The Shape of General Hospital Nursing

The Division of Labour at Work

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Contents

Abstract

This thesis is about nursing work and the ways in which nurses in a general hospital accomplished occupational jurisdiction. It is based on ethnographic data generated on a surgical ward and a medical ward in a single NHS trust hospital. The study is set in the context of recent developments in nursing and medical education (DHSS, 1987; GMC, 1993; UKCC, 1987) and health policy (DH, 1989) which have created the impetus for shifts in the division of labour in health care, reviving deep-rooted historical tensions between professional and service versions of nursing.

Drawing on the work of Hughes (1984), Abbott (1988) and Strauss and colleagues (Strauss *et al*, 1963; Strauss *et al*, 1964; Strauss, 1978) the aim of this project was to move on from the policy debates and develop a less essentialist account of the nursing role through an exploration of the ways in which nurses managed the parameters of their work in the course of their everyday activities. Hughes concept of 'dirty work' is employed as a sensitising device.

The work of hospital-based general nurses is explored through the analysis of five key nursing boundaries: nurse-doctor, nurse-support worker, nurse-patient/relative, nurse-nurse, and nurse-management. The professional and sociological literature suggested that as a result of recent policy developments, there would be an increased need for negotiation of nurses' inter-occupational boundaries with medicine and support workers and that this was likely to be subject to some tension. But field observations revealed that nurses accomplished these inter-occupational boundaries with minimal negotiation and little explicit conflict. Conversely, there were policy-related tensions at the three other key nursing boundaries - at nurses' intra-occupational boundary, at the boundary between nurses and patients and their relatives, and at the boundary between ward-based nurses and nursing and general management - which were largely unanticipated.

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Transcript Codes

Italics are used for tape-recorded interview material.

Indented extracts in normal font indicate fieldnotes unless otherwise indicated.

All tape-recorded materials and documents are verbatim transcriptions.

[...] words, phrases or sentences of the extract omitted.

(( )) descriptive material added by researcher in the fieldnotes.

( ) information added to make the context and/or meaning clear.

Data have been edited in order to preserve respondent anonymity.

All names are pseudonyms.

Introduction

In this study I explore the work of hospital-based general nurses through the analysis of five key nursing boundaries: nurse-doctor, nurse-support worker, nurse-patient/relative, nurse-nurse, and nurse-management. The thesis operates at two levels; at one, it is a investigation of general hospital work in the NHS in the 1990s, at another, it is an exploration of the social processes through which key aspects of an important domain in the hospital division of labour is constituted. It is based on ethnographic data generated on Fernlea[1] and Treetops wards at Woodlands, an NHS trust hospital.

The starting point for this study was the observation that recent policy developments in nursing and medical education (DHSS, 1987; GMC, 1993; UKCC, 1987) and health care (DH, 1989) had created jurisdictional ambiguity at two of nursing's key occupational boundaries: between nursing and medicine and between nurses and health care assistants. The sorts of questions raised in this context include: In what ways should nurses be

[1] All names are pseudonyms.

expanding their scope of practice? Should nurses be aiming to take over the work of junior doctors or are they merely recipients of allocated work? What should the role of the support worker be?

Of course there is a sense in which nurses' work boundaries have always been poorly defined. The initial occupational strategy of nursing was characterised by a willingness to embrace a broad range of work activities unified under the notion of the 'sanitary idea' (Carpenter, 1977). From the outset therefore, nursing was defined less by what it involved and more by its underlying principles. Recent policy developments have augmented the uncertainty of nurses' place in the hospital division of labour however, with competition between professional and service versions of nursing giving the occupation's underpinning jurisdictional ambiguity a new edge.

The study is framed by an interactionist perspective. It draws on the work of Abbott (1988), Hughes (1984) and Strauss and colleagues (Strauss *et al*, 1963; Strauss *et al*, 1964; Strauss, 1978) and is theoretically grounded in the assumption that occupational roles are not self-evident but have to be actively accomplished by actors within a system of work. I suggest that the division of labour at work may be considered as constituted through the dynamic interaction of boundary-blurring and boundary-creating processes. My aim in undertaking this study was to move on from the policy debates and develop a less essentialist account of the nursing role through an examination of the ways in which nurses managed jurisdictional ambiguity

in the course of their everyday work activities. In order to access the nursing boundary as defined by nurses themselves Hughes' concept of dirty work was employed as a sensitising device.

I began this study with what I considered to be well-founded reasons for anticipating an increased need for negotiation of nurses' inter-occupational boundaries. For example, in his discussions of the negotiated order perspective, Strauss (1978) makes it clear that negotiations tend to be encouraged by situations characterised by ambiguity. Furthermore, both the policy debates and work undertaken prior to doctoral study (Allen and Hughes, 1993, Allen *et al*, 1993) suggested that any such negotiations were likely to be marked by inter-occupational conflict. That disagreements between staff existed as to the appropriate allocation of work was confirmed by my interview data but this was not evident in my field observations which revealed that nurses' boundaries with medicine and support workers were accomplished with minimal negotiation and little overt conflict. Although initially generating some anxiety as to the focus of the research, these findings actually raise important sociological questions as to why the debates in the literature were so little in evidence on the wards. This is a central issue addressed by the thesis.

By employing the concept of dirty work as a sensitising device my attention was also drawn to largely unanticipated policy-related tensions at nurses' intra-occupational boundaries, at the boundary between nurses and patients

and their relatives, and at the boundary between ward-based nurses and general and nursing management. The focus of the research was thus amended to take into account these developing themes.

This thesis is organised in four parts. Part 1 is an exploration of the historical, political and theoretical background to the research. In the first chapter I examine recent policy developments in terms of the deep-rooted historical tensions within nursing between professionalism and managerialism. I begin by tracing the history of the NHS management 'problem' and follow with an exploration of nursing's current professionalisation project. I then examine the interactive effects of managerialism and professionalism in relation to the history of nursing's occupational development before going on to discuss the likely implications of these two forces on the shape of nursing work in the 1990s.

Chapter 2 is a critical selective review of the sociology of work and occupations in which I begin to set out the theoretical perspective employed in framing the research question. I start with a discussion of Durkheim's analysis of the division of labour and go on to examine the writings of Hughes (1984) on the world of work and occupations, Abbott on jurisdiction (1988), and Strauss and colleagues (Strauss *et al*, 1963; Strauss, *et al* 1964; Strauss, 1978) on the negotiated order perspective. I argue that taken together these authors begin to furnish a perspective which can be usefully employed in the analysis of nursing work but they can all

be criticised for their lack of critical attention to issues of gender. The chapter concludes with an overview of feminist insights into women and work and an examination of the ways in which this literature can facilitate an understanding of nursing.

Part 2 concentrates on methodological issues. In chapter 3 I outline the methodological choices I have made in planning this research. I trace the process of finding a focus, outline the research philosophy and set out the study's guiding assumptions including a detailed discussion of the application of the dirty work concept to general nursing work. Chapter 4 is a discussion of the research plan and the fieldwork processes.

The chapters constituting Part 3 of the thesis focus on salient social boundaries. In chapter 5 I examine the social worlds of Woodlands hospital. I describe the organisation, locale, and the wards on which the fieldwork is based. I also introduce the key players in the 'work drama' (Hughes, 1984): nurses, support workers and doctors.

In chapter 6 I describe how Hughes' dirty work concept alerted me to tensions at key nursing boundaries. I begin by describing the strains associated with nursing's intra-occupational division of labour. I argue that at one level these tensions reflect the problems staff had in adapting to the role changes occasioned by New Nursing. At another level I suggest that these intra-occupational strains can be understood in terms of the

difficulties practitioners face in reconciling models of care that are implicitly based on a private-practice model of professionalism, with the workplace reality of general hospital nursing. The boundary between ward-based nurses and nursing and hospital management is also examined. This section entails a discussion of nurses' complaints about paperwork as a local symbol of management control. I focus on nurses' disaffection with the nursing process which was being utilised by hospital managers as a quality assurance tool. Furthermore, nurses felt that the rationale for a satisfactory nursing record had been distorted by the new consumerism in health care and was being driven by risk management rather than patient care considerations. In the final section of this chapter I explore the tensions associated with the boundary between the work of nurses and patients and their relatives. I draw attention to the changes that caring relationships are undergoing both within nursing and the wider political climate and describe the negotiative processes through which a realignment of the division of labour between nurses and patients and their relatives was taking place at Woodlands.

In Part 4 my attention shifts to focus on nursing's two key inter-occupational boundaries. A central question addressed by the chapters in this section is the dearth of negotiation and lack of explicit conflict at nurses' inter-occupational boundaries with medicine and support workers. In chapter 7 I employ a temporal-spatial framework in order to understand the processes through which occupational boundaries at Woodlands were

blurred. Drawing on the work of Melia (1979), Zerubavel (1979) and Rosengren and DeVault (1963) I begin with a discussion of the turbulence of the ward environment. I suggest that the various strategies staff employed in managing this turbulence resulted in the routine, non-negotiated blurring of inter-occupational boundaries without which the work could not have been accomplished. I also describe the importance of individual experiential biographies in shaping the allocation of work rather than formal occupational credentials. I conclude that routine non-negotiated boundary-blurring is a taken-for-granted feature of nursing practice and argue that when this is recognised then the lack of negotiation and conflict surrounding policy-driven shifts in the division of labour can be better understood.

In chapter 8 I concentrate on boundary-creating processes. I begin with boundary maintenance and working practice. I examine the formal boundary-sustaining mechanisms employed by those senior staff at Woodlands responsible for implementing policies which entailed shifts in the technical division of labour. I also introduce the notion of 'boundary work' to refer to actors' talk-as-action; to the ways in which staff at Woodlands legitimated boundary-blurring whilst simultaneously constructing the moral division of labour. I also examine the boundary-creating functions of the oral culture of the key occupational groups, highlighting the importance of members' storytelling as a vehicle for the management of inter-occupational tension and the diffusion of overt

conflict. Chapter 8 also includes a discussion of the symbolic order in which I examine the role of uniforms and the allocation of space as boundary-markers. I conclude with a discussion of the micro-political processes through which status inequalities were sustained at Woodlands, particular attention is given to the ritual and ceremonial of the ward round.

In the concluding chapter I attempt to draw the threads of the thesis together by addressing the question of the extent to which the division of labour at Woodlands can be considered a negotiated order. In this chapter I examine the negotiative activity associated with each of the five nursing boundaries examined in the thesis, highlighting those local factors which facilitated or inhibited negotiations in each case and drawing attention to key methodological difficulties with the negotiated order perspective.

Chapter 9 also discusses the constraints within which nurses worked in order to explicitly delineate the structural context which encouraged them to constitute their occupational boundaries in the shape that they did.

PART 1

Historical, Political and Theoretical Context

Part 1 of this thesis will describe the historical, political and theoretical background to this project. In chapter 1 I am going to examine recent developments in nursing and health policy in terms of the historic tensions between professionalism and managerialism and examine their implications for nurses' jurisdiction. In chapter 2 I will critically review the sociological literature on work and occupations and begin to set out the theoretical perspective that shaped the research question addressed in this thesis.

1. Professionalism and Managerialism

Like the health care systems in countries throughout the developed world, the NHS is being reformed and restructured. Sociologists have begun to examine the impact of these recent policy trends on the health occupations. Medicine for example, is seen by some writers as undergoing a process of 'deprofessionalisation' (Haug, 1973; Haug, 1975; Haug and Lavin, 1983, all cited by Elston, 1991) or 'proletarianisation' (Oppenheimer, 1973; McKinlay and Arches, 1985, both cited by Elston, 1991). Critics have pointed out that these claims are questionable in both the British (Elston, 1991) and American context (Freidson, 1989), nevertheless the concepts of 'deprofessionalisation' and 'proletarianisation' have provided a useful framework from which to ask questions about the future shape of medical work. The application of these perspectives to nursing however is more problematic, given that both start from the assumption of an autonomous profession - an occupational niche to which nursing may aspire - but has yet failed to attain. Arguably a more fruitful way of understanding these developments in the context of nursing, is in terms of the long-standing tensions between professionalism and managerialism - a conflict underpinned by a complex mixture of economic interests and gender ideologies. The interaction of these two forces has had

a major historical influence on nursing as an occupation and on the definition of its jurisdiction, but may be seen as having entered a new phase with the introduction of Project 2000 (UKCC, 1987) and the NHS 'management revolution' (Klein, 1995) heralded by the Griffiths Report (DHSS, 1983) and further consolidated in the *'1990 National Health Service and Community Care Act'*. The tensions between managerialism and professionalism in relation to nursing and their implications for the occupation's jurisdiction are the subject of this chapter.

MANAGERIALISM

The search for improved management has been a persistent feature of the National Health Service's evolution (Harrison *et al,* 1990) and reflects two fundamental linked tensions which derive from its organisational form. The first tension stems from the requirement of the NHS to reconcile central funding and Government accountability for national standards of service, with the need for local autonomy to meet local needs (Ranade, 1994). This has resulted in an ongoing strain in managing the relationship between centre and periphery and a policy see-saw, with Governments alternating between periods of centralisation, in order to gain control, followed by a decentralising reaction against the rigidities which are caused as a consequence (Ranade, 1994).

The second tension derives from the bargain struck in 1948 between the State

and the medical profession (Klein, 1995). Despite his radical socialist image and the furious battles with the medical profession over the implementation of the NHS, Bevan's vision of the health service was essentially paternalist. Health knowledge resided with 'experts', chiefly the medical profession, and this won doctors a privileged place in administering the new system (Ranade, 1994). While Government controlled the budget, doctors controlled what happened within the budget. Financial power was concentrated at the centre and clinical power was concentrated at the periphery (Klein, 1995). For both parties this arrangement had the characteristics of a double-edged sword. On the one hand, operating within a limited budget the medical profession was left to do the Government's dirty work in rationing service provision. On the other hand, doctors enjoyed considerable clinical autonomy which meant the Government had little control over how resources were utilised. Klein (1995) describes this as a truce rather than a final settlement, and from the 1960s onwards these strains became increasingly apparent.

Taken together then, these linked tensions provide the backdrop to the management 'problem' in the NHS which has been the basis of successive reforms of the Service. Interest in improved management gathered momentum in the late 1960s and early in the 1970s (Harrison *et al,* 1990), reflecting mounting concern with the alleged poor performance of the Government machine (Harrison *et al,* 1990) and changing management ideologies in relation to the whole of the public sector (Flynn, 1990). Previously, service organisations had been seen as unique but this was replaced by the belief that

they were equally amenable to the principles of economic rationality associated with business organisations. Planning was seen as a neutral tool. Targets could be set and progress made towards them (Allsop, 1984). The emphasis on achieving greater efficiency and rationality through planning - through the use of new techniques of government - was common to both main political parties (Klein, 1995).

These ideas were manifest in a number of health policies throughout the 1960s and 70s. The 1962 Hospital Plan (Ministry of Health 1962, cited by Allsop, 1984) for example, was the first attempt since the creation of the NHS to devise a national plan designed to bring about distribution of hospital beds based not on the haphazard inherited pattern but on a centrally determined criteria for matching resources to needs. The building of 90 new hospitals was scheduled. National norms for the appropriate number of beds per head of the population were laid down (Klein, 1995). The belief was that beds could be used more efficiently by reducing the average length of bed stay and new buildings would ensure a better distribution of beds (Allsop, 1984). The concept of the District General Hospital was also part of the move towards greater efficiency through larger units of operation.

Consistent with the overall philosophy which had developed in the 1960s there was an increasing emphasis on producing better information and on organisational solutions: given better data, given better organisations, more rational decisions would follow - or so it was assumed. A new information

system was developed - Hospital Activity Analysis - which provided consultants with information about what they were doing. Also, it began to be recognised that the workforce in the NHS was continuing to increase in size and in complexity in terms of the division of labour. One response to this on the part of Governments and committees of enquiry was to look to scientific management to provide a basis for organising the work of professionals and their relationship to each other (Allsop, 1984). An early example of the managerialist approach was the reorganisation of nursing services in 1966 following the Salmon Report. A similar attempt to create a management consciousness was made with the medical profession - The Cogwheel System. The belief was that if all consultants became aware of the effects of their individual decisions on the use of resources they would themselves have an incentive to apply pressure on colleagues who used their beds wastefully. It is far from clear how well this worked however (Klein, 1995).

It was the reorganisation of the NHS in 1974 which was the zenith of the managerialist phase (Allsop, 1984). The 1974 reorganisation was based on the twin principles of rational planning and efficient management, although what was finally brought into being achieved neither (Ranade, 1994). Based on the notion of the essential unity of the NHS, the reforms were designed to transform it into a more efficient and effective service through a change in structure, the strengthening of management and the introduction of a planning system. One aspect of this reorganisation was the introduction of a more

democratic style of decision-making. Management teams in each authority, both region, and area, were charged with the responsibility of managing the services to meet the Government's policies and guidelines. The principle which came to underpin this new structure was 'consensus management' which was laid down in what was known as the Grey Book on *Management Arrangements in the Reorganised NHS.* There was no hierarchy in the management team which was comprised of the major professional groupings in the service. This was rather different from the original management proposals (Ministry of Health 1968, cited by Ranade, 1994) which envisaged far less professional and medical input into decision making but the syndicalist nature of the NHS forced a compromise (Ranade, 1994).

By the end of the seventies there was mounting concern over the NHS. The period had witnessed a number of industrial disputes and the changes of 1974 were beginning to be questioned. On the one hand the new model was attacked for being excessively managerialist and on the other hand for its bureaucratic complexity. These criticisms reflect the compromises of the 1974 reorganisation which, as Klein (1995) has argued, can be seen as a political exercise attempting to reconcile conflicting policy aims: 'to promote managerial efficiency but also to satisfy the professions, to create an effective hierarchy for transmitting national policy but also to give scope to the managers at the periphery' (Klein, 1995: 90). The result was a seriously flawed structure which certainly could not deliver the Government's stated intention of 'maximum accountability upward, maximum delegation

downwards' (DHSS, 1972, cited in Ranade, 1994: 4).

The 1979 Conservative Government, in strong contrast to its 1970s predecessor, was not committed to the ideology of rational planning (Klein, 1995). The 1982 reorganisation stressed devolution of decision making to a local level rather than at the centre. One example of delegation of responsibility was the freedom to set up units of management to best suit local circumstances. These could be focused on institutions or around particular care groups - such as the elderly. Interestingly however, although *'Patients First'* (DHSS and Welsh Office, 1979, cited by Allsop, 1984) advocated a simplification of the structure of the NHS it did not put forward any proposals for fundamentally reforming management. In fact, ministers were emphatic that consensus management teams were to stay. Indeed Patrick Jenkin in the launching of *'Patients First'* argued:

> 'I believe that doctors and other professional people in the NHS are trained to take professional decisions off their own bat, and do not need the torrent of advice to which in recent years they have been subjected. It is doctors, dentists and nurses and their colleagues in the other health professions who provide the care and cure of patients, and promote the health of the people. It is the purpose of management to support then in giving that service.' (Allsop, 1984: 139, quoting, Department of Health and Social Security and Welsh Office, 1979)

This was a view that was to be short-lived however.

1983 marked a clear turning point in NHS management policy. Whereas in the past the main preoccupation had been with the structure of the NHS, attention now shifted to its organisational dynamics (Klein, 1995). The publication of the Griffiths Report in 1983 signalled the beginning of the NHS management revolution (Klein, 1995) and may be read as the start of a systematic attempt by Conservative Governments to curtail professional power. Griffiths and the *'1990 NHS and Community Care Act'* endeavoured to control the professions in several ways: through the introduction of general management, through efforts to incorporate professionals into management roles, and by changing their working environment (Harrison and Pollitt, 1994).

These changes in the organisation of the NHS are part of a range of reforms that reached across the whole of the public sector as a consequence of the break down of the 'post-war consensus' on the Welfare State. After 1975 there was a major change in attitude towards the role of Government. Increasingly it was argued that state spending was not a solution to all economic problems and could actually obstruct economic progress. Since the mid 1970s there has been a consistent effort on the part of both Labour and Conservative Governments to reduce public expenditure. Both parties have adopted polices reflecting the view that the State should be less involved in many aspects of life (Flynn, 1990).

The Griffiths Report proposed a major restructuring of the NHS organisation, duties, responsibilities, accountability and control. The prescription was for a general management structure from top to bottom ie. individuals at all levels responsible for making things happen. The political and cultural environment of the 1980s was no longer favourable to the concept of collaboration (Dingwall *et al,* 1988).

The introduction of general managers was, in large measure, a device to change doctors. Whether by enticing, cajoling, persuading or ultimately forcing them, the aim was to bring them into the management process and instil managerial values. Nurses were already in management positions in their own area however. From the 1974 reorganisation they had been directly responsible for the massive budgets that covered the provision of nursing staff (Davies, 1995). Although nursing had essentially been 'caught in the cross fire' of changes targeted at medicine, their impact on nursing was profound (Strong and Robinson, 1990). 'At a stroke, the 1984 reorganisation removed nursing from nursing's own control and placed it firmly under the new general managers' (Strong and Robinson, 1990: 5).

Griffiths also challenged some of the assumptions that had shaped the NHS since its inception. Consumerism emerged as a key theme in response to the criticism that services were oriented to the needs of providers rather than producers. The past fifteen years has seen a marked increase in overtly expressed complaints about the quality of medical care (Elston, 1991), a trend

that the recent NHS reforms and its associated rhetoric has further encouraged.

Harrison *et al* (1990) pose the question as to why the Government pounced on general management in 1983 when only four years earlier they had rejected any shift from consensus management on the grounds that this would displease the professionals. There is no easy answer to this. It is suggested that one possible reason lies in the criticism that the DHSS lacked a sufficient grip on the NHS and that health authorities were insufficiently accountable to ministers. Moreover, the Treasury was asking questions about the growing NHS budget at a time when one of the Government's priorities was to contain and reduce levels of public spending. If the NHS was to be treated as a deserving case for additional funds then it had to demonstrate that it was using its existing funds efficiently (Harrison *et al,* 1990).

It is not clear whether the Government had itself already decided that general management was the answer or whether it accepted Griffiths because of its timeliness and instant appeal. As Harrison *et al* (1990) suggest, maybe the DHSS only knew what it wanted when it saw it. This is most plausible given that Sir Roy Griffiths was originally asked to carry out a staffing review and he managed to shift the reform agenda to that of management - on the grounds that staffing problems were symptomatic of management failure. As Ranade (1994) has pointed out however, for a radical Government committed to 'rolling back the state', the reforms of the NHS in the 1980s were remarkable

for what they left unchanged. The NHS, unlike housing and education, finished the decade battered round the edges but still more or less intact.

Griffiths was only a beginning however. In 1990 as a consequence of increasing concern with cost-containment the health service was reorganised again. The reforms introduced as a result of *'National Health Service and Community Care Act 1990'* were in many ways a logical development and strengthening of the Griffiths management philosophy, but the nub of the reforms - the creation of the quasi-market - was a radical new departure (Ranade, 1994) and marked a new ideological polarisation between the Labour and Conservative parties (Klein, 1995). The crucial components of the Act were:

* the creation of a split between purchasers of health care on the one hand and providers on the other;

* the institution of a contracting process between these purchasers and providers by which the latter would present tenders to the former;

* the creation of 'self-governing trusts' which, following the Conservative victory at the General Election in April 1992 became the normal means of the provision of health care, and

* various other policies, such as budgets held directly by general practitioners for certain services. (Paton, 1993)

Underpinning the NHS reforms and those of the public services as a whole is a particular view of what 'management' is (Flynn, 1990). Many of the recent changes have been introduced by people from the private sector and the managerialist ethic which has developed is grounded on the belief that managers should 'manage', that they should be in control of their organisations and be proactive. 'Active' management was to replace 'passive' administration. Recurring themes included: action, decisiveness, effectiveness, thrust, urgency and vitality, consumer satisfaction, quality, efficiency. Changes in management arrangements involved combining tighter accountability and monitoring with increased devolved freedoms. The units of management would be smaller and under tighter local control.

One aspect of the wider White Paper agenda involves the extension and acceleration of the Resource Management Initiative (RMI). RMI concerns the involvement of doctors, nurses and general managers in determining more effectively the use of resources. The key feature of RMI has been the formation of a system of clinical directorates, in which medical, nursing and management staff work together to manage speciality budgets. It is however a moot point as to whether this is an enabling or a controlling 'responsibility'.

These developments in clinical management have also heralded the implementation of more systematic monitoring and accounting mechanisms (West, 1992). Demands for greater 'value for money' have spawned a plethora of techniques for management evaluation and control of clinical

activity (Elston, 1991). The new acronyms, QA, PIs, DRGs, QALYs, promise an era in which the way care is organised, the way it is provided for patients, and the way in which resources are used in the provision of that care are now the subject of continuous, detailed scrutiny and review.

A key management issue in relation to the changing role of nurses in the hospital division of labour is the management of human resources. This is an area where there has been considerable devolution. While the Whitley system of pay bargaining has not been abolished for all staff groups, there is however an argument that the devolution of pay bargaining and devolved responsibility to provider units for the management of human resources would lead to greater flexibility of the workforce. In a context of market competition, where self-governing trusts are seeking to respond to market forces more quickly, ability to manage one's own work force could be of paramount importance (Paton, 1993). In this context the issue of 'performance-related pay' has moved centre-stage and the Department of Health recently confirmed that guidelines for trusts on the assessment of nursing staff are being drawn up (O'Byrne, 1994). Nurses have been quick to point out the difficulties of applying these principles to their work. 'Any definition of productivity is linked to speed and outcomes, a crude measure of performance. By that yard stick good nursing will almost certainly lose out' (Casey, 1993).

In addition to pay, issues of demarcation of work responsibilities between different staff groups have been brought centre stage (Paton, 1993). *'Working*

For Patients' (DH, 1989) questioned the parameters of nursing:

> 'As part of this initiative, local managers, in consultation with their professional colleagues, will be expected to re-examine all areas of work to identify the most cost effective use of professional skills. This may involve a reappraisal of traditional patterns and practices.' (DH, 1989)

Thus 'skill-mix' and more recently 'reprofiling' have become vogue phrases. Reprofiling may mean senior staff extending 'downwards' or junior staff extending 'upwards'. Of crucial importance for nurses in this context are changes in medical education (DHSS, 1987; GMC, 1993) and the initiative to reduce the hours worked by junior hospital doctors (NHSME, 1991).

The *'New Deal'* (1991) sets firm limits on junior doctors' contracted hours (72 per week or less in most hospital posts) and working hours (56 hours per week) to be achieved in all hospitals. As a means to this end the *'New Deal'* calls for an increase in the number of career grade posts and encourages new ways of organising junior doctors' work such as shifts, partial shifts and cross-cover between specialities. It also suggests the 'sharing' of key clinical tasks by nurses and midwives. Many current changes in skill-mix take much of their impetus from the *'New Deal'* (cf. Allen *et al,* 1993; Allen and Hughes, 1993; Hughes and Allen, 1993). In order to implement the *'New Deal'* task forces or local implementation groups have been established

throughout the UK and they have been given the power to recommend the removal of education approval from a training post if an acceptable standard has not been achieved.

On the one hand it is possible to argue that the solutions to the excessive hours of junior doctors proposed by the *'New Deal'* reflects the Government's commitment to medical career development: that all junior doctors seeking a hospital career are in training for consultant posts and that this training should last no longer than is strictly necessary (DHSS, 1987). On the other hand however, the potential 'cost' of these safeguards is the erosion of medical jurisdiction. Clearly, the processes of 'sharing' and/or devolving routine tasks has deskilling implications for doctors.

An important parallel development in this context is the White Paper: *'Opening New Markets: New Policy on Restrictive Trade Practices'* (DTI, 1989) which means that employers can now legally employ staff on the basis of competencies (Shaw, 1993). The implication is that non-professional staff may be employed to carry out those tasks traditionally reserved for those with the professional qualification, providing competence can be shown (Brown, 1990, cited by Shaw, 1993). There is a view that these trends will lead to a more flexible workforce which can be allied to demographic and social trends. Managers are working within tight financial constraints however, and thus changes in the division of labour may reflect the need to cut costs rather than improve the quality of service.

Six years on, the official rhetoric that accompanied the 1990 reforms has adapted to the complex reality of health care. In practice the internal market is characterised by monogamy rather than polygamy. Most purchasers and providers are locked into permanent relationships and hence purchasers have become commissioners. Furthermore, the internal market has become the managed market: a recognition that purchasing was about shaping the services available to a local population in the long-term as opposed to buying off-the-shelf to satisfy immediate wants (Klein, 1995). Klein (1995) points out that competition has been replaced, as a key word, by contestability, acknowledging that the NHS internal market appeared to be creating regulated local monopolies rather than a free-for-all. Moreover, the managed market turned out to be one in which politicians were active actors. The introduction of the internal market appeared to be the death certificate for the notion of planning and central planning has indeed declined. Planning but has not totally disappeared however, as commissioners have emerged as planners in a new guise.

Klein (1995) underlines the immense difficulties of assessing the impact of the reforms. He argues that because the reforms marked the beginning of a process of experiment and adaption it is impossible to come to any firm conclusions as to where it is going or what it has achieved. According to Klein (1995), there are some points on which more certain conclusions can be made however. First, the reforms have conspicuously failed to achieve the Government's objective as set out in *'Working For Patients'*, of giving

patients 'greater choice of services available'. Second, the Government quite clearly failed to achieve their general objective of bringing about greater satisfaction and rewards for those working in the NHS. Finally, although the reforms have been successful in challenging the inherited patterns of work in the NHS, their effects have been most acutely felt by professions allied to medicine. Inroads into the power of the medical profession have been limited (Harrison and Pollitt, 1994; Ham, 1992). Arguably the increased participation of doctors in hospital management represents not so much the subordination of clinicians to managers as the emergence of clinician managers. As Elston (1991) points out, it may turn out that it is the 'corporate rationalisers' **within** the profession who are in the ascendant in Britain.

NURSING'S PROFESSIONAL PROJECT

Project 2000 and its ideological underpinning 'New Nursing' (Beardshaw and Robinson, 1990) is the UKCC's strategy for reform of nursing education, structure and practice. It is a clear bid for a separation of education from service - dismantling an historical bargain which was unsatisfactory from the perspective of both learners and teachers - and also an ambitious plan to create a practitioner-based division of labour (Davies, 1995). Proponents of Project 2000 argue that it has the potential to overcome some of the occupation's most persistent problems: low status; poor retention; lack of a clearly defined area of expertise with a scientific basis for practice.

The Project 2000 reforms were wide-ranging, radically altering the orientation of nurse training and relocating nurse education from hospital-based schools of nursing to institutes of higher education. The reforms also established a single portal of entry by abolishing the SEN (State Enrolled) grade of nurse; existing SENs can take conversion courses leading to RN (Registered Nurse) status. All nurses in training now follow an eighteen month common foundation programme followed by 'branch' programmes for particular specialities - adult nursing, children's nursing, mental illness and mental handicap. Learners' contribution to service provision has been reduced from 60 to 20 percent. Academic skills are to be developed, valued and rewarded by a Diploma in higher education. One of the aims of Project 2000 is to produce a 'new type of nurse'. Project 2000 is committed to preparing practitioners who are not only 'doers' but 'knowledgeable doers'. The curriculum is health, as opposed to disease-oriented, with an emphasis on people in the wider sociocultural context. Nurses' new basic education is geared to preparing them for work in a range of institutional and non-institutional settings.

The New Nursing ideology on which Project 2000 is founded has important implications for nursing culture and practice. It emphasises the centrality of the nurse-patient relationship and advocates an holistic approach to patient care. This represents a shift from the old system of hierarchical task-allocation in stressing that nursing practice should be the jurisdiction of trained staff.

New Nursing began in the UK in the early 1970s with the new departments of nursing in universities and polytechnics generating an interest in nursing theory (Salvage, 1992). Academic nurses drew heavily on work from the USA which sought to redefine the role of nurses in order to assert nursing's unique contribution to the health care team and establish an independent knowledge-base. The nursing process, for example, was an American import.

The history of the nursing process has been examined in some detail by de la Cuesta (1983). According to de la Cuesta, the idea that nursing was a process rather than a separate set of activities developed in the US in the late 1950s and 1960s. Initially it was primarily seen as a teaching tool. Although a few hospitals experimented with the nursing process as a framework for the organisation of care, it made little impact on practice until the 1970s when the Joint Commission on the Accreditation of Hospitals, which certifies the quality of hospital services as a basis for Federal and private insurance payments, made the preparation of care plans a prerequisite for its approval of an institution. The full significance of this decision is underlined by Dingwall *et al* (1988) who, drawing on de la Cuesta's work, point to the implications of the nursing process being imposed as a management tool. Care plans became one of the book-keeping devices by which American health planners tried to contain the escalating costs of medical care.

In the UK the nursing process first began to be discussed during 1973 but no articles were published on the subject until 1975. Once arrived, diffusion and

institutionalisation were rapid. By 1977 it was being implemented at hospital level. The period prior to its emergence was one of considerable discontent and debate within British nursing. Reviewing the nursing literature, de la Cuesta identifies a number of persistent themes: a rejection of a task-oriented approach to nursing, the lack of individualised care, nurses' lack of job satisfaction, and the superficial nature of the nurse-patient relationship. British nurses were seeking satisfactory methods of nursing and, as de la Cuesta points out, there were a number of precursors to the nursing process which prepared the ground for its diffusion: patient-centred care, patient assignment, total patient care, team nursing, progressive patient care.

De la Cuesta notes the transformation of the nursing process in the British context. Comparing the UK with the US literature, she argues that issues of nursing autonomy and accountability and the intellectual skills involved in implementing the nursing process were underplayed. Furthermore, patient involvement in care is mentioned principally in terms of gaining cooperation and collaboration rather than from the viewpoint of their active participation in decision making. Arguably, subsequent UK developments in nursing and health policy have muted these early differences however.

As well as representing an attempt to establish an autonomous knowledge-base, New Nursing ideology has important implications for the organisation of nursing practice. It is a welcomed reaffirmation of the clinical, as opposed to the administrative skills of nurses. Traditionally, nursing was organised

according to a system of task-allocation. Work was arranged in a strict hierarchy of tasks which were allocated accorded to one's place within the nursing hierarchy. In carrying out tasks nurses moved from one patient to another. Under this system of work allocation, increasing seniority meant less 'hands-on' contact with patients. New Nursing promised to replace this fragmented care with an holistic approach in which the performance of tasks were integrated into the total care of the patient. The patient is seen as a whole for whom all aspects of healing work are essential, including 'basic nursing care' such as bathing and toiletting. These tasks should thus be restored to their central place in the qualified nurse's work, since they are as important as supposedly, more scientific tasks handed down to nurses from doctors (Salvage, 1992).

New Nursing, in rejecting task-allocation, has brought about a redefinition of the nursing role; the nurse is now instructed to communicate with the patient as a subjective being. Armstrong (1983a) has observed that until about twenty years ago the caring role of the nurse was restricted primarily to the biological functioning of the patient. There is some debate over the finer details of Armstrong's claims, nevertheless many of the current ideas on 'care' are either being revived or of recent origin (Wilson-Barnett, 1988, cited by James, 1992a). Exponents of New Nursing maintain that nursing is a therapy in its own right and that by the 'therapeutic use of self' nurses can help people to feel better and also get better (Pearson *et al,* 1988, cited by Salvage, 1992). The professional-client relationship is conceived of as an equal partnership and

it is through the establishment of a therapeutic 'healing association' that nurses are said to promote healing.

New Nursing theorists advocate primary nursing as the organisational expression of these aspirations for practice. Task-allocation is based on a relatively fixed timetable decided by the ward sister and imposed on nurses and patients alike. Primary nursing involves allocating 24-hour responsibility for each patient's care to a trained nurse, who plans, gives, supervises and evaluates care, wherever possible with the active collaboration of the patient. In order to provide the 24-hour care conventionally offered to patients in hospital the primary nurse leads a team of other nurses - known as associate nurses - who deliver care when the primary nurse cannot. Associate nurses are expected to administer the prescribed care rather than take diagnostic or prescriptive decisions on their own behalf. The New Nursing ideals are associated with centres of nursing excellence such as the Burford and Oxford Nursing Development Units, which although not typical of nursing today, are held up as an example of 'the contemporary ideology of nursing in action' (Pearson, 1988, cited by Salvage, 1992).

The reconstruction of the nurse-patient relationship as a therapeutic partnership has not been accepted uncritically though. For example, it is by no means clear if patients or nurses want the type of relationship held up by New Nursing as the ideal. As Salvage (1992) has pointed out, the immediate concern of patients is likely to be relief from pain and discomfort, rather than

a meaningful relationship in which they can discuss their problems. Indeed, many of the activities nurses have to perform for patients are of an intimate nature and their management may actually be facilitated by a more detached 'business as usual' approach (see, for example, Lawler, 1991). Furthermore, the part played by faith or belief might make a hierarchical relationship beneficial for patients (Salvage, 1992). The lack of research into the ways in which patients respond to this approach to their care has been used to support the claim that the reconstruction of the nurse-patient relationship has been driven more by the desire to solve nurses' problems rather than to respond to those of patients (Dingwall *et al,* 1988).

To note some of the difficulties with New Nursing is not to undermine the importance of its aspirations for practice but to highlight the fact that to be fully comprehended the movement must also be understood as a specific professionalising strategy which aims to enhance the status and rewards of the occupation. A central objective of the New Nursing reforms is the establishment of clinical autonomy as a master professional trait. Hence the emphasis on nurses' unique caring function and New Nursing's attempt to intellectualise clinical nursing. But in establishing nursing's caring function as a basis for autonomous practice the nurse-patient relationship has been reconstructed in a manner which is clearly unorthodox in terms of the professionalisation paradigm. Because of their informed position professionals are conventionally regarded as more knowledgeable than clients and thus clients are not considered as constituting a significant reference group. But

the crux of the matter is that the empowerment of patients also legitimates the empowerment of nurses. Exponents of New Nursing maintain that individually planned care and shared decision-making can only empower the patient if the carer has the power to enact those decisions.

Because New Nursing conflates the attempt to improve nursing education and practice with the pursuit of functional autonomy it is flawed by a profound insensitivity to the reality of nursing work. For example, the construction of nursing as almost totally independent of, and separated from medicine bears little resemblance to the daily practice of most nurses (Porter, 1992a). Furthermore, professionalisers' aspirations for a workforce numerically dominated by qualified nurses flies in the face of the historical evidence (cf. Dingwall *et al*, 1988) and disregards the economic realities of modern health care.

At the root of the New Nursing reforms is a private-practice model of professionalism with its characteristic emphasis on the professional-client relationship. The reality of most hospital nursing however, is one of multiple patient assignments which have to be coordinated with the needs of a complex, internally heterogenous and hierarchically ordered organisation. Moreover, it may be argued that the stages of the nursing process - assessment, planning, intervention and evaluation - inadequately represent how nurses practice (cf. Benner, 1984; Lawler, 1991). Much of nursing is arguably an intuitive response to the moment.

Studies on both sides of the Atlantic have concluded that the nursing process has had a disappointing impact on nursing practice (de la Cuesta, 1983; Buckenham and McGrath, 1983; Melia, 1987). Blame for its failure has been laid on the education and preparation of practitioners. But as a number of authors have pointed out, the disappointments of the nursing process may more accurately be attributed to its failure to take account of the fundamental nature of nursing work in a complex organisation such as the modern hospital (de la Cuesta, 1983; Melia, 1987; Milne, 1985; Keyzer, 1988).

It is sometimes suggested that the tensions of the 'theory-practice gap' are healthy and function to ensure practitioners strive for professional ideals when there is a strain towards compromise in the work setting (James, 1992a). But this places the onus for resolving these tensions on the individual practitioner. It is a moot point as to whether nurses are adequately prepared for this and the human costs may be unacceptably high. As Becker (1970) has argued, the symbol of profession is useful in so much as it helps people to organise their lives and embodies conceptions of what is good and worthwhile, but when that symbol becomes too divorced from the reality it becomes pathological.

PROFESSIONALISM, MANAGERIALISM AND NURSING HISTORY

The professionalising movement in nursing is by no means new. The conflict between service and professional versions of nursing has emerged at various points in the history of nursing's occupational development (see, for example,

Abel-Smith, 1960; Dingwall *et al,* 1988). At the root of the debates over nurse registration was the struggle between those who wanted to maintain the primacy of the organisational interests of the hospital and those who wanted to reconstruct nursing as a free profession which controlled its own fees and conditions of work (Dingwall *et al,* 1988). Nightingale's vision of nursing as a dedicated calling more akin to religion with little importance attached to rewards contrasts with Mrs Bedford Fenwick's vision of occupational professionalism, where occupational expertise brought with it the deserved trappings of status and remuneration (Witz, 1992).

At the end of the nineteenth century, nursing was tightly linked to the specific work of particular hospitals and the knowledge nurses gained was not readily transferrable to other types of patient or institutional context. The registrationists, led by Mrs Bedford Fenwick, proposed that this should be replaced by a more generalisable training which would prepare nurses to work with a wider range of patients in and outside the hospital. Mrs Bedford Fenwick had a view of nursing as a high status occupation for women, whose organisation and economic relations with patients would be comparable to those of medicine (Dingwall *et al,* 1988). The registrationist movement also wanted to achieve the dominance of general nursing over the constellation of other occupations which had become attached to it by establishing a common foundation programme for all nurses.

The registrationists' scheme had important implications for the influence of the

voluntary hospitals however. Nightingale's conception of a nurse as a devoted, disciplined and selfless worker together with the strategy of on-the-job training meant that hospitals were staffed with a cheap, disciplined and compliant labour force of probationers (Witz, 1992). In the absence of a national scheme of credentials for nurses, the voluntary hospitals had effectively created a series of captive labour markets, since nurses' job-specific skills did not allow them to easily move to other institutions (Dingwall *et al*, 1988). If the hospitals allowed the occupation to organise itself and create a more homogeneous market then instead of nurses working on terms set by the hospitals, the hospitals would have to employ nurses on terms set by the occupation.

Dingwall *et al* (1988) argue that the medical profession was divided on the issue. Elite practitioners were either indifferent or supportive; they reasoned that registration was unlikely to have much of an impact on the institutions in which they worked or the class of patients for whom they cared. General practitioners however, were concerned about the possibilities of competition from professional nurses, especially in rural areas.

Nursing's case was hampered by divisions within its own ranks between the extremists of the Bedford Fenwick faction on the one hand and those who, following Nightingale, were more prepared to compromise with hospital and medical interests on the other. These disagreements centred on where the locus of control over nursing should lie. Should it be located in an expanded

occupational role of the matron in what was essentially a de-centralised female authority structure operating at the institutional level of the hospital, or should it be located in a central controlling body of nurses at the supra-institutional level along the lines of male professions of medicine (Witz, 1992).

In the event, the *'1919 Nurses Registration Act'* proved to be a hollow victory for Mrs Bedford Fenwick's professionalisers. It seems likely to have been influenced more by the Government's intention to create a national health service after the war which would require some rationalisation of nurse training, than sympathy for the registrationists case. The act established a register of trained nurses and the establishment of the General Nursing Council in 1920 which was later charged with maintaining and determining the conditions of the register. It was the minister of health who assumed the power to nominate the members of the GNC however, and as Dingwall *et al* (1988) point out, it is here that the registrationists defeat becomes most apparent. The GNC was made up of 9 lay members and 16 nurses. The nursing membership was dominated by the Royal College of Nursing and with the votes from the lay members they had a majority over the Bedford Fenwick faction. The Bedford Fenwick group fought within the GNC for a system of training built on the model followed by the medical profession. But the early years of the GNC were marked by the institutionalisation of a regime that gave a much higher priority to the development of a wider dispersion of skills and to the encouragement of local arrangements to rationalise training provision. Furthermore, although the Registration Act gave nurses a protected

title - only nurses on the register could call themselves state registered - this was not a prerequisite for employment as a nurse. As a consequence, despite professionalisers' desire for an all-qualified work force, they were unable to resist the introduction of the SEN and the unplanned growth of the nursing auxiliary. A further setback for the professionalisers was their failure to create a generic occupation in 1919. In the event separate registers were established.

For much of its early development nursing was characterised by two paradoxical features: remarkable flexibility in its work content and an extremely conservative infra-structure (Davies, 1977; Carpenter, 1977; Dingwall *et al,* 1988). As I have argued, nursing proved itself to be extremely flexible in terms of the parameters of its jurisdiction but this was coupled with the insistence that nursing should be a life-long vocation which necessitated the continuation of a cloistered life and a harsh authoritarian regime (Carpenter, 1977). Dingwall *et al* (1988) underline the importance of the performance of repetitious mindless tasks as a mechanisms for disciplining nursing probationers. As Carpenter (1978) has pointed out however, many of the personnel policies pursued by the matron elite principally reflected occupational rather than service needs. The prime purpose was to create and sustain the institutions of vocationalism, based around the training school and the nurses' home, which were vital to protect the pristine image of nursing. Moreover, it ensured that it was only those with the highest level of motivation that reached the apex of the occupation. After the Second World

War, with the creation of the NHS, the Government began to exert increasing pressure to dismantle these institutions of vocationalism (Carpenter, 1978). As Carpenter (1978) points out however, it is some indication of the power of the occupational elite that it was only really transformed when its members themselves decided that the traditional structure no longer served their interests.

The contemporary resurgence of professionalism can be traced to the restructuring of nursing that followed the Salmon Report (1966). This is a period of nursing's occupational development that has been examined in-depth by Carpenter (1977, 1978). Carpenter (1977) argues that by the 1960s wider social and technological developments meant that there had been immense changes in nursing's job content. As a result of the growth of medical science an increasing number of clinical responsibilities were being delegated. There had also been an increase in the importance of the nurse as a coordinator of a range of ancillary functions. Nursing work was further affected by the increase in the numbers of chronically ill patients requiring long-term care. Carpenter (1977) argues that given the breadth of nursing duties the temptation was to stratify these tasks along these three dimensions. Training was clearly a prerequisite for the clinical and managerial aspects of the work but it was less relevant for the basic nursing care of the long-term sick. According to Carpenter (1977), there was an initial resistance to the delegation of basic nursing duties to auxiliaries. However, as the numbers of chronically ill increased and the rewards of this kind of nursing diminished, the nursing elite

increasingly began to look towards the clinical and managerial aspects of their work.

Carpenter (1977) argues that the particular balance of forces at the beginning of the 1960s meant that it was the managerial rather than clinical changes in job content that were given emphasis. As we have seen, the 1960s and 1970s were characterised by a general belief in the efficacy of organisation structure and management training as a means of producing better management in the public sector. Claims for managerial roles and equality of status with administrators became the strategy by which the health professions other than medicine sought to advance themselves (Harrison *et al,* 1990). The nursing elite had several concerns: staff morale, the enduring problem of retention and recruitment and the erosion of the matron's occupational territory to lay management. Nursing leaders hoped that by creating a new image for nursing and flexibility on the part of management, trained staff could be attracted back.

The Salmon structure was intended to both modernise nursing management to fit the new environments of the planned District General Hospitals and to achieve more efficient use of nursing labour. Under Salmon the managerial chain was lengthened both above and below the matron. This was to meet the demands by matrons for more influence at group level but also in the hope of creating a career structure which would enable nursing to compete again with other middle-class occupations (Carpenter, 1977). A parallel scheme was later

recommended by the Mayston Committee for local authority nursing (Dingwall *et al*, 1988). Both structures were a forerunner to the eventual reorganisation of the service in 1974.

Nursing now had a management structure which gave it parity with other interests in the NHS (Dingwall *et al*, 1988). The most significant change however was the progressive dilution of nursing by lower level staff. Carpenter (1977) argues that the wish of the nursing elite to relieve itself of its more routine tasks coincided with the wish of the state to economise on skilled manpower, and subject jobs to productivity criteria (Carpenter, 1977). Armed with new strategies of discipline the nursing elite finally abandoned their insistence on the centrality of routine duties to the occupation and redefined them as low level skills which could be safely delegated in the search for economy.

According to Carpenter (1977), the nursing elite had seen in the Salmon proposals a way of renewing themselves and for this they were prepared to abandon important nursing traditions. But the hopes vested in the new nursing structure were bitterly disappointed. The proposals were rapidly implemented leaving little time to attract to the occupation the middle class women it was hoped would fill the new administrative posts. In this situation male nurses were well placed to compete for positions.

On the one hand male nurses possessed traits which tended to propel them up

the hierarchy: they were more likely to stay in the service for longer, work full-time and have greater geographic mobility. Carpenter (1977, 1978) points out that there were other, less obvious, reasons why Salmon favoured men. The nursing elite on the Salmon Committee joined with management in a savage attack on the matron system of management and called for its replacement by an industrial model of line management. Carpenter (1977) underlines the implicit sexism of the Salmon Report in which female nurses are viewed as almost inherently incapable of exercising administrative skills. Matrons were criticised for being obsessed with details, unable to make decisions and prone to social snobbery. Carpenter (1977) argues that Salmon, in redefining 'female' positions into functional managerial ones made them ripe for male capture. Given that nursing is a quintessential female occupation, in the past, men as men could not be expected to possess the attributes of a 'good' nurse, or if they did it questioned their sexuality. But Salmon transformed the position of men in nursing. Paradoxically, the very qualities that were believed to make men poor nurses made them potentially good administrators. Carpenter (1977) suggests that in the past nursing has tended to be indirectly dominated by men in the medical profession. The effect of Salmon was to replace the middle class women who, traditionally, have directly dominated nursing, by male nurse managers of less elevated social backgrounds.

Salmon had other unforeseen undesirable consequences. Carpenter (1977, 1978) points out that although the nursing elite maintained the pretence that

in pursuing a strategy of control outside of the clinical sphere they were attempting to uplift the profession as a whole - in actuality the gains of Salmon were very narrow. Equality of nursing with other groups in management was won by virtue of the elite's domination over the nursing labour force, an equality which posed little threat to the dominance of medicine in the clinical sphere. This led to considerable disillusionment with Salmon at the lower levels of the nursing hierarchy. The new managers were often seen as career-oriented with little interest in the practical situation. The Salmon reforms overemphasised the importance of management changes in job content to the detriment of clinical changes. It created a formal structure which failed to reward clinical expertise; prestige and remuneration increased with the distance from the bedside. One important objective of Salmon for the nursing elite was to improve staff morale but this objective clearly misfired. Carpenter (1978) argues this was reflected in the increased union and professional tensions between clinicians and managers that followed Salmon. In this context Carpenter (1977) predicted that managerialism in the NHS would lead to a revival of the professional model.

Against the background of industrial unrest that followed Salmon, the Briggs Committee was set up to review nursing education. Dingwall *et al* (1988) argue that a prime motive in the setting up of the Briggs Committee was to relieve the Government's embarrassment over the threat posed by nurses to its prices and incomes policy. Like many of the Royal Commissions and Departmental Committees of this period it was used as a device by the Labour

Government to deflect short-term political problems. It was the professionalisers' vision of nursing that came to dominate the Briggs report.

Dingwall *et al* (1988) argue that to be fully comprehended Briggs needs to be set in the context of plans for reorganising the service as a whole. Unlike the Wood Committee in 1947, Briggs was not given a free hand to reconstruct nursing in line with a reorganised health service, it was directed to plan within existing 'manpower' constraints (Dingwall *et al*, 1988). Dingwall *et al* (1988) argue that once new investment was ruled out managerial interests could largely disengage themselves from the work of the committee in the knowledge that any proposals could be modified by highlighting their resource implications. This left the way clear for the professionalising segment of the occupation to direct the committee's deliberations.

Although given a contemporary flavour, the Briggs recommendations echoed those of Mrs Bedford Fenwick - a nursing curriculum modeled on medical lines with a general foundation leading to specialist qualifications. Briggs advocated a 'comprehensive' vision of nursing education, with each individual being free to select the track and pace of learning which suited them. This new training would encourage a mixed ability intake onto a common programme. The nursing curriculum would be organised on the basis of learning modules, which could be repeated until mastered. Within this an elaborate meritocracy would be created. The initial 18-month programme would lead to a certificate. Registration would require a further 18 months

of study. Selected candidates would be able to continue to a Higher Certificate after that. Graduate programmes were left outside of this structure although they were envisaged to be the main source of professional leadership for the future. Briggs proposed a single powerful council to oversee the system. All the various sections of the occupation would be brought under its remit. It looked as if the professionalisers ambitions were at last to be realised (Dingwall *et al,* 1988).

The Bill was finally published in November 1978 following a series of protracted consultation exercises, and two changes of Government. It concentrated almost exclusively on the regulatory structure and gave virtually no attention to the educational questions which had so concerned the professionalist segment of the occupation. The professionalists were clearly disappointed.

Dingwall *et al* (1988) have suggested a number of reasons for Briggs' failure to meet the professionalist segment's expectations. The authors suggest that professionalists' hopes may have been inflated by the bill. Briggs gave little attention to the fundamental nature of nursing work, focusing instead on structural details. It is also suggested that the advocates of Briggs overestimated the extent to which their own occupation was united behind the demands for change. A number of specialist interests - for example, health visitors, some midwives - feared that the concentration of power that would result from the proposed changes in the occupation's regulatory structure

would lead to the ideological domination of general nursing. These various interest groups succeeded in getting some significant changes to the original Briggs proposals.

As Dingwall *et al* (1988) point out, a further problem was that the thrust of Briggs was antithetical to the goals of the wider changes in the health service. Successive reorganisations of the service in the 1970s were directed towards efficient resource management; the means to this was believed to be through a combination of central planning and bureaucratisation. There were already grave doubts as to whether the service could afford one free-spending profession. Given this, the professionalist segment was extremely naive to believe it would contemplate another. Dingwall *et al* (1988) argue that 'instead of the construction of a new licence for autonomous practice, they were presented with a low-cost administrative reform whose concessions to a number of specialist interests limited their ability to impose a unified view of the occupations' status and direction' (Dingwall *et al* 1988: 212).

At this time the professionalisers' principal base was in the education sector. Dingwall *et al* (1988) suggest that their response to the rejection of their version of the Briggs recommendations was to employ those institutions which they did control to impose a professional ideal on new entrants or those undertaking advanced training. As we have seen a major vehicle for this was the nursing process.

Current policy developments within nursing in the form of the Project 2000 reforms and the introduction of a career structure for clinical nurses might be read as evidence that it is professionalist versions of nursing that are now in the ascendant. The removal of students from service provision, the creation of a core generic training foundation for all specialisms and the entry of nurse education into higher education are a realisation of many of the aims of Mrs Bedford Fenwick's professionalisers. But caution must be exercised before proclaiming the future of nursing as one that will be dominated by a professional vision.

PROFESSIONALISM AND MANAGERIALISM IN THE 1990S - TENSION OR CONVERGENCE?

Given that a central aim of the New Nursing reforms is the establishment of an autonomous clinical base then the question has to be posed as to why Project 2000 was accepted when it was? In the past elitist programmes of nursing reform have always been constrained by economic realities, why should Project 2000 be any different? There is a clue in the observation made by Rafferty (1992) that historically the success of nurse-driven policy changes can normally be traced to a synchronisation with wider organisational and policy concerns.

One important reason for the Government's attraction to the creation of a nursing elite relates to the much discussed 'demographic time bomb'. During

the late 1980s policy-making was dominated by the unenviable prospect of having to recruit up to half of all the suitably qualified women school leavers in order to maintain current NHS staffing and wastage levels. In this context the creation of a small, highly skilled nursing core, supported by a pool of cheaper workers makes for a more flexible workforce which could be deployed to meet changing demographic and social trends. (Carpenter, 1993; Naish, 1993).

There were also considerations of cost. A restructuring of nursing practice afforded the opportunity to make efficiency savings. Nursing salaries are one of the largest single items of public expenditure in the UK, consuming almost 3 per cent of the total. Even a small proportional saving could have an absolute impact (Dingwall *et al,* 1988). The Secretary of State for Health announced acceptance of the key recommendations of Project 2000, with the important proviso that nurses agree to a new training for health support workers which be determined by the National Council for Vocational Qualifications (Beardshaw and Robinson, 1990). As Dingwall *et al* (1988) suggest, one important objective of the Project 2000 reforms reflects a deep-rooted desire by nurse leaders to draw a sharper line between qualified and unqualified staff. However, the introduction of National Vocational Qualifications is likely to lead to a blurring rather than a sharpening of grade boundaries (Hughes, 1993; Dingwall *et al,* 1988). Within the NVQ framework alternative qualifications will be available at the level of, and in competition with professional qualifications (Shaw, 1993) and at a time when

tacit Government encouragement of professional associations like the Royal College of Nursing may have weakened the trade union movement (Carpenter, 1993; Salvage, 1985).

There is a clear strain between the belief of professionalisers that all aspects of nursing should be carried out by qualified staff and that of management which argues that this has to be set against the need to provide a cost-effective service:

> 'Project 2000 will bring out highly-trained professionals who we will have to use properly [...] Nurses are locking themselves in too tight a definition. What's a doctor and what's a nurse? There's work to be done, you get the work done by the people who are best qualified to do it [...] Hands-on care is below nurses' level of competence. The nurse will become the overall assessor of the care that the individual needs to have [...] A higher quality, cheaper service, with a competitive edge will be achieved by those who make the most improvement in their labour costs. It's just common sense' (Naish, 1990, quoting Eric Caines[2]).

There is already evidence of dilution. Between September 1990 and 1991 the

[2] At this time Eric Caines was the Personnel Director of the NHS.

NHS lost 15,400 qualified nurses - a drop of 5.2 per cent - but the number of unqualified staff rose by 137,400, a rise of 17 per cent. This changed the ratio of qualified to unqualified staff from 61:23 to 58:28 (Ranade, 1994: 32). Robinson *et al* (1989) point out that:

> 'the ratio of helpers to nurses does not merely affect what the helper can and cannot do, but also what the nurse can and cannot do.' (Robinson *et al,* 1989 quoting Dickson and Cole, 1987)

However, as Davies (1995) has shown, there was no overt bargain struck at a national level that nursing had to accept a restructuring in order to achieve educational change and the question as to who should do what within the nursing division of labour was left unarticulated. Rather the onus was shifted to the Regions to produce individual plans for replacement staff and for numbers for admissions to the new Project 2000 programmes. Davies cites the work of Elkan *et al* (1993), who paint a picture of *ad hoc* decisions, of choices sometimes being put in the ward sister's court as to whether she wanted more qualified staff, but too few of them, or more unqualified staff and a reversion to task allocation for the qualified that remain.

The aims of Project 2000 also supported other policy objectives. For example, primary nursing fits with a decentralised approach to management in which ward sisters become budget holders and primary nurses are held

responsible for the care they give (Bowers, 1989, cited by Savage, 1995). The creation of a more educated nursing workforce also meant nurses would be better placed to take over doctor-devolved activities. Nurses have been identified as having the potential to make a contribution to the initiative to reduce junior doctors' hours (NHSME, 1991; Greenhalgh and Co Ltd, 1994). But although management and professional versions of nursing support the expansion of nurses' scope of practice, the use of nurses by managers to reduce the hours worked by junior doctors hours is not without its difficulties.

Part of the problem is reflected in the distinction drawn by MacGuire (1980) between 'extended' and 'expanded' nursing roles. At the simplest level both refer to nurses undertaking tasks that are not covered by basic training. MacGuire suggests however, that 'expanded' be reserved to refer to roles in which nursing skills are drawn upon and 'extended' be used to refer to those roles where nursing is not a prerequisite and where the tasks are essentially medical. This is more than a quibble over terminology. The distinction between expanded and extended nursing roles underlines the different perspectives from which professionalisers and managers approach the role of nurses in the division of labour. Professionalisers support role development driven by patient need. The UKCC document: *'The Scope of Professional Practice'* (1992) brings to an end the requirement that nurses needed extended role certificates to undertake tasks not covered in basic training; instead the onus for defining the boundaries of nursing work is shifted to individual practitioners themselves. For example, a great number of nurses have

integrated complementary therapies into their practice (Wright, 1995). Much of the recent impetus behind nursing role developments however has been driven by cost considerations and the desire to improve the hours and working conditions of the medical profession.

A further way in which the Project 2000 reforms resonate with broader policy objectives is in its underlying philosophy of care. Both ideologies emphasise individual responsibility and individual solutions. New Nursing is a curious mixture of left wing egalitarianism and right wing individualism and its emphasis on holism and patient participation should not be allowed to obscure its strongly individualist elements. Furthermore, as a number of authors have pointed out, the nursing process may be seen as a pervasive form of social control (Webb, 1981; May, 1992; Dingwall *et al*, 1988; Armstrong, 1983a; Armstrong, 1983b). In advocating an holistic approach to care, areas which did not formerly enter into treatment of the body now become available for treatment of the person; health care penetrates the personality of the patient. As Dingwall *et al* (1988) point out, such an approach provides a defensible strategy for service providers trying to cope with a chronic shortage of resources. If the roots of disease can be seen as lying in inappropriate life-choices then the nursing process could be used to deny resources to all but those who comply with a given moral order, exonerating care providers from the burden of making rationing choices.

As I have already hinted, a further attraction of the nursing process from a

managerial perspective is the amount of paperwork it generates. The nursing process has become an important tool for quality assurance programmes:

> 'There is a general consensus in the professions that providing patient care on an individualised basis, and developing and establishing monitoring and audit systems in each provider unit and in primary health care are the foundation stones of a high quality service, and that these elements should be included in the service contracts and will serve as bench marks in collaboration between purchasers and providers in their standards setting programme.' (NHSME, 1993: 10)

The individualisation of care, coupled with its detailed documentation can actually increase the scope for external control over nursing, not by direct intervention but by standard setting (Dingwall *et al*, 1988; Salvage, 1995). Furthermore, the elaborate planning of care increases the personal accountability of the nurse for delivering that care (de la Cuesta, 1983; Salvage, 1995).

New Nursing ideology brings nurse-patient relationships centre-stage. Yet ironically caring work is invisible to the language of business and is written out of the charts (Samarel, 1991; Diamond, 1988). Davies (1995) interprets these problems as a reflection of the masculine vision embedded in the new managerialism. Davies questions what she perceives to be a widespread

uncritical acceptance of the rationality and neutrality of new management techniques. The language of managerialism, with its targets and indicators, its performance culture, its apparently calm scientific approach turns out to be blind to the business of caring she argues. There is a real danger that in the new managerialist culture in health care, nurses' emotional labour will remain unacknowledged and nurses will fail to be rewarded for it.

The links between New Nursing and Government ideologies find their most explicit expression in the notion of the named nurse. Standard eight of *'The Patient's Charter'* states that every patient has the right to receive the care of a named nurse, midwife or health visitor. In its implementation however, the links with primary nursing have been down-played - presumably because of the cost implications. In the absence of resources which would facilitate the development of primary nursing, the named nurse concept can hardly be taken to represent Government recognition of the value of nursing. Rather as Salvage (1995) has pointed out, it might be more accurately read as an attempt to appease a disillusioned electorate, a means of auditing service provision and a strategy for placing responsibility for quality care on individual nurses rather than on trusts and Government.

It is clear that the linkage of Project 2000 with the major NHS reforms has the potential to undermine professionalisers' aspirations in fundamental ways. This point can be illustrated by the failure of Project 2000 to achieve its principal aim: a demarcation between education and practice. The uncoupling

of student service has been accompanied by the attempt to achieve a more closer coupling of supply and demand. As *'Working For Patients: Education and Training; Working Paper 10'* reveals, in the future education and service will still be tied together through the internal market. The extension of the purchaser/provider model from service delivery to educational delivery, are a long way from the ideas of the Project 2000 report of giving educational establishments greater freedoms and ensuring that programmes are education - not service-driven (Davies, 1995).

Muddying the Waters

The strain between professional and management versions of nursing does not reflect a straight-forward tension between nurses on the one hand and management on the other however. Nursing is an extremely heterogeneous occupation (Melia, 1987). Professional status is not supported by all groups within nursing (Salvage, 1985; Porter, 1992a) and a business culture may attenuate the clinical values of nurse managers (White, 1986).

A number of authors have attempted to delineate the principal divisions within British nursing. Writing in the mid 1970s Carpenter (1977) identified three main groups within nursing: 'new managers', 'new professionals', and the 'rank and file'. Emerging after the Salmon Report, new managers functioned according to an industrial model of professionalised management and were organised in the form of bureaucratic line management rather than a collegial model of professional behaviour. The 'new professionals' were clinical

specialists who creamed off the more complex parts of nursing. The 'rank and file' represented the mainstream of nursing: these are nurses who enjoy doctor-devolved work.

Drawing on Carpenter, Melia (1987) suggests the existence of a fourth group: the 'academic professionalisers'. This group are to be found, in the main, in academic circles and they tend to be removed from the patients. Melia argues that a major cleavage within nursing is this division between service and education sectors. Two versions of nursing exist and students find themselves caught between the two. The nursing school presents an idealised, 'professional' version of nursing whereas practitioners adopt a more pragmatic 'workload' orientation. The aims of these two groups are disparate. The education segment is concerned with the production of competent registered nurses, capable of independent practice and professional judgement. The concerns of the service segment are more immediate: the accomplishment of nursing work.

Similar observations are made by White (1986) who identifies three distinct cultural groups within nursing, melding Carpenter's 'new professionals' with Melia's 'academic professionalisers'.

More recent studies suggest that although useful heuristic devices such categorisations are far too simple. Salvage (1992) for example, has underlined the difficulties in identifying the leaders of the New Nursing. She

argues that '(t)oday's clinical leaders are neither ivory tower academics nor privileged specialists'. Furthermore, within the 'rank-and-file' it is possible to identify two differing views of the nursing role which have been stereotyped as the 'caring' and 'curing' approaches (McKee and Lessof, 1992). The 'curing' group are anxious to expand their role to include more technical tasks, whereas those advocating a caring role support the ideology of New Nursing with its emphasis on the development of skills within the context of nursing.

Professional and service versions of nursing can thus be found within nursing. Moreover, in their everyday talk professional and service versions of nursing are often intertwined (cf. Robinson *et al,* 1989). Arguably a more useful way of understanding these strands is to view them as competing discourses which can be differentially emphasised by nurses as 'vocabularies of motive' (Mills, 1940) when they are called upon to legitimate their actions. The different nursing segments function in different contexts where different versions of nursing have differential legitimacy.

Summary and Conclusions

The revival of professionalism in the 1990s, like the rise of managerialism in the 1960s, is the response of nursing to a crisis of legitimacy. The status anxieties of the occupation are the product of wider social, organisational and technical changes which have wrought a similar crisis of legitimacy in health care more generally. Recent health policy initiatives may be seen as an

attempt to develop a way forward following the break-down of the post-war consensus over the role of the state in health care. These separate policy initiatives in nursing and in health care create jurisdictional ambiguity for nursing for different reasons. Both however, are predicated on the assumption of the existence of a Platonic ideal nurse. This is an assumption that sociological analysis suggests is unfounded.

The classification of work into occupational categories is a way in which a key feature of the division of labour in society can be rendered more meaningful, but there is no necessary relationship between those occupational categories and the tasks that adhere to them (Dingwall, 1983b). From this perspective there is no such thing as an ideal nurse, rather a 'nurse' is what people called 'nurses' do in a particular historical context.

In the 1990s the work of nurses will be shaped by a complex configuration of social forces mediated at the level of service delivery by the interactive effects of professionalism and managerialism, which I have argued generate considerable jurisdictional ambiguity. At root however, these are only ideas (albeit influential ones) about the appropriate work for nurses. The actual work of hospital nurses is likely to be the product of nurses' practical management of this jurisdictional ambiguity in the course of their everyday activities. Thus while it is useful to use macro-sociological terms in order to conceptualise the research problem such an approach ultimately fails to capture the complexity of nursing work in the hospital division of labour.

This is where the sociology of work and occupations can augment understanding.

2. Sociology of Work and Occupations - a Selective Review of the Literature

Within the sociology of work and occupations there is a well-established body of literature on nursing. The principal focus of much of this work however, has been around the question of whether or not nursing can be considered a profession (see, for example, Porter, 1992a; Salvage, 1985; Storch, 1988; Dean, 1983; Antrobus, 1993; Kelly, 1991). The professions literature is vast and many of the ideas that it raises can be usefully employed in the analysis of nursing. However as Freidson (1970b, cited in Dingwall *et al,* 1988) reveals, its direct relevance is limited by nursing's position in a medically dominated division of labour (Dingwall *et al*, 1988). In view of this, Dingwall *et al* (1988) have suggested a more fruitful way forward would be to examine nursing within a general sociology of occupations. Rather than asking 'What is a profession?', such an approach entails turning attention to occupations and the ways in which the work that has to be done in a society is divided between them.

It was with these sorts of questions that Durkheim was concerned when he wrote *'The Division of Labour in Society'* which was first published in 1893.

Writing in this turbulent period, he sought to explain the functions and causes of the increased specialisation of activities he perceived industrialism or 'civilization' as he called it, to have occasioned. Durkheim's work has subsequently been the subject of much criticism but his sociology has remained of crucial significance. My purpose in beginning this literature review with this formative text is to highlight its contribution to two key themes which have been of enduring interest in the sociology of work and occupations: the increased complexity of the division of labour which accompanies social development and the normative dimension of work. These are topics which have been variously analysed from different sociological perspectives. In this chapter I will critically examine the work of those contributors whose work has been most influential in shaping the scope of this thesis: Hughes' writings on the world of work and occupations, Abbott's work on professional jurisdiction and Strauss and colleagues' negotiated order perspective. In reviewing this literature I will argue that whilst providing key concepts which can be usefully employed in the analysis of nursing work, these perspectives are seriously flawed by a lack of critical attention to issues of gender. The gendering of nursing is a complex and problematic phenomenon. I therefore conclude this chapter with an overview of feminist insights into the relationship of gender to work and explore their application to nursing.

DURKHEIM - THE DIVISION OF LABOUR

In the introduction to *'The Division of Labour in Society'* (1933) Durkheim begins with the observation that mechanisation and the concentration of capital and forces brought about by the developments of the nineteenth century had led to 'the extreme division of labour'. The economists have remarked on its importance Durkheim argues, but the division of labour has extended far beyond the economic and is increasingly becoming a feature of all social life. Durkheim adopts a broad definition of the division of labour, referring to the occupational specialisation of society as a whole and the separation of social life into different activities and institutions.

The significance of the division of labour for Durkheim lay in its moral, rather than its economic role. Durkheim believed that increased specialisation in society generated mutual interdependence and thereby contributed to the maintenance of social order. He criticises the assumptions of Spencer and utilitarian economists that the basis of social order resides in numerous incidents of calculative maximisation of self-interest.

> 'If interest relates men, it is never more than for a few moments [...] There is nothing less constant than interest. Today, it unites me to you; tomorrow, it will make me your enemy. Such a cause can only give rise to transient relations

and passing associations.' (Durkheim, 1933: 203)[3]

Durkheim proposes two sources of social integration: likenesses and complementary differences. He contrasts two types of society which are characterised by these different principles of social solidarity.

> 'Social life comes from a double source, the likeness of consciences and the division of social labour. The individual is socialized in the first case, because, not having any real individuality, he becomes, with those whom he resembles, part of the same collective type; in the second case, because, while having a physiognomy and a personal activity which distinguishes him from others, he depends upon them in the same measure that he is distinguished from them, and consequently upon the society which results from their union.' (Durkheim, 1933: 226)

Mechanical solidarity, which is characteristic of primitive and traditional types of society, is 'born of resemblances'. This type of society, according to Durkheim, is constituted by a 'repetition of similar, homogeneous segments' (Durkheim, 1933: 181). Social life is concentrated in a multitude of little centres, distinctive and alike. Likeness and similarity bind one group member

[3] It is a common but erroneous view, that there is a significant difference between the thought of Spencer and that of Durkheim. Turner (1984) has argued that in his efforts to distinguish his contribution to the field, Durkheim exaggerated the differences between his ideas and those of Spencer.

to another. Societal members are born into clearly defined social situations where their obligations and roles are precisely delineated and little room is left for individuality or uniqueness. Cohesion in this type of society derives from shared beliefs and ideas; there is little to mark off the thoughts and sentiments of one member from those of another and thus 'the whole psychic life of society [...] take on a religious character' (Durkheim, 1933: 179).

Mechanical solidarity is contrasted with organic solidarity, which Durkheim maintains characterises the modern social order and is constituted by a 'system of different organs each of which has a special role' (Durkheim, 1933: 181). Societies characterised by organic solidarity are organised on the basis of difference and social cohesion arises from an interdependence of parts. Herein lies the significance of the division of labour.

Durkheim outlines a number of examples of labour being divided on the basis of complementary differences. For example, he argues that 'the sexual division of labour is the source of conjugal solidarity' (Durkheim, 1933: 57). According to Durkheim, as humankind has evolved men and women have become increasingly different. Durkheim maintains that as society develops women withdraw from public life and devote themselves to family life; women take care of psychic functions and men the intellectual ones. Acknowledging the cultural specificity of women's role, Durkheim observes that '(t)he further we look into the past, the smaller becomes the difference between man and woman. The woman of past days was not at all the weak

creature that she has become with the progress of morality' (Durkheim, 1933: 57). Durkheim also recognises that within the public domain work was becoming differentiated along gender lines. More recently, feminist sociologists have underlined the implications of this separation of social life into 'public' and 'private' domains for women's lives and value of the work that they do. This is a theme to which I will return. Durkheim however, sees these gender differences in a positive light. For example, he argues that where the two sexes are poorly differentiated conjugal solidarity is weak.

For Durkheim then, the function of the advanced division of labour is moral rather than economic; in all cases it is not to increase the output of functions divided, rather 'it renders them solidary' (Durkheim, 1933: 60). In contrast to the widely held fear that the increasing internal differentiation of modern society would lead to its eventual disintegration, Durkheim maintained that it was the source of whatever social cohesion it possessed. The growing complexity of society created a new basis of reciprocity arising from socioeconomic specialisation rather than commonly held beliefs characteristic of simple societies.

Durkheim's ideas on organic solidarity are developed further in the Preface to the Second Edition of *'The Division of Labour in Society'* and in a posthumously published set of lectures *'Professional Ethics and Civic Morals'* (1957) in which he maps out the role he envisaged for occupational groups in industrial society. In the Second Edition Durkheim underlines his belief in the

normative dimensions of work. According to Durkheim, occupational groups spawn their own body of moral rules: 'it is impossible for men to live together, associating in industry, without attaching themselves to that whole, preoccupying themselves with its interests, and taking account of it in their conduct' (Durkheim, 1933: 14). Durkheim looked to the occupational structure of industrial society to take over from the moral functions performed by old social structures - such as religion and the family - and provide the basis for social cohesion as well as moralise economic life.

> 'What we especially see in the occupational group is a moral power capable of containing individual egos, of maintaining a spirited sentiment of common solidarity in the consciousness of workers..' (Durkheim, 1933: 10)

In these later writings however, Durkheim seems less optimistic that organic solidarity would spontaneously emerge from the division of labour. He argued that in order for occupational groups to spawn their own ethics then it was necessary to give the groups in the economic order greater stability. He points to the need for greater planning and conscious effort and emphasises the importance of ridding society of inequalities if the division of labour was to reflect natural differences. Observing the disorders of his time, Durkheim believed reform to be a matter of some urgency. The solution proposed by Durkheim is largely corporatist. If economic life was to be moralised then the occupational group had to be revived.

Tracing their historical development, Durkheim argues that the occupational group has become an increasingly necessary element in the political structure.

> '(T)he facts [...] show clearly that the professional group is by no means incapable of being in itself a moral sphere, since this was its character in the past. It is even obvious that this was its main role during the greater part of its history' (Durkheim, 1957: 23).

Durkheim argues that occupational groupings do not simply have a utilitarian function. They also have a moral role, safeguarding group welfare and enabling their members to fit into the wider society. He looks to the professional associations of the army, education, law and government as a model for all occupational groups under capitalism. There are professional ethics for the priest, the soldier the lawyer, why should there not be professional ethics for the industrialist Durkheim asks. For Durkheim, this plurality of professional norms would constitute a 'moral particularism', a 'decentralisation of moral life' in which 'professional ethics find their right place between the family morals [...] and civic morals'(Durkheim, 1957: 5).

Durkheim also suggests a political role for occupational groups which he envisaged would mediate between the individual and the State so as to maximise individuality - 'it is out of this conflict of social forces that individual liberties are born' (Durkheim, 1957: 63). The State protects the

individual from being monopolised by occupations, or secondary groups, as Durkheim calls them, and in turn these secondary groups are an important counter-balance to the State's intervention in collective life.

The finer details of the relations between the individual, occupational groups and State are far from clear in Durkheim's writings however. He talks about an occupationally controlled division of labour and yet seems to anticipate increasing State intervention into all spheres of social life. Moreover, Durkheim casts secondary groups in an important role protecting individual citizens from State tyranny, but there is little indication as to how this would work.

There are further difficulties in Durkheim's assertion that evidence for the existence of the two different types of solidarity may be found in the nature of the sanctions incurred by those who transgress 'the moral conscience'. Durkheim makes a distinction between repressive and restitutive laws and asserts that the former is characteristic of societies which cohere 'mechanically' and the latter of those who do so 'organically'. He endeavours to show that as the division of labour has developed, repressive laws have been replaced by restitutive laws. Unfortunately subsequent research has suggested that Durkheim was wrong in these assumptions. Indeed contemporary scholars have suggested that the reverse actually holds (Roberts, 1979; Cotterrell, 1992).

In Book Two of *'The Division of Labour'* Durkheim proposes to uncover the causes of the division of labour and account for the observation that 'if one takes away the various forms the division of labour assumes according to conditions of time and place, there remains the fact that it advances regularly in history' (Durkheim, 1933: 233)[4]. For Durkheim there is a continuing tendency for movement to take place from mechanical towards organic solidarity. Durkheim dismisses the argument that the division of labour has advanced in order to increase man's (sic) happiness. He points out that civilisation has imposed monotonous labour upon 'man', whereas the 'savage' has greater variety of work.

Durkheim locates the causes of the division of labour in the increase in 'moral' and 'material' density, that is, 'the progressive condensation of societies'. As societies develop Durkheim argues, their volume and population density increases. But this in itself is insufficient to accelerate the division of labour - moral density must increase also. The increased numbers of people must be in enough contact to act and react to one another.

Drawing on Darwinist theories, Durkheim underlines the role of competition in the acceleration of the division of labour. He argues that in a given society different occupations can coexist alongside each other in as much as they

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[4] Irrespective of where their theories start from or the motors of change they predict most sociologists have held to the basic assumption that as societies develop, work becomes more complex and the division of labour more specialized. Dingwall, (1983b) has suggested that these assumptions may be overly simplistic. On the basis of an analysis of the development of health visiting Dingwall suggests the addition of two further concepts: occupational fusion and occupational capture.

pursue different objectives but the more alike their functions and the more points of contact they have, then the greater is the risk of conflict.

> 'In reality, there is always a considerable number of enterprises which have not reached their limit and which have, consequently, power to go further. Since there is a free field for them, they necessarily seek to spread and fill it. If they meet similar enterprises which offer resistance, the second hold back the first; they are mutually limited, and, consequently, their mutual relationships are not changed. There are, to be sure, more competitors, but as they share a greater market, the part of each remains the same. But if some of them present some inferiority, they will necessarily have to yield ground hereto occupied by them, but in which they cannot be maintained under new conditions of conflict. They no longer have an alternative but to disappear and transform, and this transformation must necessarily end in a new specialisation. For if, instead of immediately creating another specialty, the feeblest preferred to adopt another occupation, already existent, they would have to compete with those in practice. The struggle would not then be over, but only placed somewhere else, and it would have consequences in another sector. Finally, somewhere there would have to be elimination or a new differentiation' (Durkheim, 1933: 268-9).

There are clear parallels in the above quotation with the theories of human ecology associated with the Chicago School (cf. Hughes, 1984; Dingwall *et al*, 1988), although as his critics (see, for example, Campbell, 1981) have pointed out, Durkheim's emphasis on social integration led him to down-play the role of conflict. Moreover, he is unclear as to the precise mechanism through which conflicts would be resolved and also as to why specialisation should be the outcome of the struggle for existence rather than the other possible alternatives he suggests such as emigration, colonisation or resignation to a more precarious existence of competition (Lukes, 1973). But Durkheim was an optimist. For him the division of labour was a progressive force. The conflicts of industrial society would be neutralised by the advance of a new social order based on organic solidarity arising out of differentiation and specialisation. With the benefits of hindsight it is clear that Durkheim's optimism was misplaced.

Durkheim's misplaced optimism in the integrative powers of the division of labour is revealed by the well-established observation that the so-called 'pathological' forms of the division of labour he outlines in Part 3 of *'The Division of Labour in Society'* have actually become the more typical ones. Durkheim argued that a healthy division of labour would see occupational divisions on the basis of natural differences. Normally the division of labour produces solidarity but occasionally it can produce contrary results. Such cases, he argues, are exceptional. 'The anomic division of labour' - as evidenced in recurrent industrial crises and the struggle between capital and

labour - is the result of the absence of regulatory rules so that parts of the social order are uncoordinated. Functions become separated from each other and contact is reduced and thus the rules which regulate contact cannot become established. The opposite conditions obtain in the second abnormal form Durkheim identifies - 'the forced division of labour'. Here there is an excess of rules which have arisen to enforce the division of labour coercively. Individual occupations are not freely chosen but forced upon each person by law, custom or chance. 'Another abnormal form' outlined by Durkheim describes the isolation of the worker whose task is so highly differentiated that its relationship to the division of labour as a whole is unclear.

Durkheim delineates the functions and gross structural properties of the increased internal differentiation of society, others have highlighted the dynamism of the division of labour by focusing on its more intricate workings. One such scholar is the Chicago sociologist E. C. Hughes.

E. C. HUGHES - THE WORLD OF WORK AND OCCUPATIONS

Hughes' (1984) contribution to the sociology of work and occupations is to be found scattered in a number of selected papers. Despite their initial disordered appearance there are several recurrent themes which run through them.

Hughes emphasises the commonalities of work. He asserts that the central

problems of 'men (sic) at work' are the same; any differences are a matter of degree.

> 'Until we can find a point of view and concepts which will enable us to make comparisons between the junk peddler and the professor without intent to debunk one or patronise the other, we cannot do our best work in this field' (Hughes, 1984: 342).

Whilst it may be true that men face comparable problems at work, it is a moot point as to whether these are the same as the problems faced by women. As we will see, feminist analyses have shown gender to be crucial in structuring the experience of work. Nonetheless, this criticism should not be allowed to detract from the legitimacy of Hughes' general concern to develop concepts which have a broad applicability to the world of work and occupations.

Two common elements of occupations identified by Hughes are those of 'license' and 'mandate'. These are important concepts in his thought. By license Hughes means the implicit or explicit claim of an occupation to carry out for money, goods or services, a set of activities which are different from those other people do. He suggests that if the members of an occupation have developed a sense of solidarity by virtue of their common work experience, they may also claim a mandate to define - for themselves and others - suitable conduct with regard to their occupational domain. Hughes wishes us to

conceive of license and mandate in the broadest terms. The scope of license and mandate is not fixed, it can expand and contract. Some occupations have greater power to broaden their license and mandate than others. Professions more than any other occupation claim a broad license and mandate.

> 'Not only do the practitioners, by virtue of gaining admission to the charmed circle of the profession, individually exercise a license to do things others do not do, but collectively they presume to tell society what is good and right for it in a broad and crucial aspect of life. Indeed they set the very terms of thinking about it'(Hughes, 1984: 288).

Hughes regards these features as differences in degree rather than kind. Any occupation may aspire to professional privileges by attempting to reconstruct its license and expand its mandate. According to Hughes, occupations may try to gain a more secure standing by claiming professional status. They do this by a series of 'symbolic steps': for example, insisting on increased educational qualifications of aspirants to the occupation, by going into research, by asserting that themselves and not some outside authority shall judge what is their proper work, by putting their more routine duties onto the shoulders of others, and by claiming a mandate to define the public interest in matters relating to their work. Hughes suggests that by examining the ways in which occupations try to change themselves or their image we can come to a greater understanding of what profession means in our society.

The concepts of license and mandate refer to a type of social exchange - that between an occupation and society. Hughes argues that the division of labour involves many types of exchange. For example, at the level of the person and the various others with whom interaction takes place within the occupation. Hughes' underlines the importance of work group cultures and their power to set the levels and direction of effort, define 'a fair days work' and 'mistakes and failures.' He argues that we can conceive of industry as a grid of these informal work groupings. According to Hughes, auxiliary characteristics can adhere to a particular occupational status. A failure to possess such attributes he argues, can result in dilemmas and contradictions of status and the creation of 'marginal men' (sic) and social segregation in order to accommodate them.

At the heart of Hughes' analysis of the division of labour is that of a social system. Throughout his work he stresses that the tendency to conceive of an occupation as a distinct entity is misplaced. For Hughes, no occupation can be fully understood without reference to the system of which it is a part. It is impossible, argues Hughes, to describe the work of one individual without reference to that of the others with whom they work. He emphasises the significance of the peripheries and boundaries of occupations. For Hughes, the concept of the division of labour is unsatisfactory because it stresses the divisions rather than connections and interactions between parts. These inter-relations are technical but most importantly they are also social.

For Hughes, an occupation is comprised of two intricately linked elements:

role and tasks. An occupational role refers to the 'who I am' rather than the 'what I do' in the work organisation. Hughes maintains that the study of work should focus on the parts people think they are expected to play or allowed to play in the work drama. It is erroneous to try and study tasks separate from people he argues. Sometimes a change in role may be justified by a change in technical tasks. Sometimes changes in technical tasks create a role problem. Some roles are more sensitive to technical changes than others.

For Hughes, an occupation is comprised of a 'bundle' of tasks and both technical and role factors can affect the tasks in the bundle. Not all of these tasks have the same value nor do they require the same types or degrees of skill. They are held together by the fact that they are performed by one person with a particular occupational title. Some tasks may be grouped together because they entail similar skills, others because they can be conveniently carried out together, and others because they seem natural parts of an occupational role. An activity within the bundle may be symbolically valued far beyond its importance, others may be considered 'dirty'.

The notion of 'dirty work' is a central one in Hughes' thought. He argues that there is ambiguity within all occupations as to what tasks are regarded as honourable and respectable. All occupations have their dirty work. Hughes argues that, in as much as all occupations have a notion of personal dignity, then it is likely that at some point it will have to do something that challenges

that dignity. Work can be 'dirty' in several ways; it may be literally physically dirty, or the 'dirtiness' may have a symbolic or moral character. Hughes' concept of dirty work is discussed further in chapter 3.

Hughes suggests that the history of an occupation can be described in terms of the changes in these bundles of activity, their value, and their function in the total system. For Hughes, the items of activity and social function which make up an occupation are historical products. The tasks in an occupational bundle are not fixed and their symbolic value may change as a result of other shifts in the system of work. Occupational mobility may involve the attempt to drop certain of these tasks and acquire tasks with higher symbolic value.

> 'The composition of an occupation can be understood only in the frame of the pertinent social and institutional complex (which in turn must be discovered and not merely assumed). The allocating and grouping of activities is itself a fundamental process' (Hughes, 1984: 294).

For Hughes, the system of work is dynamic; the world of work and occupations is analogous to the city of Chicago urban ecology (Dingwall, 1983a). 'Ecology' is a concept Hughes learned from Robert Park, a term used by human geographers and students of evolution to refer to the competition of a species for group survival in the absence of fixed boundaries. He paints a picture of new occupations being constantly created and the

boundaries of old ones continuously shifting. Social, economic technological and organisational changes all impinge on the system of work and have their effects on the division of labour. New tasks enter the system and older ones get passed on to other occupational groups, new workers come in at the bottom to take over those tasks cast off by occupations ascending the mobility ladder. The frontiers between different occupations expand, overlap and retreat in an ongoing evolutionary process. Hughes concludes that:

> 'the rhetoric of our time should emphasize study of whole settings in which particular occupations (professional and non-professional) occur, with attention to the shifting boundaries between them and the kind of cooperation required for any one of them to perform effectively; to the shifting boundaries between the professional systems and the clienteles they serve; and finally to the development of new definitions of wants growing out of constant social interaction and change. In the course of doing such study, we might learn more about the fate of professional mandates - and pride including our own' (Hughes, 1984: 426).

Although Hughes emphasises the dynamism of the system of work he does not explicitly consider the possibility that gender can be a crucial influence on the outcomes of these processes. Hughes' lack of specific attention to gender may in part be explained in terms of his concern to develop a study of

commonalities of work. Indeed he was clearly sensitive to the consequences of gender for women and work although he appears to have regarded the gender order as 'given' (Stacey, 1981). He taught his students how to understand the situation of women (Deegan, 1995) and he recognised the possibility of gender segregation and sex-typing (cf. Hughes, 1984: 141-150). He also argued that '(a) woman may have a career in holding together a family or raising it to a new position' (Hughes, 1984: 138). Although this sees women playing a limited role, it at least puts women's domestic work on a par with men's paid employment (Dex, 1985).

Hughes developed many of his ideas in relation to nursing (Hughes, 1984: 307-315 ; Hughes *et al*, 1958). A recurring theme in *'Twenty Thousand Nurses tell their Story'* (1958) for example, is of the tensions between nurses' paid careers and their domestic careers. A theme subsequently taken up by other prominent Chicago sociologists (Davis and Olesen, 1963; Davis and Olesen, 1965).

Nonetheless, whilst Hughes clearly recognises that gender matters he does not take this anywhere near far enough in his writings. For example, in keeping with his emphasis on the division of labour as interaction, he argues that any study of nurses' work will be meaningless unless developments on the boundaries of the occupation are taken into account. However in his discussions of nursing work he does not even acknowledge that the boundary between medicine and nursing work is inherently gendered. As we have seen,

since its rise as an organised occupation, medicine has been dominated by men whilst nursing has long been regarded as one of the archetypal female occupations (Porter, 1992b). Gamarnikow (1978) has argued that Victorian doctor-nurse-patient relationships could be equated with husband-wife-child relationships. Despite recent increases in the number of women entering medical schools, the profession remains firmly in male hands (Elston, 1977). In 1993, 11.1 per cent of nurses in England were men (DH, 1995).

Notwithstanding these criticisms however, Hughes' contribution to the study of work is undoubtedly a valuable one. Even though his ideas were developed in the 1950s in relation to American nursing he raises questions that have a striking relevance to the British health service in the 1990s. Hughes observed two contrary trends in American nursing. With developments in medical technology, tasks were downgraded and delegated from the physician to the nurse, who passed other tasks down to the support worker. At the same time 'within certain limits' occupations and people were being up-graded. According to Hughes, the nurse was moving up nearer the doctor in technique and devoted more time to the supervision of other workers. New workers were coming in at the bottom to take over tasks abandoned by occupations ascending the mobility ladder.

Hughes suggests that one of the aims of studying nurses' work should be to uncover the ways in which various tasks, old and new, have been regrouped and with what effect. Hughes believed that the dropping of low prestige tasks

was part of the process by which nursing was becoming a profession. Interestingly, nursing's current professionalising strategy attempts to reverse these trends, reunifying previously devolved tasks (Brannon, 1994), underlining the importance of placing professional projects in their social and historical context.

Although only loosely formulated, the ideas of Hughes have been extremely influential, stimulating a wealth of empirical studies of work and the development of sociological theory. Abbott's (1988) *'The System of Professions: An Essay on the Division of Expert Labour'* is a recent example of the ways in which Hughes' ideas have been developed.

ABBOTT - PROFESSIONAL JURISDICTION

Through a comparative historical study of the professions of nineteenth and twentieth century England, America and France, Abbott builds a detailed theory of professions. His chief concern is with the evolution and interrelations of professions, and the ways in which occupational groups control their skill and knowledge. According to Abbott, traditional theories of professionalisation have been more concerned with the forms rather than the content of professional work. Abbott proposes that the proper unit of analysis should be the professional task area which he calls jurisdiction. Case studies reveal that it is the content of the professions' work that is changing he argues. The focus on jurisdiction also enables Abbott to get at - what he

regards as a fundamental fact of professional life - interprofessional competition. For Abbott, jurisdictional boundaries are perpetually in dispute, both in local practice and in national claims. 'It is the history of jurisdictional disputes that is the real, the determining history of the professions' (Abbott, 1988: 2).

Jurisdiction is a key concept in Abbott's thought. According to Abbott, each profession is bound to a set of tasks by jurisdictional ties. Analysis of professional development is an analysis of how this link is created in work. For Abbott, jurisdiction has cultural and structural aspects. The cultural dimension of jurisdiction refers to the construction of tasks into professional problems. Professions are distinguished by the ways in which they control their knowledge and skill argues Abbott. Craft occupations emphasise control over technique *per se* but the distinguishing feature of professions is the centrality of abstract knowledge. Any occupation can obtain licensure or develop a code of ethics but 'only a knowledge system governed by abstractions can redefine its problems and tasks, defend them from interlopers, and seize new problems [...] Abstraction enables survival in the competitive system of professions' (Abbott, 1988: 9). Abbott identifies diagnosis, treatment, inference and academic work as the cultural machinery of jurisdiction. They construct tasks into known 'professional problems' that are potential objects of action and further research.

According to Abbott, the mechanisms of jurisdictional contest are mainly

cognitive. Abbott outlines the rhetoric employed to justify jurisdictional attack. One such mechanism is that of 'reduction'. According to Abbott, this is a device employed by an attacking, secure profession, which shows some task to be reducible to one of the attacker's pre-existing stable jurisdictions. Reduction replaces one profession's diagnosis of a problem with that of another. Abbott points out that rhetoric justifying jurisdictional attack may also be directed at the other modes of professional practice: inference and treatment. For example, an attacking profession may claim that its treatments apply to problems diagnosed by others. A further important impetus to jurisdictional change Abbott identifies is, what he calls, the 'gradient argument'. This refers to the claim that those who hold jurisdiction of the extreme versions of a problem should also hold jurisdiction of the milder ones.

No profession can stretch its jurisdiction indefinitely however. Abbott argues that the more diverse the set of tasks then the more abstract the cognitive structure which binds them together. And the more abstract the binding ideas he argues, the more vulnerable they are. According to Abbott, a number of mechanisms help professions to maintain an optimum level of abstraction. Sometimes professions may join to form into single units - Abbott refers to this as amalgamation. Alternatively, specialisation within professions can lead to official division.

Abbott argues that the construction of tasks into professional problems

provides the cultural machinery of jurisdiction but this does not in itself constitute jurisdiction. According to Abbott, jurisdiction also has a social structure. Abbott maintains that jurisdictional claims can be made in legal, public and workplace arenas.

Public opinion is the most familiar arena for professional claims. According to Abbott, a jurisdictional claim made before the public is generally a claim for legitimate control over a particular kind of work. This control normally entails the right to perform the task as the profession sees fit, the right to exclude others from performance of the task, the right to dominate public definitions of the tasks concerned and to impose professional definitions of tasks on competing professions. Discourse in the public arena, argues Abbott, is typically very constrained. In these claims it is assumed that there are clear boundaries between homogenous groups of professionals and that tasks can be objectively defined. Abbott argues that public images of jurisdiction typically last for decades.

The legal system confers formal control of work. According to Abbott, contests for legal jurisdiction occur in three places: in the legislature, in the courts and in the administrative or planning structure. Abbott maintains that legal jurisdictions for professions are more durable than public ones. In the legal arena the contents of the claim for jurisdiction are more explicit. Abbott points out that the rigidity of discourse noted in the public arena is further exaggerated in the legal system. All members of an occupational category are

identical in legal eyes. The absolute necessity to abolish all uncertainty leads to an almost arbitrary definition of the margins of professional jurisdiction he argues. The boundary areas which are precisely delineated have little resemblance to real life situations.

The third arena for jurisdictional claims Abbott identifies is the work setting. In the workplace, jurisdiction is a simple claim to control certain kinds of work. According to Abbott, in the work setting there is typically a well-understood flow of work. The fundamental question is who can control and supervise the work and who is qualified to do which parts of it he argues. In open markets of independent practitioners jurisdictional boundaries between competing professions are established by referral networks and similar structures. The situation is very different in an organisation though.

Abbott points out that the intra-organisational division of labour often locates professionals in settings where they must assume many extra-professional tasks and cede many professional ones. The organisational division of labour may be formalised in job descriptions but these are only loosely related to reality he argues. According to Abbott, in most organisational settings the actual division of labour is established through negotiation and custom. Abbott maintains that boundaries between professions in organisations can disappear, especially in overworked ones.

'There results a form of knowledge transfer that can be called

workplace assimilation. Subordinate professionals, nonprofessionals, and members of related, equal professions learn on the job a craft version of a given profession's knowledge systems. While they lack the theoretical training that justifies membership in that profession, they generally acquire much of the diagnostic, therapeutic and inferential systems.' (Abbott, 1988: 65)

Abbott argues that this assimilation is encouraged by the fact that in reality professionals are not a homogeneous group. In a work situation it is the output of an individual not their credentialed status that is important he argues. According to Abbott, the reality of jurisdictional relations in the work place is a very 'fuzzy' one; it is in the workplace that the complexity of professional life is thrown into relief.

Abbott underscores the profound contradiction between the formal arenas of jurisdictional claims - public and legal - and the informality of the workplace. According to Abbott, professionals must themselves reconcile this tension. They accomplish this by continually reemphasising their public image in the workplace.

According to Abbott, jurisdictional disputes may be settled in various ways. The ultimate goal of most professions, he argues, is for full jurisdiction. Full jurisdictional claims are made in both public and legal arenas. Within

organisations they are backed by organisational rules. But given that professions constitute a system argues Abbott, there is a limit to the number of full jurisdictions to go round. The claim for full and final jurisdiction is only one possible settlement he argues.

Occasionally, professions may share an area without an explicit division of labour. Abbott suggests that an example of a shared division of labour is riot control which has been claimed in the last fifty years by the military, by the police, by private police agencies and also social scientists. Another solution identified by Abbott is for one profession to assume an advisory control over certain aspects of work. Law enjoys many advisory jurisdictions and medicine has expanded its jurisdiction by advancing advisory claims. Professions may also divide their jurisdiction not according to the content of the work, but according to the nature of the client he argues. According to Abbott, examples of such settlements are legion. In American law today, two virtually separate legal professions handle on the one hand the problems of large corporations and a few wealthy individuals and on the other the problems of small corporations and the mass of individuals.

A further alternative settlement - one central to the focus of this thesis - entails the subordination of one profession under another. Abbott gives examples of subordinated divisions of labour under architects (Boyle, 1977, cited by Abbott, 1988: 339) and solicitors (Johnstone and Hopson, 1967, cited by Abbott, 1988: 339). Nursing is also identified as an example of this latter

form of jurisdictional settlement, the result of an unsuccessful attempt to subdivide a full jurisdiction. Unfortunately however, Abbott does not bring out the significance of gender in the subordination of nursing to medicine. To be fair Abbott's focus is on the system rather than the minutiae of individual professions. However, the use of a gender lens would arguably have led to the development of important analytic sub-types which would have enriched Abbott's model.

According to Abbott, there are great advantages of subordinate groups for professions with full jurisdiction. For example, it permits delegation of dangerously routine work. Most importantly it settles the complex legal and public relations between incumbent and subordinate from the start. This is essential given that subordination often involves extensive workplace assimilation and fuzzy workplace boundaries which would be a threat if public and legal boundaries were not already established.

In Part 3 of *'The System of Professions'* Abbott examines the wider system environment. Here the level of analysis moves below the system to examine the internal composition of individual professions and above it to consider the effects of wider social forces.

According to Abbott, professions are internally differentiated and these differences both generate and absorb system disturbances. For Abbott, one source of internal differentiation which may be a source of system disturbance

is what he calls 'professional regression'. This relates to the observation that professions tend to withdraw into themselves away from the tasks for which they claim public jurisdiction. This pattern is a result of internal professional status rankings in which the professionals who receive the highest status ranking from their peers are those who work in the most professionally pure environments. According to Abbott, although public admiration tends to be for practitioners, within the professions highest status is accorded to academics and consultants who work with knowledge alone. According to Abbott, the mechanism of professional regression is irreversible. Abbott maintains that even under a clear threat, professions do not try to eliminate the internal status distinctions which cause regression, rather they tend to try and control their heartland by other means. For example, a career in medicine has traditionally been structured so that it begins in the heartland and in the case of professional elites works its way out.

Abbott argues that the division of labour may reflect intraprofessional status forces; professionally impure work may be given to particular members of a profession for example. Abbott maintains that the most important division of labour is that which divides routine into non-routine elements, with the two falling to different segments of a profession or even to groups outside the profession. According to Abbott, this results in the degradation of what was previously professional work to nonprofessional status. This is sometimes accompanied by degradation of those who do that work. There is one exception to this rule Abbott argues and that is when the division of labour is

tied to a career - for example 'scut work' (Becker *et al,* 1961) in medicine. Recent developments in medical education in the UK suggest that in health care at least this could now be changing as routine medical work is delegated to nurses and support staff. It remains to be seen if this will be accompanied by degradation of the tasks concerned.

In the final level of his analysis Abbott outlines the wider social forces impinging upon the system of professions. According to Abbott, the technological and organisational changes of the nineteenth century created vast areas of new work for professions and destroyed relatively few others. They have also had subtle and far-reaching indirect effects. The 'commodification' of knowledge for example, has become increasingly important in the twentieth century. The computer means that esoteric expertise can be reduced to a key stroke. Furthermore, technological and organisational changes have uprooted the work and personal lives of individuals creating what Abbott calls 'the problem of adjustment'. This generated a need for professionals who could help individuals adjust to life within a changed society. Other social forces may impact upon the system of professions. For example, social movements may identify social problems which later become potential professional work. For Abbott however, it is changes in knowledge which have had the most profound effect on the system of professions. Abbott argues that developments in knowledge can add to existing knowledge and methods or replace old ones. One important change in the organisation of professional knowledge identified by Abbott is the emergence of the artificial intelligence

community where researchers have developed systems which mimic professional thinking. Abbott suggests that expert systems will compete with those professions whose work is to scan large, but reasonably well-known, bodies of knowledge under a set of specified rules. Those professions whose work is largely 'constructive' or an 'art' will be less susceptible because their jurisdictions tend to be more general and vague he argues. Although Abbott does not make this explicit this last point has clear links with the work of Jamous and Peloille (1970) who apply the principles of 'technicality' and 'indetermination' to the reproduction of medical knowledge. They employ the ratio of technicality to indetermination as a devise for the classification and understanding of occupations and their work.

One way in which professions establish cultural authority for their jurisdiction is to legitimate their work by reference to the central value system of a given society. But, as Abbott points out, central values can change giving rise to new forms of legitimacy which impact on the system of professions. Abbott argues that there has been a major shift in the legitimating values of professions from a reliance on social origins and character values to a reliance on science, rationality and efficiency of service. Abbott argues that these changes reflect value shifts in the wider social culture. Abbott points to the rising value of organisational efficiency. According to Abbott, the most striking effect of this value change has been the emphasis on measurability of outputs. Abbott argues that in America the public popularity of efficiency moved interprofessional competition away from conflict over general values

towards conflict over measurable results. In chapter 1 I highlighted the particular challenges that the recent emphasis on organisational efficiency in the NHS poses for nursing.

The final facet of the rise of modern rationality which Abbott examines in relation to the system of professions is the rise of the universities. Abbott argues that the rise of universities has tied the professions to a central cultural institution of their societies. According to Abbott, the universities play several roles in professional life. They train young professionals; they can function in a legitimating capacity providing authoritative grounds for the exclusive exercise of expertise. They may also be a centre for the advancement of knowledge allowing academic professionals to develop new techniques outside of practice. The simultaneous presence of many professions on campus make universities another potential area for interprofessional competition - for example, over matters of funding and also questions as to who would teach what to whom. This is an issue that has particular salience for British nursing as a result of the recent relocation of its educational base into institutes of higher education. Professionalisers attempts to develop a separate nursing knowledge base by borrowing eclectically from the behavioral and social sciences is likely to lead to precisely the sorts of inter-professional conflicts Abbott describes as nurse educators struggle to keep control over the nursing curriculum. It is somewhat ironic that nurses' attempts to secure functional autonomy from medicine may have led them into new jurisdictional disputes over the content of the nursing curriculum.

Abbott's thesis is detailed and wide-ranging, furnishing important conceptual tools which may be employed in the study of the world of work and occupations. The model he proposes is deficient on two counts however. First, I suggest that he gives insufficient weight to the importance of power in inter-professional competition. Abbott assumes that no profession delivering bad services can stand indefinitely against competitors however powerful. If professions fail to deliver service Abbott argues, then ultimately clients will go elsewhere. Even if this was empirically the case (which is debateable) it does not necessarily follow that power is therefore unimportant. For example, the power of dominant professions to control the ways of thinking about a problem and to define success and failure are given scant attention by Abbott. Furthermore, although Abbott acknowledges the importance of the central value system for professions' jurisdictional claims, he fails to acknowledge that the dominant societal ideas can systematically devalue the skills of certain groups within society - women, for example. Abbott maintains that he has chosen this model because he wishes to explain interprofessional conflict which others, using a power model have treated as incidental and largely ignored. Arguably however, acknowledgement of the importance of power within the theory would not necessarily close off the possibilities for explicating inter-professional conflicts. Indeed it might further our understanding of why they take the form that they do (cf. Witz, 1992).

Second, whilst Abbott's systems approach is laudable its restriction to professions is more problematic. Given that Abbott does not offer a definition

of the term 'profession', we are left with the question of identifying the boundaries of the system. For example, certain of the so called 'external' influences Abbott discusses - the state, the media and the universities - could arguably be considered as elements of the system of professions. Moreover, in excluding work that falls outside the system of professions Abbott excludes important areas from his analysis - for example the relationship between work areas shared between a profession and, what Freidson (1978) has called the 'informal economy'. That is, legitimate economic activities which exist adjacent to the official work force, performed for money, goods or services. Among the full-time informal occupations the most conspicuous is the housewife. Historically the relationship between formal and informal caring has been crucial for nursing's professional project both in terms of the value accorded to its work and also, the career paths of its members. There is then a sense in which Abbott's thesis is both too systematising and not systematising enough. If the focus of analysis is to be restricted to the system of professions then the limits of that system need to be more clearly defined. Given the problems in defining profession (Becker, 1970; Freidson, 1983; Roth, 1974) however, arguably a more fruitful approach would be to focus on the system of work as a whole, as Hughes and Durkheim do.

Although Abbott builds on and develops Hughes' thought, by his own admission he writes as a theorist rather than as a sociologist of professions. As a consequence there is a greater emphasis on the system than there is on the social in his thesis. The most explicit articulation and development of this

second thread in Hughes' thought may be found in the negotiated order perspective (Strauss, 1978; Strauss *et al*, 1963; Strauss *et al*, 1964; Strauss *et al*, 1985; Maines, 1977; Maines, 1978; Maines, 1982).

THE NEGOTIATED ORDER PERSPECTIVE

The term 'negotiated order' was introduced into the literature by Strauss *et al* (1963, 1964) as a way of conceptualising the ordered flux they found in their study of two North American psychiatric hospitals between 1958 and 1962 (Maines, 1982). In order to address the question of how social order was maintained in the face of change, negotiated order theorists attempted to transcend the micro-macro distinction and tried to show, on the one hand, how negotiation contributes to the constitution of social orders and, on the other, how social orders give form to interaction processes, including negotiations (Maines, 1982). Strauss *et al* (1963) argued that hitherto, students of formal organisations had tended to over-emphasise stable structures and rules at the expense of internal change. It was suggested that a more fruitful approach would be to conceptualise the social order as in process, reconstituted continually. From this perspective, concerted action had to be worked at.

The negotiated order approach to the study of organisations seems likely to be regarded as one of Anselm Strauss' most distinctive contributions to sociology (Dingwall and Strong, 1985). The model was an important shift from the then dominant paradigm which, based on a particular reading of Weber (1947,

cited by Dingwall and Strong, 1985), drew a clear line between formal and social organisation. This classic model of formal organisations stressed their supraindividual character as rational, rule-governed systems in pursuit of specified goals. Research involved the comparison of structures for their efficiency in achieving intended objectives, neglecting the problem of how such structures were constitued in the first place (Dingwall and Strong, 1985). According to Dingwall and Strong (1985), this neglect resulted in the rapid accumulation of anomalous findings within the paradigm. For example, observations of members' actual conduct proved difficult to reconcile with the tenets of the theory. As the Hawthorne studies had already shown, members simply did not act in a straightforward rule-governed manner. During the 1950s and 1960s various attempts were made to accommodate these findings by splitting organisational life into 'formal' and 'informal' aspects. The informal aspects of organisational life were still accorded a residual status however, and there was a growing disillusionment with the paradigm.

Dingwall and Strong (1985) argue that the negotiated order approach eliminated the problems caused by the split between social and formal organisation by abolishing the very distinction. No assumptions were made of a separate order of organisational reality, of uniform goals, of rational rules or of institutional hierarchy. Everything was negotiable. Dingwall and Strong support their assertion by quoting the following extract from *'Psychiatric Ideologies and Institutions'*, (1964).

'The realm of rules could then be usefully pictured as a tiny island of structured stability around which swirled and beat a vast ocean of negotiation. But we could push the metaphor further and assert what is already implicit in our discussion: that there is **only** vast ocean.' (Strauss *et al*, 1964: 313)

Closer inspection of the early texts however, suggest that Strauss *et al* did not discard the notion of formal organisation as unequivocally as Dingwall and Strong (1985) claim. For example, Strauss *et al* talk about the organisational hierarchy shaping patterns of negotiation:

'These negotiations do not merely happen by chance: They are patterned. They occur in discernible proportions among the occupants of the various hospital statuses.' (Strauss *et al*, 1964: 304)

and the constraining effects of formal organisational policies and rules:

'(P)olicies and rules serve to set limits and some directions of negotiation.' (Strauss *et al*, 1964: 313).

Strauss *et al* suggest:

'that future studies of complex relationships between the more

> stable elements of organisational order and the more fleeting working arrangements may profit from examination of the former as a background against which the latter evolve - and sometimes as the reverse.' (Strauss *et al,* 1964: 313)

Of course it is possible that Strauss and colleagues were themselves genuinely muddled and should therefore bear some responsibility for the confusions surrounding their perspective. Furthermore, I suggest that the preoccupation with the underdog characteristic of much interactionist work gives some substance to the criticism made by Dingwall and Strong (1985) that the negotiated order perspective may have inverted the error of the traditional model. Organisational studies undertaken within the perspective have tended to concentrate on the social worlds of lower level participants at the expense of those responsible for the formulation and implementation of organisational policies and procedures.. Moreover, few look to wider societal influences on the negotiated orders they study. As a consequence it is this radical reading of the negotiated order perspective that has dominated conventional sociological wisdom and has resulted in the assumption that within negotiated order theory the notion of formal organisational structure had been discarded. This in turn has led to criticism that the perspective assumes that everything is indefinitely negotiable and as a consequence the paradigm is unable to deal with limiting factors in negotiation settings (Benson, 1977a; Benson, 1977b; Benson, 1978; Day and Day, 1977; Day and Day, 1978).

> '(The negotiated order perspective is) a processual conception of organisational life and a tendency to undermine confidence in seemingly fixed features of the organisation [...] Thus, while the negotiated order analysts have effectively challenged the static view, they have fallen into the error of disregarding structural limits [...] While it may be true, as they contend, that negotiation is present in all social situations, the structural problem is to grasp the relations between situations - the ways in which some negotiations set limits upon others.' (Benson, 1977b: 12)

In later reworkings of the perspective Strauss clearly backtracks from the radical position implied in parts of the earlier writings. In *'Negotiations: Varieties, Contexts, Processes, and Social Order'* he categorically asserts:

> 'Of course not everything is either equally negotiable or - at any given time or period of time - negotiable at all. One of the researcher's main tasks, as it is that of the negotiating parties themselves, is to discover just what is negotiable at any given time.' (Strauss, 1978: 252)

Strauss (1978) is also far more explicit in acknowledging the importance of extra-situational constraints on the negotiation of social organisation. He introduces two new concepts: 'negotiation context' and 'structural context'.

The former refers to local properties of a situation that enter directly as conditions in the course of negotiation, the latter refers to the larger overarching context in which negotiations take place. Strauss (1978) suggests that the negotiation context may be shaped by the following types of conditions: the number of negotiators, their relative experience in negotiating, and whom they represent; whether the negotiations are one-shot, repeated, sequential, serial, multiple, or linked; the relative balance of power exhibited by the respective parties in the negotiation itself; the nature of their respective stakes in the negotiation; the visibility of the transactions to others; the number and complexity of the issues negotiated; the clarity of legitimacy boundaries of the issues negotiated and, the options to avoiding or discontinuing negotiation.

A number of studies have subsequently attempted to examine the dialectic between structural constraints and negotiation processes (cf. *Urban Life* Special Edition - October 1982). Busch's (1982) analysis shows the historical processes through which structural conditions are produced by negotiations and, once produced, shape subsequent negotiations. Sugrue (1982) described the effects of emotions, and Kleinman (1982) examines the import of actors' theories of negotiations, on negotiation processes. Hall and Spencer-Hall's (1982) comparison of two North American public school systems suggests ways in which varying organisational arrangements suppress or encourage negotiations. Levy (1982) employs a dramaturgical perspective and introduces the concept of 'staging' in order to describe the mechanisms through which

the various parties to negotiations attempt to alter the negotiation context to secure their desired outcomes, for example by attempting to gain control over organisational rules and ground rules. A valuable body of work examining the relationship between interaction processes and social structure has thus started to accumulate. However, a number of unresolved issues within the perspective remain.

Researchers have experienced difficulties in applying the concepts of 'negotiation context' and 'structural context' to real life situations (cf. Hall and Spencer-Hall, 1982: 346; O'Toole and O'Toole, 1981 cited by Dingwall and Strong, 1985: 227). Hall and Spencer-Hall (1982) argue that the concepts remain partial and unclear and suggest that work remains to be done. They suggest the addition of an intervening level - the 'organisation context'. Reviewing the literature there appear to be several dimensions as to what might be regarded as structural constraints: the immediate social setting, formal organisation (Dingwall and Strong, 1985; Hall and Spencer-Hall, 1982), practical constraints (James, 1992a), large scale national impingements (Benson and Day, 1976; cited in Strauss, 1978: 249), and macro-influences such as historical forces and the fundamental issue of power (Day and Day, 1977: 131). Many of the studies in *Urban Life* (Special Edition, 1982) for example, concentrate on a single element entering into the negotiation context and thus the analysis of structural limitations remains partial. Although of course this might reflect the availability of relevant data.

In later work Strauss (1982b) elaborates on the concept of structural context. Taking inter-organisational negotiation as an example, he points to various conditions - social worlds, intersections of subunits between organisations, and industries encompassing organisations - in order to suggest what researchers employing the perspective need to look at and analyse alongside examination of negotiations and their patterning. These ideas are further developed by Maines (1982) who points to the role played by social worlds in organising lines of communication between actors and defining the terms in which social structures are enacted. Of crucial importance here for current purposes is the ways in which social worlds may be gendered, although regrettably Maines does not make this explicit. I suggest the adoption of a broad conceptualisation of extra-situational constraint including actors' orientations to social structures, the immediate negotiation context, practical and material constraints, wider organisational factors, as well as historical and political considerations.

A further weakness of studies employing the negotiated order perspective is that they are typified by a looseness of fit between their analyses and empirical data. Not only does this makes it difficult for the reader to assess the validity of analyses, it also gives little sense of the actual **process** of negotiation - of the social order truly at work. To be fair this in part reflects real methodological difficulties in collecting data of this kind. Nevertheless, even when it comes to the detail of more easily available material - such as actors' perceptions of negotiation or theories of social structures - the raw data

is rarely available in the analyses and the reader has to be content with the authors' redescriptions of the field setting. As Dingwall and Strong point out 'the original formulation of negotiated order would in all likelihood have assumed a very different character had its methodology allowed recognition of the ways in which members themselves, on certain occasions, formalize organisations' (Dingwall and Strong, 1985: 212). Arguably the negotiated order perspective could be augmented by following the lead of ethnomethodology and paying closer attention to talk. As well as offering access to actors' theories of organisational structures, the ethnomethodological emphasis on talk offers clear methodological advantages in that one's empirical observations can be reproduced, others can do further analysis and potentially challenge the analysts' rendition of events, thereby avoiding the risk of bias from second order readings.

Although Durkheim, Hughes, Abbott and Strauss *et al* pursue their analyses in different ways, a number of commonalities emerge. First, the division of labour is conceptualised as a social system. External and internal forces may impact upon the system of work and may reshape occupational boundaries. New tasks may enter the system and others may leave or be passed on to other occupational groups. Second, emphasis is given to the connections and interrelations of the parts constituting the whole. Durkheim emphasised structure and function, whereas Hughes, Abbott and Strauss *et al* conceive of the division of labour in more dynamic terms. Strauss *et al* underline the role of negotiation in the accomplishment of occupational jurisdiction which,

as we have seen, has to be claimed and sustained in public, legal and workplace arenas (Abbott, 1988). In the combined insights of these authors we come close to a perspective which can be usefully employed in the analysis of nursing work. As I have indicated in my exposition however, a third commonality in the perspectives reviewed thus far is the absence of critical attention to gender issues.

Stacey (1981), in an inspirational paper *'The Division of Labour Revisited or Overcoming the Two Adams'* revealed the way in which British sociology has persisted in dividing its subject matter into the two worlds of Adam Smith and Adam and Eve. On the one hand was the public world of work, class and industry and on the other was the private world of domestic life. Not only has there been a dearth of empirical accounts of women's work experiences but many of the concepts employed in 'malestream' sociology have been based on inherently sexist assumptions (Dex, 1985). It is argued that the marginalisation of women in studies of work is paralleled by their marginalisation in academic institutions (cf. Deegan, 1995). Dex (1985) has bemoaned the failure of the Chicago tradition to build on Hughes' insights but as Deegan (1995) has pointed out, many women Chicago sociologists did indeed focus on gender issues but their work is rarely cited. There is now however a considerable body of feminist literature highlighting women's experiences and attempting to develop a satisfactory theoretical framework through which to understand women's place in the wider social structure. In the final section in this chapter I want to briefly review the critical insights

that have been brought to bear on the study of work and occupations by sociologists employing a gender perspective and to examine the ways in which they may facilitate an understanding of nursing work.

GENDER, WORK AND NURSING

A fundamental criticism made by feminists has been directed at the restrictive concept of work that sociologists have traditionally employed. 'Work' has been equated with 'paid work outside the home' and thus excludes women's work in the form of housework (Oakley, 1974a; Oakley, 1974b) and motherhood (Oakley, 1979). Some form of a sexual division of labour has been a feature of virtually all societies and periods in history, but the characterisation of women as 'non-productive' home-makers is relatively specific to the later stages of industrial capitalism (Oakley, 1974a; Mies, 1986). Parsons (1956, cited in Harris, 1983) for example, saw the sexual division of labour according to the public and private spheres as best suited to the needs of industrial society. He argued that there was a functional necessity for segregating the nuclear family from the economic system in order to avoid a conflict of the different values underpinning the family and economic life. Parsons assumed that the husband would participate in the public sphere - performing 'instrumental' family functions (eg. earning a wage), whereas the wife would be principally based in the domestic domain where she would perform 'expressive' family functions (eg. the socialisation of children). In fact women's confinement to the private sphere is empirically

moot as Parson recognised. Indeed part of the impetus for the study of women's work roles has come from the observation that women are an increasingly visible force in the public sphere of work. Nevertheless, as feminists have pointed out, the normative division of social life into 'private' and 'public' domains throws up irresolvable tensions with which women have to deal, and which shape their lives in critical ways as well as the value accorded to their work.

Feminists have pointed out that in the public sphere work is also divided by gender and is crucial in understanding the limitations of the equal pay act. The occupational structure is segregated by gender horizontally - with women and men working in different types of occupation - and vertically - with women concentrated in lower grade occupations (Hakim, 1979). Nursing provides a powerful illustration of this point. More than ninety per cent of British nurses are women and yet men occupy a disproportionate share of senior posts (Davies, 1995).

There is considerable debate as to the root causes of women's segregation in the occupational structure. Orthodox accounts related women's position in the public sphere to their role in the private, suggesting that women's patterns of work reflect the fact that their primary responsibilities are home-centred. But as Needleman (1988) has pointed out, women's working patterns often reflect the lack of opportunity rather than the exercise of choice. Studies reveal that the work world is structured in a way that makes it extremely difficult for

women to combine paid work and motherhood (Homans, 1987). Work is organised as if every worker had a full-time housewife at home (Apter, 1993). Moreover, studies show that irrespective of whether women work in the public sphere, responsibility for domestic work tends to rest squarely on their shoulders (Oakley, 1974a; Hochschild, 1990). The difficulties of combining paid work with domestic responsibilities and child-rearing means that women are particularly susceptible to exploitation by 'understanding' employers. Women tend to be concentrated in part-time poorly paid work, which lack employment protection, have no training or paid holidays.

Davies (1995) has highlighted the failure of health service managers to rise to the challenge of managing a predominantly female nursing workforce. Davies argues that any realistic model of planning for nursing needs to take into account an episodic pattern of participation, where losses due to a career break and gains due to those returning after a career break will be a substantial part of the equation. Instead however, the nursing workforce has been based on a high recruitment/high wastage model of womanpower, which contrasts with the low intake/low waste one of conventional manpower planning. Support for post-basic courses and continuing education is not treated in the same way as medicine because of the assumption that nurses would leave.

Davies argues that a more positively woman-friendly approach to the management of woman power would look at flexible hours not in the sense of

a few more part-time jobs but of reorganising work schedules and perhaps individualising hours; carry out the kinds of cost-benefit studies of different forms of childcare that took into the equation the real costs of turnover and failures to return; work with a notion of lifetime participation and the management of career breaks to enhance this, and be underpinned by a concept of the extended nursing labour force which would involve the production of data on not only those nurses in work but also those working elsewhere and those not working at all.

Others have highlighted the importance of labour market structures in confining women to their subordinate position in the household (Walby, 1989) and the role of gender as a key variable in labour market processes (Witz, 1986; Witz, 1988; Witz, 1992; Walby, 1989; Crompton and Sanderson, 1990; Gamarnikow, 1991). Witz (1992) for example, employs a neo-Weberian perspective to develop an historical analysis of the relationship between gender and professionalisation in medicine, midwifery, nursing and radiography. Witz argues that gender makes a difference to both the form and the outcome of professional projects.

Witz points out that the patriarchal nature of the nineteenth century institutions which provided the background for professional projects placed severe constraints on women's ability to engage in such projects. According to Witz, civil society was the sovereign sphere of bourgeois male actors and it was very difficult for women to act collectively in that sphere. Thus if women did

form occupational associations and seek state-sponsored registration they had to mobilise male proxy power in order to represent their collective interest at the institutional level of the state. Moreover, if women wanted to pursue credentialist tactics in order to forge a link between education and occupation their exclusion from the modern university system meant they had to utilise other institutional locations for education and training. According to Witz, the disparate work and market situations of health care professionals today, must be recognised as the product of past struggles by occupational groups whose access to the resources of occupational professionalism were facilitated or constrained by gender.

Feminists working within a psychoanalytic perspective (Chodorow 1978, cited by Edwards, 1993; Gilligan, 1982) have argued that women's primary existence within the private sphere of nurturance and self-sacrifice, results in the development of a distinctive psyche which is inherently relational. It is argued that for men, separation and individuation are linked to gender identity, as separation from their mothers is essential for the development of masculinity. Feminine identity, it is claimed, does not depend on the achievement of separation from the mother or on the process of individuation. Gilligan (1982) has developed these themes arguing that women have a orientation to compassionate relationships and connectedness, whereas males have an orientation to separation, autonomy and individuation. Gilligan (1982) argues that women judge themselves in terms of their ability to care for others and to maintain social ties. The history of nursing and of women's

entry into the medical profession for example, shows that women have referred to their gender-specific competence for 'emotion work' in making claims to the work related to the caring aspects of health care (Carpenter, 1993; Gamarnikow, 1991).

Critics have pointed to the dangers in the notion of a separate feminine psyche which reifies gender and reinforces gender stereotypes (Gould, 1988). Others have argued that we must 'risk difference' if we are to develop understanding (Davies, 1995). Whilst such an approach enhances our comprehension of why certain occupations may be more or less appealing according to one's gender it may be criticised for failing to attend to fundamental issues of power.

Gender affects not only the kinds of jobs that people do but also the kinds of rewards accruing to the occupation in question. The status of an occupation may have been decisively influenced by gender (Crompton and Saunderson, 1990; Gamarnikow, 1978; Gamarnikow, 1991; Davies, 1986; Davies, 1995; Rothman, 1988). The concept of skill is far from unequivocal; it is a socially constructed concept which is intricately bound up with the sexual division of labour (Phillips and Taylor, 1980). In its everyday usage it excludes much of the work done by women. Because many of the tasks in traditional female occupations are considered 'natural' for women - an extension of the feminine role - they are not classified as skilled work, they are often not classified as work at all (Needleman, 1988). An important obstacle to nursing's claims to professional status derives from the fact that most caring work is carried out

by women unpaid in the private sphere. This is a major barrier to nurses arguing that they have specialised knowledge and expertise necessitating a long theoretical as well as practical training.

> 'Skill definitions are saturated with sexual bias. The work of women is often deemed inferior because it is women who do it. Women workers carry into the workplace their status as subordinate individuals, and this status comes to define the value of the work that they do. Far from being an objective economic fact, skill is often an ideological category imposed on certain types of work by nature of the sex and the power of the workers who perform it.' (Phillips and Taylor, 1980: 79)

Reflecting on the position of nursing, Abbott and Wallace (1990) remark:

> 'The possibilities of nurses achieving professional status are limited as a consequence of its association in popular ideology with mundane bedside drudgery that is seen as 'women's work' (Gamarnikow, 1978). The characteristic features of nursing are low pay, low prestige, unsocial hours, high turnover, and lack of job autonomy.' (Abbott and Wallace, 1990: 5)

Examined from this perspective, the concentration of women in lower level 'professions' defined as 'semi-professions' by some theorists (Etzioni, 1969) -

reflects their social status as women. As feminists have pointed out the professional model is inherently gendered (Witz, 1992; Davies, 1995). According to Witz (1992), this is because sociological analysis has taken what are in fact successful professional projects of class-privileged male actors at a particular point in history and in particular societies and treats them as the paradigmatic case of profession.

The explicit gendering of nursing as 'women's work' has made its analysis inherently problematic for feminists. On the one hand it is possible to develop a powerful argument that women, as a result of their sex-roles have a body of knowledge which, although largely unrecognised, is unique to their gender (Ungerson, 1983). Indeed it has been suggested that the most appropriate occupational strategy for nursing is for it to be unashamedly feminine - emphasising the unique caring and nurturing skills of women (Oakley, 1984). Others have cautioned against this, arguing that it traps women and men into gender stereotyped occupations (Savage, 1987), excludes the possibility of men's involvement in caring (Ungerson, 1983) and does nothing to address the devaluation of female skills (MacPherson, 1991).

Historically gender has been both a liability and a resource for nurses. On the one hand it has been utilised by nurses as a justification for jurisdictional claims. However because historically the division of labour between nursing and medicine was based on a sexual division of labour, gender has over-determined inter-occupational inequalities (Gamarnikow, 1978). These

tensions have been captured by Gamarnikow (1991).

According to Gamarnikow (1991), nursing reform was based on an ideological equation between nursing, femininity and women's work to which both doctors and nurses subscribed. The politics of occupational reform suggest however, that this equation was also a political strategy employed by nursing reformers and doctors to mean different things and to achieve diametrically opposed ends.

Nursing reformers employed ideologies of femininity in an enabling manner, femininity was not seen as a form of restriction. The objectives of nineteenth century nursing reformers was to carve out an occupational space in the public sphere for unmarried or widowed middle-class women and to impose moral discipline over patients and working class nurses. To this ends they deployed explicit ideologies of feminity to legitimate nursing reform; women ought to do nursing work it was claimed because the tasks involved were identical to those women performed in the home, and because the caring qualities of the nurse were uniquely feminine. Gamarnikow (1991) argues that by contrast medical men defined femininity in terms of patriarchal female subordination. As the division of labour between doctors and nurses became difficult to sustain in practice, doctors used the ideologies of femininity to distinguish between dominant and subordinate forms of health care to safeguard their own position. Gamarnikow argues that although both doctors and nurses accepted a subordinate position for nurses within the health division of labour, doctors'

dominance was justified on the grounds of female obedience, whereas nurses went out of their way to argue that their subordination was purely professional. Gamarnikow points out that somewhat paradoxically, the advice given to nurses for handling this unequal relationship recognised the patriarchal dimensions of the relationship. Gamarnikow (1991) quotes from a writer in the *Nursing Mirror* (1909) who reminds her colleagues that doctors 'like most men generally, they can be led where they will not be driven' (Gamarnikow, 1991: 126). As the sociological literature reveals this is a tactic that has continued to be significant in shaping patterns of nurse-doctor interaction (Rushing, 1965; Stein, 1967) although there is evidence to suggest that increasingly it is being utilised by nurses in conjunction with more egalitarian interactional strategies (Hughes, 1988; Porter, 1991; Svensson, 1996; Stein, *et al*, 1990).

A central problem in feminist theorising has been the question of the part played by capitalism and patriarchy in sexual inequality. Bradley (1989) and Walby (1986) provide useful overviews. Bradley (1989) discusses this literature in terms of a continuum. At one extreme traditional Marxists have argued that gender divisions could be explained within a general theory of class; women's position was analysed using existing Marxist concepts. Key themes in this context are the 'domestic-labour debate' and the 'reserve army of labour thesis'. These approaches have tended to see the position of women purely in terms of the needs of capital, they have little to say about gender relations *per se* (Walby, 1986) and fail to see that men as a social group might

benefit from the position of women (Walby, 1986; Bradley, 1989).

At the other end of the spectrum radical feminists have concentrated on the analysis of patriarchy. From this perspective, gender is seen as the primary form of inequality from which all others derive. Within feminist thought the concept of patriarchy is 'essehtially contested' however. It has proven to be quite hard to define and has tended to be used in a vague way to refer to male dominance in every form. Moreover, although the relationship between men and women may show many clear instances of oppression, efforts to establish the existence of a system of patriarchy have not been particularly successful, despite the existence of empirical regularities (Crompton and Sanderson, 1990). As Bradley (1989) has pointed out, not being rooted in a general theory of change the concept of patriarchy also lays itself open to the charge of being ahistorical.

Most feminists agree that neither capital nor patriarchy alone adequately account for gender inequalities and more recently debates have centred on the nature of the relations between the two. Some have argued that capitalism and patriarchal relations are so entwined that they form a mutually interdependent system (Eisenstein, 1979, cited by Walby, 1986). Critics have countered however, that the very interdependence of the two systems proves the case for the need to distinguish between the two systems analytically and this is contrary to the claim that capitalism and patriarchy are fused into a single system (Walby, 1986).

Others have argued for the development of a dual systems approach - in which capitalism and patriarchy are separate but interacting systems. Advocates of the dual systems approach argue that class cannot be reduced to gender or gender to class and that the two should be theorised separately but at any historical moment they are found interacting. Dual systems approaches are of two types. In one type of dual systems theory class relations and gender relations are conceived of as founded in different spheres of the social structure (Kuhn, 1978; Mitchell, 1975; Hartmann, 1979; Hartmann, 1981; all cited by Walby, 1986). In another version gender and class relations articulate at all levels and spheres of society (Walby, 1986). A further thread in dualist feminist thought is the precise character of the articulation between the two systems. Some have assumed relatively harmonious relations between capital and patriarchy (Hartmann, 1979; Hartmann, 1981, cited by Walby, 1986) whereas others have highlighted the ways in which the two systems can be in tension and conflict (Walby, 1986).

Witz (1992) has employed a dual systems approach in her analysis of female professional projects within the health division of labour. She criticises the inattention of mainstream sociology to the relationship between gender and professionalisation. According to Witz, although it has been recognised that there was an important relationship between gender and professionalisation this has been taken little further than a simple equation between gender and status, rewards and degree of autonomy enjoyed by practitioners. Witz

maintains that the origins and persistence of job segregation by sex in the labour market are best explained within a dual systems framework which explores the intersection between two structuring principles - those of patriarchy and those of capital. I have already delineated Witz's observations on the significance of gender in shaping the process and the outcome of women's professional projects within the division of labour in health care. She also underlines the importance of powerful economic interests in resisting nursing reform and moulding the structure it was to eventually assume. As I argued in chapter 1 the historical tension within nursing between professionalism and managerialism is underpinned by a complex mixture of economic and gender interests.

Structuralist feminism has been criticised for its tendency towards universals (Komter, 1991; Bradley, 1989). It fails to account for the ways in which women are differentiated by political, cultural and sexual loyalties and by racial, class and ethnic identities (Bradley, 1989). Moreover, in certain of these analyses there is often a purposiveness to men's actions which is not always there. As McAuley (1987) has argued, the dynamics of women's exclusion are often much more 'shadowy'.

Feminists working within a micro-sociological framework have underlined the variability and complexity of women's experiences and this has provided an important counterbalance to the over-simplistic generalisations of structural theories. Micro-sociological studies of women in the work place have

revealed the ways in which the operation of social processes shape women's work experiences in systematic ways. Studies of women working in male dominated professions, reveal how the structure of work constitutes 'a discriminatory environment' (Spencer and Podmore, 1987) resulting in women's careers being shaped in detrimental ways as a result of gender (Epstein, 1970; Elston, 1977; Elston, 1993; Leeson and Gray, 1978; McAuley, 1987; Homans, 1987; Ashburner, 1994; Greed, 1994). Others have directed attention to the importance of social processes which operate in the workplace in constituting 'a gendered work environment' or 'gendered work culture' (Westwood, 1984; Gottfried, 1993; Cockburn, 1985; Davies, 1995) which may play a crucial role in preserving conventional views of proper masculine and feminine behaviour both inside and outside of work (Bradley, 1989). Gender ideologies are clearly an important factor in the continued occupational segregation and sex-typing.

Davies (1995) has recently brought both structural and micro-sociological insights to bear on the analysis of nursing. Davies develops a gender analysis of policy development in order to understand why nurses have been so marginal to the debates that have shaped health policy since 1948 despite the fact that they constitute over half the NHS workforce and their services consume about a quarter of total NHS expenditure. According to Davies, the discontents of nurses have to be seen in terms of a broader societal devaluation of women and the work that they do.

Davies' analysis puts gender at the heart of understanding how organisations function. For Davies, the world of health policy is not simply a gendered world in terms of the predominance of men in positions of power, but also in the ways in which metaphors of masculinity have come to shape the visions of what is achieved. According to Davies, gender is embedded in the design and functioning of organisations. She argues that an organisation cannot be seen as a configuration of pre-given gender-neutral spaces, which are subsequently occupied by people with gendered identities - rather they must be seen as a social construction that arise from a masculine vision of the world.

Davies points out that bureaucracy and profession are of particular importance for nurses. It is normal for them to decry the former and celebrate the latter. According to Davies however, both derive from an essentially masculinist vision, which raises the question as to whether nurses' professional project might need to be seriously rethought. Davies points out that the ideal decision-making types of detached bureaucratic rationality and autonomous professional practice are in fact both myths which cannot be accomplished without a great deal of support work which is typically performed by women. In this respect there are clear parallels with the work of nurses, secretaries (Pringle, 1989) and the 'shadow-work' of women in sociology (Deegan, 1995). Drawing on Pringle's (1989) work on secretaries, Davies argues:

> 'It is because secretaries do attend to needs that are personal,

sexual and emotional, and because they carry out work that is under conceptualized, devalued and ignored, that their bosses can continue to act in a disembodied way and can continue to present their decision processes in terms of the abstract ideal that has been described.' (Davies, 1995: 55)

Davies maintains that the ideal-typical fleeting encounter of the consultant on the ward round is sustained in an analogous way through much preparatory and often considerable follow-up work with patients by others - performed mainly by women.

Davies concludes that there is a sense in which nursing is not a profession but an 'adjunct' to a gendered concept of profession. Nursing is the activity that enables medicine to present itself as masculine/rational and to gain the power and the privilege of so doing. Davies suggests that the problems of nursing need to be considered as deriving from the efforts of the leaders of the occupation to put a conceptual frame around those aspects of the work of health and healing that are 'left over' after medicine has imposed an essential masculinist vision.

At times Davies is clearly guilty of overstating her case. As I have argued in chapter 1 and as dual systems theorists point out, economic interests have also been a significant force in fashioning the shape of nursing work. Nevertheless, Davies' work is immensely stimulating and demonstrates the

insights to be gleaned by the application of a gender perspective. A gender lens has also been applied to the analysis of the content of nursing work (James, 1992a; James, 1992b; Smith, 1992), nursing and the trade unions (Carpenter, 1988) and patterns of nurse-doctor interaction (Porter, 1991; Porter, 1992b; Campbell-Heider and Pollock, 1987). Davies (1995) provides a useful brief guide to the literature.

It is clear then, that 'gender matters' (Beechey, 1988) and feminist analyses have provided critical insights. What is less clear is how it matters. Moreover, in recognising the import of gender there is also a danger of exaggerating the differences between men and women's work experiences whilst ignoring the similarities. As Beechey (1988) has pointed out, there is a tendency to adopt a gender model to analyse women's work and to adopt a job model to analyse mens. There is also a risk that feminist sociology will become a marginalised sub-discipline within the field and the crucial insights it provides will remain isolated from those working within the mainstream. Indeed recently there have been some attempts to analyse gender within mainstream theoretical perspectives (Komter, 1991; Davies, 1991; Cooper, 1994).

Summary and Conclusion

In this chapter I have critically reviewed selected sociological theories of work and occupations. A number of key themes have emerged. First, a conceptualisation of the world of work and occupations as a social system in

dynamic interaction with internal and external factors. Second, an emphasis on the inter-relations and boundaries of the constituent parts of the system of work. Third, a stress on the division of labour as social interaction. Fourth, a recognition of the significance of gender as a integral component of all of the above. In the next chapter I want to more explicitly examine how taken together these four themes came to shape the scope and direction of this thesis.

PART 2

Method and Methodology

The aim of Part 2 is to delineate the research methods and methodology employed in this project. In chapter 3 I will describe the process of finding a focus and outline the study's underpinning philosophy before going on in chapter 4 to discuss the research process.

3. The Study's Focus and Research Philosophy

This chapter outlines the methodological choices I have made in planning this study. It traces the process of finding a focus, outlines the research philosophy, and maps out the study's guiding assumptions. In constructing this thesis I write with the explicit intention of laying the research process bare. In so doing I endeavour to faithfully capture the emergent and problematic character of the research process. Yet despite my best intentions, in the interests of clarity, it has been necessary in constructing this chapter to impose an order on the research that is still somewhat artificial.

BACKGROUND TO THE STUDY

My academic interest in the tensions between professionalism and managerialism in relation to nursing grew out of two research projects: a review of the ethnographic literature on the modern hospital exploring the background to recent concerns with organisational mission and related problems of governance (Hughes and Allen, 1993), and a questionnaire study investigating the potential for expanded nursing roles in relation to the junior doctors' hours initiative (Hughes and Allen, 1993; Allen and Hughes, 1993; Allen, *et al,* 1993).

The roots of this thesis are also personal. My own experience in nursing, both as a student and a staff nurse, was of an on-going strain between the professional ideals I had been taught in the classroom and the practical constraints of service reality.

FROM 'FORESHADOWED PROBLEMS' TO RESEARCHABLE QUESTION

In my application for a DoH studentship I proposed a project to examine the interactive effects of professionalism and managerialism on the division of labour in nursing and mapped out a variety of issues the study might address. These were: the effects of the new support workers on the nursing division of labour; the development of expanded nursing roles; nurses' management of professional ideals and service realities; the impact of changes in the division of labour on the quality of patient care; senior nurses' adjustment to general management roles; the nursing response to the junior doctors' hours initiative; and barriers to change. I proposed a multimethod (Brewer and Hunter, 1989) research strategy which combined interviews, with a questionnaire survey and focused observations. This initial proposal describes a rather different project from the one that I eventually carried out. In this section I want to describe the process of finding a focus.

It was a condition of my DoH studentship that I submit a formal research proposal (including a budget) by the end of the second term. Accordingly, my

efforts in the first six months of postgraduate study were directed towards this end. A review of the literature was undertaken on a number of fronts: policy background; sociological literature on work and occupations; ethnographic literature on the modern hospital; gender; and methodology. At first the prospect of drafting yet another proposal seemed an unnecessary distraction from the real job of the research but it proved to be an invaluable exercise as I began to recognise the difference between having a set of 'foreshadowed problems' (Malinowski, 1922, cited by Hammersley and Atkinson, 1983) and a researchable question. In addition I began to develop more realistic expectations of what doctorate research entailed.

A brain-storming session about three months into the work produced even more questions than I had started with (see appendix a) and, although I was commended for my efforts by my supervisors, at times it felt as if I was going backwards rather than forwards.

The waters were further muddied by my own pragmatism. Text books describe the research process as one in which a researchable question is first defined prior to making one's methodological choices. It is a moot point as to how distinct these stages are in practice (Johnson, 1975) but for some time I was trying to run the process in completely the opposite direction. I wanted a research design that was compatible with family life. In my early notes I toy with the idea of questionnaire surveys as a practical research tool. The desire for a pragmatic research method in the shape of a questionnaire survey

jarred with my developing sociological interests however. As a result of my reading I was beginning to focus on nurses' inter-occupational boundaries. More specifically, I was concerned with the *meaning* nurses' gave to their work and the division of labour as an interactive *process* - all questions which indicated an in-depth qualitative study.

Looking back on the brain-storming session the seeds of the final thesis are clearly visible. Almost half the questions relate to nurses' inter-occupational boundaries but it fell to my supervisors to point that out to me. The empirical questions I was by now asking reflected my developing theoretical interests. Influenced by my grounding in the ethnographic literature on the modern hospital I was increasingly attracted by Hughes' (1984) writings on the world of work and occupations, Strauss *et al*'s (1964) negotiated order perspective, and Abbott's (1988) work on the system of professions. Taken together they suggested an approach that conceptualised the division of labour in dynamic terms. Occupational boundaries, in this view, are not self-evident but have to be actively negotiated within a system of work or, to put it in Abbott's terms, jurisdiction has to be claimed and sustained in the work arena. It was Abbott's concept of jurisdiction that provided the anchorage for my research question and it was on the nature of nurses' jurisdictional claims in the work setting that this study came to focus.

As I have outlined in chapter 1, the policy debates suggested that recent developments in nursing and health policy had generated increased

jurisdictional ambiguity for nursing at two of its main occupational boundaries - between nursing and medicine and between nurses and health care assistants. My principal interest was in the question of how nurses' managed this jurisdictional ambiguity in the course of their everyday work activities.

ETHNOGRAPHY - THE ONLY METHOD?

As an undergraduate I had always found qualitative studies more engaging than quantitative work. At the time this was simply a reflection of my personal preferences rather than the result of a carefully considered ontological position. Qualitative studies had an appeal because words held more meaning for me than numbers and I have a personal predilection for in-depth knowledge and understanding. I do not consider qualitative research methods to be inherently superior to quantitative ones however. Each have their characteristic strengths and weaknesses. One's choice of method inevitably entails a trade-off depending on the circumstances and the purposes of the research.

> 'Methods must be selected according to purposes; general claims about the superiority of one technique over another have little force.' (Hammersley and Atkinson, 1983: X)

The theories I have drawn on in framing the research problem have their roots in interactionist sociology with it's characteristic emphasis on meaning and

social process. Drawing on the negotiated order perspective I wanted to explore the division of labour at work in a dynamic sense, paying attention to the effects of context in shaping the boundaries and the meaning of nursing work. I find it hard to imagine how the drama of work can be studied as it unfolds in any way other than by being there and watching it happen. In terms of the interests of this study therefore, ethnography, as the title of this section implies, was the only sensible method of choice.

One advantage of ethnographic work is its flexibility in allowing the researcher to adapt the research depending on the themes emerging from the field. As the preceding discussion has suggested I had a very clear idea at the outset that this research was about nurses' management of their occupational boundaries with medicine and health care assistants. As the research progressed however it became apparent that other key nursing boundaries were subject to strain: the intra-occupational boundary, the boundary between ward-based nurses and nursing and general management, and the boundary between the work of nurses and patients and their relatives. I thus amended the focus of the research to take into account these developing themes.

REFLEXIVITY

In attempting to lay the research process bare in my writing I am following a trend that started with Whyte's publication of a methodological appendix to *'Streetcorner Society'* in 1955 (Hammersley and Atkinson, 1983) and has

subsequently been taken up by numerous others (cf. Johnson, 1975; Wax, 1971). Reading Johnson's (1975) and Wax's (1971) accounts of doing research were an invaluable part of my pre-fieldwork preparations, although like the methodology text books, they made more sense after I had actually gained first-hand experience of fieldwork.

The collection and analysis of data on the research process has come to form part of a broader distinctive approach to research methodology most explicitly developed in the writings of Hammersley and Atkinson (1983). It is a methodological stance which cuts through the well-rehearsed polemics around positivism and naturalism and emphasises the inherently reflexive nature of all social research. It is, they argue, an unavoidable existential fact that we are a part of the world we study.

In the main these early extended commentaries of the research process tended to be produced separately from accounts of the studies that generated them. An obvious advantage in following such a strategy is that the material is readily available for those designing research methods courses or for neophyte researchers wanting to gain a sense of what being in the field is **really** like. For the reader whose principal interest is in the empirical study however, it denies easy access to an important resource on which they might wish to draw in assessing the work. Understanding the process through which the research data were generated is a central mechanism through which the validity and reliability of the research findings can be assessed. For this reason I wanted

to integrate a discussion of the research experience into the main body of the thesis rather than relegating it to a methodological appendix which I felt would marginalise its importance. Nevertheless, at the end of the day this thesis is about nursing. The challenge for me in writing this will be to reflect on the generation of data in a way that enriches the reader's critical appreciation of the empirical study and not to succumb to the pleasures of relating experiences in the field in a way which distracts from the substantive content of the thesis.

Reflexivity has important implications for research practice. Rather than trying to engage in futile attempts to avoid the effects of the researcher on the research setting one should set about trying to understand them. Reactions to the researcher within the field thereby become a source of data. This theme is taken up in the discussion of my field relations in chapter 4.

Reflexivity also underlines the role of the researcher as an active generator of data, engaged as s/he is in the processes of interpretation and pattern making common to everyday social life. 'He or she is the research instrument *par excellence*' (Hammersley and Atkinson, 1983: 18). The fieldworker is not a neutral research tool who goes out and participates in a given setting and trawls in social facts. Rather, it is the researcher who must decide what to observe, who to talk to, what questions to ask and how to interpret events. These decisions will be made on the basis of the researcher's personal values and theoretical assumptions. It is therefore incumbent upon the researcher to make their value and theoretical assumptions explicit in order that the reader

can assess the reliability and validity of the account.

GUIDING PERSPECTIVE

Jurisdictional Ambiguity

To recap, the starting point for this study was the observation that recent policy developments in nursing and medical education and health care had led to increased jurisdictional ambiguity for nursing at two of its main occupational boundaries - between nursing and medicine and between nurses and support workers - rekindling historical debates between professional and service versions of nursing. That tensions were experienced by practitioners themselves appeared to be supported by the literature.

A survey study of nurses, juniors doctors, and support workers undertaken prior to doctorate work, revealed rank-and-file staff to be deeply ambivalent about the bracketing of nursing role developments with the junior doctors' hours initiative (Allen and Hughes, 1993). Most significantly there was a discrepancy between doctors' and nurses' understandings of what nursing role developments would entail. Doctors on the whole were supportive of the devolution of discrete tasks to nurses, whereas nurses preferred to develop distinctive nursing roles. There were also tensions in respect of the nurse-support worker boundary. Qualitative data deriving from the comments section of the questionnaire suggested nurses strongly believed that additional qualified staff were needed in preference to support workers (Allen *et al,*

1993).

Walby and Greenwell *et al* (1994), in an interview study of nursing and medicine in the changing health service, devote a whole chapter to exploring boundary conflicts between nursing and medicine. As for the nurse-support worker boundary, studies reveal that nurses have tended to express objections to the principle of delegation of patient care tasks (Ball *et al*, 1987) although the ethnographic literature suggests that often this reluctance to delegate has failed to be realised in practice (Melia, 1987; Roth, 1963; Webb, 1977; Germain, 1979; Hughes *et al*, 1958; Burling, Lentz and Wilson, 1956; Johnson, 1978; Field, 1989; Hall, 1977; Wells, 1980).

Within the interactionist perspective employed in this account the division of labour is conceptualised in dynamic terms. I suggest that occupational jurisdiction can be considered as constituted through the interactive effects of boundary-blurring and boundary-creating processes and that nursing as a bounded occupation may be considered a practical accomplishment (Dingwall, 1977a). Strauss (1978: 105-141) makes it clear that negotiations will tend to occur in situations characterised by change, uncertainty and ambiguity, disagreement, ideological diversity, newness and inexperience. This was the premise on which the research was based. I believed that the policy changes that were taking place and the debates they had precipitated would throw the processes through which occupational boundaries were shaped into sharp relief.

I wanted to develop an analysis of the nursing response to jurisdictional ambiguity as defined by nurses' themselves and although Abbott's work on jurisdiction was instrumental in getting me started - in the sense that it enabled me to formulate a researchable problem - he provides few methodological clues as to how 'jurisdiction' might be operationalised within an empirical study. In order to bridge this gap Hughes' (1984) concept of dirty work was employed as an initial sensitising device.

Dirty Work

In pointing to the presence of dirty work, Hughes was drawing attention to the existence of a moral division of labour in society; that there are different degrees of honour and prestige associated with different types of work. Hughes differentiates, although only in passing, between work which is literally physically dirty and work that is morally impure. Hughes himself elides this distinction however. Given Hughes' concern with moral order and with occupations he quickly turns even physically disgusting work into a discussion of degradation, noting that the janitor's physical disgust is not just a reaction to filth but to tenants, who to quote one janitor, 'don't cooperate - them bastards' (Strauss *et al*, 1985, chapter 10, quoting Hughes, 1971: 343-44).

Hughes maintains that dirty work may be managed in several ways. One possible strategy identified by Hughes is concealment. Dirty work can also be delegated as part of the process of occupational mobility. Where

delegation is not possible dirty work may be integrated into an occupational role to become an intimate part of the activity which gives the occupation its charisma. For example, Hughes argues that part of the reason for the mystery of professions in society is that their work cannot be carried out without 'guilty knowledge'. 'The priest cannot mete out penance without becoming an expert in sin; else how may he know the mortal from the venial?' (Hughes, 1984: 288). The priest as part of the exchange involved in his license to hear confessions and absolve has to convince the lay world he will not yield to the temptations of his privileged position.

To a greater or lesser extent all of these strategies have been employed in nursing as Lawler (1991) has shown. In the more traditional system of work allocation low status staff were assigned dirty work associated with the body. More recently dirty work has been integrated into the job. The evidence also suggests that nurses also practice concealment, finding it very difficult to talk about their work to people outside the occupation (Lawler, 1991).

Hughes does not explicitly delineate how dirty work comes to be defined as such however. He appears to assume dirty work to be universal and inevitable. All societies have dirty work. It is here that I have found the ideas of Douglas (1966, 1975) useful. Douglas (1966, 1975) has powerfully demonstrated that ideas about 'dirt' and 'dirtiness' are socially constructed and may be seen as a by-product of our attempts to impose order on the external world.

'Perceiving is not a matter of passively allowing an organ - say of sight or hearing - to receive a ready-made impression from without [...] As perceivers we select from all the stimuli falling on our senses only those which interest us, and our interest is governed by a pattern-making tendency [...] In a chaos of shifting impressions, each of us constructs a stable world in which objects have recognisable shapes, are located in depth, and have permanence. In perceiving we are building, taking some cues and rejecting others. The most acceptable cues are those which fit most easily into the pattern that is being built up. Ambiguous ones tend to be treated as if they harmonised with the rest of the pattern. Discordant ones tend to be rejected. If they are accepted the structure of assumptions has to be modified.' (Douglas, 1966: 36)

For Douglas (1966), dirt is matter that is morally contaminating. At the heart of Douglas' work is the idea, borrowed from Lord Chesterfield, that 'dirt is matter out of place'. From this perspective dirt is something that does not fit into the categories of a system of thought. '(D)irt is essentially disorder. There is no such thing as absolute dirt: it exists in the eye of the beholder' (Douglas, 1966: 2). According to Douglas, 'all margins, the edges of all boundaries which are used in ordering social experience, are treated as dangerous and polluting' (Douglas 1975: 56). Douglas illustrates her arguments with examples drawn from primitive societies and is principally

concerned with the role of pollution beliefs in protecting the boundary between culture and nature. Her central ideas however are equally applicable to occupational culture in contemporary society as Hughes has shown.

Dirty work can operate at different levels of analysis. In *'Good People and Dirty Work'* (1984) Hughes examines work defined as dirty by the dominant value system of a given society. In his empirical analyses however, Hughes concentrated on the consequences of dirty work for workers' sense of self. Accordingly, subsequent studies focused on the strategies employed by workers in handling morally discrediting work - for example, through the development of 'collective pretensions' or 'dignifying rationalisations' - in order to give their work value in their own eyes and in the eyes of outsiders (see, for example Gold, 1964).

Dirty work may also be the reflection of a particular occupational perspective. According to Hughes, insofar as every occupation carries with it a self-conception, a notion of personal dignity, then it is likely that at some point some of the work that they do may threaten this dignity. The dirty work of one occupation may be much sought after by another.

My first introduction to the idea of dirty work was a paper in which Emerson and Pollner (1976) analyse the origins and consequences of mental health workers designation of certain tasks as 'shit work'. Staff considered their role to be the provision of psychotherapeutic work. Everyday work also included

a crisis intervention service however, and in this staff perceived they operated as instruments of social control. Emerson and Pollner argue that workers' dirty work designations could be seen as a mechanism through which workers distanced themselves from those work activities which threatened their occupational identity and in so doing reaffirmed the legitimate limits of their jurisdiction.

> 'Just as [...] embarrassment shows that the actor is aware of and committed to the moral order that his (sic) particular act has just violated, so the designation of dirty work reaffirms the legitimacy of the occupational moral order that has been blemished.' (Emerson and Pollner, 1976: 244)

These ideas have also been taken up by Brown (1989), who studying the field of mental health about a decade later, found that staff's dirty work designations were different from those found by Emerson and Pollner. In Brown's study of a community mental health centre, staff were unanimous in objecting to performing services for external non-psychiatric agencies. Brown argues that dirty work designations in this context may be seen as a boundary-defining stance in which workers in mental health institutions sought to distinguish modern psychiatric specialisation from general social services.

It is in this the sense that I felt dirty work could be fruitfully employed in this study in order to identify work that was symbolically polluting from the

perspective of workers themselves. In practical terms this meant entering the field with a sensitivity to those aspects of their work nurses moaned about.

Theories of dirt have been used in the analysis of general nursing work before. A number of studies have examined how wider societal pollution beliefs impact upon the status and work of nurses (Somjee, 1991; Hendry and Martinez, 1991). Others have focused on nurses' day-to-day management of dirty work (Wright, 1981; Diamond, 1988; Lawler, 1991). Whilst these studies have provided valuable insights into nursing work, they all examine nursing primarily in terms of the moral division of labour **within society as a whole.** They do not study nurses' own dirty work designations which may not resonate with the wider cultural beliefs.

Failure to fully utilise the analytic potential of Hughes' ideas in relation to general nursing may in part be attributed to a lack of clarity surrounding the dirty work concept itself. In many studies of dirty work it is not always clear if the concept is being discussed in terms of the moral division of labour in society as a whole, as a reflection of a particular occupational perspective, or indeed both. This is a point that Emerson and Pollner have picked up. These authors refer repeatedly to 'dirty work designations' in order to underline the fact that they are referring to the workers' use of the term.

Given that the dirty work concept as it reflects a particular occupational perspective has been employed with illuminating effect in the study of mental

health nursing (Emerson and Pollner, 1976; Brown, 1989) failure to employ the concept in this sense to general nursing must also relate to specific attributes of this branch of the occupation.

General nurses' work involves the intimate tending of bodies and the handling of body products. In any society the body is a powerful symbol of the relationship of culture to nature (Douglas, 1966) and of our experience of being in or out of control of ourselves (Littlewood, 1991). The body itself is a symbol of dirt (Douglas, 1966; Lawler, 1991). Because general nurses do work that by societal definition is so clearly dirty, the potential for employing the dirty work concept in a metaphorical sense to refer to work that is morally discrediting **from the view point of nurses** themselves - appears to have been completely obscured.

I felt that entering the field with a sensitivity to nurses' dirty work designations would provide a starting point from which to relate the technical to the moral division of labour in health care. In designating work as dirty, nurses' express to outsiders that an activity should not be taken to exemplify the nature of their work. I concluded that in this sense then the notion of dirty work is a central element in nurses' everyday claims to jurisdiction and was a way of linking Abbott's concept of jurisdiction with the empirical reality in the field. Douglas argues that even within a system of thought 'dirt' is a relative concept: 'What is clean in relation to one thing may be unclean in relation to another, and vice versa. The idiom of pollution lends itself to

a complex algebra which takes into account the variables in each context' (Douglas, 1966: 9). Of particular interest in relation to nursing was whether activities were defined by nurses as 'objectively' dirty or whether the symbolic meaning of a task depended on the context in which it is performed.

By focusing on dirty work I intended to:

(i) discover nurses' dirty work designations and through this the nursing perspective;

(ii) examine the relationship of dirty work to gender;

(iii) analyse nurses' management of dirty work in order to understand the ways in which the nursing perspective was constituted through nurses' performance and accounts of their work;

(iv) relate this emic perspective to professional and wider organisational culture;

(v) root nurses' dirty work in the ward setting through an analysis of the situational and contextual factors which shaped its management; and,

(vi) examine the role of dirty work designations in the maintenance and disputation of occupational boundaries.

Gender Issues

As I have argued in chapter 2, whilst providing a valuable starting point both Abbott (1988) and Hughes (1984) pay insufficient attention to the role of gender in shaping the experience of work. Given the importance of its

definition as women's work I wanted to address this weakness and to integrate gender issues into the overall analysis.

Since the inception of the NHS in 1948, nursing has always been marginal as far as the policy making process in health care is concerned (Beardshaw and Robinson, 1990; Robinson, 1992; Davies, 1995). As Davies, (1995) points out, in all the discussions about health policy changes in the 1980s and 1990s nursing is never given more than a cursory and passing mention. From his vantage point at the head of the RCN, Trevor Clay observed that in the Griffiths Report, save for a whimsical reference to Florence Nightingale, nursing was deemed 'monumentally unimportant' (Clay, 1987: 57, cited by Davies, 1995: 163).

In terms of the issue of the division of labour I felt there was a sense in which nursing work, like women's domestic work (Hochschild, 1990), was perceived by policy makers to be infinitely elastic, and that nurses as the largest occupational group in the health service represented an endlessly absorbent sponge ready to soak up every additional duty. In undertaking this study then I had in mind the desire to give nurses a voice.

Summary

To sum up, the starting point for the research was the implications of recent developments in nursing and health policy for nursing's inter-occupational boundaries. Employing an interactionist framework the aim of the study was

to move on from the policy debates and develop a less essentialist account of the nursing role through an exploration of nurses' management of this jurisdictional ambiguity in the course of their everyday work activities. Abbott's work was instrumental in framing the research question and Hughes' dirty work concept provided the link between the concept of jurisdiction and the empirical reality in the field setting. Both however neglected gender issues. Drawing on the work of feminist scholars it was my aim to examine the role of gender in shaping nurses' jurisdiction and, in writing the thesis to give nurses a voice.

4. Fieldwork - Plan and Process

THE FIELDWORK PLAN

This research was planned as an in-depth study using established methods of ethnographic research. Data were generated using participant observation, tape-recorded semi-focused interviews, and the analysis of documents in context. Fieldwork was undertaken on a surgical ward and a medical ward within the same hospital. Interviews were carried out with nurses, doctors, auxiliaries, health care assistants and clinical managers. I also attended nursing and management meetings and in-service study days.

Fieldwork lasted ten months. Twelve weeks were spent on each ward. In each case I scheduled a mid-way break from the field to allow time for reflection and provisional analysis of the data. There was also a period of three months between data collection on each ward to the same ends. This was rather longer than I had originally planned but after twelve weeks the labour intensiveness of the fieldwork had taken its toll. I was physically and mentally exhausted. Following discussions with my supervisors I felt that from both a personal and an intellectual point of view I needed time away from the field. During this interim period I maintained contact with the

research setting. I attended a number of meetings and study days and carried out interviews with non-ward based staff.

Selecting Cases

The Hospital

One of the aims of the research was to contextualise the wards within the overall organisational culture. Data collection was restricted to a single hospital, thus holding constant the background against which my findings on the wards might be analysed. This also obviated the need to negotiate access to two different hospitals.

In selecting the site for the research I obtained background information from three NHS trust hospitals in the area. Two were district general hospitals and one was a large teaching hospital. The final choice was made on practical grounds. I do not drive and Woodlands was within walking distance of my home. Not only was this personally more convenient it also meant that I would be more able to opportunistically sample key events if the travelling costs were minimal. Many of the interviews were carried out during quiet periods on the wards in the evenings. I first telephoned the ward to see how busy they were and could be on the ward in under half an hour if the ward nurses were agreed. On only one occasion had the pace of work changed so dramatically as to make my journey a wasted one.

The Wards

The ethnographic literature vividly describes the internal heterogeneity of the modern hospital, a feature which compounds the usual methodological difficulties in assessing the representativeness of case study data. Fieldwork was undertaken on two wards in order that contrasts and comparisons could be made. Originally an acute-chronic comparison was planned on a surgical ward and a dermatology ward. I felt that the contrasting balance of medical and nursing inputs characteristic of such settings might influence their respective technical and moral divisions of labour. Fieldwork began on the surgical ward but as the research progressed the basis for the selection of the second site shifted for a number of reasons.

I had several concerns about the suitability of the dermatology ward as the second site. First, it was a new unit and there were hopes that it would be a flag-ship area for the hospital. Second, in terms of the workload it was unusually quiet. Third, I discovered that medical cover was provided by GP (general practitioner) clinical assistants and not junior doctors. The surgical ward was also unusual in terms of its medical staffing. It did not employ PRHOs (pre-registration house officers): ward work was carried out by SHOs (senior house officers) and a nurse practitioner. I had assumed that on those wards used for the purposes of medical training the medical cover would be provided by a traditional configuration of house officer, senior house officer, registrar and consultant. My fieldwork experiences raise the question as to how normal this composition actually is in practice, and it seems likely that

as a result of recent policy developments they will become even less typical. Given that links were increasingly being made between nursing role developments and the junior doctors hours initiative (SETRHA, 1992; Hughes and Allen, 1993; Allen *et al*, 1993., Allen and Hughes, 1993) however, I felt that this classic configuration of medical staffing ought to be present in at least one of the wards in the study.

One option would have been to have selected a care of the elderly ward as an example of a chronic care setting. However, these wards had recently moved to the hospital from a separate locale and were still adjusting to the new environment. Whilst this would be an interesting topic for sociological study, I felt that the disruption to working relations and routines created by the relocation of care of the elderly wards made them inappropriate sites for this particular project. Owing to the difficulties in selecting a chronic care setting, I decided to undertake the second part of the fieldwork on Fernlea, a medical ward where I knew PRHOs were employed. Furthermore, as the fieldwork progressed nurses' intra-occupational division of labour had emerged as an interesting and unanticipated theme. The second site was sampled in order that the wards might be compared in this respect also. The ward was identified by a key informant as one in which the division of labour between nurses was very different from that of the surgical ward. The original basis for the comparison was thus changed to a medical-surgical contrast.

Within Case Sampling

Observational Foci

I began the fieldwork with a thorough grounding in the ethnographic literature on hospitals and five years nursing experience. I therefore entered the field with a fairly clear idea of what aspects of ward life I wanted to observe and mapped out a list of critical observational foci: nursing handover, ward rounds, ward meetings, the introduction of new staff to ward, drugs round, work allocation, admission and discharge processing, interaction at the nurses' station, interaction in 'backstage regions', and interaction between staff when the patient was and was not present. In keeping with the principles of theoretical sampling I anticipated that this initial strategy would be modified as the research progressed and observations focused according to my developing theoretical concerns.

Time

An important feature of hospital social organisation is its temporal order (Zerubavel, 1979). Fieldwork was organised in order to sample the major temporal divisions. A timetable of observations was constructed. I planned to spend four hours in the field, on three days each week. I scheduled my observations over the following time periods: 06:00-10:00; 10:00-14:00; 14:00-18:00; 18:00-22:00. Fieldwork was arranged to cover each of these different time periods for each day of the week including weekends and public holidays. I made observations on four nights in each ward setting where I stayed for the duration of the nursing night shift. On a number of occasions

I also spent whole shifts in each ward. My preparedness to work unsociable hours was met with approval by participants in the field and did much to demonstrate my sincerity and commitment to understanding their work.

People

A key research objective was to understand the division of labour at work from the perspectives of all those involved in its construction. This included participants involved in daily negotiations of work boundaries as well as clinical managers concerned with broader aspects of work roles. Tape-recorded interviews were carried out in order to represent all the relevant occupational groups and intra-occupational sub-groups. Only one person did not agree to be interviewed but this did not appear to undermine the representativeness of the sample in any way. On two occasions whilst observing at night, members of the nursing staff from the neighbouring ward expressed an interest to talk to me - effectively selecting themselves. Although they were not staff from the ward on which my fieldwork was based I nevertheless agreed to interview them as they represented categories of staff whose perspective I was interested in but formed minority groups within nursing: SENs and male nurses.

This sample was complemented by other categories of staff deemed theoretically relevant. Thus for example, on the surgical ward the nursing staff identified the existence of two different camps on the ward - it was therefore necessary to sample from both camps in order to appreciate both

perspectives.

57 tape-recorded interviews were carried out. Three were with the same person throughout the course of the fieldwork and one was a joint interview with two auxiliary nurses. 37 interviews were with nurses: 2 G grade sisters, 2 F grades sisters, 4 E grade senior staff nurses, 12 D grade junior staff nurses, 3 state enrolled nurses - 2 of which were C grade and 1 was D grade, 8 senior nurses, 4 third year students and 1 nurse practitioner. 4 of the nurses were male. 6 of the nurses worked permanent nights and comprised: 2 SENs, 2 E grade senior staff nurses, 2 D grade junior staff nurses of which one was male.

5 auxiliaries and 3 HCAs were interviewed. All were women. 2 of the auxiliaries worked permanent nights and were interviewed together.

I interviewed 11 doctors. The sample comprised 5 consultants (of which one was a clinical director and another a clinical tutor), 1 registrar, 2 SHOs, 2 PRHOs and the director of medicine. 1 of the doctors was female.

I will discuss the interview process in greater depth later in this chapter.

I also planned to shadow a selection of staff in the course of their everyday work activities. Before the fieldwork started however I was far from clear how this would actually pan out recognising that it would be subject to

negotiation over the course of the fieldwork. It is these fieldwork processes which are the subject of the next section.

THE FIELDWORK PROCESS

Access

Initial Entry

This study has benefited from collaborative supervision from representatives of two different departments: the School of Social Studies and the Department of Nursing and Midwifery Studies. Formal access was negotiated with the close involvement of my supervisors. Not only did this give me invaluable support at a crucial stage in the research process it also enabled us to draw on powerful symbols of academic respectability in establishing the legitimacy of the proposal. Moreover, we were able to capitalise on the links of one of my supervisors and myself with nursing. It was my supervisor with a background in nursing who was most actively involved in access negotiations.

Access was initially negotiated through the Director of Nursing who was telephoned by my supervisor in my presence. My supervisor did some pre-access homework through a mutual acquaintance at Woodlands hospital who informed us of the name of the Director of Nursing and also encouragingly suggested that the hospital had a positive attitude to research. This contact served as an useful opening in my supervisor's introduction of herself to the Director of Nursing. In this first telephone call my supervisor introduced

herself, outlined my research interests and stressed my nursing background and my status as a holder of DoH studentship. The Director of Nursing agreed to meet us in order to discuss the possibilities of taking the research forward at Woodlands.

The date of the meeting was confirmed by letter using University letterhead stationary, which was signed by both supervisors (see appendix b) and accompanied by a two page outline of the research (see appendix c).

During preliminary investigations into possible sites for the research I had contacted Woodlands' marketing manager and had obtained some literature about the organisation including the recent application for trust status. This document contained useful practical information on the organisation, details of the services provided, clinical directorates and management structure. In addition it also allowed me to start to form an initial sense of what the organisation was like - or at least its public presentation. I had also visited the hospital in order to establish where the Director of Nursing's office was situated and what the arrangements for parking were so to eliminate some of the uncertainties with which we would have to contend at a time when, for me at least, adrenaline levels would be high.

The First Meeting

The morning of the meeting with the Director of Nursing I woke and felt 'as if I was going to the gallows'. I had thought carefully about my public presentation but as this extract from my fieldwork diary shows, in selecting

my clothes I failed to take account of their interaction with the body's physiological response to anxiety.

> I put on a smart silk shirt only to have to wrap myself in a cardigan for the interview because my shirt was drenched with perspiration - such was my anxiety.

I met with my supervisor an hour before the meeting was scheduled in order that we might review our strategy. Our main objectives for the meeting were to establish the credibility of the research and discuss access to the different occupational groups. Our plans quickly went awry however, when the Director of Nursing immediately agreed to the study. Indeed from the outset, we had the support of the Director of Nursing and the Director of Medicine.

> The Director of Nursing explained that she had felt unable to agree to the study without the support of her medical colleague. She had thus forwarded the details of the study to the Director of Medicine who had approved the research plan. I was momentarily stunned. We had come prepared to argue and present our case and as far as this objective was concerned at least, there now seemed nothing more to be done.

By the end of the meeting we had agreed a starting date for the fieldwork and had in place many of the practical arrangements needed to take the work forward. Communicating the details of the research to staff was an important issue and I looked to the Director of Nursing for guidance as to how I might

approach this. She suggested that I gave a presentation at the next senior nurses' meeting.

It was agreed that Treetops, a urology and mainly surgical ward, would be the first site for the research. Treetops was suggested by the Director of Nursing because they employed a nurse practitioner in a role that was perceived to cross traditional inter-occupational boundaries. I also had a personal preference for urology. I already had some knowledge of this speciality and I felt this would be a useful interactional resource. At this stage in the research I was planning an acute-chronic comparison between the two wards and wanted dermatology to be the choice for the second site. As the dermatology ward was in the throes of change however, we agreed to leave the selection of the second site until I had a better knowledge of the organisation. This, as I have indicated, had the additional advantage of allowing me to base my decision on the data and theory emerging from Treetops ward.

It was clear that my research topic was a significant organisational concern. While this created a very positive sense of shared interest, it also carried the risk that the Directors of Nursing and Medicine were looking for solutions to practical problems. Indeed as part of the research bargain I agreed to write a report of my findings for the hospital. In terms of research ethics however we were able to make the exploratory nature of the research clear and highlight the real possibility that it might generate more questions that it

answered.

The Director of Nursing suggested that I had monthly meetings with her in order to discuss the progress of the research and raise any questions that had occurred. We arranged a date for the first meeting. It seemed that I had already found myself a key informant. As for the Director of Nursing, she saw my presence in the hospital as providing a positive role model for any nurses considering further education or undertaking research.

Presentation of the Project - Senior Nurses' Meeting

The senior nurses' meeting was held in the boardroom. About fifteen people were in attendance, mostly senior nurses from within the organisation. Two were guests from the local branch of the RCN. All were women.

As the senior nurses started to drift into the board room I realised, initially to my horror, that I had already made contact with the Maternity Services Manager who had come to my home in order to make arrangements for a home confinement almost a year before. My midwife and I had fought a prolonged, and locally famous battle, with the medical staff over key aspects of my antenatal care. It was far from clear what impact this aspect of my personal biography would have on my public presentation. It actually proved an interesting point of contact and I was proudly referred to by the Midwifery Services manager as 'one of our home confinements'.

Two other presentations were scheduled for the meeting and since the others had more pressing commitments I went third. I had already read a number of personal recollections of fieldwork experiences and in the forefront of my mind was Johnson's (1975) account of his attempts to give a similar presentation in his study of social workers. Johnson refers to the event as 'the crucifixion' in which he was accused of being a Government spy and was unable to talk to his notes at all. It had occurred to me that since the DoH was funding my studentship I might face a similar accusation. In planning my presentation I considered preempting such an accusation and state in categorial terms that I was not a DoH spy. I decided however, that this might create suspicion where none existed and that I risked sounding overly defensive. I therefore elected to cross that hurdle should it arise which, thankfully it did not.

I began the presentation by describing my academic and nursing background. I emphasised my recognition of the practical nature of the problems I was concerned with and my interest in understanding what it was like for practitioners 'on the ground'. In setting out what participation in the study would involve I stressed that my nursing roots had provided me with sufficient native wit to assess the appropriateness of my presence according to the context.

I gave assurances that I would seek the informed consent of all those involved in the research and that the confidentiality of respondents and anonymity of

the hospital would be safeguarded at all times. I promised that any data I collected would be securely stored and that in any publications resulting from the research I would present data in such a way so as to 'safeguard' the anonymity of patients, personnel and the hospital. I recognised however, that despite my best intentions, in practice these could often be difficult promises to fulfil. I will elaborate on this further in my discussion of research ethics.

In outlining the research I did not discuss my theoretical interests. I explained that I was concerned with the ways in which nurses on the shop floor were responding to the changing division of labour and the impact that this was having on their working relationships. I also omitted discussion of the practical application of the research findings. The reasons for this were partly practical and partly strategic: I didn't have time to cover this in my ten minute slot and I decided that in leaving the issue out of the formal presentation it would shape the sort of questions that might be raised following the presentation.

I felt the presentation went well. A number of the nurses said that the study sounded interesting. I was asked about the practical benefits of the research. A question I had anticipated. There was also interest in why I had chosen their hospital to do the research when the university I was attached to was some distance away. I explained that my reasons for selecting the site were entirely practical.

I had taken copies of the study outline with me to the meeting and explained that they were available for anyone who was interested. Everybody at the meeting requested a copy. As I was distributing the outline a number of people took the opportunity to introduce themselves to me and offer their help.

Sponsors

At the first access meeting I had been introduced to Debbie - the Clinical Audit Nurse - who was allocated by the Director of Nursing to act as a sponsor within the organisation. The sister from the dermatology unit was suggested as a second link person. She also had good clinical contacts and she frequently acted as nurse manager. A meeting was arranged between the three of us in order that the practical details of the research could be sorted out. Because of the direction the research subsequently took however, I had little further contact with the dermatology sister during the course of the study.

After this initial meeting I spent the rest of the morning and early part of the afternoon with Debbie who took me to various departments at Woodlands and started making introductions. Debbie was a relatively new addition to the hospital staff. Nevertheless, she proved a valuable contact, providing important background information on the hospital and suggesting people to talk to. We very quickly established a rapport and I was bitterly disappointed when she confided that she had applied for another job and it was possible that she would be leaving the hospital before the research was finished. Debbie

was successful in her job application and three months into the research she left the hospital.

Debbie was a member of a small nursing elite within the organisation who shared an office on the same corridor as the Director of Nursing. Through my contacts with Debbie I became a familiar face in the office and by the time she left for her new post I had established two further key informants.

Greta had responsibility for the implementation of Project 2000 within the organisation and was also involved in professional development issues more generally. Through Greta I was able to attend a variety of in-service training days. She was also an important link with the health care assistants as she was responsible for their training.

It was Pauline however, who formally took on the role of link nurse. She had trained at Woodlands and was signposted as someone who 'knew all the gossip'. Moreover, her responsiblities for tissue viability meant that she had established links with the clinical areas. Pauline provided me with the information I needed to select the second site for the research and was instrumental in the negotiation of access.

Negotiating Access to the Wards

Treetops - The Surgical Ward

Access to Treetops was negotiated through the formal nursing hierarchy. My first contact was a telephone call to the sister in order to set a date for a meeting. Although the sister agreed to see me, it was obvious that she did so very reluctantly and felt she had little choice but to cooperate with the study.

> 'If they've said you can do it here, then really we have to accommodate you dear. As long as you keep out of our way when we're busy'. (Sister)

Our conversation left me feeling bemused and raised important ethical dilemmas around the notion of consent. Formal access had already been granted by powerful individuals within the organisation. The ward sister made it clear she felt unable to refuse access without incurring official censure. Without her support for the work however, it was hard to see how access could be achieved in any meaningful way. A key objective of my meeting with the two ward sisters was to gain their trust by establishing myself as an honest and decent person with enough practical knowledge of nursing to keep out of their way when it was busy.

The meeting was a strange event. The two sisters were both very friendly and welcoming but I found it frustratingly difficult to give anything like the comprehensive account of the research I had planned to do. I was constantly

interrupted by the sisters who were eager to give me the information they felt I needed. I had to perform a delicate interactional balancing act. I did not want to appear uninterested in the work on the ward but at the same time I needed to ensure that I left the meeting having accomplished my own goal, which was to explain the purposes of the research in sufficient detail to satisfy research ethics.

On reflection it is clear that the sisters and I had come to the meeting with quite different agendas. I aimed to give a comprehensive account of the study to ensure that it was was taken forward on sound ethical grounds. As far as the sisters were concerned however, research was a rather esoteric exercise carried out by 'very clever' people which neither interested or concerned them. Nonetheless, it was hard not be disappointed that they were not particulary interested in my work. Furthermore, it is clear to me now that the sisters had already resigned themselves to the fact that the study would be taken forward on the unit although they did not explicitly say so at the time. As I have indicated they felt they had little choice but to accommodate me. Having reached this point then, the sisters saw the meeting as an opportunity to discuss the practical implications of the research for the staff and to make it clear that the ward was a busy one and that I was not to get in the way.

I arranged to send the ward sister a timetable of scheduled observations, based on the understanding that I would need to remain flexible in my movements depending on what was happening on the ward.

I left copies of the research outline with the senior ward sister which she agreed to distribute to all nursing staff. I stressed that I also wanted nursing auxiliaries and HCAs to receive copies but she clearly did not think this would be necessary, suggesting that they could look at the staff nurses' copies. Although the senior sister did eventually agree to my request, she clearly regarded it as rather strange. I left the meeting unconvinced she would do as she promised but was unable to pursue the issue further without straining friendly relations. In actuality the support staff were never given any information about the research not even verbally. At ward level I dealt with this by explaining that I had left outlines for them but they must have been overlooked. I made sure that I gave them a copy of the research outline. The support staff were unsurprised that they had not been informed and the incident did not appear to damage my relationships with them in anyway. Indeed they were flattered that anyone should be interested in what they had to say. The event proved to be an early sign of the strength of the nursing hierarchy on the ward and was in marked contrast to my experiences in negotiating access to the medical ward.

Fernlea - The Medical Ward

Access to Fernlea was negotiated through Pauline, the second link nurse, who had herself been a sister on the ward. She arranged a meeting between the sister and myself and paved the way by explaining the study and vouching for my personal acceptability. The meeting was with the junior sister, who explained that the senior sister was unable to join us but was happy for the

study to go ahead. Although I did not appreciate it at the time, this was an early indication of the division of labour between the two sisters on the ward which was a source of strain.

This meeting was easier than the one on the surgical ward but there were important differences between the two events. Firstly, the first meeting was a triadic rather than diadic exchange. Secondly, I now had a greater familiarity with the organisation and first-hand knowledge of what the fieldwork would mean for the staff. Thirdly, the senior sister on the surgical ward had said she would be happy to vouch for me if the staff on the next ward I was going to wanted to know what it was like having me around. Although the offer was never actually taken up it was valuable to be able to say this.

Like the sisters on Treetops, the medical sister was chiefly concerned with the practical implications of the work rather than the details of the study itself, but at this stage in the research I had come to expect this as normal and did not feel the same disappointments as I had before.

The sister was happy for the study to go ahead but first wanted to meet with the rest of the ward staff - nursing, medical and support workers - in order to explain the research details. She offered to photocopy the outline I had given her to ensure everyone knew about the study but I had actually come to the meeting with copies of the study outline which she agreed to distribute to

ward members. I agreed to contact the ward a week later in order that the staff could be told about work and given the opportunity to raise any questions or objections they might have.

In practice the consultation process took rather longer than anticipated and I contacted the ward on a number of occasions and spoke to the senior sister who said that they had been busy on the ward and were no further forward. I became concerned that the ward was going to withdraw from the study at the last minute and in the event of this happening I wanted to start access negotiations to an alternative site. Eventually I made a spontaneous decision to visit the ward one afternoon when I was in the hospital for another purpose. This time I met with the junior sister who said that she had not had an opportunity to discuss the project with everyone as yet but that she did not envisage that there would be any problems. As a result of this visit I was able to arrange a start date for the fieldwork and agreed to send the sisters a schedule of my planned observations. When I arrived on the ward a copy of the research outline was displayed on the notice board. All staff knew about the research even if they were not clear about its finer details.

Night Staff

Separate negotiations were undertaken with night staff. This entailed sending the night nursing managers copies of the research outline and making contact by telephone in order to introduce myself. As far as ward-based staff were concerned, I purposively scheduled my routine observations to overlap with

their shift times in order that I could make myself known to them and explain the purposes of the study.

The Research Role

It is now widely accepted by ethnographers that entrée into the field is not a discrete event concluded once access is granted by organisational gatekeepers. The negotiation of access is a continuous part of the research process and is inextricably bound up with the establishment of trusting field relations. This trust is the foundation on which the quality of field data rests. In developing and preserving the trust of field members the researcher necessarily relies on their own common-sense competencies as a member of society (Johnson, 1975). The character of the relationships established in the field however, differs in important ways from those established in everyday life. This section describes the management of my field relationships.

Self Presentation

It was agreed with the Director of Nursing that I should wear a white coat in the clinical areas. Like other white coat wearers at the hospital I left this unbuttoned and so it was necessary to give some thought to what I wore underneath. I adopted a style of dress with which I felt personally comfortable and that was in keeping with the broad dress codes of non-uniformed personnel within the hospital. It might be best described as informally smart. I had mixed feelings about wearing the white coat. The Director of Nursing felt it would identify me in the eyes of the patients with

the clinical setting. Few personnel whose work brought them into regular contact with patients were non-uniformed. One of my supervisors also pointed to the practical benefits of having plenty of pockets in which to keep my notebook, pens and tape-recorder. Initially however I was unable to shake off my nursing background and overcome the power of the white coat as a symbol of the medical profession. I feared that it might get in the way of my relations with the nursing staff. Indeed in my first few days in the field I could not bring myself to wear it. I finally resolved to wear the coat for mainly practical reasons and found it evoked some informative reactions.

It was fairly commonplace to be mistaken for a doctor. On many occasions when I was at the nursing station, patients and relatives directed their questions to me even though I employed a number of subtle interactional cues to discourage this - for example avoiding eye contact. On one occasion, whilst shadowing a nurse assisting a consultant on the ward I was pressed for details on the generic name of a drug.

I was provided with a badge which had the hospital logo on it and on which I elected to have inscribed - 'Davina Allen Research Student'. I avoided the 'nurse' label, least it set up expectations on the part of patients and organisational members as to my role. This also allowed me to play down my nursing background as was necessary.

In developing my relationships with different participants in the setting it was

necessary to augment or minimise various aspects of my personal biography depending on the circumstances. Those elements of my self that proved to be particulary salient were: nurse, student, 'local', mother, woman, researcher.

The Issue of Participation

I was clear that I did not want to work as a qualified nurse on the ward. I lacked confidence in my competence after six years absence from practice. Furthermore, I felt that working as a nurse would restrict my access to certain groups, limit the activities I would be able to observe, and make it difficult to stick to my plan of keeping detailed fieldnotes of participants' talk. My own experiences in nursing had taught me the importance of 'rolling your sleeves up'. Given this busyness culture, I knew that being on the wards without making a contribution to the work would be a source of considerable personal discomfort. When I described the role I hoped to adopt in the field to members of the nursing staff, they redefined it in terms of positions with which they were familiar. It was described as 'like an auxiliary but you don't want to be counted in the numbers'. My role was also compared to that of a first year student nurse. As far as any role is static, the one I adopted might be best described as that of the researcher with her own specific purposes for being on the wards but who had a good practical knowledge of nursing work and could help out when it felt appropriate to do so. In exchanging my labour in return for the nurses' cooperation I hoped in some way to balance the inevitable parasitic relationship that exists between researcher and researched.

At the begining of the fieldwork I desperately wanted to help out. This in part reflected my own discomfiture with the research role which felt very alien to me, but it was also an indicator of my own dis-ease with being on the ward and not making any contribution to 'getting through the work'. In the early days in the field I spontaneously volunteered to do things without giving any consideration to my competence to carry them through. I was very much responding to the situation as a nurse in trying to be useful. As the fieldwork progressed however I was able to carve out a role with which I felt more comfortable and which could be adapted to my purposes in the field at the time. The role that I developed in my efforts to gain an understanding of the setting had three main elements - researcher as helper; researcher as observer and researcher as shadow - with the precise combination of these elements on any one occasion depending on the context.

Sometimes I involved myself closely with the ward work and on a number of occasions found myself making beds on my own! I answered the telephone, relayed messages to staff and to patients' relatives, gave out meals and drinks, assisted patients in the toilet, made patients comfortable, disposed of bedpans and urinals, loaned books, provided bibliographic references for students, chaperoned male doctors examining female patients, and acted as a 'go-fer' for both nursing and medical staff. It was however, an on-going dilemma as to how involved to become in the ward work without being perceived by the nursing staff to be interfering. I felt I walked a precarious line between being helpful and appearing intrusive and had to make largely intuitive judgements

as to which path to take depending on the particular context. These anxieties were informative however. I realised that the difficulties I experienced in negotiating the nursing boundary mirrored those faced by patients and their relatives.

On other occasions I adopted more of an observer role, positioning myself in a strategic spot in order to watch the ebb-and-flow of ward activities. The nurses' station proved a useful vantage point. It was here that much of the work activity was coordinated. By locating myself in this area I was able to observe the division of labour at work and transcribe members' talk directly into my notebook. I also adopted the observer role in attending meetings and study days around the hospital although on several occasions I was invited to contribute in some way.

The third strategy I employed in the field was to shadow participants in their everyday work activities. The character of shadowing varied with the different occupational groups. Shadowing the medical staff took the form of prolonged contact - up to fourteen hours at a time with the on-call doctors - and might be best described as the 'a-day-in-the-life-of' variety. As I shall outline in chapter 7, the work of doctors and nurses has a different spatial and geographic organisation and shadowing medical staff in this way provided access to those aspects of medical work that are largely invisible to ward-based nurses.

I adopted a different strategy in shadowing the nursing staff. In the early stages of the fieldwork I attempted to shadow a single nurse in the same way as the doctors. On one occasion I spent a prolonged period of time observing the work of the nurse in charge of the ward. I found this almost impossible to sustain however, and felt very much in the way. I therefore tended to observe individual nursing activities: patient processing, escorting patients to and from theatre, technical procedures, nursing handover, work allocation, liaising with medical staff, tidying the ward, drugs administration, care-planning and record-keeping.

I experienced the work of HCAs and auxiliaries from working alongside them as many of the activities I undertook on the wards were tasks that routinely fell to support staff.

The field role I negotiated enabled me to experience the division of labour at work and gain an understanding of the perspectives of the major occupational groups in this study: nurses, doctors, and support staff. It did however restrict my access to those aspects of caring work that takes place 'behind the screens' (Lawler, 1991). I felt quite unable to shadow nurses and auxiliaries when they were carrying out physical tending of patients. This was partly because much of this work was undertaken at speed, first thing in the morning in a general atmosphere of busyness, but also because I felt that without a caring purpose it was illegitimate for me to intrude into patients' privacy.

Given that nobody spent time in the patient areas without having a definite purpose I would have looked very conspicuous and felt extremely uncomfortable simply hanging about observing what was going on. I endeavoured to overcome this problem by spending time in the patient care areas doing other mundane tasks from which I could observe the work activities and listen to the talk behind the screens. I would often involve myself in bed-making. Another tactic I adopted was to accompany the nurse administering patients' medications as she moved round the ward. There were other ward routines which I was able to utilise in a similar way. For example, I accompanied nurses measuring and recording patients' observations or the auxiliaries as they tidied patient bed areas.

Field Relations

Although I was principally interested in nurses' management of their occupational boundaries I wanted to develop an appreciation of the perspectives of the other groups within the organisation. In interactional terms this entailed a degree of 'impression management' (Goffman, 1959). It was necessary to augment or minimise different aspects of my identity according to the audience and the circumstances. These are tactics employed in everyday life in order to satisfy requirements of tact and polite social interaction. Moreover, they are skills at which I was already well-practised having negotiated my way through a succession of different wards during the course of nurse training (cf Melia, 1987). Relations established in the field however differ in important ways from those established in everyday life. In

everyday life one has allegiances and groups with which to identify. In trying to develop a multiple perspectives approach within an ethnographic study one must be able to move deftly between different groups and at times even have one foot in each camp whilst simultaneously coping with intense feelings of isolation in belonging nowhere. This was a dominant feature of the fieldwork which was at times excruciatingly difficult to live with.

The Nurses

I had, perhaps rather naively, assumed it would be a fairly easy matter to establish relationships with the ward-based staff. After all it was not long ago that I myself had been one of them. My first encounter with the nurses on the wards was a shock and gave me a tremendous jolt. My main contacts up until this point had been with senior nursing staff and I was surprised to discover that my interaction with them was rather easier than with the rank-and-file with whom I still strongly identified. In the research outline I had stressed my nursing background but in the early days of the fieldwork it became clear that the ward staff did not identify with me. Initially I was cast as expert research nurse which instantly created social distance. It was a role I went to great efforts to resist. I protested that I was learning how to do research and was not an expert in any sense, especially in nursing. I also hoped to narrow the social distance between myself and the ward nurses by involving myself in ward work.

I had to work hard at convincing nursing staff that I was not in the business

of assessing their practice. Most nurses have an acute awareness of the theory-practice gap and I suspect that my background in academia made them assume that I would make invidious comparisons. In attempting to counter these fears I talked about my own experiences on the wards and in so doing tried to establish myself as someone who knew what it was **really** like. I also shared stories from my own experiences of nursing a senior figure in nursing and how threatening I had found the experience.

On both wards the nurses expressed concern that I would report my findings to the Director of Nursing and that as a result they would get into trouble. This was difficult to deal with because I had indeed agreed to write a report for the hospital as part of the research bargain. I endeavoured to demonstrate my appreciation of their concerns and admitted that I would undoubtedly feel the same in their position. It would have been inappropriate to have made bland claims about maintaining anonymity as many of the nurses were very aware of the difficulties of honouring this in practice, especially in relation to holders of specific posts. I explained that these would be difficult ethical decisions that I would have to make in the course of writing. I presented myself as a morally scrupulous person who was not going to betray the trust of those who had helped her. For these reasons I was ever-wary that my relationships with certain of the senior nurses within the organisation had the potential to antagonise ward staff by associating me with the nursing hierarchy. Fortunately as a result of the spatial organisation of their work activities I mostly managed to keep my relationships with the two groups

separate.

The Doctors

At the initial access meeting the Director of Medicine suggested that I might encounter some resistance to my efforts to shadow junior medical staff. I was told that junior doctors had refused a similar request by student nurses at Woodlands on the grounds that they were too busy. After discussions with my supervisors I resolved to try and befriend one of the junior doctors and attempt to persuade them to allow me to observe their work.

It was difficult establishing contact with the junior doctors on the surgical ward. I had to make my own introductions and, in the early weeks of the fieldwork, fearful of a hostile reception, I found it difficult to pick the right moment. My difficulties were further compounded by the spatial-geographic organisation of the SHOs' work which was divided between the ward, theatres and out-patients clinics. The doctors actually spent very little time on the wards. Once the initial contact was made and I had explained my research interests however, both SHOs often took the opportunity to chat with me about their work and both agreed to an interview.

On the medical ward I had little contact with the two SHOs. In one case this was because the SHO covered the outlying patients - those patients under the care of the firm who could not be accommodated on the consultant's ward. The second SHO worked for the rheumatology consultant and, for reasons that

were never entirely clear to me or anybody else, spent little time on the ward. I established the closest relationships with the PRHOs on the ward. During the fieldwork period the PRHOs rotated. I managed to establish a good relationship with the first PRHO who agreed to allow me shadow him on two occasions including when he was on-call. Shadowing the on-call doctor facilitated introductions to other PRHOs at Woodlands and when they learnt of my research interests were happy to discuss their work in the doctors' mess over lunch or supper.

As Wax (1971) points out, it is frequently the bored or lonely who seek out the company of researchers. This was certainly the case with the medical staff. During a period of observation at night the PRHO, spotting me on the ward, inquired as to why I had not shadowed him and suggested I join him for the next few hours. The doctor explained that half the battle of being on-call was the social isolation. He was not busy and was grateful for my company until the time came for his scheduled sleep break.

In my relations with the medical staff my nursing background was important. It established me as someone with a knowledge of medical issues. I was anxious that I was accepted as someone who was receptive to the medical perspective also. It was my identity as a student, and in particular my status as a PhD student, that provided the common ground on which to build a rapport.

The Support Workers

The fact that I was interested in their work and wanted to hear their views was, I think, the most significant factor in helping me to establish my relationships with support staff. But as with the nursing staff there was a certain amount of suspicion about the purposes to which the information I was collecting might be put.

Interviews

Formal Interviews

All the interviews were tape-recorded. Most lasted between an hour to an hour and a half; some were as short as half an hour and one was as long as three and half hours. In all but 7 cases the interviews took place in private spaces away from the main working areas.[5]

The interviews may be best described as semi-focused. I had a set of topics I wanted to discuss. I did not have a list of standardised questions however, although for certain categories of respondent certain questions became more-or-less standardised as the research progressed. For example, I asked the nursing and support staff to outline the work activities in which they had been involved on the day of the interview. Their responses were then used as a springboard from which to develop further topics of conversation.

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[5] In one case the interviewee shared an office and the interview took place in the presence of the co-occupier. Two consultants were interviewed in the presence of their secretary and a further two were interviewed in the consultants sitting room when, for at least part of the time, another doctor was present. I also interviewed a nurse manager in the presence of her assistant with whom she shared an office. On nights I interviewed two auxiliaries together at their request.

I had hoped that the interviews would have a conversational flavour and indeed many of them did. Some were interactionally more difficult however, more closely resembling a job interview with respondents clearly anxious to be giving the 'right' answer. This was particularly the case with support staff but also true of some of the nursing staff. However hard I tried to define the interview situation as an informal occasion - 'as just an opportunity to have a chat away from the ward' - and despite explaining to staff that there were no right answers this was not always the way in which it was perceived. I myself found these interviews personally very unsettling and was grateful that they characterised only a minority of those I carried out.

Ethnographic interviews differ from standardised interviews in important ways. For example, Hammersley and Atkinson (1993) argue that the distinguishing features of ethnographic interviews are their reflexivity and lack of pre-formulated questions. Furthermore, in ethnography interviews are part of a much larger body of data on which the researcher may draw. Another important difference of which I became acutely aware is that an ethnographic interview is not an isolated interactional event. It is inextricably bound up with field relations and impacts upon the researcher and researched in important ways that continue to shape the data.

It is commonplace for methodological text books to emphasise the importance of establishing rapport with the interviewee before the interview takes place, but little has been written about the interview's impact on subsequent field

relations. On the surgical ward I found that my rapport with the nursing and support staff improved noticeably after I had started interviews. I had postponed conducting tape-recorded interviews until a month into the fieldwork because I wanted to use my observations as a way of shaping the focus of the interviews. Moreover, I felt that by spending time in the field I would already have established a rapport with those individuals I eventually interviewed. However, shortly after I started the interviews it became clear that the ward staff were discussing them amongst themselves and I found that as their informal style and non-threatening nature became common knowledge my relationships with the nurses significantly improved. As a consequence of my experiences on the surgical ward I began by interviews with the nursing and support workers at a much earlier stage in the second site.

Often during their interviews nurses and support staff used the opportunity to discuss interpersonal difficulties. In a number of the interviews I turned my tape-recorder off as staff broke down and cried, such was the strength of their feeling. I did not consider myself to be researching a sensitive subject and was therefore unprepared for this. I found the experience emotionally exhausting. Moreover, cast as counsellor or agony aunt, I was unable to direct the interview to cover all the issues I wanted to discuss. Given that I was to have a continuing relationship with those that I interviewed, to have attempted to do so would have been wholly parasitic. As I became more enmeshed in these complex web of relationships I experienced tremendous personal discomfort about different members' disclosures. There are clear

links here with the findings of feminist researchers who have underlined the difficulties of disengaging from the interview process (Oakley, 1979; Oakley, 1990; Stanley and Wise, 1983, all cited by May, 1993: 102-104).

Informal Interviews

I also carried out informal interviews with field members. These took the form of spontaneous extended conversations which were not tape-recorded but had a different flavour to the briefer discussions I had with staff as they worked. Much of the data generated on the medical perspective came out of informal interviews of this kind. I only carried out tape-recorded interviews with two PRHOs but in the course of shadowing medical staff I had extended informal conversations with three additional junior medical staff which lasted over an hour and shorter informal interviews with three others.

Documents

I have drawn on a wide range of organisational literature: formal public documents (patient information leaflets and strategic documents such as the hospital's application for trust status); formal internal literature (policy documents, job descriptions, minutes from meetings, memoranda, the hospital newspaper, duty rotas, team brief, ward philosophies, quality monitoring documents, medical and nursing records); and informal organisational literary culture (local staff notices, communication notes between staff, ward round books, and ward diaries).

Data Recording and Organisation

Field observations were recorded in a spiral-bound shorthand notebook. Notes were taken either contemporaneously or as soon as possible after the event. Fieldnotes were subsequently transcribed and fleshed out usually the same or the next day. On a few unavoidable occasions two days lapsed before notes were processed. Key findings of each field contact and their relationship to my developing theoretical ideas were recorded on a 'contact summary' *pro forma*. I maintained a separate file of memos in which I documented analytic ideas. In another 'strategy' file I made notes on the practical implications of the work - what to see, who to talk to, which meetings to negotiate access to etc. I also kept a diary in which I reflected on my own feelings on the research process and its impact on my life.

Over the course of the study the style of my fieldnotes varied. Initially I made abstract and generalised notes on lots of things. As the work became more focused my notes became more detailed. I recorded naturally occurring talk on those samples of social interaction that were central to the developing interests of the thesis. On the advice of my supervisors I employed a behaviourist approach to my fieldnotes and adopted a policy of keeping observations separate from my personal feelings, although I did not always succeed. I also had tape-recordings of interviews, meetings, study days, nursing handover and ward rounds. Tape-recordings of nursing handover and ward rounds were completely transcribed. Initially interviews were completely transcribed but as the developing themes of the research began to

emerge this was limited to relevant sections only. A note was made of the content of non-transcribed material, which provided a sense of the context for the transcribed data and allowed me to identify material that may have become relevant at a later date. I listened and re-listened to tape-recordings of meetings and study days. I transcribed relevant sections and made notes on the remainder of the contents.

Data Analysis

As Dey (1993) has argued, qualitative data analysis requires a dialectic between ideas and data analysis. This dialectic informs data analysis from the outset, rendering arguments about whether data analysis is based on deduction or induction redundant.

In the Field

As I have argued I began this study with a thorough grounding in the ethnographic literature and clear ideas about what areas of ward life I was interested in. At the same time, I also wanted to keep an open mind and was prepared to alter the focus of observations according to the themes emerging from the field.

To a considerable extent the fieldwork progressed along these lines. The labour intensiveness of the fieldwork however meant that the level of analysis I found practically possible was based on an intuitive grasp of what the important issues were, rather than the systematic and fine-grained analysis of

data implied in the methodological literature. Nevertheless, this did enable me to narrow the focus of the study as the data collection progressed and to theoretically sample key events and activities. On a number of occasions an unrecorded observation became relevant in the light of something that happened later and I made a note of this in my fieldnotes. I have termed this 'retrospective theoretical sampling'. On leaving the field a number of interesting themes had emerged and I had started to make links between them. I was able to map out a provisional plan of the thesis structure. Nevertheless, my overwhelming feeling was of intellectual chaos.

I adopted an holistic approach to data analysis - comparing data from different sources in order to make judgements as to how each piece should be interpreted. There was then a process of constant cross-checking in which slices of data were related to the larger picture in order to evaluate its meaning and, in turn, on the basis of my analysis of each snippet the meaning of the whole would itself be modified. As I shall demonstrate of particular importance in this study was the discrepancy between actors' reports of inter-occupational conflict and my field observations.

The selection of any research method inevitably entails a trade-off and whilst ethnography was the most appropriate research method given my research interests it nevertheless has characteristic weaknesses. A common criticism relates to the question of research validity. Put simply how does one know that the participant observer has not provided a totally subjective account?

As I have argued, Hammersley and Atkinson (1983) have provided some hints as to how these issues may be addressed in their discussion of researcher reflexivity. Following Hammersley and Atkinson, I have endeavoured to lay the research process bare in order to allow the reader to assess the validity of this account. Hammersley and Atkinson also recommend that the researcher reflects on his/her developing analysis as part of the research process itself. In practice I found this extremely difficult to do given the labour intensiveness of data collection. With hind-sight however, I realise that in the field I may have suffered from what Lacey (1976) calls 'the it's all happening elsewhere syndrome' (cited in Hammersley and Atkinson, 1983), a common ailment in fieldwork where the researcher feels it is necessary to try to be everywhere at once and to stay in the setting for as long as possible thereby leaving less time for theoretical reflection.

A further problem in much ethnographic work is the looseness of the relationship between the data and the analysis. Most ethnography seems to be an intuitive grasp of what's going on, based on the authority of the researcher as having been there and seen it (Dingwall and Strong, 1985). This is a criticism that I levelled at the negotiated order perspective in chapter 2. In writing this thesis I have endeavoured to make the material available in order that the validity of my analyses can be judged and other alternative interpretations made.

Computers

It had always been my intention to utilise a text database and productivity tool to assist with data management. *'HyperRESEARCH'* (1992) was already being utilised by staff within the School of Social Studies and, given my own lack of computing experience, it made sense to utilise a software package with which others were already familiar. To my horror however, I discovered that *'HyperRESEARCH'* (1992) had important software problems and was unable to perform the tasks I had in mind for it. Thus at the end of the second year of the research I was confronted with mountains of data and no qualitative data analysis package with which to manage it. The knowledge that qualitative data analysis had always been carried out manually in the pre-computing age was of little comfort to me at this time. I was surprised at how little advice was available on the use of computers in qualitative data analysis from within the academic community moreover. I had read a number of books on the subject (Dey, 1993; Fielding and Lee, 1991) but felt that what I really needed was face-to-face advice from someone who had employed computers in projects of their own.

I obtained copies of two qualitative data analysis packages for assessment. I was clear that in selecting software I wanted to utilise the computer as clerk rather than as a research assistant. In other words, I wanted a package that would assist in the management of the volumes of data I had, I did not want to employ the computer as a theory-builder. I had my doubts about the theory-building claims of qualitative data analysis packages. For someone

with minimal computing experience it seemed that computers had the potential to complicate the process of analysis rather than facilitate it. Moreover, my reading suggested that computer-assisted theory-building encouraged a fragmented and mechanistic approach to data analysis which had little room for intuitive reasoning based on a critical appreciation of the whole. Given that I wanted to get on with the process of writing my thesis I did not feel that I had enough time to invest in developing another skill about which I had reservations.

I eventually selected *'FolioViews Infobase Production Kit version 3.1'*. Unlike most qualitative data analysis packages *'FolioViews'* is a commercial package and not specifically designed for social researchers. The language in which its functions are described do not make its uses immediately clear. Guided by my partner, a computer expert, who was able to translate the functions of the package into my language, it became clear that this would be a useful tool. Most importantly it was very user-friendly.

Coding

I adopted an holistic approach to categorisation. Categories were based on my overall comprehension of the data, and reflected general themes and issues, rather than the line-by-line coding associated with grounded theory. This enabled me to access data relating to particular themes and to undertake more detailed analysis and sub-categorisation. Data were coded at other levels: according to key occupational categories, according to source - I differentiated

between fieldnotes, interviews, documents, and analytic memos - and according to broad field contexts - I differentiated between data generated on each of the wards and in other areas of the organisation. In this way I was able to employ Boolean style searches and take different slices through the data. For example, I could retrieve data coded under a single theme, as it related to the support staff interviews from one ward area. Furthermore, as I became increasingly familiar with the data I was able to quickly retrieve specific quotes by doing word searches within a narrowed frame of reference. It was a tremendous psychological boost once coding was completed and made the prospect of analysing the data and writing the thesis seem far less daunting.

In this particular study I did not employ *'FolioViews'* until the fieldwork was completed. In future projects I would utilise *'FolioViews'* from the outset. It is an extremely powerful tool for use in project management, enabling the researcher to link literature review materials, with analytic memos and research data. Moreover, its 'hypertext' link facility would greatly facilitate the concurrent collection and analysis of data allowing links to be made between raw data and analytic memos.

Reflections on the Research Process

Ethical Considerations

Informed Consent

I wanted to be as overt about my research interests as possible. There was no

reason for the study to be undertaken covertly and I would have felt deeply uncomfortable with anything other than an honest approach. I openly took notes and often walked about the ward areas within my note book in my hand. I did not often make notes during conversations as it tended to stifle the flow of talk but I did so overtly straight afterwards. For example, I would often remark - 'That's very interesting. I'd better go and write all that down before I forget it'. However there were occasions when I was privy to talk, particularly in the canteen, that participants might not have perceived as having relevance to the research. I reasoned that having been exposed to the information it would influence my interpretation of the other data I had and it was therefore more methodologically sound to record it.

Over the course of the fieldwork, as I have indicated, my research interests shifted to include nurses' intra-occupational boundaries, the boundary between ward nurses and general and nursing management and the boundary between nurses and patients and their relatives. I was open about this shift in focus and it did not have any bearing on the demands made on participants in the setting.

In setting out ethical considerations in the research outline I stated that the informed consent of all those participating in the research would be sought. This was easier in theory than in practice however. The research was more or less overt depending on the circumstances. Dingwall (1980) has highlighted the ethical difficulties caused by the strategy of minimal situational

intervention preferred by ethnographers. One particular difficulty I encountered was the continuous throughput of different personnel on the wards which meant that I encountered and observed many people during the course of the fieldwork who had little idea of my purposes. When it was appropriate I explained my research but on many occasions it was interactionally extremely difficult to have attempted to do so - arriving on the scene of a cardiac arrest whilst shadowing a junior doctor for example - and would have interfered unduly with the scene I was observing.

Maintaining Anonymity

Every effort has been taken to ensure the anonymity of field actors, by the use of pseudonyms for example. But there are real difficulties in maintaining anonymity in the case of certain individuals whose position in the organisation makes them more readily identifiable by someone with a knowledge of the field setting. Although in my discussions of the fieldwork I have identified individuals through their specific posts, I have made every effort to safeguard their identity in terms of the presentation of the data by the use of generic categorisations.

Patient Care Dilemmas

Within a few days of starting the fieldwork I was faced with a situation in which I had to decide whether to intervene in a patient's care on ethical grounds. I had assisted a nurse in taking an elderly patient from the toilet back to his bed. The old man was very frail and spoke little. After we had

settled the patient the nurse went to leave the bay. I noticed an untouched tray of supper on the patient's table. The meal was tightly wrapped in cling-film and from my short contact with this patient it was clear that he would require some assistance. When I asked the nurse if the patient needed some help she replied, 'I don't know. To be honest I don't take much notice of the one's that aren't in my team'. She then left the patient bay area. To my eternal shame I left with her. I do not know whether the elderly gentleman got his supper. At the time however, I was working very hard to break down the barriers between myself and the nursing staff and show myself as someone who was interested in their work and not concerned with assessing their practice. I reasoned that to have intervened at this early stage would have had catastrophic effects on my field relations. Shortly afterwards I raised the matter at the nursing interest group at the British Sociological Association Medical Sociology Conference where we reached no firm conclusions. Thankfully this was the only incident of this kind I experienced during the research.

Being a Nurse Researching Nurses

Throughout the course of the research I reflected on the effects of my nursing background on the research process. It had always been my intention to include a section on this within the methodology chapter of the thesis. In practice however it has been impossible to extricate the effects of my nursing background from discussions of the fieldwork role - it is woven right through it. There are a number of methodological issues worth separate discussion

however.

An issue raised in the methodological literature (Burgess, 1984) is of the relative advantages and disadvantages of the researcher researching settings with which s/he is already familiar. Having a background in nursing had a number of advantages. First, I was well-versed in nursing and medical 'speak' and so for the most part I did not have to grapple with understanding a strange language. Second, knowing that I had a background in nursing meant that I was perceived by participants as someone who knew 'what it was really like', a factor which I felt made respondents more inclined to give candid accounts of their action. Third, in negotiating access to the wards I was able to persuade gatekeepers that as a result of my nursing experience I had sufficient native wit to know when to keep a low profile.

The methodological literature suggests that familiarity with a setting may disadvantage the researcher in that s/he may not be able to recognise cultural patterns other than those things that are conventionally there to be seen. The way in which I endeavoured to deal with this was by taking detailed fieldnotes of my observations which, as I have indicated, had a behaviourist character. As Burgess (1984) has pointed out however, the debate concerning the degree of familiarity or strangeness the sociologist may encounter in a cultural setting has been polarised in some of the literature. The assumption seems to be made that situations are either totally familiar or totally strange. This is clearly not the case. As a nurse researching nursing I, like Robinson (1992),

was not studying a strange tribe. Nevertheless, I had not practised as a nurse for some six years and I had never worked at Woodlands. There were then many things that were strange to me. But as a nurse studying contemporary nursing issues I could only play the naive researcher to a limited extent with the result that many of the interviews I carried out and the conversations I had took a form that more resembled a dialogue between two people grappling with the problems facing practitioners in the 1990s. This was particularly the case with many of the senior nurses who, because of the positions they occupied within the organisation, had a special interest in the subject of my research.

The Research Experience

One of the chief difficulties I have encountered in conducting a study of an ethnographic nature is it's sheer labour intensiveness. As I have indicated this meant the extent of data analysis that was possible while the fieldwork was in progress was limited, despite scheduling breaks in data collection. This was a state of affairs that left me feeling both frustrated and inadequate. A chief lesson I had to learn over the middle year of the research was how to live with the intellectual chaos generated by masses of data.

Conclusion

I believe that the study would certainly have been improved had I interviewed patients and relatives about their part in the hospital division of labour, given the discovery of unanticipated tension at this nursing boundary. Equally

however, it is questionable as to how realistic that would have been within the time constraints of this particular project. Moreover, it would have been necessary to have sought approval through an ethics committee which would have introduced delays into the work. The issue of how patients negotiate their role in the division of labour in health care would certainly be an interesting sociological issue for future research.

PART 3

Boundaries

In the preceding chapters I have set out the historical, political, and methodological background to the thesis. In Part 3 I want to begin to describe the social and organisational context in which the nurses in this study accomplished occupational jurisdiction. In chapter 5 I will introduce the main social worlds of Woodlands hospital. I shall describe the locale and the wards on which this study is based and introduce the key players in the work drama: nurses, doctors and support workers. In chapter 6 I shall describe the ways in which Hughes' concept of dirty work alerted me to tensions at key nursing boundaries. I analyse nurses' dirty work designations in order to explore the nursing perspective.

5. The Social Worlds of Woodlands Hospital

The purpose of this chapter is to introduce the setting in which the research took place. I begin by describing the hospital, the local community, and the two wards on which my observations were primarily focused before going on to introduce the key players in this thesis: nurses, doctors and support workers.

THE HOSPITAL AND LOCALE

Woodlands is a district general hospital situated in the middle of England. It has almost 900 beds and provides general, acute, obstetric and elderly services to a local population of 254,000. At the time the study was undertaken the hospital had an annual budget of £60 million and employed about 2,800 staff.

Along with two other local hospitals Woodlands had formed an NHS trust in 1993, delivering services previously provided by the General Hospitals Unit which it replaced. It had, however, been a third wave resource management site in 1990 and had undergone significant changes in management structure and style before acquiring full trust status. A system of 11 clinical directorates had been established and key management functions devolved.

This merged the management arrangements for all three hospitals. At the time the study was undertaken clinical directors controlled over 65% of Trust expenditure and there were plans for further devolution. Each directorate had a clinical management team headed by the clinical director who was a consultant, and included a general manager, nurse manager and accountant. The clinical directors were members of the Trust management board.

I first visited Woodlands Hospital four years before this study began. On this occasion the encounter was brief and, preoccupied as I was with the well-being of my son, I retained few lasting impressions. The hospital was much the same as the others in which I had worked over the preceding seven years. Returning to the hospital four years later however things seemed very different.

Since my initial visit in 1989 Woodlands Hospital had witnessed the large scale organisational changes in the NHS heralded by the *'1990 NHS and Community Care Act'*. The reforms were wide-ranging but the thread most evident on revisiting the hospital was the emphasis on the patient as consumer of health services. Woodlands did not look like the hospitals with which I was familiar. Cold grey eggshell walls had been replaced by soothing pink and floral borders. Areas of the floor were now carpeted. On the walls, picture boards introducing department staff were interspersed at intervals by quality assurance notices, and consumer suggestion boxes.

This was the outpatients department however, which was the shop window of the hospital and, as I was later to discover, generally regarded as something of a showpiece. Moving further into the building the sights became more familiar. I discovered a restaurant with its daily menu chalked on a blackboard outside the entrance. Inside, orange plastic chairs arranged around formica tables were set against fluorescent strip lighting, dark orange wall-paper and beige tiled floors. It was a combination altogether more reminiscent of the hospitals in which I had worked. The contrast with the outpatients department was striking but, as I was later to discover, such symbols of the old and new order were regularly juxtaposed at intervals throughout the hospital.

The chief executive's corridor is carpeted in blue with a red surround. It gives the impression of the 'red carpet treatment' [...] The walls are painted in a pastel pink colour with a border at waist level. All the woodwork is pine [...] By contrast the nursing corridor is more clinical in appearance - its walls are painted a plain beige and the floor is a 'lino' type flecked effect. A few water colours decorate the walls and there is a rectangular planter with plants in it.

Woodlands hospital is situated in what was once a major industrialised area. For over two centuries heavy industry had been the principal employment in the town. Between 1978 and 1987 more than 8,000 jobs were lost. Much of

the industry had gone forever with large areas undergoing extensive regeneration - a pristine shopping complex now stands where once (mainly) men toiled. With the decline of its industrial base, Woodlands hospital had become the largest employer in a locality blighted by high levels of unemployment. Local shoppers had witnessed the gradual replacement of big names in the town's high streets by bargain basement stores. In 1995 a report on poverty undertaken by the Borough Council's Anti-Poverty Unit revealed unemployment in the area to be 16 percent (about 6 percent higher than the national average), with local employers offering some of the lowest rates of pay in the country. Over four thousand jobs had been lost between 1990 and 1995, leaving 20,000 people without work (8% of the total local population). More than 55,000 (22%) of the local people were receiving income support. Many of the women working in the hospital were the principal breadwinners in their household - a significant role reversal in a traditional working class community.

> Jenny (staff nurse) explained that she was the sole bread winner in her household - she described how she broke down and started crying in the bank when she got her pay check because it was so low.

The community was closely integrated. I had lived in the area for six years and, as someone who was not born and bred in the locality, had always felt an outsider. Without the distinctive regional accent one was immediately

marked as 'not from round ere'.

Woodlands was ostensibly a local hospital. It was the name of the town that was given most prominence on the corporate logo. In its mission statement Woodlands' stated aim was to provide the best in hospital care for the people of the town.

Not only did it concentrate on serving the immediate community, Woodlands also drew on the local people for most of its non-medical staff. One senior manager suggested that 80-90% of the hospital staff were local people. Few of the nurses who trained at the hospital came from outside the immediate area. Even the term 'local' was used in the narrowest possible sense. People from towns less than five miles away were perceived as different. Nurses who did not train in the hospital never quite fitted in it was felt.

> *I'm an outsider even though I've been here a long time. I didn't train here so I'm an outsider.* (Senior Nurse)

Woodlands hospital, like the local community it served, had a cohesive culture. Hospital employees included many members of the same family. Hospital wide activities - staff lottery, art competition, summer fete and hospital outing - aimed to further facilitate this integration, but as the following extracts from my fieldnotes show this was differentially experienced as friendly or oppressive depending on one's viewpoint.

I like it because it's not big. You know most of the people in the canteen or if you don't they'll always say hello to you. Like I smoke [...] You can always find somebody to sit and have a natter with. It seems quite sociable. (Staff Nurse)

She explained that [...] the pregnancy was not planned. She said that she had needed time to get her head round it herself so she did not tell anyone. This hospital is such a gossipy place, she said, that I decided I couldn't deal with people questioning me so I didn't tell anyone.

In terms of its clinical work however, there was a sense in which Woodlands functioned in the shadow of the large teaching hospital in a neighbouring town.

We were all very worried that we wouldn't get on with the new consultant. He'd come from Greensleeves hospital - I suppose everybody thinks that Greensleeves' got so much more than what Woodlands has and I'm pretty sure it has. Perhaps he'd come from a dynamic team and whether if coming to Woodlands was like a step down because we weren't as dynamic. (Sister)

Considerable effort went into selling the hospital and promoting a slick

corporate image. Woodlands employed its own marketing manager. As the fieldwork progressed I became aware of the variety of ways in which the organisation was promoted both locally on hospital vehicles, badges and public information literature and, more widely in the glossy folders in which prospective employees from outside the area were sent job details. Clinical staff were frequently derisory about the effort put into organisational 'impression management' (Goffman, 1959).

> Clare showed me some coasters with the hospital logo on, which apparently had been organised by the marketing manager. I asked what they were for. She said that she did not really know - but she thought it was for when people came to visit the hospital so they could put their coffee on them. She said rather sarcastically that it was all about marketing.

> As I sat at the table at the far end of the ward this morning I overheard the SEN nurse talking to the patients about the hospital and the NHS. She was complaining about the ways in which the hospital chose to spend its money - 'on posh carpets and things like that rather than on things for the patients'.

WORLDS WITHIN WORLDS - THE WARDS

The principal focus of this study was on two wards: Treetops - a 33-bedded

surgical ward - and Fernlea - a 34-bedded medical unit.

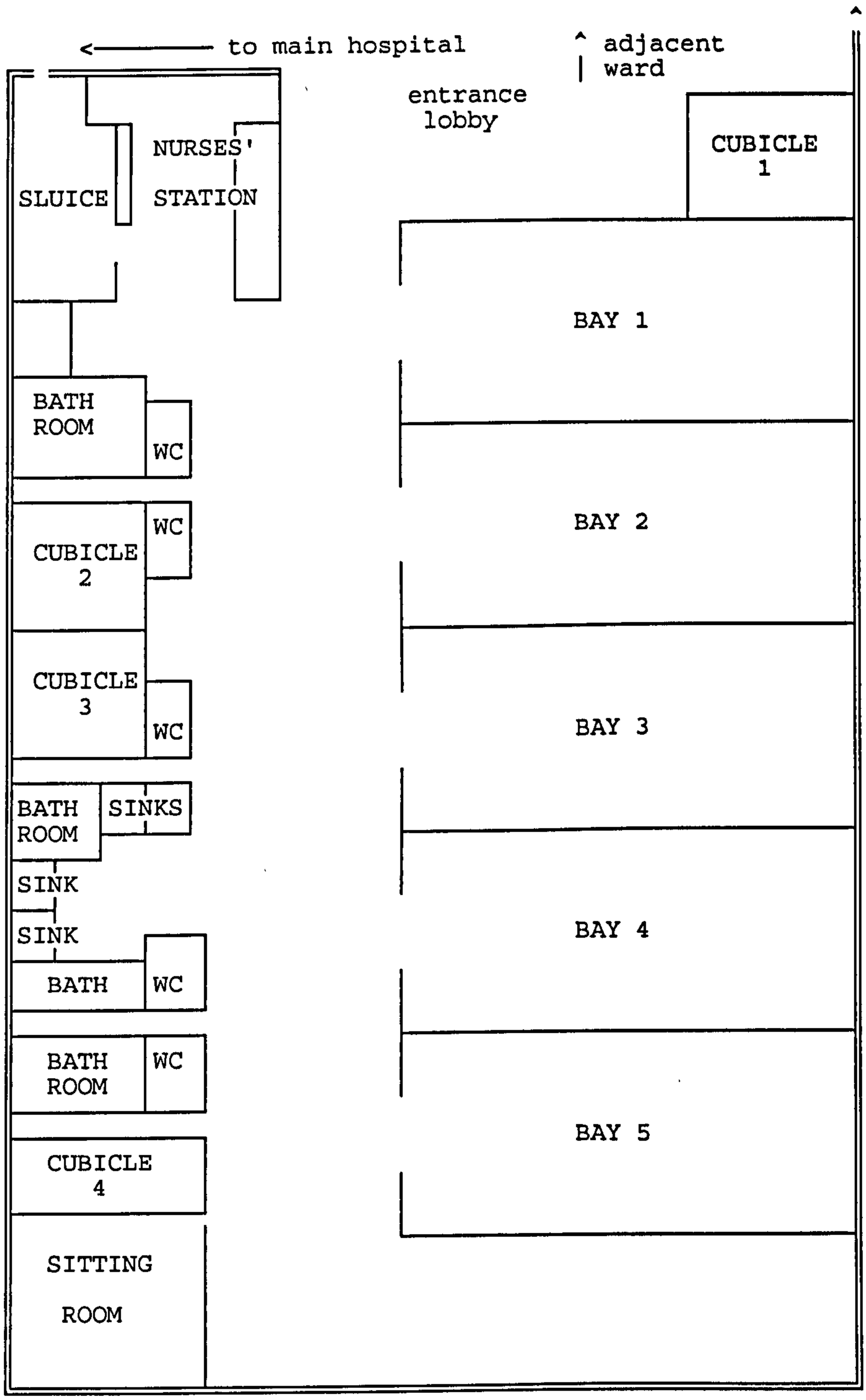
Treetops and Fernlea were two of a group of four wards which ran end-to-end, the length of one side of the main hospital building. The only physical separation of the wards was a partially glazed door between the middle two wards, which effectively separated the four wards into two pairs. Access to each pair was via a corridor which branched off from the central trunk of the hospital. Treetops was coupled with a fellow surgical ward and Fernlea with another medical ward. The physical arrangements of the two wards were more or less identical.

Approaching the wards from the main hospital thoroughfare, signs directed you to the end of an office-lined corridor where a ward stretched out at right angles on either side. The two wards were continuous and, to the uninitiated it was not immediately apparent where one ward started and the other ended. The only boundary-marker between the two wards was a shared entrance lobby where two steel linen trollies stared at each other blankly from under half open tarpaulin covers. Two single patient rooms - one for each ward - were also situated in the lobby area.

The ward area spanned either side of a central corridor. One side comprised five, six-bedded patient areas with large windows that overlooked one of the numerous hospital car parks. The patients' bays were separated from the main ward corridor by a partially glazed panel maximising patient (and

nursing) visibility. On the other side of the corridor were the toilet and wash areas, a rarely used patients' sitting room, and three other single-bedded rooms. On Treetops ward one of these rooms had been converted into an office for the nurse practitioner. Pieces of equipment, hidden under covers, flanked the central corridor with its sludge grey marble effect floor. Fluorescent strip lighting illuminated public information notices which lined the walls opposite the patient bay areas.

At the entrance to the ward, facing the first patients' bay area was the nurses' station. This was the focal point of ward activity. Behind the nurses' station to the right lay the sluice and to the left was a small recess which housed the ward computer, drugs trolley and fridge. One side of the recess was entirely devoted to storage. On each ward a cupboard had been procured by nursing staff for their personal belongings. The recess was a backstage region - the only area on the ward where patients were not permitted access - and it was in here that nurses and support staff would retreat for an informal break if workload pressures permitted. The only other staff to utilise this space were the doctors who mainly used it in order to access the computer. On the wall in this area there were a number of notice boards where information for ward staff was displayed.



Ward Layout (not to scale)

Treetops ward was a mixed-sex urology ward. The majority of the patients attending the ward were men undergoing surgery or investigation of the prostate gland or bladder. Less commonly, patients who had undergone surgical removal of a kidney or the bladder were cared for on the ward. Although managed under the surgical directorate the ward also catered for patients suffering from urological conditions where no immediate surgery was indicated - for example, renal colic and urinary retention. During the period of the research patients in the terminal stages of bladder or prostate cancer were admitted to the ward although plans were in place to change this in the future and care for them on the elderly medical wards.

Like Treetops, Fernlea was a mixed-sex ward but the population was more varied in terms of the conditions the patients were admitted with. 10 beds were allocated to rheumatology patients and the remaining 24 to patients with acute medical conditions. Nurses on the ward cared for patients with a range of medical problems - cardiac, respiratory, vascular and gastric disorders - alongside patients admitted for management of rheumatoid disease. The allocation of beds to rheumatology patients on Fernlea was regarded by both medical and nursing staff as unsatisfactory. The rheumatologist felt that the pressures on nurses from the acute medical side meant they were less involved with the rheumatology patients than they had previously been when rheumatology patients were housed on a 'dedicated unit'. Many of the nurses found caring for rheumatology patients less interesting than caring for the other types of patient on the ward.

Staff Nurse: (M)ost of us came to this ward wanting to do acute medicine not rheumatology.

I think rheumatology patients tend to be a little second best on the ward because well the care that they get is very - what's the word - it's very much the same. There's nothing acute about it. Do you know what I mean? It's boring really. Looking after rheumatology patients is boring. (Staff Nurse)

Compared to Fernlea ward, patient throughput on Treetops was rapid. According to the ward activity analysis figures, during the period I spent there the average length of patient stay was 5.1 days. The nurses frequently struggled to differentiate one patient from another. In comparison to other speciality areas however, the urology ward was regarded by nursing staff as having a relatively 'light' workload.

Tanya explained that compared to other surgical wards the men on urology recovered fairly quickly from their operations and were therefore relatively independent. She drew a comparison with a previous ward she had worked on where the patients often had abdominal wounds and were unable to do very much for themselves. She said that gastric surgery could be very 'heavy'.

Patient throughput on Fernlea ward was slower than Treetops - the average length of patient stay was 8 days during the period I spent there and compared to the surgical ward the pressure on medical beds was intense.

> (Senior Nurse) said there were an average of 40 medical admissions per day for February.
>
> *(I)t's a case of survival in terms of keeping the bed numbers, because with the pressure of admissions in acute medicine - you know - one has to sort of try and arrange it where possible such that the patients are going out on days that the arranged admissions are coming in and if you don't do that when things are really bad in the winter months then one's own arranged admissions end up being cancelled.* (Consultant)

The average daily bed occupancy on Fernlea during my field observations on the ward was 31 out of a total bed availability of 34. On Treetops however, empty beds were fairly common. Throughout my time there the average daily bed occupancy was 22 out of a daily bed availability of 33. Towards the end of my fieldwork on Treetops, bed occupancy was unusually low as one of the urologists had reduced his admissions dramatically as he was leaving the hospital. Moreover, my observations ran up to Christmas; one must therefore take into account the effect of the holiday period on routine operations - which were stopped about two days before Christmas - and consequently on the

numbers of patients on the ward.

One of the striking features of Treetops ward was the dramatic changes in the pace of the work. During the week the nurses' daily work rhythms were characterised by periods of frenetic activity punctuated by lulls. An atmosphere of busyness was associated with the daily theatre timetables - either the processing and preparation of patients for theatre or their close monitoring in the immediate post-operative period.

Normally patients went to theatre every day of the week. Nurses regularly moved patients' beds around the ward bed spaces in order to allocate high dependency beds to those patients who had undergone surgery most recently. Wednesdays were particularly busy as operations were performed in both the morning and the afternoon. The numbers of patients going to theatre in one day depended on the nature of the operations to be performed and the time this involved. If the operations were fairly short then five or six patients could go to theatre in one session. Compared to the week, weekends were comparatively quiet. Nurses used this time to prepare the paperwork for the next week's routine admissions.

On Fernlea ward the pace of work was steadier. To be sure there were daily peaks and troughs of activity but these were less predictable and related more to unforeseen changes in the condition of patients or unexpected admissions rather than the demands of external organisational timetables as was the case

on Treetops.

> Saturday it was like a nursing home. They were all well. There was only Mrs Daley who was unwell. Then Sunday it was more like ITU! They've all got PEs (pulmonary embolism) it seems. (Sister)

Furthermore, although the absence of ward rounds eased the pressures of work on nursing staff at weekends the contrast between the work rhythms on weekdays and weekends was not as marked as it was on the surgical ward.

I began my fieldwork on the urology ward and quickly became accustomed to the equipment which crammed bay one on theatre days and the sight of patients walking around the ward carrying their catheter bags full of blood stained urine and irrigation fluid in one hand and often, pushing a drip stand with the other. The sights, smells and sounds on Fernlea were altogether different and, in the early days despite my nursing background I found them quite unsettling.

> On Treetops I became used to men walking around with catheters in their hands and blood stains on the fronts of their pyjamas. On here I've felt sickened by some of the sounds and smells. There are hacking coughs, awful sounds of flatulence that go on and on, burping. A brown and blood streaked

sputum specimen has been on the front of the nurses station for two days now. I feel sick looking at it but nobody else takes any notice. A patient provided the nurses with a stool specimen first thing this morning and the stench was absolutely nauseating [...] Nobody commented.

Both wards were staffed by a combination of qualified and unqualified nursing staff and students in training. The nursing team on Treetops comprised: 1 G grade sister or ward manager, 1 F grade junior sister, 2 E grade senior staff nurses, 10 D grade junior staff nurses, 1 C grade SEN, 3 health care assistants and 3 auxiliary nurses. All the auxiliary nurses worked part-time and only one of the health care assistants worked full-time. One of the D grade staff nurses worked part-time hours and was employed on a six month contract. Third year student nurses had placements on the ward and were also included in the nursing numbers. During the period of my fieldwork there were two groups of students on the ward - there were five students in the first group and three in the second. Medical staff comprised one permanent and one locum consultant urologist, and 2 SHOs. The SHOs shared the ward work with a nurse practitioner whose post was set up out of money made available through the junior doctors' hours initiative.

The Fernlea nursing team included: 1 G grade sister or ward manager, 1 F grade junior sister, 2 E grade senior staff nurses, 8 D grade junior staff nurses, 1 health care assistant and 3 auxiliary nurses. One auxiliary and one

D grade staff nurse worked part-time. The ward had third year Project 2000 students who were also included in the staffing numbers. There were two groups of students on the ward during the period of the fieldwork. There were three students in each group. The ward had two consultants - a rheumatologist and a general physician who had a specialist interest in gastroenterology. The general medical team comprised: the consultant, registrar, SHO and PRHO. The rheumatology team comprised a consultant, staff grade doctor and SHO.

During the period of the fieldwork the numbers of nursing staff on both wards were undermined by long-term sickness. On Fernlea ward, two staff nurses were on long-term sick leave. One returned to work two weeks before the fieldwork ended. On Treetops, a staff nurse, a student and an auxiliary were off sick for most of the time I was on the ward with back injuries and another had a prolonged period of absence owing to food poisoning. A senior staff nurse was also absent as she was attending a course.

Summary of Ward Staffing

	Treetops	Fernlea
G grade sister	1	1
F grade sister	1	1
E grade staff nurse	2	2
D grade staff nurse	10	8
C grade SEN	1	
Students	5/3	3/3
HCA	3	1
Auxiliary	3	3
Consultant	2	2
Staff grade		1
Registrar		1
SHO	2	1
PRHO		1
Nurse practitioner	1	

THE PLAYERS

In this next section I introduce the key players in the hospital work drama: nurses, support workers and doctors.

The Nurses

The nurses can be considered in terms of four broad groups: senior nurses, nurse practitioners, ward-based nurses and students.

Senior Nurses

This group comprised nurse managers and specialist nurses.

Nurse Managers

The four nurse managers formed a fairly loose group, scattered as they were in different offices across the hospital and coming together for the purposes of meetings only. All were mature women who had reached their posts by virtue of their extensive nursing experience. The nurse managers were members of the clinical management teams (CMTs) responsible for the management of directorates. When I started the research the clinical management team was headed by the clinical director who was a consultant. The nurse manager and general manager assisted the director as equals. In one directorate the post of nurse and general manager were combined. During the course of the research however, the hospital chief executive gave each directorate the opportunity to alter its management structure making the

general manager the direct deputy to the clinical director and effectively relegating the nurse manager to a junior role. Not all of the CMTs elected to change their management structure and in some that did it made little practical difference to the personalities involved. Nevertheless, many saw the move as sounding the death knell for nurses in management at Woodlands.

> *(P)eople of my breed are an endangered species. Nurse management just seems to be a tier that is in between and is going [...] There used to be about eight nurse managers here until a few years back and here we are with just four. So it is a dwindling grade and I'm not of a retiring age so I don't really know what's going to happen [...] I'm too young to retire and perhaps too old to change [...] But if I am to go down - I'll go down fighting.* (Senior Nurse)

Specialist Nurses

The specialist nurses can be considered as two distinguishable groups. I have called the first group 'the fledglings' because this is a label that they had applied to themselves in order to illustrate their belief that they were being groomed for higher posts in nursing by the Director of Nursing. There were four nurses in this group, all were women in their late twenties and early thirties and younger than the nurse managers. They had all been ward sisters early in their careers and had either undertaken, or were in the process of undertaking, diplomas or degrees in nursing. The specialist nurses had

responsibility for specific areas of nursing practice: Project 2000 and professional development, tissue viability, infection control and nursing audit. The specialist nurses formed a cohesive group and shared an office on the same corridor as the director of nursing.

The second group comprised two male specialist nurses who shared an adjacent office. Both were in their late thirties. One was the IT project leader responsible for the implementation of a computerised ward management system and the other was the quality manager.

The specialist nurses' offices were situated in the management corridor, whereas the nurse managers' offices were situated near the ward areas. Despite coming together regularly for meetings the managers and specialist nurses remained distinct factions within the senior nurse group.

Nurse Practitioners

Over the course of the research there was a growing number of nurse practitioner posts at Woodlands, covering a range of clinical areas such as urology, rheumatology, IV cannulation, pain control, colposcopy and general surgery. Although Woodlands already had nurses employed as clinical specialists in areas such as cardiac rehabilitation, most of the nurse practitioner posts had all been set up in the context of the hospital's efforts to reduce the hours worked by junior doctors. Some of the positions were ward-based, some practitioners worked throughout the hospital, others operated

from outpatients clinic and others' activities took them to both primary and secondary care sectors. It would be misleading to describe these nurses as a definite group however. They had disparate roles, different titles, and wore different uniforms. Nevertheless, most of the posts were new and their incumbents were still developing the role. Furthermore, these nurses were increasingly being brought together at meetings and it seemed likely that in the future they would develop a greater sense of their collective identity.

Ward-Based Nurses

This was the largest group of nurses which embraced all qualified nursing staff permanently attached to the wards - SENs, staff nurses and sisters. These nurses were at different stages in their careers and had worked on the wards for varying lengths of time.

On Treetops the nursing staff fell into two camps: 'homeguard' (Hughes *et al*, 1958) and 'newcomers'. The 'homeguard' nurses were older and had extensive urology experience. Some of them had worked together for 14 years and the senior sister, a senior staff nurse and enrolled nurse had been friends for twenty-five years. The 'newcomers' were all junior staff nurses who had recently qualified and had worked on the ward for less than a year. Ward staff typified themselves in terms of the 'older' and 'younger' nurses - although the divisions between staff actually related less to their chronological age and more to the length of time they had worked on the ward.

There was no such division on Fernlea ward. Only one of the staff nurses had qualified within the previous twelve months. The others had worked on the ward for at least eighteen months and one for as long as nine years. A significant number of the ward nurses had worked together for between two to five years. Overall at Woodlands turnover was slow and the staff stable.

Students

Within the nursing body students formed a distinct group in as much as they were transient members of the ward team and unqualified. During the period of the study the students on the wards were all in their third year of training and therefore quite experienced. Although as a result of Project 2000 students' contribution to service provision has been reduced, all the students I encountered on the ward were included in the ward staffing numbers. As a group the students had quite specific concerns: successfully completing their studies, gaining the practical experience on the ward they felt they needed to function as a competent staff nurse, feeling part of the ward team and, ultimately - getting a job in the hospital once they had qualified.

The Support Workers

Throughout this thesis I use the term 'support worker' to refer collectively to auxiliary nurses and HCAs. It is a term that might be equally applied to ward clerks and domestics in the sense that their work supports that of nursing staff and includes tasks that historically have come under nurses' jurisdiction. For current purposes however, I employ the term in a more limited sense to refer

to auxiliary nurses and HCAs only.

As I described in chapter 2, unqualified nursing auxiliaries have long been the proverbial thorn in the side of nurse professionalisers. Contrary to much nursing rhetoric, unqualified nurses - students and auxiliaries - have historically undertaken most of the direct physical tending of patients. The introduction of Project 2000 and the reduction in student nurses' service contribution saw the entry of the HCA, a 'new' support worker, to be trained to undertake a wider range of tasks than the traditional auxiliary, within a framework devised by the National Council for Vocational Qualifications.

It seemed that there were few national guidelines on HCAs however, and it became apparent that there was local variation in the development of the role. For example, one hospital in the region had made all its existing auxiliaries HCAs over night - simply by changing their job title. At Woodlands however, the HCA and the auxiliary were formally distinct roles. The HCAs had a different title and job description and, although they wore the same dresses as auxiliary nurses, they were provided with different coloured belts. There was talk of a more distinctive uniform.

The official limits of the HCA role had been agreed by senior nurses and ward sisters within the organisation. The extent to which HCAs practised within these formal boundaries was to be determined at ward level however.

Senior Nurse: (Y)ou are working in very different areas and your areas have very different needs of you and those needs will vary from time to time and I can't go along and say to you, 'You will be doing this, this, this and this'. All I can do is say to you, 'As an organisation [...] we have things that have been agreed for you to actually start to undertake. (Training day - Tape)

Unlike the auxiliaries who developed their skills on the job, the HCAs undertook classroom-based learning. A 25-day training course was devised and taught by the senior nurse at Woodlands with responsibility for the implementation of Project 2000. At the end of the course, HCAs were given 'log sheets' which had to be completed by ward-based nurses once they were satisfied with the HCA's competence in specific areas of practice.

In addition to the 'in-house' training, HCAs had the opportunity to undertake an NVQ at level 2. NVQs at Woodlands predated the HCA role and had been originally introduced as a 'feel good' factor. Auxiliaries had been given the opportunity to undertake NVQs and senior nurses had assumed that in the future these individuals would become HCAs. In practice not all of them did. The result was that the training background of support staff at Woodlands was only partially reflected in formal occupational status differences.

Most HCAs had been functioning members of their respective ward teams

long before they entered the classroom though. Many of their skills, like those of the auxiliaries, had been acquired on the job. Moreover, it was not qualified staff from whom they learnt their skills, but the more experienced support workers on the wards in which they worked.

> They have had a new auxiliary nurse start on the ward. It is her second shift [...] (Sister) was telling the auxiliary about things to remember - giving the men a shave, pulling the curtains back, collecting any empty medicine pots, making sure the medicine pots were dried properly.
>
> *Sister*: Paula's (HCA) on tonight you can ask her. Do you know Paula?
>
> *Auxiliary*: Yes I worked with Paula yesterday.

Formally, the HCA role was wider than that of the traditional auxiliary and embraced certain technical procedures that had previously been the remit of qualified nurses, such as measuring and recording temperature, pulse and blood pressure, collecting blood from the blood bank, taking patients to theatre, removal of IV cannulae, and the removal of urinary catheters.

> *Senior Nurse:* (A) health care assistant is an auxiliary plus a little bit more on top. (Training day - Tape)

On the wards at the time of the research however, for a number of reasons,

the work of HCAs was barely distinguishable from that performed by auxiliaries. In part this reflected the newness of the HCA role. Many of the HCAs were still undergoing training. On Treetops, two out of the three HCAs on the ward were relatively inexperienced. Janice had been on the ward a year. She had completed her in-house training but still needed to be assessed by ward staff on certain practical skills. She was completing her NVQ. Caroline joined the ward staff whilst I was there and was a functioning member of the ward team although she had not started her in-house training. Following the lead of her fellow support workers Caroline began to undertake certain technical procedures - such as the removal of intravenous infusions (IVIs) and urinary catheters. After she had been on the ward a few weeks, senior nurses on the ward decided that her role should be restricted to basic nursing care activities until she had completed her training and had been assessed and deemed competent by qualified staff. Privately, the support staff on the ward were very critical of the senior nurses' lack of clarity regarding the HCA's jurisdiction.

On both wards the role of experienced HCAs was also limited. On Fernlea the only activities the HCA undertook that were different from those undertaken by auxiliaries were observations and the removal of intravenous cannulae. Within the formal parameters set by the Trust however it was difficult to see what else she could have done on the ward. On Treetops it was the informally extended practice of the auxiliaries which accounted for the blurring of the support worker roles.

Historically, Woodlands hospital had experienced difficulties in recruiting qualified nursing staff and as a consequence of pressures of work, auxiliaries had been entrusted to undertake activities outside of their official remit. On Treetops two of the auxiliaries had over ten years experience on the ward. During this time they had extended their role to embrace much of the 'little bit extra on top' that supposedly distinguished the HCAs from the auxiliaries such as the removal of IVIs and urinary catheters.

Owing to my difficulty in distinguishing the HCA and auxiliary roles I focused my observations on nurses' management of the support worker in general, rather than concentrating specifically on the HCAs as I had originally intended to.

Support workers were members of the permanent ward team. They worked the same shift system as nursing staff but were much more likely to work part-time than qualified nurses. They were all women. Taken as a whole the support workers formed a diverse social group. It is useful to consider them in terms of their orientation to work. I have identified four support worker types: careerists, opportunists, pragmatists and conscientious objectors.

Careerists

This group included both auxiliaries and HCAs who regarded the work as offering them an alternative route into either nursing or a related paramedical profession. Some members of this group were taking night classes to increase

their formal educational qualifications. Moreover, many had sat the entrance exam designed to facilitate entry into nursing for those without the requisite formal educational qualifications. The women in this group were all under thirty-five years of age and had worked in the hospital for about 12-18 months.

Opportunists

This group comprised women who had previously worked in the organisation as auxiliaries and had taken the opportunity to become HCAs in order to increase their intrinsic job satisfaction but who, unlike the careerists, had no ambitions beyond this. The women in this group tended to be older than the careerists.

Pragmatists

This group included both HCAs and auxiliaries. These women had established a comfortable balance between their paid and domestic work - and saw no reason to upset this. Their work was satisfying, helped pay the bills and gave them social contacts. Included in this group were women with extensive experience as auxiliary nurses - many over ten years - and who for various reasons had elected not to apply for any of the new HCA posts. It also included newly appointed HCAs with no career aspirations beyond the post they currently held.

Conscientious Objectors

This group comprised those support workers who limited the activities they were prepared to undertake believing that they ought to be financially rewarded for taking on additional responsibilities. This group included experienced auxiliaries who had not become HCAs, auxiliaries on nights who had NVQs which allowed them to undertake observations of patients' vital signs but refused to do them, and an HCA who believed she had taken a job as an auxiliary only to be told she was an HCA and who did not want the additional responsibilities of the role but did not want to leave the ward.

Night Staff

The ethnographic literature suggests that temporal roles can become the basis of social solidarities that cut across conventional lines of social differentiation (Zerubavel, 1979; Wessen, 1958). At Woodlands the night workers constituted a distinct social group which included nurses and support workers.

Whereas the primary focus for day staff was the ward, night staff - although themselves also ward-based - had a stronger sense of their identity as whole. There seemed to be a number of reasons for this. First, night staff had only recently become ward-based. In the past they had worked all over the hospital and were therefore much more likely than the day staff to have worked together. Second, there were fewer night than day staff, thus it was easier for them to know everyone. As one nurse remarked:

> '(W)hen you go to the dinning room on days there's that many people in there, whereas on nights there's not that many and so we all tend to sit with each other. So we all know each other and more or less where everybody works.' (Staff Nurse)

Third, owing to the small number of nurses on the wards at night, staff were frequently moved around the hospital in order to cover meal breaks - a practice which further facilitated the integration of the group. Fourthly, night staff did not feel the same compulsion as day staff to look busy when they were not. Quiet periods could be used for sociable activity and relationship building more readily than was possible on the day shifts.

Finally, as Robboy argues (1979) although working at night does not lead to the formation of a deviant identity off the job, a deviant identity can emerge during the hours of work. Such an identity is temporally situated at the workplace and reinforced as the night workers are compared with those on the other shifts. This deviant identity can act as a strong bonding mechanism.

The principal reason given for working nights by most of the women was because it allowed them to easily combine their paid with their domestic work.

> *Auxiliary*: It (night duty) fits in with the kids. I don't want them to be latch key kids. I'm there for them in the morning to get them ready for school and then I get up around four so

I'm there in the evenings. I think the family should always come first and I work around them.

The one exception to this was an auxiliary who worked nights because it allowed her to undertake hairdressing during the day.

The Doctors

In undertaking this study I talked to doctors at all levels of the medical hierarchy - from the medical director to the pre-registration house officers. It was with the perspective of junior doctors that I was primarily concerned however. Formally the term junior doctor refers to all doctors in training posts - this includes the PRHOs, SHOs and registrars. The medical division of labour at Woodlands was such that in practice the registrar spent relatively little time on the wards. Consequently my observations and conversations focused primarily on the social world of the SHOs and PRHOs.

In response to the political pressures associated with the *'New Deal'* (1991), the working arrangements for junior doctors at Woodlands hospital had been amended in the four years immediately preceding the research. Junior doctors' were contracted to work a fifty-six hour week and in all but a few speciality areas this had been achieved, principally through the employment of additional consultants and junior medical staff and the reduction in the number of on-call duties worked. Junior doctors at Woodlands hospital were now, officially at least, on-call one day in six. Medical staff were expected

to cover the work of their colleagues for periods of absence however - prospective cover - which meant that in practice on-call duties were often one day in five.

On a normal day a doctor worked from nine to five. During this time PRHOs were responsible for the routine ward work, much of which was administrative.

> *(M)ost of my days are just doing, just basically doing things like discharge summaries, TTOs (writing prescriptions for patients to take home), writing out drug cards, ordering investigations, getting the results of investigations and seeing that everything is ready for the next ward round really. And sorting out whatever problem that might crop up - patient-wise during the day.* (PRHO)

On Treetops ward as there were no PRHOs the routine ward work was shared between the SHOs and the urology nurse practitioner. The SHOs spent less time on the wards and were more involved in seeing outpatients. The SHOs on Treetops also spent a lot of time in theatres.

Only Fernlea ward had a registrar. The role of the registrar was to 'overview' the running of the in-patients. The PRHO and SHO looked after the day-to-day management of patients, whereas the registrar came to the

wards about three times a week. The registrar also worked in outpatients clinics and undertook administrative work. The registrar saw himself as the link between the consultant and the juniors.

The on-call period began at 9am and ran until 9am the following morning. During the week the on-call team were responsible for all admissions to the hospital in their particular directorate and after five O'clock they provided emergency cover for the wards in this area also. At the weekend or on public holidays the on-call team were responsible for both the ward work and emergency admissions for the full 24-hour period. Woodlands practised a team on-call system. This meant that the on-call doctors did not necessarily work for the same consultant or firm, rather they formed a team for the purposes of the on-call period only. The on-call team had four members and was headed by the registrar who acted as overseer to his more junior colleagues - the SHOs and PRHOs. At night there was a four hour sleep rota.

Woodlands hospital had introduced a number of measures to improve the working conditions of junior medical staff. An admissions unit was created ostensibly with the needs of junior doctors in mind. A staff grade doctor worked on the unit during the week between nine and five - thereby easing the pressures on the on-call team. The unit acted as a 'buffer' for medical emergencies admitted to the hospital. Patients could stay on the unit for up to 48 hours where their condition could be assessed, and if deemed necessary, an appropriate bed found on one of the wards. The admissions unit

concentrated on the efficient processing and disposal of patients; it increased the efficiency of on-call doctors by concentrating all acute medical admissions in one area rather than scattering them across the hospital. Nursing staff on the unit routinely undertook tasks previously within the medical remit and it was generally regarded throughout the hospital as an area where the doctor-nurse boundary had blurred to a considerable extent.

A number of other measures had been taken within the organisation to improve the working conditions of junior doctors. For example, the provision of a routine phlebotomy and ECG service on weekdays between 9am and 5pm and a limited phlebotomy service on Saturday mornings meant doctors were rarely required to take blood or perform ECGs. Efforts were being made to up-grade and standardise certain pieces of equipment so that an on-call doctor coming to a ward would be familiar with the available apparatus. There was a major initiative aimed at reducing the number of forms that needed to be completed to order a series of blood tests. Money had been made available to refurbish the doctors' on-call rooms. A bleep policy had been implemented which specified a bleep-free period at lunchtime in order that doctors could enjoy their lunch and interact with medical colleagues. Nurses were encouraged to 'batch' bleeps so that the work was saved up rather than the doctor being contacted for each individual problem as it arose. At night all bleeps were supposed to be 'filtered' through the night sister.

Nurses at Woodlands were being encouraged to develop their skills in order

to relieve the burden on medical staff. A group had been formed in order to implement *'The Scope of Professional Practice'* (UKCC, 1992). Senior nurses at Woodlands believed that the development of nursing skills should be driven by patient need, but at management level the driving force behind the implementation of 'the Scope' was the initiative to reduce junior doctors hours. Despite their reservations about its linkage with junior doctors' hours, senior nurses decided to take responsibility for the implementation of 'the Scope', because they feared that medical managers would otherwise take control over the process. This is a subject to which I shall return in chapter 8.

Despite the efforts in place to improve the working conditions of doctors there were still problems. The measures taken to meet national requirements for junior doctors hours had increased the intensity of the on-call workload to a significant extent.

> *I think the junior doctors' deal has been the worse thing for the junior doctors ever invented. I think it's absolutely atrocious [...] I've no problem with the argument that they shouldn't be working that length of time but it was only half thought through and the political agenda was so high that it was easy to do. The junior doctors' hours negotiators I think really sold them down badly because they concentrated on that as well and didn't have the other half of the deal which was to decrease*

intensity, to put sufficient resources in to ensure that it worked properly. So what everybody has been forced to do is to increase intensity on the back of decreasing hours. It's had [...] (the) effect of increasing intensity, it has increased enormously the disaffection of junior staff, it has decreased enormously their professionalism - they clock-watch dreadfully. Commitment to the job has just gone. (Consultant)

The pressures were most marked in the medical directorate. The hospital had recently opened a new 144-bedded care of the elderly unit bringing the total number of patients covered by the on-call medical team to 280. This meant that during the on-call period 4 doctors were caring for all of the acute medical admissions entering the hospital and 280 in-patients beds. The difficulties with the intensity of work was compounded for PRHOs by the existence of a powerful medical hierarchy which meant that SHOs were reluctant to involve themselves in covering the wards which was regarded as low status work.

As soon as you stop being a house officer you wouldn't dream of signing the prescription sheet or clerking the patient [...] It's an enormous problem. (Consultant)

During the on-call period, work was divided so that typically SHOs covered the acute medical admissions unit and the PRHOs handled the ward work. In

terms of the junior doctors' training the clerking of patients on the admissions ward was perceived to be of greatest educational value. It is during the clerking process - taking a history of the patient's symptoms and carrying out a physical examination - that doctors can practise and develop their diagnostic skills. PRHOs valued the experience of clerking acutely ill patients but were rarely afforded this opportunity - preoccupied as they were with the pressures of work on the wards. Even when PRHOs did spend time on the admissions unit they were given the less interesting cases to clerk.

Registrar: ((looking at the list and pointing)) Is that an MI?

(myocardial infarction, which means a heart attack)

PRHO1: I want the MI.

Registrar: I do the interesting cases!

PRHO1: OK I'll do the old lady with collapse and confusion.

When I'm a registrar I see the MIs!

Registrar: ((laughs)).

PRHO1: ((gets up)) OK I see the interesting case. The collapse and confusion!

PRHO2: I've seen two generally unwells!

Summary

In this chapter I have introduced Woodlands and its immediate locale in order to delineate the context in which the nurses in this study accomplished jurisdiction. I argued that Woodlands was very much a local hospital geared

towards the needs of a deprived local community and staffed predominantly by local people. Turnover of non-medical staff was low. In the four years preceding the research, Woodlands had witnessed the introduction of immense organisational changes: achieving trust status, new management arrangements, refurbishment of the physical environment, a new emphasis on consumerism and corporate impression management, new working patterns and new roles. Throughout the organisation symbols of the old and new order could be regularly found side-by-side. I also introduced the key players to the work drama: the auxiliaries and HCAs whom I have chosen to treat collectively using the generic term 'support worker' given the difficulties I had in distinguishing between the two roles; the night staff both qualified and unqualified who formed a distinct social group bound together by their temporal roles; and the junior doctors, who although working shorter hours were frequently over-whelmed by the intensity of their work, a problem exacerbated by the medical hierarchy. My introduction to the nursing staff was deliberately brief - intended only to map out the key intra-occupational groupings - the ward nurses' perspective is explored in more detail in the next chapter.

6. Dirty Work Designations - Defining the Boundaries of Nursing

In this chapter I shall describe how, by utilising Hughes' concept of dirty work as a sensitising device, I discovered largely unanticipated disquiet at key nursing boundaries. As outlined in chapter 3, I interpreted nurses' dirty work designations as a boundary-defining stance expressing a particular occupational perspective. Through their dirty work designations nurses distanced themselves from those activities which threatened their occupation identity and in so doing reaffirmed the legitimate limits of their jurisdiction. These strains did not concern nursing's boundaries with support staff and medicine as I had predicted however. In fact nursing, medical and support staff accomplished their work with minimal inter-occupational negotiation and little explicit conflict. Rather, tensions centred on the intra-occupational division of labour on the wards, the boundary between ward-based nurses and general and nurse managers, and the boundary between nurses and patients and their relatives. I shall first outline this process of discovery before going on to examine these areas of unanticipated tension.

THE PROCESS OF DISCOVERY

In chapter 3 I argued that as a result of my reading of the professional and sociological literature, I began the fieldwork with what I considered to be well-founded reasons for anticipating increased negotiation and associated inter-occupational tension at nurses' boundaries with medicine and support workers.

I started my fieldwork on Treetops ward and in both my informal conversations and interviews with ward staff and clinicians in management it became clear that there was uncertainty and disagreement about changing work boundaries.

Senior nurses at Woodlands supported the principle of nursing role development but were concerned that it had become irrevocably linked with the junior doctors' hours initiative. Privately many admitted that nurses were probably being 'dumped on' by the medical profession and hinted that the UKCC, in issuing its new guidelines on nurses' scope of professional practice, was in collusion with the Government. Nevertheless, most recognised that junior doctors' hours had a high political profile and reasoned that it was preferable for nurses to expand their scope of practice than to introduce another category of worker into the division of labour and further fragment patient care.

> *Senior Nurse*: (W)e'd rather have holistic care for the patient than have lots of different people coming round. (Meeting - Tape)

In their implementation of role developments, senior nurses emphasised the opportunities for holistic patient care that working within a wider remit afforded.

> (F)or the medical staff [...] (nursing role developments) is a sort of political issue [...] moving this forward [...] if we could try and remember it's holistic care we're after and we should be training nurses perhaps from the beginning of their training to do some of these things. (Senior Nurse -Tape)

Most of the ward nurses regarded doctor-devolved work as a double-edged sword. On the one hand they believed that there were potential advantages in terms of the quality of patient care. On the other hand however, they were concerned that in the absence of additional nursing resources, expanding their jurisdiction would make it even more difficult to undertake sustained hands-on nursing work, which was considered to be a central reward of the job.

> *Part of me wants to do it and part of me feels that if I do that then it's taking me away from the patients again.* (Staff Nurse)

I think that sometimes it takes us away from the simple idea of what a nurse is for and what the patient thinks we're for. I think it's a good idea when you haven't got the doctor and there's an IV to be given and you can't get one and the nurse can give it on time. (Staff Nurse)

These findings contrast with those of Melia (1987) who found student nurses expressed a preference for technical rather than hands-on patient care; 'real' nursing required a technical or a medical overlay. As Melia points out, Hughes (1984) has also drawn attention to nurses' attraction to technical and managerial tasks as a route to professional status. My findings appear to reflect ward nurses' assimilation of New Nursing ideology which emphasises all aspects of nursing care. As Hughes (1984) has pointed out, the value of tasks held within an occupational bundle need not remain static. Nursing's current professionalisation project involves a reunification of basic care tasks and there has been an associated change in their meaning for practitioners.

Doctors were more than happy for nurses to take over what they regarded as low status menial activities: intravenous antibiotic administration, venepuncture, ECGs and cannulation. Nevertheless, many were clear that certain of these were essential medical skills that they themselves did not want to lose.

Taking blood and putting in cannulas. Especially putting in cannulas. I think that's very important. I think it is a vital skill that doctors should have really. (PRHO)

However, doctors were equivocal about activities that came closer to the focal tasks of medicine - such as patient clerking and diagnostic investigations. Some thought that nurses had the skills to undertake this work in a limited sense providing they worked within clearly defined protocols. Others felt this was moving too far towards nurses making diagnoses and this was a responsibility that most doctors (and also nurses) believed should remain with the doctor.

I think diagnosis is likely always to remain the domain of the doctor. (Consultant)

He was grey and clammy and I was sure he was in acute LVF (left ventricular failure). So he told me to give some Frusemide. Well I wouldn't give it - we can take verbal orders - but that would have been like me making a diagnosis and we can't can we - the patient has to be seen by a doctor. (Staff Nurse)

All of the consultants I talked to regarded the junior doctors' hours initiative as an opportunity for nursing to progress.

At the end of the day I think it is in nurses' own interests to grasp this opportunity for responsibility - to allow their profession to grow. (Consultant)

Some of their junior colleagues were less certain however, and questioned whether nurses should be expected to take over medical dirty work.

I think it can be done by the nursing staff but it is the question as to why should we drop all the rubbish to the nursing staff? (PRHO)

Doctors were also divided as to whether tasks should be shared with nursing staff or permanently devolved. Most of the nurses however believed tasks should be shared with medical staff and undertaken according to the exigencies of the work.

As far as the nurse-support worker boundary was concerned, many nurses welcomed better training for support staff. There were some however, who were fearful that HCAs would be used to dilute rather than bolster nursing skills on the wards. Nurses' anxieties about the expanded role of support staff centred primarily on its threat to their job security. Few expressed direct concerns about the abilities of support staff themselves.

I think if we're not careful with health care assistants we're going to end up without a job ourselves. I can see two or three qualified nurses and a team of health care assistants under you and that's some of us out of jobs - do you know what I mean? I think they're probably putting our jobs under threat if we give them too much. And why have we done three years training - sometimes longer? I don't know. (Sister)

As the above extracts make clear, there were indeed divergent perspectives concerning changing inter-occupational boundaries. Furthermore, in my conversations and interviews with staff many recounted instances of contested boundaries. Nevertheless, my field observations revealed that on the wards, nursing, medical and support staff carried out their work activities with minimal negotiation and little explicit inter-occupational conflict. As the fieldwork progressed I started to question whether I had misinterpreted the literature and had imagined there to be jurisdictional ambiguity where none existed. But it only needed a cursory glance through the national newspapers and nursing press to reassure me that, in the public arena (Abbott, 1988) certainly, changing inter-occupational boundaries in health care was an important topical issue.

On October 15 1994, almost a month after I had started my fieldwork, *The Guardian* examined 'The Sacking of Sister Pat' (Cook, 1994), the case of the neurology ward sister sacked by the Plymouth Hospitals NHS Trust for

making out a prescription for medication that was not signed by a doctor. The 'Pat Cooksley affair' was closely followed by the case of 'the appendix nurse', Valerie Tomlinson, a theatre sister who, under medical instruction, removed a patient's appendix. The *Nursing Standard* on January 18th 1995, in an editorial expressing surprise at the public outcry and the media furore over the Tomlinson story, announced that 'Huge numbers of nurses are now undertaking duties which doctors used to perform' (Casey, 1995a). Only six months later (July 19th 1995) however, the title of the editorial conceded that 'Often "doctor jobs" have been thrust upon nursing and have added little to the enhancement of nursing practice' (Casey, 1995b). That the issue of changing inter-occupational boundaries in health care was topical and subject to disagreement and conflict seemed unequivocal.

I then turned to my observational strategy in the field, and considered whether I was always finding myself in the wrong place at the wrong time. After all, staff had talked about inter-occupational conflict in their interviews. There were no obvious gaps in my field observations however. Perplexed, I looked for a local explanation for these unanticipated findings.

As I have described in chapter 5, Treetops ward did not employ PRHOs and the SHOs spent large periods of time away from the ward in theatres and outpatients clinics. The routine medical work was performed by a urology nurse practitioner employed from funds available through the junior doctors' hours initiative. With the exception of drug prescriptions, the nurse

practitioner was able to undertake all activities typically performed by the PRHOs. The nurse practitioner was highly regarded by the ward nursing staff who valued her skills and, because of her nursing background, felt that she understood the nursing perspective. Moreover, unlike junior medical staff the nurse practitioner was, for the most part, ward-based and, within office hours, readily available to nursing staff. As I will describe in chapter 7 the different temporal-spatial organisation of nursing and medical work was a significant source of inter-occupational tension. It seemed possible therefore, that the presence of the nurse practitioner may have acted as a buffer between the nursing and medical staff easing out some of the potential strains in their relationship.

A second local factor I considered was the intra-occupational division of labour on Treetops ward. Although the UKCC guidance leaves the onus for decisions about the boundaries of nursing practice in the hands of the individual practitioners, the policy at Woodlands was to allot this responsibility to ward sisters. On Treetops, nursing role developments were restricted to senior nursing staff - G, F and E grades. I discuss Woodlands' implementation of the UKCC's guidelines on nurses' scope of professional practice in more detail in chapter 7. For current purposes however, it is sufficient to note that I contemplated the possibility that the potential for negotiation and conflict may have been reduced by the small number of nurses (four on day duty) who were actually under-taking doctor-devolved work.

With respect to the division of labour between nursing and support staff, I started to consider the significance of support workers' experience and the intertwining of the division of labour in social relationships as possible explanatory factors for the lack of conflict at this boundary. As I explained in chapter 5, two of the support workers on Treetops had worked on the ward for over ten years. The two incidents of qualified nurses defending their occupational boundaries that I was aware of related to HCAs with whom there was no such established relationship. These ideas are developed further in chapter 7.

Fernlea ward, the second site for the fieldwork, was selected partially on the grounds that it differed from Treetops in terms of certain of these key local characteristics. Firstly, it had no nurse practitioner: ward work was provided by a PRHO and an SHO. Secondly, more of the nursing staff were undertaking work that had previously fallen within the medical remit: nine of the nurses on Fernlea worked in an expanded role compared to four on Treetops. There was little difference as far as support staff were concerned however: although the auxiliaries and HCAs on Fernlea were less experienced than they were on Treetops, all had worked on the ward for at least a year and one had been on the ward for seven years.

I began my field observations on the second ward with the original ideas of the research more-or-less intact. These assumptions were very quickly quashed however when it became clear that the increased need for negotiation

and inter-occupational disagreements I had anticipated were no more in evidence on Fernlea than they had been on Treetops. Clearly, these findings raise important sociological questions as to why the debates in the literature were so little in evidence on the wards.

As I pointed out in chapter 3, Walby and Greenwell *et al* (1994) devote a great deal of their discussion to boundary conflicts between doctors and nurses but it seems that in doing so they may be guilty of reading their interview accounts as straight-forward descriptions of action. Admittedly Walby and Greenwell *et al* did not have the luxury of observational data from which to assess the status of their interviewees' responses. Nevertheless, arguably it would have been methodologically more fruitful if they had treated the interview data as displays of perspectives and moral forms (Silverman, 1993: 107) rather than as literal representations of reality. Interpreted in this way, interviewees accounts may still be understood as reflecting real conflicts of interest and perspective between doctors and nurses and nurses and support workers, but this should not necessarily lead us to expect these tensions to be manifested in their daily interactions. I want to return to this theme again in Part 4 of this thesis. In this chapter however, I shall focus on those aspects of the nursing boundary where there was unanticipated tension.

As I have indicated, although there was little negotiation and conflict where I had expected it - at nurses' inter-occupational boundaries - there was unanticipated tension at nurses' intra-occupational boundary, at the boundary

between nurses and patients and their relatives, and at the boundary between ward-based nurses and general and nursing management. Whilst I did not discover an emic concept equivalent to Emerson and Pollner's (1976) 'shit work' or the 'scut work' of medical students (Becker *et al,* 1961), in terms of Hughes' ideas on dirty work these were the areas of their work nurses regularly complained about. I therefore broadened the focus of my observations to take into account these developing themes. There was a great deal of negotiative effort in terms of the intra-occupational division of labour and the boundary between nurses and patients and their relatives, but little negotiation relating to the boundary between ward-based nurses and nursing and general management.

THE INTRA-OCCUPATIONAL DIVISION OF LABOUR

Nurses' dirty work designations indicated two main themes in respect of the intra-occupational boundary: the content of nursing work and its control.

Treetops Ward and The Content of Nursing Work

My attention was first drawn to the significance of the intra-occupational division of labour on Treetops ward by nurses' complaints about 'doing the obs', that is, the measurement and recording of patients' temperature, pulse, respirations and blood pressure. As a surgical ward, the observation of patients' vital signs was a recurrent activity, particularly in the immediate post-operative period. Nurses complained about the frequency with which

these activities were carried out and of the consequent drudgery of the tasks. As the fieldwork progressed however, it became apparent that when nurses complained about 'doing the obs' it was not just the activity itself that was at issue but the way in which the work was organised within the nursing division of labour.

> *I don't mind doing anything if it's for the patient because that's why I'm here, I'm here for the patient not for anybody else. Obs are part of your daily work and they need doing. What I do object to is being given them to do as a task and not for the patient's benefit.* (Staff Nurse)

At Woodlands, senior nurses believed primary nursing to be the optimum system for the organisation of nursing work and patient care, but recognised that this was unrealistic within the hospital's nursing establishment figures. Given these limitations, formal organisational policy advocated a team nursing system. Senior nurses saw team nursing as a stepping stone towards the more holistic approach offered by primary nursing.

Team nursing was first developed in North America in the 1950s and 1960s and is based on a differentiation of tasks among a stratified work force. At Woodlands, both wards tried to implement team nursing by allocating patients to one of two teams for the duration of their stay in hospital. Team nursing was believed to facilitate continuity of care: the idea was that each team was

headed by a qualified nurse, who assumed responsibility for the management and supervision of patient care. The coordination of the ward work as a whole was overseen by a senior nurse. My observations on both wards revealed that in practice work was organised according to an ambiguous system which combined elements of task allocation, team nursing and primary nursing depending on work pressures and the personal predilections of individual nurses.

As I described in chapter 5, the nursing staff on Treetops fell into two camps: 'the homeguard' and 'newcomers'. There was tension between senior nurses (all members of the homeguard), who were mainly in charge of the ward, and newcomer junior nurses, who led the teams. These strains related to the work content of the two groups and its control. There was a clear division of labour on the ward between the junior and senior nursing staff. Junior nurses did mostly patient contact work - physical tending, technical tasks, caring for patients in the periods before and after surgery, and the processing of new admissions to the ward. Junior nurses worked in the patients bay areas and at particular times of the day their work overlapped with that of support staff. The senior nurses typically did the ward rounds, administered medications, coordinated the ward activities, liaised with doctors, answered the telephone and undertook a disproportionate amount of administrative work - such as patient discharge planning. They worked mainly in the area around the nurses' station which was separated from the patients bay areas by a corridor.

Newcomer junior nursing staff complained that team nursing did not work well on the ward. They attributed this to a lack of support for the concept by established nursing staff, and the reluctance of senior nurses to delegate work traditionally ascribed a high status to more junior nurses. Ward rounds, drugs rounds, and patient discharges were activities that junior nurses felt ought to be devolved to the team leaders. Key senior nurses were derided by their junior colleagues as status conscious, and perceived as needing to perform these activities in order to bolster their position within the ward hierarchy.

Senior nurses on Treetops maintained that it would be impractical to change the existing division of labour and devolve patient management activities to the team leaders as it would take too many staff away from patient care delivery. Senior nurses also felt that many of the junior nurses were relatively inexperienced and some could be 'over-confident'.

It seemed initially, that the tensions between the junior and senior nurses on the ward reflected entrenched tensions between service and professional versions of nursing as this was the discourse through which many of the nurses' complaints were articulated. On reflection however, junior nurses' dissatisfaction about the content of their work seemed to highlight the belief that work should be allocated fairly, as much as any concern for holistic care or New Nursing ideologies. Students were particularly critical. They argued that senior staff were 'lazy' and would do anything which allowed them to 'sit down' while they did all the 'work' - work being defined in terms of the

physical and emotional labour involved in direct patient care. As we shall see later in this chapter, almost without exception all nursing staff complained about the amount of paperwork they were expected to do, but rather than being grateful to those nurses who undertook more than their share of paperwork, their colleagues criticised them for being lazy. Paperwork, unlike patient work, was not seen as real work.

Staff Nurse: *(Y)ou tend to get some staff nurses that would rather sit at the desk pushing the pen than actually doing anything.*

DA: *By doing anything?*

Staff Nurse: *Well I mean physically doing anything.*

Both senior and newcomer junior nurses typed each other as being preoccupied with paperwork and unconcerned with patient contact work. Individuals who were prepared to 'muck in' and 'pull their weight' were well-regarded. Nurses' accounts of their work suggested that although patient contact work is now more highly valued, staff found it difficult to sustain when performed without interruption by other kinds of non-patient contact work. As Strauss *et al* (1985) point out, dirty work is a potential aspect of all work and all tasks. These authors suggest that tasks can become so exhausting or stressful as to tip towards the non-gratifying and ultimately the dirty side of work.

> *It's not fair to put it (hands-on care) all on a small group of people. It can't be any good for the patients because I don't care who you are there comes a point when you think, 'Oh I've just had enough'.* (Student)

The importance nurses' attached to holistic nursing care therefore seemed to reflect concerns for their own job satisfaction as much as any belief in its benefits for patients.

> *I like to do a bit of everything in the day if I can.* (Student)

Many of the nurses I interviewed admitted to occasionally using paperwork in order to have a rest from the physical and emotional labour of patient contact work.

> DA: *Do we ever use the paperwork as a way of escaping from the patients?*
>
> Staff Nurse: *Oh yes - definitely - yes sometimes definitely yes. Sometimes you think a patient really wants to talk to you and they've been on at you all day about the same things so you say 'I've got to go and do my work now. Talk to me after because I've got quite a lot to do and I've got all these patients to write up you know' [...] I'd be lying if I said different.*

Treetops Ward and The Control of Nursing Work

The intra-occupational tensions on Treetops ward also related to nurses' efforts to control their work within the ward hierarchy. Under the traditional models of nursing work described in chapter 1, power is concentrated in the hands of the ward sister and any decisions relating to patient care are filtered through the nursing hierarchy. New Nursing ideologies by contrast emphasise the nurse's status as an autonomous practitioner and his/her individual accountability for patient care. Policy analysts have tended to concentrate on the tacit objective of New Nursing philosophies in promoting the occupation's autonomy from medicine (Salvage, 1992; Porter, 1992a). On the wards however, it was autonomy from the nursing hierarchy that nurses sought.

Newcomer junior staff felt strongly that they should be left to organise their own work priorities. It was acceptable for junior nursing staff to organise the division of labour between themselves and to trade and barter, but when work was imposed from 'outside' by senior nursing staff it was considered illegitimate. They complained that the ward was 'run from the top' and that key members of the senior nursing staff did not allow them the freedom to order their own work. It was felt that the senior sister found it particularly difficult to devolve responsibility to junior staff.

> *(I)f we're having teams then I think it should be up to us to say who does what. It really does get on my nerves sometimes when sister will say 'Now will you make sure you do that', and*

it might not even be for your team. 'Will you make sure that man has a drink every hour' or 'You'll do that won't you?', and it really does rile me. (Staff Nurse)

Indeed the sister herself spoke of the difficulties she had experienced in 'letting go'.

I must say I did find it hard to withdraw - if you know what I mean - from giving the hands-on experience. I was trying to do too much. (Sister)

A major complaint was that senior staff did not allow the team leaders to organise their own work priorities.

(Y)ou can be half way through a job and they say 'Can you do this? Will you do this for me?'. Rather than just giving you a list of jobs and saying 'This is what needs getting done' and then going off and getting it done because you can just prioritise it yourself rather than getting things thrown at you when you're in the middle of something else. (Staff Nurse)

It was senior nurses however, who had an overview of shifting priorities within the total complexion of ward work, whereas team leaders were focused more narrowly on the needs of their specific patients and, as I described in

chapter 5, the pace of work on Treetops could change dramatically. Because of the need to adhere to theatre schedules, nursing work on Treetops was more tightly locked into external organisational timetables than it was on Fernlea ward. Moreover, senior nurses were also very conscious of the relative inexperience of the newcomer junior nursing staff and had a strong sense of their own responsibility for the care of all patients on the ward.

> *(A)lright an RGN's is responsible for her own actions but it is my ward.* (Sister)

Fernlea Ward - A Comparison

On Fernlea, ward activities were ordered very differently. Nursing work was organised in a non-hierarchical manner. With the exception of drug administration, responsibility for all aspects of patient care management was devolved to the team leaders who also had more control over their work than on Treetops. Senior nurses on Fernlea referred to themselves as 'coordinating' the ward, whereas on Treetops they described themselves as being 'in-charge' of it. The intra-occupational division of labour was less fraught with the tensions of Treetops ward. The fair allocation of work was clearly considered to be important but student nurses spoke highly of their experiences on the ward and junior nurses seemed happy with the content of their work. The extent of devolution on Fernlea however, meant that the ward coordinator role was perceived to be an unsatisfactory one, and key senior staff on the ward were deeply unhappy with their role.

It's a bit of a nondescript role really. You're there for help if they need any help. It's a bit of a funny role really. (Sister)

I don't think the coordinator's role is very well defined on here. All they seem to do is drugs and that's not really as it should be I don't think. (Staff Nurse)

Senior nurses' referred to their efforts to reintegrate devolved activities into their work.

> *If they're very busy I'll do the ward round for them and pass that on - I try and poach little bits back.* (Sister)

Sometimes this created tension:

> *Sister*: Sarah can I put you as named nurse?
>
> *Staff Nurse*: It's alright, I'll do it.
>
> *Sister*: ((raises voice slightly)) Can I do **anything?!**
>
> *Staff Nurse*: Sorry.

Control of nursing work was again problematic but the issues on Fernlea were rather different to those on the surgical ward. On the one hand team leaders, as on Treetops, expected to be left to organise the work in their teams and disliked intrusions. However, it was also generally felt that the senior sister

had taken devolution too far and did not take responsibility for the ward as a whole. She was criticised by junior staff for leaving the ward when it was busy in order to undertake office work. Junior staff were left feeling vulnerable and insecure and this placed an intolerable burden on the junior sister who was frequently contacted at home by nurses seeking reassurance that they had taken the right course of action. Paradoxically, all the senior nurses responsible for coordinating ward activity strongly believed that they should have knowledge of the medical and nursing details of all patients on the ward. They complained that often the team leaders did not communicate the information they needed back to them, which left them feeling foolish when they were approached by relatives of medical staff enquiring after a patient's progress.

> I'm always the coordinator if I'm on and I feel lost sometimes. If there are some juniors and students on they feed back to me a bit so I know more what's going on but some of the others they're quite protective of their team and they like to sort out their own problems. So a consultant might come on to the ward and expect me to have the answers and I don't know what's going on. So I have to say 'This nurse has been looking after him'. (Sister)

It was felt that reporting back to colleagues after ward rounds had unfortunately stopped. Please could this practice be

> recommenced as it can be both frustrating and embarrassing at times for colleagues who are expected to know what is occurring on the ward. (Document - Minutes from ward meeting)

Although the intra-occupational tensions on the wards was of different kinds, at root was a common problem of the division of labour between the team leaders and the nurse with overall responsibility for the running of the ward. At one level the boundary disputes on the ward reflected staff difficulties in adjusting to the role changes occasioned by New Nursing. In mapping out the pre-conditions necessary for New Nursing, Beardshaw and Robinson (1990) underline the need for the ward sister's role to shift from involvement in supervising and administering to an emphasis on clinical consultancy, staff support, ward management and planning and coordination of research and education. Beardshaw and Robinson concede that research into the way that ward sisters work makes it clear that few are currently trained and equipped to work in this way, nor are they enabled to by higher level management. On Treetops senior staff were reluctant to let go of the traditional functions of the ward sister to the dissatisfaction of junior nursing staff. On Fernlea, where senior nurses had managed to devolve most aspects of patient management they had been left with a vacuum they had been unable to fill to their satisfaction, and, in the case of one senior nurse, responsibility had been devolved so far that junior staff were left feeling vulnerable.

Taking a broader view, the intra-occupational tensions on the wards may also be understood as a reflection of the difficulties practitioners face in reconciling models of care which are implicitly based on the private-practice model of professionalism (Dingwall, *et al*, 1988) with the workplace reality of hospital nursing. Nurses are subject to conflicting and ambiguous ideologies. The professional rhetoric of New Nursing ideology emphasises their status as autonomous practitioners but as employees in a bureaucratic organisation nurses are expected to render obedience to superiors and conform to organisational rules and regulations. Project 2000 left traditional nursing structures firmly intact. Because nursing work relies on staff working together and because work is allocated in a personalised manner however, it becomes all to easy for nurses to blame each other for the tensions in the system. The intra-occupational division of labour was accomplished by dint of a great deal of negotiative effort and for the most part the nurses' managed to contain the interpersonal strains on the ward. There remained an undercurrent however, which regularly surfaced in backstage regions such as the canteen, and occasionally on the ward itself. During their interviews some members of staff broke down and wept such was their frustration with work colleagues. It seemed that for ward staff managing the tensions in the system was a fundamental work skill.

THE BOUNDARY BETWEEN WARD-BASED NURSES AND NURSING AND HOSPITAL MANAGEMENT

My attention was drawn to strains at the boundary between ward-based nurses and nursing and general management by nurses' grievances about the paperwork. This was by far the most common complaint made by staff on both wards. At one level, nurses' dirty work designations reflected their objections to the onerous nature of the paperwork and the demands it made on their time. At another level, it also indicated the significance of key aspects of the paperwork as a local symbol of growing management control and what the ward nurses perceived to be managers' illegitimate efforts to control their work. Related to this was the belief that the emphasis on good record-keeping was being driven by consumerism and litigation consciousness rather than concern for patient care.

It was non-ward-based senior nurses who were largely responsible for implementation of the paperwork initiatives that ward staff considered illicit. They were never singled out for explicit criticism however. Rather, ward nurses referred to 'management', 'the hierarchy' and 'the higher ups' in a way that failed to differentiate between clinician and general managers. Undoubtedly, there are some interesting sociological questions relating to the role of nurses in the new NHS management structures - not least the question of how they handle the tensions between professional and management values. Indeed, as some of the extracts in this section reveal one senior nurse with

strong links with the clinical setting was also an important critic of the amount of paperwork nurses were having to perform. For the purposes of this section however, I am going to follow the lead of the ward-based nurses at Woodlands and take the boundary between ward nurses and managers to include both general and nurse managers.

Paperwork and Management Control

Nurses' complaints about the volumes of paperwork appeared to be well-founded; certainly nursing work seemed to revolve around paper as much as it did patients. There was paperwork associated with the recording of essential clinical information; paperwork involved in the ordering of clinical investigations and making specialist referrals; paperwork related to patients' discharge from hospital; and paperwork associated with bed management and the movement of patients throughout the organisation. Nurses had also developed their own informal recording systems in order to coordinate ward activity. By far the most significant source of paperwork however was the documentation associated with the nursing process.

In the course of their everyday activities nurses' complaints about paperwork were expressed in fairly general terms. They pointed to its voluminous and repetitive nature rather than singling out paperwork of a certain type for special criticism.

(T)here's far too much paperwork and [...] when patients get to notice that you're doing a lot of paperwork they must know in their own minds that they're not given as much care, or time for the care. There's too much paperwork. I'd like to drop a big match on it all. To see it all go up! (Staff Nurse)

During the period of the research, I tried to elicit whether nurses made a distinction between legitimate and illegitimate paperwork. Not surprisingly, documentation of clinical details appeared to be widely regarded by nurses as legitimate paperwork, as was the informal record-keeping nurses employed in coordinating daily ward activities. Nurses also undertook a lot of form-filling related to clinical investigations and specialist referrals although officially this was the responsibility of medical staff. Whilst nurses suspected that they were 'making a rod for their own backs' in undertaking this work when it fell outside their formal jurisdiction, they nevertheless clearly regarded the paperwork itself to be essential.

Although nurses couched their complaints about paperwork in general terms, it became clear that it was paperwork which symbolised the increased influence of hospital management which was generally held to be illegitimate. For example, many of the nurses were very critical of the copious amounts of paperwork associated with patient discharge arrangements which was part of a new quality initiative. This entailed a triplicate discharge letter and a quality assurance discharge check list that had to be signed by the nurse and

which was designed to ensure that all the necessary arrangements for patients' discharge had been made. Previously these details had simply been entered into the nursing kardex.

> *Like discharge letters. You don't have one any more there's two. One for the patient to take home, one for us to keep to say we've given them this letter to take home!* (Staff Nurse)

> *You've only got to have one discharge in a day and that's your qualified nurse taken up. You've only got to have two discharges and she's under the table. It's terrible.* (Senior Nurse)

Of particular interest however were nurses' comments about the nursing record which were equivocal. The nursing record on both wards appeared to be highly valued because of its relationship to contemporary professional ideologies and nurses were clearly loathe to criticise it directly. Nevertheless, despite the evident symbolic significance of the nursing process, nurses' increasing alienation from its utilisation in practice was clear.

> *(T)hey're (care plans) a pain in the neck. I don't know. If I said that I didn't think care was any better for them. I don't know if I should say that really.* (Sister)

The Nursing Process

The documentation associated with the nursing process was extensive. It comprised three parts: a *pro forma* on which biographical information was recorded, a nursing history obtained, a nursing assessment undertaken, and discharge arrangements documented; a nursing care plan in which nurses identified patient's problems or 'areas of concern' and set out the appropriate nursing action to be taken; and the nursing kardex, supposedly a contemporaneous record of the patient's progress although in practice it was mainly written after the rest of the work had been completed.

The difficulties that have been encountered in integrating the nursing process into nursing practice are well-documented. The literature reveals that while the nursing process has been successfully imposed on the syllabi for most areas of nurse education, with the exception of midwifery, the impact on practice has been universally disappointing (Dingwall *et al,* 1988). De la Cuesta (1983) has examined the implementation of the nursing process by ward staff in the US and UK. De la Cuesta argues that the major records in the nursing process experienced a different type of implementation. Nursing histories were instituted without great difficulty and consistently written. However they were regarded more as reference sheets containing patient information rather than as a foundation for nursing diagnosis and care planning. My observations on Fernlea ward suggested that the nursing history was actually used as the basis for care planning. Utilisation of the nursing history on Treetops ward was less clear given that care plans were routinely

written in advance of patient admissions.

According to de la Cuesta, the major barrier to the full implementation of the nursing process was the care plans. Care plans were inconsistently written and had a medical/physical rather than a nursing focus. Nurses perceived care plans to be superfluous and argued that they had no time to write them. Moreover, when they were written nurses found it difficult to state the problems and express diagnostic concepts in writing. In her analysis de la Cuesta moves beyond nurses' articulated reactions to the care plans and looks at organisational reasons for their scant success. De la Cuesta argues that although care plans are idealised by nursing theorists, in most hospitals they were destroyed after patients left and this devalued their importance. Moreover, for nursing staff the relationship of the care plan to the welfare of the patient was far from clear. Care plans were regarded as imposed formalities to be filled in when time was left to do them, something for administrative rather than practical purposes. De la Cuesta also points out that although it might not be explicitly stated, care plans imply accountability. Having committed a plan to paper, the nurse's deviations from it become all too apparent.

As we have seen, there have been major policy developments in the UK health care context since the time of de la Cuesta's study. More than ten years later ward-based nurses at Woodlands were still struggling to reconcile the ideals of the nursing process with their work practice but this was for reasons rather

different from the ones de la Cuesta describes. There were three principal grounds for nurses' estrangement from the nursing process at Woodlands: first, the increasing use of the nursing process as a management tool; second, the distortion of the content and purpose of nursing records by consumerism and litigation-consciousness; and third, the difficulty of employing the nursing process in any practically useful way in the working environment.

As I pointed out in chapter 1, part of the attraction of the nursing process from a management perspective is precisely the volume of paper which it generates (Dingwall *et al,* 1988). At Woodlands the nursing record was being utilised by hospital managers as a quality assurance tool which had the effect of indirectly controlling nursing work through standard setting. There was a clear tension between managers' efforts to set standards and the claims of nurses on the wards to provide individualised patient care. Nurses felt pressurised to routinely include certain problems on patient care plans in order to satisfy the quality assurance programme, irrespective of whether they had any relevance to the patient concerned.

> Staff Nurse: *(S)omebody went on a record-keeping day and they said we had to have 'bowels' on every one (care plan), we had to have 'psychological care' on every one (care plan) and something else on every single care plan.*
>
> DA: *Health promotion!*
>
> Staff Nurse: ((laughs)) *Yes that's it. We did it because*

otherwise they say 'You haven't put that on' and you'd have to put it on.

(S)ome questions asked in that Monitor were constipation and health education and you didn't know when they were going to come and audit you and monitor you so everyone who's in this hospital has care plans on 'constipation' and 'health education' in case they get monitored! I've had patients come to me and say, 'Nurse what's this?', showing me the care plan, and I'll say 'Well it's your care plan' [...] and they say, 'This is absolute rubbish'. You know, I've never been so embarrassed sometimes. They say, '"Potential problem of this" - I'm not this. "Allay anxieties" - I'm not this.' So I say 'Well it's something that nurse has to write'. 'It's a load of rubbish'. I just sort of laughed it off and come round to a jokey type way with them but it's embarrassing it really is. (Senior Nurse)

I think care plans are misused because management say that you need to then put on there's a problem - there's a certain problem - but each patient's an individual. (Sister)

On Treetops the satisfactory completion of nursing records was rigorously enforced by the senior ward sister. Indeed standardised care plans existed for the main surgical cases seen on the ward and which the nurses diligently

copied out at the weekend when the ward tended to be quieter. Initially staff on Fernlea had also succumbed to the pressures for standardisation. At the time of the fieldwork however, they were becoming increasingly prepared to defend their right to plan care individually.

> *(T)hey were telling us what to put on - when they don't know patients, they've not admitted them, they've not looked through their assessment. So how do they know whether they suffer from constipation or they need health education or whatever?*
>
> (Staff Nurse)

A further reason for nurses' disillusionment with the nursing process was their belief that its content and purpose had been distorted by the new consumerism and litigation consciousness in health care.

> *We're recording absolutely everything [...] and I think really it's not out of thinking, 'I've got to write this because this is the patient's day', but it's mainly thinking, 'I've got to write this because if this gets called up in court' [...] It's got nothing to do with the patient's day and the care that's been given.*
>
> (Staff Nurse)

'We're absolutely drowning in paperwork. We'd see more of the patients if we had less and in my opinion it's all because

people are afraid of litigation.' (Staff Nurse)

The in-service training day on record-keeping developed by senior nurses focused almost exclusively on the legal implications of poor documentation. Little reference was made to the benefits of good record-keeping.

De la Cuesta observes that the implied accountability of care plans resulted in a reluctance on the part of nurses' to commit their plans to paper. The nurses in my study were also acutely aware of the accountability implied by the careplans, however the satisfactory completion of care plans was ensured though standard setting. Every patient admitted to Woodlands had to have a care plan within twenty-four hours. Nurses at Woodlands managed their implied accountability for care by utilising the care plans in order to structure the written record of nursing care. An entry was made for each patient problem that had been identified by the nurse and as a consequence, kardex entries were lengthy.

You've got to answer every problem so that you've stated that you know about that problem. That's all you're trying to prove that you know about their bowels, that you know whether they've had a wash and you're trying to prove it in your little green sheet that you know. Whereas you don't know half of the time until you ask them! (Staff Nurse)

> *It's like a receipt. I look at it like a receipt. You know an itemised bill! That's what it's like. It's all it is. 'You had this today', 'Bowels open' 'Bowels not open'. That's all it is.*
> (Staff Nurse)

As a result of the combined effects of management emphasis on quality assurance and a consumerist climate in which staff were ever-fearful of the threat of litigation and patient complaints, considerable nursing energy went into maintaining a satisfactory nursing record. This supports the findings of Annandale and Clark (1996) who interpret the 'excessive' documentation undertaken by nursing staff as a defensive strategy employed in a climate of anxiety about risk management.

Arguably, nurses may have been able to justify the time they spent on paperwork if they believed the nursing record helped them in their work and had advantages for patient care. In practice however, the pressures of work on the wards meant nurses were rarely able to consult the nursing record. The only time nurses referred to the patient care plans was when they came to write the kardexes. Thus while care plans might serve as a useful reminder of aspects of care that may have been overlooked on a busy shift they were rarely looked at before care was delivered.

As I have argued, the nursing process is based on a model of professionalism taken from private-practice with built-in assumptions about a one-to-one

relationship between professional and client. Nurses on hospital wards however, have to manage multiple patient assignments and coordinate this care with numerous and often conflicting organisational timetables. At Woodlands, care plans were of little help to the busy nurse in managing his/her work priorities.

> *They do a record-keeping day here and they say that [...] You should go on and you should look at your care plans and you know exactly what care to give to that patient. But I'm sorry in an ideal world, realistically if as soon as you walk on that ward and you start walking round looking at care plans the buzzers are going, the breakfasts arrive, people want a wash, they want to get out. You can't do it. You'd get half way down and then what? Somebody might have a colonoscopy booked for ten O'clock and by the time you've got there it's too late and they've missed their enema that they should have had at eight O'clock because you started at the other end instead of that end.* (Staff Nurse)

Nurses had developed their own informal methods in order to manage the work. Both wards had a diary system and although the schemes varied in their finer details the most important feature was that, unlike the care plans which referred to the care of a single patient, the diaries included nurses' total complexion of work for the shift. In utilising the diaries, nurses were able to

see at a glance the activities to be carried out, and prioritise their work accordingly.

> *(Y)ou can see what needs doing straight away and see what you can leave until later. I like that.* (Student)

There are other reasons for nurses' failure to use the nursing process. As de la Cuesta points out, the nursing process was initially developed as a teaching device, and it is questionable as to how useful the detailed recording of the problem solving approach is for an experienced nurse. As I argued in chapter 1, much of nursing care is an intuitive response to the moment. Furthermore, qualified nurses at Woodlands maintained that they knew the care a patient needed without having to refer to the care plan. They relied on nursing handover for information about non-routine aspects of patients' care and expected work colleagues to keep them up-to-date with any important relevant developments. Handover took the form of a narrative and anecdotal story-telling, and contained information that could never have been captured in the nursing kardex. Indeed, nurses placed a great deal of importance on knowing patient details without having to consult the nursing record. As we saw in the discussion of the intra-occupational division of labour, staff felt foolish if they were asked about a patient and were unable to provide the information.

> Sister says that there have been a couple of incidents in which she's been asked something and the information's not been

passed on and she's been made to feel stupid because she didn't know.

Jean talked of her admiration for Doctor Darcey who did not need to take the patient's notes to the bed - she said it looked as if she knew the patient without having to look it up.

There are clear parallels here with Dingwall's (1977a) study of health visitor training in which not using the record was a mark of professional expertise. It was not that the nurses at Woodlands did not use the record in order to demonstrate their expertise however. As we have seen, more often than not it was simply a case of there being insufficient time. Nevertheless, managing without the careplan was essential in order to function in the ward working environment and not 'knowing the patient' without having to consult the record was felt to reflect badly on one's competence, particularly in front of doctors or relatives.

Care plans may be of little use to experienced nurses however, but arguably the greater use of support staff on the wards has now augmented their importance. Nevertheless, at Woodlands care plans were not utilised by auxiliaries or HCAs who saw them as the province of qualified staff and of little relevance to them or their work.

Non-Negotiation of the Nurse-Management Boundary

Although paperwork was a major nursing complaint there was little associated negotiation of the nurse-management boundary which was discouraged by organisational structures and the spatial ordering of ward nurses' and hospital managers' work. Any negotiation of the boundary between nurses and nursing and general management had to be filtered through the formal organisational hierarchy. Ward nurses had virtually no day-to-day contact with hospital management, which was seen as a distant force with little appreciation of the problems faced by ward-based staff.

> *I think managers sit up there don't they and they don't really know what's happening on the ward and it makes me laugh really. They kinda troop on at Christmas and you think 'Who is this person?' [...] (T)hey've no idea how a ward runs and what the staff are actually doing.* (Sister)

Hospital managers were perceived to wield immense, and sometimes arbitrary power.

> The nurses were discussing their concerns about talking into my tape-recorder. Stephanie said 'They will use anything against you in this place'.

> Rachel said that in her view hospital management 'remember everything and turn it against you if they want to.'

Although the study days - such as the record-keeping day - were an occasion in which nurses could have at least questioned the management position on paperwork, I did not observe any instances of this.

Compared to the nursing staff, management attempts to 'improve' the record-keeping of medical personnel had been resoundingly unsuccessful. I suggest that there were a number of reasons why, unlike the medical staff, ward nurses had not resisted the imposition of management control over their work. First, unlike the junior doctors, most nurses were permanent employees of the hospital and thus were more likely to have felt bound by its organisational procedures. Junior doctors looked to the consultant as a principle point of reference. Second, it was senior nurses in the organisation who were responsible for quality issues and as members of the established nursing management hierarchy arguably they would be perceived as having greater power over nurses than doctors. Third, nurses clearly felt more vulnerable to external censure than did doctors. In the stories that they told, doctors and nurses regularly contrasted the relative defencelessness of nurses with doctors' apparent immunity to criticism.

> (T)he impression he (the SHO) had was that when nurses made a mistake then they were publicly harangued for it by their

senior or a person a few layers up. He said that if a doctor makes a mistake he gets sent to the consultant's holiday cottage. He said a doctor who has erred is given a quiet talking to and its dealt with internally.

> *If a doctor messes up now it's the nurse that will probably get struck off.* ((laughter)) *They'll find a little nurse somewhere to get.* (Senior Nurse)

In summary then, paperwork was a major nursing complaint. At one level nurses' dissatisfactions reflected the quantity of paperwork they were expected to undertake and the demands it placed on their time coupled with its lack of practical relevance to their work. At another level, the paperwork was an important local symbol of the growing influence of hospital management and their increased control over nursing work. Although initially nurses were often reluctant to be openly critical, it was the nursing process that was most problematic, which illustrates the power of managerialism to undermine the aspirations of professionalisers in fundamental ways.

THE DIVISION OF LABOUR BETWEEN NURSES AND PATIENTS AND THEIR RELATIVES

By focusing on Hughes' concept of dirty work my attention was first drawn to the significance of the nurse-patient boundary when a staff nurse on

Treetops ward complained to me about being treated like a servant by one of the patients. As the fieldwork progressed moreover, I observed other expressions of tension between nurses, patients and relatives and I thus focused my observations to incorporate this developing theme.

Caring relationships are historically and politically bounded (James, 1992a) and are currently undergoing a process of change both within nursing and within the wider political context. As we have seen in chapter 1, New Nursing ideology explicitly encourages patients' active participation in care, engaging them in 'therapeutic partnerships' which allow more patient control. Alongside this there has been an effort to increase the power of clients through a new emphasis on the patient as consumer of health services. Coupled together these two ideologies have important implications for the division of labour between nurses, patients and their relatives and during the early stages of the research it seemed that it was the tension surrounding the renegotiation of boundaries that I had detected in my field observations.

Compared to my own experiences as a staff nurse, shifts in the division of labour between nurses and patients and their relatives were indeed taking place at Woodlands. Furthermore, these changes in the allocation of work were associated with a great deal of negotiative effort. As the fieldwork progressed however, it became apparent that the realignment of boundaries was not necessarily occurring in the directions one would have predicted from contemporary ideologies of the nurse-client relationship. Moreover, the

stresses in nurses' relationships with patients and relatives appeared to derive as much from workload pressures and nurses' perceptions of changes to the negotiation context (Strauss, 1978) as a result of consumerism, as it did from shifts in the division of labour itself. In this section I want to describe the work of patients and relatives at Woodlands and examine the tensions relating to their implication in the ward division of labour.

The Work of Patients and their Relatives

Within sociology explicit recognition of the work performed by hospitalised patients is associated mainly with the writings of Strauss *et al* (1981, 1982a, 1985) although Hughes also includes the patient in the division of labour in health care (1984: 308) and Goffman's (1961) work has shown that even in the most oppressed conditions the patient is an actor and not just a passive recipient of care. More recently Stacey (1981) has also underlined the importance of conceptualising the patient as a health worker.

According to Strauss *et al* there are different modes of immersion of patients in the ward division of labour. Firstly, staff expect patients to work (whether or not it is actually called work): reluctant patients are subject to sanctions. Secondly, patients are sometimes invited into the division of labour. This could be because the nurse was busy or would rather not do the work, it may also be bound up with an ideological position. Thirdly, patients may offer to do something. A fourth mode of entry into the division of labour is through negotiation, where something is offered for something else in exchange.

Fifthly, teaching the patient may be interpreted as getting the patient to work more effectively on his or her own behalf.

Strauss *et al* (1985) argue that although some of patients' work is recognised by the staff as genuine, most of the work undertaken by patients when they are in hospital goes unrecognised. Implicit patient work includes tasks relating to personal housekeeping, provision of information, reporting of discomforts and untoward symptoms, work associated with various tests in addition to self-control in the face of discomfort, pain and potentially humiliating medical interventions. According to Strauss *et al*, another reason for the nonrecognition of patients' work is when it is not visible to personnel. Patients may not indicate their work for a variety of reasons: because it could be defined as illegitimate, because it involves criticism of the staff, or because it is altogether too personal. My concern in this section is with the explicit work of patients and relatives on the wards.

During the fieldwork I was struck by the greater explicit participation of patients and relatives in certain aspects of their care compared to my own experiences in nursing only five years previously in 1989. On both wards at Woodlands, patients routinely involved themselves in housekeeping tasks. They washed medicine pots, made their beds, and cleared away coffee cups and meal trays. On Fernlea ward a female patient who was well-known to ward staff always made and distributed the evening drinks for patients - a task normally undertaken by support staff. There was nothing especially surprising

in this however: patients had undertaken housekeeping tasks during my own practice. What was new was the participation of patients in key aspects of their nursing care.

Patient participation in nursing care was of three main types: body products work, record-keeping, and certain technical tasks. As will become apparent these are not distinct categories of work but entail a degree of over-lap.

Body Products Work

On both wards a striking feature of the activities in which patients were increasingly participating was that much of it was physically dirty work which involved the handling of body products. On Treetops ward, those patients who were able, routinely maintained their own fluid balance charts. This entailed measuring and recording fluid intake and urine output and, in some cases, assessing and recording the colour of their urine. Patients with renal colic filtered their own urine for kidney stones. On Fernlea, patients with gastric disorders weighed and recorded bowel movements and collected stool specimens. Patients' participation in what was literally dirty work was reflected in their utilisation of ward spaces: on both wards patients had free access to the sluice, an area that in my own experience had been mainly off-limits. Nurses' and support workers' comments suggested, that patients preferred to handle their own body products when they could and were embarrassed that ward staff had to undertake dirty work for them.

Sister: We're just needing two more FOBs (stool specimens) off her. She's got the pots because she doesn't like us doing it. She doesn't want us to do it. She did give me a sample last night but it only covered the spatula so I said it's not enough. So she is aware. She just doesn't like her bowels. (Nursing handover - Tape)

> *The chaps - I don't think a lot like giving you the urine - they like to do it themselves.* (HCA)

Indeed patients could inadvertently create more work for staff by trying to do their own dirty work.

Sister: But she tries to do things for herself and she won't let the girls help her. She insisted on doing her bag (changing a colostomy bag) herself this morning and she didn't get it on properly and so it leaked and so she wouldn't let the girls help clean her up and so she got into a bit of a state about that. We try to help her but she won't let us. (Nursing handover - Tape)

Record-Keeping

Many of the dirty tasks undertaken by patients entailed a record-keeping component. Patients also undertook record-keeping work which was not physically dirty however. For example, some patients kept a record of the

food they had eaten. There were also various charts on which patients were asked to document details of their pain - indicating the location, severity and type of pain and its relationship to other activities of daily living such as eating.

Technical Tasks

Patients participated in technical activities in three main ways. Firstly, patients were involved in technical work where these were skills they would require on discharge from hospital. Secondly, patients on the ward who were health professionals performed certain technical tasks. For example, on Fernlea a patient with a nursing background drew up and administered her own injections. Thirdly, those patients whose day-to-day management of chronic disorders entailed technical medical work were encouraged to continue with it. For example, diabetic patients carried on measuring their blood sugar levels and administering their own insulin. To those unfamiliar with hospital practice this may sound commonsensical, but in the past nurses would have expected to have performed these tasks for the patient whilst they were in hospital. Nurses also encouraged patients to monitor technical equipment - such as drips. As we will see however, this could be a source of tension.

Strauss *et al* (1985) have pointed out that a traditional acute-care philosophy lies embedded in the medical-nursing care given in hospitals which reflects the classic picture of the patient as described by Parsons (1951) of an acutely ill person, temporarily passive and acquiescent, being treated by an active

physician and carers. Although Parsons' model is important in drawing our attention to sickness as a social as well as a biological reality, the model he proposes does not cover all of what we commonly regarded as sickness (Freidson, 1970a). For example, as Strauss *et al* argue, this is hardly an accurate depiction of chronically ill persons who, except for during the most acute phases of an illness or altogether helpless, are engaged in managing and shaping their lives in the face of physiological impairment. They also gain varying degrees of knowledge about medical technology. Shifts in the division of labour on both wards at Woodlands indicate that patient knowledge and skills are increasingly being taken into account in the allocation of work on the wards.

Patients were also being encouraged to engage in work which for the most part would remain invisible to nursing staff. Notices and information leaflets around both wards emphasised the patient's work role in relation to the prevention of pressure sores. The information leaflet was sub-titled *'Helping Us to Help You'*, and emphasised the responsibility of patients to change their position in bed every two hours, and if able, to take short walks to improve their circulation. Advice was also given about appropriate food choices. As Strauss *et al* (1985) point out, teaching is one of the ways in which patients can be integrated into the division of labour. In actuality certain of the recommendations in the leaflet would have been extremely difficult for patients to control within the ward environment. For example, patients who are 'off their food' are advised to eat small frequent meals which, given the

organisation's rigid meal timetable, represented a formidable accomplishment. A final note in the booklet also implicates relatives in the ward division of labour.

> This booklet has been distributed to all patients at risk to pressure sores on the ward, whether able to help themselves or if totally dependent on the nurse. This has been done purposely since relatives may wish to have some advice ie in choosing diet or promoting comfort at visiting times. (Document - *'Preventing Pressure Sores in Hospital'*)

Patients' relatives were being integrated into the hospital division of labour in other ways. Like patients, relatives were requested to undertake housekeeping activities such as arranging flowers, completing patient's menu cards and replenishing water jugs. They were encouraged to undertake portering work rather than wait for the hospital portering service. Relatives were also invited to undertake direct care activities such as feeding patients and, as we saw in the above extract, attending to comfort needs. Relatives of terminally ill patients were permitted to stay with them outside visiting hours and, if they were able and willing, they would undertake a lot of basic care activities. In my own training family and friends wanting to participate in the ward work and help care for their relatives had always been encouraged to do so. What was different at Woodlands however was that the approach was far more proactive: nursing staff and also hospital information leaflets invited relatives

to participate in the work even if they had not expressed a wish to do so.

Another area in which patients were being encouraged to play a more active role was in the planning of care. Patient involvement in care planning was a major organisational concern and was regularly audited by senior nurses. Participation of patients in the planning and evaluation of care was seen by senior nurses as a symbol of the professional-client partnership so important in New Nursing ideology. The experience of the nurses on the wards however was that the majority of patients had little interest in their care plan.

> *(M)ore than half the patients we get just aren't interested in care plans. They don't understand it - they don't see the relevance.* (Staff Nurse)

> *They go on about building a therapeutic relationship with your patient, involving them in planning care, yes that's fine if that's what people want, some people just don't want to know about it.* (Student)

Despite the centrality of the therapeutic partnership to New Nursing philosophy very little is actually known as to how patients respond to this sort of approach to their care (Dingwall *et al*, 1988). Indeed there is some evidence to suggest that the majority of patients see their role as an essentially passive one more in keeping with the model described by Parsons (1951)

(Brooking, 1986, cited by Dingwall *et al,* 1988). My findings appear to support this. As Abbott (1988) has pointed out, public images of jurisdiction typically last for decades.

In summary then, at Woodlands shifts in the division of labour between nurses and patients and their relatives were occurring. These changes in the division of labour were accomplished through considerable negotiative effort. As I mentioned in chapter 4 however, for ethical reasons I was unable to talk to patients about their perceptions of the changes that were taking place, and this is an obvious weakness in the data presented in this section. One question of particular interest is why patients more willingly participated in the physical aspects of their care than they did its planning and evaluation.

Sources of Tension

The importance for patients and relatives in getting the division of labour right in their relationships with health care professionals is well-established in the sociological literature (Lorber, 1979; Murcott, 1981; Kelly and May, 1982; Fairhurst, 1977; Webb, 1977; Taylor, 1970; Rosenthal *et al,* 1980; Lawler, 1991). Few of these studies analyse professional-client relationships specifically in terms of the allocation of work however. The sick work but their work is not necessarily conceived as more than acting properly or decently in accordance with the requirements of their care (Strauss *et al,* 1985; Goffman, 1961). Inappropriate participation in the division of labour by patients frequently leads to judgements by hospital staff that have a strong

moral tone (Jeffrey, 1979; Taylor, 1970; Lorber, 1979; Murcott, 1981).

Although patients and relatives at Woodlands were participating in the division of labour in health care more than had been the case during my own practice, it was nevertheless clear that in negotiating the allocation of work with nursing staff the line they walked was a precarious one. Patients and relatives' awareness of the delicacy of role boundaries was evident in their interactions with nursing staff.

> *Relative*: ((to staff nurse)) I hope you don't think I'm interfering but Mr Allen, his pyjamas are quite wet.

> On the drugs round one of the patients asked if she could have something for her bowels. Staff nurse said, 'We'll get you something written up'. The patient said, 'I'll tell you what suits me best if you don't mind me saying and that's glycerine suppositories'.

> One of the patients asked staff nurse if he was having his 'two special tablets at 10 O'clock'. Staff nurse said, 'What special tablets?'. The patient said, 'I had two orange tablets this morning and they said I was having some more tonight'. Staff nurse said, 'Oh yes. You're jumping the gun a bit. I'll come back to you with those'. The patient said, 'Sorry nurse - I

didn't want to tell you your job or anything'.

As the above extracts reveal, patient inquiries about their medication was a potentially sensitive area.

> *Patients that ask about their drugs they're always seen as trouble-makers.* (Student)

Nevertheless, I observed many occasions in which the patient's vigilance prevented the nurse from administering the incorrect medication.

> Sister had given a patient her tablets and was going on to the next patient when the first one said:
>
> *Patient:* Sister? These orange tablets - I only have one in the morning. I have seven tablets in the morning.
>
> Sister goes back to the patient, retrieves the drug chart and checks the drugs.
>
> *Sister:* They're your water tablets aren't they?
>
> *Patient*: Yes.
>
> *Sister*: ((takes one out)) I don't know why I gave you that.

Lay involvement in the technical aspects of patient care was another important source of tension. There are obvious safety reasons why the attention of patients and relatives to medical equipment would be considered undesirable

by nursing staff. Direct interference with medical equipment by the public was rare however. I only observed one incident of this type and the relative concerned in this particular case was a nurse. For the most part, strains relating to technical work involved the monitoring of equipment by patients and relatives. This was particularly the case on Treetops, the surgical ward, where technology was a readily visible component of patient care.

The nurses were talking about a male patient in bay one who had had surgery yesterday. According to the nurses he had been very 'demanding' and they were commenting on how 'obsessed' he was becoming with his bladder irrigation. Judith explained that he had kept calling the nurses complaining that it was not running. He was so 'obsessed' with it that the nurses took the irrigation down.

A visitor came to the nurses' station and told staff nurse that their relative's 'drip' had stopped and 'the other bag wasn't going'. This was the second visitor I had witnessed coming to the nurses' station and reporting on the bladder irrigation. Staff nurse moaned to herself about how sick she was 'of all the relatives constantly watching the bloody drips all the time.'

It was not that nurses felt that patient involvement in the technical component of their care was illegitimate however, indeed they encouraged patients to

monitor medical equipment.

> Sister came back from the patient: 'It's (intravenous infusion) going but only slowly. I've asked him (the patient) to keep an eye on it in case it speeds up.'
>
> *You'll say 'Keep your eye on your catheter. If it goes dark tell us and we'll come and alter your bladder irrigation', and then they'll sit and they're watching their bladder irrigation dripping, dripping, dripping. 'It's stopped dripping nurse'.* ((frustrated voice)) *'I've switched it off! I don't want it to drip'.* ((soothing voice)) *'It's OK don't worry about it'. 'This bottle's empty!' , 'My catheter's full!' and that's when I feel like saying 'Shut-up!', but they're only trying to make your job easier. They're trying to help and we don't look at it like that. You sometimes feel as though they're interfering. They are interfering it's their care isn't it but we've had the odd patient or two that's not left you alone.* (Staff Nurse)

The last of these extracts hints at the reasons for the tension relating to the monitoring of technical equipment by the lay public. Patients and relatives who engaged in over-enthusiastic monitoring and repeatedly called for nursing attention created more work for nurses, disrupting their work organisation and undermining nursing control over work priorities. Moreover, I suggest that

in their monitoring of equipment patients and relatives also risked appearing critical, in the sense that their actions carried the implication that nursing staff were not doing their job properly.

> *You get them that really do care but they go too far and are constantly running up to the desk saying 'This isn't right' and 'That isn't right'. You feel like either you're not doing your job right or they're sort of like spying on you as though - if they see you sitting down they think you're not doing anything.*
>
> (Staff Nurse)

On a number of occasions during the course of the fieldwork I observed patients that nurses perceived to be 'demanding' moved to different areas of the ward from where nursing staff would be less readily visible.

> *Staff Nurse*: He's a little bit ((lowers voice)) awkward at times. And we've moved him down (to a bed further down the ward away from the nurses' station) because his family's at you all the time. Playing with everything. So we've moved him down. (Nursing handover - Tape)

A further major source of nurse-patient tension related to demands being made on nurses to undertake activities they believed patients could perform for themselves. As Lawler (1991) has pointed out, nurses have a very 'task-

specific' approach to what they regard as situations when patients need assistance. Lawler identifies a recovery trajectory similar to the dying trajectory described by Glaser and Strauss (1968). During the recovery trajectory nurses negotiate the 'handing back' of control over the body. According to Lawler, the recovery trajectory follows a pattern and timetable which is predominantly set by the nurse rather than the patient. Variations in this pattern can cause strains. Lawler's findings appeared to be supported in this study.

Some patients could take too long to recover leading nurses to reinterpret their expectations of the patient's condition. Nurses may exert pressure on patients to resume their normal activities.

> *We've got a lady at the moment who likes to go to the toilet on the bedpan when she's quite able to walk - it's slow and it's a little bit painful for her to walk but if we can keep them walking we prefer to do that.* (Staff Nurse)

> *Student*: She had a steroid injection into her knee this morning so she's on twenty-four hour bed-rest. So she can now use the commode legally! (Nursing handover - Tape)

Other patients tried to recover too quickly, which strained with nurses' concern with their physiological well-being.

A patient wanders out of bay one with his wash things and a towel in his hands.

Patient: Sister I've just come up from coronary care. Is it OK if I have a shower?

Sister: Umm ha - umm when did you come up?

Patient: Today.

Sister: When did you come in?

Patient: Tuesday. I can leave it til tomorrow if you like.

Sister: If you would. I'd prefer it tomorrow. I'm on in the morning.

Staff Nurse: You have to watch her because she tries to do too much. So she tries to look after Violet next to her. So she needs to be watched. (Nursing handover - Tape)

The handover was a central mechanism through which nurses and support workers were able to 'stage' (Levy, 1982) their negotiations with patients. Handover ensured that all staff were aware of the appropriate division of labour for each patient and were consistent in their expectations of them.

According to Lawler, nurses' expectations about appropriate recovery trajectories are based almost exclusively on the patient's medical condition. My data suggest however, that nurses' perception of the appropriateness of patient participation in their care was also overlaid by workload

considerations.

> DA: *Do you ever feel slightly aggrieved if a patient says 'Can you pour me this orange juice nurse?' if they're capable of doing it themselves?*
>
> Staff Nurse: *If I'm absolutely honest yes because you kind of think 'We're not here just to do that. We've got other things to do' [...] it's also quite frustrating when they press their buzzer, you stop doing something really important to go and pour an orange juice.*

On the whole, patients who did too much did not cause the same friction as those that did too little. Although interestingly, there was an absence of tension relating to patients' reluctance to be active participants in the planning of their care. Arguably however, this actually made nurses' lives easier as it was less time-consuming to write a care plan without the patient. Given these findings, it is difficult to resist the conclusion that the shifting of boundaries between nursing and patients and their relatives had as much to do with easing the onerous burdens of work on nursing staff in an efficiency conscious health service, as it did ideologies of therapeutic partnerships. In the North American context, Brannon (1994) has argued that the intensification of care brought about by the shift to primary nursing in an era of cost-containment in health care led to nurses shifting tasks previously performed by auxiliaries onto patients and their families. Indeed at Woodlands, although patient and

relative participation in their care was supposedly voluntary, there was some evidence to indicate that in certain cases nurses had come to rely on it.

> Stephanie was complaining about a new lady who was not measuring her urine out as the nurses had instructed her to. She complained that the lady, 'kept letting the bedpans pile up in the toilet.' Stephanie said that there was no reason why she should not be monitoring her own urine output. Stephanie seemed quite frustrated by the patient's failure to participate in the division of labour. Sister said that they would ensure a nurse went through the routine with her again this afternoon so she knew what she was doing.

> The nurse from paediatrics commented that they would not be able to manage if the parents didn't give the children their washes and their care. She said that they had so many surgical cases that they just didn't have time. She said that she thought the children would be neglected if it were not for the parents. She said it made her feel such a failure.

> With a helpless patient, the ward Sister may welcome your offer to help during meal times. The patient may appreciate your personal help and it certainly can reduce the load on busy nurses. (Document - *'Information for Visitors'*)

Consumerism

A striking feature in the accounts ward staff gave of their work was their recurrent use of the service metaphor. As I mentioned in the introduction to this section, my attention was first drawn to the nurse-patient boundary when a staff nurse complained to me about being treated like a servant.

> Gill came out of the ladies' bay looking harassed. I gave her an inquiring look. She beckoned me into the sluice. 'That woman in bed 2 is driving me mad' she announced. 'Every time I go anywhere near her bed she is asking me to do something'. Gill said that this particular patient had asked her to turn the television down. 'There's no reason why she can't get up and turn the television down herself' Gill reasoned. Gill said 'I don't come into work to run around turning the TV down. That's not what nursing's about is it? I'm not a bloody servant' ((I smiled sympathetically)).
>
> *Student 1*: I felt like a slave this morning - you know a black slave in a loin cloth. 'Do this. Do that. Get me this. Get me that'. She might as well have been whipping me!
>
> *Student 2*: Oh we do love our patients!'

The service analogy took other forms.

You get some who think it's a five star hotel - 'Get me this. Fetch me that'. (Auxiliary)

Sometimes a patient will get a bit huffed about it and they do sometimes think you're like a waitress and you've got to do everything for them and they'll ask you to do simple things like moving a glass off of the side. (Auxiliary)

At one level the service metaphor reflects nurses and support workers' perceptions of illegitimate demands by patients which, as we have seen, were also bound up with their expectations of patient recovery and workload considerations. At another level however, I suggest that the service analogy also indicates ward staffs' sense of their weakness in negotiating the boundaries of their work with patients in the context of increasing pressures on their time. It was clear from my observations at Woodlands that nurses and support workers perceived consumerism to have had a significant impact on their power vis-a-vis patients.

I mean patient's rights - they're reporting you left, right and centre now. (Auxiliary)

(T)he patients are different... [T]hey [...] expect everything - you have to run around after them. 'Make me a cup of tea now'! Sometimes they treat you like a slave. (Staff Nurse)

Through considerable negotiative effort, shifts in the division of labour between nurses and patients and their relatives were occurring on Fernlea and Treetops wards but not entirely in the direction one would have predicted from developments in nursing and health policy. A lot of the work into which patients and relatives had been co-opted seemed to derive as much from the need to relieve the pressures of work on the nursing staff or plug other gaps in the service - such as portering - as they did from nursing ideologies of partnership in care. These findings are supported by the observation that sources of tension in the division of labour between nurses and patients and their relatives were most evident where this either created additional work for nursing staff and/or undermined nurses' control over work organisation.

The recurrence of the service analogy in ward staffs' accounts of their work suggested that, as a result of consumerism within health care more generally, nurses felt constrained in negotiating the boundaries of their work with patients. Nurses appeared to accept the changes to the technical division of labour that were occurring at Woodlands as long as the moral division of labour remained in tact. Patient activities that undermined nurses' work control and the consumerist climate threatened the moral division of labour on the wards however and was a source of tension.

Summary and Conclusions

In this chapter I have outlined how the use of Hughes' concept of dirty work as a sensitising device led to the re-evaluation of the initial assumptions

guiding this study. I describe how my field observations revealed less negotiation of inter-occupational boundaries than expected and little evidence of explicit conflict on the wards. However, as we have seen by keeping the dirty work concept in the forefront of my mind and attending to those aspects of their work nurses moaned about I discovered three other boundaries nurses found problematic.

First, we have seen how nurses' complaints about 'doing the obs' led me to intra-occupational tensions engendered by nurses' attempts to reconcile ideologies of autonomous practice with the reality of ward work. Second, nurses' complaints about the paperwork drew my attention to strains at the boundary between ward staff and nursing and general management. Finally, a nurse's complaint about being treated like a servant led me to the tensions associated with the changing division of labour between nurses and patients and their relatives.

As I outlined in chapter 3, in utilising the concept of dirty work in this thesis I was employing it in a very specific sense. Following Emerson and Pollner (1976), my interest was in work that was symbolically or morally discrediting from the perspective of nurses themselves. In this view dirty work designations should be interpreted as a boundary-defining stance, a mechanism through which workers distance themselves from those work activities which threatened their occupational identity. As Strauss *et al* (1985) point out however, aspects of work and tasks deemed dirty can be of several types.

As we have seen Emerson and Pollner follow Hughes' concern with moral order, relating observations of the work itself to a particular occupational perspective. Strauss *et al* however, focus more closely on the work itself and suggest that rather than thinking of dirty work as a special class of work, it makes analytic sense to regard all work and all tasks as potentially definable as being dirty or having dirty aspects. Work tasks may be deemed dirty if they become extremely routinised, boring, and unchallenging. Another type of dirty work consists of tasks so exhausting or stressful as to tip towards the nongratifying and ultimately the dirty side of work. Still another type of dirty work is work which is literally so physically dirty as to be distasteful.

Analysing my data it became clear that nurses' complaints about their work suggested work was 'dirty' in different ways. For example, as we have seen the nurses on Treetops complained 'about doing the obs'. At one level this reflected the drudgery of the task itself. At another level however, 'doing the obs' signified the tension associated with the intra-occupational division on labour of the ward. Likewise, paperwork was designated dirty because of its voluminous and repetitive nature and its lack of relevance to everyday nursing practice, but also because it was a symbol of management control. Similarly, the use of the service metaphor by ward staff reflected nurses' perceptions of illegitimate demands by patients on their time but also their sense of the changes in negotiation context brought about by consumerism within health care. As Strauss *et al* point out, although several types of dirty work can be distinguished analytically, in real life they can become blurred.

PART 4

The Division of Labour at Work

To recap briefly, the sociological and professional literature led me to anticipate that as a result of recent policy developments in health care and medical and nursing education, there would be an increased need for negotiation of nurses' inter-occupational boundaries and that this would be subject to some dispute. In chapter 6 I argued that the presence of inter-occupational tension appeared to be confirmed by the interview data but that this was not supported by my field observations which revealed less negotiation of inter-occupational boundaries than expected and little evidence of explicit conflict on the wards. Moreover, nurses' dirty work designations indicated unanticipated friction at their intra-occupational boundaries, at the boundary between ward-based staff and nursing and general management, and at the boundary between nurses and patients and their relatives. I discussed these unanticipated conflicts in chapter 6 and argued that the intra-occupational division of labour and the division of labour between ward nurses and patients and their relatives were associated with a great deal of negotiative effort but this was not case with the boundary between ward nurses and nursing and general management. In part four I want to focus on nurses' inter-

occupational boundaries. I suggest that if we study the processes through which these divisions of labour on the wards were routinely accomplished we can begin to understand the dearth of boundary negotiation and the lack of explicit inter-occupational conflict between nurses and doctors and nurses and support workers.

The organisation of the material discussed in Part 4 reflects the theoretical perspective employed in this thesis - that the division of labour is most fruitfully conceived as an interactive social process. Occupational roles are not self-evident but have to be actively constituted by actors within a system of work. Given these assumptions I suggest that the division of labour can be considered as constituted through the dynamic interaction of boundary-blurring and boundary-creating processes.

In chapter 7 I examine boundary-blurring processes. I shall argue that the temporal-spatial organisation of ward work led to the routine blurring of inter-occupational boundaries in ways which minimised negotiation and explicit conflict. In chapter 8 I turn to boundary-creating processes. I shall argue that certain of these boundary-creating processes were also instrumental in diffusing overt inter-occupational conflict.

7. Boundary-Blurring Processes - Occupational Jurisdiction and the Temporal-Spatial Order

Initially spatial and temporal considerations were elements in a longer list of those features of hospital work I had identified as inviting the blurring of occupational boundaries. On revisiting the sociological literature whilst planning the writing of this chapter however I realised that **all** of these boundary-blurring processes could be understood in terms of a temporal-spatial framework. Furthermore, it became clear that the temporal-spatial order at Woodlands encouraged boundary-blurring in ways which minimised inter-occupational negotiation and in so doing, reduced the potential for conflict.

THE SOCIOLOGY OF TIME AND SPACE

As Strauss *et al* (1985) point out, those who write about work in organisations inevitably include or touch upon such matters as scheduling, timing, pacing, and frequency in their descriptions. It is less usual however, for such concerns to be explicitly included in analyses. Notable exceptions to this rule

may be found in the work of Moore (1963), Zerubavel, (1979) and Rosengren and DeVault (1964) who have developed focused examinations of time, and, in the case of Rosengren and DeVault, also space.

Moore (1963) provides a general discussion of temporality and social organisation in *Man, Time, and Society*. Beginning with an investigation of the temporal ordering of activities and individual lives, Moore goes on to consider the time structure of the family, administrative organisation and voluntary associations before concluding with an exploration of temporality in large scale systems: the city, economy and, finally, the world and the universe.

Zerubavel's work on temporality (1979, 1985, 1987) is detailed and wide-ranging. His study of the temporal structuring of health care has particular relevance to this thesis. In *Patterns of Time in Hospital Life* (1979), Zerubavel explores temporal features such as the social cycles - the year, the rotation, the week, the day and the duty period - by which patient coverage and routine activity are organised and highlights the problems these cause for coordination. He also examines the effects of time on work group solidarities. He reveals how the temporal division of labour can become the basis for staff allegiances which cut across conventional sources of social differentiation. Zerubavel provides fascinating insights into temporality in hospital life. He can be criticised however for not taking his analysis far enough thereby leaving key temporal features un-analysed. Strauss *et al* (1985), discussing

the theoretical implications of the *'Social Organization of Medical Work'*, argue that analysis of the temporal order of the organisation requires a much broader range of temporal dimensions.

According to Strauss *et al* an organisation can be considered as a temporal matrix which is constituted by a variety of biographies. The authors employ the term 'biography' because past, present and future are concerned. Strauss *et al* outline the sorts of biographies they believe are implicated in organisations. Organisations embody multiple lines of work, each with its own biography. There are also technological biographies, life histories of individual occupations, different personal biographies of employees and clients, as well as the biography of the organisation itself and its sub-units. Hughes has made similar observations (Hughes, 1984: 132-140).

Strauss *et al* maintain that the components of the temporal matrix may each be affected by more macroscopic temporal conditions: movements of impinging industries, larger social movements and industry-wide or nationwide or international trends. They also underline the importance of the temporal images of actors within the organisation, which may be carried into their social interactions, with profound effects for the work drama.

According to Strauss *et al* we should not think of the temporal order as a separate kind of social order, but as a concept that can foster a deeper understanding of how work and institutions are organised. We should not

make the mistake, they argue, of conceiving the elements of the temporal order as inflexibly grounded in organisational rules or moving along through an inherent determinism. It is crucial to understand also that elements of temporal order - not just such as scheduling and pacing - but even technological and personal biographies are arguable, negotiable and manipulatable.

Thus far I have reviewed sociological insights into temporal aspects of work organisation. Others have also incorporated a spatial dimension into their analyses. Rosengren and DeVault (1964) adopt an ecological approach to the study of an obstetrical hospital. Ecology is defined as 'the study of the morphology of collective life in both its static and dynamic aspects' (Rosengren and Devault, 1963: 68, quoting Hawley, 1950). It is an approach that views social behaviour in terms of its spatial and temporal dimensions. In *'The Sociology of Time and Space in an Obstetrical Hospital'* Rosengren and DeVault examine features of the temporal order of the hospital such as the rhythm of activities, tempo and timing. They also provide new insights relating to spatial dimensions of social organisation including the spatial distribution of activities and the spatial segregation of behaviours. For example, they found that the behaviours of personnel differed markedly depending on where it took place. These authors argue it was improper to speak of the nurse-doctor relationship without specifying where those two persons interacted and when.

Taken together, then, this literature encourages us to consider time and space in the broadest possible terms. But whilst all of the above studies include analyses of the social organisation of work within their time and/or space frameworks, none specifically examine the relationship between the temporal-spatial ordering of the **work** and the division of **labour.** It is my contention that the organisation of hospital work has certain unique features which lead to the occupational boundaries of medical, nursing and support staff being constituted, in part at least, by their location in time and space. Indeed one could go so far as to suggest that the division of labour on the wards at Woodlands reflected temporal-spatial jurisdiction rather than occupational jurisdiction and that for analytic purposes it might be useful to make a distinction between the two.

TURBULENCE

As Zerubavel (1979) has shown, a key feature of the temporal-spatial ordering of hospital work is its complex work rhythms which create what Melia (1979) has called a 'turbulent' work environment. At one level this turbulence reflects the centrality of the patient, which as Strauss *et al* (1985) point out, makes medical work fundamentally non-rationalisable.

> *There's things happening everywhere [...] There's buzzers going off, and you're thinking 'Who should I deal with first?' and you have to get your priorities right.* (Auxiliary)

At another level hospitals are complex, heterogenous, internally segmented organisations, and patient care has to be coordinated 24 hours a day, 365 days a year, with numerous timetables which are often in conflict. Staff at the point of service delivery have to manage the daily tensions between the unpredictable needs of their patient with the complex temporal structures of the hospital.

> *I was talking to my student about it the other day. [...] I was discussing how he was doing and everything. [...] We were sort of saying that his care's fine what he's doing but I was saying he's not got a broad look. I said 'I have sort of a menu in my head. I have like a time clock and you're not consciously doing it but you're looking at the clock and you're thinking yes at ten O'clock such-and-such needs doing, and oh eleven O'clock such-and-such needs doing' and you just keep taking these bits of information and I think I slot them into my clock.* (Staff Nurse)

I suggest that the various strategies staff employed in managing this turbulence resulted in the routine, non-negotiated blurring of occupational boundaries without which the work could not have been accomplished. I shall begin by exploring those aspects of the ward working environment which invited nurses to undertake work that others have classed as low-skilled.

What Should the Nurse be Doing?

Non-Nursing Duties?

A central concern in the skill-mix literature is the performance of so-called 'non-nursing' duties by qualified nursing staff. Ball *et al* (1987) conclude that between 18-28 percent of nursing time is spent on tasks described as non-nursing work which could be more suitably carried out by support staff. Studies of this kind supply powerful ammunition for health service managers concerned with limiting nursing budgets but they provide few insights into the context in which ward work is carried out. Moreover, in breaking down nursing into a series of tasks rather than examining the process they gloss over the complex ways in which patient care is organised.

Nurses are uniquely placed within the hospital division of labour; no other occupational group maintains twenty-four hours a day contact with the patients, 365 days a year. As Davies, points out however, one of the dilemmas for the nurse of 'being there' is that s/he is not going to bother unduly with demarcation issues. At Woodlands, like any other hospital, the temporal and spatial organisation of work led nurses to undertake a range of mundane activities outside the limits of their formal jurisdiction - such as clerical work and portering. Nurses performed these tasks because they felt it was necessary for them to do so but their comments and remarks suggested that they regarded such work as illegitimate. Nurses undertook other types

of 'mundane' work which was handled rather differently however, intertwined as it was with the process of nursing.

On both wards nurses regularly performed activities which could be considered by an external observer as easily carried out by support staff. Often the reasons for nurses undertaking mundane work were pragmatic. Patients' washes, meal times, observations and drug adminstration, formed an elementary temporal structure for the delivery of patient care but as I have argued within these daily routines much of the work was unpredictable. Nursing staff were continuously readjusting their priorities in order to manage the routine and contingent aspects of their work. In the course of their everyday activities nurses regularly undertook unskilled work simply because they were on the spot at the time. Here we can see the effects of the interaction of time and space on nursing work: the costs involved in allocating the work to somebody else frequently outweighed any advantages of delegation.

> *Sister*: If you happen to be there and the patient needs something then you do it for them however expensive you might be.
>
> *If I'm passing and a patient wants to go to the toilet and he says 'I can't wait' then I'll take him to the toilet. I don't look round for somebody to take him. I'll do it.* (Senior Nurse)

Nurses who incurred the costs of delegation rather than undertaking low status work themselves were regarded with derision. All ward staff willingly performed low status work when it was expedient for them to do so. When mundane tasks were allocated to lower level staff without any practical purpose however, the technical allocation of work came to symbolise the moral division of labour and underline one's lowly place in the ward hierarchy.

Most staff on both wards were critical of status consciousness. The primary focus for nurses and support workers was the ward team. As Zerubavel (1979) observes copresence is an important source of social solidarity and can be so strong as to outweigh loyalty to one's own occupational group. Ward team members sat together during coffee and meal breaks. To do otherwise was to break a fundamental norm.

> An HCA had sat down with her meal and she appeared to be alone. One of the nurses I was with invited her to join us if she was on her own. The HCA declined the offer saying that staff from her ward were still getting their meal and would soon be joining her. In the event the 'staff' were two staff nurses who sat and joined some other staff nurses sitting at another table who were not from the same ward. They did not join the HCA. The HCA was furious - she blushed and begrudgingly went to join the staff nurses.

Staff who flaunted the symbols of their position were derided and subject to informal sanction.

> Laura was wearing her purple belt - the symbol of a staff nurse - over the top of her yellow apron. Marcia laughing, yanked on Laura's belt as she was going past. 'Look at this - tell everyone that I'm a staff nurse even though I've got a yellow apron on'. Laughing Laura took off the belt and then removed the apron.

The importance of minimising status differences on the ward created a particular sensitivity towards the handling of work that was literally unclean. As Hughes (1984) has suggested, a task that is dirty can be tolerated when it is part of a good role, a role that is full of rewards to one's self. Staff accepted literally dirty work when it could be interpreted as an act of caring. When physically unclean work was delegated without good reason however, it was read as an unequivocal marker of the moral division of labour on the ward. Delegated physically unclean work was symbolically dirty and was therefore regarded as illegitimate.

> *I accept it if you find it and I accept it if people are busy and - say they're going round on a round for example and somebody finds somebody in a mess and then they say, 'Would you mind clearing So-and-so up?' - the times I don't like it is when*

somebody finds it and you know that they've got time to deal with the situation but they just pass it on. (Auxiliary)

Whereas other mundane tasks, such as making a bed, could be legitimately delegated if the nurse had other work priorities, physically unclean work tended to be managed according to the principle of 'S/he who finds it, deals with it'.

DA: *Who gets to wipe the bottoms? Clear up the incontinent patients?*

Staff Nurse: *We all do depending on who finds them unless you're in the middle of doing something, you might say 'I'll come back to you', or you might say 'Could you get some stuff ready for me and I'll come and help you', but we all tend to as far as I know. I've not seen anyone say 'Will you go and clear up that patient'.*

(S)ometimes I do things that I won't ask somebody else to do even though it might be more appropriate for me to ask somebody else to do because I sort of think 'Oh God I couldn't possibly ask somebody to do that. I've found it and I know about it so I'm blooming well going to do it'. (Senior Nurse)

Nurses had to have very good grounds for the delegation of physically dirty work to be considered legitimate.

> DA: *If somebody found it and asked you to clear it up how would you feel about that?*
>
> Student: *I'd think well why can't you do it? And if they couldn't give me a good excuse then I'd be pissed off.*

Key members of the senior nursing staff on Treetops ward were perceived by other members of the ward team to be status conscious and to allocate work in a way that reflected the moral division of labour on the ward. This was an important source of intra-occupational tension.

The ethnographic literature has highlighted the importance within nursing of 'getting through the work' (Clarke, 1978; Melia, 1987); work being defined in physical terms. Clarke has argued that the language nurses use emphasise this perspective: 'the work load', 'working hard', 'pulling your weight', 'pulling together', 'mucking in', 'like horses', 'getting through it', 'getting on with it' (Clarke 1978: 76-78). However, Clarke's analysis overlooks a second feature of nurses' language use: the emphasis on working **together equally.** I suggest that by demonstrating their preparedness to 'get their hands dirty' nurses were also investing in their working relationships.

(Y)ou've got to show willing as well, that you're prepared to do it, because if you are going to ask somebody else to do something in the future hopefully they will see that you are prepared to do it and it's not just a case of you devolving that dirty task onto somebody else because you don't want to get your hands mucky. (Senior Nurse)

(Y)ou've got to be sort of managing in one sense but you've also, people wouldn't think very kindly of you if you didn't answer the buzzers now and again and did sort of practical things as well. (Sister)

'Low-skilled' work activities were incorporated into nursing jurisdiction in other ways. In managing the ward turbulence the nurses employed a characteristic mode of work practice. Like housewives (Oakley, 1974a; Oakley, 1974b; Hochschild, 1990), they were frequently engaged in doing more than one thing at a time. I have called this distinguishing feature of nurses' work strategies 'multi-tasking'. 'Multi-tasking' appeared to be of four kinds: essential, reactive, pragmatic and strategic.

By essential multi-tasking I refer to the background skills required of qualified nurses in order to function as competent members of the ward team. The New Nursing ideology emphasises the centrality of the nurse-client relationship, but as we have seen, on the wards it was the ability to

successfully coordinate multiple patient assignments with numerous external organisational timetables that was crucial. A single qualified nurse could be responsible for the care of up to seventeen patients. S/he would undertake basic and technical nursing care tasks, emotional labour (Hochschild, 1983; James, 1989; James, 1992a; James, 1992b), the coordination of the total work complex as well as the 'supervision' of support staff and students. Observing nurses on the wards, the juggling analogy so often applied to women's domestic work, seemed equally apposite.

> *Staff Nurse*: (Y)ou've got a dozen things going on in your head that you're trying to remember. You're doing three things at once. You're doing one thing, waiting for someone to get back to you about something else, and trying to remember to catch the doctor when he comes to the ward to tell him something.

Nurses also undertook reactive multi-tasking. Here a number of tasks were performed simultaneously in response to an increase in workload.

> A white male doctor came onto to the ward. He had a European accent - possibly German. Sister appeared to be expecting him.
>
> *Doctor*: What do you want?
>
> *Sister*: He said Augmentin.

Doctor: Anything else?

Sister: Can you write him up for some TTOs?

Doctor: TTOs!?

Sister: Just for those. He's got the rest.

The doctor writes on a drug kardex. Sister is talking to someone on the telephone. Sister reaches across and fetches another form for the doctor and places it in front of him.

Sister: I'll just get you the TTOs. It's just that he's going home for a few days at the weekend.

Doctor: Oh. Anything else?

Sister: Can't think of anything.

Doctor: I don't know the diagnosis or anything.

Sister: I'll do that.

Doctor: Anything else?

Sister: I can't think of anything.

Doctor: OK. See you later.

Sister: OK thanks very much.

Meanwhile a patient has arrived from CCU (coronary care unit) - he has a blood transfusion. Sister tells the porter and nurse which bed space he is to occupy. When the doctor has gone the CCU nurse hands over the patient details to sister.

The patient has had heart attack. The CCU nurse says that 'There's a lot going on with him'.

Sister: I'll have to bleep the doctor again. He's just been on the ward. I wonder if he's on the admissions unit.

Sister phones down to the admissions unit - he is not there. She bleeps him again [...]

> Sister said to me, 'When you've finished this research see if you can find out if there's any way nurses can do only one thing at once!'.

It was through nurses' use of pragmatic and strategic multi-tasking however, that mundane work activities were incorporated into everyday nursing practice. Nurses adopted pragmatic multi-tasking when it was expedient to undertake a mundane task whilst they were carrying out other skilled nursing activities. For example, nurses tidied the patient bed areas as they were checking their patients, assessing their well-being and up-dating their charts at the end of a shift.

In the case of strategic multi-tasking, nurses undertook a mundane observable task in order to carry out another invisible activity. Strategic multi-tasking regularly resulted in the blurring of the nursing and support worker boundary. On Treetops and Fernlea the most commonly utilised type of strategic multi-tasking occurred when a mundane task was undertaken in order to structure

a more complex nursing activity.

Nurses used mundane physical tasks in order to structure their interaction with patients. Everyday social interaction is governed by taken-for-granted moral rules which, if followed leads each person to regard the other as polite, courteous and reasonable. One of the difficulties nurses faced was how to put themselves in a position to build relationships with patients in a context that was socially comfortable for both.

> *(J)ust to go round each patient, sit by them and chat to them all, it can put them on edge. If it's new staff and you can go in and do something and take the emphasis off that and see what's happening to them, they feel a little bit more relaxed. Rather than you sitting there and drilling them and seeing how they are. You know 'Open up to me. Tell me all your problems'.* (Staff Nurse)

> *I would go and make a few beds but not 'make the beds'. I would do it if I wanted to chat to a child and parent and to put myself in a position to open up a conversation.* (Senior Nurse)

The ethnographic literature has highlighted the effects of nurses' work rhythms on nurse-patient relationships (Henderson, 1981; Melia, 1987; Buckenham and McGrath, 1983). Henderson's (1981) analysis of the division

of labour in a nursing home reveals that contrary to the formal allocation of work it was the housekeepers who performed psychosocial care. Henderson attributes this in part to the reduced social distance between housekeepers and patients. But he also signposts housekeepers' sustained pattern of work, compared to the episodic work patterns of nursing staff as a further contributory factor. Henderson's observations are supported by Hart (1991) who, in a study of hospital domestics, learnt that a routine health check found domestics who worked on wards where patients were receiving radiotherapy treatment registered higher levels of radiation than those of the nurses on the wards.

Owing to the turbulence on the wards, nurses' work rhythms were typically brisk and their contact with patients fleeting. Nurses recognised that their work patterns often made it difficult for patients to talk to them. Undertaking mundane work in quieter periods was also a way of making themselves available to the patients.

> DA: *I've seen you go round with your trolley - tidying up at the beginning of a shift.*
>
> Sister: *But I use that as a way of finding out if there's a problem [...] I won't spend long with everybody because some don't need you. It's just a case of 'Hello how are you getting on? How many times have you passed your water?' [...] I will also like tidy things up as I go [...] I think if it was me, at least*

if somebody's coming round all the time if there's something that they want to ask they are going to eventually ask somebody. So you just make yourself available.

Strategic multi-tasking was also used by senior staff who performed mundane work - for example bed making - in order to unobtrusively supervise the work of junior members of staff. At intervals throughout the fieldwork I too involved myself in mundane ward activities in order to observe the ebb and flow of ward life.

In sum then, the turbulence of the ward environment did not lend itself to a rationalised division of labour. Given the interactive effects of time and space on nurses' work rhythms it would have been utterly impractical to divest nurses of all 'mundane work' activities and, as I hope my discussion of multi-tasking has shown, any attempt to do so ignores the subtleties and complexities of hospital nursing.

Hands-on Care

As I argued in chapter 1, recent policy developments in nursing and health care have rekindled long-standing debates about nurses' involvement in hands-on care. As Strauss *et al* (1985) point out, ideological disputes can centre around the kinds of tasks that are to be regarded as degraded or honouring.

'[Work] is dirty by definition, not only by the person doing it, but by definition of **multiple** audiences [...] some of these audiences may be likely to convert some kinds of scut work into (discrediting) work, while at the same time other audiences might be trying to convert aspects of the same [...] work into positive virtues, deserving of honor' (Strauss *et al,* 1985, quoting Gerson, 1981b).

Contemporary debates about the value of hands-on care reflects the tensions between professional and service versions of nursing. New Nursing emphasises the centrality of the nurse-patient relationship and advocates an holistic approach to care. This represents a change from the old system of hierarchical task-allocation in stressing that nursing practice should be the province of trained staff. It is a vision of nursing however, that is clearly at odds with that of many health services managers, concerned to cut costs and faced with a Government imperative to reduce junior doctors hours. In this section I examine the ways in which ward-based nurses managed these tensions.

As I have described in chapter 6, irrespective of jurisdictional claims made by the nursing leadership in the public arena, their ward-based colleagues spent as much, if not more, time on paperwork as on patient work. Nevertheless, most of the nurses valued hands-on nursing care highly and regretted that because of their other work pressures they were not able to get as involved as

they would like. At the same time however, it was clear from nurses' accounts that direct patient care activities involved emotional and physical labour which was difficult to sustain. Nurses who disliked patient contact work were considered deviant and derided for being lazy as this led to intolerable burdens for other staff members. As we saw in chapter 6 this was an important source of intra-occupational tension on Treetops ward. Nevertheless, bathing patients' was a rare occasion for sustained contact with patients which afforded nurses the opportunity for the sort of relationship building that was felt to be a central reward of the job. It seemed to me that it was this aspect that nurses felt was often missing from their work rather than the physical tending activities *per se*.

> *I often say to my husband 'I wish I'd not done my training. I wish I was a health care assistant'. He says 'Well what do you mean?', and I say 'Well - it's a lovely job. You know they get in bathroom'. I know they end up doing a lot of baths but that wouldn't bother me what-so-ever. I might have a different perspective if I was doing it all the time but <u>you know to sit and have chance to talk to people</u> and do their hair - it would be absolutely lovely.* (Staff Nurse - my emphasis)

Davies (1995) calls the difficulties nurses face in actually doing the job for which they trained 'the polo mint problem'. According to Davies, this reflects the fact that the practitioner role is not there and that nursing has

always had to be accomplished with a variable and transient labour force. The reality is that qualified nurses have found themselves supervising and managing the work of others who do most of the care delivery. By reducing students' contribution to service provision, the Project 2000 reforms may go some way to stabilising ward staffs, but as I argued in chapter 1, there is little evidence of a Government commitment to the practitioner role advocated by New Nursing ideology. Indeed, if anything the Government support of nursing reforms reflected the opportunity it represented for the further dilution of the nursing workforce in the search for economy. At Woodlands, 'the polo mint problem' was very much in evidence.

Nurses' participation in direct patient care activities was variable, fluctuating according to the other demands on their time. Senior nursing staff had least involvement as they were most often 'in-charge' or 'coordinating' the shift. Nurses' involvement in hands-on care activities also depended on the skills of the other staff with whom they were working. The most noticeable influence on nurses' capacity to undertake direct patient care work however was the peaks and troughs of the daily and weekly work rhythms.

On weekdays, between nine and five, the demands on nursing staff were numerous. As I described in chapter 6 in addition to the more technical aspects of care, much nursing effort went into coordination work, patient processing, liaising with doctors and communicating with patients' family and relatives. Nurses took the opportunity to undertake more hands-on care work

at the weekend and on public holidays when the wards were typically quieter. The following observations were made on a Monday morning.

> Jane was in bay one doing the BMs (blood sugar monitoring). The patients were remarking that they'd not seen very much of her today. Jane said, 'I was in here a lot yesterday because I wasn't busy. When I'm busy you don't see anything of me'.

During the week nurses had to ration their involvement in hands-on care. On both wards on the morning shift nurses and support staff initially worked towards the common purpose of getting patients up, helping them to wash and giving them their breakfast. After about nine O'clock the division of labour between nursing and support staff became more differentiated. Support staff continued with hands-on care tasks and answered patients' call-bells. On Treetops ward qualified staff were preoccupied with preparing patients for theatre and processing new admissions to the ward. On Fernlea it was primarily the coordination of care activities such as liaising with doctors and making discharge arrangements that took nurses away from hands-on care.

> *Staff Nurse*: Until about nine thirty you're with your patients doing the baths. That's when you get your patient contact. But then you have to leave the auxiliaries to finish off the baths because you have all the obs to do and the diary to sort out. You spend all your time sorting out the diary. Then if you get

> an admission or, like this lady this morning who went really poorly, then that throws everything.

At night, when the working environment was typically less turbulent, nurses' involvement in direct care was again shaped by the other pressures on their time. At the beginning of the shift nurses were normally preoccupied with drug adminstration and patient observations. It was support staff therefore who settled patients, making them comfortable for the night. Once patient observations and drug administration were completed however, direct patient care was shared between nursing and support staff.

The ward work rhythms shaped the division of labour between nursing and support staff in other ways. During the course of my observations I heard nurses referring to certain of their colleagues being 'off the ward' even though they were actually still physically present on the ward.

> *Staff Nurse*: The problem with the ward round is that it takes so long. It's a qualified nurse off the ward for two or three hours.

I began to realise that when nurses talked about staff being 'off the ward' they were referring to their availability for work rather than their literal physical location. The need to adhere to organisational timetables, coupled with the uncertainty of the ward environment and the ever-present threat of an

emergency, meant that nurses' tried to keep themselves available in case their skills were needed elsewhere. This had important implications for the division of labour between nurses and support staff. First thing in the morning nurses worked in the patient bay areas from where they were able to flexibly deploy their skills rather than 'getting tied up in the bathrooms'. It was support workers therefore who assisted patients in the bath.

> *(Y)ou've got to be available to do medicines, they'll probably still be wanted to be giving an injection. I think you've got to have them floating. I don't like staff nurses tied up in the bathroom doing general baths. That's not necessary - their skill can be used on the wards.* (Staff Nurse)

On the night shift it was rare for nurses to be involved in the performance of last offices for similar reasons. This was a lengthy procedure which involved prolonged absence from the main ward area.

Within this overall framework nurses appeared to employ a number of decision rules in selecting which patients they were going to provide hands-on care for. Priority was given to acutely ill patients. For example, on Treetops, Sister insisted that the nurses focused on those patients who had recently undergone major surgery. Allocating work in this way reflected the skill needed to manage a patient with a surgical wound, drips and drains.

Nurses also concentrated on those patients where the provision of hands-on care allowed them to simultaneously engage in other skilled nursing activities. This is another example of nurses' strategic multi-tasking. For example, in the following extract the staff nurse has decided to bath a patient in order to assess the condition of her skin.

> *Staff Nurse*: Have we got anyone else in our team?
>
> *HCA*: There's Mrs Lawler.
>
> *Staff Nurse*: She's a blue. There's Mrs Wright. I said I'd do her because she says her bottom's sore.
>
> *HCA*: And then that's us done.'

If the workload permitted, nurses also allocated themselves work for interpersonal reasons. Staff developed particular attachments to some patients.

> *Sometimes you find special patients who've been in a long time, the qualified prefer to do it (perform last offices). So it's their last thing that they can do.* (Auxiliary)

Support staff on Fernlea seemed happy with the division of hands-on care work on the ward. They expressed sympathy for the nurses who were unable to get as involved in hands-on patient care work as they wanted to. Two of the 'careerist' auxiliaries who had seen support work as a route into nursing were reconsidering their future plans because of the divergence between

nursing's public jurisdictional claims and the workplace reality. What is interesting in the following extract is the emphasis on the one-to-one relationship.

> *When I first came in as an auxiliary I was going to be a health care and go on to be a staff nurse but I like the patient one-to-one care. I like to become an physio or something like that that's what I'd like but at the minute I can't really get the hours that I want.* (Auxiliary)

On Treetops however, support staff complained that certain senior members of nursing staff were lazy and spent all their time doing paperwork while they did all the real work. This was not a criticism that was levelled at all of the nursing staff however. It was felt that the 'newcomer' nurses were more involved in the provision of hands-on care but often got called away by more senior staff.

What Should the Support Worker be Doing?

Thus far my analysis has focused on the relationship between nurses' involvement in 'low-skilled' work and the temporal-spatial order. The second thread in the debates about nursing work centres on the parameters of the support worker role. Although many nurses had reservations about the HCA role and bemoaned their own lack of patient contact, there was nevertheless little inter-occupational negotiation or overt nurse-support worker conflict on

the wards. Ward-based nurses' concerns about the HCA role mainly focused on the implications of dilution for their own work and the denigration of nurse training this implied, few actually questioned the skills of the support staff with whom they worked. In order to understand how the boundaries of the support worker role were accomplished at Woodlands we need to explore the interactive effects of two features of the temporal-spatial order: the experiential biographies of staff and the temporal-spatial organisation of ward work.

Experiential Biographies

The most striking feature about the allocation of work on both wards at Woodlands was its embeddedness in social relationships. The division of labour was based on trust and personal knowledge of staff skills, rather than formal occupational credentials.

> *I would decide individually not as a job, not as a 'Well she's a D grade staff or she's a health care assistant', I would take it as who they are and what experience they've got behind them.* (Sister)

As Strauss *et al* (1985) have argued, the personal biographies of staff are integral components of an organisation's temporal order which may enter into the work drama. At Woodlands two hierarchies shaped the allocation of work on the wards: a formal hierarchy based on occupational status and an informal

hierarchy founded on experience. Experience was of two kinds: experience of work at Woodlands and personal life experience.

As I outlined in chapter 5, in the past shortages of qualified staff had led to an increase in the jurisdiction of auxiliary nurses. Many of the support staff had worked in the hospital for over ten years and for the most part their skills were acknowledged by the nurses with whom they worked. Indeed a number of nurses expressed a preference for working with an experienced auxiliary with whom they had an established relationship rather than with an inexperienced staff nurse.

> *I had two good auxiliaries and I would trust them with things that I wouldn't trust my junior qualified nurses to do [...] I've had those two auxiliaries on with me and a junior staff nurse who's just qualified - and I think 'Who do I take to break with me and who do I leave on the ward?'.* (Senior Nurse)

Tensions could develop if an inexperienced nurse attempted to use their formal status in directing the work of an experienced staff member.

> *The difficulty [...] is being an enrolled nurse for a long time, running the ward, having young little girl staff nurses coming and telling you what to do.* (Staff Nurse)

The informal hierarchy at Woodlands was also founded on personal life experience and again this could result in a division of labour at odds with the formal organisational plan. Here work was allocated on the basis of the assumed skills support staff brought into the workplace derived from their gender roles in the domestic division of labour. This was reflected in one ward sister's preference for 'mature' auxiliaries.

> Sister said that Paula was mature and this was another reason she thought she would be a good auxiliary.

In the following example a young staff nurse is talking about the involvement of an HCA in comforting bereaved relatives.

> (L)ike dealing with bereaved relatives, some people might think that she (HCA) shouldn't get involved, that it should be the staff nurses, but I think that she's had a lot more life experience than me and you know she perhaps could talk to them more. So I think get involved. (Staff Nurse)

This supports the findings of James (1992b) who argues that in the hospice she studied there was almost an inverse law of status and skill in emotional labour: the young staff nurses relied on the four older auxiliaries who were described as the 'backbone' of the unit.

The Temporal-Spatial Organisation of Ward Work

On both wards much of the work was organised according to routines in which the work of nursing and support staff was clearly differentiated in time and space. For example, on Treetops when nurses performed patient observations, the support staff emptied catheters.

> *(W)hile I'm doing the catheters the qualified staff or students are doing the obs.* (HCA)

At night when the nurses administered medications and performed observations, support staff made and distributed milky drinks, and settled patients. As I have described in my discussion of hands-on care, even when nurses and support staff worked together towards the common purpose of getting patients washed and ready for breakfast they mostly tended to different categories of patient. On a number of occasions I observed that work routinely performed by the auxiliaries and HCAs was overlooked when they were not on duty. The extent to which the nursing and support roles were differentiated is highlighted by the observation that support staff who were new to the ward were sent to work with an experienced auxiliary or HCA and not a staff nurse.

Contemporary nursing ideology is highly critical of the routinisation of ward work and a great deal of effort has gone into explaining the stubborn persistence of nursing routines. Menzies (1960) has suggested that the

routinisation of nursing work can be understood as a tacit strategy developed at the level of the organisation in order to afford staff emotional protection from the demands of the work. More recently other commentators have argued that routinisation and task-allocation developed in order that permanent staff could control and cope with a transient student work force (Melia, 1987; Proctor, 1989; Davies, 1995). By breaking patient care into a series of different tasks which are performed according to a pre-set routine, the sister creates a series of predetermined roles into which students could be slotted according to their stage of training.

Arguably however, whilst the need to cope with a transient workforce helps us to understand why the routinisation of tasks was combined with hierarchical task allocation in the organisation of nursing work, it does not offer an adequate explanation of routinisation itself. My research suggests that nursing routines may be more fruitfully understood as a means through which nurses manage the turbulence of the ward environment. As we have seen, the reality of hospital work is far removed from idealised notions of the nurse-client relationship. Hospital nurses work with multiple patient assignments in a working environment that is uncertain. The routinisation of nursing work may be seen as a rational strategy for the efficient accomplishment of work, ensuring that all patients receive a minimally acceptable standard of care. Moreover, as Zerubavel (1979) has pointed out the temporal structuring of hospital life constitutes a cognitive order. It gives hospital work some predictability providing staff and patients (Fairhurst, 1977; Roth, 1963;

Zerubavel, 1979) with a sort of 'repertoire' of what is expected, likely or unlikely to occur within certain temporal boundaries. The total absence of predictability would be psychologically intolerable (Moore, 1963). Here then we can see that routines are both facilitating and constraining. They are necessary in order to manage the work but once established constrain the context in which the work is accomplished.

There are clear parallels here with James' (1992a) analysis of nursing work in terms of 'care', 'work' and 'carework'. James makes a distinction between 'care' (which requires emotional labour) and 'work' (which requires physical labour) and which, unlike 'care', is specifiable and time limited. According to James, hospice staff used the finite and bounded demands of 'work' to regulate the seemingly endless demands of 'care'. James employs 'carework' to describe this process.

Blurring the Nurse-Support Worker Boundary

The routines on both wards afforded support workers considerable latitude over the performance of patient care. Support workers had to make daily decisions about what details ought to be brought to the nurses' attention.

(Y)ou have to work on your own initiative. (Auxiliary)

HCA: (Y)ou get a lot of pressure - because you're the ones that are actually with the patients, so they come to you all the time

and asking you if the patient's alright - 'Have you seen any breakages?', you know, 'Are they drinking?' and you've got to have all this for thirty-four patients - it's hard. (Training day - Tape)

You like find out more about the patients - you know in my team - if anybody's got problems they usually can tell you and that, then it's to your discretion whether you pass it on. (Auxiliary)

The division of labour on both wards cast support staff in a powerful role from where they were able to exercise a lot of indirect control over both medical and nursing decisions. This brings to mind Simmel's (1950) classic treatment of the complexities of superordination and subordination, and the interaction and exchange of influence that appearances conceal. Rather than a one-sided process of domination, hierarchy involves that 'in innumerable cases, the master is the slave of his slaves' (Simmel, 1950: 185). The sociological literature confirms that support staff often control many aspects of the everyday running of wards, and through their judgements and reports, may have considerable influence on ward transfers, discharges, and the modification of diagnoses (Strauss *et al*, 1964; Towell, 1975; Scheff, 1961; Mechanic, 1961). As we shall see in the second half of this chapter similar observations have been made about the power of nursing staff vis-a-vis doctors.

The working relationships on the wards were clearly at odds with the formal organisational plan in which remuneration for support workers was justified on the grounds that they worked under constant supervision. On the wards where relationships were established however, these arrangements had a number of advantages. Work could be accomplished more efficiently.

> I don't agree that a qualified member of staff should be bed-bathing a patient when there's ten admissions to be done because the HCA can't do that. (Sister)

Given that considerable effort was absorbed by the need to manage the general turbulence of the working environment nurses appreciated working with support staff who could be trusted to carry out work without supervision. Inexperienced support staff greatly added to nurses' burden of work.

> *Staff Nurse*: It shouldn't be too bad this evening because, as I say the auxiliaries are good, they just get on.

> 'Say if I'm on with Jean I know I don't have to worry about things. But Dolly - although she's good she is still learning and so if I see if I'm on with her I know I shall have to work with her and keep an eye on what she is doing.' (Staff Nurse)

Support staff also valued the autonomy these working arrangements afforded

them. As I described in chapter 6, on Treetops the efforts of certain of the senior nurses to exert more control over the work of nursing and support staff resulted in tension.

> *HCA*: (W)hat annoys me is - I know what I'm doing now - I know my role when I come on but you get one or two that like to sit in the chair and say 'You haven't done the catheters' and it's only half past nine and you don't do them until ten and it really annoys me because I've got other jobs until then and I know I'm going to do them but they're half an hour in front of you just so they can get that authority to actually say it.

Whilst permanent nursing staff appeared to accept the existing division of labour with support workers, students were more critical. However, their transient status and desire to 'fit in' (Melia, 1987) with the ward team made them reluctant to express such criticisms openly. It might be argued that because they typically worked more closely with support staff and also had an awareness of recent developments in nursing knowledge that students were well placed to judge support worker practice. We should exercise a degree of caution in interpreting students' accounts however. As the ethnographic literature has shown, support staff pose particular problems for students' management of their occupational identity because of the extent to which their work overlaps (Melia, 1987). Rather than accepting students' criticism as a literal reflection of an underlying reality one might argue that such accounts

may be more fruitfully interpreted as examples of the sociological phenomena known as 'atrocity stories', an interactional device which functions to buttress group identity (Dingwall, 1977a; Dingwall, 1977b; Stimson and Webb 1975, Webb and Stimson, 1976). The use of atrocity stories as a boundary-marker is discussed in greater depth in chapter 8.

On both wards, although support workers had considerable latitude over hands-on care activities, nurses maintained clear jurisdiction over the technical aspects of patient care. Support workers only undertook technical tasks when instructed to do so by staff nurses. It is somewhat paradoxical that despite the clear value accorded to basic nursing care activities by nursing staff they continued to exert the tightest jurisdictional control over the technical-medical dimensions of their work.

What About the Students?

As I indicated in chapter 5, third year students were transient members of both ward teams. Before moving on I would like to give a brief overview of the different ways in which students were integrated into the division of labour I have described.

On Fernlea student nurses undertook a whole range of work. They were more involved in hands-on care than the qualified staff but they also regularly undertook technical nursing procedures and patient management. Sometimes students worked under the supervision of staff nurses, on other occasions they

worked independently. All the students on Fernlea were very positive about their placement on the ward. They felt that staff were eager to share their skills and knowledge with them.

On Treetops the student role was narrower than it was on Fernlea. Both sets of students on Treetops ward were derisive about the way in which work was organised. Like the junior staff nurses I described in chapter 6, they wanted to be involved in all aspects of nursing care and resented their exclusion by senior nurses from key aspects of patient management - such as discharge arrangements, giving nursing handover and attending ward rounds.

THE NURSE-DOCTOR BOUNDARY

Nurses at Woodlands were being encouraged to develop the scope of their practice in order to relieve the burden of work on medical staff. As far as ward staff were concerned the principle areas in which nurses were extending their skills were: administration of intravenous antibiotics, venepuncture, ECGs, male catheterisation, and intravenous cannulation. As we saw in chapter 6, although most junior doctors were more than happy for nurses to undertake what they regarded as low status menial tasks, nurses perceived role expansion to be a double-edged sword. Nurses recognised that undertaking doctor-devolved work could be advantageous for patients, but they were concerned that in the absence of additional nursing support, they would be less able to undertake the hands-on care work which gave them so much

satisfaction. However as I have argued, on Treetops and Fernlea the divergent views of doctors and nurses did not lead to overt boundary disputes in daily practice.

In a paper presented at the British Sociological Association Medical Sociology Conference 1995 I began to explore the reasons for the minimal negotiation of occupational boundaries and the consequent lack of explicit inter-occupational conflict on the wards (Allen, 1995). I identified Woodlands' bureaucratic approach to the UKCC guidelines on nurses' scope of professional practice as a possible explanatory factor. The UKCC, in issuing its new guidance on nurses' scope of practice, opted to move from a bureaucratic to a professional model. *'The Scope of Professional Practice'* (1992) places the onus for decisions about the boundaries of nursing firmly in the hands of individual practitioners. This strategy presented difficulties for senior nurses at Woodlands who were responsible for nursing standards, policies and procedures. They responded to this by developing a system of self-directed learning packages, coupled with supervised clinical practice which nurses wishing to practise in an expanded role had to complete and sign to say that they were competent. Hospital policy restricted role development to nurses who had been qualified longer than a year. Furthermore, ward sisters determined which nurses should develop their scope of practice and in what areas. This meant that for a number of nurses their occupational boundaries were simply not negotiable. It seemed, then, that the potential for inter-occupational negotiation had been reduced by the hospital's bureaucratic

approach to the UKCC's guidelines.

On reflection however, I believe that the impact of hospital bureaucracy should not be over-stated. UKCC guidance on nurses' scope of practice supports role expansion providing it does not result in unnecessary fragmentation of patient care or lead to the inappropriate delegation of work. This still allowed those nurses who had completed the training to make decisions as to when it was appropriate for them to use their skills or not. In the main however, despite their reservations about role expansion and, contrary to UKCC guidelines, on Treetops and Fernlea wards those nurses who had the skills and could undertake doctor-devolved work did so regardless of their other work pressures. Indeed, in other areas of the hospital where staff had not developed their scope of practice I learnt of tensions between medical and nursing staff because certain doctors had come to believe that activities such as intravenous antibiotic administration and venepuncture were now a nursing and not a medical responsibility.

Staff Nurse: Do you want to put these (intravenous drugs) up because I'm not sure if I'm allowed to.

PRHO: You can do the Heparin but the Dopbutamine will take some time to sort out and Nick is coming to Boxtree ward and he can come and do it.

Staff Nurse: Who's that?

PRHO: Dr Deakin.

Staff Nurse: Oh! ((pulls face)) He's mad.

PRHO: I will tell him.

Staff Nurse: Thank you I don't want him prattling on about nurses not doing IVs.

I suggest that in order to understand why, despite their reservations, the nurses on Treetops and Fernlea undertook doctor-devolved work with a minimum of negotiation and little explicit inter-occupational conflict we need to focus our sights on two features of the temporal-spatial order. The first feature relates to the respective experiential biographies of the nurses and junior doctors in the ward teams and the second feature concerns the fragmented temporal and spatial organisation of nursing and medical work. I shall examine each of these features before going on to delineate their interactive influence on the constitution of the medical-nursing boundary.

Transience and Permanence

That nurses and doctors have different experiential biographies is self-evident. Nurses and doctors follow different training and undergo disparate socialisation experiences. As far as the relationships between junior doctors and nurses on the wards at Woodlands was concerned however, there was a key feature of doctors and nurses' divergent experiential biographies that was central to the accomplishment of occupational boundaries: their respective status as transient or permanent members of the ward team.

Weber (1970) has indicated the extent to which bureaucrats may have considerable power over political incumbents, as a result, in part, of their permanence within the political bureaucracy, contrasted to public officials, who are replaced more frequently. Low ranking officials become familiar with the organisation, its rules and operation, which gives them power over the new political incumbent (Lipsky, 1980). The ethnographic literature suggests that the relative permanency of nursing staff can augment their influence vis-a-vis doctors (Haas and Shaffir, 1987; Mumford, 1970; Burling, Lentz and Wilson, 1956; Myers, 1979; Hughes, 1988; Roth and Douglas, 1983; Bucher and Stelling, 1977). Where turnover of nurses is rapid relative to medical staff however, the influence of non-medical personnel is likely to be significantly compromised (Dingwall *et al,* 1983).

As I described in chapter 5, Woodlands was a local hospital and drew heavily on the local community for its non-medical staff. Most of the nurses had trained at the hospital. Moreover, few of those nurses who trained at Woodlands came from outside the immediate local community. Turnover amongst the nursing staff was low. Nurses were typically permanent employees although there was evidence of an increasing number of nursing staff being employed on short-term contracts.

Junior doctors by contrast were transient members of the ward team. PRHOs rotated as frequently as every three months, SHOs every six months, with registrars staying in post for up to a year. Furthermore, unlike the nursing

staff few of the junior doctors were locals. Indeed many junior doctors had come from overseas. Like the doctors in Hughes' (1988) study of Casualty work, their status as transient members of the ward team was therefore exacerbated by cultural difference and lack of familiarity with the UK health system.

At Woodlands nursing staff wielded considerable influence. Doctors relied on nurses for guidance on details of local protocols and aspects of ward practice as well as for the location of materials and equipment.

> Doctor asks staff nurse about the glucose tolerance test.
>
> *Doctor*: What do I have to write on here?
>
> *Staff Nurse*: Just write 'Dextrose powder for glucose tolerance'.
>
> *Doctor*: Do I need to fill in a special form or do you just carry it out?
>
> *Staff Nurse*: We just do it.
>
> *Doctor*: ((to DA)) I don't think I am the best candidate to study because I am new to the NHS and I ask more questions than I should.

Nurses did not simply wait for doctors to come to them for guidance though, they often volunteered unsolicited advice on various aspects of hospital practice. Nursing advice was vital when the junior medical staff changed over. In the following extract the ward sister explains the procedure for

admitting patients to the ward to a PRHO and a Registrar, both on their first day on the ward.

> *Sister*: ((to doctors)) If you see them (patients) in clinic you can't just send them up. You have to phone me first and I phone my bed manager to sort all the bits out.

It was not just the details of organisational practice with which nurses were more familiar, many were also frequently more experienced and knowledgeable than junior doctors about the ward speciality area. Nurses were therefore able to influence treatment decisions and also, indirectly, the training and education of doctors. I observed numerous incidents in which doctors consulted nurses on specific aspects of medical treatment. Doctors often sought advice as to drug dosages for example.

> *PRHO:* Rachel? The Becotide inhaler is fifty milligrams isn't it?
>
> *Sister:* Micrograms.
>
> *PRHO*: Fifty micrograms.
>
> *Sister*: Yes fifty or a hundred.

Nurses frequently questioned PRHOs drug prescriptions if they differed from the standard medication regimes with which they were familiar.

Staff Nurse: This has been written as a PRN (*pro re nata*, which means 'according to circumstances') MST.

PRHO: It seems fair enough?

Staff Nurse: It's a bit silly isn't it? Can't it be Oromorph instead. It's only for - she's having debridement of her shoulder tomorrow.

The house officer alters the kardex.

Staff Nurse: ((to PRHO)) I just want to query this Erythromycin. Do you want it just once a day? It's usually twice a day.

PRHO changes the prescription.

Nurses routinely requested specific drug prescriptions for patients which were rarely questioned by medical staff. The informal prescribing power of nursing staff is revealed in the observation that nurses referred to doctors as 'writing up' drugs rather than prescribing them. In the following extract an overseas PRHO has been called to see an elderly female patient on the ward who has become distressed.

Staff Nurse: What's she going to have for pain then? What about Pethidine IM? (intra-muscularly)

There is no answer.

Staff Nurse: No?

PRHO: I was going to give her Diamorphine but she says it makes her feel sick.

The nurses are chatting causally. The doctor finishes writing in the patient's notes and goes to leave.

Staff Nurse: What are you doing?

PRHO: Well she's sleeping now isn't she.

Staff Nurse: But I don't want you going and then she wakes up again because you won't be happy if we bleep you again [...]

The doctor stays and there is a discussion between him and the nurses about painkillers. The doctor has prescribed oral DF118.

The doctor goes to leave again [...]

Staff Nurse: So are you going to put that IM if need be?

The doctor is looking in the BNF (British National Formulary).

Staff Nurse: The dose is fifty.

Sister: She's happy to have oral. She's feeling a lot better now and she's tired.

The doctor is still hesitating about what to prescribe.

Staff Nurse: Just put stroke IM.

PRHO: But the dose is fifty and the tablets are thirty to sixty milligrams.

Staff Nurse: Yes but what I'm saying is they come in fifty milligram ampoules and so if you write stroke IM and I give that then I'm within that range.

The doctor does as staff nurse suggests.

As recent ethnographic studies indicate, much contemporary nurse-doctor interaction goes beyond the passive influence attempts described by Stein (1967) in his account of the doctor-nurse game, which preserve the appearance of physician omnipotence (Hughes, 1988; Porter, 1991). At Woodlands, medical staff freely acknowledged the skills and influence of nursing staff.

> *(A) nursing sister who's been on a unit for years knows far more that I do. We learn molecules and chemical biology in our training. You don't get the clinical feel until much later.* (Registrar)

> *The nurses in CCU know much more than me about cardiac rehab and it's better if you are just starting to follow them and not stick to your own ignorance.* (PRHO)

> *To be realistic about it, most of it is what they (PRHOs) learn themselves from the nursing staff by being told 'This is what happens on the ward. This is how to do things. This is what the consultant expects. This is what is required.'* (Consultant)

As we will see in chapter 8, doctors who failed to heed the advice of more experienced nurses were an important topic in the oral culture of nursing staff.

We have seen that the relative permanence of nursing staff at Woodlands resulted in nurses exerting greater influence over medical practice and education than the formal organisational plan would suggest. I now want to examine a second feature of the temporal-spatial organisation of the hospital division of labour - the different spatial and temporal ordering of nursing and medical work.

The Temporal-Spatial Organisation of Nursing and Medical Work

At Woodlands 24-hour medical and nursing coverage was provided 365 days a year but accomplished in rather different ways. Nursing care was provided by nursing and support staff via a three shift system. Woodlands employed a permanent night staff and day staff worked a mixture of morning and afternoon shifts. Nurses and support workers had timed meal and coffee breaks. By contrast, junior doctors routinely worked office hours, Monday to Friday. As a result of the junior doctors' hours initiative, doctors were supposed to have a bleep-free period over the lunch hour to allow them an

opportunity to dine with their peers. Nevertheless, often meal and coffee breaks were fitted around the demands of the work - particulary during on-call hours. Outside normal working hours medical cover was provided by the on-call team. Junior doctors were on-call one day in six. Zerubavel (1979) has contrasted the temporal flexibility of the organisation of doctors' work with the temporally rigid organisation of nursing work. Although nursing and medical coverage was achieved in temporally distinctive ways, arguably as a result of the junior doctors' hours initiative, the contrast between the respective rigidity or flexibility of this coverage may now not be quite as marked as Zerubavel suggests.

Medical and nursing work differed in terms of its spatial organisation also. Nurses left the ward for periods of time in order to accompany patients to different departments and, on occasion, personnel might be moved to another ward in order to respond to staff shortages. For the most part however, nurses at Woodlands were ward-based. Although junior doctors were formally attached to a ward, their work frequently took them to other wards within the hospital and to different departments - for example, outpatients clinics and theatres. On Treetops the SHOs were rarely on the ward.

> *Ian and I, neither of us are [...] ward-based. We pop up to the wards in our free minutes.* (SHO)

The difference in the temporal-spatial organisation of medical and nursing

work was most marked outside normal hours when doctors were on-call. The on-call period was from 9am until 9am the following morning. The on-call team were responsible for all admissions in their particular directorate as well as providing emergency cover for the wards. On weekdays ward cover did not commence until 5pm, but at the weekend and on public holidays the on-call team were responsible for ward work for the full 24-hour period. The introduction of the admissions unit at Woodlands meant that doctors spent little sustained time on the wards during the on-call period.

Priorities and Perspectives

The different temporal-spatial organisation of medical and nursing work created rather different perspectives and priorities which were a source of strain. Nurses' sights were focused on the needs of the patients on their wards, whereas doctors were concerned with patients' requirements for the whole directorate - including new admissions. During the on-call period, doctors tried to organise their work systematically so that they were not expending unnecessary 'leg-work' moving between the wards. At the same time however they had to attend to patients in order of clinical priority. Nurses were ever-conscious of the constraints of external organisational timetables and, as we have seen, considerable nursing effort went into coordinating patient care activities, and ensuring that treatments were carried out to schedule. Moreover, it was nurses who were faced with the distress of the patient requiring pain relief or the frustration of relatives wanting to take a patient home but being unable to do so because the doctor has not prescribed

their drugs for them.

The differing work priorities of nursing and medical staff are revealed in the tensions I observed over death declaration. As far as medical staff were concerned death declaration was of low importance, their priorities lay with the living.

> *PRHO:* (D)ead patients they're not a priority. I think 'Well they're dead - I'll deal with the live ones'.

The death of a patient disturbed the wards' 'sentimental order' (Glaser and Strauss, 1965) and nurses were therefore typically eager to perform last offices in order that the body could be removed to the mortuary, and the ward returned to 'normal'. Nurses were unable to begin any of their work until the doctor had declared a patient to be dead. The different agendas of nursing and medical staff are nicely illustrated in the following two extracts. The first is a recorded conversation from a day I spent with the on-call PRHO.

> *PRHO*: Are you writing down what the nurses do to me too? That Boxtree ward keep bleeping me and bleeping me to certify that lady.
>
> *DA*: Is that what all the bleeps have been for?
>
> *PRHO:* Yes and the last one was not very nice. 'You've got to come and certify her now!'. 'I'm busy'. 'You must come

now'.

The second extract are notes made when I was observing the wards at night. I had answered the ward phone because the nurses were busy. It was a staff nurse from another ward trying to locate the on-call doctor. The time is about 11pm.

The phone rings and I answer it.

Staff Nurse: Hello it's staff nurse on Elm ward. Is doctor Green there?

DA: I think so. I'll just go and check. ((I checked with SN))

DA: Yes.

Staff Nurse: ((there is a tone or irritation in her voice)) Well can you ask him to phone me? There's a patient he needs to certify. He's supposed to have been coming since seven and I'm on my own and I really do need to get this sorted out. So can you ask him to phone me.

Doctors and nurses also held divergent definitions of what constituted emergency cover. Doctors perceived their on-call role in fairly narrow terms and complained that much of the work they were expected to do fell outside their understanding of 'emergency service'.

On-call basically means to me to provide emergency services

within the hospital but to quite a large extent this is just to do things like prescribing drugs, writing ECGs, give IV drugs this sort of thing. It's not an emergency service at all. (PRHO)

PRHO: I'm really annoyed about this. I'm not supposed to be bleeped to re-catheterise patients, I'm on call for emergencies.

Nurses also recognised that on-call doctors could only provide a restricted service and left what they considered to be non-essential requests for normal working hours. Nevertheless, unlike doctoring, nursing is not temporally limited and in adhering to hospital policies nurses were dependent on the on-call doctor to carry out tasks that arose which they were unable to undertake themselves. As a consequence, the nursing definition of emergency cover incorporated a broader range of work than over-burdened doctors considered legitimate.

The on-call PRHO came to the ward.

Doctor: Have you got any jobs?

Staff Nurse: I've got some jobs.

Doctor: As long as it's only prescribing!

Staff Nurse: Oh! ((passing the doctor a drug kardex)) She needs that written up and a new drug kardex.

Doctor: She needs an **additional** drug kardex.

Staff Nurse: But it needs re-writing.

Doctor: I'm not re-writing kardexes.

Staff Nurse: But it will need doing tomorrow. Are you on? I suppose not. What should I say? You refused to do it?.

Doctor: No, that the locum on-call doesn't re-write kardexes.

Staff Nurse 2: Well this is something you should take up with your medical colleagues then. Make sure they re-write kardexes on Friday.

PRHO does re-write the drugs kardex.

Organisational Hierarchies and the Flow of Work

As well as giving rise to different perspectives and agendas the temporal-spatial ordering of medical and nursing work creates a second related tension which mirrors those described by Whyte (1979) in his study of restaurant work. Whyte argues that a central problem of the large restaurant is to tie together its line of authority with the relations that arise along its flow of work. In a restaurant the flow of work usually originates with the customer and is passed to the waitresses who then has to initiate the work of higher status 'countermen' or 'barmen'. Whyte proposes that relations among individuals along the flow of work will run more smoothly when those of higher status are in a position to originate for those of lower status in the organisation, and conversely, that frictions will be observed more often when lower status individuals seek to originate for those of higher status. According to Whyte, a number of strategies are developed in restaurants - either consciously or unconsciously - to cut down waitresses origination of

action for higher status staff. For example, the rule that orders must be written cuts down interaction, although not always enough to eliminate friction.

Similar problems arise in relation to doctors and nurses. Although nurses were able to influence medical staff in important ways, within the formal organisational hierarchy doctors had higher status. This created strains because owing to the temporal-spatial ordering of their respective activities, it was nurses who initiated much of medical work. One of the ways in which nurses managed this potentially difficult relationship was by leaving doctors lists of work. At one level this reflected the different temporal-spatial organisation of medical and nursing work. But it also had the additional advantage of disguising the identity of the nurse as the originator of a task and allowed the doctor to decide on his own work priorities.

The Bleep System

Much of the strain relating to the bleep system at Woodlands stemmed from these linked tensions created by the fragmented temporal-spatial organisation of nursing and medical work.

Nurses frequently complained that they could not get the doctors to come to the ward. I actually observed an incident in which a nurse resisted accepting an admission on the grounds that the doctors caring for the patient were difficult to get to come to the ward.

SN phones the Admissions Ward.

Staff Nurse: Hello. It's staff nurse on Fernlea. You know this Mr Smith you're sending us. Are you sure there's no beds on Elm, only they're the worse doctors to get hold of. You know with him being so poorly.

When she comes off the phone I ask what that was all about

[...]

Staff Nurse: (T)hey're the worse doctors to get hold of and with him being really poorly they just don't get the care they need and the patient suffers. You can spend three hours bleeping the doctors.

I saw that considerable nursing effort went into the coordination of patient care activities and the additional burden the unavailability of doctors placed on nursing staff. I also witnessed the work pressures of on-call doctors and how quickly they became irritated when their work was continuously interrupted by nurses bleeping them to come and attend to work on the wards. Doctors' annoyance was heightened when nurses' requests appeared trivial in relation to their other work priorities. The PRHOs felt that other members of the health care team didn't really understand the on-call experience.

(S)ometimes you would get bleeped from the gerry wards 'Come and see this patient', medical wards 'Come and see this

patient' - I can't because I'm seeing one ill patient and I get bleeped to see another ill patient. I can't be in four places or nine places at once and some of the nurses don't understand that and it's quite frustrating because although I don't get a chance to see an ill patient, like they might bleep me in the morning but I won't get down to see him until six or seven in the evening and then they get annoyed and I try to say 'I've been to see quite a few ill patients throughout the day'. (PRHO)

Interestingly however, a dominant theme in nurses' accounts is that their clear frustration with the fragmented temporal-spatial ordering of work is intermingled with the sympathetic acknowledgement of doctors' pressures of work.

(I)t's hard with the on-call doctors at night time because you're trying to get them to please come onto the ward and do this and they're obviously busy elsewhere and everybody needs them so they can't come on. So sometimes we have been known to get a bit angry. You know 'You've got to come now if you don't come I'll fast bleep you and you will come'. It's an effort to try and get them onto the ward sometimes. (Staff Nurse)

Some of them are not very willing to do things for you. I think they're busy, which is fair enough I know they've got a lot on, but when its say, something like tablets, and the ambulance has come to pick a patient up and the tablets are not there a patient can't go and the ambulance has to go. (Staff Nurse)

Staff Nurse: House officers are [...] so pulled out, they're so shattered because they're doing everything, you tend to think 'Oh I'd better take a bit of pity on them', but you can't because you can see how distressed the patients are and the relatives are and you think 'Well, you know, they've got to sort something out.

Much of the work undertaken by nurses which could be construed as symbolising a 'handmaiden' status reflected the difficulties nurses had in getting medical staff to come to the ward coupled with their sympathy for doctors' burdens of work.

It takes you so long to get them up to the ward when they're here you're so grateful you always tend to try and make it easier for them. (Staff Nurse)

Managing the Strains - Blurring the Nurse-Doctor Boundary

In their study of nursing and medicine in a changing health service Walby and

Greenwell *et al* (1994) argue that nearly half the points of conflict they identified between doctors and nurses could be traced to the different spatial and geographic organisation of nursing and medical work. It is my contention that nurses and doctors, in the course of their everyday practice, employ a number of strategies in order to manage these strains. These strategies, coupled with the different experiential biographies of medical and nursing staff, led to the routine blurring of occupational boundaries. Moreover, they give some clues as to why there is a dearth of boundary negotiation and explicit conflict between the doctors and nurses at Woodlands even though the potential for conflict was present. If we recognise that the non-negotiated blurring of the medical boundary was a routine feature of nurses' work practice on the two wards studied then the lack of negotiation and conflict associated with tasks that have been formally devolved to nursing staff becomes understandable.

Medical and nursing staff at the point of service delivery had developed a range of strategies for managing the fragmented temporal-spatial organisation of their work. As we saw nurses' obvious frustration in not being able to obtain a doctor when they needed one was off-set by their recognition of the sorts of pressures facing junior medical staff. Nurses tried not to bleep the doctor unless it was absolutely necessary. Considerable nursing effort was expended organising doctors' work, which was saved up rather than the doctor being bleeped for every single problem as it occurred. On Treetops, nurses asked medical staff from the adjacent surgical ward to help them when their

own SHOs were unavailable. Another strategy employed was to anticipate patient requirements and ensure 'P.R.N' (as required) - medications had been prescribed so that nurses could respond to patient need without having to contact the doctor. On Fernlea, one PRHO had developed the practice of signing blank dietician referral forms so that they were available when nurses required them. On Treetops where only a small number of senior nurses were trained to give intravenous drugs, doctors were encouraged to prescribe medications for times of the day when a nurse would be available to administer it - for example during the lunch-time shift overlap period and when night staff were on duty.

By far the most important way in which the strain created by the differential temporal-spatial ordering of nursing work was managed however, involved nurses routinely undertaking a whole range of work which fell outside their formal jurisdiction. The difficulties nurses faced in getting medical staff to come to the ward, coupled with their sympathetic acknowledgment of the pressures faced by medical staff and their own experience, led nurses to informally undertake medical work. This boundary-blurring was extensive and led to nurses regularly breaking organisational policies. Nurses requested blood tests, prescribed additional intravenous fluids, made dietician referrals and prescribed medications for symptom relief. Nurses' boundary-blurring was of two main types: *de facto* and purposive.

De Facto Boundary-Blurring

De facto blurring of the nurse-medical boundary is unavoidable and relates to patient diagnosis. Formally, medical diagnosis is the responsibility of the doctor. This is one underlying reason for nursing's inferior status in the hospital division of labour, since without diagnosis there is no patient and hence no need for nursing intervention. My data suggest that this is a view to which most doctors and nurses at Woodlands subscribed. During their interviews both groups used diagnosis as a boundary-marker. In everyday practice however, the line between nursing observations and medical diagnosis is almost impossible to sustain. At a fairly mundane level, out of the wealth of information nurses gather about their patients they have to decide what is medically relevant. As Garmarnikow (1991) points out, the medical 'gaze' (Foucault, 1976) is articulated through and mediated by nursing practice. At another level, nurses frequently have to make important diagnostic decisions because they happen to be on the spot at the time. For example, a nurse who finds a post-operative patient with a raised pulse and falling blood pressure and responds by increasing the rate of the patient's intravenous infusion has not only made a diagnosis (of post-operative haemorrhage) but has also **prescribed** and implemented the appropriate **treatment.** *De facto* boundary-blurring is unavoidable, and reflects the practical impossibility of sustaining a formal division of labour in which doctors diagnose and nurses simply make observations. Owing to the temporal-spatial organisation of medical and nursing work nurses have little choice but to make diagnostic decisions, although most nurses and doctors did not see them as such. This supports the

findings of Hughes (1988) who found that although nurses acknowledged making judgements about patient's conditions they did not feel this constituted making a diagnosis because they did not inform the patient about the nature of their condition or make firm pronouncements about it.

Nurses at Woodlands also undertook a wide range of informal boundary-blurring that was intentional and over which they exercised a degree of choice. I have called this purposive boundary-blurring and I have identified five sub-types: continuity-oriented, articulation-oriented, judgemental, rule-oriented and lay-oriented.

Purposive Boundary-Blurring

Continuity-Oriented Boundary-Blurring

Nurses informally undertook work that officially fell within the doctors' remit in order to maintain continuity of patient treatment. The most common example of boundary-blurring of this type occurred when nurses 'prescribed' additional intravenous fluids for patients when the doctor was unavailable. This was relatively common practice on the surgical ward which medical staff appeared to sanction.

Articulation-Oriented Boundary-Blurring

Nurses' also undertook boundary-blurring in order to ensure coordination of work. Much of nurses' informal form filling was of this type. Nurses routinely completed forms requesting standard blood tests in order that these

were ready for the phlebotomists and the tests were carried out at the appropriate times.

Judgemental Boundary-Blurring

Nurses frequently initiated various tests and referrals on the basis of their own judgement. Specimens were obtained and sent to the laboratories for investigation. Nurses requested blood tests on patients if they felt they looked anaemic. It was also relatively common practice for nurses to 'refer' patients to the dietetics department, even though formally this fell within the doctors remit.

Rule-Oriented Boundary-Blurring

Boundary-blurring of this type occurred when nurses worked in the spirit of one rule even if this meant breaking another. An example of boundary-blurring of this type occurred when nurses routinely gave saline flushes after they had administered intravenous antibiotics even when the doctor had not prescribed it. Here nurses were operating in patients' interests in honouring the hospital policy which recommended saline flushes to follow intravenous antibiotic administration but at the same time they were breaking the rule which stated that nurses were not allowed to prescribe medications.

Lay-Oriented Boundary-Blurring

It was a relatively common practice for nurses to administer unprescribed drugs to patients and request the doctor to prescribe them later. Nurses

placed limits on how far they were prepared to go in prescribing medications, restricting themselves to those medications that are available 'over-the-counter'. Nurses justified this practice on the grounds of the action the patient would have taken had they been at home and not in hospital. Recently in the UK there has been an extension of those medications available without prescription. This raises the question of whether one can anticipate a widening of nurses' informal prescribing practices in the future.

I do not wish to suggest that all nurses undertook this work all the time however. Nurses had not simply incorporated this work into their everyday practice, rather they undertook informal boundary-blurring work when the doctor was unavailable. When doctors were physically present on the ward nursing staff adhered to hospital policy and asked the doctor to carry out these tasks. Moreover, it was more common for experienced nurses to blur occupational boundaries than junior staff. Indeed I observed junior nurses asking more senior staff to do their boundary-blurring work for them. Moreover, nurses were more likely to break the rules for doctors they trusted.

> *If you were going to break the rules you'd always do it for someone that you trusted than someone you didn't.* (Staff Nurse)

Doctors perceived to be status conscious and lazy were unlikely to receive sympathetic treatment from nursing staff.

Interestingly there was little informal purposive boundary-blurring at night. This was surprising given the findings of the ethnographic literature. For example, Roth and Douglas (1983) found that during the night-shift nurses carry out many duties that they ordinarily do not do during the day in order to give the on-call physician a rest. At Woodlands there seemed to be a number of possible explanations for the dearth of informal boundary-blurring on the night shift. Firstly, the working environment at night was less turbulent than it was in the day and night nurses were far less preoccupied with coordination activities. Secondly, night staff had less established relationships with medical staff. With the opening of the admissions unit doctors only spent time on the ward attending to jobs as they arose, whereas in the past they could be on the ward for prolonged periods attending to new patient admissions. Finally, nursing care at night was provided by a separate night staff, with its own moral order. All of the night nurses I spoke to were quite clear that they would not give unprescribed drugs to patients. Many justified their positions by recounting the same 'moral tale'.

> *Well I wasn't here it's what I heard on the grapevine. She gave Temazepam and asked the doctor to write it up later which she would have done but somebody told a tale and she was sacked for prescribing.* (Staff Nurse)

Night nurses made considerable effort to ensure that doctors prescribed all medication that might be required for patients over night. The threat of the

bleep gave night staff considerable leverage in influencing doctors' prescription decisions.

> *Sister:* Can you write him something under the PRN side? He's terrified of dying this man. Write him up for something under the PRN side or else I'll be bleeping you in your sleep break!
>
> *Staff Nurse*: ((comes back to the nurses' station)). Mr Boden is very restless. Can you write him up for something to settle him to save you coming back?
>
> *Doctor*: ((to DA)) They always threaten me. Write this up or we call you back. What can I do?

Nurses' boundary-blurring may have been against the hospital rules, but given the fragmented temporal-spatial organisation of nursing and medical work, it undoubtedly benefitted patients. As a result of nurses' boundary-blurring work, patients received symptom relief when they needed it, tests were carried out on time and treatment was continued without interruption.

Nurses' boundary-blurring work was also supported by medical staff.

> DA: *Do you mind the nurses doing blood forms?*
>
> PRHO: *No I'm grateful if they do. Sometimes they forge my*

signature. If they know the person needs blood then why not? We're part of a team.

PRHO: Janice on geriatrics is brill. She really sticks her neck out. She's really good.

DA: In what sense?

PRHO: Well she prescribes things say like Maxalon. I get there and she says she's done it.

Staff Nurse: She's had some indigestion, burning pain and I gave her some Malox.

PRHO: Thankyou for being so keen. I was once bleeped at six in the morning to give some Malox!'

As I pointed out in the discussion of transiency and permanency, doctors recognised the skills of nursing staff, and were grateful when nurses were prepared to employ those skills in ways which eased their burden of work even if this meant breaking organisational rules. However I deeply suspect that because nurses' undertook medical tasks most often when doctors were absent from the wards the extent of their purposive boundary-blurring remained invisible to medical staff.

As far as nurses were concerned, given the informal influence they wielded over treatment decisions it was only a small step to take this further and

undertake the work themselves when the situation demanded it. This also helps to explain why nurses were prepared to break the rules and undertake certain activities and not others. If we look at nurses' informal boundary-blurring more closely we will see that it relates to those areas over which nurses were often more knowledgeable than medical staff by virtue of their relative permanence on the wards - drug prescription, initiation of routine investigations. Most of the formal boundary-blurring that was being initiated at Woodlands however, related to practical techniques, of which nurses had no prior experience.

In the short-term certainly, boundary-blurring was in nurses' interests. Nurses were frequently in the firing line if patients were waiting on doctors.

> *Staff Nurse*: The thing is this is really the doctors' work but if we didn't do this then the doctors wouldn't do it and TTOs aren't written up and then it comes back on us doesn't it when the patients get cross and they can't go home.

Given the differing perspectives of medical and nursing staff and the fragmented temporal organisation of their work it was frequently easier and less time-consuming for nurses to undertake work themselves than it was to try and get the doctor to do it.

(I)n the time it would take you to get a doctor to re-site a cannula you could have done it yourself. (Senior Nurse)

'You can bleep the doctor and wait for 6 hours or do it yourself!'. (Staff Nurse)

I am guilty of doing things I shouldn't do. I mean I do blood forms and things like that even though I know I shouldn't. Because it's an easier life and I know things are going to get done. (Sister)

Critics of extended roles for nurses have suggested that it undermines nurses' claim to autonomous practitioner status in bringing the occupation under medical control (Tomich, 1978). On the wards however, nurses' boundary-blurring actually gave them greater informal autonomy over their work, improved patient care, and had the additional advantages of avoiding inter-personal tension. The absence of inter-occupational negotiation and overt conflict surrounding work that has been formally devolved to nurses has to be understood in this context.

Given the persistence of 'the polo mint problem' however, there are some important questions that have to be raised as to the constraints within which nurses work that made boundary-blurring their easiest option. This is a question I shall address in chapter 9.

Summary and Conclusions

In this chapter I have examined the processes through which occupational boundaries were blurred at Woodlands in order to explain why shifts in the division of labour engendered by recent policy developments were accomplished on the wards at Woodlands with minimal negotiation and little explicit inter-occupational conflict. I have suggested that the key to our understanding lies in the temporal-spatial ordering of work on the wards.

I have argued that the ward work rhythms constituted a turbulent environment requiring a particular kind of work organisation. Without the blurring of occupational boundaries the work could not have been accomplished. Nurses routinely undertook both 'mundane work activities' and also 'doctors' work' because it was practically expedient for them to so and also because they were inextricably intertwined with the process of nursing.

I have shown how the experiential biographies of non-medical staff led to what Abbott (1988) has called workplace assimilation - a kind of knowledge transfer - and that considerable boundary-blurring occurred as a consequence of this. This was no surprise. Workplace studies have documented the divergence between public jurisdictional claims and workplace realities. What was unexpected however, was that the division of labour was accomplished with little negotiative effort on the part of the different players in the work drama. I argued that as far as the nurse-support worker boundary was concerned this non-negotiated boundary-blurring can be understood in terms

of nurses' management of the ward turbulence through the routinisation of work. I suggested that the non-negotiated blurring of the nurse-doctor boundary reflected the strategies employed by nursing and medical staff in managing the strains associated with the fragmented temporal-spatial organisation of their work.

Non-negotiated informal boundary-blurring is thus a dominant feature of normal nursing practice. Once this is recognised then the reasons for the lack of negotiation around policy-driven shifts in the division of labour become clear.

There is one important anomaly in all this however. Throughout the period of the research nurses, support workers and doctors both frequently referred to their concerns about the increase in litigation and patient complaints in health care. Nevertheless, it did not appear to have stopped them from breaking organisational rules in order to accomplish the work. One possible explanation for this is that informal boundary-blurring was such a taken-for-granted feature of normal working practice that staff did not routinely reflect on its potential implications. Their principal concerns were with the exigencies of the work.

8. Boundary-Creating Processes: Accomplishing the Moral Division of Labour

In chapter 7 I described how the hospital's temporal-spatial order fostered non-negotiated boundary-blurring. In this chapter I shall concentrate on boundary-creating processes.

As Hughes (1984) has argued, an occupation is comprised of two intricately linked elements: role and tasks. Hughes made a distinction between the technical division of labour, which referred to the allocation of tasks, and the moral division of labour, which referred to the 'who I am' rather than the 'what I do' in the work organisation. According to Hughes, there is a good case for arguing that a moral division of labour is necessary to complement any technical description of it. In this chapter I explore the boundary-creating processes through which the moral division of labour was accomplished at Woodlands. I want to suggest that certain of these processes were central to actors' management of inter-occupational tensions and that as such they are crucial to our understanding of the lack of explicit inter-occupational conflict on the wards at Woodlands.

Abbott (1988) has underlined the diverse ways of emphasising jurisdictional boundaries and occupational differences in the workplace. For example, in chapter 6 I pointed to nurses' dirty work designations as a boundary-defining device. I have organised my analysis of boundary creation in this chapter under four main headings. It would be unwarranted to regard these sections as mutually exclusive however. Even within sociology boundaries can blur! In the first section I examine boundary-creating measures operating at the level of working practice. In subsequent sections I explore oral culture, the symbolic order and the micro-political order as boundary-creating processes.

BOUNDARY MAINTENANCE AND WORKING PRACTICE

Formal Boundary-Creating Measures

As I have indicated, in addition to the informal boundary-blurring processes identified in the previous chapter, explicit measures were being taken at Woodlands to realign the technical division of labour between nurses and doctors and nurses and support workers in response to recent policy developments. Hughes (1984) has raised the question of the effects of changes in the technical division of labour on the roles concerned. He argues that sometimes a change in role is validated by a change in technical tasks. Sometimes a change in technical tasks creates a role problem.

In this section I shall examine field actors' attempts to accommodate shifts in work content with their respective conceptions of their place in the moral

division of labour. In implementing policies that entailed shifts in the technical division of labour, senior medical and nursing staff at Woodlands had undertaken a number of formal boundary-creating measures.

The Nurse-Support Worker Boundary

In chapter 5 I argued that although the senior nurses at Woodlands had agreed upon a list of HCA activities, there was no clearly defined generic HCA role. It was felt that responsibility for delineating the parameters of support worker practice should rest with the ward manager and nursing staff. However, senior staff feared (with some justification) that the pressures on ward staff encouraged the blurring of the nurse-support worker boundary beyond limits they deemed to be acceptable. They recognised that in their everyday practice ward nurses were concerned with responding to the exigencies of the work context and had little interest in the wider 'professional' implications of devolution to support staff. Senior nurses placed a great deal of confidence in the power of education to counteract these tendencies and to shore up occupational frontiers.

Training days for qualified staff emphasised nurses' personal accountability for support worker practice and on the HCA training programme considerable effort went into differentiating the role of qualified nurses from that of support staff. The following extract comes from day one of the HCA training course.

Senior Nurse: Right - you are there to assist the registered nurse. You're not there to do the registered nurse's job. You're there to assist [...] You will not be involved in assessing patients [...] You are there to assist in the implementation of care. Assessing patients can be anything from admitting a patient to doing a bed-bath and looking at them. As a registered nurse I can assess the situation there and then. It doesn't matter if it's the beginning of the patient's stay the middle, or the end. I am assessing all the time because that's what I have been trained to do. If you're in a position to assess then you're in the wrong position. Just let us take the TPR (temperature, pulse, and respirations) situation [...] from a registered nurse's point of view there is more to doing a pulse then just counting. I've got to know the rate, the rhythm, the depth of that pulse. By me putting my hands on that patient I am assessing that patient. I'm assessing all those different things there. If that's what is required then the registered nurse should be going in there and doing that, but if all that is required is a number then I don't see a problem with you getting in there. Assessment is a very fine line and it makes it very difficult to explain to you what you can and can't do. (Training day - Tape)

An entire day of the HCA training programme was devoted to exploring the

role of the registered nurse and making nursing knowledge visible. Interestingly, the HCAs themselves questioned the relevance of this aspect of the programme. Emphasis was also given to the limits of the support worker role as defined by hospital policy and of the possible legal implications of crossing the bounds of legitimate practice.

> *Senior Nurse*: Now it's very easy for me to stand here and say 'You don't do this, you do that, you do the other', very easy. But what I'm saying is: 'This organisation will not support you if you go ahead and do these sorts of things'. (Training day - Tape)

The Nurse-Doctor Boundary

Nursing staff at Woodlands had also taken a boundary-defining stance in respect of shifts in the nurse-doctor boundary. Senior nurses maintained that any expansion of nurses' scope of practice should be patient-led, but they believed that the high political profile of the junior doctors' hours initiative meant its linkage with nursing role developments was inevitable. Senior nurses responded by insisting on taking control of the process rather than leaving it in the hands of the medical staff.

There was almost like a splinter group of the medical staff and they were going to be writing the protocols for us which was one of the big pressures for the nursing staff to get their act

together and to produce these packages and things because otherwise it would have been imposed on us from the medics. It's been a hell of a struggle getting all the paperwork sorted out but we didn't want someone else setting it up for us. We wanted to do everything ourselves. (Senior Nurse)

Senior nurses had developed a number of self-directed learning packages for the various expanded role activities. They emphasised the need for nurses to have an adequate knowledge-base in undertaking devolved work. At one level this reflected risk management and litigation concerns. At another level many saw this underpinning knowledge as an important boundary-marker which differentiated nurses from the 'see one, do one, teach one' training of medical staff, and from lower level workers - such as phlebotomists and operating department assistants (ODAs) - who were also being trained at Woodlands and in other hospitals in the country to undertake similar activities. The following extract is taken from a meeting of senior nurses charged with responsibility for implementing the scope of professional practice developments at Woodlands. Two of the senior nurses in the group have expressed concern that the training packages were in danger of becoming rather bureaucratised.

Senior Nurse: I take these points that Simon and Felicity made about it - we're being in danger of it becoming a bit cumbersome - but I mean what I would want to say is that the fact that the doctors and phlebotomists aren't trained how to do

it doesn't make it right does it?

Nurse Practitioner (Felicity): No.

Senior Nurse: I mean surely we ought to be putting ourselves in a better position than that.

Ward Manager (Simon): I agree with you. (Meeting - Tape)

The efforts of nurses were ridiculed by senior medical staff however, who, in undertaking boundary-creating work of their own, claimed that the detailed knowledge included in the training packages was unnecessary for nursing staff. The following extracts begin with comments which were made in a letter to the Director of Medicine by a consultant.

re. Scope of Professional Practice - Flushing of Central Lines

[...]

I find this document exceedingly complex and probably over comprehensive for the needs of nursing staff who may be required to flush a central line. In fact, it is so complex that I myself am unable to answer some of the questions required of the nursing staff, and I suspect that the majority of the medical staff within the hospital would also be unable to satisfactorily complete the questions.

I feel that if the protocol is to be adopted within the hospital

and I myself am unable to comply with it, then I must regard myself as being unsuitable for the insertion, let alone the flushing of central lines. On this basis I would suggest that I am no longer a suitable person for the insertion of these lines, including of course Hickman and other central lines.

I would, therefore suggest that we no longer use central lines within this hospital. (Document - Internal communication)

(It's) crazy - for what is a practical procedure with some theory behind it, actually putting it into a context where the theory is totally out-stripping the practical nature what it's intended for. And nurses are practical people at the end of the day. (Consultant)

They've produced a manual! [...] It's crazy all they needed was to spend an afternoon in theatre. If someone needs two hourly turns they order her a special bed because there's a tissue viability nurse. (Consultant)

Overall medical staff at Woodlands seemed reasonably comfortable with nursing staff undertaking certain technical procedures. Where shifts in the division of labour involved nurses undertaking work which came closer to the focal tasks of medicine however, the boundary-creating processes employed

by doctors became more formalised. For example, the nurse practitioner on Treetops ward undertook the pre-operative clerking of patients but despite the assertion by the consultant that she 'was an experienced nurse who had experience working in ITU and CCU and could probably do the job better than most house officers' and that 'she probably knew more about these things than they (PRHOs) did', she nevertheless had to work from a protocol and follow a standardised questionnaire. Moreover, when doctors undertook this task it was referred to as a patient 'clerking', whereas when the nurse practitioner did it this was called a 'pre-operative assessment'. The only differences were that the nurse practitioner often carried out these activities before the patient was formally admitted to hospital and, unlike the doctor, did not obtain the patient's consent to surgery and did not listen to their chests. Similar questions might be raised as to the boundaries between nursing 'triage' and medical 'diagnosis'.

Interestingly, the nurse practitioner herself was supportive of these protocols but she saw them as a means of protection from litigation rather than as a control over her work.

Pulling in the Reins on Informal Boundary-Blurring

Staff turnover at Woodlands was slow. A number of the long-standing staff at Woodlands referred to the expansion and contraction of their work boundaries over time. This would seem to support the observations of Abbott (1988) that:

> 'every new worksite begins by accepting the clear jurisdictional relations of the public arena as a preliminary model for its own division of labor, and existing worksites are periodically reshuffled to reflect them more closely.' (Abbott 1988: 66-7)

Support workers in particular had seen a number of changes to their role.

> In the days of two staff on a ward at night with twenty-odd patients, we did a lot of duties that legally we were not supposed to. As "State Enrolled Nurses" were trained and introduced to the wards lightening the load of the "State Registered Nurse" we found ourselves back in the role of an assistant to the nurse. (Document - Essay written by auxiliary nurse)

There had also been an attempt to discourage nursing staff from undertaking informal paperwork for medical staff. As we have seen however, the pressures on the wards meant that these efforts were largely unsuccessful.

'Boundary-Work'

The concept of 'boundary-work' is taken from Gieryn (1983) and refers to an ideological style found in scientists' attempts to create a public image for science by contrasting it favourably to non-scientific or technical activities. Gieryn argues that as intellectual debates about the boundaries of science

continue, demarcation is routinely accomplished in practical, everyday settings. In this section I employ the concept of boundary-work to refer to actors' talk-as-action, to the ways in which staff at Woodlands legitimated boundary-blurring whilst simultaneously constructing the moral division of labour in line with their respective, and frequently discordant, perceptions of the placing of different occupations within it.

As we have seen doctors were happy to devolve certain technical tasks to nursing staff - intravenous antibiotic administration, venepuncture, ECGs, cannulation, and male urinary catheterisation - although many felt these were key medical skills which they themselves did not wish to lose. What was interesting from a sociological perspective was that doctors' legitimation of such boundary-blurring simultaneously performed a boundary-creating function. Medical staff typically degraded the tasks that were being devolved to nursing, emphasising their repetitive, practical nature and their relative safety.

> *(D)octors undertake simple practical skills which are well within the bounds of nurses [...] Such as routinely taking blood which phlebotomists do now. It takes about five minutes to be taught to take blood and maybe doing it ten times to be relatively competent at it. It's a skill which is simple and safe [...] There are other practical skills - sticking IV cannulas in - they can be fiddly but they're fairly safe. It's a simple*

practical skill. (SHO)

It is not difficult to put in a cannula and the more that you do the better at it you get. (Consultant)

I mean the specific skills could be taught to anybody who's reasonably conscientious, careful and sensible. (Consultant)

(A) lot of what the juniors were doing were these repetitive tasks which were no good for their educational training [...] nurses are good at doing repetitive tasks ((laughs)). So you know, to be able to get nurses to do the tasks that were indicated like IV drugs, catheters, [...] and taking blood, giving intravenous injections was fine - the so-called drudgery. (Consultant)

I suggest that the above extracts demonstrate the ways in which through their accounts of the changing technical division of labour doctors attempted to construct the moral division of labour in health care in line with their perceptions of the relative placing of nursing and medicine within it.

Nurses' accounts of blurring the medical boundary also performed a boundary-creating function, suffused as they were with references to nurses' distinctive contribution to patient care and the different approach nurses brought to these

tasks.

> Sarah said that in many cases it was doctors who would be teaching the nurses these things - which she said was a joke because they looked at things so differently from nurses. They just want to shove an IV in. They don't think about the patient as a whole.

> *(Y)ou don't only need the skills to cannulate you need the skills to look at the patient.* (Senior Nurse)

Nurses frequently claimed that they were more skilled at undertaking such activities than their medical colleagues.

> *I'm pleased that nurses do IVs because they're at least one group of people that do it right. They don't just come and shoot it in like some of my medical friends do!* (Senior Nurse)

> *I mean they (doctors) don't give any thought to what size catheter - well you get a catheter, and if there's a box full you can either take the one from the top or the one from the middle. It doesn't matter about what size. You know you just grab whatever's handy. It maybe totally inappropriate.* (Senior Nurse)

Moreover, in their accounts of working practice nurses underlined their right to control their work parameters. They maintained that the nurse's priority was nursing care and that if the ward was too busy then they expected medical staff to undertake these devolved tasks. Furthermore, many nurses still referred to expanded role developments as 'doctors' jobs'.

> *I remind the doctor that it is, well I say it is my choice.* (Staff Nurse)

> *DA*: When do you decide whether you will do these things rather than the doctor?
>
> *Staff Nurse*: Whether I'm busy or not. Nursing comes first and it's my registration on the line. I'm here to do nursing and the patient's perceive that to be my role.

On night duty the night sisters employed a courtesy rule. Rather than allowing doctors to assume that the nurses would automatically undertake IV drug administration they insisted on medical staff making a personal request for them to undertake this work. I read this as an attempt by nurses to demonstrate their continuing control over their own work boundaries and make the moral division of labour in line with their claims to autonomous practitioner status.

I don't think that it should be looked upon that the nurses are then the doctor's handmaidens that we're not developing our skills just to take off the menial jobs from the doctors that we're doing it because we want to and because it's more holistic individualised patient care. And I think that's the way we ought to be seeing it. (Senior Nurse)

As I described in the previous chapter those ward nurses who could practice in an expanded role did so. Indeed I only actually observed one incident of a nurse handing back responsibility for the administration of intravenous drugs on the grounds that she was too busy. Furthermore, this was done indirectly.

In managing shifts in the nurse-support worker boundary, ward nurses typically emphasised support staff's lack of accountability for their practice and the powers of nursing staff to determine the boundaries of their work.

> *(H)ealth care assistants [...] can only do [...] what the nurse manager sets them out to do and thinks they're capable of and they're not accountable for any of the things that they do so they're still going to have to come to the qualified nurse and we're going to have to account for their work.* (Staff Nurse)

There was some truth in this. Technical tasks were only undertaken by support workers under the instruction of nursing staff. As we have seen

however, support staff exercised considerable autonomy over basic care activities.

Ward-based nurses rarely directly questioned the practical skills of support staff with whom they had an established relationship. Criticism of support workers' skills tended to be directed at the general occupational category. Nurses typically pointed to support staff's lack of theoretical knowledge. As Abbott (1988) has pointed out this is the sort of argument frequently made against workplace assimilation by subordinates.

> *(D)oing is the simple bit. It's knowing whether something's wrong.* (Staff Nurse)

> *(Y)ou can train somebody to do a blood pressure but you've got to interpret that skill.* (Student)

> *(T)hey (support staff) haven't got a depth of knowledge and I feel we've decided what we say they can do.* (Sister)

In the following extract from a quality group meeting the quality manager (who had a nursing background) and a senior nurse discuss the findings of recent research in the hospital that the blood pressure taking technique of HCAs was often superior to that of qualified staff. What is interesting about this extract is how the discussion quickly moves to a joint attempt to clarify

the nurse-support worker boundary in terms of nurses' underlying knowledge.

Quality Manager: An interesting discussion relating to that at the Primary Nurse Group yesterday afternoon about the role of health care assistants and allowing them to take blood pressures. One sister said 'I would never allow a health care assistant to take a blood pressure because you couldn't rely on their technique'.

Senior Nurse: And yet research shows that what you've taught them.

Quality Manager: Yes and because it's a registered nurse doing it we automatically assume that it's right.

Senior Nurse: And it's not the technique but it's the knowledge behind the action to be taken with all these things.

Quality Manager: Well that's the important thing yes.

Senior Nurse: That's the important thing

Quality Manager: About the difference between

Senior Nurse: And they don't have that knowledge.

Quality Manager: They don't have that knowledge.

Senior Nurse: It's the knowledge behind.

Quality Manager: That's right. That's right.

Senior Nurse: But it's not actually the technique.

Social Worker: It's a simple recording isn't it? Surely?

Quality Manager: It's a skill you can teach.

Senior Nurse: It's a skill you can teach but at the end of the day it's understanding the result you've got in your hand when you've done it.

Quality Manager: And that's not their role.

Senior Nurse: And that's not their role. (Meeting - Tape)

In the above extracts we have seen how nurses and doctors legitimated boundary-blurring whilst simultaneously performing boundary-creating work. Through their talk nurses and doctors attempted to make the moral division of labour in accordance with their respective perceptions of their place within it.

Abbott (1988) has suggested that although the public picture is continually reemphasised by occupational groups in the work place, it is reemphasised only in part. According to Abbott, the exclusionary clarity of the public image is normally applied only to subordinates. Taking the hospital as an example, Abbott argues that since doctors dominate the medical division of labour, they invoke their clear public relations with everyone else in the hospital. Nurses on the other hand emphasise their formal separation from their subordinates, but emphasise vis-a-vis physicians, the functions and knowledge that both groups share. As we have seen, nursing staff at Woodlands were quite self-consciously attempting to distinguish the nursing contribution to care from that of medical staff. At one level I read this as a dignifying rhetoric, a form of defence against the charge that in the process

of redrawing the technical division of labour, nurses were once again being dumped on by the medical profession. At another level however, in emphasising the distinctive nursing contribution and their continuing control over the parameters of their work, nurses were endeavouring to make a moral division of labour that was consistent with the public jurisdictional claims of New Nursing ideology.

Resistance to Shifts in the Division of Labour

During the course of the fieldwork I learnt of explicit examples of resistance to shifts in the division of labour and of boundary-creating measures undertaken by ward staff.

When the ENB (English National Board) placed limits on the amount of night duty students could work during their training, the hospital responded by developing the skills of auxiliary nurses. A number of auxiliary nurses at Woodlands worked towards NVQs which enabled them to undertake patient observations. The auxiliaries felt that they should be remunerated for this additional responsibility however and protested by collectively refusing to undertake observations even though they had the requisite skills to do so. Nevertheless owing to the routinisation of ward work the boundary-defining stance of the auxiliaries did not result in disputes with qualified staff.

On Treetops ward the locum urology consultant insisted that the SHO clerked his patients even though a nurse practitioner had been employed to fulfil this

function. The precise reasons for this boundary-defining stance were far from clear. The nurse practitioner maintained that this was a political gesture, the locum consultant's protest against his failure to be given a permanent post at Woodlands. In practice the nurse practitioner and SHO managed the overlap in their work without tension. The nurse practitioner undertook a 'pre-operative assessment' and the SHO used this information to inform his 'clerking' of the patient.

In respect of the nurse-doctor boundary, one ward manager at Woodlands had refused to succumb to the pressures of the junior doctors' hours initiative and had not allowed her staff to train in the administration of intravenous antibiotics. The ward manager did not believe that it was easy in practice for nurses to pass expanded role activities back to medical staff if they were busy. As we have seen these fears were well-founded. Furthermore, committed to the belief that nursing role developments should be led by patient need, the ward manager elected to concentrate on training nurses in the application of plaster casts as she felt this would bring significant improvements in patient care. Her unorthodox actions had allegedly resulted in enormous difficulties between nursing and medical staff however. Because nurses were routinely administering intravenous antibiotics on most of the other wards in the hospital doctors had come to assume this was a nursing role. The difficulties were further inflamed by the fact that the ward was situated at the far end of the hospital and created additional 'leg work' for medical staff. As the nurses on the ward had not undertaken the requisite training their roles were non-

negotiable. However, in what had become a war of attrition, the nursing staff were regularly abused by medical staff and accused of being second class nurses. At the close of the fieldwork the ward manager was on the brink of succumbing to the pressures that were being exerted by the doctors and supporting the ward nursing staff in undertaking intravenous antibiotic administration. The stance taken by this ward sister was unorthodox but the response of medical staff raises important questions as to the power of nursing staff in negotiating the division of labour at work. This is a subject to which I shall return in the concluding chapter.

ORAL CULTURE

I now want to take a look at the oral culture of the key occupational groups in this study. Of particular interest in this section is the ways in which members' storytelling served as a vehicle for the management of inter-occupational tension and the diffusion of overt conflict.

Recognition of the role of oral culture as a vehicle for boundary maintenance is not especially new. For example, Turner (1986) draws attention to the existence of a 'vocabulary of complaint' in nursing culture. He is referring to occupational discourses which are socially produced and acquired as part of the socialisation of the job. Following Hughes, Turner argues that complaints at work are not random. Nurses' complaints are not 'factual' accounts of individual experiences of stressful situations rather they are

representations of the collective experience over time of the nursing situation, passed orally from one generation of nurses to another. Complaints are not simply descriptive but also normative in recommending and legitimating attitudes of opposition. They function to establish a solidarity between nurses, enabling them to let off steam and reassert their position vis-a-vis other occupations. In doing so however, according to Turner, they act as an essentially conservative force, thereby preserving the status quo.

There are obvious parallels with sociological accounts of 'horror' or 'atrocity' stories which serve to sustain inter and intra-occupational divisions and mark the boundaries of allegiance (Dingwall, 1977a; Dingwall, 1977b; Bosk, 1979; Finlay *et al,* 1990). Dingwall (1977) argues that 'atrocity stories' play an important role in resolving ambiguities over professional frontiers and help to define the colleague group. Acquiring an repertoire of such stories and being able to identify appropriate occasions for telling them are important parts of becoming recognised as a competent member of an occupation or any group. Dingwall examines the atrocity stories of health visitors in respect of their relationships with medicine, social work, general nursing and subordinate occupational groups with whom they came into contact. Divisions within the medical profession are sustained by comparable social process (Finlay *et al,* 1990).

Members' storytelling results in the development of powerful stereotypes which further bolster group boundaries (Hughes *et al,* 1958; Roberts, 1977;

Coser, 1962; Katz, 1985; Coombs, 1978; O'Brien, 1983; Wolf, 1988). For example, Burling *et al* (1956) observed that it was routine for aides to complain that they did all the work while the nurses stood around resting. Conversely, a constant theme of the graduate nurses' attitudes towards the aides in this study was that they worked mechanically for a wage without the sense of high calling that the graduate nurse brought to her work.

Atrocity stories are often a marker of social friction (Dingwall, 1977a) and may be seen as a remedial device utilised by the weaker party to the encounter (Webb and Stimson, 1976). In their observations of medical encounters Stimson and Webb (1975), found patients to be less directive and less active in their interaction with the doctor than the stories they told about them implied. This leads Stimson and Webb to conclude that rather than treating patients' storytelling as 'factual' accounts, they should be interpreted as a form of communication by which people make sense of past events, negotiate norms for the behaviour of doctors and patients and redress the inequalities in the client-professional relationship. The way that people reconstruct the encounter from their own perspective is seen as deriving from the more passive part they play in the consultation.

> 'Social reality can be constructed from a safe distance where those on the 'other side' do not have to be taken into account and they cannot themselves dispute that construction.' (Webb and Stimson, 1976: 113)

Stimson and Webb suggest that such stories are likely to be common among clients of other professionals. Dingwall (1977a) submits that this can be taken further. He argues that we should expect such storytelling wherever attempts are being made to control the lives of a group by others whose claim to competence to justify such action is seen as illegitimate.

Atrocity stories may be used in two ways (Dingwall, 1977b). They can be employed in order to bind a group together through the exchange of common problems and the mutual reaffirmation of their troublesome nature. Atrocity stories can also be utilised at an individual level to assert the reasonable character of an individual. These stories arise in an interview type situation and have a slightly different character in that they appeal to any person's standard of reasonable conduct as the teller contrasts the rationality of their part in the process with the implied or stated positions of others. I collected stories of both types.

Nurses' Storytelling

Doctors were the principal topic of nurses' storytelling which centred on two main themes: medical incompetence and nurse-doctor conflict.

Nurses at Woodlands frequently exchanged stories about medical incompetence in the course of their everyday work activities. In these stories nurses freely criticised the knowledge of medical staff, their technical competence, and their interpersonal skills. Such criticisms were never made

to medical staff directly however, nor were they repeated in front of patients. I felt that these criticisms carried an implicit comparison with nurses' perceptions of their own superior skills.

Staff Nurse: We called him to the ward yesterday and asked him if he could write her up for some more pain killers. He wrote her up for Pethidine 50mg!

Sister: That's why her pain's settled.

Staff Nurse: He asked me what the dose was and I just walked away. Do you know who it was? It was that Baldwin. I thought you're a senior house officer if you don't know the dose of Pethidine then you've got some reading to do. So he wrote her up for Pethidine 50mg four times a day!

Sister: That's a bit much after Cocodymal.

Staff Nurse: He wrote it up and I questioned it and he said 'Yes that's what I want her to have'. So I said OK. But she's not had any today. She's just had oral cocodymal.

Student 2: I've just seen the most fantastic aseptic technique!

Student 1: Oh really.

Student 2: He (the doctor) cleaned all around the site and then the other doctor said 'Let me have a look at this'. ((enacts how the second doctor touched all the area previously cleaned)).

((laughter))

Student 1: Did he wash his hands first?

Student 2: Wash his hands! What's that?

Student 1: ((proudly)) Well I set up my trolley and then came and washed my hands before I started.

When I arrived the nurses were talking about a death that had occurred in the night. Evidently they had been discussing it for some time. Laura was recounting the events leading to the patient's death. She explained that when the night staff had taken the patient's blood pressure when they came on it was very low - seventy over forty. She said that the doctor - (PRHO) had put up some haemacell and that she still wasn't happy and so they gave him another one. Jenny said, 'But he was Cheyne-Stoking wasn't he?'. Sally said, 'Yes. The doctor was hopeless. I said to her he's Cheyne-Stoking and she said 'What's that? What are his respirations like?''. There was generalised laughter. Sally went on, 'I said three (respirations) a minute if you're lucky'. Maureen chipped in ((laughing)), 'And that's being generous!'. Sally went on, complaining that the doctors wouldn't leave him (the patient) alone. 'They called the crash team, but he was dead wasn't he?'. Jenny said, 'Yes. Oh Yes'. Sally said, 'Why couldn't they leave him to die with a bit of dignity?'. Pauline said, 'I

don't think they assess these patients adequately before theatre'.

The bedside manner of doctors was subject to particular criticism.

> It was my first ward he was so awful to the patients. 'Well you've got cancer and there's nothing we can do!' You know just like that in front of the whole ward. I nearly gave up nursing he was so awful to the patients. (Staff Nurse)

> *Student*: And all I heard (SHO) say was, 'When you have sex', like bay five, curtains drawn round absolutely everybody can hear, 'When you have sex it will go backwards and not come down'. I thought marvellous and now we all know. (Nursing handover - Tape)

I suggest that stories relating to medical incompetence were a means of resolving the tensions experienced by nurses uniquely placed to form judgments about the calibre of medical staff but who felt unable to challenge it directly.

The second kind of story nurses told about doctors focused on disagreements between nursing and medical staff over aspects of patient treatment. Most of these accounts were derived from the interview type situation. In many of these stories nurses' judgements had been disregarded by the doctor to the

detriment of the patient.

> *I remember once [...] there was this lady in bay two bed one and we said 'If you don't do something this lady is going to arrest' and they messed about and messed about and she did arrest and then they pull all the stops out then. It's too late. I mean we don't profess to be right all the time but I remember once this young lad was in, he was only young and he'd got this chest drain in, and he suddenly went off [...] I thought this lad's bleeding somewhere but you couldn't see anything in the bottle and this registrar came up and said 'He'll be alright sort of thing'. I thought 'He won't'. And this doctor came up and saw him and I hadn't got a lot of confidence in him, that's probably why I got this other chap up. Anyway they took him down to CTR (central treatment room) and this chest drain had punctured his artery and it was bleeding into his lung and he was blue lighted to (another hospital)! When you know something's wrong, but you can't, I didn't know he was bleeding into his lung but I knew he was bleeding somewhere. And when they're sort of thinking you're fussing for nothing!*
>
> (Sister)

I was on here one night and I bleeped the doctor because I was worried about a patient who was short of breath. He said he

was busy on (the admissions unit) and would be up when he could. Well Sarah said there were five of them down there all huddled together round the desk and just two patients. He didn't come and the man was getting worse. I bleeped him again and still he didn't come. So in the end I fast bleeped him. Now if I fast bleep him then he should come to the ward but he didn't - he phoned. I said that the patient was getting worse. He was grey and clammy and I was sure he was in acute LVF. So he told me to give some Frusemide. Well I wouldn't give it - we can take verbal orders - but that would have been like me making a diagnosis and we can't can we, the patient has to be seen by a doctor. I said 'Look if you don't come and see him he'll arrest' and just as I put down the phone he did. He died. I wish I'd given him the Frusemide now. He needn't have died - all he needed was some Diamorphine and some Frusemide. I was mad - it was awful, just watching him literally gasping for breath. (Staff Nurse)

There are clear similarities here with patients' stories of medical encounters (Stimson and Webb, 1975; Webb and Stimson, 1976). Like the patients in Stimson and Webb's study, the nurse is portrayed as having a very active part, and his/her judgements, opinions and subjective feelings figure prominently. I would like to argue that the above extracts may be read as an attempt to mediate the tension between nurses' informal power by virtue of their

experience and proximity to the patient and the ultimate authority of the doctor as final arbiter on patient treatment decisions. A central feature in nurses' stories is the emphasis given to the value of nursing knowledge. Doctors should recognise nurses' experience and respect their judgements. In the following extract the legitimacy of nursing knowledge is underlined when the nurse over-rides the judgement of junior medical staff and is finally supported in her decision by the consultant.

> *(W)e had a gentleman in with cancer - last stages of cancer - he was very poorly. He was on MST twice a day but the dose just wasn't sufficient at all but he was the kind of person that didn't want to trouble any nurses and never asked for any more analgesics and because the ward was really busy at the time he didn't often get offered it. You know because it's the case sometimes if they don't ask they don't get. It's wrong and it's sad but it happens. And I actually put forward to the house officer that was here at the time that I thought it might be better if he had a syringe driver. At least then he'd be getting a bigger dose and he'd be getting a regular dose of Morphine constantly. He didn't want to make the decision so he took it to the registrar who said no. He said according to his kardex it didn't prove, because he hadn't had any Oromorph in between his MST, it didn't prove that he warranted a syringe driver or an increase. But I tried to explain that it wasn't*

because he didn't need it, it was because he wasn't getting it because he never asked for it. We went on like this for ages but he still said no. So when (the consultant) come the next day, I was really angry about it - he was one of my patients and I really felt that he was in pain and I could see his wife was so distressed - so I went over all their heads basically and just asked (the consultant) on the ward round the next day and he said yes straight away. And it caused quite a bit of conflict actually and Dr Hale who was here at the time said 'Well you've already asked me this I've said no', and I said 'I'm sorry but I don't agree with what you've said'. You know some people could say that I did that to spite him but I never. I did that because I knew that was what was best for the patient. Well that's what I thought and at the end of the day you've got to go with what you believe in I suppose. And it did work, the man was pain-free. (Staff Nurse)

In analysing their data Stimson and Webb (1976) consider the possibility that the type of incidents that become worthy of telling are ones in which the patient did actually play an active role. They conclude however that this probably owes more to the story being a vehicle for making a patient rational and sensible, and for redressing the imbalance between patient and doctor, than it does to the event itself. In respect of my own data I suggest that nurses' stories about doctors also appeared to be employed primarily as a

remedial measure. This also takes us closer to understanding the discrepancies between the numerous accounts of nurse-doctor conflict given in the interview situation and my failure to observe many incidents of overt conflict during the period of field observations. Nevertheless, recognition of the importance of storytelling as a vehicle for handling inter-occupational strains should not lead us to dismiss the possibility that incidents in which nurses did in fact play an active role were also in themselves significant, not least because these were relatively unusual events. In relation to the last episode the nurse revealingly adds:

> *It was awful actually and I was so nervous when I asked him (the consultant). I didn't know whether to ask or not because you don't want to upset anybody but at the same time I felt strongly about it and I did and I'm glad I did.* (Staff Nurse)

My data suggest that nurses were prepared to challenge medical decision making if they were strongly in disagreement with it, this was particularly the case in care of the dying. There is some evidence in support of these findings in the sociological literature (Walby and Greenwell *et al,* 1994), although I suspect that studies relying on interview data alone may have a tendency to misrepresent the frequency of such incidents. At Woodlands certainly, these were relatively unusual occurrences in everyday practice and as the above extract suggests the degree of overt conflict that could be expressed was limited by the interest of both doctors and nurses in maintaining sustainable

working relationships. Nevertheless, I submit that Turner's (1986) claim that occupational discourses within nursing act as an essentially conservative force sustaining the status quo should be treated with a degree of caution. It is reasonable to assume that by telling stories in which nurses actively challenge medical decision-making the teller may encourage the listener to do the same.

Nurses told other kinds of stories: their skilful handling of emergency situations - for example, the nurse who managed a cardiac arrest single-handedly; humorous incidents - like the occasion when a precordial thump in a cardiac arrest situation sent the patient's wig flying across the floor and reduced the nurses to tears of laughter for the duration of the resuscitation effort; different generations of nurses told stories about each other, and students told stories about qualified and support staff. What was interesting about nurses' storytelling however, was how few stories related to the nurse-support worker relationship. This may reflect the fewer everyday opportunities for the telling of such stories. For example, although support workers never told stories about the medical profession, the stories nurses told about doctors were recounted in the company of support staff during nursing handover, on the ward and during break times. The presence of support staff on such occasions would have made the telling of stories relating to the support worker boundary more problematic. Certainly all of the examples of atrocity stories told by ward nurses about support workers were recounted in interview type situations. On a couple of occasions nursing and support staff talked in general terms about strained relations between unqualified and

qualified ward staff but these tensions were always portrayed as happening somewhere else and not a problem on 'their' ward.

Most of the atrocity stories I collected concerning support workers were told by senior nurses in the organisation who were removed from the daily practice of the wards. These stories appeared to be of different kinds. One group of tales highlighted the distinctive approach qualified staff brought to care work. Support staff were portrayed as working in a task-oriented manner compared to the claims of nurses to practise holistically.

> Amanda recounted a story whereby an HCA had told her that she had learnt an efficient way of taking temperatures - she went down the ward putting the thermometers under the arms of 34 patients. By the time she had done that she returned to the beginning where the first one's were 'cooked'. The senior nurse said that she was horrified.

> Claudia said she stood in the classroom and talked at great length about treating patients as people, individualised care and 'all this wonderful stuff' and then Gill had told her [...] she went on to a ward and saw the support workers doing a back round. They had a trolley which had a pile of bed pans and a pile of bottles on it and the auxiliaries were starting at one end of the ward and working their way down.

Other stories seemed to act as moral parables, as reminders of the dangers of dilution.

> *I only went up a couple of weeks ago to work with a health care assistant and we did a bed-bath, and she hadn't really very much knowledge of this patient, and the bed-bath went on and I just sort of followed her lead if you like because I was there in a teaching capacity but also as an observer - and the one aspect that didn't get considered was the lady's IVI. She was a bit confused this lady, had a wad of bandages on her hand of the IVI site and the HCA hadn't actually considered removing that because she said she didn't think it was her job. Fair comment. But what had happened was that nobody had thought it was their job and when we actually unravelled it - her fingers were all bent, they were so sweaty that it was like cheese, and she'd actually had a very tiny pressure sore development underneath her cannula site and her nails were digging in the palm of her hand, which you know, wasn't right. It wasn't quality care. But the HCA had been told that it wasn't part of her job, yet it wasn't being picked up by anybody else.* (Senior Nurse)

Other stories related to the pressures towards dilution on the wards.

Senior Nurse: I still get phone calls now saying - I had one not too many weeks ago - 'What else can the health care assistant do' and I said 'Well what are they doing?'. Thinking 'I don't really want to know'. So she proceeded to tell me - this is a ward manager - proceeded to tell me this, that and the other and she said 'In fact they do everything'. So I thought 'Ah ha. So what is the registered nurse then doing?'. (HCA training programme - Tape)

I only collected seven examples of atrocity stories about support workers from ward-based nursing staff. Three of these related to what nurses perceived to be HCAs' spurious claims to competence.

(S)he's not started the HCA course and she's already taking IV cannulas out and she's a little bit over-confident and I kinda think 'Does she understand what she's doing? Does she realise the implications?'. She says 'Oh yes I've done thousands of them'! You know she's been on the ward four weeks and you think 'When did she do these thousand cannulas' you know. (Sister)

(T)he phone rang and they wanted a nurse in theatre recovery and I was straining hard to find somebody who - they'd all disappeared into the woodwork - and Paula said 'I could go

down for it'. I thought 'I hope she's joking', you know but I wouldn't put it past her. I mean I don't know her. I think she's had a lot of experience elsewhere Paula - but what they do elsewhere is different from what we do here so. (Sister)

Two stories related to what nurses' perceived to be the illegitimate setting of work boundaries by support staff. Both these stories related to the same 'conscientious objector' HCA. Although nurses seemed to prefer working with support staff who recognised the limitations of their expertise, one of the HCAs on Treetops ward had made herself unpopular with qualified staff by refusing to undertake certain tasks even though she had the requisite skills. What is interesting is that the actions of this HCA created tensions whereas the refusal of auxiliaries on nights to undertake patient observations did not. I suggest that there are several crucial differences here. First, the boundary-work on nights was a collective protest, whereas on days it was an individual that was singled out. Second, the routinisation of work on nights meant that auxiliaries rarely had to make a direct stand, whereas the stance taken by the HCA on days set her apart from other support workers, and had put her in the unusual position of refusing the requests of nursing staff, action that undermined their status. Nurses seemed to have dealt with the tensions created by this individual by not bothering to ask her to carry out activities she had been known to refuse in the past; I observed no direct evidence of conflict.

Two further stories related to support staff who had not treated nurses in a manner considered commensurate with their status. One story related to an incident in which an HCA would not cede space at the patient's bedside to the qualified nurse so she could assist a colleague. The other concerned a support worker who had not accepted the judgment of a qualified nurse and had solicited a second opinion from a colleague.

There are several points that require closer discussion here. First, the different content of the stories told by the ward nurses compared to those told by senior nurses. Second, the surprisingly small number of stories about support workers told by ward-based nurses. Third, the finding that all of the ward nurses' stories were collected on Treetops ward.

I suggest that the different stories told by ward-based and senior nursing staff reflected their differing perspectives. As Bucher and Strauss (1961) have argued, a profession is not a homogenous entity and may be more fruitfully considered as constitued by different segments. Members of these different segments might have quite special problems with occupations which they do not share with other members of their profession. The principal concern of senior nurses at Woodlands was with the implications of shifts in the division of labour for nursing's 'professional' status. Ward-based nurses on the other hand were most concerned with their day-to-day relations with support staff. Thus in their stories senior nurses emphasise the differences between the contribution of support and qualified staff to care-work and point to the

dangers of dilution, whereas the stories of ward-based staff focus on their control of the parameters of HCA practice and the acknowledgement by support staff of nurses' status.

As I have argued however, the examples of atrocity stories about support workers recounted by ward staff were few. Moreover, all these tales were collected on Treetops ward. Treetops differed from Fernlea in that several of the support staff were relatively new members of the ward team with whom trusting relations had still to be established. Moreover, as we have seen, a number of the stories related to the actions of a single deviant HCA. That storytelling can be understood as a marker of social friction is revealed by the observation that the HCA was herself a source of a disproportionate number of stories about qualified staff. I suggest that the overall dearth of stories relating to support workers in this study can be understood as a reflection of the extent to which the division of labour on the wards was rooted in interpersonal relationships. As we have seen the primary focus for nurses and support workers was the ward team. Indeed support staff shared atrocity stories with qualified staff.

HCA: Somebody told me that (the unit general manager) confronted somebody at the main entrance [...] and he said to her 'Excuse me would you put that (cigarette) out please'. She went. 'Why? Who are you?'. So he said 'Well I'm the general manager here and I'm telling you'. She says 'I couldn't care

a Fuck (mouthed) who you are'. He took her to (the) photograph board with photos and said 'That's me there'. She said 'I still couldn't give a Fuck (mouthed) who you were'. He said 'I shall do something about this', and walked off. ((laughter)). (Ward meeting - Tape)

Support Workers' Storytelling

Just as nurses told stories about the shortcomings of doctors, support staff told stories about deficits in nurses' skills.

> Amy (HCA) recounted her experience on the resus course which she had attended with Rebecca (an auxiliary) from the ward. She described how when it came to the practical side of things she and Rebecca were 'getting on with it and were doing it all perfectly', whereas the sister who was there was 'hopeless'. Amy said that the training officer had asked the sister where she had been for the last 20 years.

A second set of stories related to the problems and conflicts support staff encountered in managing their work boundaries.

> *I mean there was an incident with an auxiliary who's just started - she's really nice, she's never done this sort of work before - and one of the E grades asked her to do something and*

she said, 'I can't because I don't feel confident because I haven't done it', and the E grade says, 'Well you're a liability to this ward you shouldn't be working on here'. She'd only just started. (HCA)

(A)t one stage there were certain wards when I worked on days when you weren't even allowed to test urine. Certain wards just didn't think you were capable of dipping a urine ((laughter)). That really insults your intelligence. (Auxiliary)

Stories were also told about strains between HCAs and auxiliaries from both perspectives.

Well one particular health care assistant - well the first one actually - decided that she was just there to do the obs and that was it. Anything else that an auxiliary did or that she did before was beneath her then. If there was another auxiliary on with her she would be saying 'You should be doing that I've got to be doing that'. It didn't go down very well [...] She walked continually round with a stethoscope around her neck and thought that she was it. (Auxiliary)

The health care assistant has got a lot more responsibility than an auxiliary but when all this HCA was brought in a lot of the

auxiliaries felt bitter about it. We had an incident the other day when an auxiliary came off another ward to help us and I'd got a pinny on covering my badge and she was going on and on about health care assistants, yes they can do this and they can do that but they're only the same as us. It's only because they've got a different belt - you know - and I don't know why they're doing all this training because they're only on an A grade and I don't like them'. (HCA)

To complete this section I now wish to take a brief look at the stories told by medical staff.

Doctors' Storytelling

The examples of stories told by medical staff were mainly collected in an interview type situation and were elicited in the context of discussions about the working relationships of nurses and doctors. The potential subject matter for doctors' storytelling is clearly much wider than this (cf. Finlay *et al,* 1990; Bosk, 1979). Most of the stories junior doctors told about nursing staff referred to what they perceived to be nurses' illegitimate control over the boundaries of medical work. In these incidents nurses are able to exert control over medical jurisdiction by refusing to undertake certain activities themselves. In these stories the doctor is presented as the rational player in the face of seemingly irrational rule-bound behaviour of nursing staff.

Dr Damir said that a nurse had called him to the ward to give chemotherapy through a Hickman line and she had to show him how to do it but couldn't do it herself [...] He said that doctors were prepared to bend all the rules and do what was necessary for the patient. He described nurses as rule-bound and unprepared to step outside their jurisdiction even if the patient was dying. He recounted an incident in which a patient was in severe pain and needed diamorphine. He had asked the nurses to give the medication and they wouldn't do it until he had written it down on the drugs kardex. He rather mockingly recounted how it then had to be checked by two nurses before the medication could be given to the patient. Meanwhile the patient was in agony.

I had a patient a few years ago that was decidedly drowsy that needed a naso-gastric tube. The nurses turn round and say 'We're not allowed to do it because the patient is not conscious. You've got to do it'. I had never put a naso-gastric tube in my life. For nurses who have, turning round and saying 'We're not allowed to do it. You have to do it'! (SHO)

In this section I have examined the oral culture of the principal occupational groups in this study. I have argued that members' storytelling served as an important boundary-creating mechanism. At Woodlands this phenomena was

most marked with respect to the boundary between ward and medical staff. The boundary between nurses and support workers as marked by patterns of storytelling was less clear, supporting the observation that for these two groups the ward team was the principal reference group rather than their respective occupations. I have also suggested that these stories were employed as a vehicle for handling strains in inter and intra-occupational relationships and that this helped to dissipate overt inter-occupational conflict.

I suggest that understanding members' storytelling can help to explain the discrepancy between members' accounts of inter-occupational tensions and the absence of any explicit expression of this conflict on the wards. If we accept that members' storytelling should be understood as the reflection of a particular occupational perspective rather than literal accounts of individual actors' experiences then it is possible that members' accounts of their work misrepresent the extent of this conflict. That is not to say that conflict does not exist however but illustrates the fact that storytelling is also the principle mechanism through which this inter-occupational tension is handled thus preventing explicit conflict from undermining working relationships.

THE SYMBOLIC ORDER

No analysis of occupational boundaries would be complete without discussion of the symbolic order. As we have seen, a key feature of the moral division of labour between doctors, nurses and support workers is its basis in a formal

system of hierarchy and this was signified in diverse ways throughout the organisation.

Uniforms

As the ethnographic literature shows, within the hospital different occupational groups and gradations of staff are signified by a complex medical semiology (Atkinson, 1981; Haas and Shaffir, 1984; Myers, 1979; Wessen, 1958; Burling *et al*, 1956). A whole range of symbolic props - white coat, apron, buckles, stripes, caps, stethoscope, language - have been employed by occupational groups to evince their status.

At Woodlands uniforms were an important boundary-marker. In the general turbulence of the hospital environment they offered important indicators of identity for both staff and patients.

> *Staff Nurse*: Was it the OT? (occupational therapist)
>
> Student: No it was physio - she's got blue on.
>
> *Staff Nurse*: I want to contact the OT.

Uniforms also provided important clues as to the appropriate form social interaction should take where there was no established relationship between individuals.

> I was joking about my dilemmas as to whether I ought to wear the white coat or not. She (the auxiliary) laughed and said that everyone would think that I was a doctor [...] She said that sometimes the agency nurses wore white dresses and they were often mistaken for a doctor. She then said that she reckoned that if the cleaner put on a white coat then <u>everybody would speak to her as if she were a doctor</u>. You just don't see beyond the uniform she said. (My emphasis)

In chapter 4 I discussed my own discomfiture at wearing a white coat in the early days in the field such was its power as a symbol of the medical profession. It was not uncommon for me to be mistaken for a doctor or a medical student. Interestingly however, medical staff frequently went without their white coats. Neither of the surgeons on Treetops wore a white coat, although on occasion they appeared on the ward in theatre greens. Going without a white coat was not simply a privilege of status though, PRHOs and SHOs also often left their white coats off. The only detectable pattern in the medical mode of dress was that medical students always wore their white coats on the wards. I suggest that this reflected the ambivalent status of medical students and their desire to identify themselves with the practitioners in the profession to which they aspired. It was clear however, that in the public eye the white coat was an important symbol of medicine which had the power to over-ride other interactional cues.

We (me and a male PRHO) are sitting at the nurses station when a relative comes to the ward outside visiting time and asks if he might see a patient. He is looking at me rather than Dr Fresh even though Dr Fresh is speaking to him. ((I was the one wearing the white coat - and I'm older)).

The uniforms of nurses clearly differentiated them from support workers. Within these two broad distinctions, different coloured belts signified different staff gradations: HCAs, auxiliaries, RGNs, SENs and students. Qualified staff also wore buckles, silver for RGNs and bronze for SENs. It was common for staff to remove their belts when they were working however, which meant that these finer status gradations were often less visible. Sisters were clearly differentiated from the rest of the nursing staff by uniform which was a completely different style and colour. Different grades of male nurses were symbolised by different coloured shoulder stripes.

Interestingly, ward clerks also wore petersham belts and I noticed that many had added large ornamental buckles similar to those worn by the nursing staff. This appears to support the findings of Burling *et al* (1956) that non-medical staff in medical settings gain satisfaction from their identification with the healing professions and the curative enterprise. 'Not only does the hospital's mission provide intrinsic satisfactions but the prestige of professionals - doctors and nurses - tends to spread to the less highly skilled employee' (Burling *et al,* 1956: 137). Clerks in this study were observed to wear the

white jacket with its flavour of science and authority.

As we have seen, many nurses were highly critical of those colleagues who flaunted the symbolic trappings of their position. I read this as an attempt by nurses to distance themselves from the traditional nursing culture with its emphasis on hierarchy and obedience as opposed to the thinking, autonomous practitioner of new nursing ideology. Nevertheless it was clear that uniforms at Woodlands remained an important symbol of the moral division of labour. For example, when nurses were promoted they talked about changing uniform rather than job.

> Stella said that herself and Alison were singled out as high fliers and were 'blued' (made sisters) fairly early on - when they were about 24.

The importance of uniform as a boundary-marker is revealed in the following extract in which a staff nurse talks about the changes in uniform taking place in a neighbouring hospital in a context where managers were encouraging the realignment of occupational boundaries.

> *(T)hey're wearing trousers and tunics and they're very very similar colours so a sister wouldn't be immediately noticeable to the patient and the auxiliary's uniform's very similar. So they're trying to blend them all in together so that there's no*

obvious discrimination between staff. I think that's designed intentionally - I don't think that's an accident that they're all in the same. (Staff Nurse)

It will be interesting to see to what extent hospital managers elect to manipulate the symbolic order in an effort to manage organisational culture.

The Allocation of Space

The allocation of space is another mechanism through which status inequalities (Tellis-Nayak and Tellis-Nayak, 1984; Henley, 1977) are symbolised. At Woodlands consultants each had their own offices and junior medical staff had access to office space shared by doctors on two wards. Furthermore, consultants wanting to socialise with their colleagues were able to relax in their own lavishly furnished and decorated sitting room. Junior doctors were also able to relax off-stage in the doctors' mess, which was equipped with a television and pool table and provided with a selection of daily newspapers.

Compared to the medical staff, nurses at Woodlands had few private spaces and little opportunity for backstage activities. Each ward had a sister's office but this was mainly used by senior staff. In the past it had provided a backstage area for nursing handover, but a new hospital policy insisted that nursing handover be carried out in the ward areas. The change in policy had been initiated by senior nursing staff and its purpose was to facilitate communications between patients and nurses and encourage greater patient

participation in the care process. In removing handover from the nursing office however, a backstage activity had effectively been brought centre stage with the loss of an important vehicle for staff support and team building.

> *(W)e used to have some hilarious laughs. It sort of used to relieve a bit of tension as well you know. An incident that had happened in the morning you could really get it out of my our system. We miss it really.* (Sister)

Nurses took their scheduled breaks in the main hospital dining room which was utilised by other categories of staff. Furthermore, at the weekend and on public holidays the dining room was also open to the general public which undermined its backstage status.

The observation that space is the prerogative of the powerful may be illustrated by the following point. When the chief executive moved into his brand-new office at Woodlands four senior nurses and a secretary were moved into the room space he had previously occupied. Moreover, the room's former quality accoutrements were replaced with furnishings that were considerably less opulent.

I have argued that the organisational hierarchy was signified in powerful ways through the symbolic order at Woodlands. But as Hall (1985) has pointed out, asymmetric relationships are not automatic, unchanging or mechanical. They

require consciousness, effort, mobilisation, action and reaction to be maintained or changed. In their patterns of interaction field actors clearly oriented to formal organisational structures in more or less subtle ways. Nevertheless, as we saw in chapter 7 owing to the temporal-spatial ordering of hospital work the moral division of labour was frequently modified in the course of actors' everyday work activities and thus the occupational hierarchy at Woodlands cannot be understood as shaping behaviour in a deterministic way. But whereas the moral division of labour between nurses, support staff and doctors working on the wards was negotiable in daily practice, the status of consultants was quite unambiguous and was consistently oriented to by nurses, support workers and junior doctors alike. In considering this issue I have found it helpful to distinguish between the moral division of labour between individual members of occupations and between occupations as corporate bodies. Thus whilst **individual** junior doctors and nurses were prepared to negotiate the moral division of labour in daily practice this was set against the mutual acceptance of the **corporate** authority of medicine, which was embodied in the figure of the consultant. In the final section of this chapter I want to explore the micro-political processes through which the status of consultants at Woodlands was constituted.

THE MICRO-POLITICAL ORDER

Patterns of Interaction on the Ward

One of the ways in which status inequalities were constituted at Woodlands

was through field actors' choice of demeanour. Both nurses and ward-based junior medical staff employed a more formal and polite demeanour in their encounters with consultants than they did with each other.

> Staff nurse was on the phone to the consultant. She puts the phone down and remarks to anyone who happened to be listening - 'That was my posh voice'.
>
> *Sister*: ((is in bay one)) Who were you speaking to?
>
> *Staff Nurse*: Dr Kavanagh (Consultant).
>
> *Sister*: Oh!

Terms of address may act as status-markers. In English terms of address are governed by two underlying dimensions - status and solidarity (Henley, 1977). On the solidarity dimension closeness is symbolised by a mutual use of 'informal' or 'familiar' address such as the first name or nickname. Distance is indicated by the mutual use of 'polite' or formal address. Status is indicated by nonreciprocal usage: the lower status speaker uses terms of respect such as titles. The higher status speaker addresses the lower status one informally, by first name or by familiar pronouns.

At Woodlands junior doctors' and nurses always addressed consultants by their formal title but consultants frequently addressed nurses and junior medical staff by their first names. By contrast, nurses and ward-based junior doctors were often on first-name terms.

The literature suggests that status inequalities may also be constituted through members' use of space in interaction. For example, Rosengren and DeVault (1963) observed that higher status personnel could 'backstage' in regions where lower status personnel could not. I observed similar patterns of interaction at Woodlands. Consultants frequently 'held court' on their visits to the ward and appeared to feel more able to engage in backstage behaviour - such as telling jokes and swearing - in front-stage areas.

Time

Status inequalities are also constituted through our use of time. We make less demands on the time of the powerful, the powerless are thought to have more time on their hands (Tellis-Nayak and Tellis-Nayak, 1984; Schwartz, 1979).

At Woodlands it was quite evident that it was the consultant's time that was considered most important. Consultants came and went as they pleased and ward staff and junior medical staff fitted their other activities around them. On one occasion I had remained longer on the ward than I had intended in order to observe a consultant carry out a particular procedure. The consultant had arranged to return to the ward at 1:20pm but by 2:15pm had still not arrived and I asked the staff nurse if there had been a change of plan. The staff nurse said that there had been no further arrangements but confided that she took doctors' promises to come to the ward at a prearranged time 'with a pinch of salt'. On another occasion a consultant decided to start his elective investigations early - disrupting all the prescriptions for pre-medications.

Whilst I observed visitors, porters, research students and junior doctors kept waiting by nurses, consultants were always attended to immediately.

> Consultant approached the desk.
>
> *Consultant*: ((to staff nurse)) Mrs Salmon's Xrays don't show any fracture but I better inject that right wrist to see if there's any pus in it.
>
> Staff nurse stops what she is doing and gets up immediately to prepare the trolley.

(A) porter came and asked Laura for a patient he had come to collect to take to reception. Laura looked up and said, 'He's just sitting around the ward, you'll have to go and find him'.

One nurse on Fernlea who frequently protected patients' meal times from visitors and other members of hospital staff was prepared to assist a consultant undertake a sterile procedure in the middle of lunch-time.

It was not just nursing staff who treated consultants' time as more important however. Junior medical staff were equally accommodating. On a number of occasions during the fieldwork one of the consultants rescheduled the ward round for the team's on-call weekend in order to accommodate his other commitments. The ward round could take four of five hours and left only one junior doctor covering all the ward work. Despite the problems this caused

for the junior medical staff however they did not challenge it. Rather they justified it in terms of the consultant being a very busy man.

Ritual and Secrecy - The 'Fleeting Encounter'

Utilising an anthropological perspective Campbell-Heider and Pollock (1987) argue that ritual and secrecy is one of the mechanisms through which the dominance of physicians is maintained.

In the structure of hospital relations, status increases with increased distance from the patient. At Woodlands it was low status support staff who had the most sustained relationships with patients. Owing to the turbulence on the wards, patterns of nurse-patient interaction at Woodlands was often transitory and episodic. Nevertheless, nurses still had a more continuous presence on the ward than did doctors.

The patterns of interaction between junior doctors and patients on the two wards varied slightly. On Treetops, although the patterns of SHO-patient interaction were relatively informal occasions, the SHOs were rarely on the ward and doctor-patient encounters thus tended to be restricted to ward-rounds which each SHO carried out daily, normally accompanied by a nurse. The patterns of interaction between the PRHOs and patients on Fernlea were less circumscribed.

Like the SHOs on Treetops, the PRHOs on Fernlea, also tried to visit each

of their patients everyday, although often the pressures of work meant this was not always possible. Unlike the SHOs on Treetops, the PRHOs' encounters with patients did not take the form of a ward round and may be best described as a chat about progress. Moreover, unlike the SHOs who regularly worked in clinics and theatres during office hours, the PRHOS spent longer periods on the wards and as a consequence they were more available to patients who wanted to talk to them.

Consultants' encounters with patients on the wards rarely took place outside the context of the ward round however, and although there were subtle variations in style, all were highly ritualised occasions. For example, on Fernlea I observed junior medical staff on round mornings hunched over the ward computer, gathering together any outstanding investigation results so that they would be available for the consultant. Meanwhile, support staff tidied the ward as if in readiness for an important guest. Medical notes and Xrays were retrieved and placed outside the patient bays. A trolley was laid with equipment and forms that might be needed on the round, including the consultant's special stethoscope! Patients were instructed to remain in their night clothes in order that any physical examination could be carried out efficiently. Various categories of staff assembled on the ward and waited for the consultant to arrive. There is little question as to who the star of the show is.

The ceremonial of the ward round itself is a collective accomplishment. The

consultant takes centre stage, controls the flow of talk, thereby setting tone and pace. The consultant's attention is narrowly focused on the patient's medical condition and the encounter is characterised by an emotional detachment in which knowledge and technique can be applied free from constraint. Any extraneous details are dealt with by other personnel on the round who play a support role frequently without the need for explicit instruction. For example, the consultant does not have to be concerned about drawing the curtains when s/he wishes to examine a patient. This will automatically be attended to by support players - normally whoever happens to be closest. Similarly, when the examination is completed a support player - usually a nurse - makes the patient comfortable again and assists them with their clothing. If the consultant prescribes a drug or requests an investigation - the junior doctor completes the form.

At Woodlands the ritual of the ward round was an important mechanism through which the consultant's status was enacted. Through the support work of nursing and junior medical staff the professional-client relationship is enacted in its purest form, untrammelled by extraneous variables and bureaucratic constraints.

Recent sociological analysis has comprehensively challenged the long-held assumption that the working relationship between doctors and nurses is characterised by an unproblematic subordination of the latter to the former (Stein, 1967; Stein *et al*, 1990; Rushing, 1965; Devine, 1978; Hughes, 1988).

These studies reveal the ways in which both the technical and moral divisions of labour between nursing and medicine can be modified during the course of their everyday work activities. Earlier studies (Stein, 1967; Rushing, 1965) described the strategies of indirect negotiation employed by nurses which enabled them to modify the technical division of labour with medicine, whilst appearing to defer to the doctor's authority. More, recent studies suggest that these patterns of deference in nurse-doctor interaction may now breaking-down (Stein *et al*, 1990; Hughes, 1988). For example, in Hughes' study of patterns of nurse-doctor interaction in a Casualty department, nurses frequently offered advice on many aspects of departmental practice in an open way. Senior nurses would intervene quite bluntly to point out shortcomings in the work of junior doctors, and to more or less take control over the processing of certain patients. Hughes explains his findings partly in terms of the differential local knowledge of the doctor and nurses in this study and, partly in terms of the dilemmas and contradictions in status involved in the relations between young, inexperienced, Asian Casualty Officers and mature, 'Anglo-Saxon' nurses.

In underlining the situated nature of medical control, Hughes' work is clearly an important qualification of the over-simplistic assumptions of the orthodox view. However, he can be criticised for failing to consider the limits within which medical dominance is negotiable. As we have seen at Woodlands the moral division of labour between nurses and ward-based doctors was frequently modified in everyday practice but as far as nurses were concerned, the consultant's role was non-negotiable. Furthermore, in focusing so intently

on the nurse-doctor relationship sociologists have been guilty of ignoring the ways in which the status of consultants is constituted daily by nurses and junior doctors through their patterns of daily interaction.

Summary and Conclusions

In this chapter I have examined the diverse processes through which occupational boundaries were created at Woodlands. I have looked at the strategies employed by nursing and medical staff in their efforts to accommodate shifts in the technical division of labour and make the moral division of labour in health care in accordance with their respective perceptions of their place within it. I have examined the role of oral culture as a boundary-creating mechanism and the ways in which the stories told within occupational groups acted as a vehicle for the management of inter-occupational tensions, thereby dissipating overt inter-occupational conflict. I argued that a key feature of the moral division of labour between support workers, nurses and doctors is its basis in a system of formal hierarchy and I have described the ways in which this was signified in the symbolic order at Woodlands. In the final section in this chapter I analysed the micro-political order. I argued that whilst the moral division of labour between nurses, support workers and ward-based doctors was frequently mediated in daily practice, the status of the consultant was unambiguous and was constituted daily through the micro-political order. This raises the question of the extent to which the division of labour at work is negotiable. This issue is the focus of the next chapter.

9. The Division of Labour at Work - A Negotiated Order?

I now want to draw the threads of the research together by examining the extent to which the division of labour at Woodlands can be considered a negotiated order. This is a question that has a relevance to this thesis in two inter-related respects. At one level it pertains to the extent of negotiative activity and has a self-evident applicability to the principal findings of the research: that the division of labour between nurses and support workers and nurses and doctors was accomplished with minimal inter-occupational negotiation. At another level it also refers to the issue of the constraints within which the nurses in this study worked which led them to accomplish occupational jurisdiction in the shape that they did.

I shall begin this chapter with a summary of the negotiations associated with each of the five boundaries examined in this thesis - nurse-nurse, nurse-management, nurse-patient/relative, nurse-support worker and nurse-doctor - underlining the local conditions which facilitated or inhibited negotiations in each case. I will also be drawing attention to important methodological difficulties I have encountered in assessing the extent of negotiative activity and the implications of this for the negotiated order perspective. In the second part of this chapter I address the issue of the constraints in which the nurses

at Woodlands worked and the implications this had for their workplace jurisdictional claims.

NEGOTIATIONS

Negotiative Activity at Woodlands - An Overview

The main finding of this thesis was that the boundaries between nurses and doctors and nurses and support workers were accomplished with little inter-occupational negotiation. In chapter 7 I suggested that owing to the temporal-spatial ordering of hospital work, non-negotiated boundary-blurring was a routine feature of normal nursing practice on Treetops and Fernlea and that this accounted for the lack of negotiation around policy-driven shifts in the division of labour.

I argued that the experiential biographies of auxiliaries and HCAs, coupled with the routinisation of ward work and the segregated working patterns of nursing and support staff deterred negotiation of the nurse-support worker boundary. As Strauss (1964) has acknowledged, when areas of social life are ordered by routines negotiation processes are minimised. Moreover, in long-standing relationships, understandings can be so well established that negotiation is unnecessary. We saw that the routinisation of basic care activities had a number of advantages for ward members: it gave support staff the satisfaction of job autonomy, eased the burdens on qualified staff, and enabled the work to be accomplished efficiently.

In respect of the division of labour between nurses and doctors, I argued that the strains associated with the temporal-spatial ordering of nursing and medical work, coupled with the pressures on ward nurses and their genuine sympathy for the onerous workloads of medical staff, led to extensive informal non-negotiated boundary-blurring. Strauss (1978) has argued that members' perceived options to avoiding or discontinuing negotiations are of particular relevance in understanding the decision to embark upon negotiations. For ward nurses, formal and informal boundary-blurring was the easy option: it improved the quality of patient care, afforded nurses greater work autonomy, and minimised conflicts with medical staff and patients and their relatives.

There was also little face-to-face negotiation between ward-based nurses and nursing and general management although this was not really surprising. Negotiation was discouraged by organisational structures and the spatial ordering of their work. Any negotiation of the boundary between nurses and nursing and general management had to be filtered through the formal organisational hierarchy. Ward nurses had virtually no day-to-day contact with hospital management, which was seen as a distant force that wielded immense and sometimes arbitrary power but had little appreciation of the problems faced by ward-based staff. As we saw in chapter 6, even when ward-based staff were offered a relatively informal arena in which to question the management position on paperwork they did not take the opportunity.

The day-to-day management of the nurse-nurse boundary and the nurse-

patient/relative boundary were managed through a great deal of face-to-face negotiative effort however. Nurses were continuously negotiating and renegotiating the internal division of labour, which, as we have seen, was at times an important source of tension. These intra-occupational negotiations were encouraged by the ward turbulence. As we have seen although the ward routines provided an elementary temporal structure, much of the work was unpredictable. Nurses had to coordinate their activities with diverse organisational timetables and also in response to the ebb-and-flow of ward work rhythms. Strauss *et al* (1985) have suggested that 'to negotiate is to work' and this was certainly the case as far as the nursing staff was concerned. Negotiations constituted a core element of nursing work and without them other nursing activities could not have been accomplished. Changes of work organisation engendered by nurses' efforts to move away from task-allocation and implement different systems of nursing care delivery further augmented the need for negotiations as nurses struggled to reconcile their ideals with the exigencies of the work.

I suggest that a number of conditions encouraged negotiations between nurses and patients and their relatives. As I argued in chapter 6, as a result of developments in nursing and health policy, the caring relationship is currently undergoing a process of change. These changes in the division of labour between nurses and patients and their relatives was accomplished at Woodlands by dint of considerable negotiative effort. Many of the patients at Woodlands held orthodox views of the patient role, which had more in

common with Parsons' (1951) passive sick role than contemporary nursing ideologies of therapeutic partnerships or consumerism. The extracts presented in chapter 6 suggested that patients and relatives perceived themselves to be walking a precarious line in negotiating nursing boundaries however. In addition I described how nurses felt that the recent emphasis on consumerism within health care, had increased the bargaining position of patients. At another level negotiations were encouraged by the fact that in most cases these were not well-established relationships; the definition and allocation of work had to be established. Moreover, it was necessary to enter into negotiations with patients and relatives in response to changes in the patients' illness and recovery trajectories. I described how disagreements could arise over the appropriate allocation of work and pointed to the importance of handover as a way in which nurses were able to 'stage' their negotiations with patients.

Arenas for Negotiation

Although there was little face-to-face negotiation of work boundaries between nurses and doctors, nurses and support staff, and nurses and hospital managers on the wards, that is not to say that these boundaries were wholly non-negotiated. Often negotiations had taken place in arenas other than the ward itself. For example, the HCA training days were an important arena in which the nurse-support worker boundary was negotiated. As I have pointed out, senior nursing staff at Woodlands placed great confidence in the power of education and training in shoring up inter-occupational boundaries but these sessions did not go unchallenged. In the following extract the senior nurse

has been stressing that the role of the HCA is to assist the registered nurse.

HCA: You know where you say assist you mean who?

Senior Nurse: Assist the nurse.

HCA: Yes but you don't. You don't assist her. It's two auxiliaries.

HCA2: It's not often that you are with a nurse is it.

I was also aware of negotiations between senior nursing and medical staff relating to the nursing-medical boundary that had taken place in arenas other than the ward setting. Unfortunately many of these key debates pre-dated the fieldwork.

Negotiation of the nursing-management boundary was exceedingly complex. Arenas for negotiations between nurses and managers were shaped by formal organisational structures: ward sisters negotiated with their line managers at sisters' meetings; unit managers negotiated with the other CMT members at CMT meetings and the director of nursing at senior nurses' meeting; the director of nursing took nursing issues to the hospital and Trust Management Board meetings. Mapping out the formal arenas of negotiation is a straight forward enough process. As negotiations move through these different arenas however, the boundaries between nursing and management become less clear as nursing and management roles blur. Furthermore, individuals might find themselves negotiating on behalf of hospital management in one arena and on

behalf of ward nurses in another. Presumably similar observations could be made of doctors in management posts. The ways in which the tensions inherent in the clinical management role are handled and the implications this has for negotiation processes is clearly an area for further research.

In sum then, we can see that in assessing negotiative activity it is important to identify the different arenas in which negotiations take place. Of particular interest is the ways in which the different negotiative arenas shape the negotiation process. Holstein and Miller (1994), in a study of the management of disputes in North American welfare agencies, have illustrated the ways in which the issues to be negotiated and the resources participants bring to the negotiating process are shaped by the arenas in which negotiations take place. I suggest that the concepts of 'negotiative arena' and 'negotiation networks' be added to the negotiated order perspective in order to sensitise researchers to the possible network of arenas in which a given substantive concern may or may not be negotiated. Negotiation networks might transcend organisational boundaries.

Negotiation or Social Interaction?

In arguing that the nurse-doctor, nurse-support worker and nurse-management boundaries were virtually non-negotiated I have employed the concept of negotiation in a fairly restricted sense to refer to face-to-face negotiation between the respective parties to the work boundary. But could one make a case for employing the concept of negotiation more loosely? For example,

could one consider nurses' storytelling or their dirty work designations as aspects of the negotiated division of labour? After all, these were important social processes through which work identities were accomplished. Similar observations could also be made about members' boundary-work. Moreover, although there was little negotiation of work boundaries between nurses and support workers on the wards, there was a great deal of negotiation between support staff themselves. As we have seen it was established support workers who assumed responsibility for the training of new staff.

There are then some fundamental problems with the concept of negotiation. It is extremely broad and rather imprecise if one wishes to consider it as a sociological concept. Reviewing the literature ones finds that negotiation can refer to 'bargaining, compromising, brokering, mediating or collusion' (Maines, 1977), 'making a deal (an explicit compromise), trading off, reaching an informal agreement (say to respect each others' turf), or reaching more formal agreements signified by contracts and other signed arrangements' (Strauss, 1978). Negotiations can range from tacit understandings (Strauss *et al,* 1964) to explicit contracts. They can be one-shot, sequential, repeated, serial, multiple or linked and their time scale can vary from immediate transactions to ones occurring over a period of time (Strauss, 1978). Indeed the term is so broad that some appear to use the concept of negotiation and social interaction interchangeably (cf. Freidson, 1976).

Is the concept of negotiation simply a convenient shorthand for diverse

processes of social interaction or is its meaning more restricted? Given the criticisms that have been made of the negotiated order perspective it is surprising that no one has seized on the vagueness of the concept of negotiation as an important weakness with the paradigm. This is clearly problematic if the research aim is to compare the extent of negotiation in different settings or make generalisations about the types of conditions that encourage or inhibit negotiations.

I suggest that one possible route forward would be to consider social order as being continuously accomplished rather than negotiated. Such an approach would retain the underlying assumptions of the negotiated order perspective - that social order is the product of the meaningful interaction of actors - but would employ a broader approach to reality construction. From this perspective then, negotiation becomes one of a number of possible processes through which social reality is accomplished.

CONSTRAINTS

As we have seen, critics of the negotiated order perspective have argued that it assumes that everything is indefinitely negotiable (Dingwall and Strong, 1985) and as a consequence it cannot deal with the limiting factors in negotiation settings (Benson, 1977a; Benson, 1977b; Benson, 1978; Day and Day, 1977; Day and Day, 1978). In defence of the negotiated order perspective I have countered that whilst such criticisms are not without some

foundation it is still possible to examine the question of constraints within the paradigm. We all construct and shape our own realities but not necessarily in conditions of our own choosing. Limitations occur due to the presence of others, practical and material constraints, past history, established cultural meanings, and the structure of society. As we saw in chapter 1, the history of nursing's occupational development is one of constraint by outside pressure - from medicine, from hospitals and from the state - and although in their boundary-work the nurses at Woodlands emphasised their continuing day-to-day control over their work parameters it is clear that they too were working with a general model of constraint.

> *I think nursing unfortunately is moving away from the bedside. Everyday its getting that step closer to the office and paperwork and things like that. I don't think there's anything we can do to bring it back I don't think. I don't believe in taking a back seat and just letting it happen but I can't think of any other way of doing it.* (Staff Nurse)

> *Junior doctors' hours are going to reduce anyway whether we like it or not. It's something that Parliament is quite keen to do and it's going to happen [...] If your patient needs an Aminophylline drip there and then I think it's inevitable and it's a must that we do do it.* (Senior Nurse)

There are so many recent initiatives that are bringing pressure to bear on nurses. When I sit and think about it I think about the Hillsborough disaster and people being shoved up against the fence and I feel a bit like that about what's happening to nursing. [...] I know it's a little bit of a cruel sort of an analogy but I do feel a bit like that about it. (Senior Nurse)

At Woodlands nurses' day-to-day management of their work boundaries was circumscribed in complex ways: by the thrust of health policy initiatives, by material factors such as staffing and workload pressures, by formal organisational authority structures and by the turbulence of the work environment. Thus far however these constraints have remained a sub-text in my analysis, which has been principally concerned with the microsociological processes through which the division of labour on the wards was constituted. I want to conclude this thesis by making the limiting factors on nurses' actions more explicit and I suggest that taken together, the interactive effects of these constraints can be considered as constituting the structural context in which nurses accomplished jurisdiction.

Organisational Turbulence

A recurring theme in this thesis has been the issue of organisational turbulence which can be understood as constraining nursing work in two interrelated respects: in terms of its work rhythms and temporal structures and also in terms of its complex division of labour.

Temporal structures and Work Rhythms

Just as nursing routines can be understood as a rational response to organisational turbulence, timetables and routines are necessary in order for any organisation to function (Silverman, 1970; Salaman, 1979; Thompson, 1983; all cited by James, 1992a: 108). But whilst routines are facilitating - in that they provide the structure within which the work is carried out (James, 1992a; James, 1992b) and make the work possible - they are also constraining - in that they limit actors' control over the ways in which the work performed. Both the complexity of the hospital's temporal structure and the unpredictability of patients, constrained the ways in which nurses accomplished jurisdiction. Firstly, work on the wards was a far cry from the one-to-one nurse-patient relationship so central to New Nursing ideology. As we saw in chapter 7, the need to manage multiple patient assignments in response to the complex temporal structures of the hospital meant nurses found it difficult to involve themselves in any sustained hands-on care activities. Indeed, many were loathe to involve themselves with prolonged patient care activities for too long least their skills were needed elsewhere. Ironically however, the unpredictability of patients also meant that it would have been utterly impractical for nurses to have attempted to create more time for hands-on care by divesting themselves of all mundane work activities. Secondly, the energy nurses expended coordinating the ward work was also a factor encouraging them to informally blur the nursing-medical boundary. As we have seen it was frequently easier for them to do the work themselves than it was to negotiate with the doctor to come to the ward.

The Hospital Division of Labour

A further related aspect of the turbulence of hospital organisation is its internal heterogeneity which, when coupled with its temporal structures, illustrates the dangers highlighted by Durkheim (1933) of the centrifugal tendencies engendered by an excessive division of labour. Owing to the turbulence of its working environment hospitals need a point of flexibility in the system in order to function and there is a sense in which a 'usefulness' culture underpins hospital life. The imperative to be 'flexible' or 'useful' is not shared by all hospital workers alike however. I suggest that for a number of reasons, it is nurses who are expected to be the malleable workers in the system and this constrains the shape of their jurisdiction in important ways.

Nurses - Flexible Specialist or Jill of all Trades?

Unlike the periodic contact of most other categories of hospital worker, nurses are present with the patient continuously. Study after study has shown that nurses do not worry themselves too deeply about demarcation issues (Davies, 1995; Beardshaw and Robinson, 1990; Ball *et al,* 1987) indeed I suggest that most would consider it 'unprofessional' to do so. Nurses undertake whatever is necessary in order to provide the care for their patients. However, there is evidence to suggest that nurses' willingness to blur the boundaries of their formal jurisdiction is subject to abuse by work overload (Corley and Mauksch, 1988: 142; Hart, 1989). This is supported by my findings. At Woodlands flexibility was an institutionalised expectation of the nursing role.

Consultant: On the last point I was going to suggest that rather than put money into ward clerks, you put your money into the nursing side in some form or another, because those personnel are actually more multi-skilled than just pure ward clerks [...] They can do clerical, they can do nursing, they can be doing fetching and carrying. (Meeting - Tape)

As we saw in chapter 8, when doctors and support workers took a boundary-defining stance, nurses accommodated it. Whereas when nurses attempted to restrict their activities in the interests of patient care they were met with hostility by medical staff and inter-occupational tensions ensued. There were also tensions between doctors and nurses on the elderly medicine wards, where few nurses had expanded their scope of practice but some doctors expected them to have already developed these skills.

Arguably the expectation that nurses would be flexible in part reflects the legacy of nursing's occupational history and underlines the point made by Davies (1995), that gender is embedded in the design and functioning of organisations. Nineteenth century nurse reformers were heavily influenced by the feminist theory of Jameson, that there were natural spheres of activity for men and women. This natural division of work was believed to be rooted in the family and thus work for women outside the home ought to resemble domestic tasks, and complement the 'male principle' with the 'female principle' (Gamarnikow, 1978). Hence, the occupational space nursing came

to occupy in the hospital was rooted in the domestic division of labour. As Stacey (1981) points out however, in the ever-increasing division of labour and the associated increasing specialisation, it is the woman in the house who has remained the generalist. Similarly, in the hospital division of labour it is the nurse who is expected to act as the generalist when circumstances demand notwithstanding her/his specialist skills.

There are striking similarities between nurses' temporal-spatial jurisdiction and new post-Fordist management ideologies of flexible working patterns as James *et al* (1993) have shown. For example, in Britain considerable attention has been given to the notion of a flexible firm developed at the Institute of Manpower Studies principally by Atkinson (Wood, 1989). Atkinson identifies four main types of flexibility of which the two most important are: numerical flexibility and functional flexibility. In numerical flexibility employers are able to vary the amount of labour they employ at short notice in order to respond to different circumstances. Functionally flexible workers are able to take on a wider range of tasks, which is considered to increase efficiency by, for example, enabling them to perform the work of absent colleagues (Walby, 1989).

Given that flexible specialists are so sought after by post-Fordist managers, it is ironic that instead of being seen as highly skilled and worthy of investment nurses' adaptability has left them vulnerable to being mocked as 'unskilled' (James *et al*, 1993). As Jenson (1989) has suggested, this is a

feature of 'women's work'. Secretaries, Jenson argues, are the ultimate flexible specialists yet this is not recompensed but instead interpreted as something unexceptional, especially since the multiplication of tasks often bears a resemblance to domestic labour.

Material Constraints

Another conspicuous constraint on the ways in which nurses accomplished their work boundaries was the material reality of ward work which was inextricably bound up with the thrust of current health policy.

Workload and Staffing Issues

Professionalisers' aspirations for a workforce numerically dominated by qualified nurses is far removed from the practice of nursing work which is accomplished with a mixture of registered nurses, students in training and support workers. As we saw in chapter 1, nurses are one of the largest single items of public expenditure and as such represent an obvious target for cost-conscious managers. The skill and grade mix of staff on the wards clearly has important implications for the division of labour possible. In implementing Project 2000 senior nurses at Woodlands had elected to employ a strategy of fewer staff but with a higher ratio of qualified nurses.

It has been possible to make a fairly crude calculation of staffing levels on both wards over the period of the research. These figures should not be interpreted as precise indicators of overall nursing numbers and skill-mix

however. Rather they reflect the average number of nurses on duty during the times I made my observations. I have not included night duty or periods in which two shifts overlapped (which when meal breaks were taken into account were brief in any case). Furthermore, on both wards more nurses were routinely allocated to the early shift than to the late shift. I have also included figures on the average bed-occupancy figures for each ward. It must be remembered however that the average bed occupancy figures on Treetops are somewhat skewed, given that my field observations covered the christmas period when routine operations were cancelled and the ward was unusually quiet.

The figures are very similar - the main difference is that Fernlea ward had fewer qualified staff and more students than Treetops and Treetops had more HCAs and fewer auxiliaries than Fernlea.

Admittedly crude measures such as bed occupancy and the number and grade mix of staff actually tell us very little about workload. But they do highlight the gap between contemporary nursing ideologies and workplace realities. For example, how easy is it for a nurse to engage in therapeutic relationships and administer individualised care when responsible for the care of up to seventeen patients in a given shift? As we have seen, even patients and relatives were being coopted into the division of labour in order to plug gaps in the service.

Staffing Levels and Bed Occupancy - A Rough Guide

	Treetops	Fernlea
Qualified Nurses	3.45	3.31
Students	1.07	1.27
Auxiliaries	0.55	1.23
HCAs	0.83	0.38
Total staff	5.89	6.19
Bed occupancy	22	31
Beds available	33	34

The Junior Doctors' Hours Initiative

Material constraints had a bearing on nursing jurisdiction in other ways. Although individual nurse practitioner posts at Woodlands had been funded through the junior doctors' hours initiative, no money had been made available in order for ward-based nurses to undertake additional duties. Nevertheless, nurses' role expansion was being driven as a key organisational and political imperative and this resulted in a strain towards dilution at ward level. UKCC guidance on nurses' scope of professional practice states that role extension should not fragment nursing care or result in the inappropriate devolution of

nursing care tasks. As we have seen however, because of the constraints within which nurses at Woodlands worked they regularly broke these guidelines in response to the exigencies of the work.

Paperwork

Paperwork was a further restriction on the shape of nurses' work boundaries. As we saw in chapter 6, paperwork was deemed dirty work by nurses partly in acknowledgement of its voluminous nature but also as a local symbol of management control over nursing work. Paradoxically the nursing process was felt to be the most problematic, although nurses were often reluctant to be openly critical. Management emphasis on quality assurance coupled with a climate ever-fearful of litigation meant that considerable effort went into what can be best described as the paper construction of nursing care. For organisational purposes the paperwork was the principal means through which nursing work was rendered visible. Whilst good record-keeping is clearly essential to high quality patient care, I could not help but conclude that the nursing record at Woodlands was little more than an elaborate accounting mechanism which might have a function in defending the organisation against competitors and/or the courts, but had little to offer in terms of improvements in patient care, and was of little practical benefit to nurses themselves in their work. Given its visibility moreover, there was a very real danger that under pressures of work nurses would give priority to the nursing record rather than to the less visible aspects of patient care.

Consumerism

As we saw in chapter 6, as a result of the consumerist climate in health care nurses felt constrained in their negotiations with patients and this was an important source of tension. Furthermore, in addition to altering the balance of power in the nurse-client relationship, it appears that consumerism has also increased the expectations of patients. The recurrence of the service analogy in nurses' accounts highlighted the illegitimate demands they felt patients made of them. Given their continuous contact with patients it seems likely that it will be nursing staff who will feel the brunt of any new demands engendered by consumerism. Moreover, nurses are in the front-line when complaints arise. On the wards, at Woodlands it mainly fell to ward sisters to deal with patients' grievances and this could be demoralising.

> *Sometimes you feel as though that's all you're there for - that you're a whipping post really.* (Sister)

Formal Authority Structures

Nurses' orientation to formal authority structures at Woodlands was a further constraint on the ways in which they constituted jurisdiction.

Hospital Management

As we have seen, by far the most common nursing complaint was the amount of paperwork they were expected to undertake and yet this went unchallenged by ward-based staff. There are several possible reasons for this. First,

nurses' reluctance to question the paperwork may reflect the ways in which it was occaisionally used by them as a mechanism for structuring time and avoiding patient-contact work. Second, negotiation of the nurse-management boundary was inhibited by the organisation of work: ward-based nurses had little daily contact with nurse or hospital managers. Third, ward-based nurses' acquiescence to the demands of management-imposed paperwork also reflected their orientation to formal organisational structures. Arguably, the record-keeping days offered a relatively informal arena in which to challenge the amount of paperwork expected of nursing staff but the opportunity was never taken. By comparison attempts to impose management control over medical record-keeping had been relatively unsuccessful. In chapter 6, I suggested that because they were not permanent employees of the hospital and looked to their consultant as principle point of reference, junior medical staff felt less bound by organisational policies and management structures than the nursing staff. I also pointed out that in terms of risk-management, it was nurses who felt most vulnerable to external censure as a result of a patient complaint.

Medical Dominance

Another constraint on nurses' actions was the dominance of the medical profession. This was evident in the ways in which nurses accomplished jurisdiction on the wards and also in terms of the composition of the principal decision-making arenas at Woodlands. As I argued in chapter 8, although the nurses at Woodlands were prepared to negotiate the moral division of labour

with individual doctors this did not appear to detract from their overall acceptance of the authority of medicine as a corporate body.

These tensions were apparent in the stories nurses told and as we have seen, both nurses and junior doctors in their patterns of interaction consistently oriented themselves to the status of consultants. Furthermore, nurses' informal boundary-blurring work can partly be understood as a reflection of the strains that arose out of the dysjuncture between the flow of work and the formal authority structure at Woodlands. Quite simply it was easier for nurses to undertake the work themselves than it was to try and negotiate from a subordinate position with over-burdened doctors who had different priorities and perspectives to nursing staff. There are some clear parallels here with the gender division of labour as a comparison of the following extracts demonstrates. The first is taken from Hochschild's (1990) study of working parents' management of the domestic division of labour.

> 'I do think women - I should say men as well, but actually I mean women - start nagging about little things like picking up clothes. I realise that little things can really build up. Peter's father poured out to me things that go back for **years.** His wife would continually nag him about things, like not hanging up his suit at night. I harp at Peter about helping the kids. He'll let me ask him before he does it, and I don't like to have to ask him to help. If I'm continually harping, maybe I should

make some adjustments.

Given the threat of what could happen if their marriage were to founder, Nina decided not to push Peter on the issue of housework [...] She could cut back her work hours. She could keep on doing the second shift.' (Hochschild, 1990: 87-88)

The second extract is from my fieldnotes:

> *Most of the time it's easier for you to go and do it yourself as long as you've got your certificates and what have you to prove it [...] you know what they (doctors) are willing to do and the hassle it is to get them to do the little menial jobs. It's just not worth the hassle sometimes. It's just easier to get it done and get on with it and say 'Right this is the result do something with it'.* (Staff Nurse)

Nevertheless, it was possible for nurses on the wards to negotiate the moral division of labour and exert influence over individual junior doctors. In the key policy-making arenas at Woodlands the situation was rather different however. The director of nursing was the lone nursing voice on the Hospital Management Board - which was numerically dominated by doctors as clinical directors of the CMTs - all but one were also men. Furthermore, during the period of the fieldwork, changes to the CMT management structure relegated

nurse managers to a subordinate role. The director of all the CMTs was a consultant, with the general manager as the direct deputy. Senior nurses at Woodlands highlighted the difficulties they faced in making themselves heard.

> *These hospital management boards and things like that - it's difficult to get nursing things on the agenda. You know, I should have been on the TEG agenda this month and they've sort of like said 'There's too much on the agenda'. I should be on the AOB agenda to go and present my findings and all this. Agenda's too busy - go next month. So we'll see what happens next month. So you know I think it's CMTs that have the last say and clinical management teams are headed by the consultants and managers and aren't nursing as such.* (Senior Nurse)

Emphasis was placed on the importance of 'staging' (Levy, 1982) the nursing case. For example, getting the timing right and ensuring that 'hard data' was available.

> *If I take papers to any meeting with [...] a graph on, people are very impressed and they take notice. When you just try to talk to a subject, people find it hard to understand always [...] (if) you're talking about dependency. But if you can show them a picture and say this is the number of nurses we have, hours*

of time, that's the number of care hours of time required and that's the gap in between. (Senior Nurse)

Sometimes you have to deliberately think, 'Well there's no point in bringing that up now', but then maybe another time you think it's quite opportune and that's when you perhaps have to be ready really and think 'Right this is an opportune moment to do it'. (Senior Nurse)

I think we've got to have a well-developed case and I think often if you can work through the systems that are already there - like the business planning cycle and the various other mechanisms - the feeding in to the system if you like, I think if you can work through those, and then get a voice behind it - that's quite good. (Senior Nurse)

Taken together then, these inter-related constraints constituted the structural context in which nurses at Woodlands managed their work boundaries and as we have seen, this had important implications for the shape of nursing's workplace jurisdiction.

Conclusion

The aim of this research was to examine the ways in which hospital-based general nurses accomplish jurisdiction. It was set in the context of recent

developments in nursing and medical education and health policy and was theoretically grounded in the assumption that occupational roles are not self-evident but have to be actively constituted within a system of work. The professional and sociological literature led me to anticipate that, as a result of recent policy developments, there would be an increased need for negotiation of nurses' inter-occupational boundaries and that this was likely to be subject to some tension. My field observations however, revealed minimal negotiation of inter-occupational boundaries and little evidence of explicit conflict on the wards. Furthermore, Hughes' concept of dirty work alerted me to unanticipated tension and a great deal of negotiative effort at nurses' intra-occupational boundaries and at the boundary between nurses and patients and their relatives. There was also tension at the boundary between ward nurses and nursing and general management but no associated negotiation.

The five key nursing boundaries examined in this thesis were accomplished in different ways. I have highlighted the factors which inhibited or facilitated negotiations in each case. In assessing the extent of negotiative activity at Woodlands I have drawn attention to important methodological difficulties with the negotiated order perspective. First, negotiations can take place in arenas that are unobserved by the researcher. I suggested the concepts of 'negotiative arena' and 'negotiation networks' in order to draw attention to the possible domains in which a substantive issue may or may not be negotiated. Second, I have criticised the imprecision of the concept of negotiation which is inconsistently used. I have suggested that the negotiated order could more

fruitfully be considered a 'continuously accomplished order' in which negotiation is but one of a number of social processes through which social reality is constituted.

I have also identified the constraints within which the nurses at Woodlands worked which led them to accomplish jurisdiction in the shape that they did. As we have seen, nurses' day-to-day management of their work boundaries was circumscribed in complex and interwoven ways by the organisational turbulence, workload and staffing levels, policy initiatives, gender ideologies and organisational authority structures. Moreover, despite their claims to have continuing control over their work boundaries nurses themselves were clearly working with a model of constraint.

The key features of nursing jurisdiction at Woodlands were the absence of the practitioner role - Davies' (1995) polo mint problem - and its flexible work boundaries. Ward nurses at Woodlands regularly complained about their inability to involve themselves in sustained hands-on care activities and as we have seen this was one of the reasons for their ambivalence about undertaking doctor-devolved work. Moreover, support workers who had aspired to a career in nursing were reconsidering their options in the light of the reality of nursing work on the wards.

Nurses' complaints about the polo mint problem highlight the tensions between the public jurisdictional claims of the occupation and the workplace reality.

Although they establish important patient care ideals, contemporary nursing ideologies are undoubtedly guilty of creating unrealistic expectations of what is possible in the context of a busy hospital ward. Furthermore, I suggest that in their pursuit of functional autonomy New Nursing ideologies ignore the realities of hospital nursing and as a consequence have over-extended the occupation's jurisdiction by assigning ward staff an impossibly large volume of work. For example, on both wards at Woodlands it was routine for nurses' burdens of work to be overwhelming at the same time as support staff were looking for housekeeping tasks to keep themselves occupied. Support workers expressed their frustrations at not being able to do more to help the nurses under pressure.

> *(S)ometimes if you've got any free time and BPs (blood pressures) and temperatures need doing and that it's awful because we're not allowed to do that. So you think 'I wish I could help them out', but you can't - you can't do that.* (Auxiliary)

These findings contradict those of Zerubavel (1979) who argues that notions of a fair allocation of work typically do not transcend occupational boundaries. They also underline the importance of the ward team as the focus of nursing and support workers' group sentiments.

Given the current political and economic climate in health care, it seems that

if hospital-based general nurses want to involve themselves in more sustained hands-on care work, then greater consideration needs to be given to the further development of the support worker role. Indeed, moves in this direction are already in progress in North America where 'Practice Partnerships' are the most recent concept in care delivery (Manthey, 1989, cited by Garbett, 1996). The idea is a modification of primary nursing. A registered nurse and a support worker are paired together caring for a group of patients on a given shift and the division of labour between them is determined by the registered nurse with the support worker carrying out work for which she is judged to be competent.

The second principal feature of nursing at Woodlands was its flexible jurisdiction. Given nurses' concerns about their inability to involve themselves in hands-on care work they might reasonably be criticised for continuing to undertake informal boundary-blurring work. However, the division of labour at Woodlands did not reflect a straight forward trade-off between nurses' informal boundary-blurring and hands-on care activities. As we have seen, the reasons for nurses' lack of sustained patient contact were infinitely more complex than this.

Given the turbulence inherent in hospital work and nurses' unique position with respect to their continuous patient contact, it seems likely that nursing's jurisdiction will always need to be flexible. Indeed Hughes (1984) has suggested that:

> '(Nurses') place in the division of labor is essentially that of doing in a responsible way whatever necessary things are in danger of not being done at all'. (Hughes, 1984: 308)

Clearly this is only a partial description of nursing's jurisdiction, nevertheless in terms of the dirty work concept it could be argued that nurses are almost destined to moan, given the difficulties of placing clear boundaries around their work. Interestingly however, although senior nurses at Woodlands were trying to define nursing jurisdiction more tightly by discouraging informal boundary-blurring, the ward nurses seemed to accept the need for flexible work boundaries: they rarely questioned the skills of support staff, nor did they complain about undertaking doctors' work. The routine non-negotiated informal blurring of inter-occupational boundaries evidently made sense in the context of the ward environment, and as I have argued, this helps to explain the lack of conflict and negotiation associated with policy-driven shifts in the division of labour. Given the pressures on the wards then, there are good reasons for arguing for the incorporation of certain tasks - such as intravenous drug administration and venepuncture - into the basic nursing curriculum in order to bring nursing's occupational jurisdiction in line with its temporal-spatial jurisdiction. Indeed, failure to do so is likely to further fragment patient care.

As I argued in chapter 1, it is only relatively recently that the nurse-patient relationship has assumed a central place in contemporary nursing ideologies,

reflecting the efforts of the nursing leadership to develop an essentialist version of nursing work as part of the occupation's professionalising project. Clearly the nurse-patient relationship provides an important peg on which to hang the diverse activities that constitute nursing work and around which to anchor nursing's occupational identity. However, attempts to fix the nursing role too rigidly must be doomed to be in vain. Nursing work has always been characterised by flexible work boundaries both in terms of its day-to-day practice and also historically in response to the impact of wider technological, social and economic factors. The challenge for nursing in the 21st century is to reconcile the new essentialism of its professionalisers with its traditional flexibility within the hospital division of labour.

Appendices

Appendix A: Brain Storming Session

RESEARCH QUESTIONS AND ISSUES OF INTEREST

Professionalism, managerialism and hospital nurses' jurisdiction: tasks, roles and the meaning of nursing.

1. Managerialism, Professionalism and Service Delivery:

(i) The tension between management and professional aims and objectives has been well-documented in the professional literature. Given recent developments has there been a hardening/strengthening of these two cultures? How do hospital nurses manage these tensions on a day-to-day basis in the execution of their work? How do nurses account for their strategies for managing these tensions? Given the history of nursing, is the management of this tension an intricate part of the 'emotional labour' of nursing work? (Specific areas of interest might include the management use of 'nursing information systems', the organization of service delivery - holism versus task allocation, nurses' coordinating work).

(ii) Do certain groups of nurses consistently hold one or other of these different versions of nursing? If so who?

(iii) Are management/service versions of nursing and professional versions of nursing 'vocabularies of motive' employed by nurses in their accounts of their work? Is there such a thing as 'real' nursing which hides behind these different accounts of it.

(iv) Is there a gendered dimension to the tension between management and the professional culture of nursing?

2. Managerialism, Professionalism and the Clinical Directorates:

(i) How do nurses, cast in management roles, reconcile management with clinical cultures? Does one culture come to be the dominant one or do they have more or less salience depending on the circumstances? What are the implications for occupational identity? Will nurse managers come to form a new segment within nursing? What is the significance of gender? Are management and professional cultures within nursing gendered cultures?

3. Managerialism, Professionalism and Intra-Occupational Relationships:

(i) How will new nurses - Project 2000 nursing and nurse practitioners - fit into the existing division of labour? If there is opposition to these

developments how is this opposition articulated? Do the versions of nursing held by these new practitioners differ markedly from that held by rank-and-file nurses? How significant do nurses perceive the differences between diploma and traditionally trained nurses to be in practice? What is the relationship between the culture of the work environment and the 'New Nursing' culture? On a day-to-day basis does any particular version of nursing prevail or is it contingent on the context?

(ii) What is the impact on inter-professional relations of the removal of the SEN grade of nurse and students from service provision? Will differences in clinical grade and type of training become more salient?

4. Professionalism, Managerialism and the Boundaries of Nursing Work:

A. Nursing and medicine:

(i) What is the rank and file response to expanded nursing roles entailed by nursing's professional agenda?

(ii) What is nurses' response to the linkage of expanded nursing roles to the junior doctor's initiative?

(iii) What is the impact of intermediate roles on the relationship between nurses and medicine? Are there any boundary disputes between nurses and

medicine? If so on what issues do they focus? What forms do they take? What part does gender play in nursing's relation with medicine? How does the relationship of nurses with male doctors compare with that of nurses with female doctors?

B. Nursing and support staff:

(i) What impact has the rhetoric of 'new nursing' had on the division of labour between nurses and support staff? What is the staff response to this impact?

(ii) What is the nursing response to dilution?

5. Task, Role and the Meaning of Nursing:

(i) In what terms do nurses distinguish their role from other occupational groups in the division of labour? Is there a consistent belief that 'qualified nurses do it differently', and if so, how is this difference articulated? Is gender involved in what it means to nurse? I want to get beyond a description of the tasks that nurses do and uncover the underlying meaning of these tasks for nurse's occupational identity.

(ii) I would like to develop the distinction made by Hughes between tasks and role. I am interested in the implications for nurses of changes in what they do in the division of labour for their conception of who they are? Or how

nurses' changing view of who they are effect what tasks they want to do? This refers to work on the boundary between nursing and medicine and between nursing and support workers, and to the changing construction of nursing skill. What do nurses say about the importance of 'caring'? Is 'caring' a task or part of the role of nursing?

(iii) An interesting question would be how nurses account for the performance of 'ambiguous' tasks on the boundaries of their jurisdiction. How is occupational identity sustained when work tasks overlap?

(iv) How does the distinction between role and task relate to the tension between professional and management versions of nurses work?

(iv) Do nurses agree on what constitutes 'dirty work'? It would seem that for some 'dirty work' = bedside nursing, whereas for others it refers to doctor-devolved tasks which cannot be incorporated into the nursing role. Within nursing culture 'dirty work' appears to be located at the boundary with 'lower' **and** 'higher' occupations in the hospital hierarchy. Are nurses' conceptions of 'dirty work' consistent or does a task become more or less dirty depending on the circumstances? Can nurses be typed according to their perceptions of dirty work? Is there a relationship between nurses' perceptions of dirty work and the version of nursing they subscribe to? What is the relationship between tasks, role and dirty work? Can nurses' perceptions of 'dirty work' be used as a barometer by which one might predict the future jurisdiction of the

profession? Is there a case for arguing that it is through the designation of some work as 'dirty' that the boundaries of jurisdiction are articulated?

(v) How are definitions of nursing skill constructed by shop-floor practitioners? Is there agreement amongst nurses as to what constitutes 'skilled' nursing?

6. Barriers to Change:

(i) Are there any barriers to the implementation of new nursing roles?

(ii) Is there a sense in which professional and service versions of nursing may be selectively employed by rank-and-file staff as a vocabulary of motive in order to articulate opposition to changes in the division of labour.

(iii) What strategies for resisting changes in the division of labour do nurses employ?

Appendix B: Access Letter

As we discussed on the telephone, we are seeking your support to carry out a PhD research project proposed by Davina Allen under DH Nursing and Therapies Research Training Awards Programme. We enclose an outline of the study.

The project would focus on the changing role of hospital-based general nurses. As you know, there has been considerable professional and policy debate about the changing boundaries between medical, nursing and support staff. However, little is known about how these various groups actually manage the boundaries between their work at the point of service delivery.

Ms Allen hopes to fill this knowledge gap by undertaking fieldwork in one acute and one chronic ward (general surgery and dermatology might be possibilities). This type of research normally involves "shadowing" selected staff in the course of their normal work duties, observing, and possibly, recording routine activities like nursing reports, ward rounds and staff meetings, and examining relevant ward documents. A particular feature of

this project is its recognition of the importance of complementing nursing views with those of other staff. Accordingly, Ms Allen would hope to interview selected doctors and support workers. She is also anxious to acknowledge the importance of the wider context of the organisation within which the wards are located and would like to interview relevant service managers. Should the Trust be proposing any particular initiatives which affect role boundaries, she would also welcome an opportunity to observe planning meetings associated with this. We expect that the work will be spread over a period of about 6 months.

Clearly, many of the details will need to be shaped by discussion with the people who are likely to be affected by the work. We welcome the opportunity for Dr James and Ms Allen to meet you on 28th June at 11:00 to explore both the principle and the practical issues involved in collaboration. We believe that this project would make an important contribution to nursing research and we hope very much that it will be possible to take it forward in your hospital.

Yours sincerely

Professor Robert Dingwall

Head of School of Social Studies

Veronica C James, PhD

Senior Lecturer, Department of Nursing Studies

Appendix C: Study Outline

NURSING AND THE CHANGING DIVISION OF LABOUR IN HOSPITALS

A Project Funded Under the DH Research Training Awards

BACKGROUND This study is concerned with the role of general nurses in the hospital division of labour and is set in the context of profound change in both nursing and health policy. In the 1990s the work of nurses is likely to be critically affected by the occupation's professional aspirations on the one hand and management concern for service delivery on the other. The interaction between these two forces has been a major historical influence on nursing at the level of both policy and practice but this has recently entered a new phase with the introduction of Project 2000, issues around post-registration education and training, and the advent of general management as part of the wider agenda of the *1990 National Health Service and Community*

Care Act.

These policy initiatives both have implications for the work of hospital nurses. Managers concerned with cost-containment are eager to ensure that human resources are deployed as efficiently as possible. '*Working for Patients*' suggested that this might involve the reappraisal of traditional working patterns and practices and thus 'skill-mix' and 'reprofiling' have become key phrases. Nursing's professional agenda also envisages important changes to practitioners' work. Project 2000 entails the phasing out of the SEN grade of nurse, the reduction of students' contribution to service provision and the expansion of the traditional scope of nursing practice. The 'New Nursing' ideals which inform the Project 2000 reforms underline the clinical skills of nurses and stress the centrality of nursing practice as the province of qualified staff. Emphasis is given to the unique nursing contribution to health care and is used in support of the occupation's claims for autonomy.

The effects of these policies on the work of hospital nurses are likely to be wide ranging but they have particular ramifications for the division of labour between nurses and medical staff and nurses and support workers where they create some ambivalence as to the appropriate allocation of work tasks. Key questions include: In what ways should nurses be expanding their scope of practice? Should nurses be taking over tasks previously performed by doctors? What should the role of the support worker be? These issues have generated much debate. Most accounts however, examine either Project 2000

or managerialism in isolation, usually from the standpoint of service planning or the professional response. In practice however, nurses' work is likely to be shaped by the combined effects of both these initiatives.

AIMS AND OBJECTIVES The purpose of this project is to move on from the policy debate to an examination of the consequences of these recent developments in nursing and health care on the work of hospital-based general nurses. I intend to explore the impact of these policy changes on nursing staff in terms of their everyday work activities, their professional relations with other members of the health care team and their occupational identity.

Formal discussion of policy matters tends to be confined to a narrow circle of academics and policy makers who are frequently removed from the realities of service provision. Arguments tend to be expressed in terms of abstract principles and ideals which gloss over the complexities involved in the delivery of health care. I am interested in addressing this imbalance by exploring the views of hospital staff working at the point of service delivery. I intend to generate an account of nursing work which is rooted in the work setting and which is sensitive to the situational and contextual factors which shape its management.

RESEARCH DESIGN This is planned as an in-depth study using a combination of observations and interviews. One 'surgical' and one 'medical' ward setting will be studied for approximately 12 weeks each in order that

contrasts and comparisons can be drawn. Observation will be made of everyday ward work across the full range of shifts. A sample of ward staff - auxiliary, nursing and junior medical staff - will also be asked to agree to tape-recorded interviews. Interviews will last for approximately 1 hour each. About 20 interviews will be carried out on each ward.

In order that the ward picture can be related to the formal hospital plan interviews will be sought with managers. Following consultation with the relevant hospital personnel I also hope to identify any meetings relevant to the research and negotiate whether observation of these meetings would be appropriate.

ETHICAL CONSIDERATIONS This is a study of nursing and staff relations and as such is not concerned with patients; any patient data collected will be entirely incidental. The confidentiality of all participants, and the anonymity of the hospital will be respected at all times; research data will be securely stored and in all publications data will be presented in such a way that the identity of patients, staff and the location of the hospital will be safeguarded. The informed consent of all those involved in the research will be sought.

WHAT THE STUDY WOULD INVOLVE FOR THE HOSPITAL AND HOSPITAL PERSONNEL

In seeking your support for this study I am asking to be allowed:

(i) access to one 'acute' and one 'chronic' care setting for approximately 3 days a week for a period of about three months per setting in order that everyday work may be observed. In each ward, observation will take place in two blocks of six weeks with a break of two weeks in between for initial data analysis. The researcher will spend approximately 4 hours in the setting at any one time except for night shifts when it might be longer. Ward observations would entail the researcher accompanying staff in their normal work duties and observation of selected routine activities. All efforts will be made to ensure that observation is minimally disruptive of ward work; the researcher's nursing background will facilitate sensitivity to these issues.

(ii) to ask a sample of management, medical, nursing and support staff to agree to tape-recorded interview of approximately one hour in duration.

(iii) to make tape-recordings of a sample of key ward activities for example, nursing report, ward meetings.

(iv) access to ward records - nursing records, care plans, patient acuity records, duty rotas, medical records, and medication charts for example.

PRACTICAL BENEFITS My interest is sociological and is concerned with the social processes which shape the hospital division of labour on a day to day basis. It is my belief however, that a study of this kind will be of interest to all health professionals wishing to acquire a greater appreciation of the internal workings of the modern hospital.

The extension of the Resource Management Initiative as one aspect of the NHS reforms means that at the level of the clinical directorate nurses, doctors and business staff must work together to manage speciality budgets. A study focused at the point of service delivery would provide important insights into 'native' cultures and facilitate a shared perspective.

The internal diversity and complexity of the modern hospital makes it both difficult and inappropriate to attempt to impose a unified management structure. A greater sensitivity to ward-based culture would allow managers to harness locally formulated arrangements and to reap the benefits of what is already established by staff at the point of service delivery rather than trying to create something anew.

In terms of human resource management, knowledge of the everyday factors that shape the division of labour at the level of the shop floor, may be usefully employed in conjunction with more conventional workload assessment tools in reviewing the appropriate numbers and mix of staff in a particular setting.

THE RESEARCHER Davina Allen is an RGN (Addenbrookes Hospital, Cambridge) and has a First Class degree in sociology (University of Nottingham). She has eighteen months experience of health services research including a study commissioned by South East Thames Regional Health Authority on the potential for nursing role developments inherent in the junior doctors' hours initiative. She has published in the Health Service Journal. She is currently a post-graduate research student in the School of Social Studies, University of Nottingham. She is supported by a Department of Health Nursing and Therapies Research Training Award. The project is being supervised by Professor Robert Dingwall (Social Studies) and Dr Veronica James (Nursing Studies).

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