators used for a comparative analysis between stayers and leavers always emerged from leaver accounts.

A comparative table of the differences between stayers and leavers account is given below. The χ^2 statistic is also shown and asterisked if statistically significant at the 95% confidence level.

Table 10.2: Significant Factors in a Learner's Withdrawal Decision

Variable d.f. = 1	Stayers (S)		Leavers (L)		Phi Coefficient	x^2
	(+)	(-)	(+)	(-)		
JOBSAT	40	8	10	18	0.48	17.81685*
TRAISAT	35	11	11	14	0.32	7.30996*
NTCO	42	3	5	11	0.65	25.72684*
NCO	35	8	7	13	0.46	13.22267*
RAWA	34	8	7	0		N/A
RAS	1	42	0	0		N/Ap
RC	33	8	11	0		N/A
Tenure Qualifications						
E33	33	17	17	1	0.28	5.501788*
Conformity to Expectations (CE)	26	5	1	5		N/A
PERAEO	19	19	20	5	0.30	5.75481*
CW	20	28	0	0		N/Ap
CTS	34	14	1	0		N/A
D25	20	14	0	3		N/A
D23	43	5	2	10		N/A
LIBS	22	19	10	16		1.47275
CENS	33	7	5	9	0.45	10.88691*
IPHS	21	19	14	11		0.07583
PWSC	19	20	4	10		1.702235
PRST	23	20	7	7		0.05155
PERVAS	21	16	0	0		N/Ap
PERVAW	3	37	8	8		N/A

Variable	Stayers		Leavers		Phi Coefficient	χ^2
	(+)	(-)	(+)	(-)		
PASS	22	12	1	2		N/A
PAWS	33	4	0	0		N/Ap
QUALTEA	30	8	6	10	0.40	8.70395*
RSNS	26	18	2	0		N/A
RSS	24	13	3	2		N/A

N/Ap χ^2-statistic is not applicable here as no leaver comments on the variable were encountered.

N/A χ^2-statistic is unreliable because more than 20% of the call frequencies had an expected value of < 5.

* The χ^2-statistic is significant at $p \leqslant 0.05$ for 1 degree of freedom

In general, the table above has excluded the χ^2-statistic for variables in which one or more calls had expected frequencies of less than 5. Three variables, however, were retained and a χ^2-statistic calculated even when this occurred. These three variables were NTCO, E33 and CENS. In the case of NTCO the "problematic" expected frequency value was 3.7; for E33 it was 4.8 and for CENS it was 4.1. When the observed and expected distributions of frequencies were examined it was judged that there were noticeable differences between them and given the values of the "problematic" frequencies which were not far below 5 (which is a rule of thumb, in any event) the χ^2-statistic calculated in each case was accepted as valid. Below we present the observed and expected frequency distributions for each of the variables. When inspected each expected frequency differs from the observed by at least 4 and a majority of the differences are greater than that. We therefore decided that the distributions were amenable to contingency table analysis.

Table 10.3: Contingencv Table Analysis of Selected Variables

NTCO (Nurse Training Commitment)

Nurses \ Statements	Observed Frequencies		Expected Frequencies	
	(+)	(-)	(+)	(-)
Stayers	42	3	34.7	10.3
Leavers	5	11	13.3	3.7

E33 (Scores on Taylor's Scale of Manifest Anxiety)

Nurses \ Statements	Observed Frequencies		Expected Frequencies	
	(+)	(-)	(+)	(-)
Stayers	33	17	36.8	13.2
Leavers	17	1	13.2	4.8

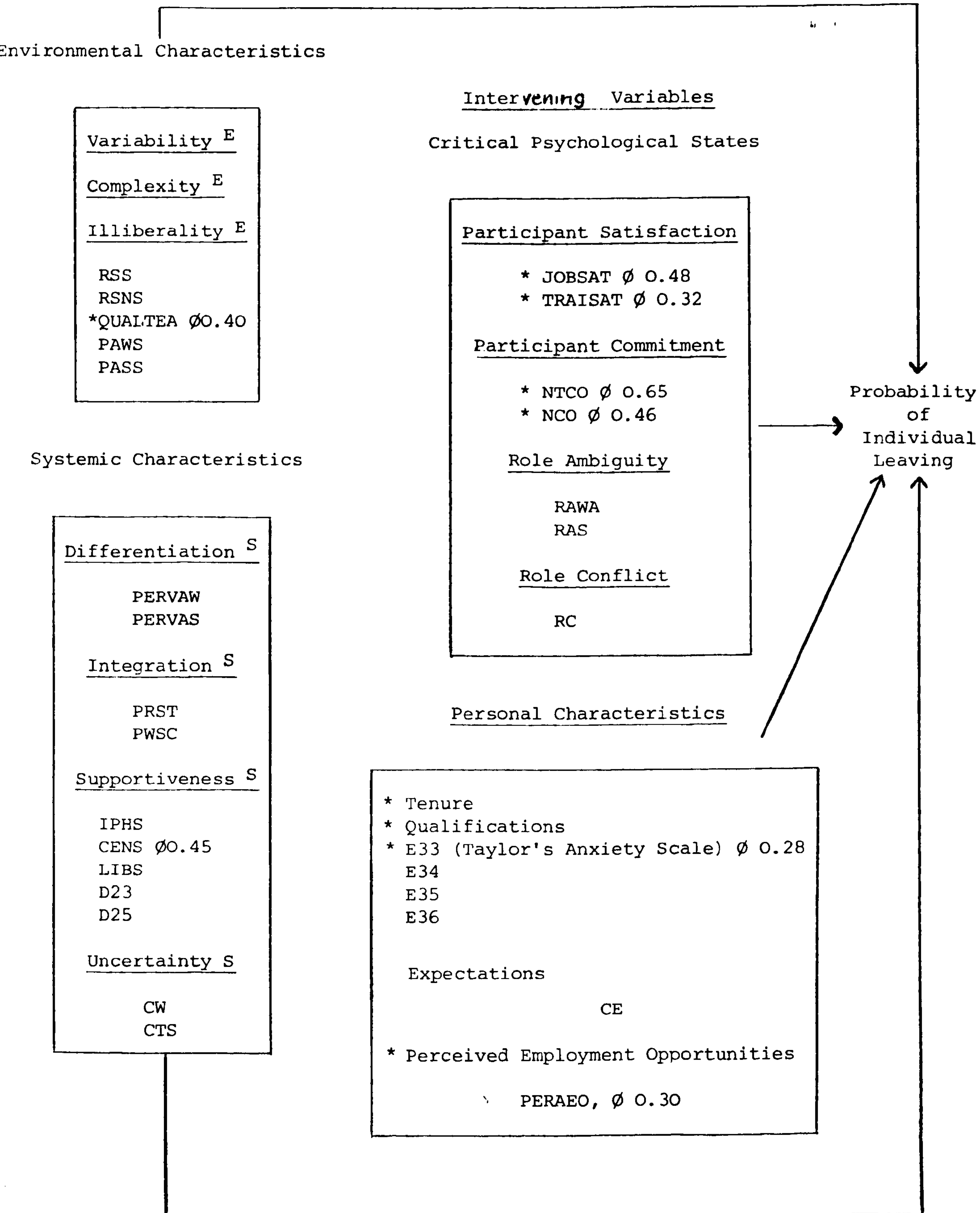
CENS (Structured Work Involvement)

Nurses \ Statements	Observed Frequencies		Expected Frequencies	
	(+)	(-)	(+)	(-)
Stayers	33	7	28.1	11.9
Leavers	5	9	9.9	4.1

Against each significant χ^2-statistic we have also calculated the phi coefficient which measures the strength of the relationship between withdrawal behaviour and the variable being used as a predictor. The χ^2-statistic by itself only helps in deciding whether variables are independent or related. It does not tell us how strongly they are related. Part of the reason is that the sample size and table size have such an influence upon χ^2. The phi coefficient adjusts for N and is a suitable though weak measure of association.

Diagram 10.1 maps out the information according to the theoretical model set out in chapter 8. It indicates that the factors most associated with the individual decision to participate are the individual's critical psychological states (levels of satisfaction and commitment) and personal

Diagram 10.1: Significant Causal Factors in Learner Withdrawal



characteristics such as tenure, qualifications, tolerance for anxiety and perceived alternative employment opportunities. Specifically leavers tended to be more dissatisfied with their work and training experiences, less committed to the demands of nurse training and to nursing as an occupation and were more aware of alternative employment opportunities. We had also argued that the longer a nurse stayed in training the less likely she was to discontinue. The S.R.N. was also less likely to discontinue and he/she is less influenced by changes in macro-employment trends. It is likely that the three personal characteristic variables of tenure, qualifications and perceived employment opportunities are related to each other and to satisfaction and commitment. However, these interactions could not be studied in our research and we could only indicate possible interactive effects on the individual decision to leave, as for example, in our discussion of the differences between S.E.N. and S.R.N. leaving.

Our analysis also indicates that systemic variables and environmental characteristics could influence leaving. Significantly more leavers reported a lack of "good teaching", that is, an increase in environmental illiberality and a lack of structured work involvement, i.e. a low level of systemic supportiveness. These results are interesting in that little research has been conducted on the effect of these variables on leaving behaviour; much "turnover" research has tended to concentrate on personal variables and/or the work context with little clear conceptualization of the role of environmental variables and sociocultural phenomena such as "climate". These phenomena then, appeared to show a discriminative ability between nurse leavers and stayers.

It was informative to note that although the χ^2-test could not be performed on RAWA, RAS and RC, there nevertheless does not appear to be much disagreement between stayers and leavers on these phenomena. A clear majority of stayers expressed experiencing high degrees of role ambiguity on the wards and role conflict. Role ambiguity within the educational

system was widely reported to be low. These answers accord with leaver opinion; a majority of leavers expressed feeling role ambiguity in the service sub-system and role conlict. No leaver reported role ambiguity within the educational sub-system. On these three processes then, there is agreement among stayers and leavers and they do not appear to predict leaving behaviour.

The responses on CW, CTS and D25 are difficult to interpret given the lack of comment from leavers on these systemic characteristics. The responses to the concept of work variety (D23) were interesting. Although the X^2-statistic was again unavailable due to one small frequency, the distribution of responses show that proportionately leavers complain of routine work while stayers report that the work is interesting and varied. Work variety, as one facet of supportiveness ^{S} thus appears to be a variable worthy of future research.

The answers to the degree of differentiation ^{S} and specifically to PERVAW also show some variance. Leavers who did discuss the extent of sub-goal differences between service and education were, on average, equivocal about the degree of such differentiation ^{S}. Stayers were, however, more united in their view that such differentiation ^{S} did not exist on a high level within the system. There is hence some doubt among leavers as to the extent of a shared value structure between parts of the training and work system. However, it is not possible to conclude that such differences contributed significantly to leaving behaviour.

The rest of the responses on environmental illiberality were again difficult to interpret given the paucity of leaver opinion on that subject.

The concept of a conformity to expectations was measured but again the χ^2 - statistic was not computable due to small cell frequencies. However, proportionately more stayers reported that they found their nursing experiences similar to if not better than what they expected. Leavers, on the other hand, reported that nursing on the whole was not what they thought it would be. Unfulfilled expectations about their job or training can clearly be a source of stress to learners and the concept of "expectation-generated role

stress" is not new. It stems from the work of Kahn et al (1964). Indeed, the concepts of role ambiguity and role conflict are derived from the theory that initial and emergent role and job expectations are a potential source of role stress. As shown, both learners and stayers reported less role ambiguity in School than on the wards and both experienced role conflict. How does this result relate to the result on conformity to expectations? Both results are in fact compatible because the items measuring role conflict referred to highly specific situations whilst the question on conformity to expectations referred to a more general sense of well-being. As such the latter concept is wider and does accommodate the former.

The work of MacGuire (1969) revealed that nursing recruits are a self-selected sample of school-leavers who have strong images of nursing prior to entry to a nursing school. Such expectations were found to vary with variables such as socio-economic class, sex and educational/school qualifications. These initial images are first confronted with experiences during the introductory part of training which takes place within the educational sub-system and then by reality-experiences in the work world of the hospital. Much work has been done to argue that the learner is socialized during introductory courses to adopt a highly "professional" and "idealistic" image of nursing which emphasizes individualized patient care on both a physical and psychological level but that such "professional" ideals are frustrated by the demands and constraints on a ward. Kramer (1974) has termed this professional-bureaucratic conflict "reality shock" and postulates that it is during this crisis that discontinuation of training is most likely to occur. The work of Birch (1975) provides additional support that a lack of co-ordination between educational and service values could contribute to withdrawal or to an outright rejection of School teaching which is but ritualistically observed during study blocks and times of assessment (Bendall, 1973; Pepper, 1977). Our own analysis has also investigated this phenomenon under differentiation S and integration S and found that a lack

of ward-School integration does contribute to withdrawal. However, much of this research has concentrated on an incongruence between emergent and socialized role expectations and little research has been carried out on the incongruence between role and job experience with initial expectations which have been formed prior to the assumption of a role. Even our data measures of role conflict essentially measure emergent role conflict rather than initial role conflict. In view of the results on the variable RC (role conflict) and on CE (conformity to expectations) it is likely that the non-significance between stayers and leavers on RC is due to a failure to measure unfulfilled initial expectations. Such unfulfilled expectations may indeed be a neglected causal factor in predicting withdrawal.

In order to analyse recruit initial expectations about the role and occupation of nursing. all 1980 recruits in our sample were given an "expectations questionnaire" to complete within their first week of introductory course. Two of the four 1980 cohorts selected were in fact administered the questionnaire (Appendix 9.5) on the very first day of training. This was done in order to measure learner expectations prior to socialization by the educational sub-system. The questionnaire sought to measure expectations on a variety of specific aspects:

(a) on nursing as a form of employment;

(b) on the educational and service sub-systems;

(c) on job characteristics such as pay, hours, studying, night-duty;

(d) on relationships with significant others such as service staff, educational staff; and

(e) on role characteristics such as a good nurse or a good nurse teacher.

These qualitative statements were then content-analysed into categories which were felt to be appropriate for the item in question. Appendix 10.4 gives details of scoring procedure and the manner in which categories were created. Appendix 10.5 shows the responses of our 1980 sample on all seventeen items and the differences between stayers and leavers. However, due to the

small number of learners who discontinued from our 1980 sample, it was not possible to conduct reliable χ^2-tests to confirm a statistical difference between the expectations of stayers and leavers. On sixteen of the seventeen items, more than 20% of the expected cell frequencies were less than 5. In such conditions, the χ^2-statistic becomes unreliable. In addition, sixteen of the seventeen results were not significant statistically. The only variable on which a statistically significant result was reached was the overall item on first year expectations. The learner was asked to complete an incomplete statement beginning with "I expect my first year to be . . ." When compared with stayers significantly fewer leavers had positive initial expectations of their first year experiences. The expected frequency for this cell was 2.7 but the observed was 0. In addition, significantly more leavers recorded neutral expectations; that is, more leavers had less well-formed views about what their first year would be like. Finally, significantly fewer leavers possessed mixed expectations. The overall picture appears to depict the leaver or the potential leaver as someone who has few definite views about their first year of training. This implies either a lack of information about their future training or a lack of willingness to gather sufficient information to form a definite view; in either case, there is an apparent lack of information. What definite view there is appears to be generally not positive and tends towards the negative. This statistically significant result is, however, problematic as three of the eight cell frequencies were less than 5 meaning that 38% of the cell frequencies were unacceptably low. As such, the result above again suggests rather than concludes but it does indicate a possible direction for future research to study the initial expectations of nurse recruits as these could have a vitally important role to play in understanding the individual decision to participate.

Although statistical analysis could not be reliably performed, an inspection was made of the proportions of stayers and leavers in each category. On six items there were differences between stayers and leavers, in terms of

the numbers of each who responded in a specific way. These six items were expectations on tutors, patients, doctors, studying, a good tutor and a good nurse. For the item on tutors proportionately more leavers had a negative expectation of what they would be like. On the item "patients" no leaver had negative expectations about nursing patients while a very small proportion of stayers (3.4%) did have negative expectations e.g. that it would be difficult, hard or dirty. On doctors, leavers proportionately registered more negative epxectations than stayers; they imagined doctors to be high and mighty, "snooty" and "not really bothered with nurses". On "studying", a large percentage of leavers had positive expectations about studying, for example, that it would be challenging, "not too difficult" or "enjoyable". On the image of a good tutor the majority of stayers conceived him/her to be synonymous with a good, thorough and competent teacher. However, the majority of leavers expected the good tutor to be helpful and to listen to their problems. Statements made by leavers included: "The good tutor . . .

" . . . helps me as much as she can."
" . . . is always ready to listen to a learner's problems."
" . . . is there when I need help."

Leavers highlighted the Helper image while stayers the Teacher image. Finally, almost all leavers conceptualized the good nurse as an altruistic, caring person who gives off her best to her patients. No leaver pictured the nurse as a "professionalizer", as a caring but efficient health practitioner, one who is a carer but a "sensible carer". There were also few leavers who conceptualized the good nurse as a technically-skilled practical person but this image was also not well-represented even among stayers.

These six items suggest that the potential nurse leaver could be one who dislikes authority and who expects authority figures like tutors and doctors to exercise their expert knowledge and their positional power in a negative way. Tutors were sometimes compared with teachers in school, a

role from which expectations were most likely formed. It was significant to note that both stayers and leavers had, on average, positive expectations about sisters who appeared to be identical with an image of "the nurse". Ward sisters and staff nurses were expected to be kind, efficient, helpful, the essence of nursing work itself. As the new recruit could envisage being in such a role on qualification, it is not surprising that ward personnel were constructed as nurses not as authority figures. In most cases this expectation would have been falsified for the ward sister has greater determination over learner behaviour than educational staff. Thus, if as is indicated, the potential leaver is one who does not adjust to imposed authority in a superior-subordinate relationship and always expects such authority to be executed negatively, he/she could experience stress coping with expected authority from tutors and doctors and unexpected authority from ward sisters and staff nurses.

He/she is also likely to have over-high expectations about the task of caring for patients and the ease with which part-time studying can be managed. Altruistic patient care and the Florence Nightingale ideal provides much of the basis for a slanted image of the ideal nurse. The role image of a nurse and indeed the self-image of themselves as nurses is one which emphasizes romantic illusions of the dedicated hand "wiping the fevered brow" and the difficulty of studying within that context is not highlighted. There is evidence to suggest that this traditional image of the nurse is already well-formed in school days and is probably reinforced by recruitment "information" issued by schools of nursing and hospitals. Some of this evidence is discussed below. Further, the leaver is probably one who requires substantial individual support and attention and thus expects such help to be forthcoming from the "good tutor". A good tutor is one who helps, not one who "teaches above my head" and who "is strict".

These initial expectations may be modified once the learner enters training but it is likely that unfulfilled expectations on these facets of the future work and training world could put sufficient stress on a learner

to enable her to discontinue training. Such expectations are most likely formed in school or college days. MacGuire's (1969) review showed that community expectations about the role of their nurses and their social importance varied according to the socio-economic status of the respondent. In order to further investigate the indication that idealistic images of the nurse were well-formed among school children a small survey was conducted.

As explained in the previous chapter, this survey was conducted among two schools in the Mayfield catchment area and consisted of a total of 119 children, 91 of which were in their fifth form and 28 of which were in their sixth form. Their responses are shown in Appendix 10.6. Each child was asked to describe what a nurse's work consisted of and their statements were content analysed into idealistic (traditional) images of nursing work, technical images and negative images. The idealistic and technical images were identical to the categories used for classifying learner expectations and mental images of nursing work. The negative image of nursing was one which used only negative perspectives - for example nursing was described as of "low status", "there's only poor pay" or nurses were described as "servants of the doctors" etc. The results show clearly that a large majority of statements made, 60%, pictured nursing work in the idealistic mode. The total number of statements made is not equal to sample size for a respondent could write a combination of statements and each was counted separately. In addition, it was found that these images of nursing work depended on the educational aspirations and sex of the respondent. Significantly more females and students who expected four or fewer "O" levels described nursing work in the idealistic mode. The higher the level of educational aspiration the more students tended to see the negative image of nursing, e.g. the "duty work", "long hours", "poor pay" and "low status of the occupation". Similarly, proportionately more females described nursing work in this idealistic mode.

These results confirm those reported by MacGuire (1969) and show that

although the idealistic image of nursing predominates among children of school-leaving age, there are significant differences between students of different educational aspirations and sex. They lend support to our argument that the initial expectations of a nurse learner as regards nursing work is well-formed before the learner enters into training. In addition, we would argue that these expectations tend to be filtered and display a lack of information about the range and depth of nursing work. A majority of leavers have idealistic images of nursing and do not appreciate the full demands of a course of training which is part-study and part-employment.

Finally, the information from school children indicates a continued sex-stereotyping of the nurse as a feminine role that is regarded with low status among children of higher educational aspiration. These results have serious implications in that the child or adolescent who presents himself/herself for nursing recruitment could generally be someone who has a lower level of educational aspiration and be female. It is this group of school-children who proportionately have more non-negative views about nursing. Yet this is the group who also tends to have a majority view of nursing as an idealistic occupation. A situation could thus arise whereby in general, the person who presents herself for nursing selection was a female who had a lower level of educational aspiration and who had a one-sided view of nursing work. Appendix 10.6, however, suggests this situation may not arise. When asked whether they would consider nursing as a possible career, there was no significant difference between children with high educational aspirations and those with low. There was, however, a highly significant difference between males and females. No male respondent would consider nursing as a possible career while twenty-one females did. This implies that although children with higher educational aspirations may present themselves for selection, the male school-leaver would on average not do so. This would lead to a continuance of nursing being an occupation largely manned by females and the nurse being sexually stereotyped as a feminine role.

This eventuality has little consequence within the technically-interested model of system effectiveness developed in chapter 8 but is of prime importance within a critical theory of system effectiveness and it will be discussed at length later. For the moment, our primary argument is that a learner's initial expectations about nursing which were well-formed by school-leaving age, when unmet leads to a discontinuation of training.

Thus far we have analysed data which looked at the historical pattern of leaving behaviour amongst learners, the different types of leaving as distinguished by reason given and have sought to identify factors which predict both the probability that a learner may discontinue and the primary reason for discontinuation. That is, not only have we sought to predict the probability of leaving but the weights given to certain causal factors within a formal hypothetical model of leaving behaviour, arguing that such weights differ depending on the course of training undertaken. The mode of analysis has been hampered by methodological mishaps and the "goodness-of-fit" of our theoretical model is suggestive but inconclusive if one takes as one's standard of reference technical, statistical measures of validity, reliability and generalizability. (See Galtung, 1967 for a definition of these terms). The primary reason for this consequence was our failure to predict accurately the size of the decline in leaving ratios and our subsequent reliance on qualitative data. We attempt now to argue that macro-societal forces were more directly responsible for this decline than intra-systemic changes; that is, environmental causes helped to bring about this greater degree of effectiveness defined technically rather than systemic strategies of adaptation.

As noted in the time-series data on leaving behaviour, leaving ratios in cohorts who began their training in 1978 declined significantly in both S.E.N. and S.R.N. cohorts although there appeared to be a time lag in the decline in the Southern District; nurse learners there continued to leave as before and an apparent time lag of at least twelve months was discernible.

A reduction in the leaving rates of Southern S.R.N.s did not become statistically significant until the second and third years whilst leaving rates amongst Southern S.E.N.s was only statistically significant in cohorts which began training in 1980. It is argued that there could be three primary reasons for this decline:

(a) declining macro-economic conditions which were associated with high levels of youth unemployment but which affected the Northern District more than the Southern;

(b) the arrival of Davies as the new Area Director of Nurse Education in January 1978 and the centralization of nurse recruitment in 1980;

(c) the raising of entry requirements and the institution of a systematic personnel recruitment programme in the Area Training System in the autumn of 1979.

Reasons (b) and (c) did not appear to explain the data well as the decline in leaving rates was apparent in both Northern and Southern Districts by April 1979. That is, the strategic actions taken by the training system in order to increase its effectiveness appear to have been instituted only after a decline in leaving rates had begun. Reason (a) appeared more relevant and we set out to test the hypothesis that macro-economic conditions were a significant influence in the decline of leaving rates. We set out two hypotheses:

HO: leaving rates in the Mayfield Area Training System are negatively related to unemployment conditions;

H1: leaving rates in the Northern District of the Training System are more sensitive to changes in unemployment conditions.

In order to test these hypotheses we required time series data which reported through time the number of leavers (S.R.N. and S.E.N.) in both districts and appropriate unemployment statistics. Appendix 10.7 shows the data available. As can be seen a chronological record of leavers could only be obtained from

the Southern District; such a record could not be obtained from the Northern District without a disproportionate amount of time spent in uncovering the information. In order to obtain the information from the Northern District we would have had to analyse the S.R.N. cohorts taken in from 1st January, 1974 onwards and the S.E.N. cohorts from 1st January, 1975 onwards, taken down the names of leavers who discontinued and checked each leaver file in order to ascertain the precise date on which the learner discontinued. Unlike the Southern District, the Northern did not have this information readily accessible. It was, therefore, decided, in view of the time and effort constraints on the study, to leave out a testing of Hypothesis 1 and to concentrate on Hypothesis 0 using only Southern District information. Even if the data from the Northern District was available it is unlikely that Hypothesis 1 could have been tested in a rigorous statistical way. A crude measure would have been used: the Pearson product-moment correlation coefficient. The leaving data from the Northern District would have been correlated with contemporary unemployment while that from the Southern District would have been correlated with lagged unemployment. The possible "benefit" of attempting to establish Hypothesis 1 hence appeared small. Finally, our research purpose was to establish a link between unemployment and nurse leaving; Hypothesis 0 was more fundamental to this research purpose and Hypothesis 1 would have only served to reinforce the argument of Hypothesis 0.

Appendix 10.7 shows the exact number of S.R.N.s and S.E.N.s who discontinued in a given quarter. Unemployment statistics were gathered on four bases:

(1) Great Britain including all male, female and school-leavers;

(2) Great Britain; aged 18-19 both male and female;

(3) Great Britain; aged 18-19 female only, and

(4) Great Britain; aged 20-24 female only.

National rather than regional statistics were used in order not to double -

count for a nurse who discontinued could have entered the unemployment register on the same day. Also it was felt that since Mayfield drew its S.R.N. and S.E.N. intakes on a national basis (though with a northern bias) it was decided that national statistics would be theoretically more valid. Bases (2), (3) and (4) were chosen because a majority of learners and leavers were female and were aged 18. It was expected that associations between leavers and unemployment statistics calculated on basis 4 would be strongest. However, statistics for bases (2) (3) and (4) posed a problem as prior to 1st January, 1978 they were calculated only on a half-yearly basis. Artificial averages were thus created for the quarters in which data was missing. In addition, the data prior to 1st January, 1976 was ignored because the basis on which the figures were calculated had changed. The information in Appendix 10.7 was then graphed and these are shown as Appendix 10.8. The graphs suggested that a linear relationship could possibly be fitted to the raw data, particularly if unemployment was calculated on bases (2), (3) and (4). The Table 10.4 below gives the range of "dependent" and independent variables with their appropriate mnemonics. The figures in the matrix show the r^2 of each set of regressions with one dependent and one independent variable, the adjusted r^2 which takes into account the degrees of freedom and the F-statistic for the regression as a whole.

All relationships were in the expected negative directions. Further, as predicted the relationship between leaving rates and unemployment calculated on a national basis for all males, females and school-leavers did not show a statistically significant relationship. However, female unemployment in the 20-24 age-group accounted for 24% of the variance in S.R.N. leaving and S.E.N. leaving was significantly explained by youth unemployment calculated on all three bases.

Independent Variables / Dependent Variables	Unemployment Great Britain (UGB)	Unemployment Age 18-19 Male + Female (U1819)	Unemployment Age 18-19 Female (UF1819)	Unemployment Age 20-24 Female (UF2024)
SRN(s)	0.0735	0.1145	0.0983	0.2433
	(0.0294)	(0.0679)	(0.0508)	(0.2034)
	F = 1.66637	F = 2.45680	F = 2.07108	F = 6.10803*
SEN(s)	0.0467	0.02720	0.2603	0.2858
	(0.0013)	(0.2337)	(0.2214)	(0.2482)
	F = 1.02788	F = 7.09852*	F = 6.68708*	F = 7.60434*
SRN + SEN(s)	0.0756	0.2086	0.1897	0.3163
	(0.0316)	(0.1669)	(0.1470)	(0.2803)
	F = 1.71808	F = 5.00750*	F = 4.4475*	F = 8.78947*

* Significant at $p \leq 0.05$

Table 10.4: R^2 of Regressions Using Ordinary Least Squares

Finally, the total number of nurses (S.R.N. and S.E.N.) leaving the Southern District was found to be most strongly explained by female unemployment in the 20-24 age-group. This is because both S.R.N. and S.E.N. leaving were found to be associated with unemployment trends in this female age-group.

The results were predictable in that S.R.N. leaving did not appear to be related to unemployment in the 18-19 age-group; this was irrespective of whether males were included in the unemployment statistic or not. This does suggest that in that particular age-group, which coincides with the first year of S.R.N. training for most learners, intra-systemic factors are more important in accounting for leaving behaviour. That is, learners may be more willing to leave at that stage of their training even though they may have no alternative job to go to. This may be that the learner is dissatisfied, finds the work stressful and is more motivated to discontinue when she has spent less time and effort in training. The S.R.N. learner being more qualified than the S.E.N. learner could also perceive more alternative employment opportunities which are denied the less qualified S.E.N. learner. The argument could also be pursued in hypothesized conditions of full employment. Because the S.R.N., as explained before, is more likely to be committed to nursing as a career, as distinct from an employment he/she could be more motivated to remain in nursing even when job vacancies are plentiful. Unlike the S.E.N. learner, the S.R.N. learner in her first year of training is thus less influenced by changes in unemployment. Her qualifications are different from those of a S.E.N. learner and so is her motivation for joining nursing.

Leaving in the later stages of S.R.N. training, however, becomes more difficult as the learner possesses less mobility, has spent a greater amount of time in training and faces the "carrot" of a steady well-marked career. By contrast, the young S.E.N. learner being less well-qualified and with fewer job opportunities may find his/her withdrawal decision more constrained by youth unemployment.

The results obtained here in fact confirm results obtained earlier via

time series analysis. Earlier it had been argued that there are important differences between S.E.N. and S.R.N. leaving primarily because of intrinsic differences between the two courses of training, the type of learner recruited and possibly the motivation for joining nursing. These same differences appear here to account for the relationship between S.R.N. leaving, S.E.N. leaving and macro-societal conditions of employment. Additional support for the arguments here is obtained from questionnaire responses of our sample of 309 learners still training within the system. Pearson product correlations show that course of training is negatively correlated with the number of "O" levels obtained ($r = 0.7079$; $p \leqslant 0.001$) and the number of "A" levels obtained ($r = 0.4006$; $p \leqslant 0.001$). For course, S.R.N. is coded 1 and S.E.N 2. This means that S.R.N.s are significantly different from S.E.N. learners where educational qualifications are concerned. In addition, Course is negatively related to PERAEO ($r = 0.1079$; $p \leqslant 0.03$). This confirms that S.E.N.s are less well endowed with formal educational qualifications and perceive fewer alternative employment opportunities (as distinct from time-usage opportunities). This in turn is consistent with our argument that the S.E.N. is less mobile occupationally and is more influenced by changes in employment trends.

In order to increase the explanatory power of unemployment as a predictor of nurse leaving, a final regression was performed using two independent variables instead of one: UF1819 and UF2024. The dependent variable was the total number of S.R.N. and S.E.N. leavers. The r^2 was indeed increased to 0.4257, the adjusted r^2 to 0.3619 and the F-statistic for the regression as a whole was 6.6082 (significant at the 95% confidence level). This meant that 42.5% of all variance in leaving rates could be explained by female unemployment in the 18-19 and 20-24 age-groups. Gratifying though this result was, the estimated regression coefficient for UF1819 was positive rather than negative. This reversal of sign suggests that multicollinearity could have affected the regression and it is not surprising since unemployment

in the 18-19 age-group is probably highly correlated with unemployment in the 20-24 age-group. Despite the existence of multicollinearity which tends to affect the relationship between the dependent and independent variables rather than r^2 itself, the results do support our initial argument that

(a) the individual leaving decision is influenced by an interplay between unemployment conditions, individual qualifications and motivations; and

(b) that the decline in leaving rates throughout the system being studied was due more to macro-societal changes rather than to adaptive strategies undertaken by the system itself.

In conclusion, it is clear that parts of our technically interested model of O.E. are particularly useful in predicting withdrawal behaviour among learners. We have also highlighted the importance of looking systematically at environments and systemic influences, in addition to personal characteristics and certain psychological states.

10. 2 Inter-Correlations Among Different Data Measures of the same Theoretical Construct.

Before analysing the correlational structure between measures of O.E. and the set of predictor variables, detailed analysis was carried out to ascertain whether various data measures of the same theoretical construct did give consistent relationships. The majority of the relations were in the predicted directions, that is, each data measure related to the hypothesized theoretical construct in the predicted direction.

Certain relations which were not in the expected directions were either weak or not statistically significant. For instance, it was predicted that the 2 measures of illiberality^E RSNS and PASS should correlate in a positive manner but instead the Spearman correlation was -0.0759 ($p<0.10$). However this relationship was due in part to confounding effects from the strong positive relationship between PAWS and PASS. When this was statistically

controlled, the partial correlation between RSNS and PASS dropped to 0.067 (p=0.111). It was felt that this type of relation did not present great theoretical problems.

The majority of correlations among different data measures of the same construct did not exceed 0.51 which means that each variable does not explain more than 25% of the variance of the other. This indicates that each data measure does measure a distinct facet and is not a redundant measure. Only PRST and PWSC had a higher correlation coefficient - 0.6103. Considerable thought was then given to the decision to eliminate one of the data measures as there appeared to be duplication. The variable PRST was analysed to locate the nature of the problem. It was found that this composite variable had sought to measure the degree to which learners perceived their education in School to be relevant and helpful in explaining their ward experiences. The variable PWSC, on the other hand, had sought to measure the degree of integration^S by measuring the degree to which School teaching and ward experiences differed from one another. Integration^S was thus measured from a positive and negative angle as we did not assume that these two perspectives would necessarily be symmetrical. The correlations show that these two measures are not perfectly related but the positive correlation would have been significant enough to cause some difficulty in multivariate analysis. However, it would not be problematic in bivariate analysis especially when partial correlations were also computed. Thus, both measures of integration^S were retained.

Apart from the instances described above, the data measures were felt to be satisfactory representations of their underlying theoretical variables.

10.3: The Individual Decision to Participate: an Examination of Absence Behaviour Among Learners

Absence was measured in five ways in this study and these are given below:

(1) GAR - gross absence ratio which measured the proportion of possible working days which were taken as non-working days.

(2) AVLSP - the average length of a spell of absence.

(3) FINCEP - the frequency of inception of a spell of absence which was measured by dividing the number of possible working days by the number of absence spells.

(4) FINCEPST - the frequency of inception of a short-term spell of absence ($\leq$ three days).

(5) FINCEPST- the frequency of inception of a long-term spell of absence (> three days).

Data on these five measures were collected from our sample of 309 nurses which formed a stratified sample of 65% first years, 21.7% second years and 12.9% third years. The descriptive statistics for each measure given below:

	Mean	Std. Deviation	Range	Median	N
GAR	0.0316	0.002	0-0.462	0.021	272
AVLSP	1.977	1.562	0-14	1.804	272
FINCEP	0.015	0.002	0-0.462	0.011	272
FINCEPST	0.011	0.001	0-0.043	0.009	272
FINCEPLT	0.003	0.000	0-0.029	0.000	272

All five distributions as can be expected are positively skewed, with many learners taking few absence spells of a long duration and a few learners taking frequent absence spells. It has long been established that a few individuals may contribute disproportionately to absence and spells of absence tend to follow a negative binomial distribution (Taylor, 1967; Froggatt, 1970) - where, for example, one-third of all employees may have no absence

in one year while a few may have many such episodes. In such circumstances, the mean value is not usually a good measure of central tendency and does not capture the distribution well.

As our aim is to gain greater understanding of leaver absence behaviour and to explain its causal antecedents then it is essential to know how the level of absence observed compared with that of other institutions. In this study it proved extremely difficult to find useful comparative data.

Little comparable information is available on absence trends in nursing. Brown (1968) calculated frequency rates differently and so did Clark (1975). However, Clark (1975) did look at the absence records of all grades of nursing staff in a teaching hospital group and some of her data is comparable after adjustments have been made. Below we give a table of comparable statistics and the differences between Clark's figures and ours. Clark's data is presented first and the information on Mayfield follows directly.

Hospital	Mean Duration of Spells (AVLSP)	Median Duration of Spells (AVLSP)	Mean Absence Per Employee Per Month (GARx5/7x28)	Median Absence Per Employee Per Month (GARx5/7x28)
A + E	3.23		0.34	
B	2.93		0.37	
C	2.90		0.57	
D	3.76		0.56	
Mayfield	1.98	1.80	0.632	0.420

Hospital A - general	658 beds	one teaching hospital group
Hospital B - long-stay/geriatric	416 beds	
Hospital C - general	354 beds	
Hospital D - general and psychiatric	285 beds	
Hospital E - paediatric	53 beds	

Mayfield comprised of (1500 beds):
- NGH - acute general - 750 beds
- SGH - acute general - 750 beds

Clark's data was collected for five hospitals within a general teaching hospital group and covered all categories of trained and untrained staff, both part-time and full-time. Our data was collected for a sample of 309 general learners who trained at two large acute general hospitals. This difference in sample could explain the difference in the mean GAR. Most studies have reported that the level of absence falls with seniority, i.e. qualified nurses have the lowest rate of absence and S.E.N. learners or untrained nurses the highest (Barr, 1967; Rushworth, 1975; Lunn, 1975), although inconsistent results are common due to different methods of calculation and time periods used to make comparisons. In addition, the above three studies also show that in general qualified S.E.N.s have a higher absence rate than learners. Nevertheless, given that Clark's sample contained qualified staff as well as unqualified, this could account for the lower mean value of GAR. Median values for GAR were not available for comparison. Note: the mean and median values for GAR have been adjusted for the fact that Clark based her calculations on a 4-7-day week-month while we worked on a 4-5-day week-month.

The data also shows that the mean duration of spells was much shorter in our sample of learners than Clark's sample of qualified and unqualified staff. Again this suggests that grade of nurse could be an important factor in explaining differences in absence patterns.

Finally, comparable data on frequency were unavailable as Clark used a different basis for the calculation of the notion of frequency.

This brief comparison of our data with Clark's has already suggested the importance of specific personal characteristics in explaining absence behaviour but Clark's figures need to be evaluated carefully. This is because she only collected information for the month of March and her "per month" figures are in reality figures for the month of March. Our data is however averaged over all months of the year and over several years. Notwithstanding the difficulties with comparison, there are some indications that parts of the model as outlined in chapter 8 will be useful in explaining patterns of absence.

Bivariate Analysis

We proceed now to look in detail at the independent (that is, excluding interaction effects) contributions of S, E, individual psychological states and personal characteristics on the effectiveness measures of absence. Appendix 10.9 gives the Spearman's rank correlation coefficients between all the "predictor" and "predictive" variables. Pearson's product-moment correlation coefficients have also been computed. The significance levels are for one-tailed tests of significance at the 95% and 90% levels of confidence.

The dichotomous variables PERAEO and COURSE have been analysed as though they were interval-level measures for zero-order correlation coefficients and at least as ordinal-level measures for the Spearman's rho. As Abelson and Tukey (1959) argue, the proper assignment of numeric values to the categories of an ordered metric scale will allow it to be treated as though it were measured at the interval level. In addition, dichotomous variables satisfy the mathematical requirements of ordering although a rank order may not be inherent in the definition of its categories or dichotomies. It does not matter which end of a ranking is considered high or low. The requirement of a distance measure based on equal-sized intervals is also satisfied because there is only one interval naturally equal to itself. Consequently, a dichotomy has been treated as at least an ordinal measure in our research situation. The majority of correlation coefficients were based on a learner sample of 309, SEX and NOLEVELS (as a measure of qualifications) was based on a sub-sample of 104 first years. All coefficients were calculated using a pairwise deletion of missing data which means that N varies; the range of variation for the sample of 309 was 309-230.

The zero-order correlation coefficients have been presented because they form the crux of comparative analysis. A majority of absence research has relied exclusively on these statistical measures (see Nicholson et al 1976; Clark, 1975; Nicholson et al 1977a) which have also been widely used for

multivariate analysis. This practice is encouraged by statisticians like Laboritz (1970) who argues that, except for extreme situations, interval statistics can be applied to any ordinal-level variable. He writes:

> "Although some small error may accompany the treatment of ordinal variables as interval, this is offset by the use of more powerful, more sensitive, better developed, and more clearly interpretable statistics with known sampling error." (Laboritz, 1970.)

Laboritz (1972) similarly argues against a strict and blind adherence to rules linking specific statistics to particular levels of measurement. Evidence from research on absence and most empirical social science research reported in mainstream journals like the Administrative Science Quarterly indicates that more and more data analysts are following such arguments, especially where the research is exploratory or heuristic.

Our position is more circumspect given the known distributional nature of absence data. Due to the non-normal character of such information it was decided that bivariate linear associations between our variables could more meaningfully be assessed via the use of rank correlations as opposed to zero-order correlations. Correlational analysis is reported by some statisticians as "a confession of ignorance" (a remark oft-attributed to Thurstone). However, after carrying out more sophisticated multivariate analysis we found that a careful analysis of the correlational matrix was invaluable and yielded information provided by these 'advanced' statistical techniques. We decided to use primarily correlational analysis and our bivariate analysis is based on rank corelations, zero-order correlations will be used mainly for comparative purposes. Taken collectively, the correlation matrix shows that as hypothesized critical psychological states, personal characteristics, systemic and environmental variables are important influences on the individual's decision to be absent. Most of the correlations are modest and do not exceed 0.25. Statistically significant relationships were found between the following pairs of variables:

Table 10.5 . Bivariate Relationships with Absence Measures of O.E.

GAR	AVLSP	FINCEP	FINCEPST	FINCEPLT
JOBSAT (-)	JOBSAT (-)*			JOBSAT (-)*
NTCO (-)*		NTCO (-)*	NTCO (-)*	
	NCO (+)*		NCO (-)	
RC (+)*	RC (+)	RC (+)*	RC (+)*	RC (+)
	RAWA (+)			
				RAS (-)*
COURSE (+)*	COURSE (+)*	COURSE (+)*	COURSE (+)*	COURSE (+)*
YEAR (+)*	YEAR (+)*	YEAR (+)*	YEAR (+)	YEAR (+)*
				LPB (+)
Manifest Anxiety E33 (+)*	E33 (+)*	E33 (+)*	E33 (+)*	E33 (+)
Neuroticism E35 (+)*	E35 (+)*	E35 (+)*	E35 (+)*	E35 (+)
NOLEVELS (-)*		NOLEVELS (-)*	NOLEVELS (-)*	NOLEVELS (-)*
RSS (-)*	RSS (-)	RSS (-)*	RSS (-)	RSS (-)*
		RSNS (+)	RSNS (+)	
				QUALTEA (+)
	PAWS (+)		PAWS (-)	
PASS (+)*	PASS (+)*			PASS (+)*
	PERVAW (+)*		PERVAW (+)	
IPHS (+)*	IPHS (+)*			IPHS (+)*
CENS (+)				
				CTS (-)*

Signs indicate the direction of association

* $p \leq 0.05$, otherwise $p \leq 0.10$

Gross Absence Ratio (GAR): the correlations revealed that job satisfaction and nurse training commitment were inversely related to the amount of time off from work. Role conflict was, however, positively related. No significant relationships were found between absence and role ambiguity; absence and training satisfaction. The latter non-significant relationship appears to indicate that the level of job satisfaction as opposed to training satisfaction plays a more dominant role in the individual's decision to be absent.

The personal characteristics variables revealed that the S.E.N. learner was more likely to take days off and that the more senior learner, irrespective of COURSE, also displayed similar tendencies. The level of manifest anxiety and neuroticism correlated positively with GAR. When the level of qualifications was used as a correlator on a sample of 102 first years it correlated negatively with GAR. This result is consistent with that for COURSE since the S.E.N. has fewer O Levels than the S.R.N.; it also suggests that grade of nurse and probably the level of educational qualification influences GAR when the effect of tenure is controlled.

The associations with environmental illiberality were somewhat inconsistent with our initial hypothesis. Although the lack of organizational skills among educational personnel correlated positively with absence, the physical lack of people and facilities correlated negatively with absence. This second result, however, could be a spurious correlation as RSS is itself negatively correlated with both COURSE and YEAR. Further discussion of this point is made below when partial correlations are computed. The correlations, however, did indicate that environmental variables did not appear to be significant in explaining the variation in gross absence.

Relationships with systemic variables were similarly less dominant with only systemic supportiveness showing a significant linear association. A learner who perceived high levels of interpersonal hostility and lack of warmth within the system was more prone to high levels of absence. Surprisingly, this was also true of learners who perceived high levels of structured work

involvement, that is task orientation which is governed by rules and procedures. It was expected that learners would welcome rule-governed behaviour which helps to alleviate role ambiguity and anxiety (Menzies, 1970) and it had been observed that both qualified and unqualified learners often performed rituals and enacted performance rules (see Goffman, 1959) in their interaction with other participant groups. For example, a learner soon learnt to label certain patients as "good" or "bad" and followed appropriate rules of behaviour with regards to each; similarly he/she related to "overdose patients", "social problems" and "difficult consultants and sisters" in ways which minimized stress and open conflict. The relationship of CENS and GAR, however, suggests that the effect of rules on organizational effectiveness is a problematic one. CENS is a composite measure which taps the extent to which rule orientation is exercised in a climate of task involvement; that is, although rules have to be obeyed and are an important chracteristic of the system they are intended to be supportive and not to interfere with the dedication and task involvement of the participants. Thus CENS taps two aspects of supportiveness S: rule orientation <u>and</u> task involvement. It was expected that CENS would be negatively related to absence but a weak positive relationship was found. This suggests that a high level of standardized task involvement is associated with higher levels of absence. This indicates that although learners perceive that rules and hard work are intended to be supportive of the task of the system, the characteristic nevertheless creates stress which is manifested in absence behaviour. Rule-governed behaviour is a complex matter: some rules are used by learners/nurses to evade anxiety and to reduce role ambiguity and yet a high level of role orientation and task involvement itself creates new forms of stress which cause a learner to take more days off. Such absence behaviour may be required in order for a learner to take a "breather", to feel less the pressure of of work and to restore his/her inducement-contribution balance. It is almost as if the learner perceives the system as being necessarily centralized and dedicated in its task execution but he/she is unable to

stand the stress of working in it for long and requires occasional breaks. Such an explanation was indeed offered by several learners who were observed by the researcher to be very involved with their work and obeyed the rules but were unable to sustain long periods in the clinical situation without taking a day off. Tiredness and migraine were often cited as the reason for absence. That such an explanation mav be valid clearly has implications for selection in that learners of a certain level of physical and psychological stamina is required. Apart from supportiveness ^{S}, differentiation ^{S}, integration ^{S} and uncertainty ^{S} were not statistically related to GAR which was somewhat surprising. However, partial correlational analysis later revealed that these were important influences.

Average Length of Absence Spell (AVLSP): the correlations showed that the higher the level of role conflict and role ambiguity, and the lower the level of job satisfaction the longer would be the average spell of absence. However, the higher the level of nursing commitment the higher was the average spell. This result is not as surprising though for it is accompanied by a corresponding decrease in the frequency of short-term absence spells. Since short-term absence spells are potentially more disruptive to the organization's work flow and more indicative of individual unhappiness with the inducement-contribution balance, the relationship between NCO and AVLSP may not be inconsistent with our initial hypothesis. It is interesting to note that role ambiguity within the service sub-system rather than the educational sub-system is associated more with long spells of absence. This suggests that role stress generated on the wards is more influential in affecting an individual's level of absence.

The S.E.N. and the more senior learner is again observed to take longer average spells of absence. So are learners with higher levels of manifest anxiety and neuroticism (as measured on the Eysenck Personality Inventory). The level of qualifications, however, does not have a significant relationship with AVLSP.

RSS, the lack of physical resources and facilities within the educational

sub-system again correlates negatively with AVLSP. But the lack of organizational skills among service and educational personnel does lead to a lower level of O.E. and is associated with an increase in AVLSP. As with gross absence, the lack of teaching skills among service and educational personnel was not associated with AVLSP. This was a trifle surprising considering the frequent complaint by leavers that the quality of ward teaching was inadequate and both service and educational staff did not do more clinical teaching. However, it is possible that the effects of QUALTEA have been confounded by the effects of other variables and hence cannot be discerned via bivariate analysis.

Systemic influences again had little influence on AVLSP; only sub-goal differentiation between the service sub-system and interpersonal hostility correlated positively with an increase of AVLSP.

Frequency of Inception of an Absence Spell (FINCEP): both training and job satisfaction did not correlate positively with this measure of absence. Only the level of nurse training commitment and the level of role conflict correlated with FINCEP in the expected directions. Role ambiguity also did not play a significant role.

The personal characteristics which were significant were identical to those influencing gross absence ratios. Again the S.E.N. learner, the learner who was more senior, with higher levels of manifest anxiety and neuroticism took absence spells more frequently. When YEAR was held constant, the level of qualifications correlated negatively with FINCEP. The results for COURSE, NOLEVELS and NTCO lend some support to the initial argument that the S.E.N. learner differs from the S.R.N. learner in terms of their attitude to training and work; specifically the S.E.N. is less committed and is more likely to take days off more frequently. The results on withdrawal and turnover had already suggested that these phenomena may be at work.

Environmental variables play little part in explaining FINCEP. RSS is negatively correlated with FINCEP but RSNS, the lack of staff resources within

the service sub-system does lead to an increase in the frequency of absence spells. This is consistent with our hypothesis that environmental hostility does lead to a decrease in O.E.

Systemic influences play no part in explaining variations in FINCEP and this suggests that where absence frequency is concerned, systemic influences may only have an indirect as opposed to a direct effect on O.E. Its effects are solely transmitted via intervening variables such as critical psychological states and personal characteristics. This result does not accord well with our initial two-way analysis of variance which showed that systemic influences did have a significant role in explaining variation in FINCEP. However, bivariate analysis does not take account of influences from other variables and/or interaction effects and this most likely explains the difference in results.

Frequency of Inception of a Short-term Spell of Absence (FINCEPST)

Nurse training commitment and commitment to nursing as a career are the most important associations with FINCEPST, both variables are related negatively as hypothesized. Role conflict is again positively correlated with FINCEPST. It is interesting to note that neither JOBSAT nor TRAISAT has any significant statistical relationship with the dependent variable. Neither does role ambiguity, whether experienced in the educational or service sub-system.

Course, YEAR of training, the level of manifest anxiety and the level of neuroticism are again related to FINCEPST in ways similar to other measures of absence. The influence of YEAR, however, appears to be less strong. The level of educational achievement as measured via the number of O Levels obtained again relates negatively.

The frequency of short-term absence appears to be more related to environmental hostility in the service sub-system than the educational. The lack of qualified nursing staff (RSNS) and organizational skills (PAWS) among ward staff are respectively positively and negatively associated with an increase in short-term absence spell frequency. The physical shortage of

resources contributes directly to work stress and this threat is countered by learners by an increase in short-term absence spells. The shortage of organizational skills, however, decreases the frequency of short-term absence but the average length of an absence spell is increased. RSS again shows a positive relationship with absence.

Finally, systemic variables are not linearly associated with FINCEPST in any significant form. An increase in sub-goal differentiation by ward personnel, does relate positively to FINCEPST. Once again, the service or "work" sub-system appears to play a more dominant part in influencing the absence behaviour of learners. It is interesting to note that neither integration uncertainty ^{S} nor supportiveness ^{S} was related to FINCEPST, thus suggesting that again their effects were probably felt indirectly via the posited intervening variables.

Frequency of Inception of a Long-Term Spell of Absence (FINCEPLT)

The frequency with which long-term spells of absence occurs is negatively related to job satisfaction and an increase in role conflict. These relationships are as hypothesized but there is an inverse relationship between role ambiguity within the educational sub-system and the frequency of long-term absence.

This relationship was unexpected given the lack of a significant relationship between RAS and other measures of absence. It was thus suspected that confounding influences could be at work which accounted for this negative relationship which suggests that ambiguity within the educational sub-system contributes positively to a reduction in long-term absence. Further analysis will be made of this relationship later in this section.

The personal characteristics correlating significantly with long-term absence are identical to those for other measures of absence with the exception of the variable LPB, the learner's preference for bureaucracy and an organizationally defined set of values and beliefs. This psychological instrument set out to measure a learner's "bureaucratic orientation" (Corwin

and Taves, 1962) and his/her adherence to the notion that "the organization and its officers always know best". The positive relationship between LPB and long-term absence frequency was thus surprising in that a learner who internalized an organizational definition of "correct", "effective" behaviour would not have been encouraged to take long spells of absence at frequent intervals. Two explanations are offered for this phenomena: (1) that the learner who is more organizationally-oriented expresses such a view verbally but finds taking more long-term absence spells to be in reality acceptable and tolerated by superiors within both educational and service personnel especially if a medical certificate is obtained to support the cause of absence. Within the training system there were frequent accusations that general practitioners often issued medical certificates "on demand", these opinions being voiced by service, educational and Allocations personnel. Taylor (1974) provides some research evidence that this is usually the case because the general practitioner cannot know, except in the clearest cases, when an individual is unfit for work. In their social construction and life-world of meanings a verbal expression of bureaucratic orientation may not be inconsistent with taking absences of more than three days. On the wards it was sometimes openly acknowledged by learners that periods of absence were a necessary "safety valve" which were "O.K." once in a while given the work conditions of learners. Within the School, learners who did not perceive the relevance of what was being taught and who perceived "School as boring" also expressed to the researcher that periods of absence "made no difference to their studying". At the same time these learners were by no means "rebellious" ones who confronted organizational definitions of issues. The more "bureaucratic" learner could simultaneously be one who knows organizational tolerance limits for certain behaviours and be able to take advantage of these; or (2) the learner who shows a higher preference for bureaucratic procedures is less concerned with the idealistic image of patient care and thus perceives long-term absence as acceptable within nursing as it is viewed as just another

form of employment. The vocational, self-denying, altruistic conception of nursing which is part of the definition of the "professional" nurse is not internalized and the learner finds long-term absence justifiable and probably feasible. He/she can "get away with it". That this may be the case is corroborated by frequent complaints from the Allocations Office and by educational staff that absence trends are not often reported and/or detected quickly. In some hospitals within the training system, absence records were two weeks old before they were sent to the educational sub-system. In addition, the southern Allocations Office found it difficult, prior to 1980 to keep accurate records of the frequency and length of absence spells due to a shortage of competent manpower in Allocations.

Both these possible explanations are evidently closely related and it may be that the relationship between LPB and FINCEPLT is accounted for by a combination of these explanations.

Environmental relationships displayed two relationships which were inconsistent with earlier hypotheses: a negative relationship between RSS and FINCEPLT and a positive relationship between QUALTEA (the availability of teaching skills) and FINCEPLT. The latter was, however, weak and could have been a spurious correlation due to confounding effects. A moderately strong relationship was found between PASS and FINCEPLT: the greater the organizational skills perceived to be available among educational personnel, the shorter the long-term absence frequency. It is interesting to note that the availability of such skills among service staff is related to short-term absence frequency whilst the organizational skills of educational personnel are related to long-term absence frequency. This suggests that individual and organizational stress caused by a lack of this particular resource produces different responses in the two sub-systems: short-term absence frequency is reduced but AVLSP is increased in the clinical sub-system and long-term absence frequency is increased in the educational sub-system. No data was collected as to whether periods of long- and short-term absence were incurred when the learner was in

hospital or in "block" but the data indicates that a lack of organizational skill in clinical situations is associated with a learner taking longer absence spells and fewer short-term ones. It is possible that such spells of absence were incurred when the learner was on the wards as frequent absences in a clinical setting would have been visible since a learner worked on the same ward for an eight to thirteen-week period. A lack of organizational skills among educational staff is associated with more frequent long-term spells which could have been incurred whilst "in block" as the learner would have had more opportunity and have been less difficult to "catch" given that he/she spends only one to two weeks in School at any one time and has an eight to thirteen-week gap before the next block.

These results are consistent with the relationship between CTS (change of educational staff) and FINCEPLT. An increase in such uncertainty ^{S} is negatively related to frequent long-term absence spells. This suggests that the retention of educational staff with poor organizational skills is related to an increase in frequent long-term spells. The effect of uncertainty ^{S} on O.E. is hence influenced by the relationship between environmental illiberality and O.E. This result, however, is the sole indicator that our weak statement of Ashby's Law which excludes interaction effects is deficient empirically. The other systemic variable which relates to FINCEPLT is IPHS and the result shows that a lack of supportiveness ^{S} as measured by this dimension is accompanied by an increase in the frequency of long-term spells.

Taking the correlation matrix as a whole, it is apparent that our hypothesized intervening variables play a more active role than S and E variables in influencing absence measures of O.E. The following "influence order" emerges: personal characteristics, critical psychological states, environmental illiberality and systemic variables (in particular systemic supportiveness and differentiation). In other words, the effects of S and E in this instance are indirect and affect O.E. mainly via intervening variables.

Indirect S and E effects, however, do not imply that a model of system-environment causal relationship is inappropriate. This is because the personal characteristics identified as most significant, upon reflection, suggest that underlying structural causes are at work; causes which relate to the entire design of the S.R.N. and S.E.N. courses of training and to a complex interplay of systemic and environmental forces which are but vaguely captured by the "fact" that as length of training increases, so does absence. Such relationships may not be fully explored via bivariate correlational analysis and at this stage the empirical information, upon interpretation, does not suggest serious deficiencies in our model of O.E. set within a technical level of interest.

The dichotomy between the "work" and "training" worlds significantly influences learner behaviour as is evidenced by:

(a) the lack of significant relationships between training satisfaction (though training commitment is relevant);

(b) the major influence of role conflict on all five measures of absence;

(c) the differential effects of resource scarcity in the service and educational sub-environments; and

(d) the differential effects of sub-systemic chracteristics on O.E.

This evidence substantiates Kramer's (1974) argument that "reality shock" for learners induces anxiety and demonstrates that the conflicts between School values v. clinical realities, trainee v. responsible nurse, trainee v. worker and individualism v standardized rules and regulations do influence O.E. by inducing withdrawal behaviour. Such behaviour itself indicates that at the individual level, participants are not coping with anxiety and erect instead defense mechanisms (see Menzies, 1970). It also suggests that learners do not receive adequate support and advice from their superiors to alleviate felt anxiety and stress; which reinforces the call from Rosenthal et al (1980) to emphasize within nursing and nurse training the "behavioural" i.e. the socio-psychological components of care and indeed, of living. A failure to do so

threatens the effectiveness of the organization by manifesting itself in withdrawal behaviour. Finally, the S.E.N. learner and the S.R.N. learner clearly differ in terms of their absence behaviour. The former consistently shows higher levels of absence. Earlier it had been shown that turnover similarly tended to be higher among S.E.N.s. The explanations for that behaviour are also relevant here: the type of learner most likely to be recruited (significant characteristics being the level of educational achievement required, the age and the degree of familial responsibilities) and the structure of the S.E.N. and S.R.N. qualification (significant characteristics being the difference in career and promotional prospects, the status of the S.E.N. in the work situation, the type of work seen as their perogative and the degree of decision making accorded to them). It was further hypothesized that these differences would manifest in different levels of nursing and nurse training commitment and satisfaction, which in combination with systemic and environmental variables would influence O.E. As yet, this last hypothesis has not been tested and cannot be in the absence of multivariate analysis but clear evidence is emerging to indicate that the effectiveness of the general nurse training system varies depending on the type of training being followed.

In order to investigate further certain unexpected relationships identified by correlational analysis a series of partial correlations was generated to locate spurious or obscured relationships. The rank correlation matrix had revealed that COURSE and YEAR demonstrated the strongest relationship with absence. Partially controlling for the effect of each showed that COURSE and YEAR then correlated more strongly with absence. The comparative statistics are given in the table below:

	COURSE	COURSE (YEAR CONTROLLED)	YEAR	YEAR (COURSE CONTROLLED)
GAR	2214	2387	1578	1934
AVLSP	1182	1595	2498	2708
FINCEP	2095	2286	1109	1147
FINCEPST	2224	2349	0695 (NS)	1041
FINCEPLT	1316	1642	1994	2217

Note: all partial correlations were Spearman's rho and significant at $p \leqslant 0.05$. The only non-significant correlation was between FINCEPST and YEAR. All relationships were positive. The coefficients have been presented without their decimal points.

These partial correlations show that COURSE and YEAR are each significant explanations for variability in absence. The relationship between increased length of training and increased frequency of short-term absence spells is particularly increased when COURSE is statistically controlled. This means that irrespective of year, the S.E.N. learner consistently demonstrates higher level of absence than the S.R.N. learner. Also, irrespective of COURSE, the more senior the learner the more absence is incurred even when length of service is accounted for. The more senior learner takes proportionately more time off, has on average longer spells of absence and absence spells whether long or short are taken with increasing frequency.

Appendix 10.10 reveals the second set of partial correlations which were performed. These correlations were statistically controlled for the effects of COURSE and YEAR. The significant relationships which still remain are:

Table 10.6 : Bivariate Partial Correlations with Absence

(COURSE and YEAR Controlled)

GAR	AVLSP	FINCEP	FINCEPST	FINCEPLT
			TRAISAT (-)	
				JOBSAT (-)
		NTCO (-)*	NTCO (-)*	
	NCO (+)*		NCO (-)*	NCO (+)
RC (+)*	RC (+)	RC (+)	RC (+)	RC (+)
	RAWA (+)			RAWA (+)
			RAS (+)*	RAS (-)*
	LPB (+)		LPB (-)	LPB (+)*
Manifest Anxiety E33 (+)*	E33 (+)	E33 (+)*	E33 (+)*	E33 (+)
Extraversion		E34 (+)*	E34 (+)*	
Neuroticism E35 (+)*	E35 (-)	E35 (+)*	E35 (+)*	
				NOLEVELS (-)*
				RSS (-)*
	RSNS (-)*		RSNS (+)	
				QUALTEA (+)
	PAWS (+)		PAWS (+)	
PASS (+)*	PASS (+)*			PASS (+)*
	PERVAW (+)		PERVAW (+)	
PRST (-)*	PRST (-)*	PRST (-)*		PRST (-)*
		PSWC (-)*		
IPHS (+)*	IPHS (+)*			IPHS (+)*
CENS (+)	CENS (+)			
		Work Autonomy D25 (-)		
				CTS (-)*

Signs indicate the direction of association

* $p \leq 0.05$, otherwise $p \leq 0.10$

This table of partial correlations demonstrates interesting linkages. With the effects of COURSE and YEAR being statistically removed more variables from the critical psychological category come into play. Training satisfaction now is negatively related to the frequency of short-term absence spells and role ambiguity in the educational sub-system is positively associated with short-term absence frequency and negatively related to long-term absence frequency. The influence of nursing commitment, nurse training commitment and job satisfaction are, however, diminished and so are the relationships between absence and RC (role conflict); absence and role ambiguity in the service sub-system (RAWA). This indicates that critical psychological states are significantly related to COURSE and YEAR but that each is nevertheless a distinct but related influence on absence. An examination of the linkages between personal characteristics and critical psychological states and their eventual influence on O.E. was thus the next logical step in analysis and further corroborated our initial model of multi-level and hierarchical causality.

The relationship between absence and other personal characteristics remained stable.

The most significant change was the alternation of the influence of the level of qualifications on absence. Previously the number of O Levels had shown significant negative relationships with absence but with the partialling out of COURSE (year was already controlled via sampling as this variable was measured for a sample of first years only) the effects of NOLEVELS was reduced to a negative relationship with the frequency of long-term spells. This attenuation suggests that the level of educational attainment is not as important in explaining absence behaviour among learners; COURSE and YEAR are more dominant. This has implications for selection procedures for with rising levels of youth unemployment and increased emphasis on "professionalism" in nursing, recruits are required to possess higher levels of educational achievement. It could be that such entrants do not necessarily increase O.E. as measured by absence.

The effects of environmental illiberality remain stable and are clearer. The negative relationship between RSS and absence proved, in general, to be spurious and to be confounded by the effects of COURSE and YEAR. A significant negative relationship between RSS and FINCEPLT remains but there is little evidence to suggest that this is a theoretically important relationship. No logical explanation was found to account for the positive relationship between QUALTEA, the availability of teaching skills and FINCEPLT. However, this relationship remains weak and is uncorrelated with other measures of absence. The relationship of PAWS with absence is strengthened especially its positive association with FINCEPST. The influence of PASS on absence remains stable.

Finally the partial correlations bring out more the influence of systemic variables on absence; no longer are these merely indirect but there are clearly bivariate correlations with O.E. Systemic integration measured via PRST and PWSC are more clearly seen as explaining variations in O.E.; significant relationships on the expected negative directions are found between PRST and GAR, AVLSP, FINCEP and FINCEPST. PWSC was also negatively related to FINCEP.

This means that where learners perceive both sub-systems to be well co-ordinated and their training to be integrated, their absenteeism decreases. Systemic supportiveness and its relationship with absence remains stable, with the influence of standardized, rule-oriented task involvement now leading to an increase in the average length of an absence spell. An additional aspect of supportiveness S is also revealed as being important - work autonomy, which has a modest negative relationship with the frequency of absence spells. This means that the higher the level of perceived work autonomy, the lower the frequency of absence. The relationship between uncertainty S and O.E. remains similar to the situation before.

It is instructive to note the absence of significant relationships with certain variables: perceived alternative employment opportunities (PERAEO),

conformity to expectations (CE), sub-goal differentiation in the service sub-system (PERVAS), systemic openness and liberality (LIBS), work variety (D23) and uncertainty in the service sub-system as measured by frequent changes of wards (CW). Given the restrictions of bivariate analysis, it is difficult to assert these characteristics do not influence learner absence behaviour. It could be that confounding effects obscure their relationships with absence..

In summary, the partial correlational analysis with COURSE and YEAR held constant indicates that all four parts of the model are related to measures of absence. Two interesting points were: (a) that the service sub-system and environment appeared marginally more influential by correlating more strongly with absence than the educational sub-system and environment; and (b) levels of training and job satisfaction were not as related to absence as other critical psychological states.

The first observation was detected even before partial correlational analysis and corroborated observations by the researcher that the service sub-system and environment being the future work world of the learner tended to represent a stronger reality for him/her. Since work stress also tended to be greater within that sub-system, it is not surprising that it has a stronger influence on learner absence behaviour. The second observation is partially consistent with Nicholson et al's (1976) work which demonstrated that job satisfaction was related to absence and they were able to find significant relationships between three measures of absence and satisfaction. In our results, JOBSAT only displayed a weak significant relationship with the frequency of long-term spells while TRAISAT was only related to the frequency of short-term spells. This is mainly because our measures of satisfaction were related to the control variables used in the partial correlational analysis, when these were held constant, the influence of satisfaction was

attenuated but the effect was not strong enough to completely eliminate the influence of JOBSAT and TRAISAT. This suggests that although participant satisfaction is associated with the decision to participate, its relationship may be quite weak and subject to a variety of other influences. Our results differed from those of Clark (1975) who found no relationship between job satisfaction and absence behaviour. However, her sample was small (sixty-two) and she only used a sample of student nurses.

10.4: The Individual Decision to Produce

To recap, the decision to produce was measured at two levels: the system and the individual. A learner was hypothesized as "producing" where he/she expressed agreement with a certain set of work attitudes and actions which, in current nursing philosophy are defined as "correct" and "professional". This set of "correct" thoughts and behaviour was measured via a composite scale called PROFORN (a mnemonic for professional orientation). For example, there is great emphasis in nursing today that each patient must be treated as an individual rather than as a 'case'. Or that all patients should be treated equally, favouritism should be kept to a minimum. In addition, a nurse should attempt to maintain her own individual standards though others around her may not and should seek to exercise independent, autonomous decision-making authority within the context of a 'multi-professional health care team'.

Looking at the table of Spearman's rank correlations in Appendix 10.11 the following significant relationships are detected:

Table 10.7 : Bivariate Relations with PROFORN

	PROFORN
	NTCO (+)*
	NCO (+)*
	RAWA (+)
	RAS (-)
	CE (+)*
	COURSE (-)
	YEAR (+)*
Extraversion	E34 (-)
	RSNS (+)*
	QUALTEA (+)
	PAWS (+)*
	PERVAS (-)*
	PRST (+)*
	PWSC (+)
	CENS (+)*
Work Variety	D23 (+)*
	CW (-)

The degree of professional orientation expressed by the learner is associated most strongly with critical psychological states and certain systemic characteristics. Compared with absence and the decision to withdraw, systemic variables seem to play a more direct role on the decision to produce. The more dominant influences include certain aspects of all 4 systemic characteristics: differentiation^S (specifically that in the educational sub-system), integration^S, supportiveness^S (specifically standardized work involvement and

the degree of work variety) and uncertainty[S] (specifically the number of ward changes). All relationships are as hypothesized and it is interesting to point out the bivariate relationships of CENS, and standardized work involvement. CENs was positively related to certain measures of absence, GAR and AVLSP, when course and year of training were statistically controlled. It was argued that this relationship could result from stress which was generated by an inability to work for long in a highly rule-oriented, strenuous work situation. However, here CENs is strongly related to PROFORN, which suggests that a high degree of standardized task involvement is associated with greater acceptance of a 'professional' code of conduct. Learners who perceive a higher level of 'rules and hard work' are more 'professionally-oriented', they display a greater degree of acceptance of prevailing definitions of good nursing. Such a result can be explained by noting that this characteristic helps to socialize the learner and develops his/her identification with the meaning of 'professional' nursing. A system which is characterized by a high level of task involvement, although executed within rule-bound parameters creates a 'favourable' impression for the learner and acts as a means of role-formation. The process is particularly strong in learners since they represent a highly self-selected sample who generally expect a nurse to be dedicated, altruistic and self-sacrificial. In addition, once a learner adopts the attitude that a certain level of rule-orientation, of 'discipline' is required for operational nursing, it becomes easier for her to follow other rules about what constitutes 'professional' behaviour. As always, rule-enacted behaviour is less stressful for the tutor as he/she has a precedent and a well-worn script to follow. The relationship between CENs and PROFORN is thus not inconsistent with our earlier empirical results.

Environmental relationship with PROFORN are only moderately strong and they are not always in the predicted directions. The expected relationship was that *ceteris paribus*, the greater the level of resource scarcity, the lower the O.E. This is the case only for the relationship between a lack of

teaching skills and the level of professional orientation. Where such skills are perceived to be absent the learner records a lower level of 'professionalism'. However, RSNS (lack of qualified nursing staff in the service sub-environment) and PAWS (lack of organistional skills among service personnel) are positively associated with PROFORN. This implies that the greater the scarcity of skills the more effective the system becomes, a result which is clearly inconsistent with our a priori hypothesis. There could be two probable explanations for this inconsistency:

(a) these are spurious correlations which arise from the confounding effects of other variables. By its very nature a bivariate correlation does not statistically account for the influence of other variables;

or (b) these are substantive relationships which could suggest that a lack resources in the service sub-system has a complex relationship with the individual decision to produce which is mediated by a role-making process not captured by our measures of personal characteristics. These new relationships would suggest that our initial hypotheses were incomplete and that illiberately[E] has differential effects on the decision to participate and produce. (Earlier our empirical results on absence behaviour had shown that illiberatity[E] was positively associated with measures of absence).

There is ample evidence in the nursing literature that service personnel and in particular the sisters, staff nurse or senior SEN is a 'significant other' in the world of the learner. That is, these roles often form the basis of subsequent role formation and the role encumbent significantly influences the behaviour of the learner. Such an influence could either be positive or negative. The learner can decide either to follow the example of the role incumbent observed or reject it; acceptance or rejection being largely based on learner expectations about the appropriate behaviour of a sister or staff nurse (see Davis, 1977; Kramer, 1974). Such a process was

clearly observed when the researcher worked on the wards and often heard comments like the following:

> "I'd like to be like Sister _____. She's really good with patients and so interested in learners and open to questions".
>
> Learner working in NGH.

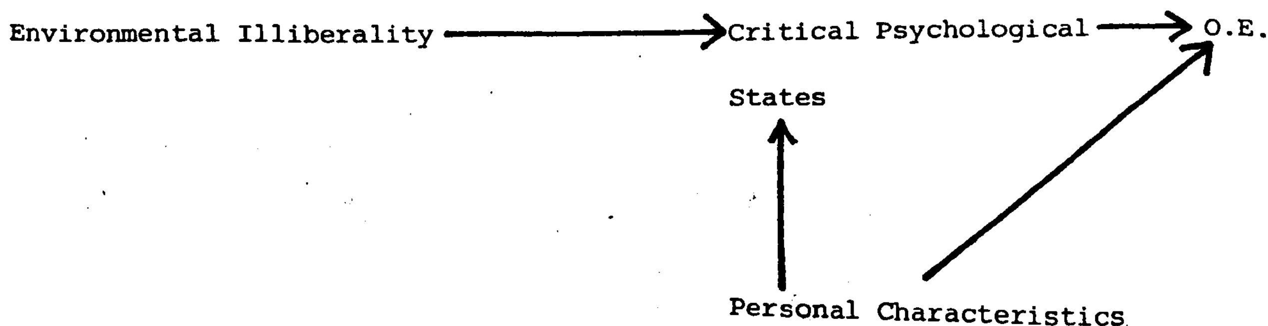
> "Sister _____ is awful. But that makes me think that I wouldn't like to be like her. When I become a sister I would remember what sisters I liked and those I didn't".
>
> Learner working in NGH.

> "I prefer to do things the way they are done on the ward, here there's no time to be finicky and do everything like they teach you in School. I would never finish my job. You know what I mean, it's a matter of giving every patient a bit less and doing more of them than just concentrating good care on a few. But everything is still safe. School can be very out-of-touch, you know".
>
> Learner working in SGH.

If the activities and attitudes of service personnel do form a significant influence on learner behaviour and there is much evidence to suggest it does, the relationship between RSNS and PROFORN and between PAWS and PROFORN could be an example of a negative role-making process. That is, the learner who perceives a high level of scarcity of both the quantity and quality of service staff rejects the negative consequences this produces and turns to alternative role-models which thereby help to develop a higher level of agreement with prevailing definitions of professional behaviour. Like the learner quoted in our second example, illiberality^{E} could have a positive influence on O.E., this influence being largely dependent on the role-making process adopted by the individual learner. The learner could develop a nursing orientation which is opposite to the scarcities observed or he/she could turn to other participant groups for the development of behavioural norms, such as their fellow learners or members of the educational sub-system. The influence of these other participants is described later when analysing the relationship between the degree of role ambiguity perceived on the wards and PROFORN. With regard to the influence of service personnel, our results appear to suggest that though they are significant role

models, the scarcity of qualified staff and a lack of organisational skills among them act as a negative motivator to learners to develop alternative models of appropriate behaviour. Learners appear to hold the opinion of our second quotation where the maxim appears to be, "A poor or a non-example tells me what not to be and how not to behave." It is likely that this reaction could come from the more mature learner who is emotionally secure and less dependent on observed role models for a profile of 'professional' behaviour. It is also likely that this kind of emotional maturity enables a learner to respond positively to illiberality[E]. Instead of being over-stressed by resource scarcity to the point that ideal notions of patient care are rejected, the learner reacts by identifying more with these norms. Indeed, our results appear to suggest that it is the learner who does not perceive scarcity who develops a lower level of 'professional' thinking, who appears more complacent and less committed to the ideal notions of nursing. Such a learner does not perceive that ward time could be poorly organized or that a severe shortage of qualified staff exists, indeed the environment is 'rosy' as far as he/she is concerned. Such an attitude or perception is accompanied by less of an identification with the current struggle for ideal 'professional' conduct. It is probable that the difficulties of obtaining a goal enhances the valency of the desired objective, where such difficulties do not exist, the learner identifies less with the objective and is thereby less effective.

The second explanation has obviously suggested that personal maturity is an important intervening variable in analysing the effects of the environment on the individual decision to produce. In our model, this relationship is studied via an analysis of the following causal relationship:



That is the influence of illiberality^E and personality characteristics on O.E. is always analysed via critical psychological states. However, it is not possible to conclude which of our two probable explanations accounts for the relationship between illiberality^E as measured by PAWS, RSNS and O.E. as measured by our scale of professional orientation. The presence of spurious effects cannot be ruled out. In addition, it is interesting to note that the more introvert learner displays higher levels of professional orientation. The more introvert person is to some extent more stable and less likely to act on impulse. It is thus probable that introversion could be the significant intervening influence which explains the relationships between illiberality^E and our individual measure of O.E.

The personal characteristics which were significant were the level of conformity of experience to initial and emergent expectations (CE), COURSE, YEAR and the level of extraversion of the learner. The more expectations were perceived to be met, the higher the level of professional orientation. The more senior learner and the less extrovert one displayed higher levels of PROFORN; they are more associated with a higher degree of acceptance of established norms. That this is so for the more senior learner is understandable given the processes of occupational socialisation and of filtering whereby nurses who did not accept the philosophy would have discontinued. There is less of an explanation why the more introverted learner is more willing to accept these norms of behaviour; nevertheless, this result appears to be consistent with absence data. There it was discovered that when COURSE and YEAR were controlled, the more extroverted learner took absence spells more frequently and in particular short-term absence spells. The introverted learner thus takes absence less frequently and this is consistent with a higher degree of professional orientation. It could be that the introverted learner is more easily socialised and persuaded to internalize a given set of attitudes and norms of behaviour. Eysenck has argued that introverts are more readily

conditioned and are therefore more likely to be social conformists who build up strong super-egos, whereas extroverts will be more inhibited and delinquent. Vernon (1963) however points out that it is doubtful whether 'condition-ability' can be accepted as a unitary trait (i.e. individuals do not consistently acquire different sorts of conditioned reflexes easily or the reverse), and still more doubtful whether ease of sensory conditioning has anything whatever to do with social learning. However, he did agree that extroversion-introversion could be linked to attitudes to authority. If such a link were to be present in the direction argued by Eysenck, we would be able to explain the negative association between extroversion and professional orientation. It is also possible that confounding effects may be at work for we know that YEAR and E34(E) are themselves negatively correlated. It could be that the negative association between PROFORN and extroversion is due essentially to variations in YEAR. A partial correlation between E34(E) and PROFORN, holding YEAR constant, however, revealed that the negative relationship between E34(E) and PROFORN holds and we would argue that our explanation for this relationship similarly stands.

The relationship between PROFORN and certain critical psychological states are in the predicted directions. Learner commitment to nursing as a career and to nurse training are the most significant relationships; NCO and NTCO are positively related to degree of professional orientation. It is interesting to note that the level of training and job satisfaction does not contribute significantly to the acceptance of a set of behavioural norms, which are commonly accepted as "proper" nursing; rather it is the degree to which the learner is committed to nurse training and has a high opinion of nursing as a career. It would thus appear that the level of satisfaction (as measured by our composite scales) does not influence significantly the individual's productive decision (as measured by the cognitive acceptance of a set of behavioural norms). That is, learner satisfaction does not influence the degree to which a learner "thinks professionally".

This lack of a linkage between a measure of satisfaction and a measure of productivity as measured by the extent to which a learner identifies with prevailing norms is interesting. It indicates that our measure of job and training satisfaction tapped a sense of well-being which was independent of "professional" orientation. The identification with the wider concept of a "profession" thus appears to override personal perceptions of satisfaction or dissatisfaction. This could have resulted from our measure of "professionalism" which contains data items that sound "correct" and accord well with prevailing theories of "good" nursing. These norms of behaviour could be so well accepted as "common sense" and "universal" that learners are able to detach a perception of their correctness from their own feelings of satisfaction. Such a phenomena in turn indicates that (a) we have perhaps devised an accurate representation of prevailing nursing philosophy, and (b) that such a philosophy is essentially taken-for-granted by learners. The second implication has important effects for it means that learners do not find it easy to question the assumptions that undergird those "taken-for-granted" notions. They sound so "right" that the ideology which lies behind nursing's professionalization project is often obscured and not recognized. Indeed, our use of the term "professional" orientation to characterize these norms may mystify instead of demystify because the word "professional" becomes equated in nursing with absolute norms of behaviour instead of prevailing norms of behaviour. The fact that a profession is essentially an occupational monopoly that needs to legitimate its privileged status in a supposedly democratic society is not made visible. And the word "profession" is thus stripped of any derogatory sense-making. The fact that learners are able to detach feelings of satisfaction from notions of professional orientation is itself an indication that nursing's professional elite has been fairly "successful" in propogating their ideology. In chapter 11 we will conduct an extensive critique of the professionalizing movement in nursing and the limits upon emancipation it imposes.

RC is not found to be significantly related to PROFORN but the degree of role ambiguity in the educational sub-system is. The higher the level of RAS (role ambiguity in school), the lower is the degree of professional orientation. However, PROFORN is also positively associated with the degree of role ambiguity on the wards (RAWA). This result is contrary to expectations as we would expect a negative relationship. There are two possible explanations for this relationship: (a) that the lack of role definition in the clinical setting, although causing work stress encourages the learner to look elsewhere for role models. Both Birch (1975) and Menzies (1970) point out that many learners obtain considerable emotional support from their peers, who could conceivably also be the source of definitions of "professional" and "proper" nursing. However, this presumes that the learner population at large has accepted prevailing definitions of "professionalism". That this may be the case is corroborated by the mean value of PROFORN. In our sample of 309, the variable had a mean of 4.2103 and a standard deviation of only 0.3325. Frequent contact with learners both in school and in the hospital also revealed that they often talked about their problems among themselves, particularly when a learner was in residence. Another alternative role model could be the values and teaching of the educational sub-system which officially concur with prevailing definitions of "professional" behaviour. A lack of direction from ward personnel could cause the learner to rely more on the 'idealistic' training of his/her teachers. This may be aided by a lower degree of role ambiguity in the educational sub-system. The means and standard deviations for RAWA and RAS were respectively: 3.46, 0.909 and 2.32, 0.802. There is learner agreement that role ambiguity is less prevalent in the educational sub-system. This is not surprising for within this system the learner has only one primary role: the learner. In a clinical situation he/she is both a learner <u>and</u> a worker, a unit of labour. Thus higher role ambiguity in the service sub-system may encourage a learner to internalise more professional attitudes as taught by the educational sub-system; or (b) the positive association between

RAWA and PROFORN is a spurious correlation that is due to confounding effects. The relationship is weak and only has a probability of .092. This correlation could be caused by the three-way relationships among the variables RAWA, PROFORN and PAWS. Earlier it was pointed out that the positive association between PAWS and PROFORN was unexpected. Now RAWA and PAWS are positively related and it may be that this relationship has influenced the relationship between RAWA and PROFORN.

In summary, the individual's decision to produce as measured by his/her acceptance of prevailing definitins of "professional" nursing behaviour is correlated with all four parts of our model: systemic, environmental and personal characteristics as well as critical psychological states. The points which were contrary to expectations were:

(a) the absence of a significant relationship between the level of professional orientation and measures of job and training satisfaction;

(b) the positive association between the level of professional orientation and the degree of role ambiguity experienced in the service sub-system; and

(c) the positive association between the level of professional orientation and the lack of organisational ability amongst ward staff; and the lack of qualified nursing staff in the service sub-environment.

Despite these unexpected results an explanation was found for the results in all three instances.

10.5: The Decision to Produce: at the Systemic Level

PROFORN was an attitudinal measure of productive behaviour in the sense that it measures the extent to which a learner accepted a given set of behavioural norms. PROBS, however, attempts to measure the extent to which such norms are observed to be in operation in the Area Training System as a whole. In other words, it is a surrogate measure of the degree of "professionalism" operative in the system. It is only a surrogate measure because we only obtain the perception of the learner as to the degree of systemic productive behaviour. The items which form the measure of the degree of professional behaviour operative in the system are similar to those of the variable PROFORN. The main difference is that whilst before the learner was asked as to the extent to which he/she agreed with a specific behaviour, now the learner is asked the extent to which such behaviour is consistently observed in the training system as a whole.

The following pairs of significant relationships were observed:

	PROBS
	TRAISAT (+)*
	JOBSAT (+)*
	NTCO (+)*
	NCO (+)*
	RC (-)*
	RAWA (-)*
	RAS (-)*
	CE (+)*
	PERAEO (-)*
Manifest anxiety	E33 (-)*
Extraversion	E34 (-)*
Neuroticism	E35 (-)*
	SEX (-)*

Table 10.8 : Bivariate Relations with PROBS

QUALTEA ($\overset{*}{+}$)

PAWS ($\overset{*}{+}$)

PASS (-)

PERVAW ($\overset{*}{-}$)

PERVAS ($\overset{*}{-}$)

PRST ($\overset{*}{+}$)

PWSC ($\overset{*}{+}$)

IPHS ($\overset{*}{-}$)

CENS ($\overset{*}{+}$)

LIBS ($\overset{*}{+}$)

D23 ($\overset{*}{+}$)

D25 ($\overset{*}{+}$)

CTS (-)

This correlation matrix shows that systemic influences are most important in relating to productive behaviour at the systemic level. Ten out of the eleven measures of systemic characteristics are related, the only exception being CW. All the ten relationships are in the predicted direction. Differentiation ^{S} is negatively associated with PROBS, integration ^{S} is positively associated with it, and so are our measures of supportiveness ^{S}. Uncertainty ^{S} as measured by the change of teaching staff is as predicted negatively associated with PROBS.

The non-significance of CW (the change of wards) is most likely due to the fact that at the individual level, CW is consistently very low and hence does not vary much with the level of productive behaviour. As pointed out earlier the Training System as a whole officially seeks to minimize the number of ward changes while a learner is on a specific allocation.

It is interesting to note that standardized task involvement is positively associated with observations of "professional" behaviour. The higher the level of rule orientation and task involvement the greater the degree of "professional" behaviour. This result indicates that learners perceive that rules - both

policies and procedures - have a place in the system and when exercised in a climate of task involvement do lead to more "professional" standards of care. This in turn implies that occasionally some procedural and even policy rules may be "bent" when it is considered to be in the best interests of the patient. However, other empirical results and participant observations suggest that such cases of rule violation which are considered to be in the interests of the patient are few, infrequent, occur amidst some controversy and do not lead to a subsequent change in the policy concerned. Rule violation is an exception to the general rule and usually allowed only under unique circumstances. Thus, although CENS is positively associated with PROBS, it nevertheless remains positively associated with FADAP1. In short, standardized task involvement is related to higher levels of professional behaviour but nevertheless reinforces the status quo as far as major policies and values are concerned.

Not only were systemic relationships with this measure of O.E. in the expected directions they were all highly significant ($p < 0.05$) and the values of the correlation coefficients were moderately high. The largest coefficient was that between IPHS, the degree of interpersonal hostility, and the level of professional behaviour observed in the system.

Environmental relationships with PROBS were less numerous, less significant and were weaker. The strongest relationship was that between the availability of competent teaching and the level of professional behaviour observed. Here, the greater the resource availability, the higher the level of O.E. As at the individual level, the decision to produce at the systemic level is positively associated with the availability of teaching skills. Similarly, as at the individual level, PAWS (the lack of organizational skill among service staff) is positively associated with PROBS. However, the relationship between RSNS and PROBS, unlike that with PROFORN is weak and non-significant. Contrary to our initial hypothesis, the scarcity of personnel in the service and educational sub-system bears no significant relationship

with professional behaviour. This is surprising since resource scarcity could conceivably be associated with poorer standards of patient care, an increased use of short-cuts, crisis management and a tendency not to keep up-to-date with the latest developments in nursing care. During the period of interviews and of participant observation, the researcher had often been told that a shortage of "pairs of hands" was often the primary cause for the necessary short-cuts in patient care. Whether this was indeed always the case is doubtful but learners and staff alike were unanimous in their belief that the service sub-system was chronically understaffed. In their construction of reality scarcity was the norm and munificence the exception. The researcher was constantly told that too many staff or a slack period was "not normal" and "it was just one of those odd troughs" or "we just happen to have too many first years and introductory course nurses which don't really count". In the reconstructed world of the hospital, scarcity was real and it did lead to observable short-cuts in patient care. The non-significant relationship between resource scarcity and professional behaviour is thus probably due to confounding effects. Given the strength of the rest of the model with PROBS it does not seem likely that our measure of "professional" behaviour is inadequate or ill-designed.

Digressing slightly from the perceptions of learners and service personnel the researcher is of the opinion that resource scarcity and its reported relationship to "cutting corners" is a "mythical construction" which is nevertheless real and objectified in the clinical sub-system. Based on observation on six wards, the researcher's own conclusion was that day-time scarcity of staff was associated with a lower standard of detailed patient care on only two out of six wards although a shortage of night nursing staff in the S.G.H. did appear to pose a serious threat to safe standards of patient care. During day-time and evening shifts, however, the shortage of staff appeared to be caused more by a specific schedule of ward activities (which demanded that all baths, bed-making and surgical dressing should be completed

as far as possible before the afternoon shift came on duty), official hospital policies on weekend staffing and an interesting conviction amongst all service personnel that they were chronically understaffed. Because service personnel persisted in this belief normality was designated by the peaks in patient-care-hours required and no visibility was given at all to the troughs. It is well-known in the nursing literature that the flow of patients follows a "normal" patternof peaks and troughs which is not often matched by the patterns of staff allocation (see Moores, 1979b). Yet normality as perceived by members of the service sub-system was defined only by the peaks. In fact, troughs were often just as common and frequent. During such slack periods, which occurred on irregular days on four out of the six wards, there was always more than enough staff. In addition staff scarcity was hardly an observable phenomena in the afternoon shift at both hospitals. There was always an overlap of morning and afternoon personnel and in the N.G.H., workload was further allevated by a visiting period. In the S.G.H. it was also considerably lightened after lunch by the imposition of a rest-period in the early part of the afternoon.

As such, the researcher felt that the objective levels of resource scarcity was considerably lower than its mythical height but the constructed, pervasive feeling of scarcity among service personnel did influence their behaviour. In this respect the empirical results obtained, which are based on learner perception, are surprising. However, it was felt that they probably reflected the objective phenomena more closely than reported answers.

Apart from the result just discussed, the relationship between PAWS and PROBS was contrary to expectations. It was predicted that a scarcity of organizational skills in the service sub-system would *ceteris paribus* lead to a decrease in O.E. However, PAWS is positively related to PROBS, suggesting that the greater the lack of organizational skill in the service sub-system the higher the degree of professional behaviour observed. Whilst an explanation could be found for the relationship between this variable and the individual

level of professional orientation, there is little theoretical argument or observational information to account for the relationship between the lack of "service" organizational skill and systemic professionalism. As pointed out above a decline in standards of care did arise due to a poor scheduling of ward activities and the consequent "bunching" of nursing activities in the mornings.

However, the size of the correlation coefficient is not large though it is significant at the 95% confidence level. Given the more detailed observations, we would conclude that a spurious correlation exists which confounds the relationship between a lack of service organizational skill and the level of professional behaviour observed in the system.

The relationship between PASS, the lack of educational organizational skill, and the level of professional behaviour was in the predicted direction. Though the correlation coefficient is only moderate and the level of significance lower than 95%, the correctness of the direction of correlation assures us that the measure of a lack of organizational skill has not been ill-designed or misunderstood by the learners.

The personal characteristics which related significantly to PROBS were CE (conformity of experience to expectations), PERAEO (perceived alternative employment opportunities), Manifest Anxiety, Extraversion and Neuroticism. Higher levels of met expectations were associated with higher degrees of professional behaviour observed in the system. This relationship was predicted in that met expectations were hypothesized to contribute to a sense of well-being, of inducement-contribution balance and hence to greater organizational effectiveness. The second relationship with PERAEO is also consistent with this hypothesis, for the results suggest that learners who do perceive other job possibilities observe a lower level of PROBS. It is likely that a learner who does foresee other job/employment alternatives is not entirely happy with her inducement-contribution balance and this sense of disequilibrium is associated with lower levels of observed professional behaviour. Where a disequilibrium exists, the individual and the system as a whole could conceivably

experience a demotivating influence which reduces the performance of "professional", ideal nursing.

The personality characteristics reveal that extraversion is negatively related to observations of professional behaviour. This relationship is somewhat ambiguous as it is open to two interpretations. On the one hand, it could mean that it is the more extraverted learner, who is more delinquent, less submissive to authority who perceives "unprofessional" behaviour. From this perspective, extraversion is "good for" the system because it allows the identification of areas of "unprofessional" conduct. On the other hand, the result could mean that the more extraverted person who is less able to control his/her emotions is associated with a perception of lower standards of care because he/she is unable to cope effectively with work stress. In this sense, extraversion would be "bad for" the system because it is equivalent to a lack of emotional stability. It is also likely that both interpretations are valid and reflect processes which are at work simultaneously in the training system, the first representing a direct effect on observable professional behaviour and the second an indirect effect via critical psychological states and work attitudes. Further analysis of this result will be undertaken later in this chapter.

The relationship between PROBS and measures of neuroticism and anxiety were not unexpected. Our results show that the higher the level of such anxiety, the lower the performance of "professional" nursing or to be precise, the less frequent the observation of such behaviours. High levels of anxiety and neuroticism cause a nurse learner to display many of the defensive behaviours perpetuated by an anxiety-girded training and work system. Some of these which relate specifically to the items measured by PROBS are:

(1) the splitting of the nurse-patient relationship. The nursing process (which forms the clarion call of "professional" nursing) is grounded in the argument that each patient is a unique individual who needs to relate in a personal and intimate way to the nurse.

However anxiety can and does cause the nurse to psychologically distance herself from the patient and his/her problems. Clearly some degree of psychological detachment is required for the nurse to confront anxiety-situations and to avoid being overcome by patient involvement. However, this requisite degree of detachment is easily extended such that the learner protects and isolates her feelings from the stress of anxiety. Although patient allocation is beginning to be introduced within the system under analysis, task allocation is still the norm. This fragments the nurse-patient relationship and reduces nurse-patient contact. A depersonalization of patients was also observed and the process of "labelling" was directed especially towards "high anxiety potentials" such as "overdose patients", patients with psychosomatic illnesses or patients with "social problems". These were classified as problems for the psychologist or psychiatrist but not the nurse. The splitting of the nurse-patient relationship is further aided by ritual task performance which minimizes individual discretion, the anxiety and fear of doing something wrong and treats each patient exactly the same. The patient is a "patient" - not so much a person. A nurse is a nurse, a bundle of skills. Even patients whom a nurse becomes more familiar with are guiltily labelled "a favourite patient" or "an unpopular so-and-so who is constantly a nuisance". The individual becomes gradually lost under a series of labels: of name-tags, of medical histories, of illnesses, even the consultant in charge. Phrases like "She's Dr. X's" or "He's Dr. Y's and Dr. Y does not like this type of dressing" were not uncommon.

(2) the tendency to form strong cliques and collusive small-groups while in training. A "professional" nurse as pointed out above is required to walk the tightrope of involved but detached care but this can and was observed to lead to categorization, a denial of the individual (patient and nurse) and a denial of feelings. The consequence

of such processes forces nurses and learners to form strong friendship-groups which act as an emotional buffer. These groups tend to be formed at social clubs or within halls of residence. They may be of two groups: single-grade or cross-grade. The former consists of learners/nurses from only one grade while the other includes nurses from other grades and courses, usually one step above or below. The formation of cohesive single grade groups reinforces authority patterns in the workplace and learners and qualified staff are always acutely aware of their "belt colour" which indicates their grade, status and area of responsibility. Such awareness easily creates a them-us feeling in an area of potential conflict and results in task assignment which is often regarded as "unfair" and "inequitable". The least-skilled and lowest-status persons, usually the auxiliary, the first year pupil nurse and the first year student nurse (in ascending order of status) whose precise differentiation of skill and experience is somewhat obscure are delegated "less skilled" jobs which also tend to be dirty, smelly or arouse repressed guilt or sexual tendencies. Such jobs ranged from the bathing of patients with lice, the mechanical opening-up of the bowels of male patients, the wiping up of vomit, urine or faeces. There was no observable reason for such delegation and the official excuse of a shortage of staff and the requisite division of labour was not always borne out. On two wards observed there were twelve nurses and eleven patients and first years and auxiliaries continued to be allocated tasks which have been culturally-defined as unpleasant. The effect of cross-grade friendship groups is both positive and negative. At the systemic level it leads to a greater appreciation and understanding of the problems of nurses from a different grade and this alleviates the "junior-senior" syndrome. But at the individual level it easily led to preferential treatment for "friends" and "non-friends". In a

system where assessment is always performed by a single role incumbent irrespective of the work unit, the matter of whether a learner is "friendly" with the sister or staff nurse becomes significant. A friend by all definitions is someone who shares one's anxieties and is aware of one's preferences. This bond of emotional support, more developed than in other work settings, was observed to lead to differential treatment among learners. For instance, a "friend's" opinion was more trusted than that of a"non-friend's" and a learner/nurse tended to institute actions which were more in agreement with a "friend's" thinking on the matter.

(3) the tendency to follow rules blindly even though in specific instances it may not have been in the best interests of the patient. Anxiety about doing the "wrong thing" often conditions a learner/nurse to follow exact procedures and policies although this may be against the nurse's own private judgment about what ought to be done and this leads to expost-guilt and anxiety. For instance, the S.G.H. had a policy rule that babies were not allowed to accompany mothers who underwent surgical or medical treatment. In one situation the sister-in-charge thus had to specifically make arrangements for somebody else to look after the baby - a process which caused some anguish throughout all grades of ward staff and especially to the mother. In another instance a staff nurse who, partly through ignorance and partly through accident, did not follow the rule book about informing relatives of a patient's death but did what she thoughtbest was thoroughly demoralized by the treatment of her superiors and the ward staff were made even more aware that they had to follow the rules of the "system".* And

(4) the tendency not to evaluate learners solely on the basis of skill, knowledge and competence. In point (2) above we have already pointed out that friendship ties which act as a buffer against anxiety may lead to differential treatment and "cliquing" on a ward. It also

* These two incidents will be described in greater detail later in this chapter.

leads to learner assessment which is coloured by extra information about the person being evaluated. The line between an evaluation based on a learner's skill and knowledge and one based on a learner's likeability becomes difficult to draw. This is further increased by the design of a ward report which specifically assesses a learner's attitude to superiors and patients. Where a learner is not thorough or careful with patients this is generally labelled "unprofessional" but where a learner is not mindful of her status or position it is also labelled "unprofessional". Learners, in general, are expected to be "juniors", not to express opinions on nursing care which are substantially different from qualified staff, to be dutifully respectful to the sister and not to question in an over-confident manner. Respect for authority was often implicitly expressed by tutors and sisters to be a facet of "professional", proper conduct. Of twenty-one sisters and charge nurses interviewed, nine felt nurses were more "cheeky" and "disrespectful" and only seven felt they were as respectful as themselves. During participant observation it was clear that a learner who was more "rebellious" or less submissive to authority was labelled "cocky" and often counselled as to her undesirable behaviour. This reaction to over-confidence is itself a defensive technique born of anxiety that the superior's ultimate authority and knowledge may be questioned and found deficient. Menzies (1970) argues that such reactions are indeed projections of the superior's conscious personality onto the behaviour of juniors. The superior's irresponsible other, which she feels she cannot control, are attributed to her juniors and she treats them with the severity that self is felt to deserve. Similarly the nurse identifies seniors with her own harsh disciplinary attitude to her irresponsible self and expects strict discipline. This process of personality splitting and of projection appears to run through the Area Training System and ob-

servedly affects not only learners but all grades of staff.

The relationship between critical psychological states and PROBS are all in the expected directions, are highly significant and moderately high in value. Training and job satisfaction are positively associated with O.E., so is learner commitment to nursing as a career and to nurse training. Role conflict and role ambiguity in the service and educational sub-systems are all negatively correlated with PROBS corroborating our hypothesis that work stress and dissatisfaction is negatively related to effective organizational functioning.

In summary, the relationships with our systemic measure of productive behaviour (PROBS) are strong and all four sets of explanatory variables are well associated with the predicted variable. The only part of the model which is less well related is the relationships with our measures of illiberality E.

10.6: The Relationships of Measures of Systemic Adaptive Capacity

Three measures of adaptive capacity were measured: adaptability, flexibility and innovativeness. The first measured the ability of the training system to adapt quickly to changes in the system's environment; the second the system's ability to respond well to sudden operational breakdowns, emergencies and unexpected interruptions in the flow of work; and the third the system's ability to innovate, to be creative and to institute new and alternative ways of performing its primary task. Adaptability was in fact measured negatively and the mnemonic (FADAP1) in fact means a failure to adapt. The other two measures flexibility (FLEX1) and innovativeness (INNO1) were measured positively. These measures of adaptive capacity are hypothesized to be distinct but related facets of the theoretical construct adaptive capacity. They are factor-analytic scales, whose exact value was generated by a series of weights produced as factor score coefficients by an oblique rotation on a principal axis factor matrix.

The relationships which were significant for FADAP1, FLEX1 and INNO1 were :

FADAP1	FLEX1	INNO1
TRAISAT (-)*	TRAISAT (+)*	TRAISAT (+)*
	JOBSAT (+)*	JOBSAT (+)*
	NTCO (+)*	NTCO (+)*
	NCO (+)*	NCO (+)*
RC (+)*	RC (-)*	RC (-)*
RAWA (+)	RAWA (-)*	
	RAS (-)*	
		CE (+)
PERAEO (+)*	PERAEO (-)*	PERAEO (-)*
	COURSE (+)*	
	LPB (+)*	LPB (+)*
	E33 (Manifest Anxiety) (+)	
	SEX (+)	SEX (-)
		NOLEVELS (+)*
	RSS (-)	
RSNS (+)*		
	QUALTEA (+)*	QUALTEA (+)*
	PASS (-)*	
PERVAW (+)*	PERVAW (-)*	PERVAW (-)*
	PERVAS (-)*	PERVAS (-)*
PRST (-)*	PRST (+)*	PRST (+)*
PWSC (-)*	PWSC (+)*	PWSC (+)*
IPHS (+)*	IPHS (-)*	IPHS (-)*
CENS (+)	CENS (+)*	CENS (+)*
LIBS (-)	LIBS (+)*	LIBS (+)*

FADAP1	FLEX1	INNO1
	D23 (Work Variety) (+)*	D23 (+)*
	D25 (Work Autonomy) (+)*	D25 (+)*
	CTS (-)*	CTS (-)

Note: * means $p \leq 0.05$. Unasterisked coefficients mean $p \leq 0.10$.

Table 10.9 : Bivariate Relations with Measures of Systemic Adaptive Capacity

Most significant relationships with the three measures of adaptive capacity are in the predicted direction. However, the systems-environment model as a whole appears to be more related to the measures of flexibility[S] and innovativeness[S]. The number of significant relationships between the set of explanatory variables and FADAP1 is substantially smaller and the size of the correlation coefficients does not register higher than 0.24, This result was unexpected and there are few theoretical reasons which account for this empirical difference. In addition, past empirical research which had used similar measures of adaptive capacity such as that of Mott's (1977) had not argued or empirically recorded a theoretical difference between adaptability and flexibility, and between adaptability and innovativeness. The only possible explanation for such a result could be methodological and stems from the fact that adaptability is measured negatively while flexibility and innovativeness are positively measured in our study. This would imply that factors which predict the ability of a system to adapt, to innovate and to be flexible are different from those which predict its inability to adapt. Adaptability and a failure to adapt would thus appear to be not symmetrical ends of the same continuum. This would suggest that the two phenomena may be influenced by different processes and factors. This possible theoretical and empirical distinction between adaptability and a failure to adapt could be similar con-

ceptually to the notion of "push" and "pull" effects which have different explanations. This distinction, for example is used in the analysis of absenteeism and turnover. Nicholson (1977), for example, distinguishes between the motivation to be absent/leave and the decision to be present/remain within the organisation. They argue that these two processes could be subject to different effects and that research from the second, more positive approach could potentially be more useful. Whether such a distinction could be drawn here between the ability and inability of a system to adapt is ambiguous. As stated, past research has not reported such a difference and in order to ascertain whether this difference between the two views of adaptability does exist further research is required which simultaneously measures the variable positively and negatively. A positive measure of adaptability^S was not obtained in the present study because the scale FADAP1 was obtained via factor analysis and it was difficult to justify a reversal of the factor score coefficients. Nevertheless, the empirical results have demonstrated an interesting line of future research which identifies the explanation for a failure to adapt rather than an ability to adapt.

The factors which are associted with FADAP1 are largely systemic and environmental characteristics. Personal characteristics, apart from PERAEO, bear no significant relationship at all and the set of critical psychological states is also not well associated with a failure to adapt. The systemic characteristics which are most strongly associated with FADAP1 are sub-goal differentiation in the service sub-system (PERVAW), systemic integration, and systemic supportiveness. Uncertainty^S was surprisingly not significantly related to a failure to adapt. Theoretically it had been hypothesised that the higher the level of uncertainty^S, ceteris paribus, the lower would be the technical effectiveness of the organization. If the system experienced considerable internal uncertainty and consistant change, it is conceivable that it would find it difficult to react swiftly to changes in its environment. The non-

significant relationship with CW can more easily be understood because the variable has a relatively low value (its mean was 2.83) and most learners when questioned did not generally complain of an excessive change of words. It is therefore highly likely that CW as a phenomena does not describe a systemic characteristic which is substantive. That this may be so is evidenced by the fact that it is only significantly related to "level of professional orientation", the gross absence ratio and the frequency of short term absence. It bore no significant relationship with all four measures of systemic productivity and adaptive capacity. However, the absence of a significant association with CTS (change of teaching staff) was contrary to expectations. Despite this, the correlation is in the predicted direction.

The relationship between sub-goal differentiation in the service sub-system and a failure to adapt is in the predicted direction and it is interesting to note that sub-goal differentiation in the educational sub-system does not appear to be associated with a failure to adapt again suggesting the vital importance of the service sub-system in determining effective organisational behaviour. The negative association between integration^{S} and adaptability^{S} was similarly in the predicted direction and were highly significant. The correlation between FADAP1 and systemic supportiveness showed some interesting results. As predicted, the degree of inter-personal hostility and of managerial detachment was positively associated with a failure to adapt. The relationship between openness and warmth and adaptability^{S} was also in the predicted negative direction. However, the variable CENS, standardized task involvement was positively associated with a failure to adapt. This is contrary to our initial hypothesis and the result differs from the relationship between CENS and the other four measures of productivity and adaptive capacity. It was predicted that standardized but committed task involvement would enable a system to adapt quickly to environmental changes, the argument being that standardization in an organisational climate of task involvement and dedication would enable a system to stabilize itself and thereby adapt

more quickly. However, the effect of standardisation appears to have reduced the level of adaptability^S although standardised task involvement is positively associated with flexibility^S and innovativeness^S.

We need, however, to be careful in interpreting this result since the correlation is low and is significant at only the 90% confidence level. If this result were to hold, there appears to be inconsistency in our empirical data set for standardisation appears to lead to higher levels of innovation but lower levels of adaptability. This apparent inconsistency was resolved by a careful analysis of the items used in measuring FADAP1 and INNO1. It was found that learners had interpreted FADAP1 to mean a failure of the system to institute frequent change in its fundamental <u>policies</u> and philosophy and INNO1 to mean a tendency to experiment with new ideas and alternative ways of problem-solving at the operational <u>procedural</u> level. This differential interpretation of the terms 'policy' and 'procedure' is reflected by the fact that on every ward there is a 'policy' manual and a 'procedures' manual. Although these manuals are not often used, they represent important differences between the concept of policy and of procedure; the former referring to major, broad, strategic attitude and values the latter to specific, operational programmes. A policy, for example, is a mandatory rule such as that forbidding learners from wearing jewelry (apart from wedding rings and earrings of specified diameters) or using Christian names in clinical areas. Another example of a policy is the SGH's rule that care is provided on a 24 hour basis and each shift is officially obligated to help members of the other shift as soon as they come on duty. A procedure, on the other hand, usually refers to specific nursing and clinical procedures such as the procedures to be followed in cases of cardiac arrest, in the treatment of contagious diseases, the conduct of aseptic techniques etc. Administrative procedures which relate to the everyday running of the ward include detailed steps for the admittance of a patient, his discharge

and the notification of relatives in the event of his death. While detailed procedures do often see minor alterations and adaptations to new conditions and research development, policies are seldom changed. Any policy change is clearly a major organizational exercise and is always discussed by the Nursing Executive Committee which may need to consult other committees within the hospital. Given these distinctions between policies and procedures, the differential effect of CENS on FADAP1 and INNO1 becomes clearer. The positive relationship between CENS and FADAP1 suggests that standardisation and task involvement within the system increases a rigid adherence to established policies and attitudes, as evidenced by the systems stand on uniform, jewellery, Christian names and indeed on rule-orientation which is re-interpreted as discipline. However, the positive relationships among CENS, INNO1 and FLEX1 indicate that task dedication within policy parameters does lead to and is associated with higher levels of procedural innovation and flexibility in coping with emergencies.

Although the differential effects of CENS on our measures of O.E. may be understandable, they still raise a fundamental theoretical issue - that of conflicting contingencies, that is, contingencies which have 'desirable' effect on certain facets of O.E. and 'undesirable' effects on others. CENS was positively associated with measures of absence and with systemic failure to adapt but was also positively associated with the individual's level of 'professional orientation', the amount of 'professional' behaviour observed in the system as a whole and flexibility^{S} and innovativeness.^{S}

The theoretical difficulty of conflicting contingencies was first raised by Child (1972a) but little empirical research has been conducted into the nature and possible reduction of such conflicts. Schoonhoven (1981) has suggested a statistical methodology for analysing the interactive effects of two contingencies on O.E. but her work is, however, only preliminary and does not present a methodology for handling more complex, three-way conflicting contingencies. More fundamentally, the conceptual and empirical issue of such

contingencies raises questions about the validity of contingency-type explanations for variations in O.E. For the problem of conflicting contingencies is clearly related to the notion of trade-offs between different organizational sub-goals and objectives.

In our technically-interested theory of O.E. we have postulated that the criterion of organizational effectiveness is the ability of a system to survive in the lon-run within its feasible act of multiple, possibly conflicting participant demands. This overall abstract principle was re-analysed in terms of an ability to survive purposefully and to maximize a systemic propensity to survive in the future. We then argued that such survival depended on two important sets of participant decisions - the decision to produce and to participate - and on the ability of a system to develop requisite variety and balance within the F-set. The effect of conflicting contingencies is to raise the possibility that in order to maintain current and future survival within the F-set, trade-offs may be required among the three facets of O.E. Theoretically, our technical model of O.E. is able to accommodate the probability of conflicting contingencies because these influences do not dislodge and are not inconsistent with a concept of long-run survival. However, it does suggest that our interpretation of the concept needs to be refined such that a technical theory of O.E. is evolved which studies the antecedents and consequences of different weights being given to the three facets of effective functioning. For example, under what systemic and environmental circumstances does the participative decision become a greater threat to survival within the F-set than the predictive decision; or when is a more pressing need to maintain a systemic adaptive capacity probable? The model as presented does not deal with the issue of conflicting contingencies but the matter should form the focus of future research as it is of substantive theoretical importance. In our empirical study, however, the issue of such conflicts did not arise often or with any significant degree of regularity; and only isolated

variables were found to have different effects with different measures of O.E. As pointed out, the relationship between FADAP1 and CENS was low and not particularly significant statistically. Elsewhere, the conflicting associations between measures of illiberality and O.E., though statistically significant could also be due to spurious and confounding influences (see, in particular the associations between resource scarcity in the service sub-system (RSNS) and the level of 'professional' orientation (PROFORN); the relationships between a lack of organizational skill among service personnel (PAWS) and the level of 'professionalism' observed in the system (PROBS) and between PAWS and the level of 'professional orientation' (PROFORN)). Thus, the neglect of the issue of conflicting contingencies though indicating a need for theoretical refinement of a technical theory of O.E. may not in the final analysis have distorted the empirical conclusion of the study to a large extent.

Apart from the association with systemic characteristics the variable FADAP1 was not well associated with measures of illiberality^E. Out of 5 possible measures, only 2 showed a weak significant relationship. Both these correlations were in the predicted direction and were those which related a lack of resources scarcity in the service sub-environment (RSNS) and a lack of organizational ability of service personnel (PAWS). The higher the level of such resource scarcity, the greater the failure of the training system to adapt speedily to environmental changes. Resource scarcity in the service sub-environment is apparently more associated with a failure of the system to adapt than illiberality in the educational sub-environment. However, though neither RSS, PASS and QUALTEA (resource scarcity in the educational sub-environment, organizational skill scarcity in the educational sub-environment, and teaching skill scarcity) were statistically significantly related to FADAP1, the correlations were in the predicted directions i.e. a high level of scarcity and of illiberality^E is associated with a high level of FADAP1

Personal characteristics were not in the main significantly related to perceptions of a failure to adapt; the absence of a relationship between our 2 measures of manifest anxiety and neuroticism with FADAP1 was surprising. Given the observation of high levels of anxiety in the Area Training System, in learners, service and educational personnel alike (the mean level of Eysenck's measure of neuroticism was 9.065 for normal populations whereas our sample of 309 leavers registered a mean of 15.82) and the observation that such anxiety led to individual and social systems of defence mechanisms it was expected that learners who recorded high levels of anxiety would report low levels of adaptability.[S] The absence of a significant relationship could, however, indicate that learners may be unable to detect or admit in their conscious self that the very system of defence mechanisms used to evade anxiety are reproducing a cumbersome nursing and nurse educational service which does not respond quickly to changes in the environment. Specific examples of how anxiety in learners prevents the system from being adaptive are given below:

(1) An over-reliance on ritualistic performance of nursing care especially among senior learners. This aspect has been described generally when its impact on the nurse-patient relationship was discussed. Here it inhibits adaptability[S] by instilling among learners/nurses an avoidance of change. One sister who was interviewed summed it up nicely:

"Nurses don't often like change, they like to cling to old habits and are defensive. They find it hard to take criticism".

Sister in SGH, 4/9/80.

This inability to change means that an old-fashioned, rigid schedule of ward activities is maintained despite changes in the environment and in staffing. A change in visiting times and in the shift hours of both hospitals studied had meant that an overlap of staff was available in the afternoons, yet all major everyday ward activities were, as far as possible, completed in the morning. Just like in Victorian days when the Matron came for a walk-round at 10.00 a.m. and the ward had to look neat and tidy.

(2) An avoidence of change and a desire to preserve the status quo also surfaces in widespread learner and nurse resistance to and resentment of graduate nursing, nursing research and the nursing process. Learners and qualified staff both stress that "A levels don't make a good nurse" and "graduates don't have much common sense". In addition, the introduction of the principles of the nursing process has been slow and

despite the fact that the concept has been in the academic literature for well over a decade, preliminary discussions to implement it were being discussed in the NGH only in June 1981. Fragmented task allocation was still very much the norm and this task-list system with minutely prescribed task-performance makes it difficult to adjust work-loads when necessary by performing or omitting less difficult or urgent tasks.*

(3) Finally, in order to evade intense personal involvement, learners quickly acquire and seldom discard a form of psychological detachment which manifests itself in an old-fashioned, authoritative maternal role. Despite a changing patient environment with patients either knowing more about their illness or desiring to know more about it or being more aware of how they would like to be treated, learners and qualified staff persist in a strong "Mother-knows-best" role. This comes out most clearly when a patient has been designated an unpopular patient and thereafter is always treated like a naughty child.

Such observations of rigid attitudes and behaviour among learners and qualified nursing staff indicate that anxiety does affect the ability of the system to adapt. However, it could be that as suggested learners were unaware that non-adaptive behaviour was being exhibited.

The only personal characteristic which relates significantly to FADAP1 is PERAEO. The more a learner perceives alternative job opportunities the greater the perception that there is a low level of adaptability^{S}. This relationship is most probably related to affective feelings of satisfaction and commitment and we would predict that this variable's (PERAEO) influence on perception of O.E. is more indirect than direct; the mediating variable being critical psychological states. A greater awareness of alternative employment is associated with lower levels of commitment and satisfaction and this in turn reduces the level of adaptability^{S} perceived.

Finally, the variable FADAP1 is related in the predicted direction with measures of training satisfaction (negative), role conflict (positive) and role ambiguity in the service sub-system (negative). Once again the influence of the service sub-system appears more important than the effects of the educational sub-system. However, there was little explanation for the non-significant relationships of FADAP1 with job satisfaction and learner commitment. Angle & Perry (1981) had argued that organizational commitment

* The reaction of ward-based rank-file nurses is to be distinguished from that of educational managerial staff who are keen to introduce the nursing process. It also differs from official pronouncements from senior service management. These differences are highlighted in the next section.

was strongly positively correlated with employee-perceived adaptability and their empirical results had shown correlation coefficients of between 0.58 and 0.52. However, they had measured adaptability positively and it could be, that as suggested earlier, the ability to adapt and the inability to do so are on two different continua and these systemic outcomes are influenced by different processes.

In contrast to FADAP1, the measure of FLEX1 was strongly related to the systems-environment model proposed. All six measures of critical psychological states were associated with flexibility^S in the predicted directions; the correlations were highly significant and were moderate. The strongest relationship was between training satisfaction and flexibility^S.

Systemic characteristics too were strongly associated with flexibility^S. Differentiation^S was negatively associated with flexibility^S, integration^S was positively correlated, systemic supportiveness was also positively correlated and one aspect of uncertainty^S (the change of teaching staff) correlated negatively with flexibility^S. The strongest relationship was the positive relationship between standardized task involvement and flexibility^S. This result is due to the particular nature of the system under analysis where the most flexible, safe way of coping with operational emergencies is for participants to follow set procedures for these processes in a dedicated manner. Every learner and nurse is taught that an emergency in their world could be a life-or-death event, and the quickest and least anxious way of coping with these situations is for the learner to follow emergency procedures. In other systems the relationship may not have been as strong.

Measures of illiberality^S are also associated with flexibility^S in a predicted manner. The higher the degree of resource scarcity - the lower the level of flexibility. Because flexibility^S had been interpreted by learners as the ability of the service subsystem to respond to medical emergencies, there is no observable statistically significant relationship

between resource scarcity (RSNS) and organisational skill scarcity (PAWS) with flexibility[S]. Scarcity in the service sub-system does not influence the flexibility of the system as such because no matter how short-staffed the Area Training Ststem was or perceived itself to be emergency cover was always the first priority. Emergencies which were recognised and labelled as emergencies were always promptly attended to and this was especially so in the casualty departments of the hospitals. Even on a ward, recognizable emergencies were always coped with and usually via standard procedures; for instance, a cardiac arrest when detected signals every nurse on a ward to immediately leave whatever that he/she is doing and to move swiftly to the patient so affected. A patient's whose condition suddenly deteriorates, when detected could be classified as an emergency and he/she receives close nursing attention or is transferred to another more appropriate health unit such as intensive care. A patient who has just returned from major surgery and who is classified as 'not responding well' is put on 15 minute observations (blood pressure, pulse and possibly body temperature) irrespective of the numbers of staff on a ward.

However, this quick response was only apparent after an incident had been classified as an emergency and it was observed that resource scarcity in the service sub-system did influence the ability of the system to respond to potential emergencies. One such incident occurred on night-duty at the SGH on a ward staffed on a specific night by 2 learnersand 1 auxiliary and occupied by 23 surgical patients. Due to the small number of staff and the workload required, one of the patient's condition deteriorated substantially without it being detected by the nurses in charge or by the night sister on her brief, infrequent visits. The warning physiological signs were not noticed until the morning shift came on duty and the patient was then immediately transferred to intensive care amidst quiet accusations by the medical "professionals" that there had been a poor standard of nursing care. The ability

of the system to proactively respond to emergencies was then influenced by a scarcity of resources. However, this dimension was not adequately measured by our questionnaire items and this accounted for a non-significant relationship between resource scarcity and flexibility^S.

However, the predicted relationship did hold for other measures of illiberality^E. QUALTEA was positively associated with FLEX1 indicating that the higher the scarcity of teaching skill the lower the ability of the system as a whole to respond to emergencies and to be flexible. This is especially so because the system studied required standardized, taught procedures as a means of coping with their constant emergencies. In order to cope and to be flexible, the system had attempted to programme responses to emergencies and clearly a lack of teaching skill and staff would have hampered the learning of such programmes.

Resource scarcity and organizational skill scarcity in the educational and sub environment were related positively to flexibility^S. Those relationships were in the predicted direction and support our argument that a lack of significance between illiberality in the service sub-environment and flexibility^S was due primarily to the specific nature of the task performed and the actor's interpretation of the word emergencies. These processes were not as prominent in the educational sub-environment and here a lack of resources and of organisational skill was positively associated with flexibility.^{S} This relationship was in fact observed on several occasions when unexpected breakdowns and interruptions occurred in the workflow of the School, as for example when a scheduled lecturer, film or visit did not materialise. Due to a shortage of staff and poor planning amongst different teaching teams, these breakdowns were not dealt with and learners were simply left on their own and got more free-time than was scheduled on the time-table! At times the workflow on a ward could also be affected as when time is set aside for a teaching session on a ward but the clinical instructor does not arrive due to commitments in school. As such illiberality in one sub-environment

influences the ability of the system as a whole to respond to sudden interruptions in their workflow.

The personal characteristics which were of significance were PERAEO (-), COURSE (+), LPB (+) and Manifest Anxiety (+). Leavers who perceived alternative employment opportunities perceived the system to be less flexible and again this effect is probably related to dissatisfaction or work stress. A learner who is more aware of alternative jobs and who is unhappy in nurse training or disillusioned with nursing perceives the system as being unable to cope with emergencies. The relationship between COURSE and learner-perceived flexibility is also consistent with this argument for it is the SEN learner who has fewer occupational choices who perceives the system as being more flexible. There thus appears to be a general link between occupational mobility and learner-perceived flexibility^S- the less mobile learner perceiving greater degrees of flexibility. This could suggest that the less mobile learner tends to be more contented with the system and thus has more favourable perceptions of the flexibility^S. An examination of the relationship between TRAISAT, JOBSAT and COURSE revealed that at the 95% confidence level the SEN learner was significantly more satisfied with her training than the SRN. However, no relationship was found between grade of nurse and job satisfaction. This appears to support our argument that occupational mobility is related to learner-perceived flexibility^S.

It is interesting to note that the more bureaucratically-oriented learner perceives a higher level of flexibility^S. This could suggest that such learners tend to have a 'rosier' picture of their system's adaptive capacity and their strong organisational loyalty prevents any critical evaluation of flexibility^S. The result could also be interpreted as reflecting a unique relationship between rule-oriented behaviour and flexibility^S. Because the system under study tends to evoke set programmes to respond to emergencies, the more bureaucratic, rule-minded learner will

find it easier to follow these procedures and hence record a higher degree of flexibility^{S}.

Finally there is a weak, positive relationship between anxiety and flexibility^{S}. The more anxious learner perceives a more flexible, responsive system. This result again arises from our measure of flexibility^{S} and the manner in which the system reacts to such emergencies. As discussed earlier, anxiety prompts rule-governed behaviour in order that the learner may evade the fear of 'going wrong'. The more anxious the learner, the greater the tendency to follow rules especially in high anxiety-potential situations like emergencies, the more these rules are followed to the letter, the higher the perception that the system is flexible and has responded swiftly to interruptions in its workflow. This argument, however, is only valid for the service sub-system and less so for the educational section. The fact that a significant relationship exists again suggests the eminence of the service sub-system in influencing the behaviour of the Area Training System as a whole.

Our final measure of O.E. is learner-perceived innovativeness^{S}. This measure, INNO1, is strongly related to systemic characteristics, critical psychological states, personal characteristics and illiberality^{E}. The strongest relationships are with systemic characteristics. The higher the level of differentiation,^{S} the lower the degree of integration^{S}, the lower the level of systemic supportiveness and the higher the level of uncertainty^{S} (as measured by the change of teaching staff) the lower the degree of perceived innovativeness. All these relationships were in the predicted directions, were statistically significant at the 95% confidence level and were moderate. The relationship of CENS to INNOI was positive, again indicating that a certain level of rule orientation coupled with a high level of task involvement can help to stabilize a system and enable it to

be creative by instituting new operational methods. Standardized task involvement was associated with high levels of "professionalism", "professional orientation", flexibility[S] and innovativeness[S]. However, it was also associated with a low level of adaptability[S] and with a high gross absence ratio. Arguments have been put forward which reconcile to some extent these apparently conflicting results because dedicated, rule-governed or disciplined behaviour was found to be necessary in order to be innovative at the operational level, flexible in responding to emergencies, in maintaining a high level of "professional" behaviour and a high level of "professional orientation". However, such involved disciplined behaviour also hampered the fundamental change of organizational policies, deep-seated values and philosophies. While the occasional relaxation of a rule was allowable in special circumstances and the nurse behaved "professionally" by putting first the patient's interest, a system characterized by strong standardization and involvement with the task at hand was slow to change its basic approach and attitudes. In addition, this characteristic also induced stress which was manifested at the individual level by higher levels of absence.

Apart from systemic characteristics the next important set of influences were critical psychological states. The significant relationships were with training and job satisfaction, commitment to nurse training and to nursing and role conflict. All relationships were in the predicted direction; a non-significant relationship was found between role ambiguity and innovativeness[S]. This was surprising as ambiguity could conceivably have hampered a learner's ability to innovate and create new operational programmes. But the positive relationship suggests that role ambiguity in circumstances which we are not clear of, may lead to positive, creative activities on the part of participants. Such a relation most probably has an optimum point beyond which increasing amounts of role ambiguity will not lead to innovativeness. However, within our study we were not able to examine this particular relation

in detail, nor were we able to analyze the limiting conditions on that relation. The weak empirical/statistical relation does suggest though that in future we may have to modify the simple causal relation now hypothesized between role ambiguity and innovativeness^{S}.

Environmental factors were not strongly related to innovativeness^{S} and the only significant relationship was that between QUALTEA and INNO1. The higher the availability of competent teaching skills, the less hostile this environment was, the more innovative the system. However, although the other four measures of illiberality^{E} were not significantly related to INNO1, their relationships were in the predicted direction.

Personal characteristics were also associated with variations in INNO1. The learner whose expectations had been met reported higher levels of innocativeness^{S}. This result is consistent with that between PERAEO and INNO1 - the learner who perceived fewer job opportunities also recorded higher levels of innovativeness^{S}. These two results again suggest that learners who are more contented, whose expectations have been met and who do not perceive alternative employment have more favourable impressions of the organization and record higher levels of innovativeness^{S}. No relationship was found between COURSE and YEAR and INNO1. The only personality characteristic which related strongly to INNO1 was the degree of LPB. The more bureaucratically inclined the learner, the more he perceived the organization to be innovative. Again this suggests that learners so inclined tend to have "good opinions" about the organization and to perceive it as being more innovative.

In summary, the results on systemic adaptive capacity indicate that on these three measures of O.E. the systems-environment model is more related to flexibility^{S} and innovativeness^{S} than to adaptability^{S}. This suggests that factors which predict adaptability^{S} and the failure to adapt could be different. Further, environmental factors were not as influential

as hypothesized and their relations to systems adaptive capacity were weaker than that between systemic characteristics and adaptive capacity. Critical psychological states were well-related to flexibility^{S} and innovativeness^{S} but not to FADAP1. Across all three measures of O.E. personal characteristics were not well-related and the strongest relationship was with the number of alternative opportunities perceived. The higher the number of alternatives the lower the level of adaptive capacity perceived.

As to the difference between the effects of the service and educational subsystem and environments, the former appeared to have a marginally greater influence on systems adaptive capacity. This reinforces to some extent the results obtained from an analysis of the individual decision to participate; where absence behaviour was concerned, the service sub-system and environment again appeared to have a slightly greater influence.

Finally, the analysis of the effects of a high degree of standardized work involvement revealed that conflicting contingencies were probably of substantive theoretical and empirical importance but no provisions had been made for these contingencies to be analysed within the present technically-interested theory of O.E. It was recognised that more research on these processes was required but there were indicators that their neglect in this study did not substantially distort the statistical analysis.

10.7 Power and Measures of Participation

In chapter 9 we have already demonstrated that learner turnover was both a theoretically-derived and an operative criteria of effectiveness of a nurse training system. The evidence for the latter part of this conclusion was argued to be the prominence of the subject in the academic nursing literature in the 1960's and mid-1970's (which was replete with suggestions for psychological testing of potential learners), in the official publications of the General Nursing Council and in occupational journals such as "The Nursing Times" and "The Nursing Mirror". This visibility was, however, not given to turnover per se but to the development of "better" selection methods which would minimize the incidence of such turnover. As such turnover was always conceptualized as arising from faulty selection which failed to match the individual personality to the requirements of the job. Only Birch (1975) hinted at the possibility of organizational factors such as a "poor learning environment" and "over-repressive hierarchical relationships" as an explanation for learner turnover. Even he, however, concentrated his study on developing a series of appropriate personality tests.

In the years 1975-1978 the Mayfield Area Training System was under the Directorship of Vane who governed the School in an authoritarian manner and seldom delegated duties to her Deputy Directors and much less to her Senior Tutors. In this period the School experienced learner turnover rates of 20% to 25% in the general nursing training area and 25% to 30% in the combined general and paediatric nurse training speciality. These rates were in line with the figures quoted by the General Nursing Council (1977) and were indeed marginally better than national statistics for comparable schools of nursing. As far as archival information shows, Vane did not accord the issue of learner turnover much visibility and turnover statistics were supplied to the Director on an irregular, informal basis. The selection of learners was performed after the reference taken-up stage on a centre-by-centre basis and no attempt was made at standardizing selection criteria and methods across

the Area School as a whole.

When Davies took up the Directorship in January 1978 he exercised his authority to give increased prominence to the issue of learner selection. The reasons behind why Davies took an interest in learner selection are multifarious and illustrate to some extent Mintzberg's depiction of "messy" interlocking organizational processes and March and Olsen's (1976) garbage can model of organizational choices; where the organization resembles a garbage can of solutions which look for problems. The selection issue is not an exact reflection of a garbage can solution requiring a problem-definition for although not given visibility by Vane, these processes were already defined as problematic in the occupational and academic literature and recognized by the educational staff at Mayfield as a potential "problem" which required some informal monitoring. However, part of the rationale behind Davies' interest in selection and turnover does bear some resemblence to the case of an individual in a powerful position possessed of a solution and seeking for a problem.

There were four main reasons for Davies' interest in selection, by this we mean four events which coincided and co-occurred in such a manner as to define learner selection as a "problem" to be attended to in order to improve the functioning of the organization. The first of these phenomena was the discussion at the Regional Health District level of ideas to rationalize learner recruitment on a regional or even national level. There had been dissatisfaction at that level with an unequal distribution of applicants to schools of nursing within the region. That is, schools of nursing like Mayfield which were attached to teaching hospitals were able to choose better qualified recruits because their available number of places was always over-subscribed but other schools of nursing which were attached to non-teaching hospitals often found it difficult to fill their places and often recruited learners from overseas. A centralized regional scheme, similar in principle and operation to the nationalized scheme for U.K. university undergraduate entry

(U.C.C.A.) was thought to be more efficient and "better" for all schools of nursing concerned. Discussions had therefore been initiated at the Regional levels for evaluating the desirability and feasibility of such a scheme. These discussions would have been related back to Davies via the Area Nursing Officer who is his executive superior to whom he is responsible and who reports back on relevant issues discussed at Area Nursing Officers meetings. The subject of selection (not turnover per se) had thus surfaced at the Regional level.*

The second significant phenomena was Davies' obvious dissatisfaction with the fact that the Area School lacked a holistic identity. Although created as an Area institution some three years ago, each educational centre still selected its own recruits and designed its own programmes. The teaching staff of each centre had little contact with one another and interview data shows that there was a strong sense of rivalry and distrust between the Northern and Southern health districts. Some attempt had been made to centralize selection with all learner enquiries being channelled through Clarke House but this was only up to the reference taken-up stage before enquiries were dispersed to the Education Centres. Davies decided that such a decentralized ambiguous entity resulted in inefficiencies, duplication and failed to exploit the initial objectives of an Area School - that of utilizing efficiently the diverse resources available for nurse training in both health districts. He felt in particular that learner administration should be standardized and eventually centralized at Clarke House in order that duplication was avoided and an Area identity could be forged. In Davies' words:

> "When I first came here the right hand didn't know what the left hand was doing. The North was doing its own thing and the South another. There were so many pieces of paper floating about just in connection with learner selection and discontinuation. Every centre uses its own form.

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* The Regional Clearing System for learner selection was in fact discussed by the Southern Nursing Executive on 17th January, 1980 and rejected on three counts:

(a) that the system would need extra clerical help
(b) that there may be a possibility that such a system would direct valuable learners away from Mayfield and
(c) that a degree of control could be removed from the management services.

Even worse, the North doesn' really talk to the South, they are all cooped up in their little safe worlds." Davies, Director, February, 1980.

There was hence a desire to standardize procedures and to rationalize the Area School in order that the system used resources efficiently. In fact Davies revised not only learner selection, learner discontinuation, the number of learner intakes but also learner curriculum, in order that the E.E.C. regulations could be implemented for the intakes of 1980.

Thirdly, Davies' interest in selection was increased because he perceived current methods as essentially "unscientific" and "impressionistic" and he desired some "simple selection tool" which would help to discriminate the stayer from the leaver. These perceptions are closely connected to Davies' definitions of effective and "professional" nursing and nurse training. He believed that scientific research into nursing was an important means by which the "profession" could advance, gain "professional" status, autonomy and legitimate a self-governing machinery which was not under the influence of the British Medical Association. In order that nursing could be regarded by society as a profession it required a research base which would delineate a body of knowledge called "nursing care". In accordance with these beliefs Davies had in fact participated in Birch's (1975) study into learner turnover. His previous school of nursing in the Newcastle region had been one of the sample selected by Birch. Davies was thus aware of turnover as an issue and his awareness was probably heightened by the uncomfortable knowledge that Birch found no indication that his ex-School was more effectively managed than other Schools in the sample. All Schools were reported as exhibiting high levels of turnover and Birch also suggested that they did not provide suitable learning environments. In short, it was not so much the individual who was not suitable to the job but the job and the institution which required change. That this knowledge could have influenced Davies' interest in learner selection at Mayfield was suggested by remarks made at an interview. Davies reported:

"You think you are doing a good job but I've read both Birch's thesis

(1980) and his M.A. work (1975). It doesn't show that my (old) School was better run than the others. A bit disappointing that." (Davies, Director, February, 1980.)

Finally, Davies' belief that psychological research and "simple" personality testing could help to make selection more scientific stems partly from his exposure to Birch's methodology and partly from his own occupational experience. Davies qualified as a Registered Mental Illness Nurse and had worked for many years in the psychiatric division of the service sub-system before moving across to the educational. In demonstrating his interest both in psychology and in academic research he had co-authored a textbook on the socio-psychological aspects of nursing care. Learner selection was yet another area where nursing as a "profession" could benefit from research and psychological insights.

These four sets of historical and current affairs, coupled with the impact of academic and occupational literature, provided a suitable climate for the emergence of learner selection and the closely coupled question of learner turnover as an important issue at Mayfield; one which required action instead of non-action and Davies took steps to solve the problem. These efforts towards greater efficiency and a vaguely defined sense of effectiveness were:

(a) the emphasis of a rule that every learner who discontinued her training should be interviewed, counselled or helped by the Senior Tutor in charge;

(b) the delegation of a search for improved selection methods to his one remaining Deputy, Adams. (There had been two Deputies but one had recently resigned to take up a Directorship elsewhere.); and

(c) the provision of turnover information to the Director by the Allocation centre of both Health Districts was provided on request.

In responding to such a delegation of authority, Adams adapted an interview/selection schedule which had been devised by Mr George Hespe. This instrument had been used to run management educational sessions.

This adapted schedule was then sent for approval to Mr. Hespe together with an invitation for further research into learner turnover and selection.

The reasons or events lying behind Adam's initiation of a formal research effort, which further gave prominence to turnover and selection at Mayfield, are difficult to report with confidence. This is because Adams left the system studied within seven months of the start of the project. It was therefore difficult to conduct in-depth interviews over a period of time and to obtain longitudinal observations of her interactions. However, available interview information with Adams suggested that two main events accounted for her move.

Firstly, there had been the interest in the subject of selection shown by her superior and by the Regional management team. Such hierarchical force (which is similar to Bonini et al's (1964) concept of hierarchical pressure) exercised in a system used traditionally to authoritarian styles of management had a clear effect on Adams. In attempting "to do a good job" and to allay a sense of insecurity she implicitly asked for the advice of someone whom she perceived as possessing more expert knowledge. Mr. G Hespe was thus asked to comment on her adapted selection schedule. However, this process is insufficient to explain why Adams went further than instructed and initiated a research effort on turnover and selection. Two charged items expressed during her final interview give some indication for this effort.

Firstly, it is possible that Adams sought to show Davies that she possessed some academic initiative and could cope well with delegated duties. Davies was relatively new in his job and it is likely that she desired to show her worth. In attempting to display her awareness of the literature and of issues currently being discussed in the "professional literature" Adams linked the crucial idea of selection to turnover. These were seen as closely related issues which needed to be studied together as one process influenced the other. Specifically past "high" levels of learner turnover

could have been due primarily to poor selection methods and the disruptive effects of such levels of turnover could in turn have prevented an analysis of methods of selection. Turnover and selection were thus argued by Adams to be sides of the same coin. This desire to exhibit an academic or research awareness, as distinct from a desire to impress her superior, is most probably linked to Davies' well-known philosophy on the importance of research to nursing.

Turnover was now introduced into the selection picture but the entire process was given yet another subtle twist by Adams. She placed a greater emphasis on research into turnover rather than selection. Although turnover had been entered into the arena of discussion under the selection umbrella, it was given further emphasis and the subject took on an importance of its own which, in fact, overshadowed in part Davies' emphasis on selection. This added stress on learner turnover per se appeared to be due to Adams' recent involvement with management in the Southern District. (She had formerly only held responsibility in the North but due to the resignation of the other Assistant Director had taken part responsibility for the Southern District as well). The Children's Hospital in the South was experiencing acute senior staff and learner shortages; the latter due entirely to the fact that combined general and paediatric learners possessed the highest turnover rates in the School. Due to this, Adams' statement of the research project became:

"A Project on Learner Turnover and Selection."

Secondly and more probably, Adams initiated a research project on selection and turnover because she wanted documented evidence of her research interest and abilities. In common with other senior educational staff Adams knew that academic and research qualifications were increasingly required as evidence of ability as a nurse teacher. The number of nursing staff in both the service and educational sub-systems obtaining postgraduate and undergraduate university qualifications was increasing and the drive towards "professional" nursing had seen an increased value being placed on academic qualifications. In

anticipation of this trend, Adams had enrolled for a part-time undergraduate degree but she had only completed one year of the course. A research project would thus add some support to an expressed interest in nursing research and development. Also it was a piece of information which no doubt was particularly useful at that time for unknown to the researchers, Adams was applying for Directorships in several schools of nursing. Later she acknowledged in her final interview that the research project had been discussed at her job interview and her prospective employer had been interested to hear of the project which she had initiated. It is, however, likely that Adams did not anticipate the scale of the project which did result for she thought only in terms of a "small" project. In her initial interview she reported:

> "I am sure this subject needs research, you know. But I don't know that it is enough for a Ph.D. It is a limited area only and may be enough for only a small project." Adams, Assistant Director, November, 1979.

In addition to Davies' and Adams' interpretations of the research project which varied among a project on selection, on selection and turnover and on turnover and selection, the service sub-system described it as either a project on selection and turnover or a project on turnover per se. In the official minutes of the Nursing Executive of the Southern District of the 20th March, 1980 the project was entitled as being on learner selection and turnover. However, all the ward sisters whose wards were involved in participant observation were told and/or had the impression that it was a project on learner turnover. On two occasions the researcher was greeted on the first day with very defensive attitudes because the ward sister thought she had come to analyse how "horrible we were to learners and why they leave nursing". Considerable stress had to be put on the positive notion of selection and the ward sister was clearly relieved to hear the researcher was not a qualified nurse and had no nurse training.

These different interpretations of "what the research was about" clearly revealed a variety of interests, a desire to protect and further these interests and show that operative criteria of effectiveness in organizations are as Hopwood

(1979) argues criteria of social construction. The theoretical criteria of learner turnover had little more than the potential to influence corporate action. The realization of that potential was a product of individual interpretation, of organizational and social histories, norms and processes. This complex series of interlocking events around learner selection and turnover reveal that the change of a single, powerful individual in the system can contribute to an increased prominence being given to a measure of effectiveness. Although turnover and selection had been discussed at great length in the academic literature it did not become important at Mayfield until Davies came. However, the arrival of Davies with his particular experience, interests and background is alone an insufficient explanation for the rise to prominence of turnover and selection at Mayfield. For his available authority is directly a legacy of his predecessor. Because Vane allowed little authority to be exercised even at the Senior Tutor level, teachers throughout the Mayfield School were accustomed to authority and to obeying orders from the top. The norm of the organization was that the Director was the executive leader of the organization and his interpretation of his role is accepted as valid and legitimate. Thus when Davies instructed that particular procedures and processes be analyzed and changed, there was little opposition from the senior staff of the educational sub-system. With respect to selection, even members of the service sub-system agreed that the procedures used in 1978 were haphazard and lacked uniformity throughout the Area School. Given this initial acceptance of superior role enactment, the Director when he first arrived was able to interpret, instruct and change with little formal, vocal opposition.

This situation was also reinforced by the historical militaristic discipline instilled in nurses and nurse teachers that superiors have more expert knowledge and experience and "know best". Menzies (1970) also recorded this phenomena and observed that anxiety in the service sub-system caused constant delegation upwards instead of down. Senior personnel were often appealed to when difficult or unpleasant decisions had to be made and they were often the final adjudicators.

This dependency on their superiors' perceived superior expertise partially explained why Davies was able to spotlight "problems" and ineffective behaviour and initiate change easily. In the case of learner selection, the change was in fact implemented with little opposition. Changes initiated in other areas and which required greater independence of action by subordinate staff, however, caused great anxiety and attempts were consistently made to delegate upwards as recorded by Menzies (1970).

Finally, the power of the Director to create different levels of prominence for different criteria of effectiveness is directly linked to societal expectations that the authority of the superior is to be respected and he has the legitimated power to dispense rewards and sanctions within the organization as he sees fit. Society invests in the superior a level of trust commensurate with his organizational level and he/she is expected to act fairly in his/her enactment of the role. In chapter 8 we have already argued that these societal norms reflect the subtle face of power whereby subordinates do not seriously consider issues of relative power. They obey not because the superior has the power to compel them to but because they expect orders to be given and followed. They take authority from the top for granted, as one of the ground rules on which ordered societies are anchored. In nursing this is especially true. A historical aversion to industrial action and an ironic bond to the patient which at the same time prevents the use of subordinate power in bargaining situations means that nurses, more so than other classes of workers, are less inclined to perform complex calculations of relative power before a decision to obey orders is taken. Even if subordinates did have considerable power this power is seldom exercised in the outright withdrawal of labour. As such it is unlikely that subordinate teachers within the Area Training System would have taken active steps to limit the power of the Director.

Davies, however, had primarily placed an emphasis on learner selection. Although when interviewed he did agree that selection and turnover were closely related issues, his strategies had been designed to centralize and make

efficient the process of selection. However, the initiative of his subordinate and the interpretation she placed on her delegated task enabled turnover to be seen as an essential part of the selection issue. These kinds of action are illustrative of our argument in chapter 8 that while normative structures and rules do define and circumscribe acceptable ways of behaving, the individual is not wholly constrained by societal and organizational values and beliefs. There is room and space for individual interpretation and manipulation of dependency and legitimated authority relationships. Adams clearly had to work within the rules of behaviour governing superior-subordinate relationships; she had to keep to organizational traditions, to nursing habits and to societal norms about the role of the dependent subordinate. Nonetheless, there were instances in which her own interpretations were able to have a sizeable impact on corporate strategy.

Further the significance of learner turnover and selection as a criteria for measuring organizational performance at Mayfield is also indicative of the unrealized power of that other subordinate - the learner. In the last chapter we have already provided statistical information which shows that the Biritish nursing service is staffed by a majority of unqualified learner nurses. Unlike the nurse training systems in North America, British learner nurses retain their Victorian role of being both an employee who is within the ambit of industrial relations law and a learner. The latter role, however, predominates only when the learner is within the educational sub-system and was often observed to be of secondary importance within the service sub-system. The learner as an employee also tends to be the role accorded to learner nurses by large sections of society and is manifested via a number of classifications: the learner nurse is paid a salary which is negotiated and determined by national pay agreements rather than a student grant from the local education authority; the learner is a contracted, salaried employee who enjoys the protection of and is bound by legal employment rules in an identical manner to that of other salaried employees; the learner is not accorded full-student status and as such

does not qualify for student benefits and services e.g. cheaper travel, trade discounts etc.

The learner is thus more of an employee than a student and indeed is so regarded by a number of groups in society. And she forms a vital part of the workforce of British nursing. On most wards at Mayfield a ratio of qualified to unqualified staff is 1:3 and ratios of 1:4 are not uncommon. This reliance on learner labour at Mayfield and in Britain generally is historically rooted in the apprenticeship system of early forms of nursing. From the medieval ecclesiastical orders of hospitallers to the Victorian women sent to the Crimean war front nurses have been "doers" first and "students" second. In medieval times this situation was due primarily to the interpretation of requisite nursing and medical skills and this was compounded in Nightingale's time by the pragmatic necessity of sending a number of nurses to the Crimea within a short space of time. When nursing knowledge of care "developed" in the late 1800's and the early 1900's this was taught and accommodated within the concept of "service to the patient". It was argued that nursing (like accounting) was best taught through practice and direct care of patients. Training was thus on-the-job and although a Sister-Tutor was formally in charge of education, her very title suggests that education and "service" were closely coupled. Nurse learners were given formal teaching for only part of her working day or week and the present system of educational blocks was not instituted till the 1960's. Although nurse training now incorporates separate educational sessions and education and work/service are more clearly delineated as separate functions the essential model of the learner as an apprentice remains. The learner spends about 27% of her time in blocks and ward personnel are officially supposed to teach as much as supervise.

There are other reasons for this retention of the apprentice model of training but these are less often discussed in the literature. The first of these is that the majority of general nursing tasks are relatively simple and the

mechanics of specific procedures are quickly taught within a clinical setting. As Menzies (1970) observed in her study.

> "The nursing service must face the dilemma that, while a strong sense of responsibility and discipline are felt to be necessary for the welfare of patients, a considerable proportion of actual nursing tasks are extremely simple." (Page 21. Menzies, 1970.)

and

> "We observed obvious under-employment as we moved about the wards, in spite of the fact that student nurses are apt to make themselves look busy doing something and talk of having to look busy to avoid censure from the sister." (Page 28, Menzies, 1970.)

These observations were supported by our own observations conducted over a dozen years after Menzies. Despite the increased use of technologically advanced equipment, the emergence of specialisms in nursing care (e.g. care of the psycho-geriatric patient, the patient with chronic renal failure) and the greater development of medical knowledge into the cause and prevention of illness, the bulk of general nursing duties consists of mechanically simple tasks which once learnt may be repeated countless times in a nurse's workday. Indeed, the bulk of time in general nursing is spent on duties which a patient would perform for a child who is unable to take care of itself. The nurse's role is often seen as maternal/paternal and the predominance of females makes the mother surrogate an easy analogy. And a nurse in the clinical setting does spend most of her time bathing, cleaning, feeding, monitoring and talking to his/her charges. During participant observation the researcher too found that nursing duties were surprisingly simple and there was a large element of routine task performance. Usually there was a general method to follow and although there were some minor variations - beds were made in more or less identical ways, patients were bathed and fed and had their dressings done in a similar fashion. However, although actual tasks were simple, the point was these had to be performed constantly and regularly; the neglect of such tasks could easily endanger the life of a patient. Hence the nursing system required a large supply of semi-skilled labour who would be willing to perform operationally simple, fragmented tasks. In addition, these semi-

skilled labourers also had to internalize the importance of their routine, monitoring role which was viewed anxiously as creating the difference between human life and death. Hence not only was a low level of skill required in large numbers of workers, they also had to be responsible, reliable nurses. This meant that the labour force had to be drawn from either mature adults or from older teenagers who could be taught to internalize a set of values and beliefs consonant with "responsible" behaviour. These requirements of numbers, level of skill and value identification have made the apprentice model the most efficient manner of staffing British hospitals. Indeed it was primarily the shortage of nursing staff which prompted the acceptance of men into nursing in the post-Second World War period (Abel-Smith 1960) and the setting of the age of entry at eighteen.

The use of a learner labour force is also a cheap way of maintaining a nursing system. Because the flow of patients and of ward work follows an irregular pattern with peaks and troughs, staffing needs to be kept at a reasonably high level. At Mayfield as at other hospitals (see Menzies, 1970), the service sub-system tries to plan its establishments to meet peak rather than average loads. As a result when troughs occur, ward personnel have little to do. Were there to be qualified staff, they would experience frequent periods of under-employment and the state would have to pay more for each unit of their unused time. Even if qualified staff were not used as a substitute for learners, the nursing service as a whole would become far more expensive if it had to pay learners a student grant and hire extra semi-skilled labour such as that of nursing auxiliaries or assistants. As the nursing service is nationalized, the State would be required to find this extra use of financial resources.

Given this series of historical and prevailing factors, it is not surprising that the apprentice model of training has survived till the 1980's despite arguments that the dual role causes severe conflict (see Briggs, 1972). The model was reaffirmed by the Merrison Report of 1979 which was issued at a time

of economic and State cuts in spending. The Report briefly reported that the Committee had decided that the learner should not be made supernumerate and be accorded full student status.

It is precisely because the service is so dependent on a learner labour force that excessive learner turnover is easily defined as a problem. As Moores (1979a) argues, a learner is a relatively cheaper type of labour but he/she is by no means cheap. A learner who discontinues training creates a vacancy at the qualified staff level in two or three year's time and represents from the State's point of view a "wasted" resource into which financial resources have been pumped but which has not realized its initial investment in training. It is probably for this reason that the term "learner wastage" arises. In addition, learner turnover at a high level makes consistent manpower planning of the service sub-system at the micro-organizational level extremely difficult. When the service sub-system expects a hundred learners to man the wards and finds only seventy or sixty, the system experiences a sharp shortage of resources which could result in a poor quality of care. The learner is thus in a potentially powerful position because there is a dependency relationship between him and the managerial participant group. However, this dependency aspect is not actualized by the learner and instead evokes a strong power situation where superiors are more concerned than otherwise to monitor the turnover of learners. The legitimated authority of the superior thus effectively overshadows the potential power of the learner. This is reinforced by the difficulty of identifying and mobilizing learners as a separate interest group. Although learners do join trade unions, they are not differentiated from their superiors who also join the same unions and their needs are not accorded special status. In addition, the diffuseness and temporal nature of the learner labour force makes it difficult for learners to adopt a collective identity. Learners often do not know well other learners on the same ward. They do not see learners belonging to their own intake for upwards of two months unless these happen to work on the same ward.

Communication among learners thus becomes a severe problem. Learners also do not stay learners for long - they either qualify within two to three years or they discontinue. Unlike university students who may be supported on student finance for long periods of time, nurse learners are a transient labour force with a fast turnover. Unlike university students who may not be occupationally restricted nurse learners are engaged in a highly specific course of occupational training. These factors jointly limit the use of potential labour power among learners and explain the ease with which a traditional authority situation has developed whereby turnover is carefully monitored.

The importance of the learner labour force in highlighting learner turnover as a measure of O.E. was also dramatically revealed in a reversed situation in 1980-82. In this period it became clear to Davies and to the Mayfield system as a whole that turnover had declined substantially and was likely to decline in the future due partly to record levels of youth unemployment. The dependency relation was therefore weakened and turnover was less of a "problem" because it no longer influenced or interrupted to the same degree the flow of work within the system. An old "problem" became more urgent - that of applicants writing in for limited training posts meant that not only could the School have a wider choice in learner selection but it required a means whereby the number of applicants could be reduced to a manageable number who were selected for initial interviews. In the past, selection and turnover had often been linked as joint problems but in the period prior to 1980 turnover was given more visibility than selection. In 1980 selection slowly began to dominate and this was heightened by the formation of a centralized recruitment office at Clarke House which was responsible for handling the thousands of applications to all courses of training. By June, 1981, further efforts were being made to devise a filter whereby only a reduced number of applicants was called for interview.

As can be seen, power relationships grounded in historical, organizational

and societal events and values played a major role in turning the spotlight on learner turnover. Essentially similar arguments explain why learner absence is formally measured and monitored by the Mayfield Area Nurse Training System. The reliance on a learner labour force and the weaker legitimated power base of the learners again partially explain the institution of an absenteeism information system.

However, learner absence, although formally measured at Mayfield, has not been given as much publicity and visibility as learner turnover. Theoretically absence, like turnover, reflects a lack of participation in the focal F-set by particular interest groups. Whether absence is seen as a predictor of withdrawal or as a short-term means of maintaining dynamic balances of a participant's inducement-contribution balance, absence behaviour is a significant indicator of the long-run propensity of a system to survive. Indeed absence behaviour could be one of the earlier signs that the focal F-set is under threat and that participants may turn to alternative coalitions for a satisfaction of their needs and wants.

Empirically learner absence is monitored at Mayfield but has not been evoked as a major "problem" and as an important means of assessing organizational performance. This was interesting given that on several informal staff occasions (chats over coffee, discussions after the end of formal senior staff meetings) and on two formal interview sessions with the researcher, Davies had acknowledged that absence among nurse learners was probably considerably higher than among workers in industry of a comparable age, salary and type of work. In one memorable "coffee session" at the S.G.H., Davies and two other members of the tutorial staff agreed in essence that absence was a "big problem" in nursing. Davies went on to report that statistics available to him indicated that nurse learners on average took 14-15 working days off a year which was equivalent to three weeks of paid absence from work, a figure reportedly considerably higher than comparable workers in industry. There was also an implication that absence was potentially a more insidious disruptive influence on workflow as

frequent absence spells could make staff planning at the individual ward level even more difficult than when learner turnover was high. The latter was at least a once-and-for all event which could be taken into account once it had occurred while the former was more unpredictable and tended to happen on a more frequent basis. Davies also complained that absence information and feedback from each individual ward was extremely slow and it could take up to two weeks before an incidence of absence was reported back to the Allocation Office housed within the Educational sub-system. This was the case for the S.G.H. Further, the reporting-back procedure was again unstandardized in the Area and each hospital (the N.G.H. and S.G.H., for example) had its own method and style of feedback.

The description of absence issues sounded remarkably similar to the "problem" of learner turnover and selection and yet there was relatively less publicity given to absence. When Davies initiated centralization changes in 1978, selection and recruitment were one of his primary concerns - not the standardization of absence reporting. Throughout the active life of the research project (November, 1979 - June, 1981) we were not invited to look at absence issues and to extend our initial investigation. In April, 1980, an Organization and Methods study conducted by members of the Regional Management Services Department revealed that absence and sickness control was minimal at the S.G.H. but was acceptable at the N.G.H. and the psychiatric hospital in the North. This statement of the absence problem was, however, put in the context of deficiencies in the Allocation Function as a whole and was used to argue that the Allocation Function had inadequate control over the movement of learners, was inefficient and unduly onerous. It failed to provide accurate and up-to-date statistical information and entailed tutorial staff being involved with administrative functions which could easily be completed by routine clerical staff. Whilst the O and M team highlighted the inadequacy of reporting procedures to date there was still no visibility given to levels of absence and patterns of absence behaviour per se. In other words, although limited

attention had been given to the mechanisms of absence reporting, no concern had been expressed as to absence behaviour per se.

Why then was not learner absence a "problem" when it could potentially be a problem? If as Davies reported, absence was "high" among nurse learners, why were efforts not made to lower its incidence?

Our own data suggests that absence behaviour among learners varied considerably depending primarily on the year of the learner and the course undertaken. The mean Gross Absence Ratio was 0.0316 which means an average of three days absence in one hundred working days and approximately eight days absence in a five-day, fifty-two-week year. This figure is unlikely to describe the distribution of absence well as the distribution is as discussed positively skewed and is binomial rather than normal. There were learners with a GAR of 46.2% which means that the mean will be distorted by such high figures and a large number of lower numbers. If the mean was taken to give some indication of the distribution of absences, the absence data from our sample of 309 learners shows that the mean absence per learner per month (0.632) was significantly higher than that reported by Clark (1975) (0.34) - for hospitals of a comparable bed size. This higher mean figure falls just outside the allowable number of absences. According to a GNC ruling of 1980 each S.R.N. learner is allowed twenty-one working days off on sick leave, maternity leave or compassionate leave and each S.E.N. learner is allowed an aggregate of fourteen days before absence is taken into account. At Mayfield, absence in excess of these limits must be "made up" and worked, either by working extra days or by a reduction in annual leave. In addition, G.N.C. rules govern the maximum number of accountable absences in total. For intakes prior to 2nd January, 1981, a S.R.N. learner had to be able to complete her training (i.e. make up for all her lost working time) by the weekend of the State Final Examination results before she could be allowed to take these examinations. A S.E.N. learner had to complete seventy-eight working days of theory and practice before he/she was eligible for examination. For intakes after

2nd January, 1981, a S.R.N. learner would be eligible for examination if he/she is able to complete her training eight working weeks after the date of the examination and a S.E.N. learner is eligible if he/she is able to complete training twenty weeks after the date of the examination. In effect these upper limits allow a learner a considerable number of absences before his/her training is seriously affected and postponement is required. For the S.R.N. learner these rules could mean an allowable limit of twenty-one days and an additional sixty-one or sixty-six days; for the S.E.N. it could mean an allowable number of fourteen days and an additional twenty days. On average this results in a learner being able to take twenty-eight days off (five working weeks) a year before the individual's training is at stake. The mean figure of eight days per year obtained for our sample of 309 learners would suggest that on average learners exceeded the allowable limit of twenty-one and fourteen days which averages out at seven working days per year. However, they did not, on average, exceed the total permissible accountable number of absences.

One probable reason then for the lack of significance being attached to learner absence could be the self-correcting influence of the G.N.C. rule which is further buttressed by a Mayfield rule that learners who are approaching this critical level of absence are interviewed and counselled by the Senior Tutors and/or the Allocations Officer in charge. The system at Mayfield thus appears operationally, at least, to have taken the G.N.C. guideline on accountable absence as the standard by which absence behaviour is compared. Although privately Davies may express doubts about the usefulness of the standard set, operationally the system appears to rely primarily on the rule and on learner motivation to complete his/her training to regulate absence behaviour. Although the mean absence at Mayfield could be higher than that in other hospitals, it nevertheless falls within accountable limits and clearly the number of learners who have had their training extended due to excessive absence has not been perceived as "high" enough to warrant an investigation into absence behaviour.

But the question still remains - why was learner absence not created as a problem when a case could be made for viewing it as a problem? Although the number of learners whose training has been extended due to long periods of absence is not considered high, this standard of measurement is a poor indicator of the effects which absence behaviour has on the system's workflow. An individual's level of absence may be within allowable limits but the incidence of absence among learners collectively could prevent the delivery of an adequate standard of care; unless one made the assumption that the G.N.C. ruling on individual absence limits was made on the basis that within the laws of probability the individual limit was equivalent to a "safe" systemic limit. However, the point remains that Mayfield as a whole lacked information about detailed absence patterns among learners as a whole. There was no data on how learner absence patterns influenced workflow, absence statistics were not compiled systematically by the educational sub-system and categories of absence were not monitored e.g. absence in block as compared with absence in service, weekend absence, certificated v. uncertificated absence etc. The service sub-system did monitor absence behaviour for all categories of ward staff but there was no integration of this information with that required for the educational sub-system. Conversely, the learner absence information which was available to the educational sub-system was not made available to members of the service sub-system. In July, 1980, the District Nursing Officer of the Southern Health District had to make a formal request for this information which at that time was only issued to the Area Nursing Officer, Area Treasurer and Regional Nurse Training Committee. No details were available as to whether the Northern service sub-system had made a similar request.

In addition, as Davies pointed out, absence information was collected in a very unstandardized manner. The researcher herself found immense difficulty in obtaining consistent absence information. For example, the N.G.H. recorded all absences on a five-day week basis while the S.G.H. used a seven-day week. The North and South changed over to recording in hours at various times

and changed back again to recording in days also at different times. Absences in the North were labelled certificated, uncertificated or "no-contact" absence while such categories were not in use in the South which maintained a separate book where all medical certificates were filed. Some attempt was made in the South to record the day of incidence of an absence spell but this was not done consistently and no attempt was made to follow suit in the North. There were also confusing, inconsistent procedures for the reporting of absence; at times the Allocation Office would be informed but not the ward or vice versa or the medical certificates would be sent to the ward sister and not to Allocation. A case could apparently be made for a rationalization of absence reporting and for greater prominence to be attached to the issue. Yet learner turnover was judged the more urgent issue. Several events are again argued to be the "cause" of this situation. (Causality is not used here to mean intention or conspiracy.)

The first of these was at an individual level. The Senior Nursing Officer in charge of Allocation was, until mid-1980, Andrews, who gradually found it difficult to cope with the demands of the job and resigned to take up a clinical tutorship. The Allocation Function was for several months without its executive leader and this created a severe staff shortage of the requisite skill and experience. This therefore prevented any additional analysis as the department was struggling to cope with day-to-day operational demands. The new Assistant Director, Eden, who had formerly been a Senior Tutor at the N.G.H. was asked to take over Allocation temporarily and her first task was to negotiate an agreed allocation of learners with the service sub-system throughout the Area School.

This second event, the "regular" allocation of learners, like most other allocation processes underscores the power conflict and struggle between different interest groups, in this case between the North and South service sub-systems and between Education and Service. Access was not obtained to these Allocation meetings but secondary reports from Eden and Davies revealed that

this allocation of resources was a time-consuming political activity. A learner is a vital unit of labour, a financial resource and an expense on any particular ward and within any hospital. Learners form the basis of night and weekend staffing and a significant proportion of day staffing. The significance of learner allocation was clearly illustrated when the minutes of the Southern Nursing Executive reported the District Nursing Officer's annoyance at the lack of a record of learner allocation. The minutes read as follows:

> "The District Nursing Officer also informed the meeting that he had been in a number of meetings recently where nursing staff establishments had been discussed and he had been at a considerable disadvantage because he did not have a record of the learner allocation <u>which was of course an essential part of the nursing establishment</u>."
> Page 8, official minutes of the Southern Service Nursing Executive, 17th July, 1980. (Emphasis added.)

Williams, one of the S.N.O.s in the Southern District, estimates that learner manpower services 80% of the workload within the hospital system. As such each service sub-system within the individual Health District seeks to obtain the optimal number of learners for the hospitals within the district. "Optimal" being defined by one S.N.O. as that number which would "run an adequate service at as low a cost as possible and which is within the budget allowance negotiated at Region." Once a learner is allocated to a particular district he/she is usually under the administrative control of that district's service sub-system for the duration of his/her training.

There are a number of factors which make the allocation of learners a political process rather than a mechanically programmed activity although the April, 1980, O and M report believes that

> "Once a programme for allocating learners has become established, . . . Allocation as an impersonal mechanical function can be completed entirely by administrative staff."

The crux, of course, lies in determining an acceptable "programme" of allocation and there are factors which suggest that the O and M view may not be realized even after the introduction of computing facilities. Firstly, as the RAWP principle (which applies only to the Area level) indicates, accurate and

generally agreed measures of "need" and of requisite staffing are not available at the individual ward, hospital and district level. All hospitals within the two Health Districts had staffing levels below their establishment allocation and specific Areas had levels below their funded establishment allocation. Although a patient dependency study was being conducted at the time of our research project, it was only conducted at the S.G.H. and one other hospital - Hospital D in the South. Such measures of patient workload were not available throughout the Area Health District. In the minutes of the Southern Service Nursing Executive Committee of 21st February, 1980, it was reported that although the District and Area Nursing Officers were in support of such manpower studies, a shortage of staff among the Work Study Team precluded the widespread conduct of such surveys. There was hence no accurate information on which learner allocation could be based, thus opening the way for coalitional bargaining between the North and South service sub-system which had had a long history of mutual distrust and suspicion. The historical analysis of chapter 7 revealed that the North often resented the status and prestige of the Southern service sub-system and when Vane (formerly of the Southern United Mayfield Nursing School) took over the Area Nursing Training System their resentment was further reinforced. Indeed, the O and M report records that during Vane's term of office the allocation of learners on an Area basis effectively "deprived" the N.G.H. of third year learners. The Northern service sub-system was thus extremely sensitive to changes in learner allocation and often felt that they would be unfairly treated when compared with the South.

North v. South conflict over learner allocation was particularly acute over the allocation of learners to Hospital E. This was a small hospital geographically situated near the Southern Hospitals which during the political process of re-organization from a three district to a two district Area came under the jurisdiction of the Northern service sub-system. This meant that all qualified nursing staff were controlled by the North. However, the geographical location

of the hospital made it impossible to staff it with learners assigned to the Northern circuit. Amidst controversy, it was finally agreed that the hospital should be staffed by learners from the Southern circuit who, however, were not controlled by the Northern service sub-system. Usually the precise location of assigned learners to specific wards is negotiated between Service and Education. In the case of Hospital E, the Northern service sub-system effectively lost control over much of this negotiation process as Hospital E's demands had to be viewed in conjunction with other Southern as opposed to Northern demands. The hospital was often all staffed by Southern learners. This created considerable bitterness among senior Service personnel in the North and served to reinforce North-South hostilities.

Secondly, learner allocation also forms the means by which conflict between the Education and Service sub-systems is created, reinforced and transmitted. Because Davies is not under the executive control of the District Nursing Officer, the autonomy and demands of this newly formalized function in the nurse training system is often resented by the service sub-system. In informal interviews with senior service personnel in both Health Districts the education sub-system was viewed with suspicion and Davies in particular was accused of being:

> "only interested in increasing his power base and influence over the Area Nursing Officer. He can be open, co-operative at times, but on the whole is self-opinionated, damned obstructive and cunning. He doesn't understand that we have a service to operate at the lowest possible cost and 80% of the service is manned by learners."

and

> "In the past the A.N.O. has been influenced too much by Davies and Service has gradually seen the decrease in numbers of learners on the wards. She is coming round to seeing the service point of view. We are severely short-staffed, especially on nights. The A.N.O. is an illogical, innumerate, emotionally but politically forceful woman. But she doesn't understand figures." S.N.O., S.G.H. June, 1980.

Changes in allocation initiated by the educational sub-system are thus resented and usually are implemented after periods of negotiation and bargaining. From November 1979 to July 1980, the Allocation Function (without an officer-in-charge) under the control of Davies, was negotiating a variety of allocation changes:

(1) changes caused by the E.E.C. ruling (effective nationally by November, 1979) that all student nurses were to have compulsory clinical training in obstetrics, paediatrics, psychiatrics and community nursing;

(2) changes in night-duty allocation. This was at that time conducted on a two-week internal rotation basis but Davies had re-interpreted the G.N.C. rules to argue that because learners had to spend night duty on a ward with which he/she was already familiar, night duty should be allocated in blocks;

(3) changes in wards and hospitals which were regarded as suitable training grounds. Where a particular ward (e.g. the cardio/thoracic at the N.G.H.) or a hospital (Hospital E in the South) is not regarded as suitable for training, learners are withdrawn from the setting, thus constituting a major decline in the staffingavailable to that ward or hospital; and

(4) changes which were brought about by the introduction of large, regular intakes of learners eight times during the year rather than smaller irregular intakes twenty-six times during the year. This change in intake flow meant that a suitable formula had to be negotiated whereby allocations were to be made to the North and South service sub-systems.

With a number of negotiations being conducted via the Allocation Function during the period November 1979 to July 1980 and learner allocation being the predominant battle ground it is not surprising that learner absence was not designated as an organizational problem. This political process also partially explains the significance attached operatively to turnover since turnover means the loss of a unit of labour and its occurrence enters into the political arena of the calculation of numbers of learners available for distribution among competing interests. Absence behaviour, on the other hand, is not an obvious resource problem; the emphasis being more visibly placed on the formal availability of a unit of labour and less on its physical availability after the battle of numbers has been fought and won.

The third event which dominated the interest of Allocation and of Davies was the centralization proposals suggested by the O and M Regional team. This

report was initially intended only to assess the possibility of an introduction of computer assistance in schools of nursing in the Region. Its particular terms of reference were to examine:

(a) the allocation of learners to clinical situations during training;

(b) the recruitment of learners to the Mayfield School of Nursing;

(c) the generalized clerical support services to all the teaching staff; and

(d) the provision of managerial information and statistics to the Senior Officers of the Mayfield School of Nursing.

However, these terms of reference were significantly extended when

> "it became apparent that meaningful recommendations on the above aspects could only be made if they included changes in the organizational structure."

The O and M team was then instructed to examine the entire organizational structure of the Area educational sub-system. The team's recommendation for a centralization of learner selection and admission at Clarke House had already been well advanced by Davies. Three major recommendations remained to be implemented: the centralization of clerical support services, the centralization of Allocation and the reorganization of the duties of functional personnel. The first and third sets of changes involved only educational personnel and though potentially problematic, they at least did not possess the added complication of Service involvement. The second, however, was given considerable visibility. Because absence-reporting deficiencies were discussed in the context of Allocation's structural problems, the former was easily eclipsed by the controversy surrounding the centralization of Allocation.

The 1980 structure of the Allocation Function was such that although the Offices and Officers were all based within the educational sub-systems, the Allocation Officers were executively responsible to the Service sub-system. Their salaries were paid out of the Service budget and they were directly responsible to the District Nursing Officer. They were supposed to "report only" to the Director of Nurse Education. However, according to the O and M report, this form of line responsibility created not only an "inefficient use of staff"

but also "intolerable conditions of control for the Director of Nurse Education". The team thus suggested ways by which the educational sub-system could control the training of learners such that both "the learners and nursing staff receive maximum benefit from the existence of an Area School.".

Three major changes were proposed:

(a) that the Allocation Officers be seconded to the educational sub-system for a period of 18/24 months. During the secondment the Allocation Officers would report to, and be responsible to, the Director;

(b) that each Allocation Officer be assigned a specific task given undiscussed funding difficulties of the setting up of a hierarchical Allocation Function;

(c) Allocation would be centralized and based at Clarke House with only clerical support at each educational centre. All learner enquiries about allocation would now be re-routed through the Central Allocations Office and Allocation like Recruitment would be given a formal, separate Area identity.

One of the tasks allocated to Officers was the design and implementation of a recording procedure for the sickness and absenteeism of learners which is acceptable to each separate location for learner training. Another was the provision of manpower and training information which would enable the Service sub-systems to complete long-term planning on ward staffing levels, improve learner allocation and training and advise the Director on the suitability of prevailing systems of training.

These proposals were met with considerable opposition from the Service sub-systems and essentially the argument revolved around the control of Allocation and the training and movement of learners. These measures for "improvement" suggested by the Regional O and M team were argued to be a more efficient method of coping with the allocation of approximately 1300 learners over a wide geographical area to over fifty different locations. However, they also gave Davies greater control over the vital areas of learner selection and

allocation. As discussed above, learner allocation is an important source of power in the system because the service sub-system is heavily dependent on learner labour and the raison d'etre of the educational sub-system depends on the constant affirmation of learners' educational needs. Each sub-system seeks to control the movement and placement of learners because they serve the official and operational aims of each sub-system. The attempt to obtain greater control is particularly important from the education sub-systems perspective because education per se was only set up as a separate function after the Salmon Plan of 1966. Historically education had always been within the province of service and of the ward sister. This was felt to be detrimental to the "profession" as the education and training of nurses was at times subordinated to staffing requirements and learner nurses were essentially unqualified workers rather than learners. The function of Education was thus to ensure the training needs of learners and to help create a new generation of "better educated", "more professional" nurses with a research interest.

The arguments surrounding the control of Allocation were eventually settled with the O and M report being slightly modified but accepted. The power of the O and M recommendations was significantly due to the fact that they were proposed by a Regional team which had had the legitimated authority of the Regional Nursing Officer, the Area Nursing Officer and the Regional Management Services Officer. The approval of these representatives of higher authority clearly carried considerable weight among the District Nursing Officers in a status-conscious hierarchy. The fact that it was a Regional team also meant that the study was perceived as "objective". In other words, the team was seen as being one step removed from the interests and prejudices at the District and Area levels and therefore was cloaked with an air of impartiality and "objective judgment". This argument was publicly expressed by senior members of the educational sub-system who were predictably supportive of the recommendations which were designed to achieve the legitimated aim of safe-guarding and making efficient the training of learners.

It is important to point out that although considerable attention was given in the O and M report to the inadequacies of absence information, this was used to argue for greater control of the Allocation Function by the educational sub-system. The issue of absence patterns and their consequent effects on learner satisfaction and patient care were re-interpreted solely as a control problem. Emphasis was placed on designing rules and procedures to monitor absence in order to better control learner manpower. Further emphasis was placed on control of the entire Allocation Function. In short, inadequate absence reporting "got dragged in, tied-up and muddied by" issues about power and learner control; it emerged as a political tool and became an insignificant part of a larger political process.

These three organizational events show that the insignificance of learner absence as an issue within Mayfield was closely coupled with the conflict for power and control among different interest groups. Specifically control over the movement of learners formed a focal point for negotiation and bargaining; this political process itself being rooted in the historical dominance of the service sub-system and the recent emergence of the education function as a separate, semi-autonomous entity. The events reveal yet again the coupling of individual power with organizational processes which enabled the emergence or subsidence of particular effectiveness "problems". The incompetence of Andrews, her subsequent resignation and the control which Davies was able to obtain over the allocation issue ensured that the "problem" of learner allocation filled the stage and obvious inefficiencies in the provision of learner absence information were relegated to the background.

10.8 Power and Measures of Productivity

Power struggles within a particular organizational and historical context played a major role in creating empirically observed definitions of "professional" nursing and "professional" nurse training. The commonsense understanding among members of the Training System was that the objective of the system was to produce "professional" nurses, hence one logical means of monitoring its effectiveness and success was the extent to which "professional" behaviour and "good" patient care was ensured in the system. Participants at all levels within the hierarchy were observed to be concerned with "professionalism"; it was an operative criteria of organizational success and strategies were initiated in order to ensure "professional" behaviour. But the meaning of "professional" behaviour changed subtly at each level of the hierarchy, each definition reflecting particular concerns and dramas of control. The layers of meaning surrounding the term also differed between the empirical interpretations and the researcher's operationalization of the term in the composite scales PROFORN and PROBS. Despite these different meanings of professionalism and professional behaviour, there was consensus about specific facets which most nurses, irrespective of station and sex, agreed were characteristics of a profession. Before discussing the differences we look first at the threads of commonality which bind different versions of "professionalism".

Publicly, nurses in general (whether they belong to Service or Education, to the Northern or Southern Health District, be qualified or unqualified, be a S.R.N. or a S.E.N., be female or male, be under thirty years of age or over) agree that "professional" nursing implies that nursing care is a distinctive, identifiable body of knowledge and skills. The professional nurse is an expert in patient care who has been trained and who acquires skills not possessed by non-nurses. As such the nurse expert should stand on an equal footing with other health professionals and experts such as doctors, psychiatrists, physiotherapists, social workers. This body of specialist knowledge and skills also means that the nurse can truly be evaluated and monitored only by other nurses, that is, by experts with an identical set of competences and skills.

A nurse may only properly be supervised by a nurse and the body of nurses collectively can only be managed by nurses. Nursing as a profession must therefore be self-regulating and possess autonomy in the conduct of its essential task. Finally, the professional nurse, it is agreed, is always bound by one single ethic - the interest of patients under his/her care. The emphasis is on patients in the plural and not the singular; the professional nurse seeks to achieve a point on a collective patient welfare function which ensures an adequate standard of care for all. This is accompanied by an emphasis on the patient as an individual client/recipient of care who needs attention which is specifically related to his/her needs. Individual care is, however, always bound by the parameters of the common good.

These proclaimed characteristics of expert knowledge, specialized training, self-government and a patient ethic are facets of professional nursing which form the value consensus among nurses. They were expressed to the researcher via their language in formal and informal interviews and through their action. At the heart of this value consensus lies the assumption and argument that nursing is a separate, identifiable body of skills which needs to be taught and learnt. This assertion of the existence of a body of knowledge is in effect a means whereby nurses collectively seek to gain a monopoly control of specific skills and gain a privileged position in the occupational and social hierarchies. As Larson (1980) points out the possession of scarce knowledge and skills is, indeed, the principal basis on which modern professions claim social recognition and economic rewards, which themselves are scarce commodities. The creation of the nurse expert is a strategy whereby nurses attempt to carve a niche for themselves in an advanced capitalistic society which is increasingly stratified and divided in the utilization of its labour force.

The attempt of U.K. nurses to attain professional status is rooted in the historical events of the 1800's when tentative moves were made by nurses and "benefactors" to organize themselves as a separate, visible body. As discussed earlier, it was the widely publicised efforts of Florence Nightingale which first gave national coherence and identity to nurses as nurses.

The attempts made by Nightingale to improve the quality of nursing care and the training of nurses were complicated by a number of factors:

(a) the opposition of medical professionals who saw their traditional authority over the nurses and their control over the patients being attacked and undermined.

(b) the extremely low social status and class bias of nurses in the voluntary hospitals and infirmaries of the 1850's.

and, (c) the subordinate role of women in the Victorian household and family unit. In the days before the suffrage movement, women were seen as inferior to men and viewed in an essential subservient role.

The fact of obstacle (a) medical opposition to nurse training, did not in itself prevent Nightingale from initiating courses of training and from creating some measure of nurse control. However, she was firmly convinced of the total clinical responsibility of the doctor. Freidson (1970) argues that she did not permit nurses in the Crimea to do anything for the patients unless requested by the doctor. White (1978) however argues that though she did view the doctor as being ultimately responsible for the patients' clinical condition nurses in the Crimea were responsible for the patients' diet, environment, comfort, general welfare and overall care. The evidence provided by Abel-Smith (1960) and Seymer (1949) suggests that Freidson's (1970) interpretation is likely to be more accurate.

It is difficult as well as irrelevant to ascertain whether Nightingale did or did not conceive of the nurses' role as subservient. But it is generally agreed that she did see the nurse as being dependent on the doctor who was always the ultimate custodian of clinical responsibility for the patient. The nurse was seen as the doctor's assistant, whether that role was interpreted as a Man or Girl Friday or as a lowly servant, the name implied a dependency relationship. The nurse's role was dependent on the existence of a doctor's role. In addition, it was the doctor who held ultimate responsibility for and legitimated authority over the fate of the patient.

As far as obstacle (b) was concerned, Nightingale sought to upgrade the social status of nurses by recruiting from the middle-class and upper class bourgeois sectors of society. The early emphasis on class is an important ingredient in the development of nursing and reflects a number of underlying factors. Firstly, class was a social qualification, a form of accreditation much used in 18th and 19th century society and an oft-used criteria of social inclusion and exclusion. For example, Larson (1977) points out that the "higher" branches of the legal and medical profession in 18th and 19th century England were invariable drawn from the upper classes.

Secondly, the concept of class is intricately bound up with education. Prior to the introduction of mass education, a University education was only available to the monied class, whether this be the old aristocracy or the Victorian upper middle class; usually the route to such a University education lay through the nine leading public schools.

Finally, the concept of class and education is also coupled with the notion of superior morality and character. The educated upper class was often implied as being more upright than the lower classes. Carr-Saunders and Wilson (1933) point out that within the early medical Royal College of London:

> " . . . social qualification became the first requirement for membership, and it was held that the necessary 'morals and manners' could be learnt only at the universities." (p. 71, Carr-Saunders and Wilson, 1933.)

The linkages between class, education, morality and social respectability make Nightingale's emphasis on these factors easily understandable. However, the foregoing section also shows that nurses or women consistently lagged far behind men and doctors in their level of education. The subordinate position of women meant they were seldom given a formal, expensive education and few of them entered the elite universities. Educationally and socially, women nurses were thus less powerful than men doctors. In later years this disadvantage served to focus on the nurse's fight for social rather than political status.

As far as obstacle (c) was concerned Nightingale did little to change the status of women. Indeed in her later years she implicitly opposed the suffrage movement and the notion of feminine emancipation. Whether this opposition was independent of her opposition to the registration of nurses which was being campaigned by feminists is difficult to ascertain. Certainly in her lifetime Nightingale did not conceive of womanhood and femininity as a barrier to the progress of the nursing occupational group. It is likely though that she did accept the subservient role of women though she found means of overcoming this in her own life.

The Nightingale efforts to reform nursing, whether intentionally, or unintentionally, left a legacy of dependency, secondary authority and female subservience. These notions were further reinforced by military discipline in nurse training and a strong Victorian emphasis on morality, education, status, class and respectability. They also enabled the medical profession to consolidate their authority over nurses and medical men in the 19th century clearly saw themselves as being more superior than nurses. (see Abel-Smith, 1960)

The supremacy of the medical profession was left unchallenged even during the run-up for the registration of nurses. For the battle for formal nurse registration was itself a battle amongst nurses and not between one occupational group and another. Indeed registration was supported by the B.M.A. and seen as beneficial to the care of the sick and the work of medical men. It was in precisely this spirit that the powerful BMA, officered by the "West End consultants in London and the consultants in the big towns" supported Mrs Bedford Fenwick in her aggressive battle to secure registration for nurses.

To a large extent registration was a struggle between the "lady nurses" and other "untrained nurses". It represented a drive by these nurses to create a selective, restricted supply of labour which would achieve greater social status by virtue of being designated as trained.

Registration was as synonymous with status as with ensuring a better quality of care via training.

Events after 1919 showed the nursing elite's continued desire to restrict supply and to enhance their social status by narrowing the eye of the needle. The new rules laid down by the GNC excluded a large number of nurses from registration. These rules were overturned by Parliament in 1923 but the GNC did manage to exclude nurses from the Volunteer Aid Detachment from being registered. They were also successful in imposing difficult and authoritarian conditions of training which effectively kept out widowed, married and other women from entering nurse training. In addition, male probationers and nurses were positively discriminated against.

These actions showed that up until the creation of the National Health Services in 1948, the nursing governing elite were mainly interested in entrenching their social status and position. Their first aim was to keep out persons whom they considered had not been adequately trained and qualified. Few moves were made to loosen the working nurse's dependence on the medical profession and nurses still depended on medical officers for such matters as employment, promotion and even certification. Several events in the 1940's began to change this. First was the 1943 approval of the State, the G.N.C. and the Royal College of Nursing (R.C.N.) to the setting up of a second grade of nurse. Severe shortages of nursing manpower during the 2nd World War had spurred the State to increase the supply of nurses heretofore restricted by the nursing elite. The creation of the enrolled nurse served to further strengthen the status and prestige of the registered nurse. It also vastly increased the potential power of the nursing profession for now more nurses would be employed and the country became more dependent on their labour.

Second was the restructuring of nurse training. By 1949 training was financially controlled by new regional Standing Nurse Training Committees and

the G.N.C. were successful in (a) putting a majority of nurses on these committees and (b) in ensuring that the budgets of teaching hospitals' training schools be submitted to the G.N.C. itself rather than to the nurse training committees. The G.N.C., however, were not willing for the control of nurse education to transfer from the Matron to these Nurse Training Committees and hence when the Bill was passed, the learner remained under the control of the hospital. A second proposal for a reduction of length of training and the number of nursing schools was vigorously opposed by the G.N.C. because it would decrease its control over training and it also disagreed on principle. The second proposal was thus shelved and Parliament was unable to move the "formidable body of the General Nursing Council". The system of training now remained firmly and wholly in the hands of the GNC which was empowered but not compelled to carry out experiments and innovation. It had succeeded in wrestling it away from the control of hospital boards and medical men.

A third major event was the initiation of the Salmon Plan. After 1948, the status of Matrons in former local authority hospitals generally improved but within limits set by the still influential medical officers. In many voluntary hospitals, however, it declined. In order to focus on this erosion of authority the GNC began a wide-ranging review of the inadequacies of the prevailing hospital management structure and essentially lobbied the State to change the distribution of decision-making authority. Great emphasis was placed on the lack of clarity of the responsibilities of the various grades of senior staff and between staff who managed different-sized hospitals. Yet again the nursing elite was successful and the Salmon Report of 1966 recommended the setting-up of a multi-layered administrative nursing hierarchy and a nursing executive committee which would provide a channel through which top nurse management could "draw on the collective advice of nurses before making decisions on policy". A greater degree of political authority may evolve in the future. The 1980 Nurses and Midwives

Act combined the hospital and community nursing services and implemented the Briggs proposals for one main governing body for nurses and midwives. In effect this creation of "one voice" for nurses and midwives consolidates the occupational group by eliminating internal competition to some degree. Historical evidence shows that for long nurses have been "far too busy fighting among themselves" than for themselves and the consolidation of diverse nurses under one governing body will help ensure that:

> " . . . an authoritative voice for British nursing and midwifery would be heard outside the profession within this country and in the long-term, of equal importance, within the E.E.C., particularly given that the pattern of attitudes and policies within the E.E.C. is still evolving." (p. 620, Briggs Report, 1972.)

This unification of the profession will serve as an important tool for the nursing leaders in negotiating with the State and other health occupational groups. The number of nurses has been increased dramatically and they "all march under one banner." At the time of writing, however, the Central Council had only just been formally appointed and the long process of choice of Council members had not been completed.

The attempt to gain greater societal status and recognition for nurses collectively has been further enhanced by the separation of education and training into two separate functions. This has enabled national visibility to be given to nurse education per se and it was substantially reinforced by the 1972 Briggs proposals. Increased State finance to improve nurse education resulted in the setting up of Teaching Divisions within nursing organizations. The increase in societal legitimacy, funds and personnel involved with nurse education also occurred at a time of major growth in the British higher education and university sector; experimental university courses in nursing were soon set up. The emphasis on research and university involvement with nurse education was positively encouraged by the Briggs Committee for they clearly realized that without a monopoly of skills and knowledge, nurses

would never be able to attain full professional status. Paragraphs 312 (a) and (b) are especially revealing:

> "There are several reasons why universities and other institutions of higher education interest themselves in nursing and midwifery and why nurses and midwives should be interested in them. Two are outstanding:
>
> (a) the development of professional knowledge itself. The professional content of nursing and midwifery depends on the existence and enhancement of a body of knowledge related to its principles and practices. A substantial body of nurses and midwives who are graduates of universities . . . is required for the advancement of such knowledge, not least through research . . .
>
> (b) the needs of recruitment. The profession must recruit . . . from people of widely differing abilities and temperaments. Among them there must be people capable of initiating ideas, carrying heavy responsibilities and meeting on equal terms with opposite numbers in other professions, including the medical profession, and other walks of life. Courses in universities . . . thus play an essential part in a long-term strategy for the profession." Emphasis added. (Paragraph 312, Briggs Report, 1972.)

This emphasis in the U.K. on nursing research and university courses for nurses has been paralleled by similar developments in the United States and the mutual influences have produced, (it was first elucidated in the Briggs Report), a vital mode of labour differentiation: the distinction between medical care and nursing care. The report states:

> "We believe that while doctors, nurses and midwives are permanent partners in care, it is possible to distinguish in the first instance between the caring role of nurses and midwives (which involves co-ordination and continuity) and the diagnostic and curative functions of doctors: both have teaching and research functions." (Page 140, Briggs Report, 1972.)

The committee took great pains to emphasize the necessity for nurses to maintain a distinct professional identity. Accordingly, they rejected the idea of a nurse practitioner who would perform some tasks now undertaken by medical staff.

This care-cure distinction between the work of nurses and doctors is also increasingly emphasized by nursing researchers who are nurses by training. White (1978), for example, writes:

> "It is only recently that nurses have been heard to distinguish their paradigm (care) from that of the doctors (cure) but many have not yet sufficiently convinced themselves of this distinction to be able to discuss 'the extended role of the nurse' in any direction but towards

> the discarded routines of the doctors. Only a few voices are heard trying to steer nurses towards a better understanding of their own role, a better and deeper recognition of their intrinsic skills and the development of indigenous nursing theory. For so long nurses have unthinkingly accepted medical values for themselves without realising that doctors and nurses have different goals and values which are sometimes conflicting. Doctors are advancing along the high technology route; nurses must realise that they must take a divergent route if they are not to abandon the care of their patients.
> (p. 216, White, 1978)

White's desire to develop "indigenous nursing theory" and to isolate the "paradigm" of nurses as caring is typical of most nurses who seek a professionalization of nurses. It is reflected in the eagerness with which the nursing bodies, both academic and in practice, have welcomed the development of the "nursing process". A process which acts as a mystical tool and gives some sense of "scientific" analysis to the work of nurses. It has helped to proliferate symbolical pieces of paper called nursing care plans - the nurse's equivalent to the medical report.

Collectively, these recent developments have helped to prevent the encroachment of other "professional" groups. Great emphasis was made in the Briggs Report (1972) on the difference between nursing and non-nursing duties. Although the Committee argued that it did not seek to draw rigid, clear-cut distinctions between nursing and non-nursing work, it was clear that the Committee had a concept of what was or was not nursing. In particular, messenger work, the cleaning of laundry, clerical work in connection with the hospital admittance and discharge of patients and domestic clearing were not nursing duties. These were the province of "ancillary staff" who are often looked upon by nurses as being "lower status" personnel who do not possess any training and who are not in continuous contact with the patient. The nurse today differs substantially from that in Nightingale's time and the ambition of the "lady nurses" has partially been realized; nursing is no longer synonymous with domestic duties. The nurse is not a domestic servant or charwoman, officially at least.

Further differences are drawn between the work of nurses and other para-medical and occupational groups. Again the distinction of "care" is used. The Briggs Report recognizes the work of "technicians" in health care, by this it means the work of groups such as occupational therapists and physiotherapists. It recommends that when work

> " . . . involves the continuing repetition of more or less highly skilled tasks unrelated to the planning, co-ordination and implementation of nursing and midwifery care for the patient, such work should be carried out not by nurses or midwives, but by technicians . . .. Their qualifications and skills are quite different from those of the nurse or midwife." (p. 159, Briggs Report, 1972.)

The use of the word "technician" is intrinsically value laden and connotes the idea of a depersonalized possessor of techniques who is substantially different from the "caring nurse".

Whilst all these changes could potentially give nursing leaders greater monopoly over a created, distinctive labour process it was clear from our observation that rapid change also created systemic instability and manifested itself in anxiety and a desire to counter change with upward delegation of decision and ritualistic behaviour. The specific expression of anxiety, again like definitions of professional and good nursing behaviour varied between different levels of the hierarchy. In the next section we shall analyse these various constructions of "good nursing" and concepts of "professionalism".

10.8.1 Senior Management Constructions of "Good Nursing"

The foregoing account has argued that there does exist a value consensus among nurses as to the status of their occupation. The criteria of a patient ethic, training, a body of distinct knowledge and skills and self-government are claimed by nurses to characterise their work. We have also shown the historical events which underlie, diminish, reinforce and advance the force of these claims. It would appear that nurses collectively now possess tools which could ensure greater political and social status and higher economic rewards. Macro-structural relationships have emerged and been created which enable the future realization of these claims of legitimacy. However, macro-structural relationships which delineate formal channels of power and communication may not duplicate themselves at the micro-organizational level, though doubtless they will form a major influence. Further, the value consensus about professional or good nursing is liable to differential emphasis at each level of the hierarchy as a result of each tier's location in the social, political and cultural matrix of the micro-organization. Each level of the hierarchy has different functions, responsibilities, relationships to the patient and nurse sub-environments and each engages in different kinds of negotiation and language games with other occupational groups. The primary relationships with other occupational groups, which will be studied, are the general nurse relationship to the doctors and other occupational groups which work within the hospital sub-environment. We begin with looking at the emphasis given by the top administrative layer of the hospital nursing hierarchy.

The senior Service and Education level comprises of the Director and Assistant Directors of Education, the District, Divisional and Senior Nursing Officers. This strata in fact forms the boundary layer between managers who still have a day-to-day contact with a system of productive labour* that is with

* The use of the term productive and its corollary non-productive labour originates in Marx's distinction between labour which produces surplus value and that which does not. I do not intend to discuss the controversy that currently exists in Marxist theory about what kinds of labour are productive or unproductive. As Larson (1977) notes, this issue becomes a matter of pure exegesis when large proportions of heretofore "unproductive" workers sell their labour to capitalist firms and when the production and realization of surplus values increasingly depends on a complex integration of scientific, technological, marketing and . . .

an institution which nursing work is performed and managers who are full-time administrators and whose upward careers are wholly within administrative lines. The Regional Nursing Officer and the Area Nursing Officer are full-time managerial and administrative posts. The Nursing Officer, on the other hand, retains, or is supposed to retain, a clinical involvement, however minimal. In between lies the hierarchy of District, Divisional and S.N.O. One could argue that in fact this boundary layer could be drawn lower at the ward sister level on the argument that patient contact is low even at this strata. However, ward sisters/charge nurses and N.O.s do not possess as much decision-making authority as those above and their duties do ensure a significant involvement with operational issues at the patient level. On the other hand, S.N.O., Divisional and District N.O. form the Service corporate decision-making body within the hospital system and this Nursing Executive Committee is the official nursing authority within the Service sub-system. Their counterpart in the Educational sub-system lies at the Director and Assistant Director level. These posts are again wholly managerial and administrative; there is no direct teaching input. Only Senior Tutors and below teach.

This strata of personnel is responsible for the formation of organizational rules and regulations as to the conduct of nurses and nurse learners in both the service and educational sub-systems. They are the layer with the most frequent contact and earliest knowledge of the "views of the profession" in as much as these views are reflected in G.N.C. and R.C.N. representations. They also interact with the medical profession at formal decision-making committees. The District N.O., for example, sits on a district management team and the district medical officer attends the service nursing executive committee meetings as an observer. Finally, they have under their legitimated

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. . . non-market services. The term is used here as symbolic references to the different kinds of link (direct or support) that different levels of the nursing hierarchy have with the production of surplus value in the human commodity called "patients". Alternatively, if client service which is exchanged for revenue is designated as indirect productive labour and the patient cannot be validly conceptualized within Marx's terms as commodities, then the distinction between our levels of nursing personnel may be refomulated as that between indirect productive labour and support labour. The point is nurses at the lower levels of the hierarchy have considerably more direct patient contact than those at the higher administrative levels.

control clinical or teaching practitioners who undertake the actual labour of bedside care and learner instruction. This strata thus forms the important boundary, communication channel and filter between the control issues of the R.C.N./G.N.C.-populace axis, the nursing-medical axis and the administrative-labour axis. These concerns are reflected in their answers to the question – "what is a good nurse?".

Appendix 10.12 sets out the answers to this question classified by the weight given to key concepts and the level of the respondent. The answers of the senior strata more or less span all the categories devised from content analysis of qualitative replies. They encompass the idealistic image of learners though it is important to note that their construct of "idealism" is less strong than learners. While learners spoke of "dedication", "sacrifice" and "vocational duty", senior managers spoke of "compassion, understanding, kindness" and "a desire to care". Senior management also conceptualized the ideal nurse in terms of "commitment and motivation to nurse". This second idea is similar to but less strong than the learner and Victorian idea of vocational work but the essential philosophy remains the same. That is, nurses must be prepared to nurse despite low economic rewards for learners, poor working conditions and strict discipline. For despite the Clegg Award of 1979, the pay of learners is still low when compared with jobs in industry with similar hours of shift work. In addition, nurses and especially nurse learners are subject to an unusual brand of moral discipline which positively disapproves of "untidy hair of violent colours", "excessive make-up whilst on duty", "too much obstructive jewellery" and enables the continual existence of strict visiting hours in nurses' residences. Whether these rules can be enforced completely is doubtful but the fact remains that official rules governing such behaviour exist and are consciously renewed each year.

The emphasis on motivation and commitment is easily used by senior nurse managers to demand that learners accept their "lot" passively and has its historical roots in the tactics used by 20th century nurses to restrict labour

supply and create a distinctive unit of labour called a nurse. The principle of narrowing the eye of the needle still persists and it is suggested that it is allowed to persist for two reasons - (a) it serves as a psychological barrier against emotional and psychological stress and (b) it allows the State to maintain a service which is relatively cheap and accords with the demands of the nursing elite. By demanding dedication, commitment and humility, the learner nurse is encouraged to do as taught and not to think; a strategy which protects the learner from self-criticism if her efforts did not produce the required results. It is at least comforting to know that a recognized procedure had been perfectly performed even though it could have been ineptly chosen. Dedication also served as a brake on collective union activity and protest. As Abel-Smith succinctly points out:

> "They were restrained by the discipline which matrons had imposed on them, by their loyalty to their group and to their hospital, and by the spirit of uncomplaining service which was taken to be the heritage of their profession. Underfed, overworked and underpaid, they struggled on rather than break a 'professional' code of honour. Activism was unprofessional, worse still, it would have undermined the cherished spirit of vocation: it smelt of hard bargaining and the pursuit of selfish material interests. It was also unfeminine." (p. 245, Abel-Smith, 1960.)

Although the number of young learners and qualified staff joining trade unions has increased in the 1970's the R.C.N. remains the largest body of organized nurses and its main spokesman. Reflecting its historical aversion to "unprofessional" strike action, this body continues to oppose direct action, mindful as always of the necessity to secure social status, the patient ethic and the advantages of a monopoly of labour power. The R.C.N. speaks for nurses alone whilst other trade unions see nurses only as part of the motley collection of health service employees. Further, historically the R.C.N. has a dominant influence on the G.N.C. - a pattern which continues in 1980 for the Secretary of the R.C.N. is the General Secretary of the new Central Council for Nurses and Midwives. Given this relationship between the R.C.N. and trade unions and the dominance of the R.C.N. on the G.N.C. it is not surprising that this senior management strata handles the axes of R.C.N./ G.N.C.-populace and management-labour by demanding motivation and commitment

from the labour force under its legitimated control.

Apart from this emphasis on idealistic images of nursing, the importance of nurse empathy with patient is stressed. Leavers did not mention this facet and this probably reflects their empirical awareness of the difficulty of a nurse stepping into the patient's shoes. Although it is easier for senior management to define empathy as an essential of good nursing, learners know that in practice this is seldom achieved nor desired given the emotional burden and stress which arise from being "too aware" of the patient's problems.

The difficulties of empathy are further increased by the sexual taboos surrounding male-female interaction, the age-gap between learners and patients and the Western hospital and medical ethic of a preservation of human life. The problem of sexuality was especially highlighted via learner and nurse reaction to "sexually deviant" behaviour. For example, it was observed by the researcher that patients who were known homosexuals or transvestites were a source of some curiousity and gossip among learners and nurses. They did not understand how they could exhibit such forms of behaviour which were regarded as "weird" or "queer". Clearly those learners could not cope with the psychological demands of nursing these patients. The age-gap between learners in their late teens and mature, old patients was frequently reflected in learner inability to adequately comfort and advise those patients. A frequent complaint was - "What can you say to a man old enough to be your father/mother or in some instances grandfather/grandmother?" In addition, learners were observed to find it difficult to make "casual" conversation which was meaningful and interesting to both parties. Learners were sometimes heard to report that Mr. X was so boring and dull or that Mrs. Y was so long-winded. The sight of old age was also observed to influence learners who found they had to cope psychologically with physical conditions which they knew would one day be reflected in themselves. Learners admitted to being worried initially by the sight of age and physical decline but reported that they "got used to things after a while." Finally, empathy between learners and overdose patients

was observed to be totally absent. On the six wards worked, there were five cases of overdose and in each instance the patient was avoided by nursing staff and felt to be the province of the psychiatrist. Nurses felt they did not know how to approach such patients and some felt that since they were not physically ill, there was little the general nurse could do for them. Two staff nurses on one medical ward were clearly observed to be annoyed with overdose patients. They felt these patients wasted the nurse's valuable time. They resented being alive and were reportedly rude to nurses. A situation clearly in contradiction to the nurse's usual altruistic role of preserving life and of being rewarded psychologically by the gratitude of patients. Many learners and qualified staff in our sample complained that their superiors never thanked them for their work but patients usually made up for this. This dependence on patient gratitude has similarly been recorded by Menzies (1970) and Rosenthal et al (1980). These three factors make the essential criteria of empathy one which learners and qualified staff find difficult to put to constant practice. The recent emphasis on academic ability and intelligence is also emphasized by both service and education senior managers and so is the learner image of technical and competent performance of skills and procedures. An additional emphasis was placed on safety as well as skill. This emphasis on education is seen by both education and service senior managers as being vital if the nursing profession is to be able to relate to the medical on an equal footing. Of the eight senior managers, only one felt that nurses were already well respected by doctors and need not worry further about their status. This was the S.N.O. at the N.G.H. but she was clearly influenced by the fact that she was married to a medical consultant. The rest of the seven senior managers re-affirmed the necessity for nurses to be free of medical dominance. However, despite this common agreement there were differences between service and education senior managers as to "who should control the learner". As expected each functional sub-system claimed that only it could best educate the learner. The service managers pointed to the necessity for learners to gain practical experience and the

educational managers argued that service personnel were liable to exploit learners as a pair of hands. Thus whilst united against the medical profession, senior managers disputed the extent to which each could best educate learners. In addition, all senior managers agreed with the idea that nursing could develop a separate body of skills which would be complementary to medical knowledge. In senior management interviews, all managers felt strongly that nurses were "as good" as doctors who were but equal partners in health care. Nurses were thus thoroughly capable of self-government.

The learner image of caring efficiency was less in evidence among senior management reflecting their distance from the pressures of clinical work. Only one S.N.O. gave a weight of 2 to the criteria of common sense, while two clinical teachers gave weights to this criteria. In addition, separate interviews with twenty-one sisters showed that nine cited common sense as being the defining criteria of a good nurse. This supports our argument that although senior management stresses care, it is the workers who see the importance of managing care efficiently in the face of a shortage, artificial or real, of resources. Finally, emphasis was placed on integrity and reliability. Of the six respondents out of eighteen who named this concept 5 were from the senior management level. This emphasis was found to be coupled with a certain meaning of professionalism.

Indeed, the questionnaire responses show a unique use of the word "professionalism". This concept is mentioned as a separate category and does not appear to coincide with textbook definitions of professionalism. For textbooks give four facets of which the patient ethic and education (which is indirectly related to specialized training) are already separated out by the managers. Clearly professionalism to senior managers is not the four-faceted idea of textbooks and is not synonymous with the four claims which form the value consensus of nurses generally. When questioned about the notion of professionalism senior managers gave learnt phrases like "one who upholds the standard of the profession at all times" and "one who behaves responsibly". Professionalism

was thus somewhat similar to their construction of reliability. Another clue as to the meaning of professionalism emerged when the Southern District Nursing Officer differentiated between setting "professional" standards for nurses and patient care standards for nurses.

A detailed analysis of the minutes of two meetings helped to consolidate this management definition of professionalism. The minutes of the meetings of Southern Service Nursing Executive Committee meetings for the period April 1979 - April 1980 and those of the Education Senior Staff Meetings for the period February 1980 - October 1981 were content analysed into the kind of agenda items which occurred most frequently. Of those which occurred and which were relevant to learner behaviour, there were three main categories: learner behaviour which was regulated by law, and related to patient care, behaviour which had implications for education and behaviour which was symbolically important. The first is reflected in agenda items like the use and control of drugs by nurses and learners, the use of participant surgical equipment or the participation in operations such as abortions. The second category is exemplified by items such as the number of hours to be spent on night duty, in various specialities or on study leave. The third category is exemplified by detailed discussions on the wearing of uniform, jewellery and the use of Christian names in clinical areas. Detailed formal and informal interviews with senior management showed that this third category of agenda items was an intrinsic part of their construction of professional behaviour. There was a strong feeling that learners should stick to the rules of uniform wearing, not be allowed to wear jewellery and not use Christian names when talking to patients or one another in clinical settings. The District N.O. of the Southern Executive Committee Meeting when ruling on the issue of Christian names said:

> "Standards of care are slipping with the use of Christian names."
> District N.O., Southern District, May, 1980.

He was seconded by a majority of other S.N.O.s who felt that the use of Christian

names was "less professional". As one S.N.O. put it:

> "Surnames are more professional for answering phones, in front of medical staff, patients and relatives."

The only dissenting voice came from one S.N.O. who felt that Christian names for patients, if not for staff, could have a therapeutic value in long-term care areas like geriatrics and psychiatrics. This voice was however ruled out by the Divisional N.O. who felt it was of the utmost importance that one rule, "one clear rule" applied across the Area. She said:

> "It is not useful to make exceptions. Either we do one thing or nothing."

The Southern Nursing Executive thus decided to ban the use of Christian names in all clinical areas. There were also other evils associated with the use of Christian names. There were openly expressed fears by, for example, one Allocations S.N.O. that "these young girls could get involved with male patients" or "patients can take advantage of nurses". This emphasis on correct attire and correct address was often cloaked with arguments about what was best for the patient and for the nurse. For instance, correct uniform was argued to be necessary in order to be practical, neat, clean, to lower the risk of infection and to be viewed responsibly by the patient. Jewellery was banned on the argument that it was not practical for physical work and Christian names were said to be disrespectful to older patients.

In essence, senior management equated professionalism partly with the old Victorian ideas of morality, respectability and they devised rules whereby outward symbols of respectability could be measured. The importance of obeying these symbolic rules translates into their insistence on reliability which in turn is connected with the notion of predictably obedient nurses who do as they are told. Professionalism thus has three main threads - morality, respectability, and predictable obedience to authority. This meaning was particularly relevant for service managers and the only senior manager who disapproved of such an interpretation of professionalism was Davies, the Director. He disapproved loudly of the wearing of uniform and argued to the annoyance of service management that these were but outward trappings which had little to do

with "real caring". It is significant to note that only Davies did not use the term "professionalism" as a separate category. However, he still emphasized the importance of "reliability". Of the two service senior managers who did not write down "professionalism", they emphasized self-discipline, self-control and self-respect; features which essentially relate to the moral character of a nurse. Senior management, especially in the service sub-system, continue to uphold the Nightingale-inspired strategy of upgrading a nurse's social status by emphasizing moral character, "respectability" and discipline. Indeed their emphasis on educational standards also harks back to the 19th century stress on adequate education.

It is also interesting to note that only one senior member of the educational sub-system listed critical and innovative attitudes as an important facet of a good nurse. A critical mind seems to be more important a requisite for senior tutors than for senior managerial staff. None of the service personnel listed a critical attitude as being important. A circumstance which again is not surprising since they, more than the educational personnel, are concerned with symbolic rule-setting and the obedience of those rules. Also, senior service management has a control relationship identical to a work-control relationship between superior and subordinate whilst the educational senior management has slightly more of a collegial-control relationship between teacher and learner. However, at the Director and Assistant Director level the influence of this second relationship is but slight; it is observably stronger at the senior tutor and below level. Although this teacher-learner relationship does prompt one of the senior educational managers to put innovation as a criteria, her exact words were - "An ability to implement planned innovation". In other words, innovation must be within agreed rules and be carefully planned and introduced. The learner is not seen as a source of innovation - only a means by which innovation may be implemented.

In conclusion, we would argue that senior management perpetuate the four textbook, consensual criteria of a patient ethic, specialized training, self-

government and a distinctive body of skills. However, greater emphasis is placed at this level on the outward symbols of respectability, morality and nurse obedience to symbolic rules. Their power is also enhanced by the fact that they can initiate a disciplinary action against the learner where his/her conduct is felt to be "unprofessional". They also stress the Victorian roles of commitment and education. The importance of empathy as part of the patient ethic is highlighted but notions of efficiency are much less evident.

10.8.2 Middle Management Constructions of "Good Nursing"

The next levelof the hierarchy comprises that of senior tutors and N.O. This strata straddles those managers who have only administrative functions and those with responsibility for productive labour. Managers at this intermediate level themselves perform both functions and both administration and productive labour are part of their formal work duties. However, informal interviews with N.O. revealed that they often found it almost impossible to carry out bedside nursing care and all S.T. agreed that since Davies became their Director their administrative function had increased substantially.

The responses of this strata shows a noticeable decline in the emphasis on "professionalism" as defined by senior management. Though the sample is small (only five) the shift from the ideas of respectability and morality are clear. However, because the N.O. also has operational control over the behaviour of learners and are as concerned as senior management with running a service at the lowest possible minimum cost, emphasis continues to be placed on reliability and integrity. "Reliability" had two main strands - (a) a nurse who was reliable if he/she could be trusted to come to work on time and did not "irresponsibly" take periods of absence; and (b) a nurse was reliable if he/she could be entrusted to carry out a procedure on a patient safely and be able to keep a patient's counsel private. The first sense of reliability/integrity clearly reflects the N.O.'s concern with the actual physical presence of learners within the service sub-system. This role encumbent has the job of monitoring levels of learner absence and of ensuring that the allocation of learners is working according to plan. The S.T. does not stress reliability as much as the N.O. because within his/her work world learner absence does not substantially influence the workflow of the system and the only "loser" is the learner herself who could face an extended period of training. The second sense of reliability/integrity clearly stems from the learner's frequent involvement with patient care and the N.O. and ward sister have to

ensure that procedures are carried out skilfully and safely. As this involvement is entirely within the educational sub-system, it is evoked in the conscious mind of the N.O. but less so in the S.T.

It is interesting to notice that senior tutors maintain a strong idealistic image of the good nurse coupled with an expected emphasis on knowledge and skills. N.O., on the other hand, are more prone to emphasize the notion of empathy, reliability and integrity. This striking difference between their responses appears to suggest that the ideology of professionalization and of the value consensus is mainly propounded by members of the educational sub-system (as evidenced by answers from all levels) and senior service management. The mystique of caring, commitment, specialized training, higher educational standards and a distinctive body of knowledge are recast in different terms by N.O. Their construction of caring is enunciated in terms of specific, practical acts. They speak of good communication, possessing empathy with patients and being able to anticipate a patient's need. The emphasis on knowledge, intelligence and academic ability is notably less than that of S.T. and when interviewed most N.O. felt there was too much emphasis in nursing today on educational qualifications. There was also little enthusiasm for the idea that nurses should continually "stand up to doctors" and assert their independent identity. The N.O. in the N.G.H. assured the researcher that they had few problems with the medical staff and both sectors had good working relationships. However, they went on to say that they had all been at the N.G.H. for a long time and "knew what the consultants wanted". This hinted of the Victorian idea of a nurse or in this case a N.O. being equal to a trusted family servant. It is also likely that this situation in the North was primarily due to the influence of the S.N.O. and her relationship with the medical staff. N.O. in the S.G.H. were more angered by the continuing dominance of medical staff but these two N.O. were younger and had strong research inclinations. In fact both N.O. have now joined the educational sub-systems of different institutions.

The N.O.'s construction of caring in concrete terms is due to her/his frequent though unsatisfactory contact with clinical situations. The S.T., on the other hand, does not frequent the wards as frequently and does so only for the purpose of learner assessment. As such, it is unlikely that she is able to conceptualize care in the same detailed terms. When interviewed S.T. often spoke of "anticipating a patient's need" but it was interesting to compare their public theoretical knowledge and their private/public expressions. The interview gave S.T. an opportunity for publicly, verbally, repeating theoretical knowledge which has been assimilated and taught countless times to learners. Yet when he/she took the questionnaire away, different results emerged which demonstrated their relative isolation from the clinical work world.

The N.O.'s unease about educational qualifications is partly a reflection of his/her lower level of educational achievement and his/her possible future difficulties in securing promotion. As such, he/she is anxious and wary of learners who appear to have more O Levels or even a university degree. In addition, being historically and daily reared on a philosophy of pragmatic nursing, the N.O. genuinely feels that "degrees do not make a good nurse". N.O. in the N.G.H. who in general were older were more wary of higher educational standards. Unlike their senior managers who have visions of "a greater profession", these N.O. were concerned that present training requirements could drive out "good caring nurses". Although the Briggs Committee did emphasize the necessity for taking in learners of a wide range of abilities, all S.R.N. learners at Mayfield are now required to have five O Levels. It is only S.R.N. learners who have a prospect of career promotion and only S.E.N. learners who may possess lower educational qualifications; a situation which in turn reduces the status of "basic nursing care". In short, the Northern N.O. were afraid that educational standards would serve to enhance the status of administrative work at the expense of bedside care - the bright S.R.N. does the paperwork but the not-

so-bright S.E.N. the bedpans and the baths. The Southern N.O. interviewed who were younger and more research-oriented, however, emphasized the positive benefits of increased educational standards in nursing.

Finally, the N.O. relationship with the medical staff differed between the Northern and the Southern. N.O. in the N.G.H. who were older, traditionally trained and militaristic in manner reported that relationships with the medical profession were satisfactory. However, interview information suggests that this was probably due to their acceptance of the historical secondary role of nurses. Observation on the wards also indicated that N.O. were slightly in awe of consultants and there was more of a willingness to avoid direct confrontation. The national restructure of the nursing profession thus appears to give only formal decision-making authority to N.O. At the ward level, control is still in the hands of medical consultants and the N.O., aware of her limited powers, is content to accept her role.

The limited authority of N.O. was bitterly reported by the younger N.O. at the S.G.H. who also complained of inadequate support from their S.N.O. S.G.H. ward sisters also provided evidence that N.O. were "useless". One ward sister reported that their N.O. had not been able to obtain a certain type of equipment and he/she was encountering long bureaucratic delays. However, once the consultant was appealed to, the equipment speedily arrived. Another ward reported a similar route to obtaining staffing resources. When asked whether they experienced a shortage of qualified staff, one ward sister at the S.G.H. replied that it depended on how powerful the consultants were in getting the number of nurses felt to be required. Her report suggested that nursing allocation, long thought to be the province of the nursing system, could be influenced significantly by medical men. A third anecdote relayed by ward sisters was the struggle between the consultant's desire to keep a child with its mother on an acute surgical ward and the N.O. → District N.O.'s disapproval as this broke official rules. The consultant, however, was able to get his way and the child stayed.

These three anecdotes were not re-checked and thus are suggestive rather than conclusive of the powerlessness of the N.O. vis-a-vis the medical consultants. However, they did confirm the complaints of the Southern N.O. It would therefore appear that at the local unit and ward level, the power of N.O. and even senior service managers to influence decisions is heavily restricted. If this were the case, it could explain the confrontation-avoidance policy of the N.G.H. N.O. and the anger of the Southern N.O. It also suggests that the complaints of senior managers against medical men might cover a lack of decision-making authority despite the setting-up of the Salmon Structure.

The S.T., on the other hand, would have found it easier to record their desire to diminish the dominance of the medical profession. S.T. do not work on a day-to-day basis with medical consultants. Being away from their authority, it is easier to protest. In addition, S.T. by virtue of being in the educational sub-system are anxious to promote the benefits of education and research to the profession's battle for societal status. Education is a new function and it seeks to demonstrate its advantage to the nursing occupational group; one such benefit being the ability to stand on an equal footing with the medical profession. However, despite this outward, verbal support for the nursing profession, S.T. in their interaction with medical consultants were again observed to be somewhat subservient. Visiting medical consultants were always treated with great respect and much emphasis was placed on the "busy consultant" who had kindly agreed to come to lecture to nurses. There was an observable tendency for S.T. to be slightly anxious that a medical consultant was due soon and apologies for late arrival were always easily accepted.

Thus far, it appears that this intermediate level of managers defines professional behaviour in slightly different terms. The notions of care are more specifically rooted in techniques, there is a differential view as to the importance of specialized training and a body of skills and

in practice there is little effort made to encourage an independence of nurses from the influence of medical men. However, there was some vocal support for the thesis that the nursing profession should seek to "stand on its own two feet".

Finally, it was observed that this strata like that above always placed great emphasis on learner obedience to authority as a facet of professional behaviour. The S.T. surprisingly continued to treat learners like school-children and their attitude to learners did tend in general to be authoritative. The following remarks were made by S.T. to several groups of learners.

> "You have arrived five minutes late and there is no excuse for such behaviour in class." S.T., Southern District, February, 1980.

> "I have come in five minutes late and you have made not attempt to get on with your work but have proceeded to make a lot of noise. This is highly improper." S.T., Southern District, February, 1980.

> "This learner has a thoroughly unprofessional manner to ward staff. She is casual, shrugs her shoulders when talked to and does not show appropriate respect." S.T., Southern District, May, 1981.

and

> "I told you not to forget your uniform. Why have you forgotten to wear your uniform again?" S.T., Northern District, May, 1980.

This insistence on learner conformity to rules and to authority from nurse teachers reflects again the old Victorian tradition of harsh military discipline and learner obedience. Although S.T. emphasized that learners should learn to question, their behaviour was in some contradiction to their spoken words. This desire to maintain control over learners by imposing a strict authority relationship was also evident in N.O. They tended to "inspect" a ward and did so with an authoritative style. The military manner of inspection was particularly evident in N.O. at the N.G.H. who marched onto wards and learners were observably more on edge when a N.O. was "inspecting". As one learner puts it:

> "We jump when a N.O. comes on. Everybody tries to be on their best behaviour and to do things properly." Second year S.R.N. learner, N.G.H., July, 1980.

Although this was less observable at the S.G.H., due partly to the

friendlier manner of the two younger N.O. observed, learners nevertheless sought to "put on a show" for the N.O. The authority and expertise of N.O. were also reinforced by the N.O. taking a learner on a ward round and the learner being supposed to give an accurate description of the patient's problems. In both hospitals, then, the N.O.'s visit on a ward was an event, it demanded certain kinds of behaviour and was always a source of some tension.

Thus, in addition to the shades of professionalism outlined earlier, this strata continues to maintain the tradition of discipline and obedience to authority, in particular that of the N.O. and S.T.

Yet at the same time it is the S.T. who reports that a learning, critical mind is essential to professional nursing. "A nurse must continually seek to learn, to evaluate the consequences of her actions and to stimulate learning in others." As argued before, this emphasis by S.T. may be understood (a) in terms of their location in the educational sub-system and their increased awareness of the importance of learning to the advancement of the nursing cause and (b) to their slightly more collegial relationship with the learner. Although the S.T. may be authoritative and seek to control the learner yet the cultural milieu of an educational sub-system demands that teachers, even senior ones, publicly support the notion of a critical, inquiring mind. From the researcher's perspective, all the S.T. observed appeared to find it difficult to relate in a relaxed manner to learners. All S.T. were spinsters bar one, were in their late thirties or forties and had clearly trained in the days when nursing was even more militaristic than the present time. In addition, most of them were openly anxious and found it difficult to adapt to changes in the organizational structure of the educational sub-system. One S.T. candidly told the researcher:

> "These changes have been traumatic for me. All along, I had been told to run my own pupil school in a small hospital. Suddenly here I am transported to this big, new, cold hospital with larger numbers of learners and a lot more administration." S.T., Southern District, May, 1981.

The S.T. in the North found it easier to adjust to new organizational

changes because they did not have the added problem of a change of hospital and were physically farther away from the headquarters of the educational sub-system. As a result:

> "We find it easier to work here. Don't have the Director or Assistant breathing down our necks. She leaves us alone - there's not much leadership but we get on with what we are supposed to do. Suits me better that way." S.T., Northern District, May, 1981.

Nevertheless, it was felt that sudden organizational changes and the difficulty of adapting to a new breed of nurse learner caused S.T. to revert to their customary didactic attitude. S.T. did not always speak of learners as "irresponsible juniors" who could not be trusted at all times. There was less of the severe projection of a senior's irresponsible, impulsive, guilt-ridden self onto learners while in School (see Menzies, 1970); this could be due to the fact that S.T. are less exposed to the emotional stress of constant patient contact. But S.T. continued to act and to relate to learners in an old-fashioned authoritative manner which was both a source of amusement and annoyance to many learners. Some learners, however, welcomed the authority, reporting that this was "right" and it gave S.T. their proper status and commanded the learner's respect. However, a significant proportion of learners found differences between the S.T.s' behaviour and their teaching a contradictory experience. While espousing the virtue of innovation, critical attitudes and learning, their manner was authoritative and did not appear to encourage questioning unless it was conducted within teacher-defined rules of acceptability and proper respect. Thus although S.T. may mentally identify with the criteria of thinking individuals their behaviour was observed to actually militate against the achievement of this criteria of essential nursing.

The absence of this criteria being reported by N.O. is located within the traditional disciplinary culture of British nursing, the training of the N.O. themselves within this tradition and the anxiety which can be brought up by an encouragement of a critical mind. The N.O. role is a new one, created only after 1966 and as the Merrison Report (1979) suggests is a

frustrating, ambiguous role which is largely administrative though supposedly clinically bound. This anxiety coupled with the anxiety of ensuring responsible behaviour among nurses and learners under their control could lead to psychological projection onto learners and nurses. But the historical tradition of military discipline was also evident and so was the superior-subordinate relationship. The bureaucratic emphasis on a clear differentiation of status and authority based on supposed differences of experience and training was behaviourally acted out by all the N.O. observed. There was a strong opinion that meritocracy was the foundation of the nursing hierarchy and the possessors of such merit deserved the rewards of authority and respect. This feeling was especially strong in the older N.O. of the N.G.H.

In conclusion, this intermediate layer shows the gradual influence of micro-political negotiations which are of a different order from those which concern senior managers. Lower down the hierarchy service personnel find it more difficult to combat the traditional dominance of the medical profession and sense that the growing emphasis on training and education may threaten their self-image of knowledge and skill. It could also influence their future prospects of promotion. They also have to ensure the efficient functioning of a service often threatened by unpredictable peaks and troughs. Thus at this level, the professional nurse is one who gets on with the practical task of caring and is "reliable". Higher educational qualifications may not make a better nurse but an obedience to authority is clearly viewed as an asset. The textbook value consensus of the professional ideology was empirically observed to be coloured differently by N.O. S.T., on the other hand, were able still to advocate the defining criteria of a patient ethic, specialized training, self-government and distinctive knowledge. In addition, the criteria of learning was put forward but their behaviour did not always encourage this.

10.8.3 Lower Management Constructions of "Good Nursing"

The final strata of interest is that at the ward or classroom level. Here we look at the definitions of professional nursing as propounded by clinical and teaching workers: ward sisters, staff nurses, clinical teachers and nurse tutors. (The word "workers" is used to show that this strata performs direct transformation processes while the support administrative duties of more senior managers are seen as less direct work but not necessarily work which is less influential.)

Appendix 10.12a gives only the response of one ward sister because only one was interviewed on the management questionnaire used and in that context. However, the researcher had previously conducted extensive formal and informal interviews with ward sisters/charge nurses and these results are shown separately in Appendix 10.12b to show that the information was gathered in a different manner. None of the twenty-one ward sisters filled in the management questionnaire. The original management sample had consisted of two ward sisters but one of them found it extremely difficult to meet at suggested times and was finally dropped from the sample. However, we felt significant information was still available to enable a representation of the views of ward sisters and staff nurses. The numbers in this second Appendix show the number of nurses responding in the left-hand column and the weights in the matrix are identical to those used before.

The Appendix shows clearly the sister's definition of a good/professional nurse - that is, somebody who is able to get on with the job at hand. Common sense was said to be a virtue by nine of the twenty-one qualified nurses and weights of 5 were given. The comments made by sisters included:

> "Common sense is essential, the nurse has to act swiftly and competently." Sister, Southern District, May, 1980.

> "The most important quality is a sense of urgency, of getting on with the work. Most nurses are too slow and this is disastrous on a busy surgical ward." Sister, Southern District, May, 1980.

> "Look at Nurse X. She's really good - always finds something on a ward

while all the others are just loitering. A nurse must get on with the work." Staff Nurse, Northern District, July, 1980.

This emphasis on common sense was matched by an equal de-emphasis on the importance of educational qualifications. Most sisters believed that graduate nurses lacked common sense. The only sister to argue that graduate nursing was vital was a night sister who was herself a graduate in English and Philosophy. The comments by ward sisters/charge nurses about educational standards included

"The School and the profession as a whole is asking for too many academic qualifications. These are not really very necessary. I find postgraduate nurses to be worse practical nurses. They find it difficult to pick things up." Sister, Southern District, May, 1980.

"Academic qualifications are not good enough. It is not right that a postgraduate with a degree in Music or Architecture can be granted a shortened course. They have not done a relevant degree. They should not be allowed to take a shorter course. Sister, Southern District, May, 1980.

"A good nurse does not have to be too clever. O levels, A levels and degrees from university are not essential." Sister, Northern District, July, 1980.

"Academic qualifications are not very essential for good nursing. Postgraduates are not usually practical minded and their training is too short. One male postgraduate I know is good-hearted and cannot do practical things." Sister, Southern District, May, 1980.

"Learners now are appalling. They have no respect for authority and no idea of their place in the team. They have a glorified view of nursing and will not do any dirty work. When I started training I spent three months cleaning the sluice. These learners nowadays are too academic-minded. Cleaning the sluice was not an auxiliary's job - everybody had to 'muck in' and work. There is no discipline nowadays." Sister, Southern District, May, 1980.

However, ward sisters felt that a good nurse should be "adaptive". By this they meant that nurses and learners should be able to cope with the work load irrespective of the number of available staff and patients. If the ward was quiet learners should still learn to "get on with the work" and when it was busy they should "get on with it faster". The sister's notion of adaptability also implied that situations were often not "ideal" and quite different from hypothetical situations taught in School. Learners were reported to be taught only one ideal method of doing things, a certain definite method. But on a ward, learners had to learn to adapt those methods to available

resources. This notion of adaptability was tied to adaptability of technique and to workload.

The results also apparently show a definite shift from the senior management emphasis on the maintenance of symbolic rules. The answers showed that none of the ward sisters mentioned the word "professionalism" as the hallmark of a good nurse. However only four out of twenty-one nurses felt that the use of Christian names for patients was "all right" and not a sign of "unprofessional behaviour". All the other seventeen nurses felt that Christian names for patients should not be used in clinical areas. The reasons given implied that Christian names would make it difficult for patients to relate to themselves as detached, uniformed symbols of care. The ward sisters seemed anxious to avoid an over-identification with patients and were observably concerned with what Menzies has called a depersonalization of the nurse-patient relationship. In addition, nineteen out of the twenty-one sisters and charge nurses felt that Christian names between learners and ward sisters were inappropriate, threatened the requisite psychological distance between a junior and a senior and showed a mark of disrespect. The use of Christian names was thus clearly interpreted as one of maintaining emotional distance and control over patients and learners. Unlike senior management who tended to use the term "professionalism" in a vague mystifying manner, ward sisters were more open as to their feelings for the symbolic rules laid down by senior management.

The wearing of uniform was also felt to be important and to be necessary in putting the nurse in a de-individualized role of a nurse. One ward sister commented:

> "You feel different when you put on that uniform. You behave differently because you know you are a sister." Ward Sister, Southern District, May, 1980.

The sisters did not have a strong view on the wearing of jewellery but most felt it would not be practical and could hamper the work of a nurse.

On all three issues of respectability and legitimacy, ward sisters in fact agreed with the beliefs of senior management but only one of the sisters used

the word "professionalism" to describe this set of behavioural prescriptions. Their preferences were clearly stated in terms of:

(a) the practicality of physically nursing patients;

(b) the necessity to psychologically distance the nurse from the patient and the learner; and

(c) the necessity to control the behaviour of learners and patients.

The senior management concern for "professionalism" was now firmly re-interpreted in terms of pragmatism and a desire to maintain control and psychological distance. Whilst senior managers were concerned with the morality of the nurse-patient relationship, ward sisters were concerned with the requirements for control and emotional stability.

The four trends observed in the answers of ward sisters and charge nurses indicate that at this level of the service hierarchy professional/good nursing is first and foremost within the sister's image of efficient caring - not the learner's image of caring efficiency. The sister's concern for both "common sense" and "adaptability" in the good nurse are but surface manifestations of a deeper work ethic: the "work" has to be done, the patients have to be "serviced" irrespective of the number of staff available or the amount of workload required. This emphasis on "getting the work done" was in turn based on an assumption that there was always a high workload, i.e. "work" to be done and/or insufficient staff to complete the work in a leisurely manner. Hence good nurses had to have "common sense" and to be "adaptive" in order to complete the work.

Ward observations, however, revealed two important insights. Firstly, ward activities were not constantly physically demanding. During a twenty-four hour working day, the period of greatest physical activity was in the morning and after 1.00 p.m. the pace of work slackened significantly. Night duty was, however, more variable and there were no predictable periods of activity and inactivity. During a five-day working week, there could also be considerable variations in the number of patients on a ward and their required degree of

nursing care. Out of the two months of participant observation, the researcher experienced one working week on an acute surgical ward which was light in workload and at least one day on each of the other working weeks which was light. A light workload was gauged subjectively by the researcher and factors taken into account were the number of staff on duty, the nursing condition of the patients, the amount of time during which ward staff could engage in "casual" conversation among themselves and the amount of time during which the researcher was called to help with the work. The research quoted before by Moores (1979b) shows that the availability of ward staff and patient workload varies considerably with peaks and troughs. Though the precise occurrence of such peaks and troughs were unpredictable, it was predictable that peaks and troughs in both staffing and workload would occur. In other words, ward activities were not always physically demanding and nurses were not constantly "rushed". The first impression given by the sister's work value was not matched by subsequent ward observations.

Secondly, "work" was always interpreted as physical activity, it was always a procedure or intervention which had to be performed for or on a patient. Work was thus equated with the performance of certain observable tasks which necessitated action or movement. Within this definition of work fell acts like writing up a patient's record, giving a bath or drugs, changing a dressing, giving an injection, removing stitches, changing a "drip", feeding, dressing the dead. This physical definition of work was clearly illustrated on the ward. An eighty year old woman constantly called for nurses but when approached was found not to require "anything" by which was meant she required no physical intervention. The nurses and learners soon realized that Annie did not want anything, she just wanted attention. Gradually, nurses and learners alike learnt to ignore some of these calls as they knew she did not require physical care. Only once in a while would they approach the patient, when her calls became too incessant and disturbed both the nurses' and other patients' peace of mind. In all these acts of care, the nurse was a specific

task-performer. What then was not "work"? The most consistent examples of this was the category of talking to patients. This act of communication with patients usually took place when a nurse was performing a task for the patient. Also there was an unspoken and taken-for-granted rule on all six acute surgical and medical wards that the tasks were to be performed first and then as one staff nurse puts it - "We encourage our nurses to talk to the patients". In other words, a nurse or a learner would not in general initiate a conversation with a patient unless she had finished her prescribed list of duties and tasks; and "there was nothing else to do." The performance of tasks was always a first priority and communication acts unprompted by task performance was clearly a second.

There was also evidence that nurses/learners who did not have many physical tasks to perform often felt stress that stemmed from a reported sense of boredom, inactivity, frustration and guilt. This was especially highlighted on working days when the physical workload was light and nurses theoretically had a great deal of time to talk to patients. Whilst more nurse-patient interaction was observed on some occasions, nurses often complained then of "having nothing to do". Most nurses stated that they preferred the ward to be "busy" and occupied as the activity made "time pass much faster". Learners made the following comments about "work":

> "I like it much much better when it's busy. Look at us now, all having nothing to do. I'm so bored. Everytime there is something to do, everybody rushes to do it." Second year S.R.N., July, 1980.

> "There are too many of us on. The second and third years always take the more interesting bits to do and we are left with the boring jobs. When there are fewer of us, I get more interesting procedures to do." First Year S.E.N., July, 1980.

> "I prefer to work the morning than the evening shift. It's too quiet for me in the afternoon. Nothing much on." Second year R.S.C.N., September, 1980.

When there was less ward activity, sisters often made the following remarks to the researcher:

> "This is not normal, you know. You've just come on a quiet spell. Usually we are much more busy." Sister, Northern District, July, 1980.

> "This is just one of those days. Usually the ward is very full and there's lots going on." Sister, Southern District, September, 1980.

> "There's not much for you to do now. Why don't you go home early. There's nothing much to see and write down in your little book." Staff Nurse, Northern District, July, 1980.

> "You see, yesterday was just one of those things. Today we have a full ward of twenty-eight patients. There were four admissions last night and a few this morning."

Not only were there feelings of boredom among learners and expressions of defensiveness among sisters, there was also some evidence that the latter disapproved of too much "hanging around with nothing to do except talk to the patients". One staff nurse on a surgical ward commented:

> "There is always something to do on a ward. Look at Nurse Frank. She is sorting out the new medical supplies and rearranging the cupboards. Always show initiative. Look at the other nurses, all sitting at the end talking. Actually we don't like nurses to sit on a bed and talk to patients. Much better to stand up. But a nurse shouldn't spend too much time just talking to patients, there's always work to be done." Staff Nurse, Northern District, July, 1980.

Learners also reported that not only did they find "having nothing to do" boring but they felt that they preferred and sisters liked them to be busy. Their reported preference and sister's demands for busi-ness led learners to engage in activities which were either less task-oriented or more domestic in nature. Non-work activities consisted of voluntary communication acts with patients or domestically-oriented task activities which helped to make the ward neat and tidy. Examples include re-organizing medical supplies, tidying up patients' beds and pillows which ostensibly made them more comfortable, washing up utensils in the kitchen, even watching television in the day-room with patients.

These observations showed that the sister's creation of a busy ward which constantly demanded learner common sense and adaptability was a social construction which had historical, institutional and psychological roots. Historically, nursing had been seen as a vocational duty with a strong emphasis on service to the sick and needy. This service ethic was manifested in Nightingale's efforts in the Crimea, reaffirmed by the "lady nurses" who trained under her instruction, provided an invaluable help to Britain during

the World Wars, helped promote the State registration of nurses and has been proclaimed ever since as a hallmark of nurses and as a means to professional status. Nurses are therefore painted as being constantly engaged, as indeed they often are, in the dramatic and busy battle to preserve life. They are depicted as having an important function to perform in society. But society has often overworked and underpaid them and the long hours worked by nurses are constantly cited in wage demands and bargaining. Thus, the stage for a dedicated, selfless busi-ness has long been set and relates to the historical social conditions which shaped nursing. In addition, as Abel-Smith (1960) records, a nurse's training has always been pragmatically-oriented. Nurses were taught to do and not to think and nursing theory was very much a phenomena after the Second World War. This emphasis on doing has been perpetuated by a pre-1974 system of nurse training which amalgamated the practical and theoretical aspects of nursing, but with the stress on the former.

In addition, the traditional allocation of tasks gave some basis for a creation of busi-ness. Extra nurses were invariably required for the morning as there was always "so much to do". This scheduling of nursing duties in the morning stemmed from the old practice of cleaning all patients in time for the Matron's and doctor's rounds in the morning. Although the former or his/her equivalent no longer goes on an inspection tour of the hospital, the latter still conducts rounds with students. Where doctors do conduct rounds in the morning, efforts are made to ensure that their patients are cleaned and ready for examination. In addition, all patients were said to like being bathed first thing in the morning. The S.G.H. had in fact instituted a rule that patients should be washed briefly in the morning and bathed later as and when they desired and when more time was available. This rule was conveniently "forgotten" by ward staff. Hence, all patients on the observed wards were given either bedbaths or "big baths" in the morning; all beds were made and the ward made to look tidy. This concentration of physical

tasks in the morning did create a necessity for more than the average number of staff and it was a "busy" time. The traditional allocation of staff to night duty was also another source of the myth of busi-ness. A traditional shortage of nurses who would be willing to work night-duty, a slowness in the early days to realize that patients could need as much attention during the night as during the day and a reduction in nursing duties when patients are asleep have all contributed to a traditionally lower allocation of staff on night duty. Often, the amount of finance approved for night-duty establishment is far below that for day. This means that when there is a full occupancy rate on a ward and patients are acutely ill, the night nursing staff are forced to be "very busy". A persistence of such traditions and habits in the face of changing conditions in turn reflects the military discipline, pragmatism and anxiety which characterises nursing and nurse training. These phenomena encourage a nurse to cling to old habits and traditional ways of performing her duties. In addition, the swift structural changes in the last twenty years have furthered encouraged an individual tendency to create stability to counter change and stress induced by change.

There are also psychological reasons why ward sisters and charge nurses like to construct the workplace as a busy situation where doing practical tasks is all-important. Menzies (1970) argued that busi-ness is often an outward projection of inner anxiety that the nurse is not doing enough for the patient under her care. Anxiety stems from emotional and physical contact with patients which Menzies argues arouses strong sexual and libidinal forces which hark back to phantasy situations in childhood and which are negatively dealt with by psychological avoidance and projection. Nurses who experience such emotional primal desires feel guilty and deal with the anxiety by performing tasks which are routinised. These tasks assure the nurse that she is doing her best for the patient and the fact that they are rule-bound ensures confidence that she/he is performing the "correct" procedure. Further, physical tasks give a tangible and an observable result and aid in keeping a

psychological distance from the patient. Tasks enable a nurse to do, not to think or to talk about the problems of the patient. A projection of a nurse's impulsive, irresponsible self onto her/his juniors and learners ensures a perpetration of this task-orientation because sisters seek to ensure that "irresponsible juniors" should carry out procedures correctly and safely. Like doctors, nurses are aware that mistakes on their part can be fatal and given the rationale of Western nursing, which is rooted in a preservation of life, the fear of mistakes is reinforced.

These historical and psychological reasons help explain why ward sisters and charge nurses define "work" primarily in terms of physical tasks, depict the ward as a constantly "busy" workplace and consequently value the nurse learner who gets on with the job and displays common sense and adaptive behaviour.

The ward sister's disdain for educational qualifications again reflects issues of control with historical and psychological sources. The work of Abel-Smith (1960) shows that although the educational standard of nursing was rising after the Second World War, there were indications that in the 1950's nursing was still recruiting learners with lower educational standards than other occupational groups like teachers. The Briggs Report (1972) notes that formal educational standards at entry for those on the general parts of the register rose between 1963/64 and 1969/70 in England and Wales: the proportion with more than three O levels was 13.6% in 1963/64 and 58.1% in 1969/70. Most pupil nurses, however, had lower qualifications. A study done by the Research Unit of the G.N.C. for England and Wales (quoted in the Briggs Report, 1972) showed that in 1970/71 most entrants to pupil nurse training in England and Wales had no formal educational qualifications from school and only 11% had two or more O level passes. Further information in the Briggs Report

indicates that more than 59% of student learners would not have been admitted had the minimum number of O levels required been five in 1970/71. This may be compared with the 28% who would not have been admitted had the minimum level been set at two O levels. This suggests that student nurses who qualified in the mid-70's were nurses who on average possessed three O levels. This national picture may not have been identical to the structure at Mayfield in the early and Mid-70's and detailed data was not collected on the educational standards of learners then or on the standards of ward sisters and charge nurses currently in post. However, we do know that the minimum educational standard for learners in 1979/80 at Mayfield was five O levels and that in the past the minimum had been set at three and four. There were also suggestions that this minimum would be increased in 1982 to six O levels and preference would be given to learners with A levels.

The Briggs Report shows that in 1970/71 of the initial entrants to student nurse training in England and Wales 94% of the male entrants and 88% of the female entrants had no A levels, 2.3% and 4.7% respectively had two and only 1.4% and 3% respectively had more than two. Only 1,654 out of 14,195 entrants in England and Wales had any A levels. Yet by 1980 Mayfield was able to set as a policy rule that learners with A levels were to be given preference subject to other criteria being met. In addition, the number of graduates entering nursing nationally and at Mayfield was increasing.

These data on educational standards may be compared with the fact that out of the twenty-one ward sisters and charge nurses interviewed, only one possessed a degree and none of the rest possessed five or more O levels. In the words of one sister:

> "I wouldn't be a nurse if I trained nowadays. To be honest, I can't get into training here. I haven't got enough O levels and they are asking for goodness knows how many." Sister, Southern District, May, 1980.

This self-knowledge of lower educational qualifications, the emphasis on pragmatism and the necessity for an authority relationship between ward sisters and learners are part of the reason why this strata of the service hierarchy

is unsupportive of the larger "professional" drive for higher educational qualifications. A nurse, so they reported, needs to be practical-minded, not to be clever (just in case he/she is cleverer than the sister). On the other hand, the ward sisters believed that specialized training was necessary for nursing and that their occupation did encompass a distinctive body of skills. The emphasis, however, was more on practical skills than theoretical knowledge. There was widespread agreement among twenty out of the twenty-one ward sisters that practical, efficient care was primary to academic theorizing. However, their emphasis on pragmatic execution of skills was not totally devoid of any notion of care. A significant proportion of ward sisters also reported that a good nurse had to care as well as be practical in their caring. This concept of care was much in the traditional nurturance line of interpretation and examples were often given by ward sisters of good, practical nurses who really "looked after" patients but did not possess formal qualifications. The qualities of a nurse who was a reliable "mother surrogate" were felt to be just as often found in people who did not possess good qualifications. Ward sisters therefore tended to identify nursing partly with skills and partly with basic, essential bedside care. The stress on nurturance, on providing comfort and help paralleled their emphasis on pragmatism.

Finally, there was much evidence to show that authority and power relationships with learners, nurse teachers, patients and doctors played a major role in this strata's definition of good nursing. Mention has already been made above of the implicit fear of ward sisters that learners who are better qualified educationally may question their basis of authority and experience. This fear is aroused because the service hierarchy is officially based on the ideas of knowledge and merit. A sister's authority is legitimated within the hierarchy by her longer period of experience and supposed expertise. Once this characteristic was removed, sisters feared that learners would no longer follow their orders. Thus a ward sister had to maintain her defining character of experience and expertise which legitimated her authority to demand

a following of his/her orders. In addition, not following orders would have been a punishable offence in a different age and within a related occupation. The tradition of military discipline which would have characterized more the sister's training meant that when they were learners they were taught to obey and do, not to question and think. Consequently they would demand the same degree of respect and discipline from learners whom they could project psychologically as being irresponsible and impusive and as requiring greater rule and monitoring.

Where a learner is perceived as an educational threat to the ward sister or he/she frequently questions the reasons and bases for action, ward sisters possess several strategies of control. One is the use of the assessment ward report which is compiled by the nurse in charge and given to the learner at the end of her period of training on a specific ward. This report was often a subject of criticism from both learners and sisters alike; the former complained of the lateness of feedback and the latter of the subjectiveness of the report. Learners who were considered to be disrespectful of authority or over self-confident were often classified on the report as not showing a professional manner to peers and senior staff. This report would then be forwarded to the educational sub-system and adverse comments such as these were invariably further discussed by the teachers. Learners reported that considerable pressure could be put on a learner for unsatisfactory behaviour. Also officially a learner could face disciplinary procedure if three consecutive ward reports were considered of an unsatisfactory standard. Another form of control was a "counselling" session held between the sister, possibly with the N.O. and the learner. These were essentially sessions where learners were advised that behaviour was unsatisfactory and superior hierarchical pressure was applied to effect a conformity to rules for professional behaviour. Non-conforming learners were also labelled as "cocky" or over "self-confident" people who did not show respect for their superiors and who did not possess self-discipline.*

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* An example of the power and authority of ward sisters was encountered in our construction of the scale PROFORN. One item which read - "Even though a learner may tend to feel that a certain criticism by a ward sister, staff nurse or clinical instructor isn't really justified, she should willingly accept it remembering that such a person has much more knowledge and experience than she." had to be deleted from the scale. Theoretically learners should disagree . . .

It was interesting to note that ward sisters often blamed the educational sub-system for a fall in disciplinary standards. Seven out of twenty-one ward sisters/charge nurses felt that the fall in standards was due to practices initiated in School and carried forward to the clinical situation. All seven of these ward sisters came from the Southern District. Comments made included the following:

> "Learners are now appalling. They have no respect for authority and no idea of their place in the team."
>
> "I don't like learners to call me by my Christian name. This means a sign of no respect."
>
> "Besides being out of date, the School is far too lenient and liberal these days. The School seems weighted on the side of the learner and the learner is always right. The tutors do not seem impartial. In School learners are treated as equals but on the job they need to conform to rules and policies.
>
> "There is too much liberality and standards are lower. Nurses need to be disciplined. Christian names in clinical areas are not proper. Surnames should be used in School and uniform worn in all practical sessions. This makes nurses behave like nurses. Learners are not taught to be nurses in School.
>
> "The questioning attitude is important in learners as long as it is done in the right manner at a right time. Learners seem far more confident and they questioned more than we used to."
>
> "In general learners nowadays do not seem to respect authority and are more cheeky. They do not seem to have been taught etiquette and manners in School - quite unlike our own training. They have a different attitude to sisters and half of them do not think we are doing useful things.
>
> "Learners are now more outspoken, more willing to ask questions - unlike my training days when we used to be very afraid of the Sister. I also notice that learners like to use Christian names nowadays - a habit they pick up from School. I myself prefer to use surnames as it seems more professional." All quotes from sisters of the southern District, May, 1980.

This tendency to apportion blame to the educational sub-system reflects the strong hostility between the two functional sub-systems, the constant negotiation for control of the learner's experience and training and the widespread awareness among nurses that the professional myth of expertise and training is an important means of power and privilege. Once that educational monopoly is lost to a separate

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. . . with the statement which shows the difficulty learners have in confronting seniors. Although ward sisters may perceive learners as being more questioning, learners certainly appear to perceive that direct confrontation with their superiors is still not organizationally acceptable.

functional group conflict is inevitable as each sub-group accuses the other of inadequate training. The service strata at this level marshalls accusations of a fall in discipline whilst senior service management rile against a decline in professionalism. Counter-accusations are made by the educational sub-system of the persistence of "tunnel vision", "anti-intellectual myopia" and exploitation of the learner as a unit of labour per se.

The desire of sisters to ensure conformity and to enforce an authority relationship also explains why sisters/charge nurses are not willing for learners to call them by their Christian names. A proper distance was felt to be necessary in order that respect could be maintained. Only one sister felt that she did not mind learners calling her by her Christian name and a second sister reported that the use of Christian names did not earn or take away respect. Respect for a sister and her authority, she felt, should be obtained by a demonstrable higher level of experience, expertise and an ability to manage the ward activities to the effective care of patients. These views were, however in the minority and most sisters felt that respect for authority and discipline were essential for nurses. The quotes already given by ward sisters showed many of them felt that conformity to rules and discipline were important. Nursing was felt to be such a vital occupation, dealing with life and death, that discipline was important and necessary. In effect, the military discipline introduced by the early Victorian nurses was being perpetuated and legitimated in terms of the Western ethic of the primacy of the nurse's role in preserving life. Because a nurse was involved with such grave matters she had to have discipline. Such discipline, of course, also eases the problem of control of a large labour force by superiors who do not necessarily possess exceptional educational qualifications and whose level of expert training is difficult to determine. A desire to care for the patient and an equal desire to impose authority encourages the ward sister to insist on respect and self-discipline.

Yet patients not only have to be cared for, serviced but controlled. Authority relationships with patients are seldom discussed in the professional

nursing literature but have been the subject of some research among medical sociologists (see Rosenthal et al, 1980; Lorber, 1975; Stockwell, 1972; McIntosh, 1977). Rosenthal et al (1980) in particular used Goffman's (1961) ethnomethodological approach and the negotiated order theory of Strauss et al (1963) to argue that the efforts of nurses and patients to mutually control one another "do not occur separately but are played out in interaction between the various parties concerning specific events or issues." (p. 51).

Patients are conceived as problems by nurses for a number of reasons. Ideally, from the nurse's perspective, all patients should be sick when they enter the hospital, should follow eagerly and exactly the therapy set up by expert staff, should be pleasant, uncomplaining, fit into the hospital routine and should leave the hospital "cured", "better" and grateful. As Lorber (1975) and Jeffrey (1979) found good patients handle their illnesses well, are co-operative, as cheerful as possible, comply with treatment, provide the staff with all the relevant information, follow the rules, and do not disrupt the ward or demand special privileges and excessive attention. Few, if any, patients approach the simplistic ideal described above. And patients are labelled as unpopular when they do not match this ideal in a significant way. Lorber (1975) categorised problem patients into "forgivable" and "wilful" categories. Rosenthal et al (1980) devised eight types - unpleasant, seeking to control treatment, manipulative, non-compliant, habitual and inappropriate, low pain threshold, violent and confused, manipulative and demanding. The control strategies used included avoidance, putting blame on the doctors, psychological consultation, discussion at nurse's meetings, annoyance and anger. Not all these strategies were observed because team meetings among nursing and medical staff, during which a management plan is agreed, occur far less often. Only one ward observed had such meetings and these occurred only once a week, with only the sister present. However, frequent discussion (informal) amongst doctors and nurses did take place.

Detailed discussions about control strategies and relationships per se will not be discussed here but are used to disentangle the meaning of professional/good nursing behaviour adopted by ward sisters.

The first obvious observation is that the very categorization of "good" and "bad" patients is itself an important dimension of definitions of good nursing. For it clearly indicates that to have favourite patients, and to have bad patients are not signs of unprofessional behaviour. Indeed there was an unspoken, taken for granted, assumption that to have unpopular patients was *natural*.* It was part of the complexity of being human, of possessing likes and preferences. Nurses often reported that favourite patients and their implicit corollory, unpopular patients, were "facts of life", to be expected. Indeed not to have favourite patients would have been *unnatural*. The natural order of social life was thus evoked as an explanation for the existence of unpopular patients. (In fact nurses seldom talked of "unpopular" patients but they freely admitted to the existence of "favourite" patients.) This reliance on "nature" and on the "natural, human order" as explanations were in fact similar to the explanations evoked by medical practitioners prior to the scientific development of Western medicine and persist today in certain alternative forms of medical therapy and in Eastern philosophies. Another method of explaining the existence of unpopular patients was the evocation of the "best interests" rule, that is, nurses being professionals and experts are the best judge of what is good for the patient. Patients become unpopular because they do not realize that nurses always seek to intervene in order that the "greatest happiness of the greater number" can be realized. Patients do not always know what is in their best interests and hence they "interfere" with a nurse's better judgment and greater experience. Such intereference "naturally" antagonises the busy nurse and leads inevitably to a "natural"

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* When the scale PROBS was being constructed for questionnairing of learners, one item which related to favourite patients had to be deleted from the scale which further corroborates our argument that participants within the system do not see favourite patients and unpopular patients as categories created by themselves in an unprofessional way. The scale was seeking to measure the extent of systemic professional behaviour and it was predicted that a preference for certain patients would be a sign of unprofessional behaviour. However, most learners agreed instead of disagreed with the item which therefore did not correlate well with other items in the scale.

categorization of patients. A third route to reconciliation is to evoke the *individual* needs of a patient. Because each patient is a unique individual he/she must needs be treated differently. If he is "nice", he is treated as a "nice" patient but if he is "unpleasant", then he is treated as an "unpleasant" patient. The principle of individualized patient care is thus sometimes used to justify a differential treatment for patients who are liked and those who are not. Fourthly, the principle of equal treatment for all patients is often felt by nurses to have been provided by the very fact that under a State-financed health structure all patients and potential patients supposedly have an equal opportunity to avail themselves of health and nursing care. On that basis, each patient enters a ward on an equal basis and it is sufficient that the average patient should appear to have this egalitarian treatment and have stood at least a chance of being a "deserving" patient. All patients, as it were, start on a common basis of equal attractiveness; should inequalities of treatment occur these are felt not to be arbitrary but the logical, natural consequence of different personal drives and personalities.

This dimension of professional nursing is clearly in contradiction with the service ethic of the notion of professionalism propounded in the academic literature and by interest groups such as the educational personnel and senior management. For this notion paints a picture of the nurse as a compassionate but dispassionate, concerned but disinterested, caring but objective dispenser of care who treated all patients as individuals in a free and equal manner. As Larson (1977) points out one of the earliest components of professional ideology was the ideal of universal service to "all of mankind." Professionals have always sought to project an image of democratic classlessness and of free access to their services. This is especially true of nurses who have evoked the vocational aspects of nursing from its very beginning. Yet nurses knew that they did treat patients differently. Patients who were unpopular were given the minimum amount of a nurse's time and were frequently avoided or isolated in a side-ward. On the other hand, favourite patients were

visited and given a good deal of attention and encouragement. And the essential difference between the treatment of popular and unpopular patients was generally the amount of psycho-social care given.

The four methods utilized by nurses to reconcile this contradiction have already been discussed. In effect, these rationalizations for behaviour seek to disguise the central negotiations which exist between nurses and patients. Little publicity is given in "professional" literature such as "The Nursing Mirror" or "The Nursing Times" to such matters and instead constant visibility is given to the vocational, service ethic of professionals. Larson (1977) further argues that these actions contribute to a professional ideology in the Marxist sense and serve to buttress capitalist forces and relations of production. These issues will be discussed in later chapters and we move now to consider another facet of the many which make up the ward sister/qualified nurse construction of good nursing.

The necessity for maintaining control over patients and the deep anxieties which may be aroused by frequent contact with death and suffering call for two other behavioural critieria. Firstly, learners are often told (usually by senior learners) to control their emotions, to maintain a distinct psychological distance from patients and to keep "a stiff upper lip" at times of sorrow. Surprisingly, even first-year learners soon learnt this self-preservation strategy of keeping a detachment from patients; such detachment being created by the standardization of uniform and procedure and a minimization of the amount of time spent discussing a patient's psychological and emotional problems. When the researcher first worked on the wards, she was surprised at the amount of time actually available for learners and nurses to talk with patients. Prior to ward observation, the impression given had been that time pressure made it difficult to talk to patients. Yet when opportunities were observed to arise, nurses and learners preferred to talk among themselves on subjects which were clearly of common interest e.g. their social activities, examinations, favourite television programmes, fashion, etc. It was suggested

that part of the difficulty of communicating with patients could be a "generation" or age-gap such that topics of common interest were more difficult to find. However, no quantitative counts were made of the type and quality of patient-nurse communication between patients of different ages. Nevertheless, older, distressed patients and their families were often felt by learners to be beyond their coping capacity. The following four situations were observed:

(a) A male patient in his late thirties had been tragically involved in an accident which resulted in severe brain damage. The patient was completely bed bound, had lost all cognitive abilities and could not perform any physical functions. Feeding was a severe problem and swallowing extremely difficult. The patient was nursed every day by his mother whom nurses often labelled a nuisance and a "pain in the neck". One day, after a particular distressful time during which the patient constantly vomitted all the food fed by his mother and had wet himself, the mother broke down in tears. A second-year S.R.N. learner who was nearby apparently did not notice her distress though clearly within earshot of her sobs. Eventually the learner turned to the researcher and said she did not know what to do. She looked round quickly for an older and more senior nurse but none was on the small ward. The researcher refused to "help" and eventually the learner moved to comfort the mother although she was clearly apprehensive. Afterwards she confided that she had been at a loss and felt inadequate.

(b) A woman in her sixties always came alone to visit her husband who was dying from brain cancer and was semi-conscious. On five consecutive days, only two nurses approached her briefly and talked to her during the length of her visiting time. For most of the time she sat completely alone and tried to talk to her husband who could not reply.

(c) A sixty year old female patient started to cry because she was worried about her husband and home. The learner who was nearby quickly

went to fetch the sister-in-charge to deal with the patient. She felt unable to comfort the patient herself.

(d) A forty year old patient who had been a former sister had had an operation which was intended to remove a malignant stomach tumour. However, the removal part of the operation did not take place as surgeons found her illness was too advanced. All the qualified nurses and learners knew this and they felt the patient knew as well. However, none of the nurses dared talk about the matter with the patient and there were clear signs of awkwardness. Nurses tended to avoid the patient and seldom asked how she felt, presuming that any forthcoming answer was bound to be depressing.

These four instances show the stress which nurses do encounter and partially explain the desire for emotional detachment. Yet they also show that such avoidance of stress can lead to a neglect of the emotional needs of both patient and nurse. Despite this most nurses and learners were observed to seek a considerable degree of detachment. Although the necessity of acquiring such a degree of "professional" detachment was seldom explicated by ward sisters, their behaviour and that of nurses and senior learners more generally demonstrated that detachment was felt to be important. As one learner put it:

> "You can't really take things too seriously. Because if you do, you just get all cut up. When I first started nursing I really cared for one lad in children's. When he died from leukaemia I cried back at the nurses' home." Second Year SEN, Northern District, July 1980.

It was also interesting to note that none of the twenty-one ward sisters/charge nurses brought up the subject of nurse-patient relationships which were felt to be "morally wrong" or emotionally undesirable. The desire to create detachment was not often seen as a means of avoiding romantic relationships and neither was the idea of symbolic rules such as surnames and uniform. The former appeared more connected with an avoidance of anxiety and the latter with social control of learners and patients.

A final facet of the good nurse was "firmness". This was particularly important, so it appears, when a nurse is dealing with a non-compliant, violent

patient who is not acting in his best interests. Firmness and the ability to use one's expert authority was felt to be necessary and the nurse often "had to be cruel to be kind." Two instances may be cited to illustrate what the sisters meant:

(a) A woman in her mid-sixties had had a hip operation and it was important that she exercised and walked as much as possible. However, she frequently complained of pain and fatigue and when sometimes instructed to walk tended to rely heavily on help from two learners. Constant sitting down also meant that the patient was developing bed sores on her lower back and buttocks. Thus despite constant encouragement by learners the patient was not progressing and eventually sister took over the task of making her walk. Instead of coaxing gently, she ordered the patient to walk to the toilet unaided knowing that the patient would be embarrassed if she wet herself in the middle of the ward. Similarly she refused to help the patient much although the latter often stated that she was about to fall and hurt herself. And with her brand of expert judgment and firmness the patient made much better progress.

(b) A man in his late twenties had been admitted for a minor medical complaint. The patient was a known "social problem" and had attempted suicide several times. He lived in an unhygeinic social welfare hostel and consequently was infested with lice. An unpleasant bath with a de-lousing solution was ordered but he refused to take the bath arguing that it was pointless since the minute he went back to the hostel he would be dirty again. His logic was not accepted by the staff nurse who tried repeatedly to make him agree with her logic that whilst he was in hospital he should be clean in order to avoid infecting other patients. The staff nurse found it difficult to persuade the patient and eventually after some effort and time had been spent in the middle of a busy morning, she visibly toughened and ordered him to take a bath. Her tone of voice changed and her manner

was more abrupt. He was going to have a bath whether he liked it or not and she cut short her conversation with the patient. In the end, the patient was bathed albeit reluctantly.

These two anecdotes show that the ward sisters needed a certain degree of authority in order to "control"the welfare of both the individual patient and other patients. Without the ascription of legitimate and expert authority the patient would not have obeyed and arguably his health and that of others around him would be disturbed. However, such firmness can lead to a regressive treatment of adult patients as children. There were numerous instances when the nurse-patient relationship resembled that between a mother and her naughty child and patients were "punished" for not having taken their medication or followed a nurse's precise orders. One particular patient was "scolded" for hiding uneaten food in his locker drawer and smoking illicitly in the patients' toilet. Such examples of maternal control are clearly more easy to apply when the patient is perceived by both himself and the nurse as being unable to judge his best interests and as needing the expert guidance and advice of a professional. A patient is by definition a reliant, depending unit who is unable to manage his/her health. And "firmness" thus have positive as well as regressive facets.

Earlier we had discussed reasons why ward sisters did not think educational qualifications were important for the good nurse. They tended to have a nurturance image of the nurse and most of them did not share senior management's view that education and research were important in gaining independence from the medical dominance of health care. Sisters appeared not to be concerned about the power of the medical profession and when opinions were volunteered most sisters reported that their consultants generally treated them with respect and only "upstart housemen" were a nuisance at times. They no longer tailored their activities around the doctor's rounds and reported that since there could be more than one round in a shift, doctors were often left to their own devices in examining their patients. The impression given was

that at their level, there were few problems with medical staff and they, the sisters, no longer "rolled out the red carpet for the consultant."

These opinions seemed to indicate that ward sisters were independent authorities on the ward and suggested that the structural reforms within nursing in the last twenty-five years had been successful in diminishing medical dominance. However, these opinions seemed to contradict academic theorizing and empirical evidence. For instance, Rosenthal et al (1980) state boldly that:

> "Nurses are subordinate to doctors in the hospital hierarchy, and this affects their ability to deal with problem patients and the strategies they employ to accommodate this discrepancy in authority."
> (p. 51, Rosenthal et al, 1980.)

and

> "With the exception of patients, no group feels more keenly the effects of the physician's superordinate status than do nurses, for while the work of other occupational groups cannot be initiated without the agreement of the physician, the work of nurses is mandated by their position with respect to the physician." (p. 53, Rosenthal et al, 1980.)

Mauksch (1971) too refers to the nurse as both the *delegate* of the hospital administrator (a bureaucratic job) and the *deputy* of the physician:

> "The cure process places the nurse (primarily the head nurse but also the staff nurse) into direct contact with the multitude of physicians who maintain their own relationships with a vast number of patients . . . she also acts as representative for the frequently absent physician . . ."
> (p. 128, Mauksch, 1971.)

And Krause (1971) summarizes the contemporary subordinate situation of the nurse thus:

> "The primary experience of the nurse in the health field is one of legally defined marginality, blocked upward mobility in the health hierarchy, and institutionalized second-class citizenry." (p. 122, Krause, 1971.)

Besides this, one traditional but persistent aspect of the definition of the nurse's role has been to emphasize the performance of functions specifically delegated to the nurse by the physician (see Bates, 1970; Krause, 1971; Freidson, 1970). Finally Larson (1977) implies that unionization among nurses may now be a contemporary route to greater self-autonomy; since no amount of externally sanctioned expertise can compensate for the subordination of

auxiliary medical/health care professions, unionization remains as feasible a choice for nurses as further professionalization. She also argues that doctors did not secure their command over nurses until the large hospital and especially the university teaching hospital had become the institutional centre of modern medicine. The creation of large bureaucratic centres for care led to the increasing power of the hospital administrator over administrative affairs and the doctors thus reinforced their monopoly over technical matters of care and cure. The status granted to links between medical consultants and the university further enhanced their prestige within the hospital framework.

These various forms of evidence suggested that the sister's lack of an insistence on self-autonomy and government were highly problematic. Ward observations showed some of the reasons why sisters did not emphasize the necessity for "professional" nurses to be self-governing. Firstly, our ward observations concurred with the evidence of earlier research and revealed that important details of patient care were entirely within the physician's domain. The admission and discharge of patients could only be performed by the doctor, so was the control of information about the state of the patient's health. Nurses could not reveal details of a patient's health without prior consent of the doctor. In fact it was usually the doctors who dictated when and what to disclose. Certain procedures which were fairly common could only be performed by doctors such as the taking of blood samples or the changing of blood packs used in transfusion. The prescription of medical treatment has long been the province of the doctor and nurses could not administer any such medication unless it had been officially authorized by the doctor. Although a sister could be consulted on her opinion as to certain matters, the ultimate authority lay with the doctors. At times sisters were heard to remark that one had to make suggestions tactfully so as not to "step on the consultant's toes". Like the proverbial good secretary who corrected her boss's errors without him realizing it; some sisters felt they had usually to make a suggestion sound

as though it had originated naturally from the consultant. In effect, sisters accepted the authority of consultants and worked instead within the constraints of that acceptance. This was most clearly demonstrated in the sister's attitude towards doctor's rounds. Prior interviews had suggested that this did not overly influence ward activities yet our observations on six wards revealed that the consultant's round was a matter of everyday significance. The sister on each ward was always careful to accompany the consultant on his rounds and activities were always organized so she could do this without being distracted with other concerns. There was always an air of expectancy on a ward when the round was to begin and this was heightened by the physical symbolic significance of a crowd of medical students, house officers and the registrar. In addition, sisters were invariably strict about which learner could accompany the consultant on his rounds. Normally only third year S.R.N.s were allowed to do so and the researcher's request to follow the round was met on two wards with some reluctance. Learners who accompanied the round invariably followed respectfully behind the bevy of doctors and listened dutifully. Too much chattering was met almost immediately by a glare from sister.

Sisters then generally accepted their secondary role and there were few active attempts to assert their independence. Where problems did arise, sisters only complained among themselves about the inefficiencies and inadequacies of doctors but few complaints were heard about the consultants who were involved with a particular ward.

Not only did sisters and charge nurses accept their secondary role, some found the consultant's and doctor's political power and authority invaluable. Mention has already been made of sisters who relied on a consultant's authority to secure equipment and even staffing resources. In addition, a consultant may be relied upon where a sister wishes to breach hospital regulations because she feels it is in the best interests of a patient. This was illustrated in the sister who secured her consultant's approval for having a baby on an

acute surgical ward and the baby did stay on the ward despite senior nurse management and hospital administrative disapproval. Also, doctors are relied upon to help control unpopular and difficult patients. Rosenthal et al (1980) give examples whereby nurses and doctors mutually agree on a management plan to counter problem patients. We give but one example of the way in which medical power is accepted and used by nurses to control patients:

(a) The patient previously discussed as being infested with lice continued to be non-compliant and "unco-operative". He refused to obey orders from nurses, was abusive, used socially unacceptable language and constantly demanded for his discharge. All these acts were reported (as was their duty) by nurses to the doctors in charge and it was additionally made clear to them that the patient "was creating trouble for the nurses." Clearly the sister in charge was seeking help from her medical superiors in her efforts to control the patient, although she was never heard to press for his discharge. The patient was indeed allowed to discharge voluntarily and the doctors were heard to comment that he had been a problem to the nursing staff and was "not worth having in hospital."

A few days later the patient was back in hospital but was on a different medical ward. He had attempted to commit suicide unsuccessfully. This acceptance and reliance on the power of the medical profession helps explain why ward sisters did not conceive the professional nurse as somebody who could relate "on equal terms to professionals of related disciplines."

To summarize then, we see that definitions of good/professional nursing by lower-level participants who are in direct contact with patients are multi-faceted: good nurses are described as people who possess common-sense, can work hard, be adaptive, need not be educationally well-qualified, be respectful and well-disciplined, detached, firm. Each of these facets was seen to be related to historical, institutional and psychological processes of control and negotiations among principal participant groups.

We come now to analyse the meanings ascribed to good nursing by teaching members of the educational sub-system. Appendix 10.12 shows that all the four tutors and clinical teachers agreed with senior management staff as to the importance of a desire to care for people. The primary requirement of a good nurse was thus the service ethic, the patient ideal. As noted, this service ideal underlies the early Victorian notion that nursing is a religious vocation, a calling. It also underlies the contemporary belief that nurses find intrinsic value in their work. In other words, nurses enter nursing primarily because they derive personal satisfaction and a sense of social value from their occupation and not because of extrinsic rewards such as commercial gain, economic status or even social prestige. That this belief is supported by some empirical evidence is shown in the work of Simpson (1979) and our own data on the reported motivation of learners who come into nursing. As Appendix 10.5 showed, a majority of learners, irrespective of year of training and grade reported that their primary motivation for entry was a "desire to care and help people". Finally, the service ethic also implies that patients are treated "equally and democratically" although allowance must also be made for important individual differences.

All these three ideas behind the notion of a service ideal were constantly and consistently reaffirmed in the experiences of the learner whilst he/she was in the educational sub-system. Within the first week of the introductory course all learners were taught the basic principles of individualized patient care and the nursing process. From the very first lectures, the patient-as-individual was the common theme of subjects like "Nursing Psychology" and "Nursing Ethics". However, the latter also emphasized that the nurse was to treat all patients equally irrespective of "colour, creed or race". Nursing care was to be democratically dispensed and not subject to obvious prejudices and forms of discrimination. One tutor in particular even mentioned the Marxist concept of "embourgeoisement" although neither its complex meaning nor its critical implications were clear to himself or his students. Nevertheless, great

emphasis was laid on treating all patients alike irrespective of their class background, their sex, race and accent. In addition, learners were also enjoined to show deep dedication to their patients and to maintain the "great" nursing traditions of high standards and self-sacrifice in the "care of mankind." The comfort and welfare of the patient was preached as the nurse's prime concern; it even took precedence over the nurse's own problems and difficulties. Tutors were heard to recall their own personal nursing experiences and occasions during which they had to suppress their own frustration and put on a "smiling face" because "patients already had enough problems of their own". Self-denial was as important and perhaps synonymous with dedication to the patient.

However, whilst tutors spoke of maintaining a "desire" to care, ward sisters had spoken of an "ability to care". The former spoke of motivation as an important criteria of a good nurse, the latter of actualized motivation - ability. This difference in emphasis has its origins once again in the location of the two groups within the everyday care of patients. Tutors are necessarily more removed from the operational issues of managing a ward of acutely-ill patients and of coping with both a teaching as well as a work relationship with the learner. They therefore find it easier to speak in more conceptual terms about the requirements of a good nurse. In addition, it is likely that educational staff also unconsciously contextualized their own role. Most tutors stressed that whilst skills and techniques were teachable up to a point, motivation was necessarily an intrinsic, personal, well-nigh unteachable characteristic of a learner. As teachers they were able to impart knowledge to willing listeners and learners but reported that their contribution to the creation of a good nurse was severely restricted if learners did not show an innate desire to care. Most teachers therefore appeared to subscribe to a new version of the old maxim - "Nurses are born not made"; "Nurses can only be made if they desire to be made." Nurses still seemed to require an element of inborn or self-bred desire to care for sick people; were this element to be missing, the opinion of tutors was that these nurses

could not be taught to be good nurses. This stress on motivation and especially on the "unteachable" aspect of motivation in effect allows tutorial staff to exploit traditional motivational theory to their advantage. For it gives a tutor a justifiable reason or excuse whenever a learner fails to make good after repeated attempts of help, teaching and counsel. Since motivation is a matter for the learner to acquire and not for the teacher to impart, the failure of a learner to be so motivated cannot be "blamed" on the teacher. Most teachers appeared genuinely convinced that such a desire to care had to be a stable, intrinsic characteristic of the learner. And in fact they ignored much academic literature in mainstream organization theory which had sought to devise ways of motivating employees to greater productivity. Whether such an ignorance is intentional or unintentional is not a point of debate here. The point we wish to make is that the net result of such a conception of their role was a teaching emphasis which was more on the skills and techniques of nursing than on devising means of inculcating a desire to care. The primary means, if one could call it that, was to apply hierarchical pressure in the form of warnings or low marks in order to prod learners to show greater caution in their treatment of patients. There was little teaching time spent on diagnosing the reasons for a lack of "proper motivation" and of conceptualizing their teaching role in a more positive way. But the difficulty of instilling a sense of motivation is again due to the lack of clinical involvement of the average tutor. Unless a learner is able to "see" and to experience an example of caring motivation it is unlikely that they will be so motivated themselves. It is perhaps the very difficulty of teaching "a desire to care" given the present structure of nurse training which encourages teachers to assume a priori that motivation is unteachable.

Earlier we had observed that during introductory courses learners were continually taught to care primarily for the patient. In so doing tutors openly cautioned learners that differences between School and hospital practice were to be expected. However, such differences were often reported to be due to

"uncontrollable" factors such as a shortage of staff or physical differences between the hospitals. For instance, the S.G.H. employed ward assistants who recorded a patient's preferences for meals and food was dished out and collected by these same orderlies. At the N.G.H. it was learners who held the responsibility for dishing out and collecting food and they had to monitor carefully patients who were not eating well. The tutors often used such differences to illustrate differences in operations but commonality of purpose for even at the S.G.H. ultimate responsibility for the monitoring of a patient's diet was held by the nurse, not by the ward assistant. The point often stressed by tutors was that in School it was only possible to teach the "principles of care" and any given set of principles could give rise to a number of different procedures and tasks. Thus although "things could be different on a ward" and procedures carried out in a different manner, the final objective was always the same - the care and comfort of the patient. This teaching philosophy was often used as a defence against frequent learner complaint that ward practice bore little relationship to School teaching and that the latter was unrealistic and irrelevant. From the tutor's perspective, it was because learners could not understand the meaning of "principles" as distinct from procedures that accusations of idealism arose. In addition, tutors felt that "a lack of time" was more often used as an excuse for inefficient, haphazard and lazy standards of care. They defended their concept of idealism by arguing that idealism, meaning ideal standards, should constantly be the objective of the good nurse. He/she should constantly strive to achieve these standards although staff shortages may occur and should not adopt "slapdash methods". Clearly, tutors felt that the procedures they taught were practical feasibilities rather than utopian ideals which were outside the grasp of an average nurse working with the facilities known to be available.

In believing that such procedures were feasible tutors often encouraged learners to discuss with ward staff specific instances of differences in practice which were in the learner's opinion indicative of a poor standard of

care. Learners were, however, to choose an appropriate time to initiate such discussions and were requested to do so in a "tactful, diplomatic manner". Interviews with learners indicated that such questioning was rarely undertaken on a ward for fear of being labelled negatively and of obtaining low marks on their ward reports. Nevertheless, this tutorial encouragement to question ward practice and legitimated authority shows that within the educational sub-system there is a relatively more flexible authority relationship between tutors and learners. Here these two participant groups are not in a direct employment contract and there is relatively less necessity to impose a strong bureaucratic authority on learners. In addition, the cultural milieu of this sub-system did seek to promote a spirit of critical inquiry among its learners. The mean scores on some climate scales reveal the strength of learner perceptions. The mean scores for LPDSCH and LPDW (Leader Psychological Distance) were 3.1 and 3.5 respectively; and those for QASCH and QAW (Questioning Authority) were 2.7 and 3.2 respectively. These show that learners did perceive the educational sub-system as being more open to questions and to argument. Indeed, four members of the educational sub-system had put as one of their criteria of a good nurse - a creative, evaluative, critical person. One of these was the Assistant Director, two were Senior Tutors and one was a Tutor. Earlier it had been argued that although more senior tutorial staff had recorded these criteria as important that in fact their actions often prevented the creation of creativity. At the tutorial level fewer tutors and clinical teachers recorded this criteria but these were often the very teachers who were more open to learners and who were perceived as being less authoritative in their manner. In effect, by being lower down in the organizational hierarchy, with less authority to "lose" if questioned and found wanting, these tutors and clinical teachers were able to encourage questions from learners. They could "afford" in a psychological sense to encourage critical evaluation since disciplinary procedures were always initiated at the senior tutor rather than tutor level. They had less of a need to control learners

who were, in their eyes, delinquent and correspondingly had less of a need to erect a psychological barrier between the learner and the teacher.

It was interesting to note that tutors and clinical tutors were the only people within the educational hierarchy who stressed the importance of a sense of humour. This is in effect a unique insight into the importance of humour and laughter as a means of alleviating anxiety and psychological stress. We argue that such an insight could only arise because this strata of the hierarchy is closer than other parts of the educational sub-system to the practical everyday life of ward activity. Yet why then did ward sisters not mention this criteria? Of the members of the service hierarchy who reported this criteria one was a Divisional N.O. in her forties, a S.N.O. in her forties and a N.O. in her early thirties. This composition may be compared with the members of the educational hierarchy who responded: a tutor who was forty, a clinical tutor in her early thirties and a clinical tutor in her late forties. We argue that a realization of the importance of humour was not reported by ward sisters because of their preoccupation with physical care and their desire to "get the work done". A work ethic which itself is rooted in traditional poor scheduling of ward activities and a neglect of the psychological and social aspects of care. Such a neglect could be related to age and emotional maturity. All the twenty-one ward sisters interviewed were in their late twenties bar three. This relative age gap between ward sisters and older, more emotionally stable members of the service and teaching parts of the system could help account for the results shown in Appendix 10.12. Because ward sisters are less inclined to or have less time for extensive psycho-social care or are unable emotionally to handle such aspects of care every day, they could be unaware of the importance of humour and laughter in social negotiations to maintain emotional equilibrium. Humour is necessarily a psychological tool and has often been shown to be of significance in social interaction. As early as 1969 Emerson argued that humour is often used in complex negotiations which in effect constitute private agreements to suspend general guidelines

of interaction and thus has crucial significance for the stabilizing or subverting of social order. Goffman (1959) too points out that joking provides a useful channel for covert communication on taboo topics or on topics which are of doubtful propriety. Laughter is also important in relieving stressful situations where for example pain is an inevitable part of that situation. Two instances of the various uses to which laughter can be put are given from our observations:

(a) A group of learners were gathered round a male patient who had to be packed with a surgical dressing in order that a rectal abscess would heal properly. This always caused great pain for the patient. Three of the learners watching the procedure winced physically with the patient and two turned their heads away when the pain on the patient's face proved stressful. The atmosphere behind the drawn curtains was exceptionally tense and it affected all the learners. At the end the nurse patted the patient and said:

"That wasn't too bad, was it?"

Patient: "Not too bad! You must be joking!"

All the learners then laughed and the atmosphere immediately became less tense. The learners were more relaxed as curtains were pulled back.

(b) An extremely large woman had had one of her breasts removed in a mastectomy. She was 4' 11'' tall but weighed fifteen stones. She was thus practically impossible to lift even though two learners were involved. In addition, her wound did not heal properly and leaked a highly odorous fluid which stained her clothes. The patient often joked both about her weight and her wound:

Patient: "Don't bother to lift me. Too heavy, eh? Never mind, just push me and I'll shift myself up . . . like this, see."

Nurse smiles in response at her (sic) agility.

Patient: "Phew, what a pong! Don't I smell."

Nurse smiles again in response.

Patient: "This hospital is going to run out of clothes soon! You see this liquid, it doesn't go into the bottle but flows all over this bandage."

Nurse: Never mind, we can afford these new clothes."

These observations are similar to the ones reported by Goffman (1959), Emerson (1969), Olesen and Whittaker (1968) and Coser (1960). They serve to illustrate that laughter is a versatile psychological means of negotiation in tricky, stressful forms of communicative interaction. And it is for these reasons that a sense of humour was felt by tutorial and senior service staff to be an important criteria of a good nurse. Realizing the stressful nature of their occupation, these participants know the importance of being able to laugh off or laugh at a problem in order to externalize it. As one tutor put it:

> "If you don't laugh, you'd cry; especially if you see some of these mentally handicapped children." Clinical Tutor, Southern District, May, 1980.

Given the relatively less amount of time spent on a ward by these tutors and clinical instructors, it was nevertheless somewhat surprising that they were able to grasp the psychological function of laughter. However, as argued, it is perhaps precisely this relative infrequency, the willingness to see a patient's psychological issues because one does not confront these in every-day work and the growing awareness in nurse education of the importance of psychological and sociological insights that tutors and clinical teachers are able to name a sense of humour as a requirement for a good nurse.

The appendix also shows that this strata of the educational hierarchy is less concerned with symbols of "professionalism" as defined by senior management (both service and educational). None of the tutors or clinical teachers mentioned the word and their behaviour whilst teaching was less rigid about issues of legitimation. They accepted the policy of the School that uniform need not be

worn in classes, did not report anxiety about learners calling them by their Christian names and were unconcerned about learners wearing jewellery or make-up in School. All four interviewed felt that these symbols did not reflect that "disciplinary standards" were dropping or were low. However, they did feel that such rules might be necessary in clinical situations where a nurse needed to be "in control" of herself and her patients. Their views in fact afforded further empirical support for our contention that such symbols and their meanings are inherently related to control issues of participants within the system. Where the necessity for such control is less, there is correspondingly less of a need to rely on symbols of "proper behaviour".

Nurse tutors and clinical teachers did comment that "doctors and nurses were always fighting" but they showed less of a concern for the nursing profession to be more independent and self-governing. The issue of autonomy which had elicited strong responses from senior management which formed the boundary between the individual micro-organization and the substantial environment produced only lukewarm support from lower level participants. For them the issues were more embedded in the everyday work of teaching and of ensuring that learners did pass their examinations and adopted safe methods of care. However, this strata like all other strata within the nurse training system agreed that nursing could be developed into a distinct body of skills and knowledge. Being in the sub-system ostensibly set up to train nurses in a systematic way, one could hardly have expected them to report otherwise. However, one clinical teacher did report reservations about the number of O and A levels now being requested for entry into specialized training. She was not entirely sure that such a basis for selection was appropriate for a caring occupation such as nursing. It is interesting to note that only one tutor required "intelligence" from the good nurse. Her definition of intelligence was, however, closer to the notion of adaptability than academic excellence. It would appear therefore that this strata, on the whole, appears to share a little of the ward sister's doubts about the role of educational qualifications

in good nursing. Both service and educational personnel at this lower end of their respective hierarchies are more directly involved with the bedside care of patients rather than the administrative support of such care. Being less involved with major negotiation with other interest groups, e.g. the medical profession, they are less concerned with the political and social status of nurses as a collective body. Their concerns are more restricted and their control problems are similarly restricted to battles within a limited arena. Thus it becomes more difficult to see the connection between good O or A levels and a high standard of direct care. Whilst such results may bear some relationship to political adroitness it is not always easy to see a simple relationship with an ability to care.

10.9 Conclusion

We have now finished the hermeneutical or interpretative project which we set out at the end of chapter 8: to locate meanings of effectiveness within their historical, institutional and individual control problematics. To this purpose we have analysed the significance of turnover information, the relative insignificance of absence data and the various meanings of "professional" nursing. The notions of adaptability and innovativeness at the individual level were seen by some participants as facets of "professional" or good nursing and adaptability took on meanings which reflected their particular concerns. We have sought to locate these criteria of organizational and individual effectiveness within their social practices and their constitutive meanings in order to make sense of and to demonstrate reasons for why a particular act was performed and a particular belief held. By social practices we mean the rules which logically constitute the very possibility of a particular action being said to occur, which is to say that without the presence of those rules there can be no action of a certain type. Rules refer to expectations of the members of a social group as to what performances are appropriate in a certain situation which itself is definable by means of these rules. Rules refer, therefore, to all socially recognized procedures and standard identifications of situations. For example, without knowing the rules of senior management, we would not know that a nurse with pink hair and strong perfume is acting "unprofessionally". Without knowing the origins of nursing as an identifiable group, we would not be able to understand the insistence on "discipline", on respect for authority. Indeed we would not know what constitutes a breach of discipline or a mark of disrespect. These social rules set the larger context of an action or belief and constitute what Fay (1975) calls the public evidence for *verstehen* explanations. By constitutive meanings, on the other hand, we mean all those shared assumptions, definitions and conceptions which structure the world under analysis in given definite ways (hence meanings), and which constitute the logical possibility of the existence of a given social practice, i.e.

without them the practice as defined could not exist (hence constitutive).

It is only because actors share certain basic conceptions that there can be certain types of social action. For example, the social practice of strict discipline can only occur given the shared constitutive meanings of (say) some conception of best patient care, the notion that in enforcing strict procedural limits some form of maximization of patient welfare will be accomplished.

Not only have we sought to locate organizational effectiveness criteria within these social practices and constitutive meanings we have also tried to relate these practices and meanings to one another and to the concept of control - defined in the sense of ensuring behavioural conformity with one's expectations. The purpose of doing this is to discover the purpose a social practice, action, belief has in a specific society, to see how it fosters the aims and satisfies the needs of the social actors as they themselves define them. This has meant that the researcher comes to terms with the culture's conception of human needs and purposes, which is to say that he must attempt to grasp the ideas which a certain culture has about the importance which carrying out certain activities have for a man, its ideas about the sense of human life and what is significant for living it.

By attempting to set criteria of organizational effectiveness as social constructions we have elucidated, though vaguely, some of the basic notions which particular social actors show about the world, society and human nature. By basic notions, we refer to the meanings ascribed to the actor's conception of nursing work, their views on human nature and the essence thereof, their ideas about authority, about the primacy of life and its preservation, about their conceptions of masculinity and femininity in relation to nursing care and so on. In revealing these, the researchers have sought to perform the hermeneutical task of explaining a given social order by articulating the conceptual scheme that defines reality in certain ways, and in terms of which the actions that he views makes sense. We have attempted to create a world of

ritual and rules of these nurses in uniform. We admit that our interpretations and our construction of their world-picture is necessarily filtered and value-based. However, as the next chapter will indicate this does not necessarily mean that such insights and forms of knowledge have no epistemic status and should not count as knowledge.

There are two other instances where we have departed from the tradition of previous interpretative studies (cf. Douglas, 1967; Goffman, 1961) for we have attempted not just to elucidate meanings and reasons for the holding of certain beliefs but the historical and structural conditions which give rise to these actions, rules and beliefs. In particular, we have sought to study the relationships between the structural elements of nursing and their quasi-causal relationships with the rise and dominance of particular meanings. We have sought to explore the complex interplay of social, economic, political, micro-organizational and individual factors which influence social practices and meanings.

Secondly, we have sought to give not only explanations for the existence of certain behaviour but the non-existence of other forms of behaviour. Unlike the traditional anthropologist who desires to give explanations as to why certain practices exist, we devote considerable attention to why practices and certain types of information systems do not exist, as for example, detailed absence reporting systems. In addition, we have been less bound by the interpretative stress on analysing the intentions of social actors and have posited the effects of unintended consequences of action. We have also analysed events which appear to be pure coincidence or due to chance. These research strategies were undertaken in order to enrich our hermeneutical understanding of the social collectivity without at the same time being bound unnecessarily by traditions of past phenomenologists. Despite these strategies, however, hermeneutics offers but a partial explanation of social behaviour and we set out in the next chapter to devise a more comprehensive theory of organizational effectiveness.

Chapter 11: Towards a Critical, Integrated Theory of Organizational Effectiveness

11.0 A Recap

In Chapters 1 - 5 we have argued that theories about social and human behaviour need to be integrated such that we obtain not only empirically-grounded insights but also hermeneutical and critical knowledge. Thus theories of organizational evaluation and of accountability, by being concerned with the effects of collective action need to be integrated frameworks. Indeed, it is a measure of the entrenched position of technical rationality in social science that the act of organizational evaluation has for so long avoided a critical function. It was also argued that the act of evaluation per se was not inherently ideological, that much depends on the manner and purpose of evaluation. An integrated theory of O.E. was developed based on Habermas's concepts of enlightenment and emancipation, concepts which themselves are anticipated in the structure of speech itself.

In Chapter 8 we set out an extended theory of the F-set which tried to avoid specific weaknesses which were apparent at the technical level of understanding. We sought to extend the F-set by situating the problem of O.E. definition within a hermeneutical framework of meanings and regimes of visibility which are rooted in power relations, both micro and macro. Our use of hermeneutics was again different from a traditional hermeneutical methodology and we attempted to overcome the criticisms levelled against mainstream hermeneutics. Thus, at each strata of knowledge we sought to extend and to enrich. Nevertheless, as it stands, the evidence cited in Chapter 10 fails to constitute an integrated, critical theory of O.E. which has a radicalized facet. Though we have opened a debate about the criteria of effectiveness which were technically defined and show that in the

empirical situation such criteria were subject to interpretations, popularity and neglect, we have not indicated a way forward. At this moment we are left with a question - "And So?"

This chapter thus seeks to achieve several purposes:

a) to critically examine the weaknesses of our empirical theory set out in Chapter 8 and to highlight the limitations of the insights given in Chapter 10;

b) to develop an integrated theory of organizational effectiveness;

and c) to illustrate the model with empirical evidence drawn from our specific research situation - nurse training.

11.1 The Weaknesses of a Technical, Hermeneutical Theory of O.E.: A Self-Critique

In order to better understand an integrated theory of O.E. we begin with a critical evaluation of the assumptions with which we ended Chapter 8. Each of these, in effect, represents a criticism of the ideas of the CF-set (Constrained F-set; Tinker, 1975) and of our extensions of the F-set.

Firstly, the theory assumes that the market for alternative employment opportunities is perfect and participants are free to move between coalitions. The words 'perfect' and 'free' are used in the sense that if and when a participant does not receive adequate benefits through participation in an organization, he/she is able to withdraw and join alternative coalitions. Hence the continuing survival of the organization indicates that it is continually able to satisfy the minimum level of needs of the participants. This formulation of a minimal level of satisfaction, which is defined with reference to alternative opportunities is slightly less problematic when it is defined with reference to the long-run. This latter extension does help ensure that should socio-economic conditions change in the long-run such that greater alternative employment opportunities persist, the absolute level of

participant satisfaction in any one coalition could be increased. And if society were to follow the developmental logic set up by Habermas, our extensions of the F-set would have been sufficient to ensure that effective organizations were also emancipatory places. However, as Habermas himself points out historical factors play a mediating role in a society's development and his developmental logic is but an ideal representation of the possibilities for societal development.

As it stands, the F-set, by adopting a relativistic definition of need-satisfaction ignores imperfections in the market for opportunities such that an absolute lack of alternatives might persist in the long-run and regretful, unhappy actors are acquiesced into accepting their present level of need-satisfaction. Indeed, it fails to offer any critique of the relations which constitute a market for opportunities, of the relations of production, of the relations of power which ensure that opportunities are structured, classified and placed in a particular hierarchical order. It fails to question the distribution of access to such opportunities and therefore appears to conservatively accept societal relations, whether they be relations of domination, as they are. But such relations necessarily influence what is available, feasible, acceptable. These terms, like Habermas's concept of surplus repression cannot be defined independent of a societal context of history; that which is 'acceptable' is so only within the expectations and demands of a particular historical matrix, of particular relations between individuals and groups. Whilst our extensions do incorporate a consideration of micro- and macro-relations of power and domination, such an analysis, nevertheless, does not point to a clear normative way forward. We may demonstrate that the sister, in struggling to control both patients and learners in a certain way adopt particular criteria of effective behaviour. But what then? Do we logically proceed to suggest that the sister change her behaviour, or the patients' or learners'? What

is 'wrong' if indeed it is, with sister creating certain rules of behaviour which may be negotiated constantly with different patients? What is 'wrong' with sister telling us what we need? The ideas of a CF-set ignored power and thereby implied one of three possibilities:

a) that it is not significant in analysing corporate behaviour,

or b) that it does not persist often enough (which harks back to (a)),

or c) that power is so pluralistically distributed that unsatisfied needs would lead to an intrinsically unstable system.

The ideas of an extended F-set avoided these three possibilities but brought with themselves their own control difficulty: on what basis could change from an identified network of domination proceed? Having said all that we have said about the struggles and conflicts between shifting coalitions and the meanings employed, what do we say about the fighting per se? Should it go on in its present form, undergo a mutation or stop altogether?

Secondly, it was argued that the concept of essential participants possesses a theoretical ambiguity. By ignoring power relations, Tinker (1975) was able to depict in his diagrammatic four-leaved clover an organization with four equal participant groups, all of which were necessary and sufficient. But what happens when some groups are more necessary than others? Who defines, anyway, who is necessary and sufficient and who is not? The theoretician, the actors collectively or one actor? Whilst the concept of 'necessary and sufficient' participants has a neat, mathematical precision, it does not withstand closer scrutiny and evaluation. This criticism is closely related to the third - that of failing to analyse conflict and change because the ideas are geared towards an explanation of order and stability. Whilst Tinker (1975) and Tinker & Lowe (1977) do attempt to incorporate change in the ideas of a Jumpy F-set, there is little which is explained and analysed. Changes in alternative opportunities 'happen', this causes the "eggmen" to "dance" and to reconsider their

conditions for participation. But how and why do these changes arise? What specific effects does it have on participation and production? Why does a non-feasible solution sometimes develop? In what conditions do we obtain a larger F-set than in others? Incorporating the notion of "jumpiness" does little to analyse change, conflict and discontinuities in the development of an F-set.

Finally, as has been hinted at earlier, the F-set and the CF-set ignore the possibilities of ideological false consciousness masking an actor's real interests, i.e. those which he would seek in an ideal speech situation. An ideology is false in the sense that actors accept a situation or set of norms which in essence contradicts their underlying epistemic principle of only accepting a norm as legitimate when it is made and applied in an unconstrained way. The only reason why they accept such norms is because they are living in a repressed and dominated manner. The Frankfurt School postulates a variety of circumstances in which critique is essential, among these being situations where actors are a) consciously contented and unconciously dissatisfied; or b) consciously and unconsciously contented. Even in such societies or historical situations where there are no manifest signs of discontent, on the contrary, where there are expressed signs of satisfaction, critique can reveal sources of domination which prevent an achievement of man's potential. Critique is required in order to prevent a world of "happy and contented slaves" - the nightmare of total ideological and physical domination by specific groups in society.

In addition, in this chapter we shall explore the relation between ideology (false consciousness) and psychological, as well as sociological effects and co-relations of such ideology. Ideology is argued to pervade not only societal relations, as for example, that between the providers of capital and of labour power, that between males and females; but also the

psychological state of man as an individual and a body corporate. False consciousness may be associated with neurotic, regressed or psychotic disorders which are projected outwards such that what Jaques (1955) calls social defence systems are created and perpetuated. In effect, ideology pervades not only societal relations, but psychological constructions of reality. Neither of these sets of effects is analysed by the F-set as presently constituted.

These four sets of criticisms which are made against the theory of O.E. set out in Chapter 8 are but concrete illustrations of the more general difficulties with theories of O.E. and of social phenomena which are located at the technical and hermeneutical levels of interest. These general issues have already been discussed in detail in Chapters 4 and 5. Co-existing with these specific epistemological difficulties, are particular issues which concern the research methodology used and the empirical evidence generated and interpreted to achieve a particular purpose.

The first of these methodological difficulties lies in the choice of criteria of effectiveness. Because we were concerned with maintaining at least a minimal level of need-satisfaction (defined relativistically) in the long-run, we were concerned with the decisions to produce and participate and the level of adaptive capacity of the system. Thus theoretically we derived the following measures of effectiveness: the level of absence, turnover, professional orientation, professional behaviour, adaptability, flexibility and innovativeness. We then attempted to set these theoretical constructs within an empirical network of micro- and macro-power and domination relations and analysed the reasons for particular emphases and meanings given to particular criteria. However, we failed to analyse critically the macro- and micro- relations identified. It is one thing to state that due to the militaristic tradition of nursing and nurse training, conditions of pay are poor and learners leave training; it is another to argue that such discipline

and poor working conditions represent a form of domination which prevent learners from achieving their 'real interests'. Similarly it is possible to point out that struggles between Education and Service lead to a poor co-ordination of nurse training but one can go further by arguing that such an increasing division of labour is a result of increasing rationalization of the labour process and is a direct consequence of the advent of advanced capitalistic relations of production. To point out that 18 year-olds find it difficult to cope with severe psychological problems but nevertheless remain "satisfied" in nursing is one matter. It is another to argue that such a situation stems from capitalistic relations of production, which due to internal contradictions make possible a reserve of unemployed youth and a scarcity of qualified nurses which ensure a reproduction of healthy labour power.

In effect, each of our criteria of effectiveness, if interpreted critically in the spirit of *Ideologiekritik* would reveal quite different insights. A concern with absence and turnover monitoring could be seen as a technical concern with control on behalf of the status quo; as a concern with maintaining what Johnson (1977) calls the "surplus value producing process". Johnson's argument is that in monopoly capitalism, the role of the capitalist is subdivided into frational operations so that the functions associated with the appropriation of surplus value are similarly collectivised into global functions of control, co-ordination and surveillance. Thus, the necessity to monitor absence and turnover in a complex, hierarchical, bureaucratic organization is not then merely the result of the co-operative nature of the labour process determining the co-ordination of the social division of labour. It also involves the function of capital, to the extent that work is controlled and kept under surveillance in respect of the surplus value producing process which is now performed by a large number of agents on behalf of the traditional, single entrepreneur.

A concern with professional norms and standards could similarly be criticised for maintaining an ideology of professionalism - an ideology which masks the 'fact' that professions are monopolies of labour which appropriate a realm of power-knowledge in order to gain social and economic regards for members within the profession. A professional is one who claims to be an expert in his field, possessing extra knowledge which gives him a societally-defined right to judge and evaluate, to define what is necessary and what is not. Further, a professional transacts in privacy with an individual client/patient and such transactions help to further individualize and isolate a person's interaction with others. A process of isolation and division which Foucault argues (1977) forms the first step in producing a disciplined society. Professionalism is essentially a form of labour specialization, of division and of class differentiation.

Clearly, such a view of professionalism and the need to maintain so-called professional norms and standards questions the validity of the latter as a measure of nurse training <u>effectiveness</u>. It would appear that if we were to define effectiveness in this way, we would inadvertently be supporting the ideology of professionalism as presently constituted - a direct result of being concerned with survival at an ideologically-bound minimal level of need-definition and satisfaction. Although the demands of the "environment" and the "community" are supposed to be incorporated in the analysis of the F-set, this is done only within a superficial, conservative manner which limits an analysis of effectiveness effectively at the resolution level of the micro-organizational system and fails to integrate an analysis from higher and lower resolution levels. An emancipatory interest would locate a concern with professionalism as being potentially a source of domination and an object of radical change. It would question the basis on which the nurse wishes to interact, and does interact with a variety of interest groups: the doctors,

patients and leaners.

The concern with adaptive capacity is similarly open to critique. Although not wholly passive in its conceptualization, a concern with adaptive capacity nevertheless tends to ignore a concern with radical and structural change and transformation. The collective coalition is seldom given primacy as an agent or catalyst of radical change. It may be seen as passively adapting to changes which 'happen' or as innovatively creating change but the coalition in mainstream systems theory or contingency applications does not possess a concept of radical change. This is unlike the concept of revolutionary change often provided by Marxists and implied by Habermas and the Frankfurt School. Not only is the organization not seen as an agent of change, but change itself as a phenomenon, is not well-analysed within the framework of the F-set.

In addition, a technical concern with order, stability and long-run survival of the minimal level of need satisfaction tends to ignore relations which may not threaten survival but which in Habermas's terms represent barriers to enlightenment and emancipation. For instance, it is not immediately evident that the F-set analyses the preponderance of females in nursing. Why is a nurse nearly always a woman? Why is she an increasingly young woman with a certain level of "O" and "A" levels? What consequences does this have for the nursing appropriation of patient-care as their domain? Apart from attributing such a situation to historical norms and to changes in social expectations about the role of women, the framework is silent as to its normative direction. It fails to answer questions of the type: Should we, with a vague sense of the "patient's best interests", continue to lower the age of entry into nursing as suggested by the Briggs Report? Should we continue to raise the educational entry requirements of learners? The model as presently constituted can only answer, "Well, it depends on what happens to the environment and the system in the long-run." Surely, such an

answer is inadequate for a critical purpose. Or it may answer "It depends on its effect on the criteria of effectiveness identified; on whether sex has a relationship to absence and turnover etc". This 'boiling-down' of issues to a significance bound by defined technical criteria of effectiveness again raises the critical difficulties of these very criteria which have been outlined earlier.

Not only are sexuality relations an issue which does not fit well in the F-set concept of O.E., it also does not fall neatly within the province of traditional Marxist analysis. The latter too seems unable to fulfill its ambition of being the only 'scientific' mode of critique and radical theory. It is restricted and bound by its insistence on ultimately reducing social analysis to an examination of the economic relations of production. Habermas, who makes some attempt to analyse superstructural phenomena, nevertheless, does not veer far from the Marxist form of analysis. His classification of system crises - economic, political, rationality, legitimation and motivation - may be approximated by the Marxist distinction between base and superstructural phenomena. But as Smart (1981) points out in his discussion of the differences between Foucault's arguments and Marxism, there presently exists a difference between Marxist theory and political policy. In particular, he argues that the events of 1968 in France, Czechoslovakia and elsewhere are placed at the very epicentre of the crisis of Marxism; the emergence of mass movement of people, organized informally or non-bureaucratically, around specific issues, and significantly, arising by themselves outside of the organizations of the Left (e.g. the trade unions and political parties). This rendered problematical the conventional Marxist analysis of class struggle and class alliances. Marxism seemed to have very little to say about these new 'social subjects'. Similarly, Marxism does not co-exist comfortably with studies of feminism and of patriarchy; Hartmann (1979) argues that in some sense there are clear conceptical incompatibilities between the two schemes of analysis. For example, woman as a class is not

identical to Marx's economic basis for the distinction between classes. Despite a theoretical divergence, however, efforts are now being made to integrate Marxist frameworks with patriarchical frameworks of analysis (Eisenstein, 1979) but as Barrett (1980) shows, there remain a number of problems in Marxist feminist analysis that may be irresolvable. Other issues and struggles which are not easily reduced to Marxist analysis include the debates round racism and the possibility of age-conflict or "the generation gap". Such specific, localized issues spring from specific concerns which bear little obvious significance to a Marxist analysis which either begin, or conclude with a consideration of the nature of the economy. Either way the economic rather than for example, the political is considered as effectively determining, and Marxism always proceeds from the economy as determining, even when in its most qualified form it is described as being 'in-the-last-instance'.

But as a growing number of Marxists are beginning to point out, there are theoretical deficiences in Marxist formulations and there are straight-forward omissions from classical Marxist theory. For example, the lack of any developed analysis of a modern capitalist state; the neglect of nation states and nationalism; the failure to analyse the fundamental historical distinction, alluded by Lenin, between Western and Eastern Europe, and the absence of any poitical theory proper in the late Marx. Also, there is the emergence of various new political movements which radically challenge the traditional form of working class politics and its organization in the trade union and party. It is not our intention here to discuss the extent of the 'crises in Marxism'; this has been extensively discussed elsewhere (see, Miliband & Saville, 1979; Anderson, 1976). However, such concerns are important to the extent that they bear upon our endeavour to derive an integrated theory of O.E. Radical social theory and radical politics have lived within the shadow of Marxism for so long that it is difficult to conceive

of another place from which to formulate alternative forms of critique and strategies for social action. Smart (1981) rather cynically argues that the appeal of Marxism has been two-fold: its claim to analyse the world scientifically and its alliance to a plethero of political movements and parties each committed to the implementation of specific and frequently differing interpretations of Marxism's theoretical analysis. This may be an over-statement but if Marxism has ommissions and weaknesses in its argument, then it cannot be, as Marxists claim, the only route to critical knowledge. In building an integrated theory of O.E. we must thus seek to place Marxist critique and its mode of analysis in context and to locate a different basis for critique.

Unlike Foucault, we do not discard entirely the Marxist mode of analysis. In our conceptualization of an integrated theory of O.E., we accord Marxist concepts a place but not a priority in helping to ensure enlightenment and emancipation. The reasons for such a position will become clear in our explication of the framework. For the moment, we emphasize the problem within a technical and hermeneutical theory of O.E. of the choice of criteria of O.E. Such criteria have a potential ideological content which may be neglected.

11.1a A Digression: A Cautionary Tale about Statistical Theory

A second theoretical issue which concerns technical formulations of O.E. is the misuse of statistical analysis. This discussion is entitled a digression because the problem discussed below is not an intrinsic feature of a technical interest in control and prediction. Such an interest does not demand that statistics be used to 'prove' hypotheses. Nor does it directly 'cause' a misuse of statistics. But clearly the widespread use of statistics and of quantitative methods of data-collection and analysis is closely linked with a technical interest in control and prediction. As

Irvine et al (1979) put it:

> "The extensive role social statistics play in the everyday workings of modern society goes hand-in-hand with the portrayal of statistical practice as a purely *technical* matter. Linked to this is the widely-held view of statistical data as a form of knowledge untainted by social values or ideology". (pl, Irvine et al, 1979)

Statistics is thus heavily relied upon in mainstream social science as it possesses an air of objectivity, precision and value-freedom. It is a form of knowledge, of 'proof', which is similar to the kinds of evidence used in the hypothetico-deductive mode of reasoning of the natural sciences. Statistics may not be inherently suspect but its excessive use within mainstream social science has tended to lead to an abuse of statistics.

Here in this section we explain why we rejected extensive multivariate analysis of our empirical data in Chapter 10. We emphasize the inadequacy of present-day statistical theory in confirming complex hypotheses. Second, we discuss the problems which remain even with our careful, limited use of statistics. By so doing we acknowledge the tentativeness of our findings and re-emphasize the necessity of integrated research which does not rely solely on statistical arguments.

The technical model of O.E. set out in Chapter 8 is a multivariate set of relations. However, present-day statistics does not study it as such. For how does one establish simultaneous confidence intervals for the entries in a population contingency table from a sample cross-tabulation for such data? This requires specifying a set of intervals simultaneously for many parameters of a multinomial distribution, but with a single level of confidence for the entire set. As Guttman (1977) points out, this problem concerning proportions is a special case of a general problem: if $X_1, X_2 \ldots X_n$ are n population parameters of a multivariate distribution of mutually dependent variables, define statistics $a_1, b_1, a_2, b_2, \ldots, a_n, b_n$ from a single sample such that, for a given level of confidence α,

$$\text{Prob } (a_1 \leqslant X_1 \leqslant b_1,\ a_2 \leqslant X_2 \leqslant b_2, \ldots\ldots\ldots\ a_n \leqslant X_n \leqslant b_n) = 1 - \alpha$$

and with some optimality condition for choice of the a_i and b_i. Contingency tables are among the commonest forms of observed data yet no solution is known for this problem of theirs. In practice, standard errors are often calculated for separate statistics in such a table, though no one has shown what relevance these have to the problem. The same abuse holds for simultaneous confidence intervals for a set of arithmetic means. Even for normal multivariate distributions, the use of a standard error with each sample mean has not been shown to yield a confidence region for all population means simultaneously. Güttman (1977) points out that it is known how to establish confidence intervals for certain linear and quadratic functions of arithmetical means, but this does not solve the problem of an interval for each mean separately. Similarly, it is not possible to establish simultaneous confidence intervals for the elements of a matrix of correlation coefficients. Our analysis in Chapter 10 relied primarily on an analysis of the correlation matrix but each coefficient could only be looked at in isolation, we were unable to employ simultaneous confidence intervals.

Our statistical analysis in Chapter 10 did not extend much beyond an examination of the correlation matrix, although detailed multivariate analysis was in fact carried out. In addition to correlational analysis, the researcher had attempted 'causal' analysis via stepwise regression and path analysis with 2-stage least squares regression. This multivariate testing of the empirical model set out in Chapter 8 took up several months of research time and was eventually discarded reluctantly but with justifiable reasons. The analysis was discarded with reluctance because it had taken up so much research time and it is mortifying for any researcher to realize that effort has been expended on a mistaken cause. However, it was felt that the analysis was built on flimsy theoretical grounds and added little to theoretical understanding. It provided a false sense of objectivity and failed to analyse

the complex interactions hypothesized in the systemic set of relationships.

As Guttman (1977) succinctly points out, causal analysis does not analyse causes. It offers neither a necessary nor a sufficient empirical condition for the testing of "causality" of relations and does not even define the word 'cause'. Indeed, any such condition, if proposed, would undoubtedly lead to things being "caused" many times over. Stepwise regression, in particular, is a doubtful statistical technique. Mention has already been made of the difficulties of stepwise regression. In addition and more importantly, seeking a simplified regression is presumably for practical use in a new sample. None of the techniques now used for curtailing regression, including the analysis of variance, has any optimal qualities for treating a new sample problem. Also, in some instances simple constant weights for prediction can do better for prediction in a new sample than can the old sample regression coefficients. Furthermore, we had only one sample and replication was beyond the scope of our present study. In the face of this state of inferential ignorance it was felt that a detailed analysis of the structure of the correlation matrix was preferable. The use of stepwise regression would actually have been a confession of theoretical ignorance as to the structure of the correlation matrix. For understanding the data collected and for developing further theoretical insights it was considered better to study the structure of the covariance matrix as a whole. Stepwise regression is at times advocated as a theoretical device for ascertaining 'independent' incremental contributions to a regression. This belief in the norm of orthogonality is also mistaken for orthogonality is created by the statistician in the very use of least squares regression.

In addition, ordinary least-squares regression does not analyse well feedback loops and interactive effects. In our model of Chapter 8, feedback effects between certain groups of predictor variables had been hypothesized

and two-stage least squares regressional analysis was performed in order to account for mutual feedback. This is, in effect, a somewhat crude statistical technique which consists of substituting a variable which is both a predictor and predicted variable with a value that is a linear function of all 'true' predictor variables. Where such mutual feedback loops are common in a system of relationships, i.e. a tightly-coupled system of relations is hypothesized, two-stage least squares may indeed add greater statistical dependence among the set of predictor variables. This is because 'predictors' which are both predictor and predicands are now substituted by values which are linear combinations of the same set of true 'predictor' variables. Some social scientists have evolved a rule of thumb which suggests that unless simple correlations between predictor variables are in the range of 0.8, multicollinearity is not a problem. But how can we theoretically assess the validity of the numbers generated? Exactly how much error is introduced by the very method designed to account for mutual feedback influences?

Correlation does not generally imply causation. This fact has been taught properly for a long time but the square of a Pearson correlation coefficient is often called a coefficient of determination. It is also often erroneously said to express the "proportion" of one variable that is "determined" by the others. Clearly, any variable may have non-zero correlations in many contexts, so the sum of all possible "proportions for determinations" for any given variable is generally infinite. For some strange reason, a coefficient of determination assesses 'causality' or determination whilst a simple correlation coefficient does not. In fact, the squared coefficient is but only the standardized variance of the predicted (or regression) values. Thus, it is theoretically incorrect to claim that the regression is 'good' because it explains a higher proportion of the variance. Guttman (1977) impatiently points out that the proportion of a variance can

never be explained. Neither can a proportion of average deviation, of standard deviation or of any other aspect of dispersion. The word "explanation" in this context, like the coefficient of "determination" has no technical mathematical meaning. Their use merely represents wishful thinking about the relative predictability of a variable in a given context. The use of the R^2 as a measure of the "goodness-of-fit" of a regression model is thus difficult to justify. It does not "prove" causality for causality has already been assumed with the choice of regressional analysis and the particular structure of predictor and predicted variables.

Finally path analysis was also attempted in order to analyse the "direct" and "indirect" causes and explanations for our empirical observations. Path analysis originated in genetics and was an algorithm for calculating genetic variances under certain conditions when the path of inheritance of genes from generation to generation was known. The term "path analysis" has been pre-empted by some researchers for non-genetic use. It now refers to some algebraic calculation for which the "causal paths" do not exist apart from the algebra itself and is without any definition of what is supposed to be transmitted over a path in time. The numbers in "path analysis" now usually represent the standardized or unstandardized regression coefficients which are multiplied in suspect ways in order to evaluate the 'direct' and 'indirect' contributions of a variable to the dependent variable. Hayes' (1977) use of path analysis, for example, fails to mention the fact that his particular method of calculating direct and indirect effects is only true under a particular assumption: equal correlation effects between his independent variables. Hayes (1977) left the relationships among his independent variables as unanalysed correlations which implies that if A and B are independent variables, the associations between A and B, and B and A are identical. Asymmetry is assumed not to exist, neither are feedback, interactive

effects. This made his analysis simpler but less satisfactory in that relations between independent variables may not be symmetrical.

Given these theoretical and inferential difficulties, causal multivariate analysis was eventually discarded and attention focused on the correlation structure instead. Ordinary least-squares regression was used in only one instance - to analyse the relation between learner withdrawal and unemployment. Its use was essentially limited and we did not attempt to extend regression or other forms of "causal analysis" to the complex set of systems - environment relationships. As Ashby (1956) argues, there is only so much information to be gained from a system and more 'sophisticated' forms of statistical analysis may not be the route to greater understanding.

Whilst we may not have abused statistics in our interpretation of the bulk of the data generated in Chapter 10 there are nevertheless inherent ambiguities in some of the techniques used which lead to results which are non-definitive. The first of these is our use of factor analysis to derive measures of supportiveness and to derive systemic measures of adaptive capacity from sub-systemic measures. In the former case, we used 8 climate scales measuring particular characteristics in the educational and service sub-systems; these 16 scale scores were then factor analysed and three systemic measures were obtained - IPHS, CENS and LIBS. In the second instance we obtained measures of ADAP, INNO and FLEX for each sub-system and these were then factor analysed into systemic measures. Scores for each of these newly generated factors were then obtained from precise factor score coefficients which were generated by the statistical package used. Our use of factor analysis is defensible in that the method matched our methodological purpose of obtaining measures of factors which are hypothesized to underlie observable relationships and correlations. Where 'orthogonal' factors are hypothesized,

a varimax rotation was used to obtain a convergent result and where interdependent factors were hypothesized, an oblique relation was used. But as is well-known, an observable structure of correlations may give rise to a number of factor structures whilst a factor structure can only give rise to a unique correlation structure. This means that the factors hypothesized to exist and which were generated may not similarly arise in a different empirical situation. And in the absence of replication across different time periods and in different empirical situations, our findings are tentative at worst and suggestive at best. In addition, we have made an epistemological assumption which is questionably simple - that a systemic characteristic is some linear combination of sub-systemic characteristics. For example, the score for systemic FADAP1 was in fact obtained by a linear sum of the factor score coefficients for ADAPW, ADAPSCH, INNOW, INNOSCH, FLEXW and FLEXSCH. This approach, like that of regression is questionable for it does not allow for possible complex interactions which are multiplicative and synergistic; factor analysis only enables the derivation of factors which are assumed to be a linear function of a set of observable relationships. Theoretically, it is difficult to argue that such a linear situation exists between sub-systemic and systemic characteristics. However, it is equally difficult to demonstrate that such a possibility could not arise. Given the lack of theoretical certainty and the knowledge that our use of factor analysis was not beset with methodological issues of the type which troubled our use of regression, we decided to use the technique. Nevertheless, the assumption remains questionable and is a weakness in our argument which stems from the limitations inherent in factor analysis itself.

Finally, we wish to point out that the use of factor-generated scales to approximate the underlying factor structure is itself problematic. As Kim and Mueller (1978b) point out, these scales do not necessarily bear a good representation of the factors concerned and indeed wide variations have been

found. Nevertheless, there is little to choose between different ways of generating factor scales and this appears to be the only consolation! In short, all methods of creating factor-scales are dubious. But a factor scale is at least less ambiguous than a factor-based scale. The latter is often used in standardized scale construction and is a means of creating greater generality in the use of a scale. But as Nie et al (1975) point out, such scales tend to abstract from a given set of data in a manner which artifically imposes generality where none might exist. However, despite being more accurate and hence more limited than factor-based scales, factor scales are still problematic in not being homomorphisms of the underlying factors. And in possibly not being accurate representations of a probable factor structure they add a further element of uncertainty in the statistics and evidence generated.

The construction of scales to measure a variable is also problematic. In Chapter 10, we used high inter-item correlations as a means of constructing scales. But the indeterminate relation between observed correlational structures and hypothesized factor structures mean that even if all inter-item correlations are positive, this does not necessarily imply the presence of a single common factor. This information is theoretically unable to tell us much about dimensionality. It tells us that all the items have a common range and are associated with one another. But a common range is not a common factor and our scales may not yield a consistent sample reliability coefficient. When calculated from a single trial on a sample, an estimate of a reliability coefficient for the population is generally inconsistent and is usually an underestimate. At least two trials on the same sample are needed to provide a consistent, unbiased estimate of a population reliability coefficient. Our reliability coefficients may thus differ in subsequent studies. However, we decided to rely on them because even if inaccurate, these coefficients would tend to be underestimates of the population parameters. Secondly, unless

replication studies were completed over a long period of time and with a variety of populations, one could still not gain much confidence statistically. A cross-sectional study with several research sites may not have yielded more information than our use of a single sample at a point in time. Besides such detailed psychometic analysis would and could form the central focus of study and we would then have been diverted from a study of O.E. It was thus necessary for us to use scales whose statistical reliability may not be accurate indicators of the population coefficients. However, we do realize and emphasize the tentative nature of our empirical data.

This section has pointed out the indeterminate nature of current statistics and its inability to provide answere to complex social questions. Our aim was not to 'discredit' statistics as a form of knowledge but to illustrate the difficulties faced by mainstream researchers in their attempts to ground 'proof' in statistics. We have also shown why we decided on our particular form of statistical analysis. It is hoped that a greater acknowledgement of the limitations of statistics would enable a more careful use of this branch of knowledge in integrated research. We begin in the next section to set out an integrated theory of organizational assessment.

11.2 A Critical, Integrated Framework for Institutional Evaluation

Our aim here is modest. We do not pretend to present, an unchangeable critical framework which is definitive. Our framework is hopefully a prototype of critical frameworks. A skeletal signpost on perhaps a more substantial guide-book depending on the reader's disposition towards our argument. It is temporary and no doubt will soon be replaced by extended argument. But we hope to have at least helped to create a generation of critical studies in institutional evaluation and in accounting. As much of

the theoretical argument underlying the framework has been discussed in Chapters 4 and 5, this section will in fact be an illustration of a critical theory which provides insights additional to those gained at the technical and hermeneutical levels, drawing its evidence from the Mayfield Nurse Training System.

Following from Habermas's concept of critical self-reflection and his rational reconstruction of the human competence for communication, the first step in evaluation is in identifying the expressed and observable indications of suffering and domination in the organization or institution studied. These signs of dissatisfaction or regretfulness are the initial tracers in an organizational evaluation. However, as Habermas argued, it is not sufficient to either a) take at 'face value' actor dissatisfaction which is manifested or expressed; or b) to limit analysis only to signs of dissatisfaction which are being expressed. This is because through false consciousness, the actors themselves may have interpreted their suffering as being due to certain events and forces. They may then be led to demanding certain forms of strategic action which upon reflection may themselves be ideological. Or the actors may not express visible forms of suffering and may be content, but an integrated evaluation may, nevertheless, reveal relations of power and domination. Thus, an integrated framework begins with either tracers of suffering or contentment, with the human condition of the actors within an organization.

The tracers of suffering/contentment are then analysed with respect to the set of complex relations between the parts of the system which constitute the whole. Relations which make possible the whole, which support it and which themselves are supported and made possible in a symbiotic manner by the whole. For the relation, which is the essence of an organization or any social collectivity is the means whereby power and domination is constituted, transmitted and effected. Power relations do not and cannot exist outside

other types of relation (those found in economic processes, in patriarchial relations) but are potentially immanent in them. Power as defined in Chapter 8 is always a relational idea and power relations are the immediate effects of the divisions, inequalities and imbalances to be found in relations and, by a feedback loop, the internal conditions of these differences. Therefore, in order to locate possible sources of power and domination, the central concept is that of understanding relations and couplings within a system. Because a power relation may emerge in any social relationship, whether economic or political, it does not belong solely to some concept of the base structure or the superstructure, neither does it relate to other relations in a rigid, fixed manner. As has been argued in Chapter 8 and illustrated in Chapter 10, a power relation is not governed by a total, binary opposition between the dominators and dominated, which is then reproduced from the top of an organization to the bottom in a definite manner. A power relation may be formed and operate in a variety of relations; that between an 18-year-old female learner and a 60-year-old male patient, that between the sister and the doctor, that between a white nurse and an Asian patient, that between a concern for life and a fear of death. Power relations within an institution are thus potentially ubiquitous for they could imbue any one of the myriad of couplings in a large system.

Micro-power relations, as Chapter 8 points out, did not exist in isolation. They are linked one to another in a complex net of series, sequences and 'jumps'. These relations may also serve as the supports for and be supported by macro-societal norms, values, power relations and divisions. These broader divisions forms what Foucault (1981) calls

> "wide-ranging effects of cleavage that run through the social body as a whole. These then form a general line of force that traverses the local oppositions and links them together; to be sure, they also bring about redistributions, realignments, hemogonizations, serial arrangements, and convergences of the force relations. Major dominations are the hegemonic effects that are sustained by all these confrontations. (p 94, Foucault, 1981)

Micro and macro-power relations thus interlock in ways which are parasitic and complex. Indeed, the division between micro and macro relations becomes difficult to draw for it is difficult to hypothesize a specific, local relation which could function if, through a series of sequences, it did not eventually enter into an over-all strategy. Foucault argues that such "double conditioning" is an intrinsic facet of all power relations. No "local center" or power relation can exist independent of a total stragegy and conversely, no strategy can achieve comprehensive effects if it did not gain support from precise and tenuous relations which serve not as a mere point of application or final outcome but as its prop and anchor point. As an example, the father in the family is not a representative of the sovereign or the state; the family does not duplicate society, just as society does not duplicate the family. But the family organization, to the extent that it was insular and heteromorphous with respect to other power relations, was used to support the great state manoeuvers for control of the birth rate and the medicalization of sex. Thus, just as relations constitute the whole and the whole gives meaning to its relations, micro and macro power relations are interlocked in a systemic manner. Where power imbues a particular relation, this relation is itself made possible by other relations within the institution and within society.

Just as power relations can potentially appear in any social interaction, it may take a variety of forms. As the evidence in Chapter 8 and 10 shows, a power relation is seldom a straightforward case of A completely dominating B; B too is able to find ways of resisting A, of controlling A and in turn B could also be the dominator of C. Power and domination thus gives rise to reaction, not "equal" as then a power relation would not exist, and to resistance. Just as entrenched interests may resist the argument of a critical theory, so resistance may exist in a power relation. Such resistance may not be strong, in which case we would either expect a heightened sense of

suffering or a pervasive ideology which masks the relations of power. Resistance may take a variety of forms and resistance is in fact the other side of power; resistance is only possible within the strategic field of power relations. Thus there are resistances that are possible, necessary, probable. Others that are spontaneous, savage, solitary, concerted, rampant, or violent. But resistance, by being the Janus-effect of power does not only exist as a passive reaction or rebound which is doomed to perpetual defeat. Resistance can produce, create inroads in a power relation. Just as micro power relations are coupled with macro relations, so resistance when connected strategically, like a current at a series of points, erupts into major revolutions. When localized struggles against local organizational relations are represented and interpreted in a certain way, then mobile and transitory struggles may take on a nature that traverses social and organizational barriers. However, we do not exclude a situation where resistance is non-existent and the total control of the dominated by the dominant possible. Such a nightmare is not likely to eventuate but forms the diametrically opposed situation to that of the ideal speech situation. Whilst both conditions may be counterfactual, theoretically they form the extremes within which our argument has meaning.

Finally, although an analysis of suffering is to lead to an understanding of power and domination, we agree that such a model does not behove the social scientist to only research for causal relationships where by causality is meant a single definable event or subject which is said unambiguously to have resulted in a situation or object. Here we wish to acknowledge Foucault's argument in shaping our own; in pointing out that

> "the rationality of power is characterised by tactics that are often quite explicit at the restricted level where they are inscribed (the local cynicism of power), tactics which, becoming connected to one another, attracting and propagating one another, but finding their base of support and their condition eleswhere, end by forming comprehensive systems: the logic is perfectly clear, the aims decipherable, and yet it is often the case that no one is there to have invented them, and few who can be said to have formulated them: an implicit characteristic of the great

> anonymous, almost unspoken strategies which coordinate the loquacious tactics where "inventors" or decision makers are often without hypocrisy." (p 95, Foucault, 1981)

Unintended systems of relations may thus be formed from local, specific, intentional relations of power and resistance. Whilst no single over-riding cause may be pinpointed, power relations and resistances of a kind exist in interaction. The uncovering of an ideology which "explains" domination is not necessarily the explanation of crude causality; we cannot always say that it was only because conditions of work were poor that male nurses in the UK did not enter general nursing in significant numbers till the 1950's and 1960's or that it was because the capitalists needed healthy labour that hospitals were built and nurses trained. The explanations may be more subtle and widespread, residing in a matrix of events, of changes in the way of perceiving knowledge and of changes in cultural norms. These coupled with social and economic processes allowed the emergence of particular forms of power relations and resistance. Foucault constantly argued that teleological evolution often played little part in determining events and in explaining causal behaviour. He stressed the importance of chance, of ruptures, of discontinuities, of transformations which lead to distinct gaps and breaks in the explanation of discourse and its relation to non-discursive practices (institutions, norms, values etc.).

Nevertheless, Foucault also stressed that despite these discontinuities, it is possible to describe these discontinuities in a regularity; or pattern with an order in its successive appearances, correlations in its simultaneous events, assignable positions in a common space, a reciprocal functioning, linked and hierarchized transformations. When speaking directly of power relations, there is always an intentionality in the order which emerges, although it may not be related to a constituting subject. There are a series of aims, of objectives, an overall strategy or system of power relations. But these may not be attributable to a single individual subject or group. Foucault writes:

> "let us not look for the headquarters that presides over its rationality; neither the caste which governs, nor the groups which control the stage apparatus, nor those who make the most important economic decisions direct the entire network of power that functions in a society (and makes *it* function);" (p95 Foucault, 1981).

But such intentionality exists in the myriad of power relations, if not discernible at the systemic level, then it is explicit at the micro-level. We accept that causality and explanation of domination is not equivalent to a delineation of rigid, simplistic patterns of cause-effect, that relations of power may not be easily attributable to a single event or subject. But an analysis of relations, of suffering, of false consciousness, of power and domination is not a citation of isolated coincidences, of Chinese classifications which define holistic understanding, a portrayal of disjointed chance events, a picture without an *idee*, disembodied, freefloating. The whole exhibits an over-all strategy; like a Breughel, there are a myriad of intentions that give meaning to a whole. These intentions may be changed, lead to unexpected events, be misinterpreted but they exist and are clearly seen at the local sites of power relations. Often Foucault is preached and followed as the master of a philosophy of ideas based on discontinuity, the proponent of an archaeological theory of knowledge. But as Sheridan (1980) clarifies, he is not that, or to be more precise, he is not only that. For one's task is to recognize coherences and differences where they appear, to see order when it may be perceived.

Also, in some cases, one may be able to speak of a definite causal subject; such an eventuality cannot be ruled out completely. Whilst we move away from a rigid concept of historical materialism and seek a theory of relations and of power which is more diffuse and subtle, let us not deny that specificities too have a place. Let us not look only for the dominant class, the KGB headquarters, Orwell's Big Brother. Let us seek to understand the matrix of relations and of transformations but let us also not circumvent at all costs the concept of a constituting subject. Foucault acknowledges

that such intentions relate deinitely to local power relations and struggles but do not do so at a systemic level. No one can be said to have invented a comprehensive system intentionally. We argue that such total control may not be the case but do not deny the event is a feasible event within the total set of power relations. Whilst recognizing the discontinuity, let us not deny the regularity, whilst allowing the diffuse let us not be blind to the specific. It is folly to do so when discontinuity itself can only have meaning within a world of regularity; when subtle emergence is often intermeshed in a world of direct, specific 'causes'.

An examination of relations, to discover relations of power and domination thus follows four methodological rules:

a) it does not limit itself to an analysis of only economic or political processes as domination is potentially ubiquitous and takes a variety of forms. This means a critical analysis must analyse the local relations which may be perceived, given the development of theoretical and practical learning, within a given historical situation or institution. There is no unchanging framework of relations which needs to be analysed, which is all-comprehensive. The perception of a relation is itself a cultural phenomena, contingent on the historical age within which the perceiver resides.

Thus we agree with Foucault that an analysis of power must begin in the first instance with an analysis of the multiplicity of local, specific, often explicitly intentional tactics of power which operate in an institution and which help constitute it. These local power relations which are organized around specific issues, may then be linked with other relations, other power tactics, other aims and objectives into a coherent whole which may not clearly reflect the intention of any one constituting subject. A situation which is similar to the systemic idea of the whole being more than the intentions, needs and purposes of a single dominating participant group. The whole of power relations may be a plural, multi-faceted, negotiated set. However, we argue

that there may be instances where one can posit a single constituting subject, where power may more reside in or be possessed by a single group such that it is valid to speak of that group as possessing more power to determine certain decisions, or to define norms of behaviour than other groups within a collectivity. The hypothetical "happy world of slaves" may be a theoretical, counterfactual possibility but it does form a theoretical benchmark, which combined with the other counterfactual ideal of a universal pragmatics, delimit the range of possibilities. Also, in analysing "causality" it is important to show the relations between the order of the whole, the over-arching strategy which emerges, the general design which is at last institutionalized into social hegemonies and the specific, multiple, intentional local relations which were our initial focus of analysis. The whole and the parts stand in a holistic relationship, each consitituting, supporting the other. And we argue that Foucault himself advocated and practised this explication of the relationship between the order of the whole and the multiple local relations. He writes:

> "The analysis, made in terms of power, must not assume that the sovereignity of the state, the form of the law, or the over-all unity of a domination are given at the outset; rather these are the terminal forms power takes .... Power must be understood in the _first_ instance as the multiplicity of power relations immanent in the sphere in which they operate and which constitute their own organization; as the process which, through ceaseless struggles and confrontations, transforms, strengthens or reverses them; as the support which these force relations find in one another, thus forming a chain or a system, or on the contrary, the dysfunctions and contradictions which isolate them from one another; and _lastly_, as the strategies in which they take effect, whose general design or institutional crystallization is embodied in the state apparatus, in the formulation of the law, in the various social hegemonies". (p 93-94, Foucault, 1981). Emphasis added

The main difference between our interpretation of this task and Foucault's is that we examine in detail the parties which intend, which possess more or less power in the local, specific areas of struggle. For us, power may be possessed, be seized, be shared; it is not intrinsic in any form of social interaction. It is a force which when extant is reflected in the

concrete tactics of persons who are parties to that relation, it is mirrored in their intentions and perhaps even in their non-intentions. We would argue that Foucault's own analysis in The History of Sexuality, (1979, 1981), The Order of Things (1970), Discipline and Punish, (1977), and The Birth of the Clinic (1973) reveals a set of two-object/person relations which are however linked in complex ways. In arguing about sexuality, he asks that we not look for those in whom power is invested and those who are deprived of it but his analysis of the process of power-sexuality reveals just those kinds of subtle relations between the dominant and the dominated. The "hystericization of the female body" could have evolved from looking at the relations between man and woman; "the hystericization ofchildren's sexualtiy" from an analysis of the child and the adult, the teacher; "the socialization of procreation" from the relations between sexuality and economic processes, the desires of the State; "the psychiatrization of perverse pleasure" from an analysis of sexuality in relation to medical and social norms. In his attempts to avoid an indiscriminate conceptualization of an over-arching teleological subject in history, in his concern to locate power everywhere, to see the whole of power relations as being more than the sum of individual intentions, Foucault appears in part contradictory and inconsistent. Whilst arguing that there is no discontinuity between micro-power relations and macro-systemic order, whilst arguing that there is a double conditioning of the whole by the specificity of intentional, possible tactics, and of tactics by the whole, he argues elsewhere that we should deny an analysis of the specific purposes of persons who inhabit these power relations. In fact, he himself is not successful in practising such exclusion and the specific tactics of people, of opposed forces and events are to be found in his analysis of holistic processes. His analysis of the machinery and alliance of sexuality, his four great strategies of the manifestations of sexuality in society are

built on an implicit analysis of the concrete, specific power relations between persons and groups. To be sure these relations interlock in complex ways, the whole may not have been intended by any one of its parts, but there are nevertheless human intentions, human ends to be served by specific tactics and strategies. Why deny the parts in a manner which is wholly unnecessary? There are concrete, material actions, intentions and behaviour which constitutes the order of the whole and within which they have meaning. There is no reason why an analysis of the dominant and of the dominated is intrinsically static, rigid and lacking in subtlety. On the contrary, such an analysis is vital if we are not to ignore the other face of Janus, the fundamental rule of sociality: that life is a holon with part-whole characteristics which cannot be separated for it is a feature of our ontology, of the conditions for our existence. Thus in analysing "causality" and in seeking to explain power relations which support ideological notions in an institution we will seek to explicate not only the whole which emerges, the specific local relations of power but the relationships between them in a manner which does not attempt to bury the intentions of man in the face of the sand at the edge of the sea.

b) it seeks to tease out relations between and among relations of power, locating a relation not just within the institution but in macro-divisions and norms; within the macro order of things. A relation of power does not exist in isolation, independent and complete in itself. There are tentacles of relations which situate a specific relation and is consitituted by it;

c) an analysis does not presume an unvarying relationship between those who are powerful and those less so. Resistance may be present and a constant negotiation possible within a power relation, thus making it a shifting, changing phenomena rather than a static distribution. Just as it does not

exist in isolation spatially, it does not have an independence temporally. Resistance and change thus ensures that power relations are subjected to constant modifications, continual shifts. Resistance may not be present and if so takes a variety of forms. Additionally those who are oppressed in one relation may in turn be the oppressor in the other;

and d) an analysis does not presume a simplistic model of causality, of direct cause and effects, of a single dominating or constituting subject. Because relations of power and of resistance may potentially be everywhere and take on a variety of forms, the 'causes' and effects of power may similarly be diffused through the dependency relations, through micro-organizational and macro-societal norms and the changes in such events. An overall-strategy of a holistic network of power relations may not be attributable to a single event or group. But neither is it always the case that such attribution is non-feasible. In certain instances, a causal constituting subject may be identified, but intentionality is usually easily determined at the micro-localized levels of power relations. Foucault, himself pointed out that the rationality of power at its local power centres is characterized by explicit tactics; the intentionality may be discerned. Thus "causality" and explanation is to be found in relating specific, local intentions and power tactics to the overall power strategy, which may or may not be the intention of a single conspiracy.

These rules guide our analysis of relations in order to hypothesize interests and relations which would persist should an ideal speech situation be attained. But it is insufficient for an integrated theory of O.E. to discuss suffering/contentment, to analyse relations of domination and power which give rise to a false consciousness or which are coterminous with a false ideology. It must also specify practical strategies whereby a move may be made towards the attainment of greater equality in relations. One must show that given the development of forces of production, it is theoretically

feasible to exist and maintain a more equal, more democratic institution or organization. Strategies are suggested which show how, were an ideal speech situation to be attained, particular relations would be structured. Such strategies necessarily mean a change in relations of power and domination. Can such changes be effected within an institution without similar movements at the macro-level of relations? If as argued local, specific relations are coupled in diffuse, diverse ways to other relations of power, can a change in power relations be negotiated without structural transformations on a massive scale? The answer must be, it depends on the power-relations themselves, on the extent to which diffuse relations are also tightly-coupled relations, to the existence of a total dominating rule or subject. Just as resistance may be localized, transitory and mobile, so a proposed change in power relations may be localized. Just as resistance may be strategically connected into a great radical rupture, so change may only be effected in certain instances as a great rupture. Where power relations are diffuse but not centralized change and resistance may not need to be a great Refusal, a source of all rebellions and a great revolution. Change, like resistance may be distributed in an irregular fashion, spread over time and space at varying times, mobilizing groups of individuals in a certain way and inflaming certain types of behaviour and action. Change may be localized and specific, evoking change in a limited surface of negotiation and exchange.

Such a framework for an integrated theory of O.E. which is built on an analysis of suffering, of power relations and of proposals for change is grounded in Habermas's principle of enlightenment and emancipation. It must thus be confirmed according to the epistemological rule associated with this normative criterion: that of acceptance by actors within the institution, such acceptance being freely given. As Chapter 5 argues, free assent and acceptance must be given by both those who are oppressed and oppressors. They must agree that the critical insights were an accurate description of their

previous state and that the only reason why they held these particular views was because they participated consciously or unconsciously in a relation of domination. Having freely accepted the theory, the actors then put into action the insights gained from the theory; should the final state then not eventuate or be not stable then the theory is disconfirmed. Thus the confirmation of our integrated the of O.E. is dependent on the free acceptance by actors of the insights, their implementation of the changes involved and the realization of the state of affairs hypothesized by the theorist. For Habermas the ultimate confirmation of a theory is the extent to which enlightenment and real emancipation is effected. Similarly, our theory of O.E. can only be confirmed to the extend that free assent is translated into action which brings outcomes that are rationally constructed, which are formed through a process of unconstrained discourse and democratic participation.

The Meaning of Integration

This framework for institutional evaluation was developed after the empirical research had been **started** and was both a product and initiator of dissatisfaction with remaining at the technical and hermeneutical levels of analysis. This thesis was begun with a technical theory of O.E. that was formulated within the ideas of the CF-set. The criteria of "technical" effectiveness : absenteeism, turnover, profesisonal orientation, systemic adaptive capacity were derived from the argument that learner participation and "productivity" were conducive for the long-run propensity of the nurse training system to survive. Then hermeneutics revealed that these criteria of "effective nursing" were given different emphases and subject to different interpretations by various interest groups within the micro-organization. In the next section of this chapter, we intend to show how these technical measures were ideologically bound up, not only with organizational but societal interests.

We wish to emphasize that this thesis was not begun with a concept of a critical, integrated theory of O.E. Integration was an emergent process and largely sequential. We did not set out with the goals of enlightenment and emancipation via integrated research but our final product is argued to be imbued by the spirit of both these ideals. As it stands this thesis is guided by the concept of emancipation in that we seek to loosen the domination of techne in mainstream organizational theory. The process of "liberation" has been achieved by :

(a) first bringing to consciousness the model or models that dominate and penetrate our thought and action; and

(b) by attempting to analyse these models itself in order to highlight their weaknesses and to provide a more adequate theory in its place.

The theory of O.E. which has resulted is argued to be "integrated", firstly, in the sense that the concept of O.E. has been analysed and informed by insights from Habermas's three levels of interest. The initial technical measures of O.E. are seen as problematic once the theorists is guided by the regulative ideal of an unconstrained consensus. The technical level of interest and traditional hermeneutics are no longer seen as adequate and sufficient explanations of social behaviour. The complete process of "integration" is similar to a process of demystification, of unpeeling the layers of a whole such that the unpeeled whole is the integrated end-product. It is not identical to a process of demystification because, secondly, attempts have been made to unite nomological and interpretive insights in critique. Thus, in the next section we demonstrate how the statistical result of a high level of rule orientation at ward level is related to issues not just of patient control and anxiety reduction but to developing discipline and expertise within society as a whole. Similarly, the negative correlation between PROBS and neuroticism which led to the initial explanation that anxiety "forces" nurses to psychologically distance

themselves from patients is found to be inadequate. Additional reasons are then given which indicate that "professional detachment" induces a physical definition of nursing work which is inter-related with a bio-medical model of man as an individual body. The word "integration" is thus justified on two counts:

(a) the insights of a single inquirer are shown to be insufficient in developing a theory of O.E. and all four inquirers identified by Mitroff and Kilmann are brought into play in developing an enriched theory of O.E.; and

(b) although the process of development has been sequential, attempts have been made to carefully set out the weaknesses at the technical and hermeneutical levels of interest and to unify some of the knowledge gained at these two levels in critique.

This process of theory development in fact illustrates Habermas's argument that each form of knowledge has its role to play but that the empirical analytical and traditional hermeneutical sciences were inadequate by themselves in grasping social action. Habermas does not argue that it is never appropriate to study human subjects with the methods of a causal, nomological science. The claim is that a science that is restricted to this procedure would - by itself - be incapable of understanding social reality. We have sought to demonstrate this argument in our exposition of integrated research.

The empirical-analytic sciences and our technical theory of O.E. do generate knowledge in the form of hypotheses which help account and identify regularities in 'observable' phenomena. The hermeneutical sciences are useful in allowing the recovery of a particular meaning of an action or expression. However, it is the critical insights which follow in this chapter which attempt to combine an interest in nomological and interpretative knowledge with a framework aimed at facilitating the

the process of self-reflection. For Habermas, an adequate understanding of all social practices; including scientific inquiry, depends ultimately on the critical, integrated sciences; for by disclosing deformations of communication they attempt to restore to men and women a true awareness of their position in history.

The technical and hermeneutical levels of interest per se are not able to understand social reality. Human life, in that it unfolds in a structure of language, labour and domination may only be captured by integrated analysis. This perspective in fact transforms the technical conceptualization of reality. No longer are technical criteria of O.E. such as the ones identified,seen as non-problematic. Instead they are elements which are constitutive of power relations. In this sense, an integrated form of analysis may be said to "transcend" insights gained at the technical and hermeneutical levels. The word "transcend" is then taken to mean "changed", "transformed" or "reinterpreted". An integrated, critical analysis is clearly different from one conducted purely within the confines of techne and of traditional hermeneutics. Thus, the critique of nurse training which follows reinterprets and makes problematic the technical criteria of O.E. identified and seeks to place the meanings of "good nursing" within wider societal struggles. The discussions in chapter 11 represent attempts to build on the statistical and hermeneutical information in chapter 10 in such a way as to simultaneously criticise their inadequacies and retain their explanatory value. Chapter 11 seeks to "do" integrated research in the second sense by re-interpretating the statistics and meanings obtained such that actors may be aware of sources of repression which prevent unconstrained consensus.

The three levels of interest are thus related to one another in the following ways:

(a) the technical and hermeneutical sciences are seen as feasible,

necessary forms of knowledge. However, by themselves they are unable to fully understand and help change social reality; and

(b) social life can only be studied and evaluated adequately by integrated analysis which unites nomological and hermeneutical knowledge in a spirit of critique. To the extent that integrated analysis enriches insights gained at the technical and hermeneutical levels and allows a reinterpretation of regularities and social meanings, it may be said to present a different, extended construction of reality.

In this thesis we have sought to illustrate and confirm Habermas's arguments of the necessity of critical, integrated research by taking a single concept and subjecting it to analysis at the three levels of interest. We began with measures of O.E. at the technical level of interest; measures which were derived from a systems modelling of the imperatives for long-run survival and which were based on an epistemology of prediction, explanation and control. We then took these measures of O.E. through the two other levels of interest. This method of argument is a more onerous, "bush-clearing" task than one which simply set forth the critical arguments in chapter 11. This is because we sought to justify the movement from one level of analysis to the next by displaying clearly the difficulties of only remaining within a single level of interest. To some extent, this approach may be criticised as being unduly pedagogical and for displaying too much "hand-holding" but as the literature survey on O.E. shows, most research to date reside firmly in the functionalist domain. In order that theorizing may move beyond that realm, it was thought a sequential exposition would not only suggest an alternative but show the weaknesses of present modes of analysis.

Finally, it should be pointed out that Habermas refers to his knowledge-constitutive interests as "quasi-transcendental. By this he meant that human knowledge can be conceived of as neither wholly

instrumental in regard to an organism's adaptive strategies towards its environment, i.e. rooted in experience nor as "the act of a pure rational being removed from the context of life in contemplation". (p. 197, Habermas, 1972). Interests are thus neither instincts nor entirely severed from the objective context of a life process. In this way, Habermas's epistemology and his structure of interests is not transcendental in the traditional Kantian sense : there is no ahistorical transcendental subject which provides the preconditions for the consitution of possible knowledge. Instead, it is only in the light of these human interests that knowledge can be comprehended. This interpretation of transcendence has been a source of much debate and is at yet unresolved (see, McCarthy, 1978; Held, 1980). However, this debate about transcendence is somewhat separate from Habermas's claim that the critical, integrated sciences provide an adequate analysis of social behaviour. The second proposition clearly forms the crux of the arguments in this thesis but is relatively unaffected by the controversy surrounding the notion of 'quasi-transcendental' interests.

11.2a: A Comment on Foucault

We have quoted Foucault in several places in our framework of analysis where his writings are pertinent to our argument. But his ideas are fundamentally different from ours. Lest misunderstanding occurs, let us clarify these differences which highlight both theoretical differences and a difference in purpose.

Firstly, unlike us, Foucault does not countenance an ideal state or a situation where resistance is non-existent. There is no ideal of a rational consensus, of a counterfactual state where relations of power and domination do not pervade discourse and the only force is the force of the better argument. For Foucault, power is everywhere; not because it embraces everything but because it comes from everywhere. Power is not something that is acquired, seized or shared, something that one holds on to or allows to slip away; power is exercised from innumerable points, in the interplay of

unequal and mobile relations. He writes:

> "The omnipresence of power: not because it has the privilege of consolidating everything under its invincible unity, but because it is produced from one moment to the next, at every point, or rather in every relation from one point to another .... And "Power", insofar as it is permanent, repetitive , inert and self-producing, is simply the over-all effect that emerges from all these mobilities, the concaternation that rests on each of them and seeks in turn to arrest their movement ..... power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society." (p.93, Foucault, 1981)

Just as power is everywhere, so resistance is everywhere. Where there is power, there is a resistance which is immanent in power. Resistance does not reside in a position exterior to power but its existence depends on a power relation, which it supports or attacks. A plurality, an ubiquity of power relations is co-extensive with a plurality and an ubiqûity of resistance.

Such a position is clearly different from ours where a counterfactual ideal and 'world of happy slaves' is countenanced. Whilst we too do not predict an inexorable process grinding its way towards an inevitable millennium, a definite attainment of an ideal state, we do not share Foucault's apparently absolute pessimism that such an ideal is merely utopian. There are no ultimate guarantees, barbarism is as possible as socialism. Habermas's developmental logic for societal evolution is but a schema that sets the range within which the empirical situation may be situated. However, Foucault's uncritical 'description' encounters the problems already discussed. From what basis does Foucault claim to 'describe' his ubiquitous power relations? Why are social relations necessarily relations of power? Is resistance always present, always possible? Granted, we may never reach a situation of an ideal speech situation but we can seek to move towards the ideal, using a rational reconstruction of man's competence for communication as the basis from which a critique of power and domination may proceed. Foucault's description and explanations incorporate presciptive norms which are implicit in his very conceptualization of power and in the mode of organization of an explanation

and description. These implicit norms appear baseless and his analysis is dulled by the lack of a basis from which critique proceeds.

Essentially the difference arises from a different concept of man, of human nature. For Foucault, the concept of man as being alienated, as possessing a repressed essence, of being capable of a greater truth is but a historical concept which arose after the breakdown of the Classical mode of representation. Man as the focus of the human sciences, as an object of knowledge did not exist in the Classical age. Rather it was the concept of representation, of language. Man, for whom and by whom representations existed, was himself absent from the table of knowledge. Foucault (1972) argues that in the Classical age, the position of language was pre-eminent and unobtrusive. It occupied the foremost position because its task was to represent thought; such representation was not, however, an act of translation or an exact physical replica of mental phenomena. Thought did not exist in a pure disembodied condition prior to its expression in language. It was considered in the nature of thought to represent itself, that is, to analyse itself into parts, to place one part beside another, to make one part stand in place of another. Thus language analyses representation and thought in a necessarily successive order; language cannot represent thought instantly, in its totality: it must arrange it, part by part, in a linear order. The study of this verbal order in its relation to the simultaneity of thought is what the Classical age called 'general grammer'. However, it does not attempt to define the laws underlying all languages, but to examine each particular language in turn, as a mode of representation. It defines the system of identities and differences that its peculiar set of 'characters' presuppose and employ. It establishes the <u>taxonomy</u> of each language via the processes of proposition, designation, articulation and derivation.

This underlying philosphy or episteme of representation which is exhibited by the Classical concerns in language is argued by Foucault to be mirrored in the Classical sciences of natural history and economics. In natural history,

for instance, emphasis was now placed on classification, on taxonomies of living beings which should be analysed in a definite order of norms, theory, kinds, species, attributes and use. Natural history in the Classical age became possible not because men looked more carefully, more closely at things, but rather because the requirement of naming things necessarily involved the concentration on what one saw to the exclusion of others. Natural hsitory, by reducing the visible to a system of variables susceptible, if not to quantity, at least to a clear, definite description, made it possible to establish an order of identities and differences between natural identities. Similarly, economics moved away from the study of money as a measure of commodities and substitute in exchange to the study of money as a representation of wealth. Just as the word is a representation of the thing and the verbal description of structure a representation of the living thing, so the metal coin is the sign of a certain quantity of wealth. Just as the individual word or natural character is capable of being articulated in a language - whether a natural language or the artificial language of taxonomy, so money has its own form of language - the language of exchange.

After the eighteenth century, however, Foucault argued that another period was ushered in, one which saw the world, not as a set of isolated elements related by identity and difference, but as organic structures. A world made up of internal relations between elements, where totality performs a function. Time now came to be of central concern; in the Classical age time was conceived only as intervening from the outside in otherwise timeless structures. Now time, history and man were seen as the foci of study. Man became a creature who lives, speaks and works in accordance with the laws of biology, philology, and economics, and who has also acquired the right through the interplay of these laws, to know them and to know himself. Modern man was now studied for himself, in his corporeal, labouring and speaking existence. In economics, this view of man gave birth to a historicist interpretation of

events. What man had hitherto attributed to the natural order, they were able to recognize as the result of historical development and men were thus equipped to reverse that development. Then alone would the truth of the unalienated human essence be restored. This *Idee* of the redemption of alienated man indicates that the image of modern man contained an element of the "unthought". That is, according to Foucault, modern man was conceived as possessing an Other, a shadow, an essence, a nonalienated form. For Marx Hegel and Husserl, man possessed an inexhaustible double,

> "that presents itself to reflection as the blurred projective of what man is in its truth, but that also plays the role of a preliminary ground upon which man must collect himself and recall himself in order to attain his truth." (p.327, Foucault, 1970)

Such a picture of modern man, Foucault suggests, is only able to emerge because of a general tendency in modern thought to rationalize, to separate folly from madness, to set up Reason over Unreason, Thought over Unthought. Because of this schism, it has been modern man's task to think the unthought, to bring the unknown within the sphere of knowledge, to end man's alienation by reconciling him with his own innocence, whether it be in the sphere of alienated labour or in the unconscious region of repressed desires. For Foucault, this central division represents an improverishment of human experience: when madness as a phenomenon, thanks to the tyranny exercised by the Reason over it, no longer enjoys the currency it once did. Therefore, tc even speak, much less conceptualize on the basis of a divided, fallen man is for Foucault a superannuated mode of thought, a mystificatory form of reaction.

Foucault ends The Order of Things (1970) with a philosophical laugh at those who continue to talk about man and his liberation, his essence. He scorns those who wish to take man as their starting point in their attempt to reach the truth. He sees those actions as but forming a false morality and foresees a possible end to man as an object of knowledge. Man is likely to sink once more into serene non-existence. He writes:

> "As the archaeology of our thought easily shows, man is an invention of recent date. And perhaps one nearing its end. If these arrangements were to disappear as they appeared ...... then one can certainly wager that man would be erased, like a face drawn in sand at the edge of the sea." (p 385-7, Foucault, 1970).

But should he sink back into this kind of oblivion in social knowledge? Is Foucault advocating that we return to a world of representation, to a language of the Classical age which is seen as the *tabula*, the space, on which things, in the form of their verbal representations, are ordered? Or is he postulating that we can but be submissive, passive reactionaries to some sudden, anonymous, sweeping knowledge change which will cause Man as a subject of knowledge to have feet of clay and to crumble as the ground of Classical thought did? Foucault seeks to argue that there is no overarching constitutive subject, no teleological development in the history of man, no great truth which will be revealed in the great beyond. But he depicts only an overarching Anonymous; a gripping, pervasive change in the manner of seeing which arrives from subtle places and whose form and arrival we can neither question or influence. We seem to be subject not only to the tyranny of Reason but the rule of the Anonymous. If for example, his argument is 'correct' and the possibility of man as a focus of knowledge declines, and a new era of though exists, are we but to accept totally, passively this new era? The invention of man may be but a transitory historical phenomena of the Western world but is the tyranny of History to be accepted so unquestionably? Is critique and moral judgement so unworthy a human enterprise that we can but describe the shifts of power and the variations in the way of seeing? We do not propose the kind of rationality which Foucault rightly attacks: that man is progressing determinedly from one epoch to the next in better developed forms, that the function of historical analysis is to restore an overarching teleology. But neither do we wish to substitute in its place an uncritical celebration of madness.

Foucault's pessimistic picture of the role of knowledge-power and his

concept of human nature rests on the argument that the rise of Reason banished Unreason in a tyrannical, wholly undesirable way. But nowhere is it made clear why such a schism, if it exists in the manner described is unwholesome. Is it because it enabled the emergence of a disciplinary society where some men are accorded the roles of Father, Doctor, Judge to sit and normalize the rest of us? But the four reasons which Foucault gives in Discipline and Punish (1977) for the possibilities of discipline - a cellular space, a control of activity, temporal discipline, the body as an element in a combination of forces - date back to ancient monastic practices, prior to the rise of Reason and Unreason. The psychiatrist judges men's condition, so does the doctor, the judge, the adult, the father. But is the rise of all such judgement due to the eighteenth break between Reason and Unreason? It is not at all clear that such judgement is necessarily tied to the purported division and why if it is, that such judgement restricts humanity. Foucault now almost appears to have his own image of the ideal man, where madness and reason are once again combined in the pre-Classical sense. Further, Foucault does not explicitly discuss why the modern image of an alienated man capable of achieving a higher essence is equivalent ontologically to a break between Reason and Unreason. Sheridan (1980) when discussing *The Order of Things* too interprets this equivalence as being made. He too interprets Foucault as saying that the ascendancy of Reason and science brought with it a certain improverishment of the human experience which is mirrored in a misconceived morality of alienated man. If such equivalence is being made, what are the precise grounds on which they can be made? Sheridan (1980) in stoutly defending Foucault argues that the Classical episteme which emerged in The Order of Things was one which underlay only the three disciplines studied, no more, no less. Were one to extend the comparison to other disciplines, the episteme would alter accordingly. It this is so, then can the analysis of madness be justifiably compared with the

three disciplines and their underlying episteme? If one cannot speak of a Classical physics or Classical mathematics in the sense used by Foucault, can one speak of Classical Reason and Madness in the same breath? In fact, there is somewhat of an ambiguity in Sheridan's discussion for elsewhere he argues that Foucault was seeking to analyse whether the mutation which occurred around 1800 in the history of medicine could also be valid for the three disciplines (see p.48, Sheridan, 1980; c.f. p.213-214, Sheridan, 1980). It is unclear, therefore, whether valid rules of correspondence may be drawn between the division between Reason and Unreason and the image of Man possessing an essence and an appearance. This ambiguity is also exemplified in a hidden image of man which is not well-discussed: that of social relations which are necessarily imbued with power and resistance. Foucault does not explain from whence this imperative derives and why a resistance-free nightmare is not possible. Also this concept of power is consistent with a deliberate view on the folly of positing ideals but is less consistent with his hidden image of man. What has an ubiquity of power to do with a re-united image of man which is spoken of prior to the break between Reason and Unreason?. Again we are given little information on this relationship.

Whilst he attempts to describe, there appears to be an implicit picture of 'what ought to be' in Foucault's writings, smuggled in under his disdain of psychiatry, his criticisms of a disciplinary society and institutions , his concept of power, his history of sexuality. There appears to be a longing of some unity once again between Reason and Unreason, the benefits of which are unclear. Whilst laughing at idealists, Foucault himself appears to have an ideal, although he writes of blankness, bleakness and a lack of promise.

And finally a minor, tentative point. Foucault argues that a view of man as being alienated but capable of attaining his essence arose in the modern period, co-existing with a break of Reason and Unreason. But surely such a

view of man is also present in the writings of Plato with his famous image of the shadows on a cave which we can but apprehend as shadows. How does *The Republic* fit then into his neat scheme of divisions at definite points in time?

The second major difference has already been discussed in the setting up of our framework for an integrated theory of O.E. This lies in our argument that power may be possessed, shared, seized and exercised by an intentional subject on and through a second subject. At the micro and possibly at the macro-systemic level, one can discern intentions, tactics and behaviour which belong to certain groups which stand in relation to one another on a power scale. The analysis of sub-systemic relations and tactics of power are essentially related to material effects of domination by groups. To be sure, at the continuous macro-level, these relations may have undergone such constant negotiations, and, shifts in balance that the order of the whole is no longer seen as the intention of a single subject but we do not deny an extreme counterfactual situation where it may be the case. For us power may or may not be present in a particular relation, it does not exist everywhere and we are not merely left with a pessimistic, passive task of describing these constant struggles and shifts of power in the matrix of transformation. Our concept of human nature is not such that once we abandon the concept of a teleological constituting Subject that will achieve its essence, we are left only with the analysis of man as a blank. He is not merely an indifferent space, lacking in both exteriority and promise. Neither are we to passively wait for the time when man as an object of knowledge will fade and we are left once again with pure Discourse or pure representation, resemblance and the unity of Reason with Unreason. We adopt an explicit, normative criterion of seeking the enlightenment and emancipation of man and our purpose in analysing power relations is to unmask domination which gives rise to false, ideological beliefs. Power, in our definition is equivalent

to subjugation or a general system of domination which may be exerted by one group over another.

In analysing the relations between the dominated and the dominant, in relating these local, intentional tactics to an overall strategy, we are but recognizing the part-whole nature of social life. This does not automatically mean that by looking at the possessors and the dispossessed, the king and the slaves, we will always present a static distribution of power which fails to grasp subtle changes. In relating micro-relations to one another and to the whole we will resort to an analysis of the historical changes which allowed the emergence of the parts and whole and which have shaped and will shape the specific use of tactics. One cannot analyse the specificity of a practice, a tactic, a power relation, the conditions ot its emergence, and its relation to other relations and the whole without a time-dependent study of change. A change which may be gradual or sudden, transitory or semi-permanent, a change which may well be the discontinuity and rupture which Foucault is claimed to favour.

Finally we see power and domination as being essentially repressive. Although the definition given in Chapter 8 does not necessarily imply that, our discussion of Habermas's concept of domination should make clear that we see power as being so. Foucault argues that power may be positive, creative and productive. Power, he claims produces reality, it produces domains of objects and rituals of truth. The individual and the knowledge which may be gained of him belong to this production. We do not take exception to this. Of course, power creates rituals of truth, of course it constructs our reality, circumscribes our mind and limits what we think to that which is feasible. But such production is not desirable in the sense of attaining an ideal speech situation. Power and domination thus represent an inequality of influence, of force which is not connected to the force of the better argument.

11.3 The Effectiveness of the Mayfield Nurse Training System: an integrated evaluation of dissatisfaction and discontent

Five main areas of dissatisfaction, of discontent were expressed by participants within the Mayfield Nurse Training System. These were:

1. Dissatisfaction with Nursing as Work and Training;
2. Dissatisfaction with Superior - Subordinate Relationships;
3. Dissatisfaction with the Doctor - Nurse relationship;
4. Discontent with the Service - Education liaison;
5. Dissatisfaction and mistrust between the North and South Districts of the AHA.

Information on each of these five areas of discontent has already been supplied in the earlier chapters, especially Chapter 7, 9 and 10. As such this section will be brief and is intended as a co-ordinating section. This information was collected via formal and informal interviewing, via archival research into the history of Mayfield as an Area Nurse Training School, via participant observation and via questionnairing. The participants talked with included SRN and SEN leaners and leavers, qualified nurses throughout the service sub-system up to the level of District NO, nurse teachers up to the level of the Director of Nurse Education, doctors, patients, nursing auxiliaries and nurse researchers in other parts of the country.

Dissatisfaction with work conditions in nursing was expressed both by learners still in nursing and by leavers, especially those who cited this reason as their primary reason for discontinuing training. It was also expressed by members of the Service and Education sub-systems. For example, some SENs spoke of a distinct "feeling" about an SEN's lower status and rank, one NO spoke of a total lack of leadership in the SGH and nurse tutors and clinical tutors complained of a lack of recognition and economic rewards for the role of nurse teachers. Such dissatisfaction manifested itself in a

variety of forms and complaints throughout Mayfield and was not limited to learner dissatisfaction.

The last variable, stated in a positive form, in fact formed the variable measured via extensive questionnairing of nurse learners. The mean for the variable was 3.4095 (JOBSAT) on a five-point Likert scale. However, this variable was a composite scale measure of 15 items which included what are usually termed "intrinsic" facets of work. When the scale was broken down into approximate sub-sets of intrinsic and extrinsic conditions of work which gave rise to satisfaction, the respective mean was 3.218 for extrinsic work satisfaction and 3.162 for intrinsic work satisfaction. This meant that for the sample of 309 learners, they were relatively satisfied with their extrinsic work facets but less satisfied with their intrinsic work conditions. However, in their language and construction of reality, their relationship with patients and auxiliaries was usually a source of satisfaction whilst hours of work and pay were sources of dissatisfaction. Although some learners recorded a "Very Dissatisfied" on some of their job characteristics, these being usually pay and hours of work, these learners nevertheless stayed in nursing. They felt there were other "good reasons" for them to stay, compensatory factors on which they were able to record "Very Satisfied"; these being usually relations with patients, auxiliaries and nursing as varied, interesting work. Stayers also felt that once their ritual of training was over and they had gone through the 'fire' of low pay and long hours for two or three years then "better" lives and jobs were in store for them. Thus, their present discontent was but for a short period, one which every nurse had to go through and for some learners one which was necessary in order that nursing attracted the "right" kinds of people. Essentially this implied people who would be dedicated, altruistic and who would not come into nursing for materialistic reasons. These learners felt that nursing was a true vocation, not just of the nineteenth century but of the twentieth and nurses

who were caring people should also be individuals who did not care about money and economic rewards at work. Also, poor pay and long hours were perceived not to be high costs given that a job per se was a priced good in the period from 1979 onwards. During the late 1970's Britain was and is continuing to experience relatively high levels of youth unemployment, where jobs are scarce for school leavers. Competition into nursing has increased such that Mayfield was able to raise its entry requirements for the 1980 intake of new learners from four to five "O" levels, with a preference being given to learners with "A" levels.

These opinions, gathered essentially from nurses who had been in training for more than a year may be compared with the views and expectations of school children and new recruits who were questionnaired on their first day in training. Out of a sample of 119 school children interviewed the 21 girls who felt they would consider nursing as a possible career, spoke of nursing as a potentially satisfying career which was concerned with helping people in need. Hours and pay were acknowledged to be relatively "poor" but "unavoidable". These views were echoed by fresh recruits to the Mayfield Area Nurse Training System. A significant proportion of these also recorded that although hours and pay were "bad", they were "acceptable" conditions of work. Our results revealed that out of a sample of 122 1980 starters 14.75% had positive expectations about their hours of work 51.64% had begun nursing with negative expectations and 27.87% had "mixed" feelings about their hours of work. On the subject of pay 72 thought pay was reasonable, unimportant, good for a "training job", 30 thought pay was distinctly poor, low, inadequate and 14 thought pay was not very good at present but would get better or that pay was poor but acceptable at present. Thus 59.02% of 1980 starters entered nursing with positive expectations of pay 24.60% with negative expectations and 11.48% with mixed feelings about the role and importance of pay in their nursing life (see Appendix 10.5)

What is striking from such information is that a significant proportion of schoolchildren who will consider nursing and new nursing recruits who actually enter nursing accept that pay and working hours will be poor but nevertheless "acceptable". They knew that hours and pay would be poor, relative to what they felt they deserved, or in comparison with other jobs but nevertheless they were willing to enter nursing. The reasons distilled from the actors themselves were similar to those given earlier, namely: that nursing compensates by being a dedicated, worthwhile vocation in which money has a definitely minor role to play, that there was always a promise of a better future and that they should consider themselves lucky to obtain a job when many of their own schoolmates were stuggling to obtain a position in society expected of and by themselves. Thus, nursing was conceptualized as providing intrinsic, social rewards first and economic rewards perhaps later.

The point remains, however, that work conditions are perceived to be "poor" in relation to some relative concept of merit and dessert. Such conditions are defined as "acceptable" only within a given context of expected, future rewards. Should these not materialise or be perceived as insufficient, current conditions of work may no longer be "acceptable". 3rd year and 2nd year learners, in particular, were observed to record increasing complaints that conditions of work were poor. Appendix 10.5 partially reveals this tendency. Upon inspection it can be seen that a larger proportion of 3rd years and 2nd year SENs report that they had negative expectations about pay. In fact they actually reported that they expected "pay to be better"; such statements were recorded as negative expectations in order to compare these recalled expectations with the expectations of new recruits. Such a statement in effect indicates a state of current dissatisfaction with such conditions of work. Further, the data from our full sample of 309 learners show that the mean value for satisfaction

with extrinsic job factors is relatively low. Thus, the research evidence suggests that fresh recruits acknowledge unsatisfactory work conditions to be "acceptable" but that learners who have had more than one year of training generally report such factors to be job dissatisfiers.

A dissatisfaction with nursing as work was not confined solely to a dissatisfaction with conditions of work but with what nursing work comprised of. Complaints were frequently heard from members of the educational sub-system that their colleagues in the service sector lacked a concept of nursing as an important social-psychological activity which was concerned with the patient as an Individual. Nursing work, so it was claimed, was not just taking pulses, temperatures and blood pressures. It was not just a set of techniques for maintaining health, for learning how and when to use an injection needle, to change a drip, to insert a surgical instrument. Nursing was to care for the psychological state of the patient, for his/her fears, worries and mental barriers to health. In order to appreciate this, the patient had to be seen as an individual with his/her particular worries and phobias. The patient was a unique person, a human being with his/her own feelings and sensitivities. He/she was a whole in which matters of the body were mysteriously but intrinsically linked with matters of the mind and in order to care for the body satisfactorily, the patient's specific individual mind had to be understood and cared for. General nursing, it was claimed had unfortunately failed to recognise this fact and had only seen nursing as a set of tasks to be mechanically applied on a body, not a person. This deficiency, they felt could best be remedied if present deficiencies in nurse training were made good. At present, too much emphasis was put on studying the medical model of man as an anatomico-physiological being. Man was seen only as a set of bodily functions which was unrelated to his mind. What was now required was an understanding of the psychological and social needs of man, of man as an individual who was situated within a milieu of

relationships to others, and, to his psychological self.

Due to Davies' encouragement and a mix of historical causes some changes in training were being tentatively implemented at Mayfield. In six weeks of an introductory SRN course, approximately two hours a week were now being devoted to a study of psychology and sociology as related to the patient. Also, the nursing process was being taught in earnest. This stresses the patient as a physiological-psychological whole who needs to be treated on an individual basis. Nurse-patient allocation was also introduced on a few wards such that a relationship could be established between an individual nurse and a patient. These practices were being introduced into the wards of the two large general hospitals and in June 1981, introductory seminars were being held at both the NGH and SGH to investigate the possibilities of implementing the nursing process into large areas of general nursing. However, despite these tentative changes, educational staff felt that effective nursing was not being practised and frequently complained of the intransigence of their service colleagues.

Dissatisfaction with nurse training per se was not only expressed by educational members but by service participants. Their main complaint to the researcher was this "misguided emphasis on "O" levels." As pointed out in earlier chapters, a majority of the sisters and NOs sampled felt that the entire emphasis on educational requirements in nursing was unnecessary. They levelled their criticisms not only against the higher number of "O" levels required, against the introduction of graduate nursing but also, albeit indirectly, against research in nursing by non-nursing personnel. Such emphasis, they felt, detracted from the essential requirement in nursing for caring people (nurses) who may not "be clever with their heads" but had a sensible feeling for others and a practical pair of hands." A nurse, it was felt, did not need 6 "O" levels and "A" levels, but she needed common sense. In Chapter 10, we argued that such a feeling could be due to a fear

for the sister's own position, and a dislike of the growing importance of education as a separate function in nursing. Later in this chapter we shall relate these micro-power relations to other power relations and to an over-arching 'sense' about nursing which is emerging. A comprehensive system of thought is developing which needs to be critically evaluated for it is potentially ideological in its effects.

A second major source of dissatisfaction which was significant is found within superior - subordinate relations. A variety of complaints were recorded. Learners often complained that their tutors treated them like children and certain ward sisters humiliated them in front of patients (see Appendix 6.1). The following quotations were obtained during participant observation:

> "We even have to have our attendance marked. Can you imagine that! It's worse than in school. We're treated like children in school and expected to be nurses on the ward. I'll be glad when this introductory course is over." (New recruit from the February 1980 intake, February, 1980).

> "Sister X is on holiday now. I prefer Sister Y. Sister X shouts down the ward at you, makes me jump. And you look so stupid .... and in front of the patients too." (2nd year SRN, Southern District, September, 1980).

> "Sister X on Ward 9 is awful. Really terrible. She's a nut - we all have to say prayers every morning. She treats you like nobody. They say they tried to offer her a NO post to get rid of her but she wouldn't take it." (3rd year SRN, Northern District, July, 1980).

Clinical tutors and nurse teachers felt they were not sufficiently consulted by their Director and Assistant Directors of Education.

> "I never know which teaching team I'm going to be in. I worked so hard with the February intake and now I'm told to move to Paediatrics temporarily and then I'm supposed to move back to General. It's really bad for the learners - having such a change of teachers." (Mrs. Andrews, Nurse Tutor, Southern District, May 1981).

> "Don't ask me what's going on in this School. We have so many changes. First, change teams, then change rooms, next change hospitals. This management manages by crisis....... We are just told to move." (Mrs. Martin, Nurse Tutor Southern District, April 1981).

> "It's alright for Davis telling us we must be flexible. But we've got our families to think about. Mrs. X lives the other side of Barnsley and now Eden wants her to work at the SGH. Its ridiculous!" (Miss Mott, Clinical Teacher Northern District, April, 1981).

Sisters, too complained of their NO, SNO and Divisional NO, as well as of Davies, the Director of Nurse Education.

> "Our NO is funny. Not very friendly. Totally ineffective - can't really do much for us." (Sister, Southern District, April 1980).

> "The NO is a bit interfering. She went for this Nursing Process Scholarship and she's now all eager to do ward work. But she just gets in the way! ...." (Sister, Southern District, April 1980).

> "Never see the SNO. Don't know who she is......... It was better in the old days. We always saw Matron everyday and she knew exactly what was going on." (Sister, Southern District, March, 1980).

> "The Divisional NO is evil. Really evil woman. She is just two-faced. Always twists and turns the things we say ...... We get on fine with Mrs. S, she's a fine SNO." (NO, Northern District, May 1981).

> "This Davies- thinks he knows everything. I don't think he cares for the learner. So arrogant and interfering ..... Now he wants to close our ward as a training ward." (Sister, Northern District, July 1980).

The Allocations Officer was also criticized, especially by learners who felt she was unsympathetic to requests and was unhelpful.

These complaints revealed a wide variety of specific sources of dissatisfaction with superiors. Indeed, dissatisfaction with the execution of legitimate authority seemed to imbue every such relationship. There were similar "grumbles" in the other direction - superiors complaining of their subordinates. Out of 21 sisters interviewed 7 felt that learners did not show them sufficient respect. Members of the educational staff at times spoke of learners as "mischievous monkeys" who complained of teachers in front of service personnel and vice versa, in order "to play one off against the other." When interviewed, the Allocations Officer spoke thus of learners:

> "Some of them don't know their place. They have to be told how to do things. School today is too liberal. Learners need to be treated with authority. I'm not saying......... we go back to the old days, but we need Authority not Delegation." (Senior Allocations Officer, May, 1981).

Similarly, a SNO when confronted with reports that some of her subordinates were unhappy with her style of management said:

> "I don't believe it is my job to go round telling people what to do. I believe in giving people freedom. But some of them have no initiative. They always want to be told." (SNO, Southern District, May 1981).

Almost identical views were expressed by Eden and Davies:

> "We have far too many disloyal people in this School. I don't agree with every decision Davies makes but once a decision has been made I don't criticise it behind his back ....." (Eden, Assistant Director of Education, May 1981).

> "There's a lot of deadwood in this School. A, B, and C, for example, are useless. Uncreative, nonprogressive. There's no way, for instance that I will promote C. He can't take the responsibility." (Davies, Director of Nurse Education, May 1981).

Expressions of dissatisfaction with superiors were thus countered by similar expressions of dissatisfaction with subordinates.

However, such expressions of dissatisfaction and at times of condemnation did not appear to actually "cause" a breakdown in the technical flow of tasks and work in the organization. The grumbles and complaints, as it were, lay dormant behind a surface of continual work. It tended to erupt only when consciously brought to the surface by specific, localized events which were directly related to a particular relation; as for example, when a person was questioned by a researcher or when a specific confrontation or event took place. These localized events included such happenings as 1) a change in nurse teaching teams which brought forth severe criticisms from amongst the lower ranks of the educational sub-system; 2) a learner who approached the Allocations Officer for a change in allocation; 3) a staff nurse who rang the SNO to ask for advice by mistake when she should have asked the NO; and 4) the designation of a ward as no longer being suitable for training by the Director of Nurse Education. Once these events and their effects had settled down, the system functioned in a manner similar, though not identical to the way it did before. An expression or a visual display of dissatisfaction was thus, in the main, generated and hence contained by specific instances and events which did not threaten the

complete shutdown or rupture of a superior - subordinate relationship. Such expressions of dissatisfaction with superior - subordinate relationships were thus usually confined to and identified with a specific relation; where the roles of superior and subordinate were clearly delineated and the line of confrontation clearly staked. This is especially illustrated by our discussion in Chapter 10 of the conditions for the emergence of certain criteria of effectiveness.

The frequency of expressions of dissatisfaction with such relationships and the manner in which such expressions were verbalized indicated that in most cases it was almost expected that subordinates would be problematic and superiors difficult and over-bearing. A superior - subordinate relationship is a unique relation in social interaction in that societal norms clearly and usually permit the superior to have greater decision-making authority than the subordinate. Such a relationship is thus often called a relation of "legitimated authority," a relation in which one party is expected and expects to exercise less influence than the other. Thus it is a relation that is easily interpreted as a power relation where A is able to make B do something which he otherwise would not have done. Or where A is able to mobilise bias and power so subtly that B does something which he thinks eminates from his own free will and volition but which is intrinsically coupled with the wishes of A. Theoretically, we have made the distinction between authority and power, and between power and domination. At Mayfield, however, it was observed that often it was expected that an authority relation would be synonymous with a power and even a domination relation. The superior - subordinate relation is one which has been sanctioned by societal norms, which is built into the rigid division of work, and whose rationality is taken-for-granted by society at large and by the subordinates and superiors themselves. It is usually spoken of as a functional, necessary

relation, yet it appeared to be one which generated the highest level of mistrust and negative expectation. We argue that it is precisely because societal norms have "legitimised" this relation that a fear of this very "legitimacy" translates into mistrust. In other words, suspicion is an intrinsic consequence and constitution of its "legitimation". It is because the superior is expected to exercise certain privileges and the subordinate to operate others that an inherent mistrust is built into this relation. Within such a background it is feasible that a process of psychological projection occurs. Menzies (1970) argues that because hospitals are places of anxiety - anxiety about life and death forces, about man's sexuality and rationality - and because such anxieties hark back to phantasies which man has while still a child, a process of projection occurs. The least desirable facets within ourselves are projected outwards onto our superior and subordinates. A self-fulfilling prophecy thus ensures: we expect superiors to be over-bearing and subordinates to be unreliable, disloyal, unimaginative. We seek information that confirms this image and superiors _are_ eventually over-bearing and subordinates unreliable. Menzies' explanation is highly feasible but she does not enquire into why a projection occurs from a _subordinate_ to a _superior_ and vice versa. Such projection, we argue, is made possible by the demarkation of the superior - subordinate relationship as an acceptable relation; such demarkation simultaneously creating an intrinsic fear that such relations of authority are in practice relations of power.

Thirdly, we observed a dissatisfaction among nurses about the doctor-nurse relationship. This relation is not included within the discussion on superior - subordinate relations because its status as such a relation is debatable and the relation links to a separate issue which will be discussed later: the professional project. Our observations are somewhat biased in that more opportunities were available for the researcher to talk with nurses or to

listen to their opinions and fewer opportunities were available for the doctor's views to be heard. When opportunities did exist, the only rank of doctor interviewed was the houseman, who works daily for a short period on a particular ward.

As Chapter 10 shows, a dissatisfaction with the doctor - nurse relationship was least frequently expressed by ward sisters and charge nurses who invariably reported a non-problematic, or even positive relation. This assertion was nowever inconsistent with our observations which showed that sisters did show respect for the consultant's power, which was relied upon in certain instances when their own decision-making mechanisms proved too cumbersome. It was also reflected in their usual organization of ward activities around the consultant's round. The traditional entrenchment of the power of medical men in the hospital world, was for us, still much in evidence at the micro-level of the ward. For the sister/charge nurse who was consciously/unconsciously cognisant of this material reality, working with or for the consultant was vital for the smooth regulation of the flow or work. Indeed a "good" relation with the consultant was seen almost as a *sine qua non* for their rank and two sisters spoke with pride that when "their" consultants changed their control of wards and specialities they were asked to move with them. The signals seemed to imply that where an unhappy relation existed between consultant and sister, it was the latter who had failed in some essential way to relate. However, this was not the case if the former was intersubjectively agreed by the nursing establishment to be a particularly "difficult" man who had been particularly "unreasonable". There were implicit norms of reasonable behaviour, if these were not transgressed there was an invisible onus on the sister/charge nurse to maintain a good relation. But such an onus was not openly acknowledged by most sisters who appeared to believe that they were on an equal "professional" footing with doctors and consultants alike. If acknowledged, the consultant's

power was often equated with his greater social function and when thus interpreted was regarded as acceptable. Thus it was not because he was powerful that his ward round was important, it was because he was such a "busy man needed on so many wards and by so many patients" that his life on any one particular ward should be as smooth as possible. That such statements harked back to similar statements made by higher placed Victorian sister-servants of the Master was a construction of reality which did not present itself.

After all, the sisters/charge nurses when compared with their nineteenth century counterparts had "made progress". They were now responsible for complicated technical processes, dangerous drugs and advanced technological equipment in addition to the thermometer and injection needle. Their profession also possessed its own decision-making hierarchy and appeared to possess the power to determine its own destiny on an equal footing with other health professionals. There was hence a set of material, technical realities which formed an overarching framework of nursing 'come of age' within which their specific relation with their consultants, was intrinsically imbued with equality. Coupled with the pragmatic necessity of working with a traditionally powerful sector which was but only dimly perceived as such, the dual consciousness posited by Giddens was not clearly visible. Instead there was a frame of equality and professional maturity within which localized spots of inequality and power were subtly compartmentalized. Power was but half there and half acknowledged.

Sisters apart, most other participants within the system believed they were still much in the grip of medical domination. Of all the senior management interviewed: one District NO, 2 Divisional NO, 2 SNO, 3 NOs, one Director of Nurse Education, 2 Assistant Directors of Education and 3 Senior Tutors, all but one agreed that nursing was still too much under the influence of the medical profession. They followed too closely the model of man used by

medical men and nurses were still lacking in social status in the sense of being seen as less important than doctors; there was still a view of nurses as "handmaidens" of doctors. With regard to patient care, it was the doctor who was regarded by patients, doctors, some nurses and the community at large as making the most critical discussions; the nurse was there only in the background, as a support. It was the doctor who diagnosed, who classified and labelled a patient, who designated the programme of care, who judged when a patient should be discharged, when he should be admitted. The definition of a patient still remained a medical privilege. Also, in hospital decision-making, doctors and the profession more generally were claimed to posess greater power in getting their own way. Further, nursing had failed to establish itself as a separate discipline with a distinct body of knowledge, tradition of research and centrality of focus.

The following quotes are examples of the opinions expressed by senior management:

> "Our most important task in the future is to be free of the domination of medicine. We must stand as an independent profession." (SNO, Southern District, May 1981).

> "I don't think we are a profession yet .... Of course, it is possible to develop a body of nursing knowledge. The doctor diagnoses but we should be responsible for a programme of care ..... Nursing needs a body of knowledge." (Davies, Director of Nurse Education, May 1981).

> "Nursing is now a profession and we should be able to make our own decisions ..... I would like to be able to help develop a body of knowledge. Won't mind doing a Ph.D myself if I have the time." (Eden, Assistant Director of Nurse Education, May 1981).

In Chapter 10 it was suggested that these opinions were due to the structural positions of the actors, as link-pins between the institution and the wider concept of a nursing profession and community. These were people who had the offical and potential power to exercise decision-making authority but also felt that in practice this was frustrated. For education personnel, in particular it was important for their existence and continual

survival that they stressed the importance of a professional maturity built on its own base of nursing research and knowledge. It was only then that they could gain acceptance as a distinct function within nursing. But such a professional ideology about nursing knowledge not only colours expressions of micro discontent, it is itself a phenomena which emerged because historical conditions facoured its existence and whose emergence creates internal contradictions within the discipline of nursing. Later in this chapter we will critically evaluate the dissatisfaction with the doctor-nurse relationship and its links with 19th century history, 19th century feminism, 20th century feminism and the role of professional status in a capitalist state with a nationalized health industry. It will be argued that such cries of dissatisfaction and the strategies suggested for liberation are themselves instruments of power within which the patient loses his identity and his ability to participate in decisions about his life. The patient is gradually seen as an individual, abstracted from his social relations and isolated in his interaction with the experts around him.

To some extent, animosity against doctors is inculcated in the learner from the day she enters training. This is because he/she then becomes a part of a traditional relation which is typified as being unequal and which is observed to operate on the wards. The new recruit hears reports from learners who already have negative images of the doctor - nurse relationship (amongst our sample of 1980 recruits 27.87% perceived doctors in a negative manner and expected them to be bossy, uncaring and arrogant) and she hears implicit criticisms of doctors from her teachers. In the educational sub-system such criticisms often came in the form of excuses or jokes like:

> "These doctors, they sometimes don't know how to talk to patients and it is the nurse's job to act as the communication line."
> (Lecture in Psychology, Southern District, February 1980).

> "It's great when doctors at last discover that patients are human! Sometimes they just frighten them and do not understand."
> (Lecture in Psychology, Southern District, April 1980).

These statements are not made directly about the nurse - doctor relationship but they help paint an image of a doctor who is not sensitive and aware of feelings and emotions and who concentrates on the patient as one of many cases.

On the wards this image is reinforced by the non-existent opportunity for a learner to speak with the consultant and his busy entourage of medical students. Only 3rd-year learners as pointed out were allowed to accompany a consultant's round and they usually do not speak. For many learners doctors and consultants were a "non-entity", actors with whom they exchanged little social conversation. Their interaction with doctors was usually focused around techniques or work performed on or for a patient and in such exchanges the nurse was often the support, at best the helper and at worst the servant whom she so resented. When the opinions of 1st years, 2nd years and 3rd years on doctors were compared, there was a marked increase in the number of negative statements registered about doctors. Appendix 10.5 shows these changes; 27.87% of new recruits recorded negative statements, in 1st year this figure was 50%, in second year 56.82% and in third year 52.4%. It is admitted that the sample statistics are problematic in that they were based on four cohorts of new recruits, one SRN cohort of 1st years, three SEN cohorts of 2nd years and one SRN cohort of 3rd years. This cohort sample was not pre-designed as a representative sample but was an opportunistic sample. Nevertheless, these tentative statistics do present quantitative representations of a phenomena frequently observed during participant observation: a dissatisfaction with the learner nurse - doctor relationship. Opinions did tend to harden through training and this served to perpetuate an animosity which is suspended but temporarily at the sister stage.

Finally, it should be pointed out that although we have discussed the apparent contradictions between the perceived equality of sisters and their quiet powerlessness, and between the sisters' perceptions and those of senior

management, we do not intend to imply that sisters are always without resistance and senior management completely passive in the face of medical opposition. In the case of interaction at ward level, we were able to observe specific instances, of counter attempts by sisters to influence a doctor's decision and the form of these counter-measures varied depending on the specifics of the situation. However, such resistance tended to function within defined parameters and the doctor retained many of his traditional privileges of patient definition and prescription. We were unable to observe much senior nurse management and doctor interaction but the little we did observe in isolated meetings again suggested that resistance was not completely absent.

A fourth area of dissatisfaction was the inadequate liaison between Service and Education. Mistrust seemed to reside in this relation. In chapter 10 we argued this emerged from the separation of Education as a separate function. This event was prompted by a State desire to increase the number of qualified nurses by improving conditions of training and by ensuring that nurses could and did qualify. Such a separation of functions decreased Service's control over the learner as a labour unit. The learner now was transformed into a resource over which competition was feasible, necessary and gradually an expected, feature of the Service-Education relation.
According to Davies:

> "All over the country, you will find tension in the Service - Education link. I've worked in different places in the North and it has been the same. But things are better here NOW.....But I still don't trust them. I'll never trust them."
> (Davies, Director of Nurse Education, May 1980).

And from the District Nursing Officer of the Southern District:

> "We get on alright with the School. They have their objectives and we have ours. They are different, yes, but we are here basically for the patient. So we compromise and move around and find a workable situation."
> (Botts, Southern District Nursing Officer, May, 1981).

However, at Mayfield dissatisfaction with this relation appeared to lessen in 1981. There were initial accusations from Service that for a while Education

had managed to have greater influence over the decisions of the Area Nursing Officer but that events were happening which permitted the greater influence of Service. The events cited were the severe shortage of learner manpower on the wards which was attributed to the efforts of Davies to "keep them within his province" and the appointment of Eden as an Assistant Director with responsibility for the Southern District. She was perceived by the Southern Service management to be more "reasonable" and more willing to compromise such that both Service's and Education's objectives could be met and competition over learner control kept within workable limits. The opinions of Education were similar, the relation appeared to be improving, there appeared to be more equality in influence and there was less mistrust. At the same time, in an effort to improve liaison, multiple Service - Education meetings, formal and informal meetings were being instituted such that more "understanding" could be forged. Similarly, at ward level a system of Service - Education liaison was being created; sisters were invited to help with School teaching because the educational system was understaffed, senior tutors now attended and attempted to participate at ward unit meetings and sisters were being consulted before an introduction of the nursing process was introduced. Towards the end of our research, there were fewer expressions of dissatisfaction with the Education - Service relation although learners still felt there was a lack of integration of course material. But educational and service personnel were less aggressive in their criticisms of each other.

A relation of power thus appears to have been neutralized but education as a function has itself created and helped sustain an increasing interest in nursing research and knowledge. Education is now put forward as a vital cornerstone for the professional project and a means of liberating nurses from a medical way of seeing treatment and care. But we argue that the educational sub-system also helps to perpetuate a false consciousness which has intrinsic

power relations. Where does the Patient stand in relation to the Nurse and the Doctor? Does emphasizing the Nurse as a professional Expert necessarily bring about greater care? Further, the educational sub-system fails to question hidden policies within its recruitment programme which continue to sterotype nursing as a feminine occupation and which do not analyse why, given the few men in nursing, its only Director of Nurse Education and one of its two District Nursing Officers are men. These issues are not overtly expressed in dissatisfaction. Only the issue of management by male nurses was briefly mentioned by a Divisional NO and the Allocations Officer who complained of men in management who only knew how to delegate and not to lead. These issues, we argue are, fundamental questions for they relate to processes of patriarchy in 20th century nursing.

A fifth area of dissatisfaction may be briefly dealt with as it has been amply discussed in Chapter 7, which outlines the historical reasons that underlie and give meaning to the continued negotiation between the two districts in their competition for resources. It was argued that because the NGH started life as a workhouse it suffered for many years from a relation of power in which the United Mayfield Hospitals in the south were able to obtain greater economic and social rewards. They attracted more prestigious doctors and had a more reputable system of nurse training. A series of national events, however, enabled the workhouse to develop into a teaching hospital with its attendant prestige and attraction to nursing learners and medical staff. Since the early 1970's, the NGH, together with the SGH has been designated as District Hospitals, centres for health care in their respective health districts. To this end, some development of the medical and technological facilities at the NGH has taken place. In 1981, the Divisional NO was proud to speak of the opening of a new mental illness and mental handicap unit and a new Accident and Emergency block. There was an implication that these new, improved facilities were a sign of a changing power relation and

indeed, in Chapter 7, our comparisons of relative power were based on the lack of certain facilities at the NGH. We do not possess sufficient information on the actual facilities that now exist in the North and South. It was not our purpose to study the two hospitals per se, but to study the Area Nurse System of Training. Thus we cannot state with certainty that a more equal relation of influence exists between the two Health Districts.

There were clear signs, however, that nurse traning has gradually been integrated, centralized and standardized across the two educational centres. Nurse teachers from the two centres were more aware of the courses of training, their content and manner of presentation in the two Health Districts. Procedures for recruitment, selection and learner discontinuation were being standardized and the former was centralized at Clarke House. The researcher also heard fewer criticisms of teachers and service personnel from their counterparts in the other Health District. There was a noticeable but not disruptive sense of competition. This tended to be manifested more in the Service sub-system as within this area, the two Health Districts competed for nursing resources, both labour and financial. Within the educational sub-system there was less a "them v. us" feeling. Among learners too, it was more difficult to identify with one specific district as in order to economise facilities, a significant proportion of learners now worked and studied in the two districts. This involved a great deal of learner travelling time but had the effect of forging an identification with the Area School and not with a Southern or Northern School.

Here there again appeared to be an equalizing of power between the N and S as far as resources within the Area were concerned. However, the means by which such equality is being forged and measured represents a social choice which is dangerously taken-for-granted in the hospital world: that of concentrating health care in a single, large institution which has an emphasis on advanced technological treatment, and which is highly dependent on

sophisticated drug treatment expensively purchased from profit-making pharmaceutical industries. We were unable to analyse the effects of such strategies of equality on the development of community medicine and nursing. Thus we offer our critical evaluation on this matter in a hypothetical, limited manner. But the expansion of hospital, technologically-based medical care has resulted in an increasing specialization in nursing and in greater prestige being implicitly given to technical nursing (see, Williams, 1978). Surveillance tasks have gained in importance, for example, the control of dangerous drugs. Simultaneously, greater social status is attached to nursing in a hospital-based complex, preferably one which is allied to a university and areas such as health visitor training or district nursing are seen as being on the periphery of nursing and nurse education (see, Dingwall, 1977). Increasingly, nursing care means care in an institution with X hundred beds and community nursing today still lacks the status of hospital-based general nursing. Medical and nursing priorities are more firmly rooted in the hospital concept and when as at Mayfield, an equality of resource distribution is measured in an expansion of hospital-based facilities, questions must be raised. Should nurses and doctors emphasize their knowledge and hospital-based care, or should they seek to demystify nursing? Should they "teach" the patient and the community that nursing may be learnt and applied by people with 'average' abilities and that care and cure is better served by prevention? Should it be assumed that the hospital is the "best" model of health care and the Nurse the sole possessor of essential nursing knowledge? Does health care have to be concentrated solely in an institution and is home-based nursing always equivalent to the 19th century middle-class model? Is the Nurse so helpless when faced with patients labelled as "social problems" that they should be left thankfully to the social worker, or labelled as "nutcases" to be isolated for the psychiatrist to arrive? Should the equality between Health Districts be measured according

to the development of new hospital-based facilities and advanced technology?

With these questions in mind, we begin in our next section to analyse the overall picture of nursing and nurse training which is emerging at Mayfield. We seek to identify a composite whole, that which is constituted by the myriad of micro-power relations already discussed. Our aim is to assess the effectiveness of the Mayfield Nurse Training system in promoting enlightenment and emancipation.

11.4 A Critique of the Emerging System of Nurse Training and Practice at Mayfield

Here in this section, we seek to link the historical development of Mayfield (Chapter 7), the historical emergence and growth of UK nursing as a distinct occupational group (Chapter 10), the visible signs of dissatisfaction manifested and highlighted by social actors (Chpater 10, Chapter 11) and the micro-relations of negotiation, power and domination between specific, material, intentional groups which give rise to particular meanings of criteria of institutional effectiveness (Chapter 10) to a holistic system of meanings and agreements about "effective" nurse training and practice at Mayfield. In seeking to analyse the conditions which allow the emergence of such an overarching system we will also draw on political, economic and social processes which have not been discussed in detail, for example, the growth of discipline as an institution, the significance of a capitalist mode of production, and the process of patriarchy within nursing. The purpose of such an exercise is to identify an overarching system of ideology which pervades nurse training at Mayfield. This system is argued to be, a microcosm of an ideological system which exists generally in the UK nursing service. Our ultimate purpose is to argue that Mayfield may technically be "effective" at coping with turnover among learners, be perceived as an adaptive, innovative, flexible system by learners and be successful in instilling a

verbal identification with professional values in nursing. However, it is ineffective within an integrated, emancipatory sense because it constitutes and is constituted by a system of ideological power relations. Here we do not wish to technically identify and measure criteria of technical "effectiveness". Neither do we identify ways of achieving a certain level of technical effectiveness by manipulating identified variables. Rather we seek to critically explain the processes of ideology which prevent enlightenment and emancipation. From such an explanation, we will discuss in the next section, strategies which could achieve a less ideological state and which need to be accepted freely by the actors at Mayfield.

Our framework in this section is, for the sake of clarity, divided and organized around four facets of the system which interrelate with each other and which collectively forms the whole. The exposition is thus somewhat artificial in that a division has been made but a holistic discourse may not be possible given the conventions of writing and prevailing definitions of clarity. But such a list of headings and of sub-titles should not mislead the reader into conceptualising the whole as a sum of its parts. For in this complex, open system, our whole is more than the sum of micro-relations or of artificial facets. Our four facets which will be discussed and inter-related are:

11.4.1 An emphasis in nurse training and practice on an individual body.

11.4.2 The professional expert and the perpetuation of a disciplinary society.

11.4.3 The contribution of nurse training and practice to a dominant capitalist ideology.

11.4.4 The process of patriarchy in nursing.

11.4.1 An Emphasis in Nurse Training and Practice on an Individual Body

In Chapter 10 we have argued that nursing work is interpreted at the level

of practice as a physical task-orientated activity. At Mayfield, it was observed that there was an eagerness to "get on" with the physical activity, a sense of satisfaction when the "work" was done, a tendency to measure the proficiency and "goodness" of a learner/nurse by her ability to cope with emergencies and events in a practical, common sense manner. According to sisters, a good nurse was not a gentlelady who supervised from above but one with a practical pair of hands and a level head; who "mucked in" with cleaning a filthy patient or a dirty sluice.

The learner tends, in general, to enter nursing with an abstract, constructed image of nursing as a caring, vocational, satisfying career with "good" prospects. He/she is confronted with nursing as work on a body in introductory course. At Mayfield, anatomy and physiology form important parts of a learner's introductory course and indeed in the early 1970's would have formed the core around which training was based. The emphasis on a body was particularly demonstrated in the learning of particular technical practices, for example, the giving of injections, the removal of stitches aseptically, the giving of mouth-to-mouth resuscitation. It was in fact, the learning of such techniques which was observed to provide the greatest novelty and satisfaction to learners who felt that by learning such knowledge, they were learning their trade. They were distinguishing themselves as nurses - trained, skilled contributors to society and were not just adolescents or adults.

SRN and SEN learners were observed to take an interest in successfully performing certain techniques well - even the practical "skill" of bedmaking was a novelty and became a ritual. First, the pillows had to be placed at the bottom of the bed, then the sheet had to spread out such that it fell neatly over the bed, the folded "half-line" of the sheet being ideally in the middle of the bed such that each side had an equal drape. Next, came the important hospital corners which were better made at the top first and

then the bottom as this saved time. Then the top-sheet had to be placed in a certain way, then the blankets and the drawsheet. In this way, a simple, everyday task had taken on a new meaning. Every step was a new design, each was imbued with a "good" reason of efficiency, time-saving and "comfort for the patient". It appeared as though a hundred years of nursing had distilled ever-increasing deposits of knowledge and experience which now benefited learners and patients alike by the teaching and practice of everyday tasks in a new "more efficient" manner.

From the novelty of learning bed-making, a learner during introductory course then progressed to more difficult techniques - the way to make a bed when a patient was sleeping on it, the administering of a bed-bath, the way to lift a patient without straining his/her back. Each of these techniques was taught in a series of steps which denoted a correct and an incorrect procedure. An incorrect procedure was in some instances dangerous for the nurse (as in lifting), dangerous for the patient (a lift which produced physical harm), inefficient or discomforting for the patient. The definition of a "right" procedure or a "wrong" one was implicitly and explicitly an important task and the basis on which such a definition was made varied and depended on the type of task performed. The four main bases were as above: bodily harm to the nurse, the patient, inefficiency (in which is included the related "sin" of untidiness) and patient discomfort. In the name of these norms, the careful performance of techniques was felt to be justified.

A standardization of techniques was felt to be important in order that "the same standard" of skill and care was exhibited by the nurse. It is important that nurses know what is a 'correct' and 'incorrect' lift, what is a 'correct' and 'incorrect' method of injection. The maintenance of a certain level of skill is required to maintain safe patient care. However, there were indications that this notion of a maintenance of skill and standards, became at times a legitimation for making everyday tasks difficult. These ordinary

tasks developed into rituals and habits, tasks which were performed in standard procedures and which appeared to add a dimension of skill and knowledge, but which upon closer analysis did not seem to require the "little extras". Bed-making is one example of such a ritual. The mouth-washing of a patient is another. The bathing of a patient is a third. Such tasks are essentially mechanically simple everyday tasks which through standardization became technical skills to be learnt. They began to form part of the cognitive base of a nurse's training. In addition, not only did these tasks become rituals, they became habits, procedures which were resistant to change and question. They became self-perpetuating procedures; once accepted and classified as part of a nurse's training, it became difficult to question these procedures for to do so was to question the basis of the nurse's skill. The line between what was standardized skill and what ritual became difficult to specify and nurses found it difficult to question the basis of their skill/habits. As one ward sister put it, "Nurses are creatures of habit, they don't like change."

It is not denied that such simple, everyday tasks may not become skilled procedures in the sense that a nurse learns to use them as means of psychological care. Performed with sensitivity, such precedures could be valuable in ensuring that the patient felt less embarrassed about being helpless, sick and alien. However, both in school and on the wards, there was a lack of emphasis on using such occasions or procedures to administer a care of the mind rather than of the body and the physical emphasis on hygiene, "tidiness" and "neatness" tended to dominate.

The words "patient comfort" were often heard during introductory courses and on the wards. When mentioned the term was illustrated in certain ways; the patient was comfortable and felt a sense of well-being when: the nurse fluffed up a patient's pillows from time to time, gave him a good wash and made him feel clean, completed a bath by wiping him/her dry, dusting on

talcum powder and combing his/her hair neatly, and making sure there were sufficient blankets. In short, patient comfort was linked in a variety of forms to bodily comfort and to a nurse-defined idea of neatness and tidiness. These concepts were important. A nurse had to dress smartly and neatly, a patient liked to be neat and to possess a tidy locker, the ward had to look neat, tidy, orderly. Together with bodily comfort, a sense of order had to emerge. The days of making sure that all beds were in a straight line by using clear markers may have gone but the rule of order, discipline and the body were subtly pervasive. To take care of the body meant to ensure that it functioned in a right order, that each organ performed as it should do, that natural order was restored. This concern for a natural order, a bodily order translated into an outward order not just of the patient but of the nurse and the entire physical surroundings within which the restoration of natural order was to take place. It seemed that one would reinforce the other and health would be better promoted when the physical environment of the patient was in order.

The concern for the body, as distinct somewhat from its order was supported by the emphasis of ward work. From introductory course the learner entered into a world in which a tradition of body-emphasis had been initiated. A new learner, by observing his/her peers and senior learners began to appreciate a paradoxical situation where persons in authority placed a greater emphasis on the performance of physical and <u>body-contact</u> tasks but whose seniority was equated with performing more esoteric <u>body-oriented</u> jobs which involved less direct patient contact. Indeed, seniority at ward-level is eventually synonymous with body-monitoring as opposed to direct body care. Sisters, for example, were concerned when a learner did not appear to have "much to do" and was "hanging around". They praised learners who would not mind any dirty, physical work. Yet the bulk of body-contact tasks were performed by 1st year learners and auxiliaries. 2nd year and 3rd year learners

moved on to more "advanced" nursing with "more difficult" body-oriented tasks which were examined only in 2nd year or 3rd year. They delegated the more unpleasant, direct patient-contact work to 1st year learners. After qualification, the staff nurse and ward sister/charge nurse took on more administrative and monitoring work. Our sample of 21 ward sisters and charge nurses reported that most of their work was "paperwork". When asked to quote percentages, the figures ranged from 90% to 25% with a mean of 57.5%. The paradox is however more understandable when it is clear that although less direct body-contact is synonymous with increasing seniority, the orientation of nursing remains centred on the performance of tasks on or for the patient in order that his body is once again in order.

The emphasis on the body thus takes on specific forms and varies from introductory course to qualification. Nevertheless it pervades and is constituted by a) the creation of ritual and magic around everyday tasks, b) the division between "simple" and "advanced" tasks which approximate to tasks with more and less direct patient contact and which are performed by learners with different levels of seniority, c) by the definitions of right and wrong procedures, and d) by the meaning given to patient comfort. It is found in the importance given by teachers to anatomy and physiology, by ward sisters/ charge nurses to practical, common sense nurses who are able to perform their appropriate kinds and levels of body-tasks.

In *The Birth of the Clinic*, Foucault (1973) argues that medicine appears as the founding science of all the sciences of man, of that proliferation of disciplines that set out to study man as an individual interacting with other individuals. It was medicine which he claims created the possibility for a science of the individual, of the individual being both the subject and object of his own knowledge. Medicine was able to bring about a different way of seeing, of conceptualising knowledge by focusing medical knowledge, not in the art of classification or observation but in the hospital, by examining and

intervening in living, diseased bodies and by opening-up dead bodies. He argues that these changes were themselves made possible by the convergence of the requirements of a political ideology and those of a medical technology; by a complex of events which included the reorganization of the hospital, a new definition of the social status of the patient, a new relationship between public assistance and medical experience, between health and knowledge.

From these events, anatomo-clinical medicine was born and it was the perception of life in death, of knowledge in dead bodies which Foucault argues enabled the expansion of medical knowledge. It was the "living night" which was dissipated in the "brightness of death." Nineteenth-century medicine was haunted by that absolute eye that cadaverized life and rediscovered in the corpse, the frail, broken nerve of life. It was death which enabled the birth of anatomo-clinical medicine;

> "It is from the height of death that one can see and analyse organic dependences and pathological sequences .... Death is the great analyst that shows the connections by unfolding them, and bursts upon the wonders of genesis in the rigour of decomposition: and the word decomposition must be allowed to stagger under the weight of its meaning. (p.144, The Birth of the Clinic, Foucault, 1973).

It was only when death became the concrete a priori of medical experience that the old Aristotelian law, which prohibited the application of scientific discourse to the individual could be lifted. Anatomo-clinical or anatomo-physiological medicine drew emphasis to man and his body. This emphasis of 19th century medicine on the body appears to be dated by even older historical events which saw a great increase in attention paid to the body of man. In *Discipline and Punish*, Foucault (1977) writes:

> "The great book of Man-the-Machine was written simultaneously on two registers: the anatomico-metaphysical register, of which Descartes wrote the first pages and which the physicians and philosophers continued, and the technico-political register, which was constituted by a whole set of regulations and by empirical and calculated methods relating to the army, the school and the hospital, for centralling or correcting the operations of the body."
> (p.136, Foucault, 1977).

These registers, were quite distinct: an intelligible body and a useful body. Yet in practice they frequently overlapped and it was after all a short step from the body understood as a machine to the use of that machine. This political anatomy of the body first understood it as a mechanism made up of separately usable parts which could go wrong and therefore required treatment in order that its economic utility could be maintained. The body was seen as docile but needed training, discipline, time-tabling in order to increase its utility; processes which at the same time diminished the political force of a body and created obedience. We shall discuss this process in detail in the next section. Foucault argues that the body became directly involved in a political field; it is as a force of production that the body is invested with relations of power and domination but its constitution as labour power is possible only if it is caught up in a system of subjection. The body becomes a useful force only if it is both a productive body and a subjected body. It was this emphasis on the body as a machine which was of doubtless advantage to the development of capitalism. The latter would not have been possible without the controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to economic processes. It also enabled the emergence of certain strategies which defined and produced sexuality in a variety of forms. Finally, in *The History of Sexuality*, Foucault (1981) implies that the focus on the body is coterminous with a power change in Western society, in which power exercised in society and for society is exercised in the name of preserving life, not of the king, but of the species, the race, and the large-scale phenomena of population. Wars are no longer waged in the name of a sovereign who must be defended; they are waged on behalf of the existence of everyone, for the preservation of a way of life. Those who died on the scaffold became fewer and those who died in wars grew. But this according to Foucault was power assuming upon itself the administeration and preservation of life.

This power of societies and governments to foster life or to disallow it however was limited by the point of death. Foucault has an interesting hypothesis that death is carefully evaded not because society has a new anxiety which makes death unbearable, which finds the discovery of a pre-Classical theme too daunting but because the procedures of power have not ceased to turn away from death. Foucault argues:

> "In the passage from this world to the other, death was the manner in which a terrestrial sovereignity was relieved by another singularly more powerful sovereignity; the pagentry that surrounded it was in the category of a political ceremony. Now it is over life ..... that power establishes its dominion; death is power's limit, the moment that escapes it; death becomes the most secret aspect of existence .... (p 138, Foucault, 1981).

It is because death limits power, because it is the most private part of existence over which power has no control that death is feared and exorcised out of normal discourse. This evasion of death, a concern with the preservation of life reinforces a focus on man as a body.

A final thread in the tapestry of events is the rise of the body as an object of study and a relation of power may be found in Foucault's argument that the middle class or the bourgeoise sought to distinguish itself by emphasising its health or its "sexuality." The aristocracy had done this through the notion of "blood", of alliances between ancient lineages. The bourgeoise's "blood" was their health and sexuality. Geneology became important, not for its age, name, or title, but for its health, its freedom from any taint of mental disorder, physical disability, consumption, venereal disease or immoral lviing. The value placed on the body and its sexuality, was according to Foucault, bound up with the establishment in society of bourgeoise hegomony. It was among the middle class, that great concern was to be found for its health and from which emerged the stock figures of ill-health: the nervous woman, the woman afflicted with vapours, the schoolboy, the child surrounded by domestic servants, tutors, and governesses who was in danger of compromising his obligation to preserve a healthy line of descent for his family

and social class. The cultivation of the body of the bourgeoise represented to them a political and economic force which would ensure their present and future. Its dominance was in part dependent on that cultivation.

Foucault's analysis helps to locate the present concern of 20th century nursing on the order and functions of the body. This is because nursing, from its emergence was tied to medicine and to its anatomo-physiological model of man. Nursing was an adjunct, a support for medicine in its study of the human body, in its concern to understand how the bodily parts worked together, how damaged and diseased organs could be brought back to healthy order and the illness controlled. It helps to partially explain the concern in Western medicine and nursing to preserve life and to evade death. It also helps us understand the reasons why Nightingale's reforms were to receive such a receptive hearing from among the class from which she came. The bourgeoise ensured the maintenance of a body of private nurses and private doctors who were concerned to preserve, understand and bring to order the human body. Later economic emergencies in capitalism arose which enabled the working class to be granted a body too. Conflicts over urban space: cohabitation, contamination, epidemics, prostitution, venereal diseases; the development of heavy industry with the need for a stable and competent, disciplined, healthy labour force, the obligation to regulate population flow and to apply demographic controls; all these confrontations had to take place before the working class attained a class. But even this identity was circumscribed within a whole technology of control and surveillance (e.g. schooling, the politics of housing, public hygiene, the institution of workhouse relief) which ensured that the working class did not present themselves as a risk to the bourgeoise.

The emphasis on the body as a subject of study and as a sole focus for medicine and general nursing was thus born of an image of man as a machine. One which needed to be controlled, put under surveillance, disciplined and made healthy. This allowed man to be a useful product, a unit of labour power,

an essential cog in the machinery of capitalistic relations and a means by which the control over man's sexuality could be extended over a large number of relations. It is an emphasis which divides man into the body and the mind, an artificial distinction, which fails to appreciate man as a social holon, an indivisible whole which cannot be understood as two unrelated distinct parts.

At Mayfield, most learners felt that psychology and sociology were commonsense subjects which need not have been taught:

> "Psychology and sociology were a complete waste of time. It's just commonsense. You can't learn how to comfort patients in a classroom!" (New SRN recruit, February 1980, February 1980).

> "I wish we'd spend more time on learning how to connect certain symptoms with certain diseases. We should have more practical sessions". (New SRN recruit, February 1980, February 1980).

These learners failed to realize that increasingly they had time only for the body, which was set apart from the mind-body whole. The domination of the Body over the whole is an artificial relation which continues today in nursing and which is rooted partially in its ideological contribution to the maintenance of capitalistic relations. Its focus ensures the reproduction of labour power, the return of a healthy unit of labour to the unchanged world of production. The emphasis on the Body is thus an ideological relation which prevents man from appreciating that he is a whole person, not an amalgam of parts. It detracts attention away from the persistence of a mode of production which is intrinsically unequal in its distribution of wealth. In particular, it gives an illusion of equal access to health and glosses over the question of: "Health for what purpose and whose gain?" What is stressed is that a healthy body emerges from the cares of the doctor and the nurse; the latter can do little about the material environ of these bodies or the "problems of their mind".

What is absent from a general nurse's training is any understanding, <u>in practice</u>, of the mind-body person. The words 'in practice' are stressed

because lip-service is often paid to the concept of a total person and of the nursing process. In practice, the nurse learner's neglect of the whole person is reflected in her attitude to the overdose patient, the "sexually deviant" patient and the psychiatric patient who is treated on a general ward. The first is seen as irrational and a "problem" in his desire to die, the second exhibits an incomprehensible ill-health which generally has nothing to do with a bodily cause and the third by definition does not come within the province of general nursing. Thus, in addition to the problem of a probable age-gap, to an inability to cope with emotional stress, to the creation of anxiety defense mechanisms (discussed in Chapter 10), the focus of the body and of the preservation of life means a general nurse is thankful to leave patients who contravene the boundaries of physical health to other health professionals.

The body and its physical health, from its conception in the late 19th century, remains the central focus of general nursing at Mayfield. However, scattered signs are emerging and coming together which appear to signal a shift in emphasis to give a new 'sense' and a radical emphasis in nursing. At Mayfield there are three sets of loosely coupled phenomena: a) the fact that Davies is a nurse trained in psychiatry and has maintained an academic interest in the socio-psychological aspects of nursing; b) the acceptance by the educational sub-system of the nursing process as a more 'scientific', systematic, holistic and human method of organizing nursing care; and c) the compulsory subject of psychiatric nursing in SRN training. These three happenings appear to consolidate weakly in a shift of emphasis in general nursing from that of the body to that of the holistic mind-body. However tentative this new movement may be, there is a faint outline of a growing trend to give relatively more emphasis to the socio-pshchological facets of nursing care. There appears to be a skeletal framework which is consolidating and which apparently mock our criticisms of nursing training and practice. Nursing appears at

last to be taking cognizance of isolated pieces of research which over the years have pointed to a lack of socio-psychological training in general nursing. Although teaching on sociology and psychology is not well done at present at Mayfield, its very presence apparently suggests a more enlightened, more humane awareness of the needs of the total person. If the growth of medical knowledge may be said to evolve to higher forms of development, nursing appears to exhibit a similar, parallel evolutionary schema. Have the scales finally fallen from the general nurse's eye and is she able to perceive the necessity of situating a patient in his social and psychological context? Has nursing, like medicine in the 19th century finally come of age, and realized the poverty of its present form of general nurse training? Is the new movement which is just discernible at Mayfield the harbinger of a different generation of general nurses?

We intend to show that this set of events which is emerging at Mayfield in the 1980's does not represent so much a shift in focus to the patient as a holistic person but to the patient as an individual body. The notion of the Body has now been given a tentative trust and is shaping into a notion of the Individual Body. A comprehensive system of this 'new' nursing focus, when it emerges fully is not likely to be the emancipatory *Idee* which it now appears. On the contrary, the notion of socio-psychological care in nursing is being caught up with a myriad of other intentions. These collectively deprive the patient of his sociality and sets him/her up as an individual body negotiating separate, specific contracts with a number of health professionals on an individual basis. The private patient-nurse relationship has ideological roots which make the future practice of general nursing even more unaccountable to the community. There are four sets of intentions which collectively do not appear to result in a more humane development in nursing.

Firstly, some of the new changes taking place in general nursing at Mayfield were not actively intended by the training system as such; secondly, liberal

and emancipatory intentions have become entangled with the professional project in nursing; thirdly, those intent on making nursing a profession with economic and social status have found it profitable to fudge the boundaries among different foci; and finally, there remains an ultimate emphasis on understanding social and psychological phenomena in order to enable the body to regain its health. The final objective of this tentative change remains the health of the body and the division between it and its mind remains irreducible. Social and psychological understanding is viewed as an efficient appendage in order to speed up the body's recovery; it is not seen as an essential part of the part-whole which has implications for our taken-for-granted definitions of rational behaviour, individual sickness and optimal allocation of health resources and care. This interpretation of psychological care may not grasp that what is irrational behaviour is but a different rationality which is perfectly understandable given the conditions of its birth; that bodily sickness and health as presently defined is indispensable to maintaining a particular mode of production; that individual cases of sickness may have less to do with the individual than his social, economic and political context; that hospital-based care breeds its own sociology and psychology which normalizes the individual and treats him as a unit of production to be processed. Whilst focusing on the Individual Body, this new change is unlikely to alleviate the essential process of normalization and standardization which prevails in institutionalized nursing care that is uncritically accepted.

We begin our critique of this new trend with a discussion of an event which contributes to a perception of this trend but which was not initiated by Mayfield's educational sub-system: the introduction of psychiatric training for SRNs. This event was in reality the result of a network of political and economic relations which dominated a different stage: that of Britain's entry into the European Economic Community. It was this entry and the need to

standardize certain forms of training amongst constituent countries which made psychiatry a compulsory subject for SRN trainees, in addition to paediatrics, obstetrics and geriatrics. This act was thus not an initiative made by the GNC or Mayfield although the former's acquiescence was required for the change in training. However, given the wide-ranging implications of Britain's entry into the EEC, it is unlikely that its effects on nurse training were felt to be of particular significance and it is difficult to imagine the GNC making strong protests as to the changes required. Psychiatrics is now a new feature in SRN training but its arrival was not planned to increase the present deficiency in general nurse training.

Also , it is doubtful what one short spell of seconded training could do in helping a general nurse trainee to see the patient as a whole. It could be all too easy for a learner to persist with a view of the patient as a body, once he/she is transferred back into general nursing. In addition, the teaching of psychiatry itself may be ideological in that the nurse now feels able to judge norms of rationality and irrationality. Not only does she become an expert in physical care, she now has an added skill of being an expert in psychosocial care. This view of the 'disbenefit' of psychiatry and psychotherapy is for example, held by Foucault who believed that Freud transformed the psychiatrist into:

> "an absolute observation, a pure, impassive silence, a judge who punishes and rewards in a judgement that does not even condescend to language .... The doctor; as an alienating figure, remains the key to psychoanalysis. It is perhaps because it did not suppress this ultimate structure, and because it referred all the others to it, that psychoanalysis has not been able, will not be able, to hear the voices of unreason, nor to decipher in their own terms the signs of the madmen. Psychoanalysis can unravel some of the forms of madness; it remains a stranger to the sovereign labour of unreason. It can neither liberate nor transcribe, let alone explain, what is essential in this labour." (p 277-8, Foucault, 1967).

Were psychiatric training for the nurse to be conducted along such lines, then the patient, instead of being liberated could find himself the subject of an even greater number of experts.

Secondly, the increasing focus on the nursing process and on holistic patient care has been intricately caught up with the fight of UK nurses to achieve 'real' professional status. In the 19th century, the emergence and registration of nursing as an occupation depended, to no small degree, on the self-interested support of the medical profession. Both Florence Nightingale and Mrs. Bedford-Fenwick, in their own distinct ways realized that for nursing to be acceptable it had to have a subservient position to the medical profession. A subservience which nurses have sought, ever since, to be rid. The desire to attain professional status is manifested in:

a) a desire to develop a distinct form of knowledge which could be appropriated as nursing;

b) a corresponding desire to encourage research into nursing which was not wholly medical or technical but which anchored itself in recognised, academic disciplines such as sociology and psychology; and

c) a desire to develop a monopolistic market over a unique product - that of the mystical nurse-patient relationship.

The desire in (a) helps explain the eagerness with which, American, British and the Mayfield nurse teachers welcomed the nursing process. Upon examination the idea is but a simple, deterministic model of decision-making which management science students learn. But it is a model which gives a coherence to nursing practice and techniques and which provides a weak theoretical base - weak, but a theoretical, scientific base nevertheless. The nursing process potentially gives a base from which the nurse as expert may be developed, strengthened and "legitimated" in society. It adds an air of scientific value and helps give the impression of an exclusive body of knowledge which can only be learnt by those who go through the rites of training.

Research into nursing has gradually been given more emphasis by the leaders of the GNC and by employers of nurses - the various State-run Regional and Hospital Area Health Authorities. With the creation of a separate Education sub-system (itself an act linked to manpower concerns), it was but a short

period before research was seen as the foundation on which a body of nursing knowledge could be created. Research has since the early 1960's concentrated on the application of the knowledge and methods of the natural sciences, psychology and sociology to problems in nursing. Attention has been centred on the medical/technical problems of disease, treatment and care. On the implementation of new methods, new treatments, new drugs, or new equipment which would enable a nurse to look after her patient "better". Interest has been focused on the issues of nurse selection, nursing curriculum and an identification of criteria of good nursing care. In short, research has sought to use a variety of theoretical bases (medical, psychological, sociological to create a distinctive body of nursing knowledge.

Much of this research was in fact performed by sociologists and psychologists who were not nurses for the focus on bodily tasks and functions has isolated British nursing from the mainstream of further and higher education. The gradual influence of American models of nursing, the increasing insistence that research should be carried out by <u>nurses</u> trained more directly in the social sciences; the belief that graduates and a University relation enhanced the professional project and nursing's occupational status; the worsening prospects for youth employment which allowed the raising of entry qualifications and the increasing difficulties of full graduate employment created the conditions for a University relationship and the establishment of graduate schools of nursing. The process had begun by which nursing could eventually be considered a distinct body of scientific knowledge, a respectable academic discipline which straddles the social and medical sciences. Nursing could develop into a discipline in its own right, one which did not have to rely on medicine or on medical sociology or psychology as a cognitive base. However, despite the initiation of a few nursing degrees and the production of nurses trained in the social sciences, nursing has so far only <u>applied</u> social science techniques to solve pragmatic, everyday questions. In particular, what has not developed, is a critical

awareness of nursing. Apart from Dingwall & McIntosh's (1978) book of readings there has been little in the form of a detailed study of nursing as an institution in society, with complex relations to other institutions. The emphasis remains technical.

The nursing process, too, remains firmly within the desire to delineate a distinct body of knowledge and to apply social science knowledge in nursing. It is a concept which emerges from a concern to develop a theoretical coherence over a diverse group of everyday, at times ritualistic, set of practices which has been accumulated in an ad hoc fashion and which lack a scientific basis. (Roth, 1978, shows for example that the methods used for controlling contagion are based more on myth than reality). Whilst attempting a holistic approach, the nursing process does not truly analyse man as a social being, as an interactive being which is situated in a complex of micro-power and macro-structural relations. On the contrary, the notion tends, and therein perhaps lies its attraction, to isolate the nurse-patient relationship. It behoves the nurse to humanely look after the needs of a patient viewed as a whole. But this identification has the effect of transposing the doctor-patient relationship to nursing. Whilst such a private relationship ensures privacy for the patient it also confers secrecy on the doctor/nurse's interventions; it isolates the patient as an individual interacting with another individual. It makes the evaluation of medical/nursing practice inscrutable and the accountability of a doctor/nurse even more obscure than it is at present. It tends to add the privacy of the nursing cubicle to the doctor's consulting room. As Larson (1977) points out, one of the reasons for the power of the medical profession is this veiled one-to-one transaction between patient and expert which cannot be discussed or evaluated except by peers. But as Freidson (1960) has argued, the privacy of sole practice is also impenetrable to colleague review. Beyond the requirements of a training, obtained no matter how long ago, there is little more than the medical/nursing profession expects of its members

and little more than it controls. Whilst, the isolation of a unique nurse-patient relation may enable holistic patient care it potentially aids the creation of a unique product which is susceptible to monopolistic control. One which leaves the patient as an individual isolated from the rest of his sociality, unable to question the effectiveness of the expert services he is supposed to receive. The patient in this new nursing could relate to the nurse as an individual, and the nurse becomes accountable only to "God and his/her conscience."

It would then be difficult to organize a collective voice for general patients who are unhappy with their nursing care and treatment. It is not by accident that patient pressure groups have been more easily formed and more visible in specialities of nursing dealing with long-stay patients who remain in one institution. A typical medical or surgical patient is not, in the main, a long-stay patient and has little to compare his experiences with. The patient may be unaware of the services he could obtain and must rely exclusively on his/her own uninformed judgment since, indeed, the information he has about the effectivness of the services he is getting is always indirect or expost facto. He also finds it impossible to compare his own short, limited subjective assessment and experience with other short-stay patients. In addition, although the nursing process appears to imply increased individual accountability, the reality of peer control may make professional accountability restricted. Moreover, the patient's anxiety about what may be, to him, matters of life or death leads him to make an emotional investment in the nurse-patient relation. Since there is a general tendency to attribute to one's nurses quasi-vocational attributes, an uncritical acceptance of their expertise is frequent: a patient wants to believe that somebody can help. He wants to believe that the reason why a nurse has not been attentive is because he/she is overworked and has other patients to attend to. There is also a tendency among patients to forget unpleasant nursing or hospital experiences which are short-stay experiences.

Research into patient evaluation of nursing care has found thst an evaluation given during a hospital stay and several months after differs in that the latter always constructs the experience as being more pleasant. Thus, organizing patient evaluation and determination of general nursing is highly difficult and faces severe logistic problems.

Although the nursing process appears to hold forth an enlightened holistic approach to patient care, its institutionalization as a "scientific" method and its tendency to consolidate the nurse expert position in the drive towards professionalism , throws doubt upon its emancipatory value. Indeed, there are signs that its introduction into nursing research and practice has not loosened the ideological tentacles. Nursing appears to be frozen into the first tentative era of the emergence of the social sciences: when man was not perceived fully as interacting with other men but as a unit plucked out of context. This stage in nursing almost parallels the state of economics before the time of Ricardo and Marx who saw man, not as the creation of supernatural forces but the subject of a myriad of concrete, material relations. Nursing at present is moving towards caring for each individual on an independent basis. Whilst this notion has liberal ideas of the assertion of the individual, it paradoxically also detracts from an essential part of that individuality, its sociality. The general nurse at Mayfield is limited in her task: she may only contribute towards a patient's bodily health. Once a healthy body leaves her ward and is returned to the world outside of her hospital her task is ended. It is only within the context of an individual care of the body that we can understand the observations of negotiation between the general nurse and her overdose patient.

a) General nurse and her overdose patient:

"they are usually no problem, they don't need anything doing for them. Sometimes they come in and go out within a few days."
(Qualified SEN, Southern District, September 1980).

"... I know this sounds unkind but overdose patients are ungrateful, Here I am, trying to save lives and they turn round and are aggressive to you for saving theirs .... I have no patience with them now ....." (Staff Nurse, Southern District, September, 1980).

"I don't normally talk to overdose patients about their problems. Don't know what to say ..... Don't know whether they want to talk about it ..... Usually leave that to the psychiatrist or social worker." (2nd Year SRN, Northern District, July 1980).

b) The general nurse and her demanding patient:

"Annie is always calling "Nurse" but she doesn't want anything .... only attention. Sometimes we don't bother to go up to her. She doesn't really need any help." (Staff Nurse, Northern District, July 1980).

"Mrs. X is always finding something wrong with her. She just doesn't want to go home ....." (Qualified SEN, Southern District, September 1980).

"Herbert is really inconsiderate. He complained the whole night very loudly. Why can't he be less noisy about his pain ......" (Staff Nurse, Northern District, July 1980).

"I just get so tired talking to Mrs. Collins. She goes on and on .... and she always likes to bribe nurses with chocolates and sweets ... I try not to stay too long in there. She just exhausts me mentally." (2nd Year SRN, Southern District, September 1980).

and c) The general nurse and her "social problem" patient.

"He's got lice but he doesn't want to be cleaned.
He's got to be cleaned ....
I know he'll get the lice again once he goes back to that man's hostel ...
but that's nothing I can do ...
He's got to be deloused."
(Staff Nurse, Southern District, September 1980).

What the general nurse is unaware of or is aware of but does not voice is the image of man as a social holon which creates his own individuality within a context of sociality. The economic, social, psychological and political roots of sickness and health and the domination of cure and care over prevention are processes which are not easily visible within each individual patient-nurse intervention. Even where a nurse is dimly aware of such material conditioning factors, the consciousness is grasped only in a single relationship with a particular patient for only a short period of time. The patient leaves the ward and the visible reminder is gone. Because of the individuality and the temporality of such isolated experiences, there is also created an air of

helplessness and an acceptance of conditions outside the traditional definition of nursing care. The phrase "But what can I do, I can do only so much" was sometimes voiced by a nurse/learner frustrated with her inability to prevent a reoccurrence of a sickness. As health care becomes more clearly divided into areas of expertise governed by different health professionals, each of whom relates on an individual basis, the difficulty of linking and integrating knowledge becomes more pronounced. Man perceived life in death and death in life, this perception did not have the same function as in the Renaissance. Then it carried with it reductive implications: the differences of fate, fortune and conditions were now equalized and death drew everyone to itself. Death unfailingly compensated for fortune; both kings and slaves were buried and disintegrated in the same earth. In the 19th century, however, it was constitutive of singularity and individuality. It was only in the perception of death that the individual could find himself escaping from a monotonous, average life. In the half-subterranean but visible approach of death, the dull common life became an individuality at last. Thus medicine is linked in its epistemic configuration with all that was meant by Romanticism, with that sense of the doomed, isolated individual, with his dark, secret interiority. Medicine, however, has also developed another view of the individual, as a subject interacting with others. Nursing, by advocating the nursing process appears to freeze at the earlier stage; although an outflow of researchers from the social sciences could enable the emergence of a social science of nursing, rather than in nursing but its critical nature may not make it the desired object so sought after by the "professionals" in nursing.

Finally, there are indications that even nurses intent on introducing social-psychological care in general nursing do so in order that the general nurse may be better equipped to get on with the job of getting the body well. Davies, for example, when criticising the weakness in general nursing says:

> "These nurses are stupid. They can't understand that a body can't get well unless you understand the psychological problems. The patient may be worried about a dog at home, whatever. But if he is worried, then h's worried and this may prevent the patient from getting better." (Davies, Director of Nurse Education, May 1981).

Thus, the Body or the Individual Body remains the final objective of the general nurse and social-psychological knowledge is subordinated to that overall aim. Although lip service is paid to the patient as a whole with physical and psychological needs, nurse training and practice at Mayfield does not critically see the value of understanding the mind-body.

11.4.2 The Professional Expert and the Perpetuation of a Disciplinary Society

A concern with understanding the body was and is closely coupled with controlling, manipulating and using that body. In the last section we concentrated on how a focus on the Body and the Individual Body is reflected in nurse teaching; in this section we intend to show how a societal concern with a discipline of the body and mind is transformed through power relations in nursing practice and training to produce an obedient community.

In *Discipline and Punish*, Foucault outlines four processes by which discipline of the body and mind may be implemented. The first is the cellular division of the space in which individuals are subjected to discipline; this space being divided and sub-divided into more or less self-contained units. In the school this is reflected by the substitution of mixed ability classes with single ability classes. In the hospital and training system this is reflected by the division of a mass of patients into wards and bays and of learners into distinct classes. The hospital of the 18th century owed its new organization to the armed forces: it was the naval hospital at Rochfort that pioneered methods of segregation, regulation and strict control. A strict supervision of supplies and expenditure led to techniques of observation: patients were registered, their progress monitored and contagious patients were isolated. Curiously, nursing too owed its organization to the military model.

In the Crimea, Florence Nightingale effectively served with the British army. She gave each of her patients an identifiable space and each of her nurses an identifiable station.

The second process is a control of activity and the dependence on a time-table. This process dates from ancient monastic times and is clearly revealed today in the order of ward activities with its set tasks and a definite rhythm of events. But regularity and rhythm is not only applied to a ward's series of general activities but also to the exact movements of a learner's/nurse's body when performing these tasks. There is a definite rule to be followed when a nurse lifts, performs an asepsis procedure or removes a stitch. Procedures exist which break down the apparently simple task of bathing a patient into a series of minute acts performed by various parts of the learner's/nurse's body. Also, the position of a patient's body in relation to the nurse's must be correct; he should be on his side or lying flat on his back depending on the procedure performed.

Thirdly, discipline was imposed upon the body in a temporal sense: the process of training could be broken down into stages with a view to the development of even greater skills as time went on. The procedure used in prisons, schools, training institutions and monasteries is training and exercise. In its mystical or ascetic form, exercise was a way of ordering earthly time for the conquest of salvation. In the nursing world, exercise is replaced by graduated training, where certain procedures are considered advanced and may only be discussed and examined in school at certain times. A learner/nurse could have performed a task numerous times on a ward but is not able to be certified until the destined time arrives. For instance, a learner SRN may be allowed to perform an aseptic procedure on her first ward but is not permitted to sit for the practical examination for this procedure until the end of her second year of training.

Fourthly, in order to obtain the combination of forces, the individual

body must be moved and combined with others. Teamwork is of the essence on a ward and a learner's contribution to teamwork is assessed. The more heavy jobs are always performed by pairs of nurses - lifting, at times bathing and bedmaking. The handing-out of drugs is officially a two-person task, one to check and counter check that a prescribed drug has been correctly dispensed.

These four processes collectively help ensure the emergence of an efficient, controlled, disciplined nursing system which is able to ensure, in the main, bodily health. It enables the co-ordination of useful bodies and develops forces of production which enable a technical expansion of the survival capacity of society. Such discipline is not intrinsically power-impregnated and ideological for without some form of discipline, of regulation and predictability, society as a system could not be understood. Totally devoid of regular behaviour our system would truly be out of control with anarchy rather than a negotiated order being the norm. Discipline may be conceptualized as a constraint in cybernetic terms and a system without constraints of any form could not be understood; indeed, we may not perceive it as a system if its behaviour and structure is utterly without some form of predictability. In nursing, discipline has made some positive technical contribution; without the separation of patients into different types of illness and the separation of the infectious from the non-infectious we would not have been able to understand certain forms of illness. Without the discipline of a schedule of activities and the concept of there being an optimal time-action relation efficiency would be lacking in nursing care. As has been argued earlier, technical efficiency and rationality is necessary but not sufficient for an integrated evaluation of institutional effectiveness.*

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* This view is somewhat opposed to Foucault's view that when the sciences of man became possible a new technology of power and a new political anatomy of the body was implemented. That once we made man and his individuality/sociality the subject of study we have also introduced a disciplinary society which appears to possess a technical rationality (see, p 191-3, Discipline and Punish). There is a suggestion that discipline is intrinsically calculative and normalizing, that it possesses but a secret underside. But technical rationality and its discipline also plays a positive role in the expansion of the forces of production and in widening the range of survival or prosperity possibilities.

However, discipline and its close relation - legitimated authority is not without its dark side. For discipline can easily be interpreted within a military scheme for and dream of society. A dream whose fundamental reference is not to man but to a meticulously subordinated cog of a machine,

> "..... not to the primal social contract, but to the permanent coercions, not to fundamental rights, but to indefinitely progressive forms of training, not to the general will, but to automatic docility.
>
> 'Discipline must be made national,' said Guibert. 'The state that I depict will have a simple, reliable, easily controlled administration. It will resemble those huge machines, which by quite uncomplicated means produce great effects; the strength of this state will spring from its own strength, its prosperity from its own prosperity'".
> (p 169, Foucault, 1977).

Discipline then becomes a mask for domination and creates a docile, obedient community which is not allowed to question the wishes of those who discipline. It creates a society where legitimated authority and discipline has its own rationale and self-sufficiency. Thus the four disciplinary procedures could combine to produce the dream and something of the reality of a totally technically rational, totally efficient and totally controlled society. Discipline then has a paradoxical effect on man; it creates individuals by regarding them as the object and instrument of efficiency but it also abolishes that individuality with one quiet sweeping gaze. Through a process of normalization and standardization discipline enables the easy development of 'labelling' and experts. It brooks no question and denies the possibility of psychological processes of projection and introjection, processes which we have discussed in detail in Chapter 10.

In addition to psychological effects, discipline has organizational and macro-structural causal effects. In nursing the dark side of discipline operates in a variety of forms. It operates through hierarchical judgement and observation which often shades into and overlaps with expert judgement. Such forms of judgement are not only pervasive in superior - subordinate relations but also learner-teacher and nurse-patient relations. They emerged partly because

of the cellular mode of division which is characteristic of discipline. The military camp was one of the earliest forms of such observations but the technical necessity for observation and separation soon spread to hospitals, schools and asylums. A new kind of architecture was required: one that would make it possible for those who were experts to observe continuously the condition of those who "needed help". The perfect disciplinary apparatus would make it possible for a single gaze to see everything constantly. The Florence Nightingale ward evolved and is still regarded by nurses today as the 'safest' method of ward organization, where the inmate of each bed is in full view of the sister's office. The patient never knows when he is being observed and tends to behave at all times as if he is. A state of conscious and permanent visibility introduces the functioning of power. For through the practice of constant observation, the observer or expert begins to notice differences and to create classifications of the observed. It makes it possible not only to observe the symptoms of patients, without the proximity of beds, the confounding effect of contagion but also to define norms for 'good' and 'unpopular' patients; 'hardworking' and 'uninterested' nurses. Among learners, it makes it possible to observe performances (without there being any imitation or copying), to typify attitudes, to assess character and to draw up meanings for cleverness and stupidity. To distinguish 'quiet and shy' from 'loud and boisterous'; 'sweet, docile nature' from 'aggressive, demanding troublemaker'. Such norms, once defined and congealed tend to exist and persist with a life of their own. A rigidity in classification may in essence be a subtle form of domination, of normative inequality.

At Mayfield such norms were seen to operate and to suppress a voice of dissent and dissatisfaction from the observed. At recruitment, a woman who attended the interview in a cocktail dress was put in the marginal category because such modes of dress indicated 'improper' attire and a lack of 'sense'. A learner who forgot to wear her uniform for two days and her proper shoes on

another was classified within three days of introductory course as a rebel and as disrespectful of authority. A girl who was active, boisterous and jovial in class was spoken of by teachers as 'somewhat of a ringleader among her friends'. These norms were communicated to learners and several spoke of an immediate negative labelling process whenever he/she complained of specific facets of his/her training. The notion of a 'troublemaker' or a 'ringleader' was particularly mentioned; so were the concepts of being 'self-confident and cocky'. Learners reported that they did not wish to complain because they would be negatively labelled and no change would be effected in the system as a result of their complaint. Patients too were aware that they might be labelled a nuisance and often prefaced a request with "I don't wish to be a nuisance but ......" They could clearly observe that unpopular patients were often left on their own and only essential requests and procedures attended to.

The constant process of observation and the knowledge that the observer is only privileged to do so because he is skilled or has had more experience in observation easily leads into a domination of the observed. Classifications and norms become sacrosanct because to question them is to question the basis for observation and expertise. To deny labels is to show disrespect and a lack of discipline. To be noticed often takes on a negative connotation unless the notable exception is one which conforms to prevailing norms of "goodness" and "likeability". The following quotes underline our concerns:

> "No learner is going to tell me what to do on my ward. I am the sister around here and there should be proper respect."
> (Sister, Northern District, July 1980).

> "I have had far more experience than some 1st year learner. Nobody is going to walk in here to tell me what she <u>wants</u>. That's the trouble with nursing today. There's simply no discipline. No respect for authority. In our days we wouldn't dream of asking for special privileges ....." (Senior Allocations Officer, June 1980).

> "I can't see why we can't be like the police or the army. Discipline is not a bad word. We need discipline. More in nursing, not less. What we lack today is discipline. We are getting too liberal".
> (SNO, Southern District, May 1980).

In addition, the picture of the good nurse which emerged contained a significant measure of "sweetness and docility". As various individuals were pointed out as good nurses, a distinctive characteristic was observed. All were classified as "nice, dedicated" people. Essentially they were learners who showed a genuine concern for their patients, were technically competent and "sweet-natured". That is, learners who were not highly dissatisfied with or critical of the system of nurse practice or training. This preference for a non-threatening learner may be examined in reverse order, by analyzing learner perception of the degree of "Questioning Authority" present in the system. Of our sample of 309 learners, the mean for this climate scale was 2.7270 for the hospital and 3.1926 for the school (on a 5-point Likert scale ranging from 1-5, Not Permissible to Very Permissible). The results indicate that learners know that to question legitimate authority is not considered "good practice" especially within the service sub-system, within which the employee status of the learner predominates and observation of the kind usually accorded to workers is in practice.

Such a rigid authority structure is also enhanced by the attempt to link seniority with expertise, experience and an awareness of esoteric rituals. The professional is viewed as an expert who knows what is best - for the learner, for the patient, for the subordinate. The professional has been examined and certified as an expert. It is this facet of the examination process which imparts a supply fitter, a societal legitimacy and a standardization of procedures that has enabled the nurse to claim to be an expert. Both Larson (1977) and Foucault (1977) place the examination and its standardizing mechanism at the heart of a profession's ideological domination. Larson writes:

> "But even a body of knowledge that is esoteric and theoretical - and therefore difficult to routinize - is still not a sufficient condition for the control of a competitive market. Take, for instance, the case of the Protestant ministry in America: despite the undeniable existence of an esoteric body of theological knowledge, and despite the rise of separate seminaries from 1784 on, the established denominations could not protect themselves from the challenge of the evangelist movement. Similarly, the law was not protected from outsiders until the

> institutionalization of formal teaching and qualifying for examinations". (p 31, Larson, 1977).

and Foucault condemns the examination as a

> "normalizing gaze, a surveillance that makes it possible to qualify, to classify and to punish. It establishes over individuals a visibility through which one differentiates them and judges them...... in all the mechanisms of discipline, the examination is highly ritualized. In it are combined the ceremony of power and the form of the experiment, the deployment of force and the establishment of truth. At the heart of the procedures of discipline, it manifests the subjection of those who are perceived as objects and the objectification of those who are subjected." (p 184-5, Foucault, 1977)

It is through training and examination that a profession is able to create cognitive exclusiveness, to make esoteric and ritualistic everyday practice but also to standardize and to unify knowledge into a coherent whole. Professional expertise needs to be esoteric yet formalized and standardized enough to be, in principle, accessible to all who would undergo prolonged training, thus projecting an image of apparent disinterestedness and universal equality. Ritualism operates a requisite principle of exclusion: where everyone can claim to be an expert there is no other expertise. Ritualism teaches a nurse to believe in the superiority of her work although the material, objective state may be quite different. At times, ritualism breaks down as when learners preserve a whole ritual only for examination purposes (Bendall, 1975; 1973) or learns through everyday experience that certain rituals have little scientific basis e.g. the wearing of gowns and masks to control tuberculosis contagion (Roth, 1978) or the use of mouthwashes diligently according to prescription. But ritualism is a powerful means of ensuring social control over an increasingly educated labour force and of convincing them that their work is more "difficult" than lay practice. Ritualism establishes expertise, social control and works well with the standardization required for examination. For it is the examination which provides the vital anchor for the establishment of nursing expertise: it stamps out destructive competition and establishes monopolistic control over a "fictitious comodity". In order to be examined, a nurse has to standardize, to learn correct and incorrect methods, to get used

to remembering a procedure in a series of distinct steps and to follow these steps taught by a higher authority. In order to be certified, she must learn correct professional behaviour which is proper for the expert. Hence, the examination and its standardization reinforces a false notion of standardized expertise, helps create a follower who is used to following procedures and enables the transmission of a set of behavioural norms in a subtle quiet way. It reduces innovation and flexibility in the operation of a human practice. In everyday work, when the examination is over, learners and qualified nurses often found a decrease of standardization and "minor" variations in practice.

In one heated and agitated discussion on Ward 10 in the NGH, 1st year learners were amazed to learn that neither the staff nurse, nor the qualified SEN nor the sister could agree as to whether a pair of "dirty" forceps did or did not exist in an asepsis procedure. Each of these three qualified experts performed the procedure in slightly different ways and had apparently equally logical reasons for doing so. But a correct procedure had to be learnt for examination and the lack of a 'correct' method caused some anxiety among the learners. Eventually, Sister rang the School and requested the clinical teacher (who would be an examiner) to pronounce on the correct procedure. He too explained that variations could exist but that he himself preferred to assume the traditional existence of a pair of "dirty" forceps. The pronouncement made, the learners visibly settled down. They now knew what was required in the examination though several felt that in practice a nurse often had to decide for herself what was a "best" method. The individual variability of the nurse and patient were acknowledged to be conditioning factors and certain steps in a procedure were felt to be necessary only for the teacher and the examination. Even the seemingly unchangeable method of bed-making was found to have variations; a little fold could, for example, be made in the middle of the top sheet so that patients were not tightly covered and when they stretched their legs, could feel

comfortable. But such variations were felt to be due to the variability of individuals and not threats to the legitimacy of the examination. That remained important in the nurse's eye. It provided the ideal standard against which actual practice could be compared. It was only because of the vagaries of staffing, of resource scarcity and of individual preferences which presented "minor" variations. Qualified and unqualified nurses alike continued to believe in the central necessity of the rituals they had learnt but now practised in a destandardized way. The long process of socialization, the importance of the qualifying examination was sufficient to contain the reverse trends of a breakdown in total ritualism and standardization. At the level of the individual, practice varied. But instead of this being viewed as the assertion of the independent act of a thinking person it was glossed over and neutralized, situated wholly and only within the parameters of the standard. The examination prevailed.

Moreover it was the examination which had certified doctors as judges of normality and allowed the medical profession to gradually take charge of the hospital. In the 17th century the physician made infrequent visits to the hospital from the outside; he took little part in its administration. After the consolidation of the infant British Medical Association, the visits became more regular, more rigorous. Resident physicians were eventually appointed; indeed their appointment was a sign of prestige. At Mayfield, for example, the northern workhouse was for a long time served by university-based surgeons and physicians from the southern voluntary hospitals. Also, with the physicians came the trained nurses, the 19th century sisters and their untrained pupils. When registration was won, one of the first tasks of the GNC was to organize the syllabus and to oversee examinations. The possession of a certificate was the possession of a means of employment, the route to joining a respectable group of organized skilled women. It was the examination which divided the skilled nurse from the Sairey Gamps, and from the thousands of middle-aged country nurses who served in 19th century England's cottage

hospitals. It was through the examination that the nurse became an expert in patient care and in observation.

The examination not only tested the knowledge imparted to the pupil, it also provided the teacher with a knowledge of the pupil. Further, the knowledge extracted from the various forms of examination and observation was committed to writing in the form of reports and files. Each individual learner like each individual patient becomes a case, which is at once an object of information and a site for the exercise of power: the individual is described, judged, measured and compared with others in his very individuality, classified and normalized. His weaknesses are highlighted and marked for correction. His strengths are depicted as an example to all. Such files are acknowledged by learners to be constraints on their voice of dissent. They know that they themselves need qualitative, institution-based certification in the form of "employment references"; they know that should misbehaviour be recorded or a "too-high" absence rate be noted, job prospects in a future nursing institution are unfavourable.

Patients too are acutely aware of the existence of such files which are forbidden to them. The doctor-judge and the nurse-expert 'know' that such information is best kept away from the patient and he can only know what the experts feel justified to reveal. The secrecy afforded to medical files on patients is a powerful tool for ensuring a continual dependancy of the patient on his experts for they alone know what treatment has been prescribed for which illness. The study by Rosenthal et al (1980) shows how control over information by both doctor and nurse is a means by which compliance is ensured and control exercised. The study by McIntosh (1974) also shows that many patients feel they do not get enough information; even cancer patients react well to being told of their prognosis (see Wilkes, 1977; c.f. McIntosh, 1977). Thus while patient files are ideologically judged to be the sole province of the experts, research has indicated that some patients desire more information not

less about the state of their health. We are not arguing that every patient, regardless of circumstantial conditions should be told in great detail about the state of his health. Some patients make clear their desire to be uninformed as to their diagnosis or prognosis; but this position is often assumed by health experts on the basis of little evidence from the patient. Such withholding of information from a patient who does not indicate a preference for a lack of information is a clear appropriation of the rights of that patient. An appropriation which denies that the nurse is serving or working for the patient and instead makes the patient's desires secondary to the convenience of work routines and the maintenance of monopolistic control. When the patient's family is brought into collusion in controlling information there is the additional complication that the family might be working for the health care team. A patient does not belong to the family or to his experts in any sense which would justify contradicting his desire for information. A nurse, even if only following doctor's orders, plays an active role in maintaining a power relation with a patient who desires but is denied information.

There are few checks to curb the control of such information. Patients have no legal right to examine their medical files and such information is denied even upon request. Learners are also denied access to their files. Even if they were granted access, there is still an underlying power relation because an 'employer's reference' is as much a certificate of acceptability as the SRN/SEN badge. The reference remains an essential part of the examination. Learners are allowed access to their ward reports and in fact are obligated to certify the truth or falsity of the remarks written. This evidence is of little help in equalizing a management control over information for learners feel that protest is an indication of misbehaviour. There was a strong feeling that when authority issues arose the School and the Service closed ranks and presented a united front of legitimated authority, experience

and expertise exercised by reasonable, thinking adults. This was indeed the case when the two functional sub-systems agreed as to the character of the learner and the reasonableness of the other authoritative party. Where a sister had been classified as a reasonable person, the learner's complaint was viewed skeptically by the School; this also resulted when the learner had previously been classified as a troublemaker. Thus, the examination, the observation and the file remains and, creates the expert and enables the subordination of the observed. An examinatory justice is born which renders an accumulation of men and women who are docile and useful.

The irony of the individuality - normality axis is given a further twist when the observed can only see his own observation by others and fails to grasp reality when he himself is the observer. The sister who complains of her NO fails to see the power-relation which hinders her evaluation of the learner; the learner who views her teacher/sister with resentment fails to sympathsize with the demands of the patient. When the observed so often changes position and becomes the observer - the judges of normality are truly present everywhere. For the distortive power of ideology is such that the observer always feels that his observation is justified and his role as the observed is not. Indeed, the observed cannot even conceptualize of himself as an observer in the same terms and often creates distinctions between his observer-role and his observed-condition. Thus, a learner is always unfairly treated by her teachers but does her best to control information only in her patient's best interests. This ubiquitous reversal of roles in a multitude of situations ensures a widespread, almost universal reign of the expert; who guards his expertise jealously and seeks to free himself from observation by in turn observing and controlling others.

Finally it is the rise of the 20th century expert who introduces an intrinsic contradiction in the relation between the state as an employer and the nursing profession. In its effort to gain economic rewards and social

status, and to be an independent profession which taps a separate monopolistic market, nursing has clamoured for an increase in scientific research and exhibited a desire to anchor their practice in scientific theory. This is so because a profession's capacity for standardizing training and research within the confines of what Kuhn (1970) calls normal science and for excluding competing paradigms is not only augmented by its connection with science; it is also given the ultimate legitimation of an objective, independent, more effective inquiry. But in addition to this scientific anchor, a profession requires affiliation with the modern university for entry therein gives the profession a core of scientific educators who are best equipped to defend the universalistic guarantees of professional competence and to legitimize the professional's claim of monopoly and autonomy. This is because the university is apparently universalistic and independent of lay demands and private interests and it also monopolizes the production and dissemination of new knowledge.

Nursing's liaison with the modern university has only recently been forged in the UK and is not a liaison happily accepted by all nurses. However, most of the senior nurse educators at Mayfield felt that it was right for nursing to have an academic knowledge base in order that it could develop "properly" into an autonomous profession. Nursing sisters and senior service management (who did not possess such academic qualifications) were less doubtful about its worth. The conservatism of these older-trained nurses developed at times into a strong anti-academic outlook; to them nursing was the practical, physical sctivity of caring. 'Basic' nursing, in effect, consisted of everyday tasks. Although no qualified nurse admitted it, the ordinariness of nursing tasks was often unconsciously implied in their conversation and their examples of quick-thinking common sense (e.g. the learner who is not afraid to wipe up vomit or faeces). This traditional emphasis on nursing the individual body in fact retarded the process of professional mystification.

It was not until the late 1950s that the GNC approached London University with a serious proposal to introduce a degree course in nursing. This development in fact implied the construction from scratch of a body of standardized 'scientific' knowledge around the traditional patchwork of random skills which had to that point been the core of nurse training. Then there were doubts within the professional elite itself as to the extent to which nursing was an academic subject. The talks with London University proved abortive as both sides failed to agree on the content of a nursing degree. In the event it was Scotland's Edinburgh University which introduced the first degree course in nursing, in 1960. In England, it was not until 1966 that the GNC and the University of Surrey were able to find sufficient common ground; the latter then in the midst of a transition from a college of advanced technology at Battersea to its new site at Guildford. Its newness, its lack of prestige compared with older, more powerful universities and its origin as a college of vocational training helped it to develop a necessary experimental outlook which coincided with the demands of the GNC. However, this course was then ended in 1975 when communication difficulties between the University and St. George's Hospital in London proved insurmountable.

Today, university degrees in nursing are centred at Manchester, Chelsea College (London University) and at Edinburgh. Manchester's first professor in nursing was appointed in 1974 and was knighted in 1980, a sign of the slow but gradual acceptance of nursing as a legitimate academic discipline. Due to a lack of qualified teaching personnel, the degree course at Southampton University, was held up until 1980. So was that at Bristol Polytechnic. The polytechnics have in fact played a larger role in helping nursing to develop a link with higher education. Whilst the university's concept of an academic subject has, in the main, not matched the aspirations of the nursing profession, the polytechnics were more receptive. They appeared in significant numbers at the time of the Briggs Report of 1972 and had carved out vocational training as

their socially valued, marketable product. This philosophy was prima facie well matched to the infant 'science' of nursing which of necessity required a practical, labour-oriented component. There was, however, some hesitation on the part of the nursing elite who felt that liaison with polytechnics could lower the status of graduate nursing (see p 9 The Times Higher Education Supplement, 30th January, 1981) but given the non-receptiveness of most universities and the problems of staffing, there was little choice. Despite this setback, nursing has made some progress towards its hope of "full" professionalization. The numbers taking graduate degrees, though small are rising, 33 in 1971, 163 in 1975, and 238 in 1979. In % terms, this growth is less than that predicted by the Briggs Report (2%-5%). In 1971 degree nurses made up only 0.2% of general nurses beginning training that year. In 1975 the figure had risen to 0.9% but in 1979 it had barely crept up to 1%. Nonetheless, the graduate industry now supports some 20 degree courses in the United Kingdom whilst 22 years ago there was only one; nursing research has been gradually accumulating and sustains two major British journals of nursing research and there has been a gradual increase in senior nurse management pursuing higher degrees in nursing or the social sciences. Although the necessity of a university link for nursing's desire to be a profession and to monopolize a sphere of competence is not recognized and accepted by all nurses, a firm foothold has already been gained. Nursing is now a recognizable and increasingly acceptable part of the academy.

In addition to this necessary liaison with the university the profession has also been able to strengthen its link with the general educational system by basing its entry requirements more on "O" levels and "A" levels. Out of necessity, inundated with applications and adopting the ideological import of credentials nurse managers at Mayfield are beginning to take educational achievement as evidence of self-discipline, of the ability to care and of the potential for promotion. Trainability is now assumed albeit reluctantly to

correlate with educational achievement, as are productivity, adaptability and personality. As nursing "progresses", demands more "intelligence", develops more its links with the august bodies of science, it is beginning to undergo an educational upgrading which at present causes unease among its less qualified teachers.

The first effect of this increased use of credentials as a screening device is to further reinforce the power of the examination and its normalizing gaze. But it also contributes to structural, perhaps unintended effects. The emphasis on credentials, on expertise and on being a profession has caused the expert to compare his wages with that of other experts and, more importantly, to ally himself with the trade union movement when the RCN appears not to champion his rights. The Royal College is in an ambiguous position; being closely allied with the GNC, its members explicitly or implicitly support the professional project, yet it is also aware that the State requires a cost-efficient health service with wages that are within state-defined limits. The GNC and RCN leaders are aware that nursing was granted registration by an Act of Parliament only 60 years ago. Soon after its inception, the State in fact overruled one of its proposals. Today such overt power may not be exercised by the State but it is implicit in the RCN negotiations with the government on wage claims. It has also never repealed its founding rule not to take strike action, arguing that such action would in fact worsen the nurse's professional interest and put patient's lives at risk. This appeal to emotional and "professional" reasons for not striking has restricted the nurse's ability to negotiate on wage claims and this coincides, in the main, with a State desire to maintain a cost-efficient service. But it has also spawned an increased interest in trade union activity. Although the RCN represents some 190,000 nurses, a significant minority of some 600 are joining unions like NUPE (National Union of Public Employees), COHSE (Confederation of Health Service Employees) and NALGO (National Association of Local and

Government Officers). The late 1970's has seen a noticeable growth of trade union membership among nurse, especially among younger learners who complain of "unprofessional" wages and who view aggressive trade unions as offering nurses solidarity among a broad trawl of NHS employees. To some extent, the nurse's established position within the community as a dedicated, traditionally lower-paid occupational group (a position which the GNC is keen to elevate to that of a profession on par with medicine) means that nurses know they can probably go much further without forfeiting public sympathy. Also, medical and technical advances have lessened slightly the moral issues which lie behind a nurse's strike. Collectively, this set of factors is changing the traditional image of the nurse from being dedicated and starchy to being politically active and radical. Finally, the younger age of most learners and qualified nurses and the need to be financially independent has made the present-day nurse more susceptible to trade union membership. This activity is antithetical to the professional project which has sought so far to distinguish the nurse from other unskilled, ancillary hospital workers. Moreover, nursing organization has, since the Salmon Plan, being nationalized and bureaucratized in order to achieve efficiency and professional independence. This event has helped transform nursing into an industrial work setting with less of its vocational mystique and altruistic requirements. Such a requirement is also becoming difficult to assess; dedication and altruism is better assessed via a face-to-face interview but the large pool of unemployed young people applying for nursing jobs has made such interviews difficult to carry out. The credentials of general school education are then used as a first filter in selection.

When nursing first developed, both education and money were the possessions of the lady nurses. Florence Nightingale herself epitomised the gentlewoman who had had an upper-class education and had no need to a wage. The service ethic then became the over-riding legitimation for nurses, rich and poor alike. It

explained the presence of a gentlewoman in dubious surroundings, it fitted well within the Victorian moral framework, it belonged to a long tradition of religious practice and most of all it appeared to be relatively independent of capitalist relations of production. 19th century nursing and even 20th century practice still tries to be connected with universal service and with the protection of the social fabric from the subversive effects of the market. It still seeks to preserve precapitalistic ideals of community bonds and responsibility but in a way which incorporates precapitalist legitimations of social inequality. Its model of gentlemenly disinterestedness appears, for example, as a secularized version of the feudal notion of noblesse oblige, which embodied the nobility's ideological aversion to commercial pursuits and its belief, anchored in a religious view of the of the social order, that high rank and noble birth impose duties as well as conferring rights. Today education, money and altruistic service do not co-exist in quite the happy manner that existed in the 19th century. The contradictory demands of maintaining a large (hence young) labour force of trained nurses, a bureaucratic concern for efficiency and a professional desire to possess cognitive exclusiveness are intrinsically meshed with a decline of the magic of altruistic service, of the "professional" willingness to go through the ritual of training with low pay, of the efficiency of maintaining a labour force at low cost, and with a significant rise of unionization among nurses; events which are themselves antithetical to the desire to run an efficient, cost-effective health service and to raise nursing to the status of an established profession. A series of micro-objectives are linking together to form a comprehensive system shot through with contradictions.

A third effect of the use of credentials as a means of professionalization is a justification of the existence of a growing industrial reserve of the unemployed. A permanent surplus population who have only themselves to blame

for a lack of ability and talent. After all, everybody began with an equal chance in school. Thus a system of inequality which is perpetuated at the level of the school is reinforced by the nurse training system and the reality of class and exploitation is deflected and concealed. It comes as little surprise that the population of trained nurses, qualified nurse teachers, managers and learners at Mayfield is predominantly white. Of the 4 cohorts of 1980 recruits sampled, only 2 West Indian learners were found and both were in SEN training. The majority (over 80%) of our sample of 309 learners was also white. Given the probable links between social origins, race and educational achievement, a system of training which places emphasis on educational credentials does not break the spiral of inequality. As Larson (1977) points out, the ideological foundations of inequality are deep and are intertwined with the roots of subjective illusion. Learners blame themselves: "If only I was smart enough, if I hadn't fooled around so much in school, if only I knew how difficult it is to become a nurse ....." Because they believe, that working themselves up depends on their ability not on the chances they have, they blame themselves for not being something other than what they are.

A fourth effect of the network of secondary school, nurse training and university is the creation of a moral hierarchy which overlaps with a social hierarchy of jobs. At school, children know implicitly and explicitly that nursing is not as prestigious an occupation as medicine. Our own sample of schoolchildren revealed that children with higher educational aspirations conceptualized nursing negatively. (Appendix 10.6). Different tasks and skills no matter how important and exacting for the self, do not have the same social value, in the same way that different kinds of manual and honest work do not have the same dignity. This hierarchy of competence is presented and lived, from early childhood on, as coincident with a moral system of intelligence, effort and freedom. Thus challenging the structure of inequality

requires, to a large extent, an ideological redefinition of the self. The emphasis on badges, on credentials convinces man and woman that they must first gather these gems, must first achieve dignity on a class society's terms before they can challenge the limits on their freedom. They must first become acceptable and legitimate, their children must have more education, go to "better" schools and in this way achieve greater freedom. It is in this sense that an examinatory justice ideologically bounds man to themselves; by holding in front of them the possibility of purely personal and individual solutions and thus preventing them from even conceiving that there may be collective and cooperative ways of challenging the very structure of social inequality and of the ubiquitous presence of the observer-expert.

A fifth effect of a desire to professionalize and to be certified as an expert is the creation of a status-differentiated hierarchy which paradoxically divides the apparent homogeneity of the profession. A desire for credentials was generated and enabled by nursing's militaristic history. Such a desire can now be easily served by the hierarchy of ranks which are available to nurse experts organized via the Salmon Plan into a bureaucratic system. It may also be achieved by the accumulation of recognized academic degrees and at Mayfield, nurse teachers are increasingly aware that a degree or a Ph.D is a distinct asset in nurse teaching. Such forms of differentiation by credentials when connected with promotion, then become fused with differentials of rank, expertise, money and influence: general societal criteria of success. As Larson (1977) points out these two hierarchies - the one of power, with external origins and visible, and the other of excellence and prestige, defined internally and translated into influence - tend to coincide. Together, they destratify a profession. Hence, a SNO's job is more prestigious and well-paid than that of an NO's, to train at Mayfield is "better" than training at Rotherham because the former is a teaching hospital

and to possess a Masters degree is "better" than a Bachelors. Such status differentials further make difficult the questioning of authority and the institution of a rational consensus based on free speech. There are indications that such stratification could potentially destabilize the unity of the profession and lead to sub-groups who dissent from general norms (e.g. unionized nurses). However, the fragmented nature of the nursing professional service, its identification with individual practitioners and its created sense of privilege and importance vis-a-vis the laity and other occupations are likely to act as strong stabilizing forces. On the one hand, vocation, career, training, expertise and authority are individualized attributes of privileged work. On the other hand, the unconscious or conscious comparisons with other kinds of work, made by professionals themselves and by the larger public, ultimately set professions apart as communities of "superior" workers. These general elements of consciousness elicit consent and compliance from educated workers and are likely to underplay the realities of professional stratification. However the currently required degree of internal equality within the profession is only relative and a question remains as to whether the ideological effects of a professional consciousness can in the long-run resist forces which objectively undermine the privileges of professional work. In the meantime, stratification persists and sets one expert over the other, and the danger of the patient receding to the background becomes real.

In summary, the desire of senior management at Mayfield and of nursing elites more generally to develop a scientific discipline with appropriate social rewards and economic privileges is essentially an ideological enterprise. It seeks to certify experts who are given the privilege of secret information, prestige, status and power over specific concerns, and who are difficult to call to account or to question. Their authority tends to become entrenched and so does their ability to label, classify, judge and normalize. In seeking to give eminence to scientific research, a university liaison and credentials, the

system of nursing and nurse training which is exemplified at Mayfield, is concentrating knowledge and its production within educational and occupational hierarchies which are inegalitarian, and alienating. These structures also achieve a fusion between the progressive content of special competences and the requirement of a system of ideology which prevents the emergence of the force of the "better argument". However, they also produce contradictions which emerge in local confrontations between nurses and the state, between superior and subordinate, between service and education. In seeking to be free and independent of the doctor - nurse relation, the nursing profession is creating, perhaps unintendedly, a system of examinatory and credential justice which is self-contradictory but which appears stable enough to dehumanize the patient and to increase his dependence on a variety of experts.

11.4.3: The Contribution of Nurse Training and Practice to a Dominant Capitalist Ideology

From a broader analytical perspective, Mayfield's and nursing's professional project is part of a basic structural transformation - that of the extension of exchange relations under capitalism to all areas of human activity. Marx argued that the institutionalization of exchange relations, which itself presupposes some development of the social division of labour, establishes the distinction between the use-value and exchange value of an object. The development and use of money further stripped commodities of their natural use-value and the characteristics of the particular kind of labour to which they owe their creation; instead they are transformed into uniform, homogeous labour. Also labour, the value-creating substance does not appear as concrete labour, creating specific use values but under its abstract guise: it is labour-time measured by its duration, which is itself a function of the average labour-power of society. Hence, the extension of market relations tends to introduce a double abstraction: value, which is related to the money equivalent, and labour-time, which is related to an abstract notion of average labour-power in society.

Labour-power then appears as a commodity on the market, inseparable from the appearance of capital and the capitalistic epoch is characterized by the transformation of the labourer into a commodity of wage labour which may be exchanged on a market - a commodity whose exchange value is enhanced via a period of training which in nursing is governed by a monopoly of instruction, examination and credentialing. In the previous section we highlighted the ideological aspects of training which nursing exhibits at Mayfield: the ritualism of everyday practice, the unnecessary standardization of procedures and the creation of an expert insensitive to the expertise of the patient and the learner. But training performs yet another ideological function: it falsely equates value and quality with the

quantity of credentials. Excellence, it is implied, can be measured by "units of training" and by a series of objective examinations. In nursing the generalization of bureaucratic patterns of recruitment reinforces the connection between competence and length of training. While the use of I.Q. tests and personality descriptions are used to recruit stable learners, expertise at the professional and managerial levels tends to be equated with years of schooling, of observational practice and number of credentials. Instead of a measure of anxiety proneness being used to highlight the degree of anxiety perceived in the training system, it is used to preserve the system and to filter out the "non-adaptive" learner. This false equivalence is further compounded by the fact that training - considered as the co-operative activity of instructors and students - is a social activity which produces exchange value which is invested in an individual. A nurse's skill and her certificate may be considered as exchange value created; homogenized years of schooling and standardized credentials provide a "natural, universal equivalent" into which these exchange values can be translated and by which they can be measured. But as Larson (1977) points out, it is inherently contradictory that the exchange value of a professional's skill should depend on cognitive and educational monopoly. This monopoly means that length of training can be arbitrarily determined; a situation brilliantly demonstrated when the condition of one year's training was first imposed by Mrs. Bedford Fenwick and her lady friends, who in turn helped set up a three-year programme of training for new recruits. As Abel-Smith (1960) wryly points out, if three years of training was sufficient in the 1920's, it was either too much then or too little now. This monopoly, taken together with the unquantifiable nature of intangible skills, destroys the real equivalence between length of training and a notion of the average labour time that is socially necessary for the production of the professional. Monopoly of training means, in fact, that the price of professional services is <u>not</u>

the market expression of socially necessary length of training. Thus although training produces use-value in the professional and in this sense may be classified as productive labour in Marxist terms, the creation of exchange value contains an internal contradiction which places the price of the professional commodity (the trained nurse) outside the realm of market determination. Also length of training and credentialing appears to be ideologically related to the market value of the professional. They function more as an implicit justification for the price of the commodity and for the privileges associated with professional work, than as the actual quantitative translation of average socially necessary labour time into market value.

Apart from the contradiction inherent in nurse training, nursing, like medicine, also contributes albeit indirectly, to the capitalist mode of production. Larson (1977) argues that the classic personal professional services which were sold on a competitive market could claim to be relatively independent of capitalist relations. These early professions, like medicine and law, could argue that their product (the professional service) tends to be immediately used or consumed by the client or consumer who purchases it in a "free" market. In terms of Marx's theory of exploitation, this implies that professional labour which is sold on a competitive market under the form of direct services, independently that is, of the capitalist relations of production, does not contribute to capitalist accumulation by producing surplus value. Since only labour which produces surplus value is productive, those professional services sold directly on a market are, strictly speaking, unproductive. This ideal of universal service to all mankind appears, in fact, to reflect the equalizing and democratizing effects of the market (equalizing if compared, for instance, to aristocratic patronage which reserves professional labour power for the use of an elite): unproductive labour can potentially be purchased and consumed by all, whether they own capital or not. The

claim of disinterestedness conceals the potential venality of the actual transaction of services but it does, nevertheless, reflect the fact that this kind of professional labour remains outside the capitalist mode of production. But professional labour which is performed for the benefit of a capitalist firm is not structurally different from other kinds of labour which are subject to capialist relations of production. Marx writes:

> "If we may take an example from outside the sphere of production of material objects, a schoolmaster is a productive labourer, when, in addition to belabouring the heads of his scholars, he works like a horse to enrich the school proprieter. That the latter has laid out his capital in a teaching factory, instead of a sausage factory, does not alter the relation." (p. 509, Capital, Vol. 1.)

And he adds:

> "An actor, of example, or even a clown, according to this definition, is a productive labourer if he works in the service of a capitalist (an entrepreneur) to whom he returns more labour than he receives from him in the form of wages." (p. 157, Theories.)

Thus, when nurses work for the benefit of a capitalist firm as industrial nurses or as private nurses, their labour directly supports a capitalist relation. At Mayfield, however, nursing labour is expended and consumed within a state-run institution and here nursing labour is indirectly related to the capitalist mode of production. But it is related, nonetheless, by its contribution to the reproduction of the labour force, and by its concern to restore sick and diseased bodies who are then fit for work. Carpenter (1979) also suggests that the N.H.S. itself was set up in order that the state could intervene in the inherent crises and contradictions created by capitalism, and that it in fact acts as a buttress of capitalist relations of production. Moreover, inequalities in the distribution of health services still exist in the U.K. and are subject to power negotiations (Nahapiet, 1981). To the extent then that the nursing service contributes to the reproduction of labour power without challenging the capitalist mode of production, it indirectly acts as a support. In addition, the iedology which pervades nurse training leads to a false equation between credentials, length of training, and price of professional

labour power. It is an ideology of expertise which when linked with the organizational and educational structure reinforces a system of inequality of material opportunities.

Nursing training and practice not only emphasizes the patient as an individual, it also creates the nurse as an individual possessor of his/her own skill. What is missing in nurse training and practice is an emphasis on the social nature of training, which is subsidized by the state out of public funds. This lack of emphasis is further compounded by the fact that a nurse <u>earns</u> a wage which implies that even as a learner her training has not been subsidized. The learner has in fact worked during training and rightfully deserved a wage. Indeed we have argued that a learner's wage does not equate to the amount of work done and that in fact her labour has been exploited in order that the state might maintain a low-cost health service. We are not now contradicting ourselves and are not arguing that a learner's wage for her labour is undeserved. But the exploitation of her wage labour is exacerbated by the private appropriation of a social product. What is disturbing in the unionized nurse's reaction to her labour exploitation is the demand for greater money for the individual to the exclusion of an appreciation of the social nature of her services. And at the centre of the professional rhetoric we find an ideal which is the general postulate of bourgeois ideology: that the individual is essentially the only proprietor of his own person and capacities, for which he owes nothing to society. This is the cornerstone of a bourgeois theory of democratic liberation; of a market model of society in which "free" individuals consent of their own will to the necessities of political society in order to protect their own natural rights, most important of which, is the right to property. In the foundations of liberal theory, the force that links atomized individuals to each other is the market. But a market society which is founded on the equal rights of free individuals but which equates freedom with a

possession of commodities inherently produces inequality and class differentials. The focus on freedom is associated with an individual appropriation of socially produced knowledge, with an individual right to property and to a hereditary transference of that property and knowledge. Such a process tends to generate individual and group or class differentials. And it is within this contradiction that the traditional emphasis of nursing on vocational service takes on a new meaning: as an attempt to reconcile the contradiction between social production and individual appropriation. It acts as an ideological device which legitimates the contradiction. It also serves as a guarantee that such individual competences are being "returned to society", that really the nurse has the best interests of her patient and the community at heart. Larson (1977) writes that such an ideological device is not really needed in a society where the large majority of people must sell their labour power in order to survive and where special skills are sought only with a view to their sale. There are indications, as pointed out earlier, that nursing is being stripped of its vocational face and being demystified due to a sense of contradictory aims within a system of state and monopoly capitalism. But the intervention of state education provides a powerful antidote to such demystification. For state education ensures that every average individual has at least been given a chance to prove his or her gifts. The generalization and apparent equalization of access to educational opportunities helps solve the contradiction implicit in ideological egalitarianism: on the one hand, men are not all equally the best judges of their own interests, but they are all given, in theory, the means to become the best judges. On the other hand, natural inequality of intelligence makes itself manifest in educational and occupational achievements. Elitism and elite rule can, therefore, be legitimized without renouncing the essential postulates of the egalitarian ideology: free and compulsory schooling has been provided on an "equal" basis to equip everyone equally. For if all

men start on some basis of equal potential ability, then the inequalities they experience in their later lives are not arbitrary, they are natural, the logical consequence of different personal drives to use those powers. The intrinsic inequality of the educational system is not made visible, neither is the equivalence between "natural" intelligence and societal rewards questioned, and social differences now appear as questions of natural inequality, of character, moral resolve, will, competence and luck. The pre-modern concern with fate appears, indeed, to be reintroduced as the determinant of human affairs; a supernatural overseer that gives each individual his due. The liberal and utilitarian construction of the individual as a "natural unit of measurement in social sciences" and as the basic unit of the social order, appears to be the cornerstone of a new system of inequality in training. Because the intervention of the state as universal educator appears to establish equality of opportunity at the outstart, special categories of individuals who monopolize competence appear to have ipso factor proved their ability. They may thus claim special societal privileges and act as observers.

But the professional nurse is herself deluded as to the degree of individual freedom available. The bourgeois theory of individualism provides but a subjective illusion by which the individual expert believes that he is a free agent who has gained superior knowledge. Because actions, meanings and words appear to emanate only from his subjectivity, the individual professional cannot grasp the shaping of his self by social definitions, by ideological forms of media. Because every person can be convinced that he or she is a free agent, endowed with equal rights, individualism appears as a crucial mechanism by which the ideology of the ruling class becomes dominant - it is shared by both the dominant and the dominated. By the doctor, superior, teacher, nurse, patient, subordinate and learner in a series of swift changes of the dominant-dominated role. Professionalism and individualism are related in

intricate ways: in the professional's tendency to treat patients as individuals, to seek individual remedies, in the individual appropriation of socially produced knowledge and most of all, in the professional's subjective illusion that he is freer and more of a "developed" human being than others. The social worth accredited to his expertise, his apparent greater social productivity and the value of his time are asserted in hierarchical structures. Himself the victim of a subjective illusion of individual superiority and freedom, the professional nurse is an efficient propagator of bourgeois individualism.

A major source of differentiation in nursing has already been discussed - hierarchical and institutional differentiation which is linked to hierarchies of competence and external structures of prestige, power and influence. This bureaucratic division of labour is also an efficient division of authority, of autonomy. It is an observational ladder, at each step of which is a role encumbent certified to perform only specific tasks of observation. As one progresses up the ladder, one's certified authority to observe widens but only in a relative sense. The autonomy of the professional nurse is in practice subscribed by the power of the medical profession, by her own nurse management structure and by professional norms of correct and appropriate modes of thinking. An individual nurse may negotiate more or less autonomy with an individual superior, consultant or teacher but the alleged professional autonomy and freedom of determination of work does not exist in nursing. As one nurse leaver insightfully points out, nursing as a career is a continuing process of "kowtowing" to various greater experts and forms of authority. A learner has her staff nurse, the staff nurse the sister, the sister the N.O., the N.O. the S.N.O. and so the ranking goes on. There are some signs of autonomy: nurses for example do not have to punch time cards, they take their coffee breaks when they like (although this is not strictly true as this depends on the consultant's round and schedule of ward

activities), they can arrange their work schedule with limited freedom, their vacations and off-duty with relative ease. But these limited concessions to autonomy must be viewed with regard to more general areas of decision-making. At each level of the hierarchy a nurse's decisions are inserted within the framework of goals and strategies chosen by others. The coming and going of patients and thus a ward's workload is to a large extent determined by the consultant, so is the identification and treatment of an illness. There is some evidence that delegation upwards is due to psychological anxiety about a patient's life and death but control over less emotional issues is firmly and jealously guarded at each level of the hierarchy.

Although there was some complaint of such restrictions, the observed has begun to accept that such hierarchical limitations on autonomy are a natural part of life. No contradiction between practice and professional ideology is noted because the hierarchy of autonomy is coupled with a hierarchy of expertise and experience; and is held forth as being available to all with sufficient intelligence and initiative. A long process of socialization into systems of discipline, authority and individual effort allows the nurse/learner to see limitations to autonomy as obstacles to be overcome by individual resolve. The individualism taught in school, within the nurse educational sub-system and the service sub-system is that rewards, both material and psychological, are rationally distributed to the ablest and the hard-striving. The upward career ladder is one which keeps open the road to freedom through more credentials, more education, more expertise, more individual ability. "If only I can be cleverer, better than my neighbour, my colleague, I will move to a more expert stage" - seems to be the guiding principle in nurse training. Colleague control is not depicted as inequality, as the unequal distribution of authority to people of doubtful status but as the rightful ascription of status and influence to better experts. The profession is often advertised

as a company of equals, of colleagues but the Salmon Plan has shown that it is in fact a common fate which is shared among unequals.

By pointing out that the ideology of autonomy does not materialize for the learner upon qualification, we are not implicitly supporting the form in which the nursing elite is seeking to establish independence and autonomy. Indeed our views are radically different as will be shown in a later section. Our purpose here is to show that the professional expert is herself a victim of the mystification of professional individualism which couples with the dominant ideology of bourgeois liberalism.

The career within nursing is yet another stabilizing device. With the development of the Salmon Plan and its hierarchical service structure, the expansion of the educational sub-system and the increasing variety of specialisms within nursing, it is no longer incorrect to speak of nursing possessing a clear career plan. A significant number of new nursing recruits when questionnaired wrote that they chose nursing because it was a "worthwhile career". It provided several employment opportunities upon qualification; one could go on to specialize, to work in private practice, in industry, on board ships and planes etc. But a career is associated with stability in work patterns, is dependent on continual employment and a continual demand for nursing skill; all of which depend crucially on the stability of relevant institutions. A career, in fact, closely binds a professional to the professional institution which ensures a continual status in a monopolistic labour market. It acts as a powerful socializing device which ensures conformity with the existing social order and is a source of basic conservatism. Careers, Wilensky (1960) remarks:

> "give continuity to the personal experience of the most able and skilled segments of the population - men who would otherwise produce a level of rebellion or withdrawal which would threaten the maintenance of the system. By holding out the prospect of continuous, predictable rewards, careers foster a willingness to train and achieve, to adopt a long view and defer immediate gratification for the later pay-off. In Mannheim's phrase, they lead to the gradual creation of a life-plan." (p. 555, Wilensky, 1960.)

It is the prospect of a career, a form of valued future employment, which makes the learner complain less, which makes the currently dissatisfied look to the next rung of the ladder as a better picture. It is also the career, with its long years of socialization, of created specialization and dependency, which helps contain contradictions and observable conflict within the nurse service and training system as a whole. A career is a life-plan which is a privilege accorded to a minority, it is denied the S.E.N. and the nursing auxiliary who, because of their "natural" inability, are fit to do "basic" routine nursing care.

A career structure cannot exist without a social division of labour, a division of autonomy and of expertise. The form with which such division is emerging in nursing shows a consolidation of an essentially surveillance-oriented expert who becomes more divorced from the concrete labour of nursing. The desire to maintain monopoly control, prestige, mystique and ritualism in the nurse training caused the early nursing elites to set a three-year programme of training for state registered nurses. However, the state demanded more nursing manpower than could be provided by such a long period of training, poor work conditions, a high learner turnover and male discrimination. Also, the requirement for monopolistic standardization had routinized many nursing jobs which were increasingly being perceived as "dirty" and "boring" for an educated labour force. From the early 1920's till now, the number of "O" and "A" levels possessed by nursing recruits has continued to rise, especially in S.R.N. training (Abel-Smith, 1960; Briggs Report, 1972). This labour force has typically been overtrained and taught far more than it will normally apply in the course of practice. It is almost impossible to distinguish the real from the ideological effects of this overtraining. On the one hand, overtraining acts as a hedge against incompetence in unfamiliar situations and crises; on the other, it serves to impart a greater sense of superiority and expertise which is required for certification. In both instances over-

training leads to high expectations of the content of nursing work.

A final thread in this myriad of events and tendencies is the Salmon career structure which awards greater material and psychological rewards for administration and surveillance operations; itself necessitated by the demands of efficiency in large-scale and monopoly forms of production. The picture and overall system that eventually emerges and crystallises is a form of nursing practice which contradicts itself. This contradictory system has several facets. Firstly, routinized practices are hived off as "basic", "simple" or "dirty" work to other grades of nursing personnel. The unqualified learner, the S.E.N. and the "semi-skilled" nursing auxiliary today form the primary productive team in ward-based nursing. They undertake the bulk of the concrete services performed on or for patients. More and more the staff nurse and the sister are taking on bureaucratic forms of work - administration and observation. As Williams (1978) points out the patient is being increasingly looked after by unqualified, semi-experts who possess a custodial attitude; who evaluate helplessness in adults as a regression to infant behaviours and who tend to treat an adult patient as an undignified child. Important questions are never asked: if so many unqualified people undertake the majority of patient-centred activities, why is qualification necessary? If a lowly educated S.E.N. or a nursing auxiliary may be entrusted with the actual care of a patient, what need we of the university graduate and the sister? The introduction of a second grade of nurse and of a "semi-skilled" nursing auxiliary was intended to counteract the scarcity of nursing labour whilst at the same time preserving monopoly control. But it undermines the nurse-patient relationship and does not reconcile sufficiently the difference between educated labour and the everyday ordinariness of the bulk of nursing work. Indeed, the concentration on physical care takes away the essence of variety - the human person situated in a particular social, psychological context.

When confronted with these questions nurse teachers and managers stoutly deplore the association of "simple" tasks with activities such as bed-making and bed-bathing. Davies, in fact, argued that these were in fact highly complicated (sic!) activities, and the latter in particular afforded a nurse (in reality, more often a learner) an opportunity "for psycho-social care". But why then are such complicated nursing procedures never performed by the sister, the N.O. or the S.N.O.? Why is it that the most prestigious, most well-paid, most powerful jobs in nursing are bureaucratic functions of observation and surveillance? If the price of labour-time is equal to some criteria of social worth or market necessity, does this mean that the value of the nurse is her ability to "manage and co-ordinate"? If so, what claim does nursing have to a particular body of knowledge which is unavailable to other workers, other managers? On what grounds do nurses claim to be a profession set up to serve the needs of a community when care is increasingly becoming an abstract service?

The custodial and regressive treatment of patients is accompanied by an abstraction of the patient. The ideal of bedside nursing is work which is centred importantly on patient helplessness but carried out in a way that preserves the person as a social whole who is capable of rational (in the Habermas sense) decision-making. Where an expert's work increasingly focuses on clinical procedures and observation, helplessness as a human condition becomes less human. We get the "incontinent" patient, who in the first stages of his illness suffers "a degree of circulatory collapse". What becomes important is the level of blood pressure, the pulse, the body temperature, the monitoring of "input and output information". When these observations are divorced from the person who makes up those observations, the concept of physical care is reinforced.

Secondly, specialization is offered as a means whereby educated labour may reconcile this network of contradictions. Because of overtraining, specialization is not seen by the public (or by the expert) as a narrowing-

down of competence, but as a deepening knowledge, and added skill. However, the specialization of functions inherent in an organizational hierarchy and the development of specialist courses in nursing give to incumbents a specialized knowledge which is increasing fragmentary and potentially obsolete. In nursing obsolescence is not an issue but specialization does tie the individual expert to nursing, thus removing to some extent the polyvalence of skill and its market value. Whilst more credentials, especially academic credentials, are being rewarded in the profession, they also tie the nurse to the occupation. Once she has invested time and effort to gain economic and social rewards within nursing, she is not likely to be able to, or desire to, move outside of her specialist skill.

Finally, the reconciliation of educated labour and routine tasks is but partly achieved by the forms of inter-professional differentiation already described; by the ascription of status, prestige and power to different functional roles and tasks. Such a division appears to promise more interesting work and more autonomy which is available to the better expert. But in fact this process serves to splinter the unity of the profession. It could be that in the future a radicalization of a dissatisfied educated labour force, especially at the training stage may shake the confidence of most managerial professionals who are smugly located in the middle- and upper-class strata of society. At present nursing is imbued with the ethos of the dominant class ideology: meritocratic motivation and individualism; it may be that when objective conditions become unbearable there could be a general demystification about the necessity for and the role of experts in our society.

To summarize, we argue that the values which undergird and support nurse training and service, as observed at Mayfield, are intrinsically consonant with the contradictions and ideology of its wider societal environment. Nurse training is an example of the extension under capitalism, of exchange relations to all areas of social activity. Its emphasis on meritocracy, its

false equivalence of expertise with credentials and length of training are bureaucratic requisites which contradict its professional claim. Nursing's emphasis on individualism, on individual expertise and its reliance on an apparently equalized educational opportunity itself reinforces and buttresses a wider educational and occupational inequality. Its system of hierarchical observation and reward is closely linked to co-ordination imperatives created by an expansion of monopoly capitalism and a technical-efficient rationality. In these ways, nursing's mode of training and of production are directly dependent on and helps constitute a capitalist mode of production.

11.4.4: The Process of Patriarchy in Nursing

This final critical insight will be brief as (a) it is not our intention here to develop a theory of patriarchy or to analyze the relation between patriarchy and capitalism per se, and (b) we have since discovered that our independent insights have been discussed in a variety of forms in the "feminist" literature of the 1960's and 1970's. Thus this section is more a summary but points of departure from prevailing feminist critiques are also highlighted. Our purpose here is to argue that nursing is an example of an occupational group dominated by men and that its desire for professionalization is likely to increase this male domination. We also intend to show the links between patriarchy as a form of labour organization and capitalism as a mode of production.

The term patriarchy has been used several times before in this thesis and is used in a general sense of describing a societal system of domination of women by men (see Millett, 1971). The term itself has recently been the subject of much debate and as McDonough and Harrison (1978) comment there is as yet no consensus about the meaning or status of such a term. Whilst its usefulness as a concept is rarely contested, it is nevertheless the focus of much debate amongst radical feminists, separatists, Marxists and socialist feminists alike, and the debate is often one which the very term patriarchy occludes as much as it illuminates. Without wishing to review this tangle of conceptual arguments or to delineate the minute differences between different ideas about patriarchy, we propose a working model which is particularly relevant to an analysis of nursing and which appears to be gaining acceptance in the literature. Flowing from our definition of patriarchy we agree with the argument that patriarchy pre-dates capitalism (Rowbottom, 1973) and did not emerge as a consequence of capitalistic relations of production. A sexual division of labour and the possession of women by men existed in pre-capitalist societies; with patriarchical authority based on male control over the woman's productive capacity and

over her person. However, unlike Millett (1971) we do not accept an ahistorical analysis of patriarchy and we do not substitute the concept of sex for the theoretical Marxist concept of class. Millett is correct in arguing that traditional forms of Marxist analysis are inadequate for an analysis of patriarchy because the family,marriage and women are assumed to be merely economic phenomena which are capable of transformation by economic or institutional methods alone. In subsuming women under the general problematic of class, the labour process and so on, traditional Marxism fails to confront the specificity of women's oppression. There is too much automatic assumption that emancipation from economic or ideological domination will bring enlightenment to all members of society, whether male or female. However, this does not mean that Marx and his method no longer has anything to offer. Neither does it mean that patriarchy has to be redefined or Marxism remodelled to fit the two critiques of contemporary society into one unified theoretical framework. That such an enterprise is being energetically pursued may be observed by a spate of publications on patriarchy and its relation to capitalism (see Kuhn and Wolpe, 1979; Eisenstein, 1979). We do not view Marxist analysis, as traditionally interpreted, as providing the only answer to critical analysis. As already discussed earlier there are several instances of omission and historical specificity in Marx's analysis which limit its relevance to an analysis of monopoly capitalism. Hence, we do not argue the absolute necessity for the theoretical fusion of capitalist critique and patriarchy notions. Indeed, as Hartmann (1979) points out there are clear incompatibilities between the two schemes. Despite such instances of a theoretical divergence, however, there are specific instances when the two processes are closely meshed and each supports the other. In this way an analysis of patriarchy cannot be divorced from an analysis of the historical rise of capitalism and the form of capitalism cannot always be understood without reference to the structure of dominance. This is especially the

case in analysing the form of patriarchy in nursing which was clearly shaped by the features of class and property relations of a capitalist mode of production. Thus the concept of patriarchy is asserted here and argued via empirical evidence later as being closely coupled in some instances to relations of production. Also, in following Hearn (1982), the concept of patriarchy is seen as associated mainly with three forms of reproduction: sexual reproduction, biological (human) reproduction and the reproduction of labour power. The first form of reproduction is in part related to biological reproduction but includes the social organization of sexual practices and concern issues such as the societal norms governing sexual practice and the elevation of the family as the centre of, and the deployment for sexuality. The concept of social reproduction is not directly relevant to patriarchy although the latter may require ior its legitimation and persistence specific forms of ideological notions.

Given this working definition of patriarchy we begin to analyze the domination of female nurses by medical men. This has been frequently referred to in the thesis but not historically analyzed. We have argued that medicine, to some extent, forms the starting point of the human sciences, of the study of man as an object and subject. The discipline of medicine gradually became male-dominated but it was not always so. Ehrenreich and English (1974) report that women healers dominated in precapitalist peasant society; they acted as priestesses, prophetesses, and wise women, healers and were connected with the mysterious forces of magic and creativity. In the Medieval world their traditional medical role was in fact sponsored by the Church who from the eighth right to the thirteenth century adopted an other-worldly anti-medical stance. It was women who acted as the practitioners of domestic medicine and male physicians were rare since time and the desire for study were almost confined to monks, Jews and others debarred from the masculine occupation of fighting. In late Medieval times, however, things changed through a combination of the

Church, state and universities and the men who dominated these institutions. Women healers were increasingly labelled as unscientific and unsafe. As medicine consolidated into a scientific pursuit, the terms of entry into training effectively excluded women and places were available only for the sons of wealthy families. This barring of women from access to medical schools and universities effectively prohibited their entry into the medical profession until the end of the nineteenth century. This domination of the medical profession by men was reinforced by bourgeois concerns for health and the coupling of a woman's health and sickness with her sexuality. As Foucault (1981) points out, the hysterization of the women's body at the end of the nineteenth century gave rise to one of the first figures to be sexualized: the "idle" woman and the upper-class "nervous" woman. At the same time a medicalization of sex took place; medicine isolated a sexual instinct capable of presenting constitutive anomalies, acquired deformities, infirmities or pathological processes. Further, dominant forms of psychiatry and psychotherapy, both Freudian and Jungian, rely on the concept of a life or sex-instinct and the foundation of the Oedipus Complex. This association of illness with sexuality, and in particular with a woman's sexuality was encouraged and constituted by the rich female who was attended by a male doctor.

Despite this nineteenth century dominance of men in medicine, the new technology of medicine meant that the men needed a reliable aide. The new relationship of the doctor and his patient, based on the doctor's direct response to the signs and symptoms of the patient, demanded new forms of continuous and detailed observation of the course of disease. Initially these tasks could be carried out by the doctor or his students. After the innovatory stage, however, such a use of doctors became increasingly less attractive since there was a lack of novelty and an apparent waste of painfully acquired skills. The way was open for the delegation of such tasks to a trusted subordinate. This scarcity of observers developed against a

background of Victorian morality and family order and a demographic imbalance which had generated a pool of unmarriageable middle-class women. These women had the type of education deemed necessary and their class was assumed indicative of moral trustworthiness. Moreover they had few alternative employment possibilities and possessed little bargaining power. Florence Nightingale, helped through personal power and powerful political connections, was thus enabled to be a nurse and to go to the Crimea. But as has already been shown, the nurse was always the "skilled servant of medicine" and nurse registration was eventually won only after the power of medical men was established. A 1904 *Hospital* editorial stated this subordinate position of the nurse succinctly:

> "The nurse has no certificate which entitles her either to diagnose cases, or to judge whether a patient is so seriously ill as to need to be received into the wards; and the public have a right to demand that cases sent to a hospital should be treated by a registered practitioner and not by a nurse . . .
>
> "The nurse cannot be too careful to keep a clear dividing line between her duties and those of the medical man, and she is culpable indeed if she rashly, and with her eyes open, grasps at responsibilities which are beyond her limit." (p. 121, *Hospital*, 1904a)

As Gamarnikow (1978) argues, nurse training in the nineteenth century was preoccupied with teaching the limits of the nurse's role in the provision of health care.

> "Training has to make her, not servile, but loyal to medical orders and authorities . . .. Training is to teach the nurse to handle the agencies within our control which restore health and life, in strict obedience to the physician's or surgeon's power and knowledge." (p. 6, Nightingale, 1882.)

A view which was naturally reinforced by the doctors and hospital administrators.

> "There is nothing to justify a nurse in going beyond her limit and diagnosing and treating patients . . .. Her training ought to teach her above all things to keep within her own province." (p. 121, *Hospital*, 1904a)

The division between medicine and nursing which mapped out nursing spheres of competence was not a neutral or "natural" division, based on equal contribution to, and participation in, the healing process. Instead it created stratified health care and interprofessional inequality. The

dominance of medicine in health care and its control over initiating and directing the healing process relegated nursing practice, to a subordinate position.

The structure of the medical-nursing professional relation was inferred from the alleged imperatives of medical science whose practice depended upon a combination of diagnosis-prescription and treatment-observation. Because medicine was able to first develop a new way of seeing the body and treat it, it was able to appropriate the first role which successfully limited the access to patients by other health practitioners. Medicine, in effect, has a monopolistic gate-keeper role and controls the initial intervention which designates a patient *qua* patient. This technological determinism produced an unequal partnership in health care and it is discernible even today in the nursing profession's attempts to appropriate the competence of "caring" while being resigned to the doctor's appropriation of "curing".

> "A nurse should never diagnose . . .. A nurse who realises her part of the work may be of invaluable service to the doctor and patient . . .. We nurses are and never will be anything but the servants of doctors and good faithful servants we should be, happy in our dependence which helps accomplish great deeds." (p. 11, *Hospital*, 1906.)

> "Once the great principle is established that nurses must not usurp medical functions, their sphere of usefulness in relation to medical men is clear enough . . .. This principle of the proper division of labour defines the relation of medical men to nurses." (pp. 251-2, *Hospital*, 1912.) Emphasis added.

> "The duty (of the nurse) is to obey him and recognize his sole responsibility for treatment . . .. Rightly or wrongly, we cannot have every subaltern of genius discussing his superior's orders. Only one battle has been won in this century by the disobedience of orders. But let not the nurse think herself a Nelson!" (p. 163, *Hospital*, 1897.) Emphasis added.

Such appeals to science which situated obedience within the division of labour inherent in the dual nature of medical science did not by themselves provide a sufficiently legitimate ideological basis for power relations between nursing and medicine. It was further stressed that the healing process per se was dependent on obedience and on a harmonious relation between

the two health care occupations. An obedient but disloyal nurse could undermine the patient's confidence in the doctor and arrest or retard the healing process which depended "as much upon their confidence in their doctor as upon anything else." (p. 231, *Hospital*, 1904b) If a nurse did not obey she was not only accountable to the doctor but the patient which she had been called to serve.

This ideological reconstruction of interprofessional relations and their abstraction into a technological imperative is itself inseparable from sexual politics. For as Garmanikow (1978) points out, the nurse-doctor-patient triad is essentially an isomorphism of the Victorian father-mother-child triad. The power of medical men as men was linked with their powerful roles as husband and father. Just as a father controlled a child, so a doctor dominated, via his expertise, over his patient; just as a husband could dictate his Victorian wife's behaviour and the constitution of her labour power, so the doctor could define the limits of the nursing area of competence. Indeed, the quotations given in this thesis indicate that the essential features of the Nightingale and post-Nightingale role were defined in the columns of the medical journals of the nineteenth century. Medicine had been successfully taken over by men, their required subordinate could only be women whose previous tradition of subordination and taught discipline happily "coincided" with a demographic imbalance and the gradual acceptance of female labour under capitalism. If the rise of the nursing profession is considered in relation to the growth of capitalism, it comes as no coincidence that female labour power emerged as an independent labour force in Britain in the late-nineteenth century, by which time large sectors of the population had been drawn into capitalist production. In certain occupations, like health care, more manpower was required but men (i.e. medical men) were not willing to undertake certain tasks. At the same time women from the working classes were being drawn into wage labour to supplement the low wages of their men. This, together with the limited range of work open to a large pool of surplus bourgeois female labour, whose

only "respectable" occupation was being governesses, allowed the emergence of nursing as a lowly paid or free (vocational), "respectable" female occupation. Its emergence was necessary in order to "man" certain reproductive systems which would help maintain capitalist relations. Its creation was possible because it was essentially non-threatening to the superior position of men, of medicine, and to the moral, class and family order of Victorian England. Moreover, the wages to be paid, if paid at all, were poor in order to legitimate the position of bourgeois ladies in the labour force. A series of separate but inter-related objectives thus emerged and solidified into a comprehensive system of medical, male domination over nursing - female labour. As one doctor wrote:

> "My name and reputation as a man and surgeon depend on my ideas being carried out as I would have them carried out . . . .. The nurse is not employed as consultant, as critic, as arbiter, she is strictly an executive officer." (p. 164, *Hospital*, 1897.)

It is somewhat ironic that today we should criticize Nightingale for her efforts to create nursing specifically as an occupation for women and which reinforced the oppression of women by men. For she and her reformers were essentially motivated by a desire to open up non-industrial occupations for women, especially single women from "respectable" families. A "life without love" and "an activity without aim" was horrible in idea and even more wearisome in reality. In order that a single life be as happy as a married one, a natural object was required; a sphere of activity and a necessary occupation which would free unmarried, single women from a dependence on fathers or brothers. Nursing was to appeal to women, who for example, not finding husbands and not having the education to be governesses, desired a useful life. It was due to Nightingale's liberal tendencies that nursing was open to women from all classes, though girls from "doubtful" families had to undertake an extra year of moral training. In addition, Nightingale sought to make nursing a paid job thus preventing it from becoming yet another form of Victorian female charity. She wrote:

"Perhaps I need scarcely add that Nurses must be paid the market price

> for their labour, like any other workers, and this is yearly rising . . .. Our principle . . . at St. Thomas's is to train as many women as we can, to certificate them, and to find employment for them, making the best bargain for them, not only as to wages, but as to arrangements and facilities for success. (p. 2, Nightingale, 1867.)

But the ideology of vocation equally required to effect employment for "respectable" girls from bourgeois families acted as an efficient barrier to the provision of high wages for nurses. It was a virtue to be called, and high wages and money could have but tainted the pristine, noble nature of nursing and the women thereof. In addition, by defining nursing as being designated for women, Nightingale did not "emancipate". On the contrary, by not disturbing the authority of medical men, she brought women under the direct control of men. Women were now relatively independent of the material support and dependency of men in the family, but they came under the control of men at work, and this paved the way for a twentieth century dependency on medical authority, male expertise and wage labour.

Nursing from the start became stereotyped as women's work, being coupled with the activities of mothers or female servants. A nurse was to provide the indulgence of a mother for her child; that is why women are portrayed as better nurses than men. She was to provide the gentleness while medical men supplied the firmness characteristic of men. The family analogy became the major *leitmotif* in nursing literature and fitted well with Nightingale's desire to create an occupation for women. It also became rooted in a naturalistic ideology in which certain tasks were classified as women's work. Gamarnikow (1978) points out that the Victorian reformers were heavily influenced by a proto-feminist theory which is called the "communion of labour". This claimed that there were natural spheres of activity for men and women and demanded that women be allowed to participate with men in non-domestic duties but in a way which resembled domestic work. Hence a natural division of labour in the family was to be transplanted to the sphere of work and a woman's work outside the home was to resemble domestic tasks, thus complementing the "male principle" with the "female"

principle. Thus :

"Nursing is distinctly women's work . . . Women are peculiarly fitted for the onerous task of patiently and skilfully caring for the patient in faithful obedience to the physician's orders. Ability to care for the helpless is women's distinctive nature. Nursing is mothering. Grown up folks when very sick are all babies." (p. 237, *Hospital*, 1905.)

And nursing work became closely connected with the domestic tasks of keeping a ward/home clean and hygienic.

"A good nurse must first be a good housemaid." (p. 12, *Hospital*, 1902.)

"The elements of making the true nurse must be in the woman. The bottom of the whole question is home training; women who have had good mothers, who taught them obedience and self-discipline with a thorough domestic training are the women who will make the best nurses." (p. 445, *Hospital*, 1917.)

Nightingale, in fact, reinforced the domestic nature of nursing. Whilst acknowledging the power of medicine and surgery as prime helpers of cure, and to some extent superior over nursing, she nevertheless felt that neither medicine nor its subordinate - nursing - cured. Instead it was Nature who cured. Medicine and nursing merely provided the conditions under which Nature could undertake her restorative process. In this helping process medicine and surgery provided the essential support of prescription and diagnosis. Nursing was "naturally" allotted the secondary support task of maintaining hygienic conditions. Nursing, therefore, should signify the proper use of fresh air, light, warmth, cleanliness, quiet and the proper selection and administration of diet. Such emphasis resulted in the allocation of domestic work in hospitals to nurses, especially probationers. Scrubbing, cleaning, charring, washing up, and polishing were essential for nursing and for the patient's health. After all, the discovery of asepsis was purported to show the great necessity of keeping things clean and germ-free. If a nurse declined these "menial" tasks, nursing was indeed not her calling (see also Davis , 1977).

Not only was nursing a woman's work, a good nurse was synonymous with a good woman. This moral requirement for a nurse exemplifies yet another aspect of sexual domination. For male doctors there did not appear to be a

stringently-applied, publicly-required rule of moral behaviour. But for a woman to be a nurse, to be accepted within the workforce, to be caring for patients, it was important that she be moral. Nursing, in order to be "respectable", and to attract "respectable" girls had to be a moral occupation. In this way the sexual reproductive function of women, her very sexuality, implied a tendency, a danger of immoral behaviour, which had to be countered by explicit moral controls. A good nurse was thus characterized in this period by good character, not by skill, and these characteristics had essential feminine facets which were important for subordination. A good nurse was a good woman who was patient, gentle, humble, unselfish, obedient, disciplined; she was orderly, quiet, punctual, alert. Character and femininity were tightly locked as attributes of the good nurse. Femininity itself, became defined in a way which differentiated men and women in their ability to exercise authority, in their relation to the patient and in their freedom to undertake sexual relations. A nurse equalled a woman who obeyed, observed and was pure.

That nursing is still seen today as women's work and that nurses must be moral was evidenced by our sampling of school-children's images of nursing and the emphasis shown by senior nurse management at Mayfield to maintain the ideology of morality. That discipline is still a virtue is clearly exhibited in the opinions on "liberal nurse teachers", "cheeky learners", and "the good, old days when everyone knew their place".

But two significant changes have been occurring which were potentially emancipatory but which enslaved in reality. One was the reclassification of nursing work. This hived off "menial" tasks to lower grades of worker, lessened a qualified nurse's amount of bedside nursing and replaced professional scrubbing with professional observation. The indulgence of the mother became professionalized and ushered in the clinical gaze of the technical nurse, thus exposing the patient to potential custodial, regressive care. In a sense removing domestic tasks from nursing while

removing the sexual emphasis of the female servant constituted the elimination of a relatively autonomous nursing practice from the overall functions of nursing. It also served to increase monopolistic control. Nursing at Mayfield in the 1980's is a far cry from Nightingale's grand notion of "nursing the room"; it is more concerned with the sanitary aspects of patient care. At the same time it reinforced the nurse's dependence on the doctor. Today's nurse is more the eyes of the doctor, the observer who is able only to report clearly the events she has been able to witness. Indeed the 1980 nurse approximates more the role designed for her by nineteenth century doctors who wrote that the nurse:

> "may, by careful watching and timely reporting, save time, assist correct diagnosis and thus facilitate a good result." (p. 11, *Hospital*, 1906.)

> " . . . When required she should report clearly and concisely upon the symptoms she has been able to witness; but she should stop there." (p. 11, *Hospital*, 1906.)

In carrying out such observations on behalf of the doctors the nurse is susceptible to orders from above which she must obey with "a rigid discipline that should not be second even to that of the soldier." (p. xxiii, *Hospital*, 1894.) The aspirations of a nursing profession have thus introduced changes in its labour process which are more dependent on the medical profession. It has also reinforced the dark side of disciplined observation in which the patient loses his humanity and is, in the last instance, a collection of observations. The control of experts over the wishes of patients is strengthened, while the bulk of bedside nursing is performed by young learners (who in the main are inadequately prepared to handle the anxiety of life and death problems) or nursing auxiliaries (who are not taught that an adult patient is not equal to a helpless child while physically he may resemble one).

The second significant change is the institution of a career structure in administration which provides nursing with their own management structure and makes nursing potentially more well-paid. But this structure falsely equates credentials, years of experience and years of schooling with

expertise and institutes a hierarchical system of domination in which superiors dislike a questioning of their authority. It provides higher pay for observation, not for bedside care. Indeed Carpenter (1977) sees the onset of managerialism in nursing as essentially sexist because it is an implicit critique of female authority in nursing. He writes:

> "The feminine 'qualities' of the spinster nurse, reinforced by occupational socialisation, are seen as opposite to those required by administrators.
>
> "In general Matrons are over-conscientious and not good at delegating. They have not been trained in management and their training as nurses, . . . leads in a contrary direction. Ward Sisters on the whole are self-reliant people but when . . . they venture into administration many seem unable to make decisions. (Paragraph 3.32.)
>
> "In other words nurses have a trained incapacity for management." (pp. 98-99, Carpenter, 1977.)

The Salmon Plan, intended by the R.C.N. elite to obtain more autonomy, by the then Labour Government to introduce a cost-effective method of health administration and to suppress demands for a general increase in nursing salaries, in effect led to the rise of men in nursing management. Male nurses had often felt their ambitions were being frustrated. Up until the late 1940's they were relegated to a separate register and in psychiatric and mental handicap hospitals matrons typically controlled the training school and the administration, while the power of the Chief Male Nurse was restricted to the male wards (Jones and Sidebottom, 1962). The National Board for Prices and Incomes also found that in psychiatric hospitals male nurses got stuck more than twice as long in the staff nurse grade as their female counterparts (paragraph 17, N.B.P.I., 1968). Also the artificially depressed low pay for nurses meant that for men promotion was central to maintaining their income level. This coupled with the sexist view that men should be the bread-winner in the family structure added impetus to the male desire for promotion. Thus when Salmon was implemented and new posts thrown open to national competition men, because of their greater geographical mobility, were better placed to compete. Moreover, the higher paid jobs were in administration and few female nurses, socialized

for too long in the concept of patient care, desired those jobs. Although the reality of 1980 patient care meant that even ward sisters were performing little bedside care, and were usually observers, ward sisters (as evidenced by our small sample of twenty-one sisters/charge nurses) still cling to the false idea of desired patient contact. Few expressed a desire to move up to a nursing officer grade and this in fact was reinforced by a large salary rise awarded to sisters by the Clegg Commission in 1980. The creation of more posts in nursing management made them ripe for male capture and helped to further masculinize the occupation. Hearn (1982) points out that infact the institution of a professional code of conduct which is universally applicable helps to masculinize the behaviour of practitioners and to some extent defeminizes it. This makes nursing more attractive to men; coupled with the Salmon structure, men are beginning to find nursing more acceptable as a career (Carpenter, 1977). Once in men are better equipped to enter the more prestigious jobs. Thus, as men enter the market they enter in a highly discriminatory way and there is now the prospect of long-term subjection to men <u>within</u> the profession. A new managerialism is leading to a new professionalization in which men could dominate both in management and the ranks. Hearn (1982) argues this is the fate which inevitably awaits the "semi-professions" like nursing but our evaluation is that bedside nursing below ward sister level is likely to be dominated still by females - in the form of the S.E.N. and the nursing auxiliary who are relatively lowly paid. Females too would tend to remain longer in the ward sister role but it is certain that males will move more into hierarchical positions of management.

Further changes are imminent in the Health Service at the time of writing this thesis. In the autumn of 1982 the N.H.S. as a whole is to be plunged into a new and complicated reorganization which top administrators fear could be more chaotic and traumatic than the problems that beset it after the Conservative Government's reforms of 1974 (Sir Keith Joseph being

the then Health Minister). Discussion documents circulating among the new 192 district health authorities show that thousands of administrative jobs in hospitals are about to be regraded and some top administrative posts are being given salary rises of £5,000 a year. These drastic changes appear to affect only the position of hospital administrators per se but it is likely that increased status for such personnel will affect once again the power relation between the nursing elite and other health care decision makers. One of the reasons for the R.C.N.'s agitation for the Salmon Plan was the gradual erosion of the influence of senior nurse management vis-a-vis lay management and administration. With the present Conservative Government, being more keen to tighten financial control to increase administrative efficiency and to end its policy of marginal growth in health care, administrative functions are seen as the means to managerially-defined efficiency; and this could reverse whatever impact the Salmon Plan has had on the nature of hospital decision making. It therefore comes as no surprise that the R.C.N. is opposing the upgrading of certain administrative jobs; its protest over proposed changes in the Wandsworth District Health Authority has already made the headlines in national newspapers (p. 5, *The Guardian*, 10th May, 1982). Not only do the proposed N.H.S. changes affect the nursing-hospital administration relation, there are indications that nursing management may itself be divided with new staff divisions being set up within the nursing organizational framework and nursing directors being given higher salaries. More money and status could be given to administrative functions, either extant or to be created in nursing itself. This increased emphasis on administration is again likely to be an opportune time for male competition as more than 30% of the English senior nurses are male (see Carpenter, 1977) and these are likely to be favoured for the new posts due to their greater "experience" and geographical mobility. Also, the traditional, implicit feeling that female nurses do not make good administrators may further aid the process of patriarchy. Finally

these administrative changes serve to further emphasize administrative efficiency as a criteria of effectiveness in health care, in contrast to the ideological notion of "good" patient care.

In this section we have sought to locate the critique of (a) the dissatisfaction implicitly and explicitly expressed by members of the Mayfield nurse training system; and (b) the micro-relations of power and meanings uncovered in four facets of an inter-related overarching structure of domination. Such a structure which we have identified is argued to give an integration to the phenomena observed; it is not claimed to be all-comprehensive and we do not profess to have uncovered every relation of domination. However, the integrative structure proposed appeared to make holistic "sense" and is argued to have related the more important observations of discontent and the actors' attempts to overcome their perception of discontent. In the next section we outline some initial implications which flow from an integrated evaluation of the Mayfield system of training.

11.5 Implications for Strategic Action

Habermas argues that theory can never justify wholly the strategic and risky actions of practical life. *Theoria* may illuminate *praxis* and critically evaluate forms of false consciousness which differentiate an empirical reality from its unconstrained ideal. However, theoretical discourse can never be used to legitimate activities and changes which should always be the decision of free agents interacting in an unconstrained manner. Thus the implications for strategic action which flow from our integrated evaluation of the nurse training system at Mayfield and in the U.K. more generally, are offered as suggestions for participative discussion. They are possibilities which indicate that enlightenment and emancipation from certain forms of domination are within the productive capacity of the institution and society being analyzed. They are tentative proposals and are offered in a spirit of hesitance. Moreoever, an analysis of the micro-level power relations and manifestations of dissatisfaction show that while some forms of discontent and relations are apparently specific to the system itself (e.g. the conflict between the North and South Health Districts), these micro-relations are a part of and constitute an over-arching system of domination which pervade hospital-based general nursing in the U.K. To the extent that Mayfield as a system, is at a different resolution level, a part of a larger system; to the extent that its relation to certain aspects of its environment are tightly coupled; the strategies for change will influence and effect change in both the system and its environment. Thus it becomes difficult to view the strategies as being essentially institution-specific. While directed at Mayfield, our suggestions clearly have relevance for other schools of nurse training and for general nurse training per se. In addition, the categories under which these strategies are discussed closely follow the scheme of integrated evaluation of the effectiveness of nurse training at Mayfield; effectiveness, having been defined as the extent to which the empirical situation of the

institution achieves an ideal speech situation.

1. The Institution of the Whole

There is a dire need for participants throughout the Mayfield General Nursing Training System to see the body as a part-whole of a mind-body person. In the realm of patient care, this entails a shift in emphasis from the Body to that of the Whole, from a focus on one diseased organ to the patient as he relates to his environment and to his inner self. This requires the nurse to understand and respond to the patient's experience of illness and hospitalisation, to recognize that although a particular problem may be primarily in one domain - physiological, sociological or psychological - the individual responds as an integrated whole. Competence in interpersonal skills is clearly an essential condition for achieving an understanding of the patient but a thorough understanding of human behaviour at the individual, group, organizational and societal levels is required if the nurse is to respond effectively to the patient.

The nursing literature of the last five years is replete with statements emphasizing the importance of a holistic approach to patients and the development of inter-personal interactive skills (see Gerrard, 1978; Roberts, 1978; Rosenthal et al, 1980). But at Mayfield it was observed that a variety of traditions and of conditions have limited the extent to which the patient is treated as a whole. Doubt was cast on the effects of compulsory psychiatric nursing and of Davies' efforts to introduce psycho-social training in general nurse training. In addition, the nursing process, which ostensibly advocates a holistic approach was seen as being potentially mystifying: giving a pseudo-scientific legitimacy and coherence to nursing practice and over-emphasizing the individual basis of a nurse-patient exchange. Finally, the content of psychology and sociology teaching at the School was criticised; such teaching being allocated only a small amount of time and the focus remaining entrenched in a biomedical model of man. Psychological and sociological issues were

essentially of secondary importance and only to be retrieved when they seriously hampered a patient's psychological progress or when they surfaced in the form of psychosomatic illnesses.

Such a view of the whole remains inadequate. As a starting point, the behavioural component of care should not be hived-off to short courses on psychiatry, or psychology or sociology. Instead these essential components could be thoroughly integrated in the technical, physiological discussion of illness and disease. In particular the social, economic and political relations which undergird forms of illness could be highlighted in the light of critical analyses on the limits of medicine and its unequal distribution due to macro-relations of power (see Illich, 1976; Navarro, 1976). It is argued that it is increasingly unrealistic to expect medicine and acute illness cure to solve the health problems of society. Individuals and society as a whole could learn to accept a great deal more responsibility for their own health both directly in their own lifestyle and indirectly in the kinds of political programmes which they support and the degree to which they are prepared to permit the continuance of policies which promote public ill-health for private gains. In order to live in a healthier society there needs to be a recognition that we need more stringent environmental control - on smoking, alcohol, diet, pollution, transport and the like - as well as more abstentions in personal lives.

A knowledge of sociology does not mean classifying patients according to their social class purely for classification's sake but recognizing that such material realities are linked to a myriad of micro-local power relations which link up in comprehensive systems of domination. Nurses, so far, have played little part in this critical, consciousness-raising process, preferring to see caring as a passive, asocial, apolitical process which patients receive. Caring is confined to the hospital ward, like a monastic concern for salvation which is confined within the cloisters of a nunnery. Even health visiting which could potentially "see" the reality of social

forces has drifted away from being a radical form of change. Nurses could also debate the historical tradition of a focus on the individual and its ideological relation to the mode of relation which promotes multi-layered forms of inequality. The profession's desire to be a profession, its fight to free itself of medical domination could be critically evaluated for its false equivalence of credentials with the ability to care and its implicit alliance with forms of inequality which pervade educational systems. Individualism, monopoly control over training, the promotion of exchange relations of production, meritocracy, the association of social and economic rewards with administrative functions are inherently contradictory with patient care and the sociality of men. An ideology of liberal equality, democracy and individual merit itself breeds conditions of inequality, represents a monopolization of rights and privileges and is basically divisive. The patient is not an atom plucked out of context but relates to a social world with a particular construction of reality.

An emphasis on the Social Whole also has implications for the nurse herself who is at present deluded as to the value of her services and the skills required to be a good nurse. In particular, the social input into nurse training is obscured, the low pay for women is implicitly affirmed by a power-relation between the elites of the profession and the state, and the fragmentary, gradual de-skilling of the nursing labour process is inadequately covered up by appeals to differential status and vocational calling. The call to be "professional" has ideological roots in promoting disciplined obedience and in preventing alliances with other workers to effect collective action against processes of patriarchy and inequality.

An emphasis on the Mind-Body of a patient also involves much more than a superficial understanding of psychosomatic diseases. It means understanding man as a whole, not as an amalgam of parts. It means realizing that there are other forms of reasonable behaviour, that reason and rationality is a social construction of reality which is significantly related to social and

individual relations which appertain and meet at crucial moments in time; that rationality in Habermas's terminology means the achievement of an unconstrained, free consensus in the activities of theoretical and practical discourse; that a focus on the Body to the exclusion of the Mind is bound up with relations of power which are supportive of a mode of production which defines need, health and normality only within certain limits that ensure a conservative stability; that man viewed solely as a machine in a world of production is devoid of his humanity and is in danger of being observed, trained and made to obey in a network of subtle structures which include the nurse and the hospital. A knowledge of psychiatry and psychoanalysis should be taught so as to emphasize the relation between the conscious and the unconscious. Despite Foucault's reservations about psychiatry as a form of power-knowledge, which alienates the patient from the expert, certain Freudian concepts may be helpful in understanding the holism of human behaviour. Mitchell (1975), for example, argues that the psychoanalytic basis of the Oedipus Complex does not recommend a patriarchical society but that Freudian analysis is an analysis of one. Psychoanalysis could thus give us the concepts to help understand the functioning and mechanisms of ideology and the place and meaning of sexuality and gender differences within society. Also, the neo-Freudian analysis of anxiety and the operation of defense mechanisms may help illuminate the reaction of patients to nurses, nurses to patients, and nurse-doctor relations. At present there is little discussion in Mayfield of the work and implications of Menzies' (1970) study of a nursing service. There is also little study of the working of groups which may be usefully supplemented by Bion's (1955) study of basic assumption groups; these being groups which exhibit repressed and psychotic ways of combating anxiety - such as flight, fight and belief in the ability of a charismatic leader (a Jesus/Saviour figuire). An open participation

inissues of this kind could help a nurse or learner to partially understand the endemic distrust between superiors and subordinates, the unwillingness of nurses to be involved with the psychological problems of patients and the reasons for discontinuation and absence given by learners. An understanding of anxiety is not limited to an analysis of the nurse-patient relation but is extended to an analysis of other forms of relation and behavioural manifestations of dissatisfaction in nurses.

A greater understanding of the psychological issues which underlie learner behaviour, super-subordinate interaction, nurse-patient relation and doctor-nurse relation should be conducted in a participative manner. The nurse does not set herself up as a cleverer expert who is able to observe "deviant" psychological reactions, classify and briskly deal with them in a neutral, efficient manner. Listening to a patient's problems does not only mean a quick, superficial assurance that "things are not as bad as they seem", neither does it mean a mystifying classification of expected forms of psychological problems, e.g. "post-suicidal depression", "post-natal depression", "adjustment difficulties", "worry about relatives and family" or" worry about pet" etc. Such classifications are potentially open to a process of clinical neutralization which gives the nurse an impassive gaze and judgement over her patient. To understand the Mind-Body is not to create even more labels to describe the "missing link"; but to appreciate that the combination of individuality and sociality intrinsic in human nature, means a patient's response to a physical disturbance or treatment is to a large extent unique and socially created. The nurse needs to gain a personal awareness of self, values, motivations, and behaviours. She learns how to learn, how to effect emancipatory change in social systems of varying complexity and how to relate to the Janus-effect of part-wholes. Research calling for a greater priority to be given to the psycho-social dimension, while better received in the profession in recent years, has yet to penetrate far into the conscious deliberate organization of its everyday professional practice, especially in the general hospital.

There are a few notable exceptions and interestingly enough it is is in the fields of medical practice where chronic disorders and disabilities are common that greater recognition has been given to the fullest implication of illness and treatment. This is the case, for example, in the treatment of renal disorders, in rheumatology, dermatology and to some extent in psychiatry and geriatrics; although the danger of psychiatry and our reservations about some aspects of it have already been discussed. However, these areas tend to be among the low prestige and "cinderella" specialities of modern medicine in both Britain and the U.S.A. In rejecting a career in rheumatology, half of the medical practitioners in a Scottish study actually referred to their dislike of chronic disease and a preference for "life and death" medicine (Bennett et al, 1972). A long-standing tradition to recover a diseased body quickly, a socially-created satisfaction associated with the quick psychological rewards of seeing a patient well (and thus indirectly demonstrating the power of the physician), and the created prestige given to acute medicine have all helped to accord greater social status to acute illness and nursing care in this area. A large proportion of general nurses work in acute surgery and medicine and are largely based in the general hospital. The necessity of acute medicine was also historical in that an infant science could best demonstrate its social worth and its legitimacy to be an exclusive monopoly by performing "miner" miracles which could be instantaneously recognized as such. Larson (1977), in tracing modern medicine's professional success, argues that one of its advantages was its ability to demonstrate quickly its superior efficiency in dealing with disease. The state and various other public authorities have always been relatively disposed to facilitate monopolistic control over practice by those professional healers who appear to be more effective or at least more convincing, than others. The fact that medicine operated in an area of vital concern for the individual and the community compelled the state to intervene and stamp out the extreme

competitiveness which existed in nineteenth century England. Once scientific medicine had offered sufficient guarantees of its superiority, the state contributed willingly to the creation of monopoly by means of registration and licensing. Indeed, only in a quasi-monopolistic situation can the producers be supervised and a minimum of professional competence obtained. The rise of acute medicine was thus contributory to the establishment of the medical monopoly and a foundation stone for its present strength.

Yet since the 1960's and 1970's it has become commonplace for those concerned with health, illness and medical care in Britain, the U.S.A. and other highly developed societies to make the observation that chronic illness has replaced acute disease as the central problem in the second half of the twentieth century. As long ago as the mid-1950's, for instance, a major four-volume report on the subject was published in the U.S.A. by a "Commission on Chronic Illness" (see Strauss and Glaser, 1975). This referred to chronic illness as the challenge of the era. Yet little has been done in Britain to shift medical and nursing resources to the chronically ill. Health professionals for the most part are trained and work with a role model rooted in acute illness, to the detriment of the needs of those with longer term health problems. Hospitals, we postulate, are criticised as institutions organized for short-term physical intervention in reversible disease processes, with little regard for the fact that in many cases the episode of acute illness bringing the patient into the institution represents merely one phase of a continuing wider problem. As early as 1970 Strauss pointed to the:

> "almost complete lack of health professionals for what happens to chronic patients after the immediate period of post-hospitalisation, when they and their families are very much on their own, coping with the medical and psychological effects that follow on the worsening of symptoms and the requirements of medical regimens." (p. 6, Strauss, 1970.)

In part, this problem is linked to the wider issue of a fragmented illusion of man: as a biological mixture of parts requiring pharmacological or surgical action and as an atomized individual existing alone within the

hospital complex.

More importantly, this neglect of the whole is tied up with medical and nursing resistance to a demystification of the role of the expert and the power of expertise in matters of life and death.

2. The Demystification of the Expert

Discussing the "erosion of medicine from within" and challenges to the doctor-patient relationship, Zola and Miller (1971) have pointed out the problems faced by practitioners constantly involved with the chronically ill. In particular, they argue, the chronicity of illness has diluted the exclusive control of the physician via expansion of the team dealing with the patient and his illness. The doctor recedes as other practitioners come to the fore not only in terms of primary day to day management but in terms of the transference relationship as well. Moreover, Shortell (1974), in an ingenious attempt to unravel the meaning of the low prestige ratings repeatedly accorded to some fields of medicine, has indeed shown that they are those characterized by mutual participation and (near) equivalence status and influence of the doctor and patient. The specialities ordinarily assigned high prestige are those in which the doctor's remoteness, authority and dominance are more assured. Moreover, the latter situation prevails to a greater extent in acute, emergency medicine, while mutual participation is believed to be more common in the former.

Part of the reluctance of medical men to award a high status to chronic disease treatment may thus be due to a fear of demystification and a loss of control. For it is in these fields that the expert displays his lack of expertise, his inability to order and to predict the consequences of his treatment. It is here that medicine and medical men exhibit their limits and disease and illness are more clearly shown to be related to imperfectly understood, wider macro-structural forces, psychological and individual factors. Geriatrics, for example, is partly related to the break-up of the nuclear family which arose after the institution of widespread

capitalist relations, the rise in urbanization and the creation of exchange value by increasing geographical mobility. Psychiatry does not proclaim to have all the answers to psychoanalytic issues and the madman remains a black box to the expert. Moreover, a patient's psychological response to therapeutic treatment cannot always be predicted in advance and idiographic psychoanalysis is, in fact, rooted in the construction of unique personal histories. Similarly, in dermatology it has been said that each administration of any drug is essentially a one-off clinical trial because of the unique possibilities of interaction between that drug and an individual's physiology.

In such specialisms chronic patients may become wise in their own clinical management and in the manipulation of treatment regimes to suit their personal metabolism. MacIntyre and Oldman's (1977) essay on migraine in Davies and Horobin (1977) has some discussion of the process. Jobling (1978) has written an interesting account of nursing without professional nurses. He describes how in the management of chronic psoriasis (a skin disease), the relation between a patient and his "experts" is more a partnership and patients are less subject to the tyranny of information control. There are three factors permitting a demystification of the expert. Firstly, a psoriasis patient is not really the patient that the general nurse is used to seeing. He is ambulant, fully in possession of his adult faculties, non-regressive and he often becomes a lay expert in managing his case. He does not fit the model of the acutely ill, short-stay, largely bed-ridden patient; he has entered hospital only because it has proved impossible to clear his skin by self-treatment and the burdens of the condition and the therapy has become too great. Secondly, a patient learns to be less dependent on the supposed "progress" and "scientific advance" of medicine for he knows there are many manifestations of sickness and disorder which it cannot deal with. Similarly, the ministration of the nurse and her careful application of

ointment and treatment loses some of its expert-effect. Patients know there is no "cure" for psoriasis and therapy is directed towards control of the symptoms. Clearance of local lesions can in most cases be achieved but is commonly short-lived as these may re-appear or occur elsewhere on the skin more or less immediately. Thirdly, psoriasis is an unsightly and disfiguring disease, one which creates severe emotional problems for patients and their families and ruins the lives of the persons with severe manifestations. It is a disease which makes a patient somewhat of a social outcast, unable or unwilling to participate in a full and normally active life and he is viewed askance by those who observe his affliction.

This combination of factors provided an opportunity for a new nurse-patient relationship, in which the nurse becomes more concerned and involved with the longer term and far-reaching problems of her patients. A psycho-social element thus crept into and enriched the nurse's work. Naturally enough, once present, this concern can become institutionalised, judgemental and false. Jobling (1978) briefly quotes the experience of one nurse in an American hospital who was highly critical of being "into the psychological and social side". Clearly, such a concern is emotionally demanding and given the poor teaching of psycho-social care in nurse training it was not surprising that the nurse in question "gave up". But its institution as argued before is vital and appears irrevocably linked with the democratization of health care. For the dermatological nurse adopted a new role: that of being a facilitator and an anagogical educator. In particular, the nurse adopted a more active, mobilising role; educating and instituting self-help groups among patients. Patients were taught a little about their disease and although the objectives of such educational sessions were limited and essentially restricted to the maximization of compliance with maintenance regimes after discharge, nevertheless, they received more information about their condition. Unlike the general acute patient, the psoriasis patient suffered less from the domination of

expertise and the control of information. They realized the limits of medical and nursing expertise and often formed groups among themselves to discuss their common problems and diverse experiences. Nor was it uncommon for the patients to apply ointments on one another or to engage in general "duties" about the ward or further afield.

Jobling's account is important and has been discussed at length because it demonstrates the possible links between (a) a development of psycho-social care; (b) the recognition of the limits of medical and nursing expertise; (c) the provision of greater information on the treatment of illness; and (d) the possibility of forming patient self-help groups who are less dependent on a limited medicine based on technological, physical care. The nurse, in this situation, recognizes her limited expertise, is more aware of the holistic nature of health care and provides information which allows patients more freedom to participate in decisions about their health and life. It is argued that such a demystification of nursing expertise, a provision of information to patients about their illness and treatment and an initiation of self-help groups among patients should emerge throughout nursing as a whole. Jobling has provided evidence of the successful breeding of a more democratic nurse-patient relationship; such a relation developed in chronic cases but is equally required in the case of acutely ill patients. The provision of information to patients, in particular, may expand the nurse's educative and facilitative role. At Mayfield, for example, general nurses do not help patients to prevent their illness/disorder or prepare their patients for the long-term effects of their illness. For instance a patient with a history of cardio-thoracic problems could more formally be taught as to the origins of their problems and the preventive measures which a patient and his family may take; a patient with burns due to a home accident could usefully be taught simple preventive measures; a patient who is to have a mastectomy could be carefully informed as to the possibilities available. At Mayfield these preventive, educative functions are either not performed

or conducted via one-way posters from hospital notice boards or undertaken by ill-organized voluntary groups. The nurse could substantially help to better inform these voluntary and self-help organizations,* which could in the future prove to be more powerful in lobbying for greater patient participation in health decision-making and greater environmental regulation.

Within general nursing then a nurse or learner should be trained in the teaching of adults. Such education requires the nurse to be a facilitator and not a teacher in the pedagogical sense of the term. She should seek to teach others to teach and help themselves, to be more aware of the limitations of modern nursing and medicine, to emphasize the preventive as opposed to the curative aspects of care and to highlight the combination of social and psychological factors at work in determining life and death. Participative discussions among nurses, patients and doctors could thus be usefully conducted at ward level where the impact of illness and treatment is most immediate. Such discussions could also highlight the particular social-psychological issues facing particular patients with identical or similar physical disorders. A rational, participative process of health decision-making which is undertaken in real time is felt to be more efficient and enlightening than separate time-lagged, educational programmes. Such programmes are now being conducted by another section of the Mayfield Area Health Authority. However, because such programmes are divorced from the reality of illness and at present are staffed by a small number of personnel fighting to obtain more resources, they lose much of their potential impact. Such an impact could be tapped by the general nurse holding discussions at the ward level with appropriate groups of patients and health workers. Even the "lowly" nursing auxiliary

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* It is likely that self-help groups would vary significantly in operations and effectiveness but at least it lessens the dependency on experts (see Shearer, 1982). Moreover, in the short-run, there could be implicit state support for such groups which lessen the demand for health services and thus help defuse the scarcity of health care resources brought about partly by a reduced state spending on the N.H.S.

could be included in such discussions for they in general undertake a significant proportion of physical care.

Not unnaturally, such a democratization of health decision-making requires the support or acquiescence of the medical profession, which in Britain, via the British Medical Association and the British Medical Union, still retains a near total hold on patient information. But there are signs that American influence may challenge this hegemony. In the United States, the political rights movement has spawned a number of organizations that are confronting doctors with mounting demands for patient's rights - including the right to participate in medical decisions about their treatment. Ethical issues have always troubled physicians but they have become increasingly pressing in recent years because of technological advances that make it possible to prolong life. The highly publicised cases of "living vegetables" suspended by respirators have initiated a good deal of conflict over when and whether doctors should pull the plug and whether patients should be allowed control over their own death. So have the issues of abortion, infant euthanasia, "brain death", and priority in patient admittance to scarce health care e.g. access to kidney machines. Rosen (1982) reports on experiments being carried out in American hospitals to call on philosophers and lawyers to discuss the key moral conflicts in medicine and to recognize that doctors have a moral responsibility not to abrogate a patient's irreducible right to his determination of his life and death. Doctors need to realize that a patient may "know better" in some instances, that he should be given sufficient technical information such that a medical, and we argue, a nursing decision may be made on a participative basis. Why should a nurse assume that her patient likes to be bathed at 9 o'clock each morning? Or that it is definitely healthier to sleep in a tidy bed? Or that patients cannot know, should not know or is definitely uninterested in how his broken bones heal together and why he must exercise without

crutches although he fears falling? At Mayfield it was observed that nurses instructed patients to behave in a certain way, to comply with a specific regime but there was little detailed and careful explanation as to the rationale and the basis for such a rationale. For example, when asked why certain procedures were necessary when they seemed superfluous qualified nurses and learners could give only vague answers. (Examples: why should a patient have a mouth wash four times a day? Why were pressure sores treated differently on different wards? Why was the "dirty" pair of forceps non-existent on other wards in the conduct of an asepsis procedure?) Clearly when a patient lacks information as to the "scientificity" of his treatment, he is unable to question the orders he is given, thus reinforcing his dependence on experts. Also, an acutely ill patient as well as a chronically ill patient requires information in order to participate in a decision about his life and body.

The decentralization of the locus of expertise and knowledge may be achieved by the creation of the general nurse as an educator of adults and an initiator of self-help. It could also be achieved by state legislation which radically provides patients with access to their medical records and information. In Britain, at present, a patient has no legal right to medical or nursing files on his illness and treatment; were such a right to be granted the unequal relation between patient and expert could be redressed in a dramatic way. However, such a strategy could lead to extreme conservatism on the part of medical and nursing personnel who could become unwilling to risk new treatment and create different forms of care. The strength of such a tendency cannot be accurately assessed and we lack detailed information on this possibility. Clearly greater participative debate and research evidence is required, for example, comparing the more litigation-prone health system of the United States and the more secret and closed system in the U.K.

A third approach to the reduction of control exercised by the nurse

over the patient is the greater involvement of a patient's family in the management of illness. By involvement is meant the greater provision of information to the family, the actual inclusion of family members in the decision making process and the relaxation of restrictions surrounding visiting and a family presence in the hospital. Rosenthal et al (1980) points out that the family and the nurse often have conflicting aims. The former desires more information about the nature, course and treatment of the patient's illness, the latter tends to withold just such information. The nurse who wants a co-operative and compliant patient also wants a co-operative and compliant family. She wants a smoothly functioning ward, without disruptive scenes, or emotionally exhausting situations and "unnecessary" loss of work time. The nurse, in other words, wants a situation where nursing work may be satisfactorily performed according to definitions stemming from training and socialization. To this end the nurse in Rosenthal's study, in fact, sought to control the work setting and the family therein. The family was controlled to some extent by typecasting them either in the role of substitute worker or a patient in their own right. The former role does provide emotional support for the patient but was observed to free the nurse from bedside care for more administrative tasks and to place the relative in a subordinate position to the nurse. The relative came under the normative control of the nurse and in fact cultivated a sense of team loyalty. Typecasting the family as a worker also enabled a nurse to evade emotional contact with patients, especially dying patients. The second role - the relative/family as patient, was observed to be preferred by nurses for it meant that the nurse was now the expert over both patient and family. In some instances this meant the nurse increased her emotional support for the relative but it also meant that the patient-relative had less autonomy and less information. The family now, like the patient, was managed by the nurse.

Such typecasting of the family into either the worker or patient roles were in effect strategies used to "pseudo-involve" the family and to defuse

their demands for information and real decision making ability. Family involvement, in itself, is consistent with contemporary nursing philosophy in the United States and Canada because it emphasises the importance of the patient's support systems in "total patient care". However, Rosenthal et al shows that this theoretical desire to be holistic, in practice, resulted in strategies to maintain nursing control. The potential threat to the nurse's autonomy and authority, to her right to be a skilled expert was quickly neutralized by a new set of power relations which now involved the family.

Such "pseudo-participation", to borrow a term from industrial democracy, is clearly insufficient in loosening the power of the expert. For unless the family has sufficient information it is potentially under the subordination of nurses and could be typecast into neutral roles. At Mayfield nurses seldom face the problems of "difficult families" that Rosenthal et al describe. There is no open visiting policy and no official commitment to family participation in patient care. Only on one relatively smaller ward was open visiting allowed to the mother of a brain-damaged man. It is felt that such an isolation of the family from patient care contradicts the claim to holistic care. If care must be provided in disciplined, centralized, depersonalized and standardized institutions the role of the family in counteracting domination may be considerable. There could, however, be instances when the family's and the patient's wishes conflict and instead of being an emancipating force, the family could alienate - like the nineteenth century families of sexual deviants. But this eventuality is less significant when confronted with the amount of information currently provided to the majority of patients and their family on the form and treatment of their illness. An expert can only be demystified when the limits of his expertise are highlighted and exposed. Without information, such demystification is not feasible.

A fourth possible strategy for the demystification of the expert is

to expose the ritualism which surrounds simple tasks and to show the falsity of boundaries of competence which are being monopolised by various health professionals. The concept of the "nurse practitioner" may be important in this respect. This notion was pioneered in the United States and Canada and is currently opposed in England by the British Medical Association and the R.C.N. It is one which crosses professional boundaries in an attempt to meet the needs of the patient. Although not quite a barefoot doctor, the nurse practitioner was born out of necessity. The failure of prevailing health care systems to cater adequately for the needs of inner city dwellers had gradually led to an invidious downward spiral of an exceptionally high demand for services and an inability to attract general practitioners. G.P.s who did remain in such areas found the pressure of work heavy and the length of patient consultations falling to well below five minutes (see Sharron, 1982). The nurse practitioner is a role intended to alleviate the demands on a G.P.'s time. Such a practitioner shares the medical responsibility for patients with doctors by holding surgeries, carrying out initial examinations and prescribing, under medical supervision, a limited range of drugs. A practitioner is also likely to have similar night and weekend on-call duties to the G.P.s at a practice, to make routine and emergency visits and to refer patients directly to the hospital. He/she in effect forms a filter between the patient and the G.P. and allows the latter more time to deal with serious or acute medical problems in an area where there is a gross scarcity of G.P.s. Sharron (1982) briefly reports that a controversial nurse practitioner project started in one of Birmingham's poorest inner city areas appears to have satisfied a real patient need and despite opposition from established elites has recently received a research grant of £26,000 from the West Midlands Regional Research Council. The nurse practitioner involved reported that her role not only possessed a curative, medical aspect but also an educative and emotional care aspect. In effect, the nurse

practitioner was a cross between a doctor with limited medical responsibilities and a health visitor or a district community nurse with extended nursing responsibilities. Through direct contact with patients and having some form of ascribed curative responsibility the nurse practitioner was able to know a large number of patients quickly and to be able to act as a front-line consultative defence for some 189 patients in six months. Only six patients were referred to the G.P. urgently, no complaint was made by a patient in six months and not a single patient subsequently consulted the G.P. for a second opinion. Moreover, the illnesses which were common, such as insomnia, hypertension, depression and dietary problems had more direct social and psychological roots which the nurse practitioner was able to identify and to highlight; at the same time educating patients as to preventive measures and simple self-help remedies. In addition, her informal surgeries and her ability to spend more time with patients encouraged them to unburden some of their deeper, emotional anxieties. Listening and a sympathetic ear had its proverbial therapeutic effect but the nurse practitioner was also able to supplement listening by suggesting ways by which patients could better manage their health by changing their environment or lifestyles.

The experiment quoted above is still in its early stages and it is difficult to extrapolate American experience with the new role and to compare the American and British experiments. Its potential is, however, obvious for it demonstrates that the desire to monopolize specific areas of competence, to obtain economic and social rewards by equating credentials with ability and the tendency to concentrate health care resources in general medicine and nursing in hospital-based acute care centres, seriously neglects health care where a need arises - among the poorer, less well-educated and racially discriminated sectors of industrial society. The nurse practitioner is a role which may expand nursing's contribution to health care; it may help shift the current focus in nursing from a blitz-like

concern with an individual body in an institution to a long-term preventive interest in a social being within his psychological and societal context. It could demonstrate the ritualism which surrounds nursing and medical practice and the ordinary basis on which a powerful body of knowledge is grounded. By blurring the distinction between the clever doctor and the not-so-clever nurse we could loosen the medical domination of men over nursing women, lower the status of experts and make visible the ideology which makes a monopolistic privilege acceptable in a system supposedly based on liberal democratic principles.

However, this potential may not be realized and the nurse practitioner concept could be shaped by a variety of forces into an ideology which (a) enables the nurse to feel "cleverer" because he/she now takes on some medical responsibilities; (b) further entrenches medical domination; and (c) encourages the G.P. to "delegate" psycho-social care to his nursing subordinates thus allowing him to become further occupied with the illusion of real (i.e. physically-focused) medicine. The liberating effect of the nurse practitioner is thus not altogether assured. Dingwall and McIntosh (1978) point out that many simple treatments, diagnostic and investigative tests in general practice can in fact be performed with a minimum of practised ability. A nursing assumption of these tasks should point to the essential simplicity of such tasks and the ordinariness intrinsic in them. However, it is possible that doctors would seek to protect their underlying decision making authority by emphasizing the prestige value of these "special", additional skills which ascribe an "equality" to the nurse practitioner role. In this manner nurse practitioners, like the health visitor and district community nurse, would come under medical subordination and their "practice assistant" relationship to doctors would remain at best unobserved and at worst barely recognizable. The fact that some senior nurses in community nursing are enthusiastically endorsing the move by nurses into the field of investigation and diagnosis, suggests that doctors have been partially successful in concealing the true

state of affairs.

Dingwall and McIntosh, when speaking of the relation of health visitors and community nurses to G.P.s in fact argue that any movement into limited medical responsibilities away from the traditional emphasis of bedside care and health and social counsel, i.e. any blurring of responsibilities, would further entrench the domination of medical men over nursing women. The Mayston Report (1969) on the management structure of local authority nursing services also wrote that care should be taken to ensure that the health visitor or home nurse was not diverted from her essential functions and treated as a clinical or practice assistant to the general practitioner. The research reported by Dingwall and McIntosh and by Dingwall (1974) more generally indicates that the primary health care team was in fact continually dominated by doctors and health visitors, and district nurses were unable to exercise any independent authority or autonomy. Indeed the two groups of nurses possessed a conflictual relationship with health visitors being accused of arrogance and interference.

Such a concern to loosen the nursing dependence on medicine and to assert the autonomy of nursing in health care, however, indirectly contributes to the rise of the nurse expert. An expert who like the medical expert is likely to seek peer control and similar insulation of his/her practice from lay scrutiny. Medical practice is not under democratic control in Britain; the dissolution of its monopolistic privilege is surely not to create yet another monopoly of expertise which is currently under medical control. While it is important to loosen medical domination and to demystify the basis of medical expertise, it is equally vital that we do not mystify and make abstract the knowledge of the nurse. Rather than attempting to raise one expert to the level of the other, effort should be directed towards the critical evaluation of the basis of all expertise. In what sense are medicine and nursing, both domains of knowledge which have a powerful effect on men's lives, so knowledgeable that they empower the expert to judge in

isolation the patient's best interests? Do modern medicine and nursing perform the minor miracles we associate with them or is the process of healing nearer to Nightingale's nineteenth century belief that it is neither the nurse nor the doctor which cures but the process of Nature? Nursing and medical expertise is naturally important but only in so far as it provides the conditions under which health is recovered. To the extent that the nurse practitioner role exhibits the relative ease with which certain medical tasks may be learnt, there is a possibility that a blurring of boundaries could loosen the monopolistic controls which now exist in health care and which make public accountability of professions well-nigh impossible. The equality sought between medical men and nursing women may in fact be obtained by the recognition by the latter that the bulk of medical practice, especially in the community, is centred on relatively simple technical tasks.

The nurse practitioner could also recognize the importance of preventive health education which indirectly displays the limits of a medicine which classifies "psycho-social" care and concern as not being properly within the domain of medicine. By putting the nurse practitioner "in charge" of health education and the psychological, societal factors in illness, the doctor may in fact be able to reproduce a system of partial analysis which already prevails today. The nurse practitioner may indirectly be buttressing the current focus on an individual body which when ill is similar to a machine with a number of faulty parts which need repairing. The brief report on the Biriminghan matter indicates that the nurse practitioner involved may, in practice, be functioning in this manner. Clearly such a one-sided division of labour is unsatisfactory and it would be necessary to ensure that both the doctor and nurse, viewing the patient in his totality and collectivity, participatively negotiate a feasible outcome with the patient and his family. This implies not only changes in the education of the nurse but of the doctor and the patient so

that all three parties in the triumvirate construct the whole and are made aware of potential power relations and the probable abrogation of the rights of the patient which are supposed to be paramount. Like Dingwall and McIntosh, but for different reasons, we recognize the need for public awareness and a much greater lay involvement in the control of activities at present monopolized by the health-related occupations.

The nurse practitioner role is also potentially ideological for it may hide the reasons for the necessity of nurse practitioners: the association of economic and social rewards to prestige care in prestigious institutions, the equivalence of meritocracy with credentials, of money with merit and the basic contradictions operating within a "welfare state" which is primarily dominated by capitalist, unequal relations of production. The new role may in fact be used to plug gaps and crises in the N.H.S. and in the state as a whole in a manner which hides rather than reveals the contradictions which beset unequal health provision. On the other hand, these practitioners could serve as a constant reminder of the inadequacies of health care and a visible sign that health care is breaking down in a serious way. Again, the ideological distortion of the nurse practitioner role depends on the kind of emphasis given to nurse practitioners and the manner in which the public views or is taught to view them.

Despite these reservations about the potential mystification of the nurse practitioner role, it is a possible catalyst for change. It is a notion which disturbs sacrosanct subject boundaries and its combination of bedside, educational and mind-body care could merge to some extent the roles of the doctor, the health visitor and the district community nurse. It also focuses attention on non-institutionalized care and greater links could be forged between hospital-based general nursing such that the latter plays a more active role in the initiation of preventive, self-help groups and is more aware of the patient and his family as a social, unique whole. In short, greater visibility to the nurse practitioner role could help shift money, men and knowledge from short-term physical care to long-term

holistic care which is less subject to the domination of the hierarchical, disciplined gaze of an expert.

What we have argued for so far is a radical change in the content of nurse training, the concept of the role of the nurse and the location of health expertise. Training, so we have argued, is to teach an appreciation of the whole and to discard artificial divisions between the individual and the social, the physical and the psychological. The nurse is not so much a trained expert as a facilitator who but helps adults to learn better to teach themselves, to manage their own health, to recognize the limits of nursing care and to realize the significance of collective decision making in health decisions. The expert is to be demystified and his power to make sole decisions about life, death and treatment decentralized.

Such change requires not just a radical change in focus in the channeling of nurse education resources but in the increase in supply of a certain type of nurse educationalist. Mayfield at present, suffers from a chronic shortage of suitably qualified nurse teachers and Davies pointed out that there was, and is, an acute national shortage. Wells (1981) too reports that only 75% of all nurse education posts are filled in England and Wales and that a serious malnutrition is undermining nurse education. The major factors are a continuing high pressure of work due to staff shortages, low morale, low status, and most of all, poor pay levels. Often a nurse tutor's take-home pay is less than if he/she had stayed on as a ward sister. In addition, as Davies pointed out, many schools of nursing are under the control of the service sub-system and Mayfield was, in fact, one of the few Area Schools of nursing. In such "service-dominated" Schools, the educational aims were allegedly easily subordinated to service aims, thus leading to a poorer education for the learner. Wells (1981), himself an Area Director of Nurse Education, also argues that (a) greater resources should be directed to nurse education and the teaching of teachers; and (b) a separate education budget should be instituted which is not under the

control of a service head but a separate education committee. This financial system already exists in Mayfield but this did not prevent whole cohorts of new recruits being axed when the Area budget was overspent in 1981. Thus even in Area Schools nurse education was likely to be viewed as an expendable expense, as a lender of last resort.

To a large extent, Well's and Davies's criticisms of the state of nurse education is accurate and explicit controls may be required to prevent education being used as a stopgap for inefficient financial planning. Indeed, having a separate Education budget may not be sufficient and additional controls may be needed to emphasize the role of education. However, the kind of nurse teacher required and the content of nurse education envisaged is quite different from that implied by Davies. He, above all, was concerned that the nurse teacher be highly credentialed, have a strong research outlook and be determined to help nursing carve out a distinct body of knowledge. These aims, as argued, were linked to the need to legitimate the division of labour into service and education and for the educational sub-system to gain material support from less well-qualified, more traditional nurses. Education as a new function had less power and prestige; one way of gaining both was to show its indispensability to the professional project. Davies's picture of the nurse teacher differs from that proposed: an anagogical facilitator who educates potential teachers to appreciate holistic care and the importance of participative decision making. Her task is not to create complicated rituals and esoteric labels for everyday tasks but to be willing to openly discuss the normalizing power of the examination and the unequal access to information on learners and their classification: to be able to critically evaluate the ideology of examination procedures which test techniques and methods which are then rapidly forgotten in the everyday life of the qualified nurse; to recognize the contradiction between awarding money and status to functions which are more distant from clinical practice, which is left to supposedly "less

clever" nurses and nursing auxiliaries. The nurse teacher as a depository and purveyor of new knowledge and the creator of new nurses requires a more critical insight into the institution of nursing within society. Instead of propounding the ideology of professionalism, he/she could expose that very ideology.

All of which requires radical change in the education of nurse teachers and the education of doctors and patients. For as Stein (1978) shows, the doctor nurse game which characterizes the doctor-nurse domination situation is learnt by both parties during training. The medical student, in particular, is argued to project his anxiety about the price of personal failure into an air of omnipotence which does not welcome suggestion from the nursing staff and in fact the medical student quickly learns to treat the female nurse as a subordinate. Moreover, the combination of public expectations and the tradition of medical domination reinforces this idea. At Mayfield the nurse learner was not overtly taught to revere the knowledge and expertise of the doctor. Indeed there was no need for them to be taught as a majority of them (see Appendix 10.5) had entered nursing with the image that doctors were superior beings; an image which is reinforced via ward experience. Not unexpectedly learners were also observed to develop a dislike of this omniscience. It appears that while initially learners and nurses were able to accept and acknowledge the power of the doctor the daily practice of being compliant and subordinate created a strong dissatisfaction and a desire for autonomy. Our observations thus differ from Stein's argument that student nurses are told the doctor has infinitely more knowledge than nurses. But we agree that the forms of discipline which prevail in the service and educational sub-systems contribute to a sense of obedience. Nurse learners, for example, are constantly evaluated, observed and classified. Their misdemeanours are discussed, or penalized and they are taught correct forms of address, of dress and of "professional" relation to their teachers and ward sisters. The inevitable result of

such discipline, the lack of emotional support in handling anxiety-ridden situations and the tradition of medical superiority makes a learner and a qualified nurse afraid to take independent action. Reference has already been made to the tendency to refer decisions upwards to nursing superiors. Such fears also encourage the learner/nurse to defer to the knowledge of the doctors thus reinforcing the medical projection of male omnipotence. The medical domination persists and inhibits open, unconstrained dialogue in a stifling, anti-intellectual manner. The doctor-and-nurse game is basically a transactional neurosis which freezes both professions into sex-stereotyped, artificial functions.

Changes in medical training are thus essential if the doctor-nurse relation is to be more equal and in particular the processes of patriarchy need to be more formally and visibly highlighted. Specifically, joint discussions between medical and nursing students might be considered in which such issues are critically explored and interaction between students from both systems of training is encouraged at early stages in their training. In this way the equality of training and of student status may enable both sets of trainees to appreciate the importance and anxieties of each other; thereby alleviating the status and knowledge differences which are set up after accreditation and entrance into the work world as qualified adults. Not only should nursing move from a physical, individual picture of man and his body, medicine, too, should appreciate the mind-body as a whole. A deeper understanding of the psycho-social facets of living would not only enable a change in patient care, an appreciation of the nurse as an autonomous person capable of participation in decision making, but would also promote a willingness among medical students and doctors to discuss their own deep-seated anxieties and forms of projection and introjection.

Moreover, the dark side of discipline should be highlighted to both teachers and learners alike, for it is partially this which will always

make the nurse less equal to the doctor. In particular, the nurse training system should consider a more open access by learners to their secret files and provision should be made for the greater involvement of the parents of a learner or the trade union in specific instances of dispute and complaint. At present there is little the learner can do if he/she disagrees with the contents of a ward report or a file reference. The rigid adherence to discipline and the tendency to circumscribe tasks and responsibilities at each level of the nursing hierarchy also instills a demotivation to initiate, to innovate, and to make independent decisions. Due to the current bureaucratic division of labour, which provides an unsatisfactory, neurotic, anxiety defense mechanism and which deskills the nursing labour process in an increase of observational duties, there is ample opportunity to diffuse a decision and to constantly refer to a source of higher authority. If nurses are to develop their potential as capable human beings, as equals to doctors, there is a need for the nursing elites to examine fundamentally their current structure of service, of organization as well as nurse training. For in maintaining that their subordinates should relate to them as unequals, nurses are themselves promoting systems of inequality which incapacitate their ability to relate to other health providers as equals. Without greater respect for and encouragement of the views of subordinates throughout the hierarchy, without perhaps fundamental changes in this hierarchy such that fewer status distinctions are made and fewer resources directed to administration, nursing breeds its own inequality.

In conclusion, we wish to acknowledge once again the tentativeness with which these strategies for emancipatory change are proposed. These ideas are intended more as catalysts for thought and action on the part of the participants and thus are not claimed to be comprehensive blueprints for radical change. These suggestions and the evaluation which has gone before must first be freely accepted through a process of participative discussion by all members of the system.

11.6: A Theory as Yet Unconfirmed

We have come to the end of our exposition of an integrated evaluation of a nurse training system. But our theory remains unconfirmed in Habermas's theory of universal pragmatics. That is, the theory has not been wholly accepted by members within the nurse training system. While discussions are still being conducted with the nurse training system, to date we have only been able to discuss in detail the technical section of our results although efforts have been made to point out the critical problems with remaining within a technical frame of analysis.

However, as yet, we have not explicitly related the social construction of our technical criteria of effectiveness to the micro-power relations which were observed to operate within the nurse training system, Neither have we constructively talked through the overarching systems of domination which give body and are embodied by these micro-relations. In effect, the practical (end of chapter 10) and the integrated/critical (chapter 11) levels of analysis have not been discussed by the research insitution.

In this sense, our argument and work to date is unfinished and non-definitive. In terms of achieving a significant degree of enlightenment and emancipation, it is doubtful whether a four-year piece of research by a single researcher will produce important results. In a fundamental sense, this is no place to conclude this section for the material effects of research should form the crux of our argument for that, after all, is the raison d'etre of practical and theoretical discourse. Although the theorist cannot justify risky strategic actions which must be undertaken by the participants within the system, nevertheless he/she can and should play a vital role in initiating discourse about the kinds of strategies which the community, at a given level of expansion of its forces of production, can afford.