The Ideological Framework of Nursing Practice within a Health Care System in Transition

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Submitted for the Degree of PhD
Abstract

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Nurses who have practised within the NHS over the last decade have arguably experienced more change and concomitant demands upon their clinical practice than any other period in the history of modern nursing. The research problem is concerned with the material and temporal relationship that pertains between the processes of structural and organisational change within the health care system and nurses discourses of practice.

The research question that follows, is what are the discourses or frames of meaning that nurses as a profession draw upon in managing the practical problems of delivering care to patients, and what are the social structural mechanisms that shape this knowledge? In addressing this question, the thesis employs a qualitative research method, a series of focus group discussions involving different groups of nurses in order to establish the range of discourses concerning the developments that have occurred in their professional practice. In particular those changes in practice that have directly resulted from the organisational reforms within the NHS that have been instigated by both Conservative and New Labour governments in the 1990s. The analysis of this qualitative data is not tied to either a subjectivist or objectivist understanding of social reality, but seeks to apply an analytical framework informed by the methodological principles of critical realism. The objective is to postulate those necessary rather than contingent causal social structural relationships that are the condition for the generation of these nursing discourses during a time of organisational transition within the NHS.

The thesis concludes with the assertion that the professional practices of nurses are shaped by a range of disparate and often contradictory ideological elements, which in many ways mirror the tensions, contradictions and politics that characterise the state provision and delivery of health care within a late modern market economy. In addition, the specific context of nursing practice, whether this be the ‘community’ or the hospital-setting, is central to the shaping of the specific combination of ideological elements that nurses draw upon in their discourses of practice.
Acknowledgements

My thanks go my supervisor Dr Paul Higgs and to my colleague Professor Ian Rees Jones, for all their help and encouragement. And to Sara & Elliott.
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1. Introduction

1.1 Research Problem

1.1.1 Background to the Research

In its first annual report, the NHS Modernisation Board, which has the responsibility for overseeing the implementation of *The NHS Plan* (DoH:2000) - the ten year programme of reform for the NHS set out by the New Labour Government - claims that nurses are failing to embrace modernisation because of old-fashioned ‘working practices and attitudes, some unchanged since 1948’ (DoH:2002). This view reflects a now well established pattern of governmental criticism, both Conservative and New Labour, directed at the perceived intransigence of the health professions as regards supporting the drive towards greater ‘efficiency’ and ‘productivity’ within the NHS. Whilst the medical profession has been the primary target of criticism for its alleged conservatism, nursing has not been immune to the accusation that it is clinging to an outdated ideology of professional practice which represents an obstacle to the rationalisation of the system of state health care.

In fact, the tensions between the ambitions of nursing as a professional occupation and the organisational needs of health care are historical; they predate the creation of the modern NHS. However, these differences have been exacerbated following a series of substantive ‘reforms’ of the NHS which began nearly two decades ago with the introduction of what became known as ‘general management’. The ‘internal market’ reforms introduced by the Conservative government in 1989 deepened these tensions and put pressure on nurses to adapt their traditional working practices to meet new ‘performance targets’. One example of this process was the ‘standard’ set out in the ‘Patient’s Charter’ (1991) requiring nurses to assess patients ‘immediately’ upon admission to an A & E Department. The charge levelled by many nurses at the time was that the imposition of this target led directly to a distortion of nursing priorities which actually increased waiting-times for treatment in A & E Departments.
The pressure upon the health professions in general to subsume their 'sectional interests' in order to meet the efficiency requirements set by the organisation of the NHS have continued with New Labour's 'modernisation' programme for the NHS (DoH:1997).

One of the most significant developments associated with these rigorous reforms of the organisation and structure of the NHS has been the establishment of a new managerial stratum operating at the level of the local hospital or community care Trust. These new professional managers, who have an entitlement to productivity bonus payments, have been given the power to shape local clinical priorities to meet nationally-determined standards of treatment and care. This development poses a significant challenge to the clinical autonomy traditionally enjoyed by the medical profession and hence by the occupation of nursing. Nevertheless, there are as yet no organisational 'fixes' that can directly alleviate human suffering and treat the disease process within individual patients. As a consequence, the implementation of any reform programme for the NHS remains dependent upon a willingness on the part of the health professions, including nurses, to subsume their professional concerns and ambitions in order to meet political objectives for the system of state health care as set by others. Hence, the tensions, disputes, and ideological conflicts that have marked relations between the Department of Health, local health service managers, and the health professions over the last twenty years.

Significant differences still exist between the professional bodies of nursing and the Department of Health concerning the changes to nursing practice required to bring about the effective and productive delivery of patient care. However, there is some common ground (albeit for very different reasons) concerning nurses' openness to new ideas. A long held view of nursing academia is that, while an essential conservatism does exist, it springs from processes of informal socialisation associated with the hospital as a social institution. It is this organisational culture which is responsible for and sustains a set of working practices and attitudes that are bounded

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When specifically discussing health care systems within this thesis, the term 'structure' will be defined as the NHS policy framework and mechanisms responsible for the delivery of health care, whilst 'organisation' will refer to how staff and resources are managed to provide such services.
by routine and ritual and that are resistant to (and at odds with) the philosophical and academic base of nursing itself. The consequence of this process is a 'theory-practice gap', a social phenomenon identified as a central obstacle to the achievement of nursing's 'professionalisation project' (Bendall:1976; Melia:1987; Wilson & Startup:1991; Landers:2000). Whilst there is broad agreement within nursing academia that such a 'gap' exists, there are a number of different explanations for its persistence (Porter and Ryan:1996).

The most straightforward explanation offered for the existence of the theory-practice difference is that it represents a 'reality gap' between the didactics of the classroom and the requirements of the clinical setting. However, a more analytical approach would see the 'gap' as representative of the dichotomy that exists between the discursive model of practice (or 'grand theory') espoused by the educational and hierarchical establishment of nursing on the one hand and the institutional values and requirements of the system of health care on the other. This explanation emphasises the importance of an understanding of the organisational context of nursing work, i.e. of seeing the NHS as a health care organisation which has the power and authority to determine what constitutes nursing competence. Thus, what is defined as effective nursing is professional behaviour consistent with the goals and functional prerequisites of the organisation itself rather than a code of practice internal to the profession of nursing.

The organisational reforms within the NHS that occurred in the 1990s which brought about pressure for change in nursing practices may be seen as reflecting wider changes in the health and welfare relationship existing between state, health professions and the individual. Whilst theorists of the 'postmodern' might identify these organisational developments as consistent with the trend towards greater consumerism and a greater level of uncertainty associated with the 'risks' of scientific medical practice, others would identify a more regulatory role for the state in shaping the clinical practice of health professions. However, the consequence of these wider structural processes as they impact upon nursing remains a largely unexplored area of research.
1.1.2 Establishing the research problem

This research is concerned with the impact of processes of structural and organisational change that occurred within the state system of health care in the 1990s upon the practice of nurses working within the NHS. This will be assessed by drawing upon nurses' own perceptions of the ways in which these structural processes have mediated their working practices. Certainly, nurses who have worked within the NHS over the last decade will have experienced more changes to their everyday practice than at perhaps any other period in the history of modern nursing. Yet, the working practices of nurses are still largely perceived by the Department of Health as constituting a potential obstacle to 'modernisation' of the organisation of the health service.

The research problem arising from these developments concerns the nature of the material and temporal relationship existing between these processes of structural change and their influence on the professional practice of nurses as reflected within the discourses that nurses draw upon in delivering care to patients. The research questions that then arise are as follows: firstly, what are the actual discourses that nurses draw upon in managing the practical problems of delivering care to patients; secondly, what are the underlying social mechanisms that shape those ideas, values, and understanding?. In examining these questions, there is a practical need to move beyond the classic sociological explanatory duality of individual agency versus structure. Addressing these questions (it will be argued) requires a critical realist analysis of both the institutional context in which patient care is delivered and the historical and ideological framework of nursing.

Developing a systematic analysis of these influences offers the potential for evaluating nurses' responses to the increasing demands that follow the further structural re-organisation of the NHS currently being implemented by the New Labour Government.
1.1.3 Contextualising the problem within the literature

Within the literature, accounts of change affecting the practice of health care professionals (and here the literature is primarily concerned with the challenges posed to the autonomy of the medical profession) have a marked tendency to come down on one side or the other of the 'structure versus agency' duality. Few studies seek to explore a transformational relationship between the beliefs and actions of health professions and organisational change. Hence, changes that have occurred in the role and practice of nursing are usually discussed either as processes internal to the profession itself or as some inevitable outcome of wider macro-developments in health policy.

There are a number of limitations associated with the relevant literature. First, the nursing professionalisation literature focuses essentially upon those social or organisational developments that are seen as representing either progress towards or an impediment to meeting the objective of becoming 'epistemologically demarcated' from doctors. Clear lines of demarcation are seen to be a necessary requirement to achieve the goal of an independent status and autonomy for nursing.

Second, only a relatively limited number of studies have attempted to make a transformational connection between structure and agency in the context of changes occurring within nursing practice. If connections are made, they tend to be conceived as going in only one direction: they are either structurally or individually determinate. Thus a duality becomes established between the view that nurses as a professional group have themselves effected a change towards a more holistic approach to the patient-health professional and the view that it is structural shifts in health policy that have shaped the practice of nurses in recent years.

Third (and arising out of the previous point) there has been a tendency to forgo the theoretical work necessary to identify the generative or causal mechanisms that operate in the relationship between the structures of health care and the material practices of nurses. With this in mind, it will be argued here that the relatively neglected concept of ideology offers the potential to contextualise the impact of wider
social and organisational changes upon nurses' own understandings of their role and function.

Finally, there is a general failure to acknowledge the significant differences that exist between the practices of different groups of nurses, e.g. between specialist and generalist nurses or between hospital and community-based nurses. Nurses are too often seen as being a homogeneous group, ignoring the ways in which their different roles and functions may shape nurses' own conceptualisations of practice.

1.1.4 The Aims and Objectives of the Research

The broad aims and objectives of this study are to present an analysis of the discourses of practice utilised by nurses working within a health care system that experienced significant organisational and structural changes in the 1990s, under both the Conservative and New Labour governments. This process of organisational transition is ongoing. The methodological objectives are to seek to apply to the research object an analytical framework informed by the philosophical principles of critical realism, so as to be able to postulate those generative mechanisms that, in the social context of the contemporary NHS, result in a specific set of nursing practices. This objective requires that the study focus upon the material basis of nursing within a late modern system of health care, as well as upon nursing as a shared collective practice. This is necessary if we are to move beyond the idealisations of the role that all too often appear within the nursing literature.

In summary, achieving the research aim involves setting and meeting the following objectives:

- Drawing on the fieldwork research material, to engage in a process of inductive analysis in order to establish what are the common (as well as the deviant) themes that characterise nurses' discourses of practice.
• Drawing upon a deductive analysis of the literature, to establish those social structures and processes that frame the activities of nurses as social agents.

• Following a process of retroductive analysis, to postulate the set of social mechanisms that constitute the necessary conditions for the generation and reproduction of these practice discourses.

• To recontextualise these abstractions in relation to the actual or concrete discourses of nurses, in order to be able to identify the relationship between the very different sets of (often contradictory) ideas that influence practice and shape responses to organisational change.
1.2 An Outline of the Methodological Assumptions informing the Thesis

The methodological framework adopted within this thesis has an explicitly realist orientation and offers no pretence of philosophical neutrality. Realism, as Lawson has argued, essentially involves a concern with ontology, elaborating 'the broad nature, constitution and structure of the object of study' (1997:15). Tim May identifies the key assumptions of a realist social research paradigm as:

"The knowledge people have of their social world affects their behaviour ... the social world does not simply 'exist' independently of this knowledge. As such, causes are not simply determining of actions. However, people's knowledge maybe partial or incomplete. The task of social research is not simply to collect observations on the social world, but to explain these within theoretical frameworks which examine the underlying mechanisms which structure people's actions..." (May:1997:12).

Hence, an important element of this research enquiry is the attempt to go beyond the structural determinism versus methodological individualism dualism that effectively constitutes a theoretical cul-de-sac. In examining the practice and beliefs of nurses, the position that will be adopted here follows Mouzelis in recognising:

"For a full explanation of social stability or change one must look at social phenomena from both an institutional i.e structural, and an agency perspective... The crucial point here is that although the system-social integration distinction is an analytical one, it refers to aspects of social reality that can vary in relatively independent fashion" (1995:122).

The decision to focus attention upon the social processes underlying the development of nursing practice within the late modern system of heath care reflects a concern to avoid the trap of assuming that some sort of causal hierarchy exists between structure and agency. Rather, the objective is to come to some sort of conclusion concerning the relative determining influence of one over the other in relation to the practice of nurses. The way in which this 'structure-agency problem' is tackled within the present thesis is not with the aim of achieving some form of synthesis, as is found for example in Berger and Luckman's (1967) work. Nor will there be any attempt to follow the 'elisionism' found in Giddens 'structuration theory', which effectively collapses or conflates structure and agency together (Archer:1995). Instead, this thesis takes the view that, as the critical realist philosopher Roy Bhaskar has argued:
"Society is both the condition and outcome of human agency, and human agency both reproduces and transforms society...(however) the social world is always pre-structured...meaning that agents are always acting in a world of structural constraints and possibilities that they did not produce. Social structure, then, is both the ever-present condition and the continually reproduced outcome of intentional human agency" (Bhaskar:1975 cited in Archer et al:1998:xii).

The methodological approach adopted within this thesis is informed by such a critical realist understanding of the human agency-dependent nature of social structure. The reason why it is deemed necessary here to add the prefix critical to the understanding of the constituents of a realist research paradigm, as briefly described in the quotation taken from Tim May above, is precisely because social structures are, "...open to transformation through changing human practices which in turn can be affected by criticising the conceptions and understandings on which people act" (Lawson:1997:158 – emphasis in original).

In Bhaskar’s account, social structures and social interactions between individuals are distinct but real ‘levels’. Both are interdependent; they interact with one another. This position is presented in a schematic form in Bhaskar’s (1979) ‘Transformational Model of Social Activity’ (TMSA), which is set out below (Figure 1). In the TMSA, social agents are recognised as being born into a society in which they confront pre-existing transcendental generative structures. These structures define social agents’ possibilities for interaction but not necessarily the social interaction itself. In this sense, social structure and social interaction can be seen as being analytically separate for the purpose of social theorising. This is the epistemological position known as ‘analytical dualism’. It constitutes the central philosophical underpinning to the methodology utilised within this thesis.
An additional consideration for realists is the importance of acknowledging the existence within any analysis of social practice of a temporal disjuncture between structure and interaction:

"Structure always predates the interactions which reproduce or elaborate it, and because interaction always predates the elaborated or reproduced structure which result from it, it follows that the two cannot be identical" (Creaven:2000:6).

A conception of society that neglects this temporal dimension is seen to result in a reductionism in which social structure and social actors become epiphenomena of one another. In conducting this research into nurses and their practice, there will be no assumption that changes in the work of nurses directly follow on from formal shifts in health policy and restructuring of the organisational institutions of the NHS. This concern with the potential for temporal disjunctures occurring between structural developments and the activity of social agents will be reflected in the importance attached to ideology as a key analytical construct within this thesis.

Working within the framework of critical realist social theory necessarily (as the discussion above has indicated) involves rejecting the opposition between subjectivist and objectivist approaches to social research still found within social theory. Adopting an 'analytical' or methodological dualist approach to social research means focusing
attention upon the dialectical interplay between the distinct levels of 'structure', 'individuals', and 'interaction' in order to understand the particular social or systemic outcomes that are of concern. Therefore, the decision about which is the most appropriate research method to adopt (qualitative or quantitative?) is one that should be based solely upon its relative efficacy in furthering a realist understanding of the interplay between these underlying processes giving rise to the social phenomena or research object. Because this thesis is particularly concerned to privilege nurses' own understandings of the changing social and structural context in which nursing care is currently being delivered, the focus group discussion has been chosen as the primary fieldwork method. A qualitative approach is seen as appropriate to the objective of empirically establishing the frames of meaning or discourses used by nurses to inform their practice. However, whilst the analysis of the discussion material necessarily involves the process of induction and interpretation, this does not tie the research to a subjectivist understanding of social reality.

In seeking to go beyond the choice of subjectivism or objectivism, the thesis has developed an analytical schema (figure 2) which acknowledges that the activities of social agents (such as nurses) relate not to one particular structure, but to this range of inter-related structures and practices. This is an approach informed by the central critical realist notion of 'stratification', which recognises the operation of below-the-surface mechanisms. Hence social objects, such as nursing practice, consist of different structural layers, some of which (operating below the surface) may both complement and contradict one another. This necessitates a process of abstraction in order to identify generative mechanisms and causal structures. However, the process of analysis and explanation is not purely one of 'metaphor' or 'transcendence' (a criticism that has been directed at the apparent failure of critical realists to engage in the process of empirical enquiry – see section 3.2.3 below). Rather, it begins firmly with the accounts of the nurses themselves and then seeks to establish empirically identifiable 'regularities' in these discourses.

Here, there is broad agreement with the point made by Bourdieu (1992) that subjectivism and objectivism, as theoretical modes of knowledge, are both equally opposed to the practical mode of knowledge which is the basis of ordinary experience of the social world. For Bourdieu, objectivism is seen to exclude, "...both the
individual and collective history of social agents...it ignores the dialectic of social structures and structured, structuring dispositions through which schemes of thought are formed and transformed” (1992:41). Subjectivist approaches, on the other hand, fail to acknowledge the impact of what Bourdieu terms ‘durable dispositions’ upon the actions of individuals (1992:47). These ‘durable dispositions’ in relation to nursing would include those ideological and institutional structures which continue to frame, but not to determine, the work of nurses as a collective occupational group.
2. Literature Review

The overarching objective for each of these chapters is to provide a theoretical account of the material and historical context of modern nursing within the contemporary NHS at the same time as establishing the mechanisms and processes of continuity and change that characterise nursing practice.

The first chapter of the literature review begins with an examination of the historical development of nursing practice and the structural and organisational constraints that have long thwarted nursing’s attempts to establish for itself the status and autonomy enjoyed by the medical profession. The chapter also critically assesses the relationship between nurses and their patients and in particular the idealisations of that relationship frequently associated with the professionalising literature.

The second chapter concerns the hegemony of biomedicine within the system of health care generally; specifically, it looks at the ways in which that hegemony has circumscribed the practice of nurses. The assumptions of biomedical science have traditionally provided the epistemological framework within which modern health care (and by extension nursing) is structured and practised. In this sense, nursing has and largely remains dominated by biomedical imperatives. Consequently, an analysis of the question of whether we can still legitimately talk about hegemony of the biomedical paradigm, coupled with an examination of the dominance of the medical profession within the health care system, continues to be of fundamental importance.

The third chapter aims to ground an understanding of the professional practice of nurses within wider social changes in the organisation of work. This requires an assessment of the continuing relevance and centrality of class as a relational construct for an understanding of the formation of social consciousness. The role played by institutional cultures in the acquisition of professional role identities will also be examined in the context of the modern organisation of the NHS.
The fourth chapter of the review begins by examining the extent to which there can be said to have been a fundamental shift in the 'state-individual' welfare relationship in recent times. This constitutes the background to any discussion of the challenges faced by nurses practising within what is the largest of the state welfare institutions, namely the NHS. The chapter critically explores the post-war welfare relationship between citizen and state, which was once (naively) generally conceptualised as marked by beneficence but is now challenged by a variety of social and political processes that, collectively, have been said to constitute a 'postmodern neoliberalism'. It will be argued that much of this work is marked by an idealism concerning the profundity of such processes and that the empirical nature of such changes (in this case the work of nurses) is all too frequently relegated to the realms of epiphenomena.

The function of the final chapter is to examine the ways in which ideas, understandings, and social consciousness are constructed in stratified societies. Ideology and discourse as distinct conceptual constructs are introduced and discussed in relation to the transformational relationship existing between social structure and social interaction. The objective is to establish a framework for understanding the ways in which the discourses of nurses reproduce a hegemonic ideology regarding the appropriate role and function of the subordinate health care professional at the same time as articulating the unique capacity and contribution of nursing as a practice-based profession. In seeking to utilise the concept of ideology within a Marxist theoretical framework, the thesis is aware that ideology as an explanatory concept has been all but expunged from contemporary social theory and replaced by the all-embracing notion of discourse. Hence there is a concern to examine the development of the concept of ideology within Marxist and 'post-Marxist' frames of meaning critically as well as to trace the disappearance of the active subject in social theoretical explanations of social change.
2.1 Nursing Practice and Organisational Change in
The Late Modern NHS

This section will begin by reviewing accounts of the development of the modern profession of nursing from a historical perspective. It will then focus on the occupational strategies adopted in the attempt to achieve a professional status within the health care system that is comparable to if not commensurate with that of doctors. Key areas of concern are the attempt by professional nursing bodies to build a distinct or autonomous theoretical base for nursing and the impact that this has had upon the actual practice of nurses themselves. This professionalising project, originally embarked upon more than a century ago, only really began to have a serious impact on health care organisation in the late 1970s; it has since taken on the generic title of the ‘new nursing’. The review will go on to assess the ways in which the waves of structural reorganisation (or ‘reforms’, as they are often euphemistically called) that have occurred within the NHS since the late 1980s have reshaped the nurse-patient relationship. This more recent process of politically directed structural changes in the health care system, it will be argued, has been characterised by a shift towards greater professional managerial control over the resources and delivery of health care. Consideration is therefore given to the description and analysis of this ‘new managerialism’ and to the ways in which its associated organisational principles of productivity, efficiency, and target-setting have resulted in significant changes in the conduct of nursing practice.

The objective of this chapter is to establish a level of theoretical and empirical understanding of nursing practice in the ‘modernised’ NHS that will make it possible to address and contextualise the following questions later in the data analysis chapter:

- To what extent are nurses able to identify with the objectives of the ‘professionalisation project’ driven by nursing’s hierarchy? Or to put it another way: is the pursuit of professional autonomy of primary interest to practising nurses?
In what ways do nurses actively interpret the theoretical discourse known as the 'new nursing' within their individual practice?

Following the claims made in the literature about nursing autonomy, in what ways and by what means are nurses able to manage their occupational boundaries?

To what extent do nurses engage holistically with their patients (or is it still true that the traditional mechanistic or utilitarian approach to patients characterises the delivery of nursing care)?

Do nurses perceive managerialism and other aspects of recent organisational reform within the NHS as having fundamentally changed the nature of nursing work?

2.1.1 Nursing in Modernity: The pursuit of professional closure

The long-standing pursuit of professional status (or more precisely: some measure of occupational autonomy within the system of health care) is arguably the defining feature of the history of modern nursing. Nursing as an occupation has historically lacked the power to demarcate its field of practice, and as Macdonald has vividly argued:

"Nursing has pursued its professional project for over a century, striving to achieve some autonomy and jurisdiction of its own. The professional milieu is one which the powerful forces of medicine and the hospitals constantly seek to control, or to change the metaphor, they represent the upper and nether millstones between which nursing has always been ground" (Macdonald: 1995:143).

Within mainstream sociological analyses of professions, a distinct knowledge base is usually seen to be a ‘core generating trait’, the epistemological basis for the establishment of any profession. This basic assumption (present in the work of Larson:1977, Abbot:1988, Macdonald:1995) will be subject to a critique below, but it is nonetheless a useful starting point for an analysis of nursing’s professionalisation strategy. The issue of professional ‘knowledge’ is especially pertinent given the
frequent criticism of nursing knowledge as being essentially 'indeterminate' because allegedly 'practice-based'. The origins of this problem have often been attributed to the ‘Nightingale movement’ of the 1870s. This was the position represented by Florence Nightingale in her attempt to ensure women’s control over nursing as an occupation; it sought to emphasise the female ‘virtualities’ of nursing practice over the development of a more esoteric knowledge base. This approach is a particular example of Weber’s concept of social closure. Here, men were to be excluded from the profession by virtue of making the indeterminate aspects of nursing impossible for men to acquire. This was the opposite case to that of the medical profession, which excluded women by making it virtually impossible for them to acquire the technical and scientific knowledge necessary to enter the profession. Florence Nightingale’s position was opposed by the other strand of late nineteenth century nursing led by Mrs Bedford-Fenwick. The objective of the latter group was statutory registration of nursing, the aim being the establishment of an occupational professionalism for nursing with its own knowledge base.

In combination, these positions amounted to a ‘dual closure’ professionalising strategy but one which Witz (1992) argues was also explicitly gendered. The occupational strategy required the creation of a new occupational field or the usurpation of an area of the field operated by medicine as the dominant exclusionary profession. Nursing then set about operating its own gendered exclusionary practices, which excluded men from the profession. However, it is difficult to determine whether, within this historical account, it was as women excluded by men from practising medicine or as doctors’ ‘hand-maidens’, forced into a subservient position by the profession of medicine, that nurses first embarked upon such a gendered professionalisation strategy?

Witz (1992; 1994) has also argued persuasively that there are clear historical continuities with contemporary nursing’s dual closure ‘professional project’, which can be seen as having (following Weber) both a ‘usurpationary’ and an ‘exclusionary’ dimension. Nursing, having traditionally sought to achieve occupational authority through its efforts to institutionalise a distinctive knowledge base, subsequently, after more than a century, hailed the major reform of nurse education in the late 1980s as a successful outcome of the usurpationary dimension of the strategy. This development
known as Project 2000 is discussed in detail below. The exclusionary dimension has traditionally been pursued through legislative means in an attempt to secure state support for a set of occupational control mechanisms. The first historical success was achieved with the passing of the 1919 Nurses’ Registration Act.

This initial success has subsequently been seen as a Pyrrhic victory in that, whilst a General Nursing Council (GNC) was set up to establish central control over the occupation, this was not a self-regulatory body since the Council did not contain a majority of nursing members. Nor was the original aim of having only the one-portal entry system to nursing achieved. There remained many entry points via the different branches of nursing. Indeed, it can be argued that nursing’s strategy for achieving professional status achieved very little progress over the next seventy years. This was largely because of the continuing dominance and control of the medical profession over the work of nurses, and the ‘inaccessibility’ of hospital organisational decision-making structures for nurses. Such was particularly the case after the formation of the NHS, when these institutions came under the direct control of central government. In fact, the creation of the NHS served to reinforce for a time the conception (originally championed by Florence Nightingale) that the organisation of the hospital rather than professional concerns should constitute the locus of nurses’ knowledge (Macdonald:1995:142).

These structural and organisational realities have, for over a century, represented significant barriers to nursing’s professionalisation project. In the meantime, the process of socialization or initiation of new recruits into the mystique of the ‘professional nurse’ has continued unabated since the era of Florence Nightingale. There are many examples in the literature of the ways in which these conceptions have formed an essential component of a ‘culture’ of nursing. For example, Dingwall’s (1979) classic study of the professional socialization of health visitors focuses upon the apparently trivial aspects of everyday life represented by the clues or cues that we utilise in order to structure our actions and responses. Health visitors are seen to ‘accomplish professionalism’ by acquiring a repertoire of behaviours and a knowledge of norms ‘appropriate’ to the occupation. This is a process instilled in them through their professional tutors. Professional socialization is therefore not purely the acquisition of an occupational knowledge base; it is also about “…the
assimilation of a comprehensive style of providing a service based on that knowledge, which helps to convey the impression to the recipients and the public at large that the service is special and its practitioners are special” (Macdonald:1995:51). In addition to these formal processes of socialization, there is a large literature pointing to the importance of an informal set of socialization processes which constitute a ‘hidden agenda’ of nursing. Perry (1993) has argued that, whilst nursing’s professional code of practice (UKCC:1992a) equates good nursing with compassion and care, the institutional values of the hospital or clinic frequently equate nursing competence with behaviour that supports the rules, rituals, and the status quo. Thus, an important part of the occupational socialization of nurses is about ‘learning their place’ in the organization. These informal socialisation processes, in particular the importance of ritual and traditions, have consistently frustrated those within nursing’s hierarchy who have sought to establish a thorough-going scientific theoretical base for nursing practice.

In 1972, the Briggs Report into the state of nursing recommended that the government of the day implement a radical reform of nurse education, calling among other things for nursing to become a ‘research-based profession’ (the recommendation was only finally enacted in 1989 when the training of nurses was transferred to institutions of higher education). The subsequent thirty years have seen a less than enthusiastic implementation by nurses of such research-informed care (in its current guise, the process has become known as ‘evidence-based practice’). Traynor’s review of this problem of dissemination concluded that:

“(t)here is a tendency toward discomfort on the part of many nurses in the face of the ‘externality of ‘scientific’ knowledge, perhaps because of a view of practice that is highly contextual and relationship-focused, and second, despite professional rhetoric to the contrary, a tendency to experience practice as offering only limited scope for decision-making” (Traynor:1999a:194).

Thus, the reality of practice within a medical division of labour, combined with an ‘informal’ nursing culture which has its own sets of priorities, has served to cut across the macro-professionalising project of nursing. The implication of this reluctance to respond to what Traynor (1999a) describes as ‘the ideology of research’ demonstrates the enduring power of the processes of socialisation. This process can be seen as
reproducing a set of traditional and institutional values corresponding to Gramsci's (1971) 'stratified deposits' of previously influential ideas.

2.1.2 The 'New Nursing': The response of nursing to the changing demands of the late modern health care system

An alternative reading of the development of modern nursing from that of the activities of a group of volitional social agents (i.e. middle class philanthropic women, in the mid-nineteenth century) is a view of nursing as the material product of the changing science and technology of medicine generally, and the development of the organisation of the modern hospital in particular. From this technological perspective, the post-war stagnation of the profession of nursing can be seen as (for example) reflecting the increasingly widespread use of antibiotics, a development that has had the effect of making the skills associated with nursing patients with fevers and sepsis effectively defunct. However, as Dingwall and Allen have argued, nursing and the role of nurses did begin to develop in a different direction in the 1970s in response to new technical and demographic demands:

"(T)he combined implications of advances in surgical techniques and an ageing population produced new constituencies of patients for whose treatment a reliable subordinate profession was important. That profession needed new skills and, in certain respects, a more advanced theoretical understanding of those skills to use them effectively" (Dingwall and Allen:2001:68).

It is within this context of social, technological, and organisational change that nursing's more recent attempts to achieve an occupational autonomy and authority within the health care division of labour will now be appraised. These more recent developments have been coterminous with, although not necessarily determined by, the shift towards greater managerial control over the resources and decision-making process both locally and centrally within the NHS. The two most significant developments have been, firstly, the reorganisation of nurse training which became known as Project 2000 (UKCC:1987) began to take effect in the early 1990s with the overt aim of uncoupling the historical ties between training and the organisational demands of the health care system. Objectives included the creation of a practitioner-
based division of nursing labour, with trainees now having the status of undergraduates taught within universities and no longer constituting a cheap supply of labour for the hospitals (Davies:1995). A second significant development has been the support and encouragement provided by nursing’s professional hierarchy for nurses to take up what are termed ‘extended roles’ (UKCC:1992b) encroaching on technical areas of clinical practice traditionally seen as the preserve of the medical profession.

Preceding (and providing a theoretical justification for) these organisational developments within nursing education and practice is the epistemological paradigm known as the ‘new nursing’. This essentially idealist framework for nursing practice, which draws many of its central notions from Humanistic philosophy and psychology, has been concerned to push nursing beyond its traditional embracing of the reductionist biomedical conception of the patient as an object in the delivery of health care towards a more ‘holistic’ approach to the nurse-patient relationship. Its origins in Britain lie in the development of academic departments of nursing within a small number of universities in the late 1970s. These new professional nurse academics drew upon a longer tradition of nursing theory in the USA, where much progress had been made since the 1960s in situating nursing’s ‘unique contribution to health care’ through the establishment of embryonic forms of autonomous practice ‘epistemologically demarcating nursing from medicine’ (Allen:2001:10). One of these initial developments that was eventually adopted within Britain in the early 1980s subsequently became known as the ‘nursing process’. This approach to practice encouraged nurses to see patient care as a unified ‘process’, rather than as a series of allocated interventions or ‘tasks’. The approach was generally welcomed amongst British nursing academics because it challenged the distinction that had long existed in practice between ‘basic’ and ‘technical’ nursing care. This distinction had resulted in a ‘skills hierarchy’ in which more senior nurses carried out one set of interventions and less skilled nurses the more ‘basic’ ones. For a long time this had produced a fragmentary system of care delivery (Melia:1979 cited in Allen:2001:12).

The new academic nursing departments now acted as advocates for this new ‘holistic approach’ to care delivery. The key element of this paradigm (subsequently termed the ‘new nursing’) involved the individual nurse moving away from a primary concern with the biological functions of their patient towards a more direct
engagement, seeing patients as subjective beings, as individuals with their own subjective experience of illness and care. The nurse-patient relationship was to be reformulated on a more equal basis and the attempt made to establish a 'healing association'. Nurses were now to be encouraged to promote healing rather than treating patients instrumentally. That meant moving away from the traditional form of nursing practice known as 'task-orientation'. This new approach to patient care has been described as 'emotion work' (following the work of Hochschild: 1983), and has come to refer to the nurse's use of self in attending to the psycho-social needs of patients. This is generally seen to constitute a key element of the 'new nursing’s’ claim to have a ‘distinctive jurisdiction’ within the health care division of labour (Abbott: 1988). Indeed, the concept of the management of emotions is an essential feature of what has been broadly defined as ‘women’s work’ together with the notion of the gendered occupation. The issue of gender and professional identity is discussed in detail in Section 2.3.3 below.

Within the ‘new nursing’ paradigm, emotion work has also been linked to more general assertions about the history of nursing, in which nurses are traditionally seen to have been concerned primarily with establishing a ‘therapeutic’ relationship with patients. However, it is highly questionable whether there was ever a ‘golden age of humanistic care’ within the health care system, as implied by the advocates of the new nursing strategy:

“We must acknowledge that much of what nurses actually did, which is now presented as evidence of their caring, was actually the medical technology of the time. The nurse who bathed the patient with a fever was not performing a simple caring act but carrying out a prescribed intervention just as much as her modern successor on a drug round” (Dingwall and Allen: 2001:67).

Dingwall and Allen go on to argue that, whilst holistic work with patients may have facilitated the carrying out of such technical tasks and assisted in pain relief at a time when analgesia was much less reliable, in itself such caring work was probably a secondary consideration.

Away from these historical idealisations, the question arises as to whether the ‘new nursing’ paradigm and its promotion of holistic emotion work through nurse education
programmes has a place within the contemporary NHS. Both the Conservative government’s ‘internal market’ reforms (DoH:1989) that were introduced at the beginning of the 1990s, and the self-styled ‘modernisation’ programme (DoH:1997; DoH:2000) currently being implemented by the New Labour government have resulted in a strengthening of the managerial ethos within the NHS. It has been argued that this has been to the disadvantage of traditional clinical autonomy (and arguably this applies to all the health care professions, not just doctors) over patient interventions. As a result, attempts made by the then regulatory body of nursing, the United Kingdom Central Council for Nursing, Midwifery and Health Visitors (UKCC), to raise the educational level and professional profile of nurses inevitably run onto the buffers of a managerial ‘value-for-money’ bottom-line. This organisational ideology posed the question of whether increasing the educational development of nurses could be justified on cost-effectiveness grounds alone. In the decade following the introduction of the *Project 2000* reorganisation of nurse education there has been widespread and consistent criticism both from hospital trusts and from local health authorities concerning the ability of newly-qualified nurses to fit in with the needs of service. Increasingly, a university-based system of training is seen by the government as reflecting an overly theoretical education programme which lacks relevance and practical experience for student nurses. The House of Commons Health Committee which subsequently examined nurse training advised “… *education consortia, universities and the NHS to collaborate to ensure that the opportunity exists for student nurses to experience clinical practice in a safe and supervised environment as early in the training programme as possible*” (House of Commons:1999). Evidence from the NHS Confederation is cited in a recent report by the UKCC entitled ‘*Fitness to Practice*’, which states that:

"When newly-qualified nurses arrive in our trusts, they are not ready to practice. There are deficits in a variety of ways, some to do with practical skills and some to do with what our members have characterised as ‘simply not being streetwise’, not being ready for what it is like with shift patterns, multi-professional working, dealing with difficult situations” (UKCC:1999:40).

The changes that are required in the words of yet another recently produced report into this issue of ‘relevance’, this time produced by the Chief Nursing Officer for England and Wales, are that theory must be integrated with practice (DoH:1999).
Nursing academia has reluctantly had to rethink its educational curricula to make them more relevant to the needs of the organisation of the NHS.

Ironically, the power of such managerialist rationalisations to influence the work of nurses was actually crucial to the implementation of the *Project 2000* proposals in the first place. This was because, at that time (the late 1980s), the health service was facing a so-called 'demographic time bomb' of nurse recruitment. The problem lay in the wastage in staff arising out of career disillusionment and low pay levels and the need to attract increasingly large numbers of essentially female school leavers to maintain staffing levels in the NHS. These young women had to be enticed into nursing just at the time of university expansion, when more career opportunities were opening out for women in the job market generally. In this context, as Carpenter (1993) has argued, a small, highly skilled nursing core supported by a large pool of cheaper unqualified support workers could provide a more flexible workforce to meet the changing health care needs and social demands. From the standpoint of the Department of Health, the creation of a university-educated nursing workforce meant that qualified nurses were potentially well equipped to take over 'doctor-devolved activities'. At the time, the hierarchy of nursing was generally supportive of this 'skill-mix' (as it was generally termed) rationalisation process, since it fitted the goal of expanding the opportunities for autonomous practice. The UKCC subsequently produced a policy document, *The Scope of Professional Practice* (1992b), which formally brought to an end the requirement that nurses needed to have medical approval to undertake tasks that had not been included in their basic training. Now the responsibility for taking on an 'extended role' lay in the hands of individual registered nurses, who would be held accountable for their actions. These new roles invariably meant taking on activities previously performed by junior doctors.

It can be argued that what these developments amounted to in essence was the professional body of nursing falling in behind the needs of the organisation (the NHS) in the hope of making short-term gains for the project of professionalisation. This would mark a continuity in the tradition of compromising the professionalisation project, reflecting nursing's very real lack of effective power within the health care organisation. In the contemporary NHS, now more than ever, cost containment is a primary directive, and the pressure on nursing from health care managers is for the
development of skills substitution or 'skill-mix'. In fact, rather than creating opportunities for nurses to become 'autonomous practitioners', skill-mix has generally resulted in the delegating of many of nursing's 'basic' hands-on patient activities to unqualified support staff. In this health care environment, the case for qualified staff carrying out holistic work is weak because it is not measurable. The reason for this is that the 'new nursing' paradigm has no clear input-outcome relationships that could constitute evidence-based best practice. It has therefore become side-lined within the clinical setting.

Dingwall and Allen have concluded that this organisational devaluing of holistic care has resulted in a measure of what they term 'professional demoralisation'. This is because nurses in practice are not actively engaged in the work they are trained to value. They also argue that this 'alienation' can lead on to a drop in standards of care and 'drop-out' from the profession (2001:66). This point certainly illustrates the contradictions between the ideal and the reality of nursing. The question then arises: do nurses actually oppose these professional-organisational tensions by leaving the profession or possibly by confronting the organisation in some way? Or do they simply learn to live with these contradictory demands in their practice?

"Many nurses are able to critique effectively the medical institution as engaged in a process of maintaining a significant power base...but they often appear to take at face value the nursing profession's own rhetoric of holism, patient advocacy, professionalism or feminism, unwilling to understand those arguments and rhetorics as cultural resources, discourses that are adopted to further the profession's desire for power" (Traynor:1999b:63).

Certainly, there is still a gap between the reality and the language of the professionalisation project. The attempt to construct a 'new nursing' framework of theory and practice has in many ways been undermined by the reality of the practice of nursing, in which the patient care provided by nurses has to be co-ordinated with the needs of a complex organization (Allen:2001:14). As Porter (1992) pointed out at the time, the attempt to build nursing into an autonomous profession in some way separated from medicine bore little resemblance to the actual practice of nurses. For historically, whilst the 'bundle of tasks' which comprise nursing work has always been fluid, the role that nursing plays as an adjunct to the medical profession in the health care division of labour has remained unchanged:
"(A)s we move into the twenty-first century, this (adjunct) role may now have evolved to allow its tenants to diagnose and prescribe, within certain limits, rather than simply carry out treatment in a conscientious and informed fashion, but this is an adjustment of the bundle rather than a fundamental re-specification" (Dingwall and Allen: 2001:69).

2.1.3 A critical assessment of the nurse-patient relationship

The view of practice which nursing academics and the professional bodies of nursing continue in large part to espouse is based largely on an assumption that the nurse-patient relationship has been irrevocably reformulated on a more equal basis since the introduction of the ‘nursing process’ and the end of task-orientated nursing. It is further assumed that the dissemination of a distinct nursing theory-base has somehow firmly established the importance of a therapeutic relationship between nurse and patient in practice. This, it will be argued, has had the effect of producing a nursing theory blind-spot which fails to acknowledge the very different sets of interests and expectations that can exist in the professional relationship between nurse and patient. After all, this is a nurse-patient relationship which occurs in the context of a health care system with its own organisational objectives, not some decontextualised 'healing association' as implicitly assumed by a good deal of the (professional) literature.

Nursing care continues to be delivered primarily in high-tech hospitals, and the organisation of the hospital retains many of the disciplinary or surveillance aspects described by both Foucauldian and Marxist critiques of the system of health care within capitalist societies (this is discussed in detail in Section 2.3.2). In this regard, Armstrong (1983) has applied the Foucauldian notion of the ‘clinical gaze’ to describe a contemporary situation where the patient is now no longer identified or known in terms of biomedical pathology but is now open to examination as a ‘social case’. May (1992;1993) has since described, from within the same theoretical frame of analysis, how the introduction of the nursing process, together with the emphasis given to the importance of emotion work, have actually led to the increasing ‘subjectification’ of
the patient. This process is seen as manifested in the requirement upon nurses to construct personal relationships with patients which enable them to ‘know’ the patient as more than an ‘object of clinical attention’. This theoretically enables the ‘needs’ and ‘problems’ of the patient to be assessed and resolved. However, as May argues, this opens the potential for negative judgements to be made by nurses which can affect the delivery of care:

“...be­cause ‘knowing’ patients and ‘involvement’ are so intimately linked, the patient who will not permit herself to be known and with whom ‘talk’ cannot be conducted represents an obstacle to (these) kinds of nursing practice...the patient who is unwilling to open himself up to the therapeutic attention of one nurse may be approached by others” (May:1993:186).

Issues of compliance and legitimation have always been important elements in the typification of ‘good’ and ‘bad’ patients (Kelly and May:1982). Whilst the ‘bad’ patient continues to represent a problem in the carrying out of concrete nursing tasks, as well as disrupting the ‘social order of the wards’, the nurse is now required to understand such non-compliance in terms of patient ‘culpability’; such ‘behavioural disturbance’ reflecting a particular view of the patient’s ‘subjectivity’. Patients also continue to be isolated and controlled within hospitals as if they were deviants in the original Parsonian sense of the term. These are, after all, places where people have things done to them; choice and decision-making options are limited, whatever the talk about patient autonomy. Whilst hospitals can be more effective if patients actively co-operate (as recognised by some aspects of the more recent reforms within the NHS), they are certainly not ‘consumers’ (despite the rhetoric from the Department of Health) of a ‘health service’ in the same sense that people using a health spa or private alternative healing services might be. There is certainly continuing resistance from health professionals to treating patients as if they were consumers. This is evident in the considerable amount of anecdotal evidence that nurses regularly complain about patients who will not take on responsibility for their own health care treatment (this aspect is explicitly explored within the focus group interviews that form part of this research).

Dingwall and Allen (2001) argue that, underpinning such views held by nurses (if in fact they do exist), is the idea that somehow the public has lost sight of the implicit
bargain behind the 'sick role', particularly within a publicly-financed health care system such as the NHS. This is that patients are exempted from normal obligations on condition that they co-operate with treatment from the socially-sanctioned nurse professional. Dingwall and Allen (2001:72) see this undermining of the sick role as a consequence of a higher level of expectations held by the public concerning the health care service. However, this is an argument which uncritically accepts the premises underpinning the original concept of the sick role (as per Parsons:1951) that health is a purely functional state and that the interventions of doctors and nurses are always effective and should therefore be complied with by patients.

2.1.4 Reforming the organisation of the NHS: Crises and the impact of the 'New Managerialism'

For political economists, crises are a manifestation of a range of capitalist contradictions, but at the same time they throw up necessary if temporary solutions to those contradictions. In Marx's words, "...crisis is the forcible establishment of unity between elements that have become independent and the enforced separation from one another of elements which are essentially one" (1972:512). If the more recent history of the NHS, certainly since the late 1970s, is marked by organisational turbulence and financial crises, then the outcomes could be said to confirm Marx's original statement. The attempt has been made to 'forcibly unify' market forces and a consumerist ideology with the founding social democratic political principles of public service and welfare rights. In relation to the 'enforced separation' element of crises, we have seen the decline of the health service bureau-professionals or hospital administrators as they were known, who essentially existed to support the work of clinicians and other health professionals (however subordinate their position). They have been replaced by a new elite of managerial professionals, which has sought to establish its ideological hegemony over the health care professions within the NHS. These 'new managerialist' solutions to the crises of the NHS have undoubtedly had an impact on nursing practice, as reflected in some of the significant developments discussed above. Allen (2001) has noted that there are now clear tensions between a managerial and a nursing profession view of the ways in which health care should be managed. Such tensions were not apparent when the NHS was managed by the
principle of ‘consensus’, as it was until the mid-1980s. However, health service managers and nurses (as well as other health care professionals) now appear to be pulling in opposite directions:

“Cost containment concerns have reduced and diluted the nursing work force to a level that is a long way removed from the professional vision of nursing based on a skill-mix rich in qualified staff. Moreover, the very notion of ‘management’ is anathema to the professional model of the autonomous practitioner engaged in a therapeutic alliance with his or her patient” (Allen:2001:59).

John Clarke (1997;1998) also sees the development of this ‘new managerialism’ as marking a significant shift in the role traditionally played by health care professionals within the NHS. This analysis argues that the introduction of professional managers into the decision-making structures of the NHS represented an ideological assault on the traditional relationship between professionals and patients. As such, this development represented a re-establishment of state control over the day-to-day running of the NHS, delivered in the name of the ‘consumer’. Postmodernist commentators have argued that this shift towards managerialism at the expense of traditional professional interests reflects an inevitable process of change in the structure of welfare provision. The ‘new managerialism’ thus represents a ‘discursive’ shift towards a much more decentralised way of working in general, evidenced by the emphasis placed on individual professionals to engage in self-monitoring and attitudinal change. This process is reflected in the development within the NHS of Trust mission statements, Patient’s Charter standards, and total quality management (TQM) initiatives (Carter:1998:12).

Despite the important epistemological differences that exist between these two positions, there is agreement about the significance of the shift to managerialism within the health service. There is also a correspondence in the argument that ideological or discursive factors are driving these processes of professional change, as in the case of a restructuring of nurse-patient relationships. However, very different conclusions are drawn about the significance of this apparent increasing responsiveness towards the rights of patients (or consumers) to become directly involved in the decision-making process surrounding their care and treatment.
As an ideal-type the 'new managerialism' (or, as it also termed, the 'new public management' -Dunleavy & Hood:1994) is characterised as a 'hands-on', 'business-like' style of professional management in which decision-making power is now the prerogative of managers, "... 'discretion' as attached to a managerial rather than professional calculus" (Clarke:1998:176). The form of organisation in which such managerialism is dominant would set great store by explicit output controls, to be measured by explicit performance indices, and by a commitment to the creation of a 'transparent' organisation in which all employees are expected to strive to meet the 'corporate' objectives. Loyalty of staff is primarily to the organisation itself rather than to some more esoteric notion of 'public service', as traditionally associated with the Civil Service. Such notions of public service or a 'service ethic' are a feature of the Weberian 'bureau-professional' ideal-type and as such could be said to characterise the outlook and approach of the replaced health service bureaucracy known collectively as 'hospital administrators'. An important outcome of the introduction of the 'new managerialism' as an organising principle and the new professional managers as a concrete representation of this principle was arguably the diminution of the public service ethic within the NHS. For doctors, such an ethic has meant (and continues to mean) a primary commitment to the profession of medicine itself, while for nurses the notion of public service has traditionally reflected a commitment both to the health care organisation and to the care of patients in equal measure. As an occupational group, nurses continue to be less than committed to their own professional body (the UKCC) than doctors traditionally have been to the British Medical Association (BMA). Clearly, these differential concepts of public service have produced well-documented tensions between professional attachments and organisational loyalties. However, it has to be said that this dichotomy is not always so clear-cut as has sometimes been alleged. This is because the more senior members of the medical profession have traditionally held dominant positions within the health care organisation, whether at the level of the Department of Health, in local health authorities, or on the old hospital boards, and this has occasionally produced divided loyalties.

The 'new managerialism' was an organisational strategy initiated by the Conservative government as a central plank of their NHS reform programme (DoH:1989). This restructuring of the relations of power has subsequently been repackaged (but not
Clarke (1997:1998) recognises the new managerialism as not simply introducing rationalist business methods into the NHS but as refashioning the role of the state in the delivery of health care. Clarke chooses to focus upon the impact of what he sees as the global phenomenon of 'new public management' on the form of the welfare state in Britain. This process of managerialisation is seen to be proclaiming itself as the universal solution to the global problems of inefficiency, incompetence, and chaos that are seen as characterising the public provision of welfare services throughout the developed world (Clarke:1998:174). But while Clarke would reject the notion that national welfare restructuring is purely some inevitable effect of global changes, underplaying the influence of national formations, he does recognise that this process of managerialisation has been a central feature of the British experience. And although managerialisation is associated with the political ideological agenda of the new right, again it does not follow that in Britain 'Thatcherism' was simply a local manifestation of global neo-liberal politics.

Clarke (1998) goes on to argue that it would also be wrong to see managerialism as merely a tool of the political new right, utilised to implement its neo-liberal reconstruction of the welfare state in Britain. Viewing the new public managerialism as being purely a component of a politically driven reform of the health and welfare system sets limits to an understanding of why and in what context it emerged:

"There has been a danger of submerging the specificity of managerialism as an ideological formation and social project within the attention given to the new right" (Clarke:1998:175).

Clarke's position is that this mechanistic understanding of the introduction of managerialism within the public sector amounts to an ideological 'naturalisation' of the organisational reconstruction, assuming some evolutionary process in the development of public service organisational structures since the war. Additionally, the failure to see managerialism as a 'distinct formation' with its own dynamic (the 'right to manage') means not seeing it as a source of instability in its own right, on top of a range of instabilities that have been associated with the process of state reconstruction. Managerialism should therefore be seen very much as a double-edged
sword which can be directed at curbing the autonomy of health care professionals but also at curbing political interference in operational matters. It is no mere tool of the neo-liberal project. For Clarke, the introduction of these new managerial structures into the NHS not only represents an attack upon the power and influence of the medical profession; it also offers a ‘solution’ to (and is a consequence of) the spiralling costs of a ‘needs-based’ national health service. Both problems are a historical consequence of central government’s lack of regulatory control over the NHS, coupled with uncertainty about what exactly constitute the wider goals of state health policy after 50 years of the NHS.

The impact of public sector managerialisation as a ‘social formation’ is central to Clarke’s characterisation of the form of the state as one of ‘dispersal’ rather than the postmodernist notion of ‘fragmentation’. He has argued that ‘dispersal’ “...is a way of signalling such processes as the effect of strategic calculation rather than inevitable occurrences” (1998:176). The central power of the state remains. It is not fragmented, rather it is delegated. This is a ‘strategy of reconstruction’ designed to bypass the older bureau-professional organisations of the welfare state, subjecting them to control from below, with the notion of the ‘citizen as consumer’, and from above by central government setting financial and performance targets; “Managerialism is presented as the ‘cement’ that can hold together this dispersed organisational form of the state.” (Clarke:1998:176). Whilst this form of the state power may be dispersed, Clarke and Newman (1997:61) do utilise the concept of the ‘organisational regime’ to describe how power is organised within and between organisations. This is the ability to act and to control decision-making not just within one organisation; it reflects the ways in which power flows across and between organisations. Managerialism can thus be seen as serving to unify the organisational regime of the NHS, which operates both at the national level of the Department of Health and at the level of local health authorities and Trusts.

Accompanying these organisational managerial changes within the NHS in the early 1990s (and central to them) was the discourse or language of ‘change’. Clarke argues that within this change discourse, “…competing values are reduced to alternative sets of options and costs and assessed against their contribution to the organisation’s performance” (1998:177). It thus constituted a new ‘rational analytical’ and
‘depoliticised’ form of decision-making. This essentially ideological framework is then able to represent the groups of health care professional who oppose change, for whatever reason, as at best pursuing a set of parochial interests and at worst undermining the best interests of the organisation. The interests of the public are therefore, by definition, best represented by a neutral management.

As acknowledged by a senior nurse manager at the top of nursing’s hierarchy, “(T)he shape of nursing is determined by health policy” (Hennessy:2000:1). The reshaping of nursing work over the past fifteen years can been seen as one outcome of the change to a more managerial approach to health care organisation and service delivery, not just in Britain but across the European Union. These changes have occurred in response both to the pressure to reduce system costs and to the changing health needs of the population flowing from longer term demographic (greater percentage of people over 75 years of age) and epidemiological changes (the increasing number of those living with chronic degenerative illnesses). One outcome of these processes within the NHS was the development at the end of the 1980s a health care policy known as ‘community care’, which had as its objective the shifting of the site of care delivery away from the high-tech hospitals into the ‘community’. This policy was particularly aimed at those groups requiring long term support such as the dependent elderly and the mentally ill. The idea of shifting care for these groups, away from what has generally been recognised as ‘inappropriate’ institutional care towards providing care in the ‘community’ was not a new concept. The principles of community care have long been accepted by governments of both main political parties, and from the late 1960s a series of government reports in addition to research studies and media investigations had drawn attention to the problems. However, by the late 1980s, as Malin pointed out: “The history of community care policy could be described as a patchwork of broken promises and moral posturing” (1994:3). Little had changed in the organisation of care for these priority groups since the inception of the British welfare state in 1945, with services being highly fragmented and spread between a wide variety of formal and voluntary organizations.

The introduction in 1990 of the NHS and Community Care Act (DoH:1989) had the effect of formally redefining the boundaries between health and social, formal and informal care. The legislation introduced a new commissioning role for Social Service
departments (SSD's) in promoting and co a 'mixed economy' of care (involving the private and voluntary sectors in provision). The local SSD's and H.A's (now Primary Care Trusts - PCT's) were given the responsibility of jointly planning assessment strategies for the locality and producing an annual 'Community Care plan'. They now also have the responsibility for devising discharge policies for anyone leaving hospital and in need of care in the community. Patients or 'clients' as they were to become known, were not be discharged until that care is made available (when enacted this was to massively increase the so-called 'bed-blocking' problem). One of the most significant changes was placing the identification of health 'need' at the centre of health management and service delivery processes within the community. This 'needs assessment' is carried out by a 'case manager' who can be a community nurse or a social worker. The policy was also intended to give service users and their carers more say in determining the nature of the services they received. However, financial constraints subsequently limited this broader inclusive role for users of community health services.

Focusing on the work of primary care nurses (health visitors and district nurses), the consequence of this move to community care has been a shift towards a more integrated role. This involves working with local authority social services departments and voluntary agencies as well as forming a closer working relationship with GPs in the delivery of the new 'needs-led' service. The process has had a significant impact on the work of health visitors in particular. The demands of this new role require nurses to identify the health needs not only of individual patients but also of the local community. No longer is the primary concern the organisation and delivery of care to patients, which has meant that the traditional role of health visitors as NHS staff is now less tenable. Consequently, "...the nature of caring and what is purchased legitimately as 'health care' has also been narrower. Many dimensions of nursing are now only finding expression outside the NHS or not at all" (Walsh & Gough:2000:211).

Across the range of nurse specialisms, organisational changes driven by the introduction of the managerialist principles of 'efficiency and effectiveness' have led directly to a shift in the mix of nursing staff and skills, with unqualified staff taking on a much greater role in the delivery of care. The spur for many of these developments
came with the creation by the Conservative government of an ‘internal market’ in health care in 1990. This ‘quasi-market’ necessitated a split in the functions of health authorities and GPs. The latter became ‘purchasers’ of health care, and the hospitals (the new ‘trusts’) became the ‘providers’ of health care. This new form of contractualism had a major impact on the work of nurses. However, nurses themselves “... were often absent from the purchasing process or, where they existed, their role was unclear...the lack of involvement of nurses suggests that they did not figure prominently in the initial policy discussions” (Spurgeon:2000:192). At the same time as these organisational changes were occurring, the government attempted to put into practice its ideological commitment to individual responsibility for health. Nurses were now given an additional professional responsibility: they were expected to promote ‘healthy lifestyles’. This followed the British government’s adoption in the late 1980s of the targets (but not all of them) set out in the World Health Organisation’s ‘Health for All’ strategy (WHO Regional Committee for Europe:1985). Targets for health promotion which focused on individual rather than social change were set out in the Conservative government’s ‘Health of the Nation’ White Paper (DoH:1992). This made the promotion of health a responsibility of local health authorities, with nurses being given a central role in the delivery of these targets, which were set out in the form of contractual obligations for the new providers of health care, the community and hospital Trusts (DoH:1993). This health promotion strategy has subsequently been refined by the New Labour government in its public health reforms for the NHS (DoH:1998).

2.1.5 Concluding Comments

The nursing profession (like all the health care professions) has voiced strong criticism of the outcomes of the introduction of managerialist principles within the NHS. However, the question of whether patients actually want or need what largely remains a top-down or even paternalistic (no irony intended) relationship with the nurse (or doctor) charged with caring for and treating them is one that is rarely addressed in the nursing literature. So whose needs are holistic nursing practice designed to meet, exactly? Is it designed to meet those of patients or those of nurses themselves? The temptation is to see the ‘therapeutic use of self’ or ‘emotion work’
more as a professionalising strategy than as something to which nurses are committed in practice. This view is supported by the lack of empirical research evaluating the delivery and the outcomes of holistic nursing practice. What evidence there is from patients suggests that they attach greater importance to everyday social interaction with nurses and the general atmosphere on the ward (Baker & Lynne 1996; Ersser 1997; cited in Dingwall and Allen:2001:72).

It is also questionable whether nurses are fully committed in practice to the professionalising project as envisioned by nursing academics and the hierarchical bodies of nursing. Traynor (1999b) has argued persuasively that nurses are generally more comfortable with the idea of nursing as a profession that is primarily engaged in liberating itself from the ongoing ‘oppressions’ of the medical profession rather than as one that is engaged in a scramble for a slice of that power themselves. In this sense, the present thesis needs to establish whether the principles of the ‘new nursing’ have any resonance with the ideas of nurses themselves regarding the constituents of professional practice. If it is found that the principles of holistic care are side-lined in everyday nursing practice, this does not necessarily imply a rejection by nurses of this discourse. It may simply reflect the hegemonic power of the organisational regime to determine the outcomes of nursing interventions.

In concluding this scene-setting chapter, it can be said that any attempt to identify an essentialist and ahistorical conception of nursing practice is a fruitless exercise. Nursing work must be located within a given historical and material context; it must be seen as being shaped by the organisational demands of the system of health care delivery. Critically acknowledgment must also be accorded to the attempts by nurses themselves to manage their work boundaries in the course of their everyday practice.
2.2 The Dominance and Power of the Medical Profession within the Health Care Division of Labour

Within the modern system of health care, the delivery of nursing care has historically been shaped by the imperatives of biomedical science and the clinical decision-making autonomy of the medical profession. Whether we can still legitimately talk about the dominance of medicine within the health care division of labour that now exists within the ‘modernised’ NHS remains a question of fundamental importance to any contemporary analysis of nursing practice.

Science in general and biomedical science in particular is unproblematic if understood purely as a proven, reliable, and valid method for developing our understanding of the natural world of illness. However, such constructions can never exist at a purely ideational level; they are always applied through sets of material practices, and it is within and through such practices that ideology and power become embedded. The biomedical understanding of human illness and suffering is reflected in the material practices of the medical profession, which over a period of a hundred and fifty years or so has been able to establish its hegemony over all the health care occupations and within the evolving organisational system of health care. This hegemony has historically operated at a number of distinct levels. At the micro-level of doctor-nurse interactions it is reflected in the differential in power and knowledge associated with the medical profession’s claims to ‘clinical autonomy’ and team leadership. At the meso-level, it is reflected in the influence that the profession has traditionally enjoyed as a corporate body within the health care system. And at the macro-level it is reflected in the privileged status of the biomedical paradigm in accounting for health and illness. In this sense, medical dominance has long been regarded as a defining feature of modern health care systems. Today, however, that perspective has changed. Now the focus of analysis is increasingly upon the reasons for the apparent decline in the power of the profession. This concern with the challenges to the professional hegemony of doctors is no longer limited purely to organisational issues within health care systems. The influence of both Foucauldian and poststructuralist thought has
challenged the claims to 'truth' of biomedicine through the notion of the 'social construction' of knowledge.

No attempt will be made here to determine the veracity of biomedical scientific knowledge as such. Instead, this thesis seeks to assess how such knowledge becomes codified and applied in practice. A number of key assumptions of the biomedical paradigm can be identified from the literature. They include the defining of health as the absence of biological abnormality and its obverse: illness as a predominantly biological state. This reification of disease categories has led to a rejection of the conceptualisation of a continuum between health and illness in which the individual patient is viewed as the 'locus' of an illness resulting from the interaction of the body and a pathogen; 'Man as decontextualised host' (Comaroff:1982). Challenging any aspect of this positivist biomedical knowledge means, it will be contended, mounting a challenge to the hegemonic power of the medical profession in which questions of fact or validity will always be secondary. This is an argument that appears particularly pertinent in relation to the history of nursing's own attempts to establish its occupational authority within the system of health care by attempting to demarcate itself from medicine epistemologically and to develop its own unique body of clinical knowledge.

The overall objective of this chapter is to establish, through a critical reading of the literature concerned with the hegemony of biomedical knowledge and of the medical profession within health care systems, the ways in which that power has determined the role and function of nurses within modern health care systems. The aim is to achieve sufficient depth of theoretical and empirical understanding to be able, later in the data analysis, to address and contextualise the following questions:

- How important for the carrying-out of effective nursing interventions is a deep understanding of biomedical knowledge?

- To what extent do nurses as members of a health care team currently (within the 'modernised' NHS) feel able to challenge the clinical decision-making autonomy
of doctors where they feel the care and treatment of patients is being compromised in some way?

- In what ways are doctors able to set limits to the health care interventions of nurses?

- Are nurses in any way complicit in helping the medical profession to assert its clinical dominance within the structure of health care?

The application of the constructs 'power' and 'dominance' that appear in the title of this chapter can be problematic if little account is taken of their underpinning theoretical and epistemological assumptions. Therefore, for purposes of clarity of analysis, the differing theoretical approaches to the assessment of the status of biomedical knowledge and the significance of the health care division of labour will be examined separately. Those identified as being of particular importance are, first, the 'post-functionalist' medical dominance perspective characterised by the work of Eliot Friedson (1970;1994); second, the Foucauldian conception of power, knowledge, and regulation; and finally, the postmodernist (for want of a better term) understanding of the challenge to medical professional expertise in a period characterised by risk and uncertainty.

*Note* - The broader question of the future of state health care provision in 'post-modernity' is discussed in detail in Section 2.4.3, drawing extensively on the work of Bauman and others.

### 2.2.1 Power and Knowledge: Constructing the Biomedicine Discourse

Foucault's work conceptualises power as the property not of any particular social group, nor indeed as being exercised through a structural instrument such as the state; rather, "... it is a relationship which was localised, dispersed, diffused and typically disguised through the social system, operating at a micro, local and covert level through sets of specific [discursive] practices" (Turner:1997:xii). Power is a 'strategy' or set of discursive practices that characterise the working of modern social
systems, summed up by Foucault’s much-quoted statement that ‘power is a machine that no one owns’. Hence, for Foucauldians, traditional forms of governmentality depend on systems of knowledge and truths that constitute the object of its activity, and here the roles of experts and their expertise are central. As Miller and Rose argue, such experts (the medical profession, for example) play a mediating role between ‘authorities’ and individuals, “…shaping conduct not through compulsion but through the power of truth, the potency of rationality and the alluring promises of effectivity” (Miller and Rose: 1993:93).

In the case of medicine, power is embodied in and comes with the day-to-day rational-scientific practices associated with the work of doctors in the hospital or clinic, which Foucault (1973) termed the ‘clinical gaze’. Such everyday practices contribute to the (social) construction and reproduction of what has been termed the ‘biomedical discourse’. For Foucault, the relationship between power and knowledge is an inevitable and inextricable one (he in fact uses the single term ‘power/knowledge’): any extension of power involves an increase in knowledge. Specific forms of power require highly specific formations of knowledge. In this sense, institutions such as medicine (also the law and organised religions) exercise power not through overt coercion but through the moral authority over patients associated with being able to explain individual problems (such as an illness) and then provide solutions (i.e. treatment) for them. In this conceptualisation of medical practice, power is essentially relational rather than something that is possessed by individual doctors or the medical profession as a social group. This moral or disciplinary approach means that power is exercised most effectively as the subject of the discourse ‘interiorises’ this gaze “…to the point that he is his own overseer, each individual thus exercising this surveillance over, and against, himself” (Foucault: 1980:155).

It is in this context that Foucault discusses the place of medicine in the monitoring and administration (‘surveillance’) of populations and their bodies. This disciplinary form of power is not seen as openly coercive; rather, it might be thought of “…as a facilitating capacity or resource, a means of bringing into being the subjects ‘doctor’ and ‘patient’ and the phenomenon of the patient’s ‘illness’” (Lupton: 1997:99). This corresponds to what Lupton terms the ‘collusive nature’ of power relations within medical practice. The power of medicine for Foucauldians lies within the biomedical
discourse; it is not a possession of the profession itself. This is a world in which the lives of individuals (or at least the ways in which they interpret their health) are experienced and understood through the discursive practice of medicine. Hence, whilst there is a recognition of the role of the state in the reproduction of this medical dominance, it does not then follow that the medical profession simply serves the interests of the capitalist state. For example, Armstrong's (1993) work on the 'New Public Health', argues that this is purely a contemporary example of medical power exercised through the surveillance of a population's health behaviour. Such an approach would deny that health promotion strategies have emerged directly from a policy process instigated by the British State, which has its own particular sets of interests and goals.

A central criticism of Foucault's theorisation of discursive practice, particularly in relation to medical power/knowledge, is that it is overly deterministic. It focuses attention almost exclusively on the ways in which the discourse of medicine (as represented in official texts, medical notes, etc.) both subjects and subjugates patients. This is the 'docile body' view of the patient, subject to the clinical gaze; there is very little discussion of the ways in which this discourse might be resisted by patients. As Lupton argues, this approach tends to "...present a consonant vision of a world in which individuals' lives are profoundly experienced and understood through the discourses and practices of medicine and its allied professions" (Lupton:1997:94).

What follows for Lupton is a tendency to neglect examination of the ways in which medical discursive practice is 'negotiated' by the lay population in their avoidance of suffering and in 'maximizing their health status'. As Shilling has cogently put it, "(B)odies may be surrounded by and perceived through discourses, but they are irreducible to discourse" (1991:26).

Nevertheless, Lupton (1997:101-103) argues in defence of Foucault that he did indeed recognise that resistance does occur at the local level, where this disciplinary power of medicine is directed at the patient. Lupton also points out that in Foucault's later work, such as Volume Three of *The History of Sexuality* (1986), he moves away from the position that power acts upon individuals and focuses upon the formation of personhood or self-identity through what he termed the 'technologies of the self'. This involves seeing individuals as acting consciously or rationally through a reflexive
evaluation of their environment, local or otherwise, in order to maximise their chances of well-being.

The question of the power relationship between the work of nurses and the autonomy of the medical profession does not arise within Foucauldian accounts. This is because of the reading of power as dispersed and tied to discursive knowledge; an approach that does not allow such a reading to recognise separate sets of interests as being involved. The previous chapter looked at how Foucauldian accounts would see nurses as operating within the same discursive framework as doctors and therefore as being party to the same processes of surveillance, conceptualised as the clinical gaze, albeit in relation to health behaviour of patients rather than diagnosis as such.

2.2.2 Dominance and Autonomy: Conceptualising the power of medicine within the health care system

Medicine has long been seen as the ‘paradigmatic profession’ by sociologists. As Elston has argued, medicine remains “a publicly mandated and state-backed monopolistic supplier of a valued service” (1990:58). The question that follows is: how has the medical profession been able both to achieve this dominance within the state controlled system of health care and to maintain it over a period of significant organisational change? It was Eliot Friedson’s influential work, ‘The Profession of Medicine’ (1970), that firmly established what became known as the ‘professional dominance’ model. This approach, strongly influenced by Weberian notions of power, knowledge, and status, consciously sought to challenge the Parsonian view of an ethical profession using its expert knowledge rationally and altruistically. Friedson argued that the power of medicine in modern societies did not derive from a social consensus concerning a gate-keeping role serving to legitimate sickness but rested upon two essentially self-serving pillars. The first is the ability of the profession to control its own work activities, its ‘autonomy’. The second is the control the profession exercises over the work activities of other health care occupations within the division of labour of health care systems, namely its ‘dominance’.
However, since the early 1980s, this model of professional dominance has been subject to increasing criticism from sociologists who have attempted to describe and explain professional decline. The 'proletarianization' thesis, particularly associated with the work of McKinlay and Arches (1985), identifies two key changes as being responsible for the medical profession's loss of dominance within the health care system: first, the relatively recent development of 'managerialism' within health care systems, which has reduced doctor's control over clinical decision-making; second, the process of deskillling in the face of increased specialization and technological developments within the medical field. Together, these processes have meant doctors have become simply one group of employees (albeit one with a high degree of expertise) within the health care system. The 'deprofessionalisation' model associated particularly with the work of Haug and Lavin (1983) argues that the knowledge gap between doctors and patients has narrowed. Consequently, there has been a shift in power towards the health care consumer. Haug argues that this general trend leads to a diminishing of the cultural authority and health knowledge-monopoly of medicine. Both these models of professional decline were developed as specific commentaries on the situation of American medicine. However, this does not necessarily rule out their applicability to the state system of health care in Britain, especially following the introduction of the internal market in the NHS in 1990.

Friedson's (1994) more recent work rejects any such conclusions about the loss of power of the medical profession. He is particularly critical of those analyses employing overly generalized concepts such as 'dominance', 'proletarianization', and 'deprofessionalisation'. Elston (1991), who has actually developed Friedson's (1970) previous limited notion of professional autonomy, identifies three distinct categories of autonomy: 'economic autonomy' as the ability to determine remuneration, 'political autonomy' as the ability to influence policy choices, and 'clinical autonomy' as the profession’s right to set its own standards and to control clinical performance. This enables the author to argue that a decline in one of the forms of medical autonomy does not necessarily effect change in other areas of autonomy and status. Elston maintains that the 1990 internal market reforms within the NHS, in challenging the post-war political consensus over the organisation of the NHS and the unregulated role of the medical profession, represented a decline in the political autonomy of medicine but not in its continuing clinical control over health resources.
Friedson (1994) himself has shifted his analytical position over the years and now adopts a rather different approach to the question of the relative power of the medical profession. He argues that it is best understood by an assessment of the actual work of doctors within the context of the health care division of labour that involves interactions with managers, nurses, technicians, and other groups of carers. Friedson’s concern is thus with the micro-level of power, and here he identifies what he terms a ‘zone of discretion’ specific to medical work. At this level, a professional monopoly over certain skills ensures that even rank-and-file doctors are able to maintain a large amount of discretion in their daily work vis-à-vis other health workers. Together, these discretionary powers usually enable doctors to prevent encroachment upon their clinical autonomy, whether that comes from managerialist attempts to monitor their performance or from the nursing or midwifery professions in taking on aspects of work doctors regard as being within their prerogative.

Friedson further argues that, if the profession is seen in terms of being a ‘corporate body’ rather than primarily in terms of the work practices of individual practitioners, then its power has not been seriously undermined over the last two decades of organisational change. Nevertheless, he does recognise that the divisions within the profession have increased, not merely between rival specialisms but between the elite and the rank-and-file. This process of ‘internal stratification’ is seen as an adaptive response to external pressures from state and market to limit the spiralling costs of medical diagnosis and treatment. While the profession has maintained its autonomy at the ‘corporate’ level of the health care system, the price for this control has been the opening-up of internal policing systems in order to monitor standards of individual performance of the profession. In Britain, evidence of these developments also came with the Conservative government’s 1990 NHS reforms, which whilst giving the new groups of professional managers a greater role in decision-making also effectively endorsed the medical profession’s control over its own standards and activities of work. Although a new process of clinical audit was introduced, the profession was allowed to manage this process internally. In addition, many senior doctors were incorporated into formal management roles, given titles such as ‘clinical director’, and charged with formally managing the work of other doctors and health care professionals.
Whilst acknowledging the force of Friedson’s argument concerning the adaptability of the senior members of the medical profession in the face of the managerialist reforms to the organisation of health care, a point must be reached when it is possible to say that ‘things aint what they used to be’. In relation to the traditional dominance and autonomy enjoyed by doctors within the NHS, that point has now been reached with the introduction by the New Labour government of national standards and frameworks of treatment and care, as well as the imminent (at the time of writing in late 2002) imposed reform of medicine’s self-regulatory bodies.

2.2.3 Circumscribing the limits of nursing practice: The medical division of labour

The power of the medical profession has historically limited the expansion of nursing spheres of practice within modern health care systems. The profession has been able to extend its ability to engage in ‘social closure’ beyond the excluding of ‘ineligibles’; it has also used demarcation strategies to delineate the boundaries of ‘subordinate’ occupations such as nursing and midwifery. Doctors have been able to achieve this through the role they play in defining areas of competence, i.e. whether a particular clinical skill should be passed over the professional boundary or retained by the medical profession itself (Witz:1992). Nursing as a caring profession is thus subordinated within the clinical division of labour associated with medical interventions. This position very much reflects the fact that nursing is regulated by the state, not only in terms of its activities (an Act of Parliament lists the ‘competencies’ required of each ‘State registered nurse’) but also in terms of career opportunities within the organisation of the NHS and through the funding of training. Also, given the small size of the private health sector in Britain, the state continues to set the economic remuneration scales for nurses. The British state continues to control the autonomy of nurses, both in their interaction with the medical profession and in terms of their wages and conditions.

Strauss (1982) has described how the need to achieve medical ‘legitimation’ has shaped the nature of nurses’ work. He argues that this need on the part of nurses for
legitimation has manifested itself in the emphasis placed on 'instrumental work' over 'sentimental work' in nursing practice (NB: this will be discussed in detail in Section 2.3.3). Other ways in which the power of nursing is circumscribed reflect the traditional focus of nursing upon the practice of caring and a consequent devaluing of the acquisition of esoteric knowledge, although this began to change with the introduction of 'academic' nursing and with training being sited within universities. Whilst nursing practice requires the exercise of judgement, this is seen by both the lay public and all too frequently by the medical profession as being based upon knowledge that is insufficiently esoteric. According to Macdonald (1995:134-5), this has had the consequence of diminishing the standing of nursing as a profession. However, where in-depth knowledge of bioscience has been linked to the clinical competence of nurses operating within existing spheres of responsibility, it has been found that doctors respond favourably to nurses requiring further clinical skills. That is "...providing these skills are not threatening to the doctor's sense of being in charge" (Walby et al:1994:82). Significantly, it has also been found that, when nurses have acquired and then applied a knowledge of physiology, some have increased their questioning of medical decisions (Hogstan:1995; Nolan et al:1995).

Jordan and Hughes (1998) studied the views of nurses concerning the impact on their practice of the bioscience component of a post-registration Diploma in Nursing course that they had recently undertaken. The authors argue that the medical profession's dominance in the health care division of labour was challenged when those nurses sought to apply the bioscience knowledge gained through higher education. Respondents in the study reported that the bioscience expertise gained through the course gave them a familiarity with the language and terminology of biomedical discourse. This in turn allowed them to communicate more effectively with their medical colleagues, particularly in relation to decisions concerning patients' medication regimes. Indeed, the respondents in the study were able to provide clear examples of where their increased bioscience knowledge had enabled them to detect medical errors or oversights. However, the study itself concluded that whilst "(B)ioscience knowledge was a valuable interactional resource that some nurses could use to re-shape their relationship with (their medical) colleagues ... it provided no leverage for real occupational advancement " (Jordan and Hughes:1998:1067). The implication is that the profession's control over the medical division of labour
was the ultimately constraining structure. Additionally, it should be said that in order for nurses to reach the position where they are able to acquire the level of bioscience understanding which might give them the legitimacy to question medical decision-making, formal nurse education will have to go even further down the line of embracing the biomedical model, possibly to the detriment of a distinct 'nursing knowledge'.

2.2.4 The challenge to the relative autonomy and expertise of the medical profession in the late modern system of health care delivery

Those social theorists such as Bauman who recognise the existence of a postmodern society characterised by greater political and economic uncertainty and risk typically argue that the state now responds to these more externalised risks through more subtle means of control than the top-down policies of the past. As summarised by Lash, the social changes that have occurred are as follows:

"If simple modernization's totalising inversion of the social rights of the Enlightenment project is the impersonality of the bureaucratic welfare state, then its reflexive counterpart understands that welfare services are a client-centred co-production and advocates a decentralised citizen-empowering alternative set of welfare arrangements" (Lash:1994:113).

Postmodernity is thus seen to mark the decline in the hegemony and universalism of science in general and of biomedical science and its power of surveillance in particular. A picture is painted in which there is a new beginning for 'the expert'. A health expert need not be a medical professional in the traditional sense, but someone whose knowledge is purchased by the consumer. That knowledge it is asserted may or may not incorporate the biomedical paradigm of understanding. The expansion in the number of 'experts' advising the subject about the health choices they should be making is seen to be an outcome of a 'free market' of expertise. Information about risks is provided, but the choice about what course of action to adopt is left to the individual. However, it is acknowledged that this social process will result in different 'expert' groups promoting their own particular assessments of risk (an example would be the current conflicting expert claims regarding dietary intake). This means that the
individual consumer of expert advice can never be certain about expert knowledge, about whether one set of advice is more likely to guarantee security than another; the subject and their uncertainty remain central (this position is discussed in more detail in Section 2.4.3 below).

But does the main threat or challenge to the continuing hegemony of the biomedical profession within the system of health care come from some insidious process of individualisation which is breaking the traditional sources of power in society? Certainly, in analysing the recent history of the British health care system in relation to this perceived failure of the modernist project to control ‘risk’ we find that the state has been moving towards more rather than less central regulation of the health professions. This reflects, at least in part, the ongoing attempt to regulate health care spending in the NHS through processes of ‘efficiency and effectiveness’. Examples of this greater regulation are the development of clinical governance frameworks, the creation of NICE and its role in setting guidelines for the medical profession concerning the suitability of particular drug technologies, and the move towards direct involvement in the medical profession’s self-regulatory bodies.

The traditional distinction between the work of doctors and nurses was said to be that between ‘care’ and ‘treatment’. However, this boundary is becoming increasingly indistinct as nurses take on physicians’ work, even with the tacit approval of the profession, as described above. What are the reasons for this shift in clinical work boundaries? First, in an attempt to reduce costs, nurse specialization has meant that a broad level of medical knowledge is not required when limited clinical interventions are divided into a set of discrete tasks that can be delivered as well as (but more cheaply than) by expensively trained doctors. The second reason is to make it possible to reduce junior doctors’ working hours (the 1993 ‘new deal’). The third, bearing in mind the caveats discussed in the preceding chapter, has to do with nursing’s own professionalization strategy. This has involved, amongst other factors, the adoption of systematic and distinct nursing models of care, the move of nursing training into the higher education sector with a concomitant widening of nursing’s theoretical knowledge base, and the subsequent development of ‘knowledgeable doers’.
These developments point to the historical dependence of the medical profession upon state forms of health care delivery. Utilising Gramsci's conception of ideological hegemony (discussed in detail in Section 2.5), the restructuring of the functions of the state which have occurred in the late modern period can be seen to reflect changes within the 'historical bloc' and the associated balance of material forces. This has meant that the need to reproduce particular ideological forms disappears. In this late modern period, the post-war form of the state in the shape of an ideology of state welfarism could be said to constitute one such example. And with this has gone the form of the paternalistic and altruistic doctor, to be replaced by more consumer-friendly health care practitioners. Whether there are signs of an ending of the traditional hegemonic role of the doctor at the micro level, to be replaced by a more patient-centred role for the nurse in care delivery, is something which is explored in the nurse focus group discussions, the results of which are set out in the data analysis (Section 4).
2.3 Professional Identity, the Organisation of Work, and the Question of Gender

If ideology is conceptualised as arising within material practice, then it becomes necessary to think about the understandings and meanings of practice present in the discourses of nurses, within the theoretical context of the literature concerned with the relationship between work and social and personal identity. This is not to ignore the centrality of class as a social relational product of the process of capitalist production but rather to acknowledge the influences of organisational processes and structures, together with their associated work cultures. Here, conceptions of what constitutes professional practice will be examined in detail, exploring why it is that the notion of the ‘professional’ has become such a central leitmotif of modern nursing. Both in terms of nursing’s development being seen as tied to the expansion and power of the medical profession and in relation to its own active pursuance of an occupational authority and autonomy within the health care system.

The objective of this chapter is to explore the ways in which occupational identities become established. For nurses, this identity is often implicitly tied to gender, and as such it has been seen to act as a barrier to the development of nursing as an autonomous profession. The overall aim is to achieve a sufficient depth of theoretical understanding to make it possible to address and contextualise the following questions later in the data analysis:

- To what extent do nurses in practice attach themselves to a distinct nursing identity?
- Do nurses recognise any contradictions between the claim to professional autonomy and nursing’s actual (subjugated) role within the state health care system?
- Do (female) nurses overtly recognise any specific gender-related qualities that they bring to their practice?
• Is it possible to identify a defined set of shared social and cultural ‘dispositions’ which shape nurses’ interactions with other health care professions as well as with patients?

2.3.1 Social stratification and the professions in the context of a changing structure and organisation of work

Esping-Andersen has asserted that, “orthodox class theory is nested in an institutionally naked world” (1994:121). Given the focus of the present thesis, the discussion of the identities and beliefs held by nurses and indeed the very occupation of nursing itself have to be contextualised both in terms of class analysis and in terms of an understanding of organisational processes. Indeed, the shifting nature of what it is to be a ‘profession’ and the striving towards occupational professionalisation evident in the recent history of nursing only really make sense in the context of the changing structure and institutional pattern of work that emerged in the latter part of the twentieth century. As Savage has argued, the institutions in which people work, coupled with the organisation of work itself, have formed the largely unacknowledged basis of class analysis: "...(O)rganisations are both a cause and an outcome of class relations (which) encode and embody cultures of class" (Savage:2000;122).

There are exceptions to this general statement, of course, one example being the Weberian tradition of class analysis, which focused attention on bureaucratic structures as the ‘ideal-type’ of modern organisation. However, these were bureaucracies that lacked any sort of historical specificity. Bureaucracy was a ‘given’ in Weber’s understanding of class and status. Goldthorpe (1980) developed this notion of bureaucracy as being a foundation of class with his notion of the ‘service relationship’. This was the bureaucratic basis out of which a ‘service class’ of managers and professionals was said to have emerged; a fusing together of capitalist productive and bureaucratic processes. As Savage argues, these Weberian accounts of bureaucracy were used as ‘a hook on which to hang an account of class’ (2000:124). The fact that these bureaucratic ideal types of organisation are now very much part of history rather undermines this particular attempt to make the link between
organisational structure and class.

Many sociological assessments of the emergence and power of the professions do not acknowledge the importance of organisations and their structures in this process. Here again, the Weberian tradition has been influential in two major ways. First, it tied the professions into a model of social stratification that sees these occupational groups as operating within both economic and social orders. The labour market experiences of professionals (i.e. their relative income levels, job security, etc.) are dependent upon the level of demand for their knowledge and skills as well as by the level of concentration of those skills within the profession, as compared to the rest of the labour force. This focus on the demands of the capitalist labour market is important, given the way in which the professions are analysed within other sociological traditions, such as symbolic interactionism and Foucauldian-inspired post-structuralism, as existing outside any notion of class structure. Second, the greater emphasis placed upon social action than upon structure in Weberian analyses of social processes has led directly to the development of the influential notion of the 'professionalization' strategy or project. This Weberian 'ideal-type' is employed to conceptualise a particular occupation's pursuit of both economic and social interests and its subsequent strategy of 'social closure'.

Friedson's work (1970) is a prime example of the use of this form of action-orientated analysis, applied to the development of one profession. Interestingly, however, it contains no explicit reference to Weber's work on social stratification, although this may well reflect Friedson's background in the Chicago School of interactionist sociology (Macdonald:1995:28). As discussed above, Friedson sought to move beyond the then current functionalist orthodoxy concerning the role of professional groups within a rule-bound organic society, as well as beyond the socially functional 'traits' approach informed by Durkheim's notion of professional ethics. Friedson was concerned primarily with the day-to-day world of the medical profession which, whilst employing such abstract professional principles at some ideological level, was in practice actively engaged in the process of maintaining and developing its power and autonomy. This 'power approach', as it was subsequently called, soon became the orthodoxy in sociological analyses of the professions (MacDonald:1995:5).
Larson’s (1977) equally influential conceptualization of the professions builds upon the work of Friedson in the emphasis given to professionalisation strategies, whilst explicitly incorporating a Weberian framework of social stratification. Larson also introduces some insights taken from Gramsci’s work in relation to the apparent ‘detachment’ of professionals from the class system of power and exploitation. Larson sets out four essential features of the processes that have brought prestige and power to professions. First, he says, their distinctive autonomy is dependent upon the power of the state and those state elites which ‘sponsor’ them. Second, the normative features associated with professions are not fixed characteristics but are used to set the boundaries of membership. Third, drawing on Friedson’s analysis, once autonomy has been achieved the task is then to build a position of prestige independent of the original sponsoring elite in order to occupy a distinctive place in the system of social stratification. Fourth, an ideology is produced which builds on the normative aspects in order to construct social reality within the areas where the profession functions. Larson seeks to emphasise the social mobility and market control of professions, not as a straightforward reflection of skills, expertise, and ethical standards but as the outcome of this ‘professional project’. Here, specific collective goals and strategies are actively pursued by a given occupational group (Larson:1977:6). This Weberian-inspired account of the process of professionalisation points to the connection between labour market structures which provide secure institutional arrangements, and the demand for the specific forms of knowledge possessed by professional groups. Professional knowledge is thus able to achieve a level of legitimacy that allows it to define clients’ problems in ways which require professional practice to solve them (Martin:1998:667).

There are alternative sociologies of the professions, namely the approaches influenced by various readings of Marx and by the work of Foucault. Marxist-informed analyses of professions are rather thin on the ground, this should not be too surprising, given Marxism’s emphasis on class analysis. Such approaches have tended to focus on two areas of explanation. The first of these is the integration of the processes of professionalisation and state formation, and here Johnson’s (1980) historical account is particularly influential. Johnson’s position is that the state was actively instrumental in the development of the professions in the nineteenth century and that there was a trade-off between the professions (e.g. medicine) providing a service for the state and
the latter in return extending the professions’ influence and increasing their membership. The second is the ‘labour process’ approach, which was influenced by the work of Braverman (1974). Braverman sought to analyse the changing role of the professions in terms of wider changes to the labour market, and here the processes of ‘de-skilling’ and ‘proletarianisation’ were seen to be increasingly applicable to the work of the professions. Foucauldian approaches on the other hand tend to emphasise the interpretative role of the professions and the associated expert discourse, which generate particular standards of normality justifying disciplinary power. However, this power is seen as diffuse and contingent, and the later works of Foucault also discuss resistance to this power-discourse (Rabinow:1984)

More recently, the sociological literature has become much less concerned with the power of collective groups such as professionals and more with those social processes said to be associated with ‘reflexive individualisation’. Savage’s (2000) work, for example, does not dismiss the continuing importance of certain class-cultural ‘internalizations’ (his work incorporates Bourdieu’s notion of the ‘class habitus’) but argues for a sociological focus on group goals and strategies. This approach is seen as capable of accounting for the diminishing of the traditional autonomy of professionals, which is deemed no longer applicable in today’s world of work with its new modes of non-hierarchical organisation. The concern here is thus less with the ‘professions’ than with the contemporary position of the ‘middle classes’. Savage employs the notion of the ‘career’ as a way of historically linking conceptions of individual development with ‘structured (job) mobility’ as well as with organisational processes. Until the 1960s, careers were associated with certain ascribed characteristics, as well as with movements ‘through the life course’. One outcome of this process was the concept of ‘women only’ careers. However, the argument goes that with the trends of the 1980s and 1990s towards greater organisational restructuring and with it the development of core and peripheral workers, there has been a ‘de-coupling of the career from its anchorage in bureaucratic hierarchies’. This process is seen to have led to the diminution of the ‘service class’ and an ‘individualizing’ of the career (Savage:2000:139-140). On this point of individualizing, Bourdieu’s notion of class habitus is utilised in the argument that people’s implicit assumptions about what constitutes a ‘good’ career now play a key role in leading them onto particular career paths (2000:142). Savage’s argument could
be applied to the postwar history of recruitment to both nursing and teaching in terms of these being seen as ‘good careers’ for young women drawn from skilled working class and ‘lower’ middle class families. In other words, these were the best they could aspire to, at least until the expansion of university education in the 1980s.

However, applying Savage’s assessment to the ‘careers’ of health professionals such as nurses gives rise to a number of potential problems. This relates to the way in which he pushes the notion of the ‘individualized’ middle class career to the point where an occupation becomes a ‘project of the self’. Structural and organisational constraints on career development seemingly become less ‘foundational’ in his analysis of the present day situation, where ‘game playing’ as a career strategy is said to be widespread, and the internalization of ‘career values’ no longer holds true:

“This shift represents a new way of linking individuals and hierarchies. As individuals pursue their project of the self they are able to draw upon those around them, including those ‘above and ‘below’ them, as resources to help them pursue their tactical moves” (Savage:2000:144).

Implicit in Savage’s argument is the assumption that within less than a generation there has been a fundamental shift in attitudes regarding the place of work and career in an individual’s sense of self-identity and by extension in that of social groups. If this analysis appears almost postmodernist in its universalising about the disintegration of social barriers, and for that matter notions of occupational groups and their identity, then it may be seen as a reflection of the breaking down of ‘traditional’ sociological models of professionals and professional labour markets. These latter models certainly do appear to conform much less to the reality of professionals’ work and career experiences, whilst professionalism as a strategy for maintaining labour market position and advancing occupational interests now has to contend with “... a range of challenges and limitations, most notably growing competition, shifting market emphasis towards purely technical expertise, and outbreaks of scepticism about the efficacy of professional knowledge” (Martin:1998:661). All these challenges certainly have resonance in relation to the contemporary position of the medical profession, and they may explain the opportunities now available to nursing to improve its market position in the health care system.
2.3.2 Professionalism and Identity: subjectivity verses individualisation?

This section will explore the link between occupation as a referent of class position and as a determinant of individual identity. The specific concern is the question whether social identity is a phenomenon which operates at some pre-reflexive internalized level, as per Bourdieu's notion of habitus, or is it formed through socialisation processes occurring at the level of the workplace or institution? That is, does identity have anything to do with the everyday experience of working in an occupation deemed to be a 'profession', other than in the most rudimentary sense of determining the type of occupation a person is likely to gravitate towards. Or do occupational cultures, and specifically the ideology of professionalisation, directly shape the identities of social agents such as nurses? This question therefore reflects the traditional sociological dualism of structure versus agency.

Until the late 1960s, the sociology of the professions continued to be dominated by a functionalist assessment of professional roles which was in large part influenced by Durkheim's notion of the 'professional association' and the personal service ethic. This was the idea that division of labour and occupational groups formed the moral basis of modern society and that the professions in particular embodied a set of normative ethical values which Durkheim believed gave them a moral authority. The clear implication is that individual professionals somehow embodied these virtues in their everyday practice and that therefore there was an individual identification with these values. However, this professional 'traits' approach was largely abandoned with the recognition that such authority derived less from establishing an ethical high ground and more from a collective pursuit of power, the 'professionalisation project' discussed above.

Wilmott's (1990) 'materialist theory of subjectivity' focuses on the symbolic aspects of people's existence and the central role played by work in the formation of identities. This approach reflects the attempt to revitalise 'labour process theory' which had become bogged down in discussions around the efficaciousness of Braverman's (1974) de-skilling thesis (discussed above). Wilmott's recognition of symbolic identities does not deny the essential subjugation and exploitation of labour power (in the form of wage labour) within capitalist relations of commodity
production. Rather, this position seeks to develop Marx’s dialectical understanding of the way in which individual and social development occurs through the application of human capabilities or 'senses' in the act of production. Nevertheless, the formation of self-identity through labour is seen to reflect the ideological contradictions of the exploitative relations of capitalist production:

"In a way which parallels the fetishism of commodities, where the social characteristics of human labour take on the appearance of 'objective characteristics of the products of labour themselves' (Marx: Capital Vol 1), the fetishism of identity disregards the social processes through which identity formation and reproduction are accomplished" (Willmott: 1990:355 - emphasis in original).

Whilst the formation of such 'fetishised' identities may well have the effect of subjugating individuals, it does not then follow (as some have mistakenly accused Marx of implying) that individuals have an instrumental view of their 'labour power' as purely a means of acquiring the means of subsistence. This would be to ignore the valued, symbolic aspects of occupational identity which people will both defend and seek to enhance; even though, following Marx, it is against their class interest to do so. All this is by way of making the point that, whilst the Weberian action-orientated approach may be compelling in accounting for the professionalisation strategies adopted by occupational groups such as nursing, the contradictions inherent in the class relationship of work and production necessarily bring social structure back into an account of social actors’ occupational roles and identities. The so-called 'service ethic' adopted by public sector occupations such as nursing and social work sits uncomfortably with the realities of such work, which is generally characterised by poor financial rewards, less than satisfactory working conditions, and rigid hierarchies. However, as will be discussed below, such a service-orientated identity is often freely adopted by nurses, and this may be cited as an example of both altruistic behaviour and occupational identity fetishism. As Willmott has argued (in contradistinction to the position of Savage discussed above), the individualised 'career' is not some new social phenomenon. The ultimately 'self-defeating' search for security in a coherent identity has long been encouraged and sponsored through the 'individualised institution' known as the 'career' in the capitalist mode of production. This is an individualising strategy which only succeeds in reproducing the power of others (Willmott: 1990:369).
From a different epistemological position, the work of Bourdieu has been of particular influence in studies of the relationship between class and identity. For Bourdieu (1990), culture is seen as a ‘field’ in which class relations operate but which is not itself a product of socio-economic class relations. Bourdieu’s concerns were with the social character of individualisation and with the socially constructed ways in which individuals distinguish themselves or put distance between themselves and others as a result of occupying a different class ‘habitus’ that produces different cultural ‘dispositions’. However, these internalised social distinctions may not always be apparent to the individuals themselves, manifesting themselves in a lack of class awareness, something that is often demonstrated in social attitudinal surveys. Bourdieu does not see class cultures as collectively uniting people but as something with the potential to mark individuals out because of their taste, demeanour, etc. In this sense, class is something to be denied. Bourdieu’s (1990) argument is that, whilst class continues to be a powerful factor in the formation of identity, a habitus produces forms of individuality but does not necessarily produce values held in common by members of some specific socio-economic occupational class. Savage has attempted to apply at least elements of Bourdieu’s analysis to the ‘British context’, concluding that: “Professional identities are the most salient of any contemporary class-like identifier. People voluntarily identify as being ‘professionals’, or espouse the idea that people should act ‘professionally’” (2000:157). Nevertheless, for Savage, the continuing importance of the notion of ‘professionalism’ is less about the importance of cultural and social hierarchical structures (as it is for Bourdieu) than about a notion of the self as engaging in a form of reflexive individualism. The latter is a conception that also appears in the work of both Giddens and Beck.

Martin (1998) has also sought to develop the notion of identity in relation to ‘new middle class’ groups. Like Savage (2000), he argues that the traditional model of the ‘professionalisation project’ is much less applicable in a more unstable (neo-liberal) labour market for middle class skills and knowledge. He rejects the idea of identity in relation to occupation as formed through a collective set of norms, arising in the case of professionals out of a sense of ‘vocation’ and commitment to a ‘collegial community’. Martin argues that, for the ‘new middle classes’ (following Savage:2000), identity is built upon a personal reflexive project. Here, Martin utilises
a 'narrative approach' when defining the concept of identity, which includes ongoing individual accomplishments or 'autobiographical narrative', in combination with wider 'public narratives' connected to 'cultural and institutional formations'. Martin's understanding of social identity reflects something of Bourdieu's notion of class habitus in that, generally speaking, much of the social action we engage in is seen to be 'habituated', with identity not essential for all social action. However, identities are ultimately fundamental to action because they provide "...both the reference point for evaluation of action when reasons for action are sought, and the emotional source of motivations for new forms of action" (Martin:1998:669). In particular, identities are seen to provide the crucial link between types of knowledge and labour market structures. They act to 'guide' and motivate the new middle class groups in developing the distinctiveness of their particular types of knowledge and skills. The approach adopted is thus a kind of individualised 'social action' that is used to explain how, when faced by a changing labour market and demands for new patterns of working, these new middle class groups have been able to respond by drawing upon a particular set of 'meta norms'. These are not shared norms or identities but a sharing of values concerning the importance of the 'project of self formation' and associated forms of knowledge, and they are mobilised in order to modify the institutional demands of the labour market.

This approach shares some of the limitations identified in relation to Savage's (2000) work. First, it plays down the existence of very real structural limitations to modifying institutions. Second, it does not satisfactorily explain why collective occupational socialisation has ceased to be significant in the formation of social identities. That is, the collective character that marked the developmental model for the traditional professional groups is somehow no longer applicable (significantly, the example of a new middle class 'profession' cited is that of IT consultant). Third, it does not discuss whether an individual's pre-employment 'identity narrative' or 'project of the self' (the influence of Giddens is acknowledged by the author) is at all determinate in the type of occupation that is ultimately taken up, as it is for example in the work of Bourdieu. Nevertheless, the work of both Savage (2000) and Martin (1998) seeks to examine the ways in which middle class occupations are responding to changing institutional demands upon traditional middle class professional knowledge and ways of working. Utilising an analysis based around the 'micro-foundations' of class and
employing the notion of identity (although this is over-individualised), this approach does potentially offer one way of exploring the ways in which nurses have responded to the changing institutional demands and (internal) labour market of the NHS. Nursing certainly does not appear to correspond to Martin’s notion of an emerging new middle class group or fit in with Savage’s notion of the individualised ‘career’. However, unlike medicine, nursing is not a traditional profession and thus certainly requires an analytical approach that goes beyond traditional professionalisation models.

The question of whether a relationship continues to exist between an occupational identity and a particular notion of public service, if discussed purely in terms of a Durkheimeian set of professional ethics involving a shared altruism, is probably no longer of contemporary relevance. However, if notions of ‘public service’ are seen in terms of an occupational commitment to the acquiring of ‘people-centred skills’, then this form of ‘emotional work’, as it has been termed (James:1989), and the ways in which it becomes embedded in organisational and professional relationships may well continue to be relevant to an understanding of professional and occupational identities. This particular approach has been widely adopted in discussions of the work and identity of the ‘caring professions’, such as nursing and social work.

2.3.3 The Notion of the Gendered Occupation:

The work of Hochschild (1983) is concerned with the attempt to link ‘emotion work, feeling rules, and social structure’. Carrying out ‘emotional labour’ involves the management of feelings in such a way that they become appropriate to a particular social situation, for example an air stewardess’s encounter with a passenger (the specific subject of Hochschild’s original research) or giving health advice to a patient in order to produce the desired response from that person. An even simpler way of characterising this concept would be to describe it as emotion management regulated by the labour process. Hochschild identified the occupations requiring such emotional labour as those that involve face-to-face contact with the public or require the worker to produce an emotional state in another person (e.g. gratitude or fear). This enables
the employer, through training and supervision, to exercise control over the emotional activities of employees (1983:147).

The way in which the concept of emotional labour is linked to the practice of individual employees begins with the notion of the 'gift exchange' (Hochschild:1983:76). The use of this expression by Hochschild is a reference to the social process by which social actors who care for somebody special, or who find themselves in a situation which is in some way special, may then put an extra effort into their emotion management as a form of 'paying respect with feeling', i.e. as a gift. Hochschild argues that in certain types of service occupation such everyday social 'gestures of exchange' can become commodified, that is, they become an aspect of saleable labour power. However, Hochschild does recognise that there are different 'degrees of control' exercised by employers over employees. So that if an air stewardess, for example, is not whole-heartedly smiley and helpful to passengers, and if she is not prepared to play the game of treating each passenger as being in some way special, then she may lose her job. In relation to work within not-for-profit institutions, such as the NHS, nurses would be expected to identify with and present themselves in such a way that does not undermine their professional role. However, they do have the relative autonomy to offer patients in their care extra emotional work as a 'gift' rather than as an occupational requirement (Bolton:2000:582).

Implicit in Hochschild's (1983) work, and explicit in others (James:1989; Stacey:1988), is the gendered nature of emotion work, whether it occurs within the home, in a hospital, or in an airliner. This leads back to the question: why is it that women predominate in these type of occupation? Clearly, there are different theoretical approaches to explaining the existence of a gendered division of labour. However, both feminist and Marxist accounts would point to the impact of the development of the capitalist market economy and the associated process of industrialisation. Beyond that point there are important divergences, especially given that the epistemological basis of much feminist work is a conception of patriarchy and the patriarchal society.

However, feminist explanations which embrace the conception of what has been termed 'capitalist patriarchy' would see both capitalism and patriarchy as mutually

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dependent and self-reinforcing. This produces a situation where both men and women are exploited economically but with the addition that women are exploited politically as well as socially. Such an approach would interpret the fact that economic activity was taken away from the home and located in factories and mines as creating a class of predominantly male manual workers and consequently as marginalizing women's domestic activities. The development of new knowledge-based occupations such as medicine would be also seen as being problematic for the position of women in society: first, because men were able to monopolize these new knowledge-based occupations, being in a better social position initially to exploit the new market opportunities; second, because what might be regarded as exclusively female skills were removed from the home and placed on the market, thus depriving women of such activities and the status that went with them. Examples of this process are the ways in which women’s work concerned with health and healing was gradually drawn into occupational organisations already dominated by men, such as the evolving system of health care. Doctors were then able to exclude women through a process of social closure (as defined by Weber).

Witz’s (1992) work has developed this notion of social closure, using stratification studies to illustrate the operation of the medical professionalisation project within patriarchy and explain how membership of the professions became explicitly gendered in the second half of the nineteenth century. The consequences of these developments for women (Witz is less than specific about class differences among such women) wishing to enter the labour market were that very few occupational areas were left open to them. The only tasks available were those already socially defined as ‘women’s work’, since they involved the application of some aspect of feminine qualities’. These areas were typically health, caring, and childbirth. Therefore women were only able to establish themselves and set about the process of professionalization “...(in) the residual activities left by the male professions with their claims to a scientific or esoteric knowledge base” (Macdonald:1995;137). Subsequently, in caring professions such as nursing, the idea of practice (although essential to all professions) took on a special significance in that it began to be seen less as being based on a body of esoteric knowledge and as having more to do with supposedly ‘innate’ feminine qualities of intuition. Within nursing, such gender role stereotyping has contributed to an institutional socialisation process which has
resulted in nurses ‘making themselves invisible’ within the medical division of labour (Jolley and Brykcynska:1993).

However, it is now possible to argue that, to the extent that there are now more varied career opportunities available to women within society, it becomes probable that the need to fall back on socialised gendered stereotypes in order to support a professionalisation strategy such as has occurred within nursing will diminish, not least because of the numbers of men now entering nursing.

2.3.4 Realism: Structure and social identity

For Collier (1994), a critical realist approach to social theorising should seek to address not only social relations (as between social agents and social structures) but also ideas about such social relations. This is a position that recognises a stratified relationship between the operation of social structures and the action of social agents. This approach offers the potential for being able to postulate the continuing salience of social class as an abstraction of the relationship between the forces and relations of production. In the context of the theme of the present thesis, a critical realist analysis of social class position might point to the ways in which shared collective beliefs and social identities are produced and reproduced, as reflected in the practices of nurses. It would also assess the ways in which organisational processes impact differentially upon the work of occupational groups, for example the medical division of labour.

This approach opens up possibilities for moving beyond the more traditional sociological action-orientated versus structural determinate forms of analysis towards a model of reality which is able to appraise the formation and reproduction of nursing discourses by nurses as social agents, but in the context of the demands made upon them within a system of health care in structural transition. These demands can be seen as reflecting not only the changing organisational structures of the NHS but the wider shifts in public expectations concerning personal health and the responsibilities of the state in meeting the needs of consumers of health care services.
Lawson makes the point that, when examining social practices (the organisation of work, for example), we need to focus on the interconnections between human agency and social structures, asking ourselves in particular: “...how do they come together in such a manner that different agents achieve different responsibilities and obligations and thereby call on, or are conditioned in their actions by, different social rules and so structures of power?” (1997:164). In focusing upon the ‘internal relationality’ of social life, Lawson is moving beyond the perspective of an individual’s social identity being associated with membership of a particular profession towards a recognition that such relationality is less about individuals per se than about the ‘social position’ which they occupy. A social position (the point of contact between agency and structure) is associated with a set of rules or ‘generalised procedures of action’, which are in turn defined and determined in relation to other positions and their rules and practices. However, whilst such social rules govern and facilitate action, they cannot be reduced to or identified with such action (as for example within the functionalist perspective). This is because social rules can and are contested and mediated by human agents (1997:163). For Lawson, social positions form an internally related network that constitutes the ‘basic building block of society’:

“All the familiar social systems, collectivities and organisations - the economy, international and national companies, trades unions, households, schools and hospitals - can be recognised as depending upon, presupposing, or consisting in, internally related position-rule systems of this form” (Lawson:1997:165).

Here, a ‘collectivity’ or social group would consist in, or depend upon, a set of people distinguishable by their occupancy of a specific set of social positions (noting that any one individual can occupy a number of social positions at any one time, e.g. mother, nurse, woman, student, etc.). As Lawson goes on to argue; “...in this relational conception any specific collectivity can be understood in terms both of its relations to other groups, especially those against which it is defined and/or is oppressed, and of the complex of internal relationships within the collectivity itself” (1997:165). If nurses are thought of as such a collectivity, then we can think about the rules that govern the activities and practice of nursing as being structures which are both tied to its social position in relation to other positions, such as medicine or ‘new managerialism’ for example, and as emerging from within the profession itself as a
result of internal resistance to changes imposed from above. This then is one realist approach to the problem of synthesising human agency and social structure in accounting for social practices, for example of nurses as a collectivity positioned within institutions ('a relatively enduring social system') such as the NHS. Lawson presents us with a realist conception of a stratified society consisting of a network of internally related positions, rules, and practices. He recognises that human agents such as nurses draw upon social structure (social rules, ideological frameworks, organisational directives, etc.) which in turn is reproduced or transformed through *praxis* or 'human action taken in total' (1997:169).

Beyond the primarily economic concerns of Lawson, it is difficult to find a body of sociological research that is specifically informed by critical realism and certainly very little (if any) that specifically addresses the relationship between work, occupation, and social identity. However, of the literature so far examined, Bourdieu's conceptions of the 'habitus' and 'cultural capital' may have some potential for developing a relational understanding of the interconnection of agency and structure. Whilst Bourdieu's concepts are certainly useful in accounting for the spontaneous actions of individuals and as a critique of rational action models of human behaviour, they are less useful in accounting for the 'dispositions' or shared discourses of collective groups (such as nurses) who operate within large institutions with a distinct set of organisational values. This is because Bourdieu did not see cultural capital as a collectively shared set of values and beliefs but rather as an individually internalised set of behavioural mores. Class, for Bourdieu, is tied to an individual rather than to collective identity. Although Bourdieu neglected the role of occupational or work roles in structuring class, his conception of social distinction and cultural capital do have a potential for explaining the distinctions or social distance that are held to exist between social groups. And here it could be said that there is some potential common ground between Bourdieu's notion of the habitus and Lukác's duality of 'psychological consciousness' and ideologically 'ascribed class consciousness' (the latter is discussed in detail in Section 2.5.2 below). This has relevance for a stratified understanding of the hospital as institution, for example, where the products of different class habitus come into regular professional contact with one another, as is the case with doctors and nurses. This is of course to assume that there continues to be a difference in the social class background of people entering the medical profession.
as against those who take up nursing. In addition, a further application of Bourdieu's concept of habitus could, if it was modified or extended beyond his concerns with processes of individualisation, offer an explanation of the ways in which occupational 'cultures' become internalised through educational and organisational socialisation processes. This in turn produces a set of professional identities and distinctions that are manifest in the practices and responses of occupational groups such as nurses and doctors.

As alluded to at the beginning of this section, critical realism attaches particular importance to the ideas that are held about a social phenomenon as much as to the phenomenon itself. In the context of nursing work, it is arguable that what is meaningful for nurses are primarily those discourses associated with the identity of being and practising as a nurse. The articulation of this relationship between occupational identity and practice in the context of institutional change is where the critical realist process of 'retroduction' or synthesis begins. Focusing upon identity places the nurse as a social agent right at the centre of the analysis whilst also recognising the material forces that shape the demands on nursing within a late modern system of health care.

(These initial ideas about realism and identity will be developed in the later data analysis section, which attempts to construct a realist framework of analysis focusing upon nursing practice and discourse).

2.3.5 Concluding Comments:

The work of Bourdieu on class habitus and Willmott on fetishism, as reviewed in this chapter, would argue that occupational identity is an internalisation rooted in a set of common cultural or material experiences. Savage's notion of 'projects of the self', on the other hand, would see occupational identity as a 'reflexive' personal identification with the values associated with particular forms of work, whilst the discussion of 'emotional labour' in the context of nurses engaging in 'extra emotional work' in caring for their patients would point to an internalisation of a set of institutional values.
The problem with the type of analysis found in the work of Savage (2000) is that it emphasises individualisation whilst at the same time playing down the significance of institutional processes and the importance of career structures as well as occupational cultures in people's own experience of work. This approach arguably reflects the analytical dangers in reading social structural change through the postmodernist prism of the end of class-based identities. Whilst there may have been a 'recasting' of the service relationship in some industries and organisations over the past two decades, notions of public service and professional responsibilities (although sometimes misplaced) still exist amongst health professionals. Indeed, it arguably remains a major reason why people enter the occupation of nursing in the first place. In addition, institutional and structural hierarchies (or 'positions', as discussed in relation to the work of Lawson) continue to exist within and between occupational groups (including management professionals) within the NHS, and these represent significant boundaries to and limitations of personal initiative.
2.4 Governance, Risk, and the Shifting Ground of Health Care Provision in Late Modernity

This chapter is concerned to explore the shifting ground of the provision of state health care services within late modernity and the associated developments in governance which appear to be moving responsibility for health care from state institutions and health professions towards individuals and their families. In particular, there is a concern to explore the ways in which the literature has conceptualised these developments as symptomatic of a move towards 'postmodernity'.

The overall objective is to be able to establish, through a reading of the literature, the ways in which the macro-structural changes occurring over the last two decades within the organisation of health care in Britain, altering the nature of the health care relationship between nurses and their patients within the NHS. The aim is to achieve a sufficient depth of theoretical understanding to make it possible to address and contextualise the following questions later in the data analysis:

- Does the notion of health risk or 'risky health behaviour' constitute an important element of nurses’ own discourses of practice?

- What level of recognition, if any, is there by nurses that a shift has occurred in their traditional authority within the health care system over the management of patient needs?

- Do nurses feel less certain and confident about their patient interventions; in other words, are they more or less prepared to take 'risks'?

- To what extent do nurses perceive that public expectations of the health care administered within the NHS have increased over time, and does this in any way threaten their social status as health care professionals?
In what ways have nurses as health professionals responded to the changing organisational directives within the NHS, which require them to prioritise the needs of patients (as consumers of a public service) over their own professional concerns?

2.4.1 Autonomy, Responsibility, and the Quality of Life in a Post Modern World

Within the literature, postmodernity is typically seen to be an era marked by ambiguities and uncertainties, a lack of social consensus, and an 'end to politics'. A place where the formal reciprocal obligations that existed in modernity between state and citizen are now said to be fractured and breaking down. We are now said to be witnessing the end of the period in which the state plays a central regulatory role both in managing the market economy and in ensuring the welfare of its population, these things having ceased to be possible in a globalized economy. Such social and economic processes are said to be reflected in the widespread search for self-identity through self-reflexivity; as represented for example by Giddens's (1991) notion of 'ontological insecurity'. The process can be described as a disintegration of what might be termed 'the social' rather than as a collapse of modern society as such. Here, the concept of 'the social' would be defined in terms of that cohesion and solidity that characterised modernity from the late nineteenth century onwards. The 'social', as Donzelot has argued:

"...is not society understood as the set of material and moral conditions...(but) rather the set of means which allow social life to escape material pressures and politico-moral uncertainties; the entire range of methods which make the members of society relatively safe from the effects of economic fluctuations by providing a certain security" (Donzelot:1980:xxvi; cited in Smart:1983).

These 'methods' clearly include the measures directed by the state at the welfare and health of the population. In modernity, it is asserted, politics has progressively been reduced to a 'technical question of social management' (Donzelot:1980:121). However, with this postmodernist shift in social theorising has come the assertion that
we are now facing the 'death of the social', i.e. a fundamental reconfiguration of the relationship between the state and the individual, subject and object.

The work of Bauman (1991; 1992a; 1992b; 1995) has been of particular influence in theorising the 'postmodern human condition' as being an essentially moral one. Bauman has argued that, before being told (authoritatively) what is 'good' and 'evil', we have ourselves faced the choice between good and evil in our very first encounter with the ‘Other’: “...we bear moral responsibilities (that is, responsibilities for the choice between good and evil) well before we are given or take up any concrete responsibility through contract, calculation of interests, or enlisting to a cause” (Bauman: 1995:2). Within modernity, Bauman sees the moral condition as being rationalised by the development of a legal-ethical code, giving the actor certainty about what was to be done and not done. Thus, ethical law is substituted for autonomous moral choice within modernity: “‘responsibility for the responsibility’ - that is the responsibility for deciding what practical steps the responsibility requires to be taken and what steps are not called for - has been shifted from the moral subject to supra-individual agencies now endowed with exclusive ethical authority” (Bauman: 1995:4). Responsibility is seen to be now no longer an undefined and vague dilemma for the moral self; it has been reduced to a ‘finite list of duties or obligations’.

In postmodern times, with the state ethical monopoly now much less significant, the 'tyranny of choice' is seen as having returned. However, actors are now not so much responsible for their moral choices as for their choice of ethical code from the many available. Postmodernity is seen to have preserved that which has been gained through modernity, individual autonomy unencumbered by personal obligations; responsibility without the strings attached to it. However, Bauman would contest the broad claim that with postmodernity comes real freedom, a world without the obligations and duties that were attached to what are now abandoned and discredited universals; he would dispute that it now no longer matters what principles or truths one embraces. He argues that it is precisely the fact that 'power-assisted universals' are no longer significant that makes the responsibilities of the actor more profound and more consequential than ever before. The consideration of the Other is now resurrected, after the 'obedience to the norm' within modernity (1995:6). Consequently, under the
postmodern condition the agent is not just an actor and decision-maker. This is because "...the performance of life functions demands also that the agent be a morally competent subject" (Bauman:1992b:203). The new ethical issue that now arises is whether the better-off within society can rise above their personal interests in a concern for the Other. This view of postmodern morality, then, recognises a rejection of any ‘politics of principle’ (what Gillian Rose has termed the ‘new ethics’) whilst concluding that this does not necessarily result in a better world:

"New ethics cares for ‘the Other’; but since it refuses any relation to law, it maybe merciful, but, equally, it maybe merciless. In either case, having renounced principles and intentions, new ethics displays ‘the best intentions’ - the intention to get things right this time" (Rose.G:1993:6; cited in Bauman:1995).

Bauman identifies the ‘quality of life’ discourse as a critique of daily (modern) life and as a ‘postmodern life strategy’. This is for two reasons: first, because it represents a standard for a future that offers more than merely ‘surviving’ in modern capitalist society, although, as Beck (1992) points out, the latter concern has now reappeared in a different guise as a problem of assessing and confronting risks created by science in ‘fulfilling’ the goal of ensuring survival; second, because as a goal ‘quality of life’, unlike the struggle for ‘survival’, has no finality. This is precisely because there are no fixed measures for achieving or ascertaining ‘perfection’; the goal of quality of life is ‘intrinsically open-ended’. It is the ability to keep options open, the requirement to set ever-new goals, which Bauman sees as coming closest to the popular image of the good life. This goal is seen as being, "...in tune with the essential contingency, episodicity and fragmented, ‘non-systemic’ character of postmodern existence" (1995:79). The essential feature of the quality of life discourse for Bauman is its changeability, its existence as an ‘image’, images which are said to be "...resistant to universalization" (1995:80). It is precisely this lack of the concrete that makes such a discourse so incompatible with modernity, yet intriguingly Bauman identifies a classic figure of modernity, ‘the expert’, as playing a crucial role in alleviating, if only for a short while, the ambivalence of postmodern life: '"We need them [i.e. experts] above all as authority: as someone we can trust because everybody trusts them, so that when accepting their advice we may be less tormented with doubts or guilty feelings than when we act on our own responsibility" (1995:80 - emphasis in original).
A fundamental consequence of the emergence of postmodern society, as identified by Bauman, is the collapse of the ‘patronage state’, which in modernity had become the ‘monopolistic source of needs-satisfaction, social status and self-esteem’. However, “…under postmodern conditions, when the exhilarating experience of ever-new needs rather than the satisfaction of extant ones becomes the main measure of a happy life…(the patronage state) cannot stand competition with systems operated by the consumer market” (Bauman: 1991:278). This is the process that Bauman describes as the rejection of the ‘politics of principle’, and, given that the traditional postwar welfare state represents a form of principled politics, it too must become in some way redundant. The welfare of the individual (in the widest sense) which in modernity was perceived to be a ‘social right’, becomes in the postmodern era once more the responsibility of the actor. If this responsibility is not taken up, or if the individual consequences of the ‘consumption’ of a particular lifestyle are not foreseen, then maybe others will consider it their moral responsibility to give the individual further opportunities to make alternative choices; or maybe they will not!. As Bauman puts it, “No more state-managed and institutionally supplied services for those who seek escape from the under-determination, unclarity and uncertainty of being” (1995:113).

In coming to grips with what constitutes ‘health’ in postmodernity, Bauman starts from the position that it is this ‘fear of under-determination’, of uncertainty, that drives the individual to self-assertion and the project of self-formation: “Defeat or inconclusiveness of victory in the never-ending battle of self-formation rebounds as the pain of inadequacy - now replacing deviation as the most feared penalty for individual failure” (1995:113). There is no longer the Foucauldian panopticon of medical surveillance to coerce and reassure both at the same time; now it is a question of individual responsibility and making the right choices in a consumer market. This is a ‘role’ that Bauman has described as that of ‘sensations-gatherer’. This view of health or ‘fitness’ as the ‘capacity to consume’ involves a postmodernist notion of the ‘consuming body’ very different from modernist constructs concerned with, for example, the measurable adequacy of individual calorific intake.

Bauman also recognises that postmodernity is just as guilty as modernity in creating its own set of ‘utopias’. These include the ‘healing capacity of the free market’ and the ‘technological fix’ available for the social, political, or moral problems of society.
But these utopias are seen as ‘anarchistic’; “(T)hey envisage a world with rights, without duties, and above all without rulers...” (1995:27). This is because postmodernity requires a ‘deregulating’ of the state and its assumption of a collective responsibility for ensuring that all citizens achieve their maximum potential; it ‘celebrates’ an end to these ideals, including a notion of ethics and justice, as an ‘act of emancipation’. However, Bauman concludes that this does not mean a world without morality, because by removing the boundaries of ethical legislation a new morality of ‘inter-human togetherness’ can emerge (1995:37). The ‘reality of the moral self and moral responsibility’ can now be faced openly as they emerge from the ‘life experience’ of ‘irredeemable ambivalence’ (Bauman:1995:43). But as May (1998) notes, this approach has much in common with Rorty’s (1989) ideal of universal solidarity as a regulative ideal in the discussion of what to do about those marginalised and dependent social groups that will not go away in postmodernity or any other era. As May argues, Bauman is as culpable as Rorty in attempting to create the notion of a human solidarity without acknowledging the commonalities (and differences) existing between people through work, behaviour, communication, etc.

At this point it is worth reflecting further upon some of the criticisms levelled at this ideal-type analytical approach that is adopted by Bauman in contrasting ‘modern’ and ‘postmodern’. As Kellner (1998) argues, this presentation of modernity primarily in negative and repressive terms (an approach that Bauman shares with Foucault) is open to the accusation of reductionism. According to Kellner, Bauman utilises paradigms of modernity and postmodernity that are both ‘essentialised and totalised’. Modernity is reduced to a single discourse of rationality, order and certainty:

“...too focused on the condition of knowledge and the role of the intellectual as definitive of modernity, neglecting its socioeconomic, institutional, structural, and material determinants” (Kellner:1998:77).

However, Kellner does acknowledge that Bauman’s ‘failure’ to analyse in any sociological depth the features that constitute postmodern society reflects the fact that, for him, postmodernity is primarily a change in ‘mind-set’, a new set of intellectual and moral ideals. Consequently, his concern is to establish a ‘sociological hermeneutics’ which can trace the “…continuous and changing aspects of life
strategies...back to the social figurations they serve - and forward, to the patterns of daily life in which they find expression" (Bauman:1992a:10). Writers such as Baudrillard and Jameson argue primarily that postmodernity is a new historical and social 'constellation' that has generated a new form of economy, society, and culture.

In relation to Bauman’s use of the ‘patronage state’, one of the problems with this is that his analysis is essentially limited to the collapse of the former Stalinist states of Eastern Europe and the immediate social aftermath (this is of direct personal and analytical interest to Bauman). A central feature of postmodernist analysis (which also applies to theoreticians of the postmodern condition) is the generally high level of theoretical generalisation and disregard of the local and the particular. Bauman is no exception: when he talks about the collapse of the patronage state he means ‘globally’, not locally. However, even a cursory analysis of recent developments within developed societies recognises an expanding and increasingly centralising and prescriptive role for the State.

2.4.2 Governmentality & Welfare: A Foucauldian theorisation of the regulatory relationship between State and Individual

A Foucauldian reading of power plays down its repressive functions, preferring to see power relations as being diffuse:

"Power must be analysed as something which circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody’s hands, never appropriated as a commodity or piece of wealth" (Foucault:1980:98).

Foucault utilises a conception of governmentality which focuses attention on the ways in which power is present at all levels of society, serving to regulate the activities of the population. The conception of the state as a repressive authority acting in the interests of a dominant group or indeed as acting to maximize its own power is rejected. What emerges in Foucault’s work is a view of the historical attempt by the modern state to regulate the health of the population as being deeply problematic, not least because of the highly indeterminate nature of health per se. As it appears in the
work of Foucault, the notion of ‘governmentality’ is one that is intimately bound up with the analytical troika of power, knowledge, and discipline.

Governmentality or the ‘art of government’, as it emerged in the eighteenth century, was a new system of power which articulated a triangular relationship between sovereignty, discipline, and government targeted at the regulation and control of populations (Smart: 1983). This embryonic form of the modern administrative state is seen by Foucault as the outcome of a debate conducted in the sixteenth and seventeenth centuries about the relationship that existed between those who are governed and those who are govern. This historic ‘problematic’ of government was seen on the one hand as being equivalent to the exercise of power by a sovereign ruler over a territory, in which people are submitted to the authority of a rule of law synonymous with this sovereign rule. On the other hand, the alternative was government as an art, independent of the interests of a sovereign ruler and based on rationality. The object of this art of government was the management and realisation of the ends of those subject to government, “...the focus of concern is the relationship between people and things; human relationships; wealth and resources; ways of living; and the contingencies to which the human condition is exposed” (Smart: 1983:117). The ‘solution’ was the form of the modern state, realised as a consequence of the emergence of what Foucault termed the ‘phenomenon of population’; the massive demographic expansion within Western Europe in the eighteenth century.

Foucault likened governmentality “…to a form of surveillance, of control which is as watchful as that of the head of a family over his household and his goods” (1979:10). This form of governmentality, as it operated in the early modern period, is seen by Foucault as resolving the problematisation of the relation between state and population by treating the welfare of society as being identical to the welfare of the state itself.

His concept of governmentality is thus concerned with practices rather than institutions, with ‘statecraft’ or the ‘space of government’ rather than the formal workings of state institutions. Foucault’s concept is less concerned with the law than with the way in which norms and styles of government become established.
Therefore, it is not possible to talk about a specific policy directed at 'health'; one must focus upon the ways in which a range of 'variables' seen as being necessary for the health of the state are regulated - "Health policy, here, was not really distinct from policy per se. This is because in a sense all policy is related to health, in so far as the health of the population is considered a value" (Osborne: 1997:177-8).

There has been an attempt in more recent times to re-work Foucault's conceptual framework of governmentality in order to theoretically contextualise the changing relationship of state and individual in 'neo-liberal' political and economic regimes. Garland, for example, argues that:

"The point of Foucault's genealogical approach was to make it possible to view such facts in a critical, historical perspective. It also happens that concepts such as 'action-at-a-distance', 'governing through freedom' and 'the active subject of power' are particularly apposite for the analysis of neo-liberal policies which are explicitly designed to maximise entrepreneurial activity, to empower the consumer and to replace state or professional governance with market mechanisms" (Garland: 1997:183-4; cited in Culpitt: 1999:37).

Locating himself within such a Foucauldian perspective, Osborne (1997) has identified two 'rationalities' of governmentality with regard to health: the 'liberal' and the 'neo-liberal'. The 'liberal government of health' is characteristic of the early involvement of the state in the health of its population. In Britain, this corresponds to a period beginning at the end of the last century and lasting until the establishment of the postwar welfare state. Here, the state seeks to act only indirectly upon health by imposing techniques or 'apparatuses of security' which in some way regulate infrastructures (e.g. establishing public sewage and clean water supplies as well as state regulation of the emergent medical profession). Thus 'statecraft' or governmentality in the field of health is seen as reflecting the nineteenth century liberal conception of population as 'a natural domain', requiring not direct intervention but 'delicate sustenance'. The newly-emergent scientific-medical hegemony saw individual health as predominantly a biological state and therefore outside the regulatory remit of the state. This was the view that in itself policy could never deliver health as a 'right' for the population; "(h)ealth, good health, cannot derive from a right; good and bad health, however crude or subtle the criteria used, are facts" (Foucault: 1988: cited in Osborne: 1997:179). However, the need to move
beyond this limited regime of security in the field of health began to be recognised in the early twentieth century, and a form of ‘socialised medicine’ gradually emerged, culminating in the NHS. This, according to Osborne, reflected not a ‘discontinuity’ but an ‘expansion’ of the liberal strategy of the government of health (1997:184). In this period, the state system is seen to develop towards the point where the government is taking responsibility for the health of its citizens (equivalent to Marshall’s concept of health as a ‘social right’). Here, Osborne argues that the ‘logic’ of this political shift was eventually to take state health policy in Britain in one of two possible directions: beyond liberalism to a socialist service (not defined), or away from liberalism (as has been the case in Britain in the Thatcher years) towards a ‘neo-liberal government of health’.

Petersen’s work is also very concerned to exploit a Foucauldian notion of governmentality in a critical assessment of the present-day form of ‘neo-liberalism’. The latter he defines as being: “a form of rule which involves creating a sphere of freedom for subjects so that they are able to exercise a regulated autonomy” (1997:194). Expertise continues to play a crucial role in the governmentality of the population, but this ‘authority of expertise’ begins to become separated from the formal structures of government and is now located within the market and as such is subject to competition and consumer demand. It is thus incumbent upon the individual member of the population to “enter into his or her own self-governance through processes of endless self-examination, self-care and self-improvement” (1997:194). Here, the regulation of health is manifested through the emergence of a series of ‘surrogate values’ regarding an ‘ideal of health’. The direct role of government is limited to “constructing goals and targets in order to achieve strategically limited objectives...In response to the indeterminacy of health policy, neo-liberalism constructs the possibility of its strictly de-limited determination” (Osborne:1997;185). A good example of this approach would be the Conservative government’s Health of the Nation policy (1992), which set out five strictly limited target areas for public health at the same time as specifying a whole range of personal and parental responsibilities.

In summary, then, the Foucauldian notion of governmentality as it conceptualises the ‘power/knowledge’ relationship between state and population in the present day
(rather than at the point when the modern nation state first emerges) is centred upon localised, diffused, and covert sets of practices rather than upon any privileging of forms of state power. These practices are said to be the 'micro-technologies of power' present in the everyday activities of individuals; they are directed at the goals of self-fulfilment through self-regulation. Discipline and control are now bound up with the emergence of new forms of knowledge and are reflected in the contemporary processes of self-transformation and education, what Foucault (1986) describes in his later work as the 'technologies of the self'. Health, for example, can never be a direct outcome of citizenship, only an indirect one in that government can only ever provide the conditions under which all citizens have potentially equal chances for health. Governments cannot guarantee health as such, this being an essentially indeterminate or ‘elastic’ concept.

In assessing the political consequences of an ‘elastic’ notion of health, most Foucauldians would almost certainly reject any de facto accommodation to a radical right anti-state interventionist ideology, even though both positions do reach similar conclusions about the future role of government. Osborne (1997) argues that embracing an indeterminate notion of health also necessarily means rejecting the ‘neo-liberal’ political idea of health as being a duty of citizenship, whilst recognising and having a concern for the ‘normativity of life’. The latter refers to the capacity of society to impose constantly new norms, and acknowledging this requires ‘a modesty of approach’ in setting out the aims for any health policy. It also entails “a certain respect for the necessarily mediate or technological aspect of health policy” (Osbourne:1997:181 – emphasis in original). This would appear to mean that, with the rejection of a totalising ideal of health, the focus of any health care provision (rather than policy as such, which must always necessarily fail within this perspective) must be on the ways in which the available technology can meet a norm of health existing at any one time. In short, policy formation is here seen as technological determinism.

To conclude this section on the Foucauldian understanding of the changing relationship between the state and the individual, in the work of Osborne, for example, there is no specific discussion of the historical and political conjuncture that led to the formation of the NHS in postwar Britain. Thus, there is little acknowledgement of the role of human agency and politics in that formation. A number of other commentators
such as Smart (1983) have noted that, whilst the later Foucault appears to recognise that resistance to power is possible, there is often little or no discussion of how such resistance is manifested in the face of a seemingly omnipotent discursive power.

2.4.3 Risk in postmodernity: An end to state responsibility for and regulation of health?

Traditional forms of state welfarism are generally seen within the literature to be associated with the existence of those social structures concerned with the management of the consequences of living in a modern society. These unintended consequences (or 'externalities' as they have been termed) of the capitalist system of production were seen to be potentially amenable to a new system of governance that involved a 'social contract' between state and citizen. In the case of Britain in the early twentieth century, this process began with the Fabian-inspired 'social administration' approach, and developed into what is now known as 'welfare statism'. However, in the postmodern period there is the view (discussed above) that we now lack that certainty about our ability to manage such externalities in a 'post-industrial' global economy. The emergence and gradual dominance of a neo-liberal form of politics and its central concern with state deregulation have presaged a notion of 'risk' as being both global and individual and therefore beyond the control of any state or government. The 'proper' role of the state has thus become redefined as providing security and social protection for individual autonomy, not for individual welfare needs. In addition, the emergent phenomenon of 'risk management' has become "...institutionalised as an essential aspect of the residual duties of government. Accountability not responsibility...undergirds the neo-liberal patterning of governance" (Culpitt:1999:9). A consequent neo-liberal politicising of fear to make the case that these post-industrial risks are now outside the control of the state or society results in a perception that we all now have to accept that we must live with these risks; however (it is argued), they can be somehow managed if not resolved if as individuals we make the right choices.

The work of Habermas, whilst in no way endorsing any generalisations regarding fundamental changes in capitalist society, also recognises a crisis in welfare politics.
He identified a new 'contractualism' in welfare, a "completely altered relationship between autonomous and self-organised public spheres on the one hand, and subsystems steered by money and administrative power on the other." (1986:13-14).

Widespread contractualism evident in the project to reduce state involvement in welfare and the philosophy of accounting are now seen to have become 'commonsense'.

Beck (1992) utilises the notion of governmentality in relation to the changing role of the nation state within a global economic system characterised by a culture of risk and contingency. The consequence of unchecked scientific and industrial 'progress' has been the emergence of a set of risks and hazards that humanity has never previously faced. These are new dangers which can neither be limited in time nor held in check by national boundaries, nor indeed can anyone be held to be accountable for these hazards. Beck's 'risk culture' is one in which reflexivity results in a new awareness of risk on the part of all those who have directly benefited from industrialisation such that it threatens to 'overwhelm the project of modernity' (Higgs:1998:177). This reflexive modernism reflects the shift from ignorance or private fears about the unknown to a widespread knowledge about the world we have created. Within the 'risk society', knowledge of risks has "...become the motor of the self-politicisation of modernity" (1992:181).

'Reflexive modernity' essentially requires a critique of the ways in which science has been treated as virtually a religion in modern societies, as something that is beyond criticism (what Beck calls the 'culture of scientism'). And, given that physical risks are always created and effected within social systems, the primary risk we face, according to Beck, is a social dependency upon institutions and actors that are increasingly inaccessible and unaccountable to the majority affected by the risks in question. Examples of this process would include the nuclear industry, the food processing industry, car manufacturers, and not least the state through its health and social welfare policies. Another emergent outcome of the risk society is what can be termed the 'individualisation of politics'. As a consequence of this process, Beck argues that individuals must begin the process of actively shaping the events and conditions that they experience as a consequence of their own decisions; they must, actively shape their own biographies 'on pain of permanent disadvantage'. Culpitt
(1999) argues that Beck’s notion of risk establishes a new epistemology of change, one that moves beyond the predication of crises, revolutions, social transformations. Culpitt’s view is that risk is now so ubiquitous and anonymous that it ‘escapes’ from the best efforts of modernity to calculate it (1999:105).

Giddens (1991) adopts a somewhat similar approach to risk as the outcome of human interventions into the conditions of social life, but without the apocalyptic rupture with modernity that appears in Beck’s work. Giddens identifies what he terms the ‘manufactured uncertainty’ of high modernity, wherein we are no longer able to confidently predict risk but at the same time are also faced with a massive increase in choices, particularly as regards ‘lifestyles’. Here, risk ceases to be something that can be assessed actuarially; rather, it becomes a much more abstract notion. These developments serve to undermine the modern state’s political and ideological commitment to the collective administration of society and in particular to the social welfare of its citizens. For this is a commitment based upon the (collective) belief that it was possible to make rational judgements about the ‘social needs’ of citizens and the societal costs of meeting such welfare needs. Giddens (1994) has also argued that social relations in ‘high modernity’ do not now match these post-war ideological assumptions. Within a ‘reflexive modernity’, he argues, the project of the self (that need for ‘ontological security’) requires a new approach to welfare, something Giddens has termed ‘positive welfare’. Adopting this approach, risk becomes something which can be potentially beneficial if confronted by individuals themselves, taking personal responsibility, without relying upon the (nanny) state to provide security for them; ‘...the active challenge which generates self-actualisation’ (Giddens:1994:192). This more reflexive approach to ‘life-planning’ is said to require a trust in others, especially experts (Petersen:1997:191).

Significantly, Lash and Urry (1994) criticise the work of both Beck and Giddens on the grounds that they continue to adhere to modernist notions of science, the self, and society. They also argue that the work of these authors contains little acknowledgement of the ‘embodied’ nature of the self and that it is characterised by an essentially uncritical acceptance of the notion and value of ‘expertise’ or expert systems. Petersen expresses this limitation in the following way:

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"In the work of neither writer is the concept of the autonomous rational actor of modernist discourse opened to critical scrutiny. Their notion of reflexivity...is underpinned by a meta-narrative of progress and evolving self-consciousness" (1997:191).

The paradigm of postmodern change which employs as key constructs the notion of risk and surveillance became increasingly influential within the sociology of health and illness in the 1990s (Nettleton and Burrows:1998). However, this paradigm is conceptually inconsistent in its use of the notion of risk. There are those who veer more towards a Foucauldian reading of regulation and surveillance, particularly in relation to lifestyle and health behaviour. On the other hand, there are those analysts who, drawing upon the work of Beck and Giddens, choose to focus more upon the essentially individualised processes of self-reflexivity which somehow broadens out into a public unease with and uncertainty about traditional state forms of health and welfare provision. However, probably the most common use of the notion of risk as it appears within health research is in its actuarial form. This is the technique known as 'risk factor analysis' which has as its concern the statistical measurement and assessment of 'health risks'. This information is then used to inform managerial decision-making in the re-shaping of health interventions. One consequence of this particular usage of risk is, from a Foucauldian perspective, to subvert the discretionary powers of clinicians (Garland:1997:182). Castel (1991) also utilises a reading of governmentality to point to the regulatory effects of the risk discourse. He argues that there was an important shift during the course of the twentieth century in the control of those individuals engaged in 'unhealthy' or 'dangerous' behaviour. The shift was from face-to-face medical interventions which included the use of confinement (examples being mental illness & venereal disease) to an emphasis on the anticipation and prevention of such deviant behaviour. The recognition that risk does not arise from within individuals but from a combination of abstract variables for which it is possible to establish statistical correlations has opened up, in modern 'neo-liberal' societies, possibilities for more effective interventions in the regulation of the population. A particular example is the apparent ability to identify 'at-risk' social groups, which then become the subject of 'health promotion' interventions.

Given that the notion of 'care-of-the-self' has become inextricably bound up with
reducing the financial burden of state welfare, it is no coincidence that the strategy of health promotion has emerged as a central feature of neo-liberal governance. As Petersen argues, the goals of this health promotion strategy "...have, in effect, served the objective of privatising health by distributing responsibility for managing risk throughout the social body while at the same time creating new possibilities for intervention into private lives" (1997:194). However, the health promotion discourse is distinct not only in its conceptualisation of risk as arising from external environmental hazards but also in its emphasis on internal individual factors. The latter relates to the individual’s ability to successfully, or not, manage the self. The social groups that are subsequently identified as being at particular risk, are typically seen to "...deliberately expose themselves to health risks rather than rationally avoiding them, and therefore require greater surveillance and regulation" (Lupton:1995:76). The emphasis here is very much upon the ‘moral imperatives’ underpinning the promotion of the self-management of risk and self-care. This process is seen to reflect the emergence of the ‘regulatory technologies’ of welfare. In Culpitt’s work, which seeks to reconcile the notion of risk within what is an essentially Foucauldian conceptualisation of governance, there is a recognition of what he terms ‘the conundrum of neo-liberalism’. This conundrum is the way in which neo-liberal politics seeks to reduce the interventionist role of the state, whilst "...maintaining that the state ought more properly to be involved in dealing with the consequences of a risk society " (1999:15). Another way of assessing this phenomenon would be to argue that the concept of risk alone is unable to explain the real contradictory mechanisms underlying the tensions present in the state provision of welfare services in social democratically inclined late capitalist societies such as Britain.

2.4.4 The Social Organisation of Health Care under Capitalism: The perspective of the Political Economy of Health

A very different reading of the historical development of state health and welfare policy as interventions to ensure basic levels of health and health care for the population is that of the ‘political economy of health and welfare’. This perspective, strongly influenced by a Marxist reading of class relations, recognises the modern
welfare state as a particular historical form of the capitalist state. Health and welfare policies are seen as intimately connected to the production and reproduction of capitalist social relations. However, it is also recognised that the provision of health and welfare services by the state constitutes a fundamental contradiction for capital accumulation, reflected in the periodic 'crises' of welfare that have occurred more or less continuously since the mid-1970s. Whilst the interventionist role of the state in health and welfare provision has direct consequences for the (capitalist) economy at the political level, it also serves to legitimise the state's hegemonic role in reproducing labour power and the maintenance of labour productivity. In this regard, the universal provision of medical care for the population through the NHS continues to perform a very significant ideological function. As Doyal has argued, "...it is precisely because health, and therefore medical care, are so vital to every individual that the provision of medical care often comes to represent the benevolent face of an otherwise unequal and divided society" (1979:43).

The postwar welfare state, conceptualised as a central ideological structure in the reproduction of capitalist relations of production, is a key theme of the political economy of health and welfare perspective. This perspective was particularly influential at the time when the contradictions of state welfare provision first began to be widely recognised. A series of financial 'crises', beginning with the 1972 OPEC cuts in oil production, produced the first calls (from the political right in Britain) to spend less on state welfare provision. For the first time since the 1940s, the delivery of universal welfare services became a contested area of governance. This was when 'cutbacks' first began to be made in the provision of health and welfare services, beginning in the latter years of the last Labour government and into the early years of Margaret Thatcher's leadership of a Conservative government.

The political economy of welfare perspective is represented within the analyses found in the work of Doyal (1979), Gough (1979), Corrigan and Leonard (1978), and the LEWRG (1980). The approach itself draws heavily on Gramsci's conceptualisation of hegemony in developing the position that the modern welfare state builds consent for capitalism through a process of dividing the population into discrete groups of 'clients', each with its own specific 'needs'. The state then offers welfare 'solutions' to these 'individual problems' via a plethora of state institutions and agencies. This
has the effect of individualising what are actually widespread social and health problems associated with living in a capitalist society. Thus a common experience of poverty can be stood on its head through the construction of separate client groups such as ‘single parent families’, the isolated elderly, people with a depressive illness, ‘under-achieving children’, etc.

The state provision of health care through the NHS had undoubtedly been of huge significance in the lives of the majority of the population, but by the mid-1970s it had come to represent a serious ‘cost’ for capital accumulation. These ‘contradictions’ of welfare capitalism were seen to manifest themselves in three ways: first, in terms of those ideological values that underpinned the role of the state in health and welfare provision, such values involving notions of collectivity and ‘social rights’ as against the individualism and profit motive which drive the market; second, by creating state institutions to deliver welfare provision, which in principle met social need on a non-profit basis, although in fact political economy of health recognised a system in a permanent state of ‘crisis management’ (Offe:1984), this form of analysis becoming known as the ‘fiscal crisis of the state’ (O’Connor:1973; Gough:1979). The third evident ‘contradiction’ was that the collective welfare provision form of the state became, ironically, extremely problematic for both accumulation and legitimation alike. As the burden of taxation on private capital hit profitability, and as it became apparent that these state services were failing to meet the welfare expectations of citizens, this particular form of the state began to be called into question by its very failure to act functionally for capital (Offe:1984).

One manifestation of such contradictions and crises in relation to state health care delivery was the opening up of a political debate concerning individual responsibilities for health and the burdens that behavioural ‘irresponsibilities’ placed upon a financially stretched NHS. In this regard, as Navarro argued at the time (and well before the contemporary enthusiasm for postmodernist notions of risk culture), this was a politics that sought to individualise health through moral exhortations to take a personal responsibility for health; it thus had the effect of strengthening

“... the basic ethical tenets of bourgeois individualism, the ethical construct of capitalism where one has to be free to do whatever one wants... Far from
being a threat to the power structure, this life-style politics complements and is
easily co-optable by the controllers of the system, and it leaves the economic
and political structures of our society unchanged. Moreover, the life-style
approach to politics serves to channel out of existence any conflicting
tendencies against those structures that may arise in our society”

Some twenty-five years on, the political economy perspective would recognise that
the role of the state in reproducing the forces and relations of capitalist production has
changed. However, this is not because we now exist in some postmodern state-less
deregulated globalised economy in which it is a case of “every man for himself”.
Rather, it is recognised that the form of the state has changed to match the needs
associated with inserting a national economy within a globalised or international
economic system. This has produced an ‘internationalisation of welfare policy’, which
involves subordinating but not massively de-regulating the role of the state in the push
for economic innovation and competitiveness. In describing this internationalisation
process, Bob Jessop (1994) identifies differing regimes of accumulation and modes of
regulation which exist in ‘advanced economies’.

The ‘Regulation School' approach, as it has become known, is concerned with exploring the historically specific constitution of different ‘regimes of accumulation' and the social forces which serve to stabilize, at least in the short to medium term, the inherently unstable capitalist economic system. This position argues for the continuing importance of the ‘geopolitical’ and cultural context in which nation states respond to these economic changes. No one single ‘globalised’ mode of capitalist regulation or accumulation is recognised, and marked differences continue to exist in the form of Western European welfare states. The instruments of ‘regulation', of which social and economic policies are the most important, are designed to respond both to the demands of international competition for markets and investment and to internal (to the nation-state) requirements for social order.

Whilst the capacity of national states to confine capital’s growth dynamic within a
framework of national welfare has been undoubtedly weakened by the processes
associated with globalization, particularly in its neo-liberal form, the state
nevertheless retains considerable powers. These are responsibilities involved in
ensuring the social reproduction of labour power, securing the conditions for stable
capital accumulation, and with maintaining social cohesion (Jessop:2001). Thus, when looking at changes in the health and welfare relationship between state and individual (and by extension at the role played by state-employed professionals in the delivery of health and welfare systems), mono-causal explanations of social change are to be rejected. Jessop’s (2001) analytical concerns are with the continuation and elaboration of capitalist social and economic relations, so we need to look at the specific contingencies ('spatio-temporal fixes') which produce specific modes of regulation adopted by the British state; however weakened.

The work of John Clarke is a contemporary example of the critique of political economy directed at what are seen to be postmodernist developments within contemporary welfare policy. Clarke asks whether, while it is possible to identify ‘discernibly postmodern elements’ in the provision of welfare in Britain today, such developments are examples of fragmentation of the power of the state or in fact represent a process of reconstruction of the form of state welfare (1998:171). Clarke goes on to identify and critique four such features of the apparent ‘transition’ to postmodernity that appear in the literature.

First, there is the break-up or ‘fragmentation’ of the welfare state itself. This is said to be reflected in the increasing importance of the private sector in welfare provision as public provision has been reduced and targeted at those ‘most in need’. The introduction of market relationships within the public sector, competitive tendering, and the purchaser-provider split within the NHS would be relevant examples. This process is also reflected in a changing relationship between the public welfare services and their ‘clients’, i.e. the growth of ‘consumerism’. These changes have in turn meant a shifting of power away from the integrated bureaucratic-professional structural hierarchies that have traditionally characterised the Beveridgean welfare state services and towards the new professional managerial structures which are somehow more responsive to the needs and demands of the new consumers.

The second feature is an apparent movement away from a ‘universal’ form of welfare provision. This is said to be associated with those demands and challenges from social groups or movements pressing for their particular interests and needs to be recognised through development or reformation of the welfare system. Examples of such groups
would include single parents, the homeless, pensioners, and ethnic minorities. The policy response is typically to ‘target’ these groups for state support, but often this response has involved a greater use of ‘means-tested’ benefits. Tied to this process is the development of a more individualistic approach to service delivery. Examples would include ‘rights’ granted under the heading of the ‘Patient’s Charter’ (DoH:1991), parent governors sharing in the governance of individual schools, and the introduction of the Child Benefit Agency (charged with seeking financial support from fathers on behalf of the now single-parent family).

Third, traditional forms of authority have declined and traditional conceptions of social progress been abandoned. This process is seen to be reflected in the growing detachment of social subjects from what had been a broad political consensus built around the postwar role of a ‘progressive’ state which meets the welfare needs of all its citizens (‘the grand narrative of welfarism’) and in an increasing public alienation from the state institutions charged with carrying-out these functions (the state education system, the NHS, the social security system, etc). This is particularly seen as manifesting itself in a growing distrust of and challenges to the institutionalised power of the state health and welfare professions such as doctors, social workers, teachers, and local government officials: “The organisational subordination of such professional practices and claims to the logics of markets, contracts, customer service or external audit has simultaneously challenged their base of social and occupational authority” (Clarke:1998:172).

Lastly, there is the articulation of these postmodern elements within the discourse of social policy itself. These elements are seen to be present in the identification and recognition of such developments by academics and politicians in the field of social policy bringing about a ‘dislocation’ of the founding assumptions of state welfarism, including notions of social improvement. This development is seen as reflected in the formation of policy itself, from the ‘Thatcherite revolution’ to the ‘Third Way’ of the new Labour government. As Clarke argues, there is an element of the ‘chicken and egg’ scenario here. For it is both possible and tempting “...to tag a trend, change or phenomenon with the label ‘postmodern’. In doing so, one treats it as exemplifying a particular feature or tendency of postmodernity...postmodernity as a historical condition which is manifested in its epiphenomenal forms” (1998:173). But if, as
Clarke argues, the discernible elements of a ‘fragmentation’ and restructuring of the relationship between the state and welfare provision and the tensions that are said to exist between the public and the authority of state professionals are not the effects of a ‘postmodernisation of the welfare state’, then the question naturally arises: what social processes do these developments reflect?. Part of the difficulty in answering this question lies in attempting “...to hold onto the analysis of specific national formations in what is now widely understood to be a global or globalised political economy. This has particular salience given that postmodernity...is represented as wrapped up with globalising processes” (Clarke:1998:174).

Clarke’s work specifically focuses on the phenomenon that is the spread of ‘new public managerialism’, and whilst this development could be said to be discernible in all those social formations where reconstruction of the relationship between the state, the public, and public services is occurring, significant national differences exist. This reflects differences in political conception of the scope of the state’s responsibilities, expectations concerning levels of public service, and the specific organisational forms of service provision. In this, Clarke’s argument about the specificity of managerialism in the NHS or the Prison Service mirrors the conclusions of Bob Jessop, as discussed above. Clarke argues that managerialism is an example of a strategy aimed at reconstructing or reconfiguring the form of state welfare in an attempt to resolve the contradictions of state welfare provision discussed above. Managerialism is seen to be an example of the reconfiguration of state forms of welfare through a process of ‘dispersal’, as opposed to postmodernist notions of ‘fragmentation’. The objectives of such a strategy are to bypass or marginalise the ‘old institutional sediments of state organisational power’ (such as doctors in the case of the NHS) and to disperse power ‘beyond them’ to the citizen as consumer. Here, control and the sources of power remain at the centre, albeit in a new form. This policy of dispersal is thus a ‘strategic calculation rather than some inevitable occurrence (Clarke:1998:176-177). The outcome of the attempt to managerialise the contradictions of health care provision and its impact on the practice of nurses was discussed in detail above (Section 2.1.4).
2.4.5 Problematising governmentality and risk as explanatory constructs of the changes in health and health care relationships in late modern societies.

The concerns of this chapter have been with the significance of developments within the health and welfare relationship between the state and the individual within late (or alternatively post-) modernity. The 'risk' literature in the field of health and welfare relationships is largely dominated by three currents: the Foucauldian notion of governmentality and its particular reading of discursive power and the regulation of populations, the reflexive notion of risk as conceived in the work of Beck and Giddens, and a reading of what has been called the 'postmodern condition' (in which Bauman's work is of particular significance).

As we have seen, the work of Foucault has been influential in mapping an 'archaeology' of the ways in which particular 'knowledges' bring about specific patterns of governance which regulate the health and welfare of a state's population. Culpitt (1999), for example, argues that a Foucauldian understanding of power is crucial in 'illuminating' the ways in which neo-liberalism conceals its reliance upon 'pre-modern notions of sovereign power'. Culpitt goes on to argue that a critique of the neo-liberal concept of there being 'no alternative' (to the deregulation of state structures of health and welfare) requires an understanding of power as: "...the ability not just to 'speak the truth' but to influence the 'domain' of truth utterances" (1999:42). Nevertheless, whilst Foucault's work does indeed pose many important questions concerning the relation between state and individual, at bottom it utilises an essentially idealist conception of power. This is a conception of power as 'knowledge-discourse' but one that broadly lacks a material and historical specificity. Foucault, for example, never really examined the shift away from welfare provision by central mechanisms of government towards the individual. Alternatively, the influential work of Beck and Giddens has posited the notion of 'risk' as being central to an understanding of welfare relations in late modern society. However, they have also been criticised (Beck in particular) for a failure to contextualise this notion of risk within a historical analysis of welfare state development and change.

The constructs of 'risk' and of 'governmentality' are frequently bracketed together in texts. However, as Bryan Turner has noted, there is "...a profound tension between
the metaphors which lie behind risk society and governmentality’ (1997:xvii).
Nevertheless, Turner goes on to argue that, whilst Foucault’s paradigm of the
disciplinary society, panopticism, and governmentality cannot easily explain the new
global economic environment and the moves towards the deregulation of welfare
systems, it has the potential to be reconciled with the notion of a ‘risk society’. This is
because, as the global economy develops into a culture of risk, the nation state is
required to make a greater investment in internal systems of governmentality. Where
public utilities have been deregulated, the state is forced to create regulatory systems
of quality control. And where financial deregulation increases the scale of economic
risk and large organisations (including public institutions) fall into debt with
potentially large-scale job losses, governments typically intervene. The winding-up of
Railtrack plc and its replacement by a ‘not-for-profit’, essentially state-run
organisation in late 2002 is a recent example of such a process. Whilst agreeing with
Turner’s assessment of the continuing interventionist role for the nation state, not least
in health and welfare provision, the argument that there are possibilities for linking
risk with Foucault’s notion of governmentality is at best problematic. The ‘profound
tensions’ that he himself identifies between the two positions exist largely because the
use of the notion of reflexive modernisation in the context of global risk culture by
both Beck and Giddens largely rules out any future role for the regulatory state. This
is because their use of the risk construct, despite different emphases, essentially
reflects a postmodernist reading of the relation between state and individual.

The position adopted here is that the ‘risk society’ and ‘reflexive modernisation’
constructs cannot, other than through highly generalised notions such as the
emergence of a new ‘positive welfare’, account for contemporary developments in
health care and welfare policy. Nor can they easily account for any consequent
changes in the relationship between health care professionals and their patients, nor
indeed for the inequitable health and welfare experiences of different social groups.
This is because, at least in relation to health and health care, such constructs, in
seeking to explain some universal and global shift in the understanding and
experience of health risk, do so through an essential denial of social and material
differences. In Beck’s ‘risk society’, it is the collective nature of risk that is
emphasised, and whilst this may go some way towards challenging the neo-liberal
fallacy of individual autonomy and thus the need for a new welfare contractualism, it
has the consequence of placing inequalities in health outcomes and access to health care in the back seat as regards any analysis of shifting patterns of health and welfare provision. As Allen and Sprigings (2001) argue, the risk society actually serves to exacerbate rather than transcend the forms of social and economic inequality which contribute to health difference.

The notion of risk has now attained an almost reified status within postmodernist conceptualisations of the state-individual welfare relationship. To take just one example, Culpitt in his book on social policy defines risk (as per Bauman:1997) as the public perception of what is universally dangerous and threatening. As such, risk is now said to be "...a central defining motif of late modernity" (1999:4). At the same time, in the specific area of health care and health policy the notion of the 'at-risk self' is recognised as the leading paradigm in the field (as discussed above). As with all ideological constructs, the notion of risk has some basis in material reality, namely in the social processes that Beck points to: the failure of science and technology to deliver on its promise of eradicating many of the mundane burdens in people's lives, the consequences of ever-greater advances in knowledge and understanding combined with a very real public disillusionment with the actuality of state welfare services, etc. However, the construct itself is an ideological one in that it can be said to reflect the outlook of a particular social stratum, e.g. the 'organic intellectuals' of the dominant class (to utilise a concept of Gramsci's), with little or no attempt to ground itself in an understanding of the everyday material practices of social structures and social actors.

The notion of risk is also ideological in that it is presented as being a universally shared way of comprehending the world, as demonstrated for example in Culpitt's argument that "(r)isk is antecedent and not only consequential. It is part of the organising ground of how we define the personal and the social" (1999:10). This statement is an example of why the notion of risk could be said to be an archetypal postmodernist construct. For here, only limited attention is paid to the social structures and processes which must surely underpin what is said to constitute a fundamental development now mediating our health actions and behaviour. This use of the risk construct in relation to health and the delivery of health care can also border on the neo-liberal, as Sarah Nettleton (1997) has pointed out in relation to Ogden's (1995) use of the construct in her psychological analysis of health behaviour. Ogden argues
that it is not environmental factors, nor indeed pathogens *per se* that cause illness; rather, the important factors are individual themselves and their relative self-control. A similar point can be made with reference to the way in which Beck reverses Marx’s conception of a capitalist society in which being determines consciousness. Beck argues that in a risk society consciousness determines being: “*If people experience risks as real, they are real as a consequence*” (1992:77). In this way, the use of risk as a universal construct constitutes what Bhaskar describes as the ‘epistemic fallacy’: “...the view that statements about being can be reduced to or analysed in terms of statements about knowledge” (1978:36).

However, it must be said that a number of postmodernist-inspired analyses do recognise that the ‘philosophy of risk’ has been ‘hijacked’ by a neo-liberal politics which has ‘valorized’ the construct (Culpitt:1999:128). Neo-liberalism is seen to be exploiting a generalised disillusionment with science and with the interventionist role of the state, particularly in the field of health and welfare. An example is the way in which the notion of ‘welfare dependency’ is utilised in order to pursue a deregulatory political agenda. However, postmodernists could be said to be unwittingly culpable in this ideological process in that such approaches take it as a given that the system of governance between state and individual has already been irrevocably redefined as a consequence of the universality of risk and uncertainty. The ways in which risk and welfare responsibility are individualised within neo-liberal politics may well be challenged, but by perpetuating the idealist construction of risk as individual perception or reflexivity such analyses fail to engage critically with the somewhat messy business that is the determination and development of state welfare policy.

As indicated above, the concept of the ‘risk society’, and to a lesser extent the Foucauldian understanding of governmentality, are highly generalised constructs which seek to describe the emergence of new forms of health and welfare relationships within society. However, attempting to apply these constructs at the micro or meso level of health care delivery is much more problematic. For example, a key assumption of Giddens’s (1994) critique of health and welfare provision is the way in which its postwar form becomes less and less tenable in postmodernity because its dependence upon the calculability of ‘actuarial risk’ is increasingly impossible to measure with any certainty in the global risk economy. The problem
with this sort of generality is that it does not even correspond to the empirical history of state welfare provision in Britain. In the incremental development of the NHS since 1948 no serious attempt to calculate the health needs of the population was made until the late 1980s; the service was demand-led for nearly half a century. Certainly the language of 'risk management' and the associated concept of 'clinical governance' have, in recent years, come to assume an important place within the organisational frameworks of the NHS. However, these are quintessentially managerialist constructs which seek to eliminate omissions and errors in professional practice through a series of organisational frameworks such as 'risk assessment', audit, and evidence-based interventions.

The imposition of managerialist frameworks is probably less (if at all) about responding to an emergent 'reflexive modernity', to use Giddens's phrase, and more about achieving greater centralised control over the activities of health care professionals, notably regulation of the autonomy of doctors in such a way as to make it possible to manage resources more effectively. Giddens has also argued that the welfare state in postmodernity has become what he terms a 'risk averse system' (1998:114). This, however, does not seem to correspond to the advice offered to nurses by their state (not self-) regulatory body, the Nursing and Midwifery Council (a recent creation following the amalgamation of the UKCC and ENB in April 2002). The NMC now advises nurses to “...value the process of risk taking, following assessment and in the context of appropriate management, as it will increase your ability to help clients to achieve their potential” (NMC:2002). It is difficult to see how the concept of a 'risk society' can help contextualise this confident, almost brash expression of interventionist professional action, other than through the use of the word 'risk' itself. The question of whether nursing practice can be said to be marked by uncertainty and risk avoidance is a central concern of this thesis, the results of which will be examined in the data analysis chapter.

In the context of state health care provision, the concept of governmentality might have led us to expect to see some withdrawal of the state from direct involvement in health care, as well as a lowering of individual expectations about what can actually be delivered through such a centralised system. Yet there is little empirical evidence that people's perceptions of the role of the state in providing health and welfare
services have indeed significantly changed. Indeed, whilst public expectations of the NHS have risen, the expansion of the private market in health care has actually stalled (it is even declining in some areas). Indeed, the Conservative governments in power between 1979 and 1997 were for a long period perhaps the most radical right government anywhere in Western Europe, yet they presided over a year-on-year real increase in state health care expenditure. Certainly, Conservative health ministers did not shirk from ‘victim-blaming’ particular social groups for their ‘unhealthy lifestyles’, yet relatively few resources were put into a health promotion strategy which would reflect the shift towards a society moving into an era of the ‘management of the self’.

2.4.6 Concluding Comments

Foucauldian governmentality in the context of nursing practice should mean that nurses (as bearers of the medical discourse) become steadily more engaged in constructing their patients’ needs and problems. However, as described above, although there was some initial enthusiasm within nursing back in the 1980s for constructing models of ‘knowing’ the patient, this process has become less practical today as a result of improvements in medical technology and organisational restructuring. The introduction of day wards and a general reduction of in-patient times has been made possible by ‘keyhole’ surgery, improvements in analgesia, and patient-controlled pain relief devices, together with a concerted push to discharge patients as rapidly as possible in order to meet waiting-time targets. This has meant that, in many areas of the health service, nurses hardly have the time to ‘come to know’ their patients at all. In relation to the notion of health ‘risk’, if and when the ‘at-risk’ patient does make an appearance within the discourses of nurses, it is debatable whether indeed these are constructions of nurses themselves or whether nurses are reflecting more traditional notions of social dependency or deviancy. For instance, is the notion of the ‘frail elderly’ person or ‘substance abuser’ a construction rooted in a postmodern social discourse of risk, or is it based on a much older biomedical discourse of normality? This latter example raises an additional issue: to what extent is it still possible to talk about the hegemony of the biomedical discourse and the medicalisation of social problems within late modern health care systems? This moot
point in current debates within medical sociology will be developed in the following chapter, when we come to discuss the material basis of ideology and the meanings of hegemony.
2.5 Conceptualising Ideology and Discourse

A central assertion of this thesis is that a comprehensive understanding of the work of nurses within a late modern system of health care such as the NHS requires an analysis not only of the specific knowledge systems that are drawn upon in practice but also of the material and organisational context of that practice. Ideology and discourse are two quite distinct theoretical constructs that are concerned with the transmission and reproduction of ideas within social structures; both constructs will be examined within this chapter. The position that will be developed below is that ideology, understood as a positive and critical concept, has the potential for analytically connecting social structure and human agency in the understanding of contemporary nursing practice. However, both constructs must first be examined in detail and grounded within their distinct epistemological frameworks, given the many conflicting and ambiguous uses made of these terms within the literature.

Ideology as a theoretical construct has been subject to many conflicting uses. As Zizék has pointed out, ideology has been utilised to

"...designate anything from a contemplative attitude that misrecognises its dependence on social reality to an action-orientated set of beliefs, from the indispensable medium in which individuals live out their relations to a social structure to false ideas which legitimate a dominant political power" (Zizék:1994:4).

Eagleton (1991), in his accessible work on the subject, has been able to compile a list of sixteen definitions of the term, including the four cited above. This range of meanings can nevertheless be narrowed down to two quite distinct usages reflecting two fundamentally different theoretical paradigms. First, as used within political science, 'ideology' has come to denote a coherent system of political ideas (e.g. communism or liberalism). Hence, American political scientists felt able to talk about the 'end of ideology', just as positivist 'science' was seen to replace more 'emotional politics' in the administration of Western societies in the early 1960s. A similar 'ending of ideology' was announced with the collapse of the state capitalist systems in
Theorisations or ideals of the nursing role which derive from nursing academia (describing a shift towards a more holistic approach to patient care, planned and implemented by nurses acting relatively autonomously within the health care division of labour) have only a limited resonance with the hospital-based nurses. Rather, there is a more ‘realistic’ evaluation of nurses’ limited power to effect good nursing practice in the face of increasing work role demands; for example:

**R8 (A&E nurse)**

Time. Lack of time is the big issue, you are rushing patients through because you are very aware of the waiting-times for treatment of patients coming through from the waiting room, negotiating the ambulance cases that come through at the same time, and you are thinking, ‘I’ve only got this number of cubicles left’. But you are aware also that you want to spend quality time with that patient, but you can’t. So it’s a quick discharge, which is worrying because sometimes the patient may have been mismanaged.

A similar perspective comes from ward-based nurses; for example:

**R23 (ward-based nurse)**

The individualised part of nursing would be establishing the things that are important to them...establishing what is vital to an individual, so that for example religion may be all that a person cares about. But building up a relationship with an individual takes time, but if you haven’t got that time to go into any depth then it’s a problem.

However, the practical application of holistic care did have a degree of support within the discourse of the community-based nurses; for example:

**R12 (District nurse)**

You are a guest in somebody’s home, and it’s easier to be holistic

And from another:

**R13 (District nurse)**

I found that when I left hospital nursing, where I was doing surgery, I went into people’s homes for the first time, I could get to
know people...nursing is more satisfying to me in the community as I can see
the patient is a whole person. I can see them with their friends and family.

However, it was the non-routinised demands of nursing work within an A&E
Department (resuscitation of patients, for example) that was seen to offer the potential
to fulfil particular ideals of the professional role, as exciting and challenging:

R5 (A&E nurse) I like the acute nature of the work. It's very
sociable...lots of people around, lots of things happening all at once, it can be
very dramatic; it's changing all the time. I like the relative autonomy you get
in nursing, working in a team with the other disciplines. Nursing in A&E
leaves out the more mundane things in nursing.

The excessive demands (as a result of material and staffing shortages) on the role of
the nurse did mean that it was difficult in practice to find the time to build meaningful
relationships with patients that could lead to the delivery of more holistic care.
Nevertheless, there was a general recognition by both hospital and community-based
nurses of a need to move towards the development of more 'adult' relationships with
patients (which would respect their autonomy) and move away from the traditional
top-down professional-lay relationship; for example:

R26 (ward-based nurse) I remember when I first started nursing patients
could have only one visitor and then only for one hour, but now things have
moved on. Our patient information leaflets are improving, consent procedures
are getting better, no longer 'I am the doctor thou shalt' sort of thing. So I
think in that way, changes have occurred which have taken on the social needs
of patients much more. And maybe the new nurses, younger nurses, may
appreciate that things have not always been like this, that once upon a time we
did treat patients like little packages that come through the door.

Theorising the role of nursing as structured by the priorities of the health care system
and shaped by developments in medical technology can be found within the nurses’
own discourses. This was an especially interesting finding given the nurses’ lack of
resonance with other theoretical conceptualisations of the role. There was also a
recognition of the ways in which the requirements of and the increasing reliance upon medical technology frequently dictate the organisation of nursing.

Those many theorisations of nursing work that emphasise its gendered nature appear to have little overt resonance, at least, in the discourse of the nurses themselves. There was some implicit acknowledgement of this position when one of the ward-based nurses, in referring to the ability to communicate with patients effectively, talked about some nurses having a ‘natural’ ability. However, it is perhaps not too surprising that the nurses did not mention gender even in reference to their relationship with the medical profession. This is because the majority of junior doctors with whom nurses have daily professional contact are themselves female, as is also increasingly the case with GPs. Beyond that, the fact that nursing remains predominately a gender-based occupation (90% of nurses are female, which has not changed significantly for thirty years) may be so ‘obvious’ as not to warrant comments.

**Category 2: Providing a Public service**

The community-based nurses generally recognised that it was impossible to separate-out the delivery of health care to patients from the social care provided by local authority social services. They also acknowledged that the service they provide as nurses must meet the needs of the local community rather than the requirements of the health care system; for example:

R18 (Health visitor) I don’t know if we can divide the social care and health care, there is always an overlap, and is hard to say that is your part and this is my part. Sometimes we find ourselves going over the line, hopefully it is a two-way thing. If we have good communication with social services or GPs, whoever we happen to be working with, then there shouldn’t be a problem.

This view may well reflect the fact that health visitors (HVs) and DNs spend their working day in a community setting, within people’s homes. Therefore, it becomes difficult to prioritise professional concerns about demarcation over the meeting of these localised concerns. However, for the hospital-based nurses generally, there was
little overt acknowledgement of a role in providing a service to the local community, though they were not opposed to the notion of public service *per se*. The primary commitment of the A&E and ward-based nurses appeared to be to the institution in which they practised.

A&E nurses were very focused upon the ‘appropriate’ use of their service, rather than upon whether the service they provided actually met the needs of the local community. This finding is something that is found consistently in the literature going back over twenty years to Jefferys’s (1979) work on what he termed ‘normal rubbish’. The latter found that A&E staff typified patients as either demanding of their skills (good) or as a distraction from the ‘real’ work of the department. The following interchange between A&E nurses demonstrates this point, as well as demonstrating a degree of professional reflexivity:

R3 (A&E nurse) You have got to judge the situation, because you just can’t plough in there and say to someone who is drunk, paralytic, ‘For goodness’ sake, this is the tenth time you’ve been in this week, pull yourself together’, they would just laugh at you.

R1 (A&E nurse) But at the back of your mind, you do think ‘Oh, for God’s sake’, you might not say it, but you think it.

R3 (A&E nurse) You are only a human being, and sometimes you see this man again who is absolutely paralytic with a head injury, you just want to shake him and say ‘what are you doing!’.

R4 (A&E nurse) But you don’t.

However, this is balanced by the view held by most (though not all) of the nurses in the A&E focus groups, namely that an important part of their role is providing a safety net for people who have no ready access to the primary care services in the local community; for example:
R6 (A&E nurse) I think we play a pivotal part in the community, in the sense that people come here...it's a point of reference for a lot of people.

The themes emergent from the hospital-based (but not the community-based) nurse focus groups do tend on the whole to support those Weberian-influenced models of the professional-bureau organisation, in which employees primarily identify with the needs of the organisation. This is particularly interesting, given that the current literature appears to see such organisational models as out of place in the late modern organisation of work. The position of the community-based nurses would point to the importance of work context. This group of nurses practise outside the tight regulation characteristic of the organisational structures of hospitals, and as nurses they usually work alone or in small teams rather than in the large socialising groups found in hospitals. However, even in the discourse of community nurses, there was little resonance with those Foucauldian assessments of neo-liberalism which point to a shift in the forms of governmentality away from dominant hierarchical systems of service provision towards the consumer of such services.

Category 3: Relationship with Medical Profession - are traditional boundaries being broken down?

The literature on this issue is fairly evenly split between those who subscribe to the postmodernist notion of a breakdown or loss of trust in professional authority in general and those who continue to subscribe to the 'professional dominance' model of power. Friedson (1994), for example, would argue that, despite the large-scale organisational changes that have occurred within late modern health care systems in general, the autonomy of the medical profession continues to be determinate of the roles of other health professions. The evidence from the focus group discussions is that nurses' own accounts of the relationship recognise both a narrowing of the hierarchical gap between doctors and nurses whilst also acknowledging that the boundary between them remains firmly in place.

R6 (A&E nurse) It's difficult to make sweeping statements about us influencing the doctors as to what decision they make, but I know that I have
done. I have sat down and said, ‘I’m sorry, but I really feel unhappy that this
person is going home, for example’. But if they decide to go and make that
decision anyway, there’s not really very much you can do about it anyway.
But it would have started the ball rolling, it would have put the thought in their
head and they might actually think a bit more about what they need to do.

Whilst there is no support for the traditional view of the role of the nurse as a
‘handmaiden’ to the work of the doctor, there is an explicit acknowledgement of the
existence of a ‘zone of discretion’ which prevents nurses from encroaching upon the
clinical autonomy of doctors. However, this is not a reflection of past institutional
patterns of nurse socialisation, which reinforced the subordinate position. Such
deerential ideas do not appear to have been fully internalised within the discourses of
the nurses. Those who participated in the focus group discussions tended to see
themselves as equal but different. Below is an example of this perceived changing
relationship, which in this case is seen to arise from the development of Primary Care
Groups / Trusts (PCTs):

R13 (District nurse) They now have to work more closely with us. More like
colleagues. It used to be once upon a time, ‘I’m the doctor, you are the nurse’,
now it’s changed.

Moreover, there is little or no acknowledgement of the position that the medical
profession views nursing knowledge as indeterminate. On the contrary, from nurses’
accounts doctors appear to value nursing knowledge and skills whilst attempting to
hold on to their professional power vis-à-vis nurses; as demonstrated in the exchange
between A&E nurses below:

R9 (A&E nurse) We work as a team more than as doctors and nurses.
The Casualty Officers know the experience we have and respect that, and we
also respect their medical training. They will say to us, ‘What do you think we
should do?, or ‘Do you think it’s right that we do this?’.

R8 (A&E nurse) It depends on the attitudes of the doctors and nurses as
well. Doctors will come in as new Casualty Officers and will be so
underconfident that they rely on you, and after about four months, when they've got more knowledge or grounding, they then revert and have a real attitude problem. They will turn on you, and say, 'You're only a nurse, what do you know?'

However, A&E nurses evidently have a collective lack of confidence in the decisions and judgement of GPs; for example:

R2 (A&E nurse) You don’t take their diagnosis very seriously. A letter from a GP saying that this patient has so-and-so, very often I don’t read it at all, I go and speak to the patient myself and find out...making my own diagnosis rather than reading what the GP has written, although I might read it afterwards...

R4 (A&E nurse) But half the time it’s a load of rubbish...they probably haven’t even examined the patient.

This discourse may well reflect the more biomedically-driven interventionist role of A&E nurses as specialists, whilst (community-based) medicine is being practised in an environment of uncertainty and risk, reflected in the increasing number of referrals by GPs to local hospitals via the A&E department. But an awareness of the social nature of the practice of primary care medicine and the targets that GPs now have to meet may be the reason that the community-based nurses themselves were much less critical of GPs and generally had a good working relationship with them; for example:

R20 (health visitor) I had this conversation with a GP last week, talking about practising holistic care. I said that we as Health visitors did but I was not sure about doctors. This doctor said that he had tried damned hard to achieve a holistic approach, but that when they have such short consulting times it became very difficult. If someone came in for their diabetes to be controlled, then the temptation was to focus on the narrower aspects of diabetes management.

In general, all the groups of nurses represented in the focus group discussions articulated a concern to differentiate their work from that of the medical profession.
However, the A&E nurses appear to want to achieve a balancing act in the emphasis they place on team working with doctors: on the one hand they cherish a distinctive nursing contribution, but at the same time they accord high status to biomedical clinical skills. The one issue that all the groups of nurses agree upon as marking out the difference between the practice of nursing and that of medicine is the way in which they see themselves as patient advocates; for example:

R9 (A&E nurse)  They (the patients) have to have a lot of trust in us, and I think they do have a lot of trust in us. We do have a lot to say about the treatment they receive here, we are patient advocates, and if they don’t believe what the doctor is doing they will tell us, and then if we don’t believe what the doctor is doing is best for the patient, then we will not give the care that the doctor has prescribed, we will dispute it and not carry it out.

In this perceived advocate role, meeting the needs of patients meant that there was no automatic or unthinking acceptance of doctors’ decisions. It was a discourse that represented a shift in a crucial dimension of the traditional working relationship with the medical profession.

*Category 4 : Patient expectations and responsibilities : Nurses' perspectives and responses*

The complex and often contradictory nature of nurses’ discourses, as they emerged from the focus group discussions in relation to perceived responsibilities, demonstrates the problems of attempting to look for constant conjunctions in the process of deductively theorising such an issue. The literature on patient expectations of the health care system has in recent years been dominated by notions such as 'reflexive individualism', which in late modernity manifests itself in a greater willingness by the individual to take on personal responsibilities for health, for example, rather than relying on the state for the collective provision of health services.
Important shifts in patients’ perspectives and expectations were acknowledged by nurses, in particular a more consumerist mentality, particularly amongst ‘middle class’ users of the service. There was also the perception of an emergence of a new culture of complaint, with patients seen as being encouraged by the government to report staff. However, such changes in patient attitudes tend to be seen as politically inspired, resulting directly from policies such as the Patient’s Charter and other more recent ‘patient-led’ reforms to the health care system, rather than as a wider social process; for example:

R16 (District nurse)  I think generally people are more aware of what their rights are, so that people are more inclined to take goods back to the shop, etc. Same with the health service, people will complain. You see people at the reception, and they are shouting and carrying on at the poor receptionist.

In relation to the issue of responsibilities and in particular ‘appropriate use’ of the A&E service, the response was more mixed. There is evidently some tension between wanting to make an essentially moral evaluation about an individual patient’s clear lack of personal responsibility for their health, whilst at the same time demonstrating the concern that all attendees should receive the appropriate professional advice and support for their health problem, however trivial. This tension is apparent within the following statement:

R6 (A&E nurse)  I used to spend my time educating people about what they should be coming here for, but you just get to the point where you don’t bother anymore, it just never seems to sink in. On the other hand, I do think that people should take responsibility for their own health, but there are certain things that might happen to them that are beyond their control. There are though people who do try, and I think the system does create the situation where people can’t get GPs so they come to A&E… I don’t think it’s a case of saying these people shouldn’t be here, a lot of the reason people come here is because there is nowhere else for them to go.

This statement thus also represents a recognition by the nurse of the ways in which the system can act to subjectify patients, rather than facilitating their ‘rights’ as
consumers. Many patients are seen as in some way colluding with this structural situation by adopting the ‘sick role’; for example:

R26 (ward-based nurse) If you are dealing with an eighty-year-old, they say ‘whatever you say, nurse, whatever you say’. That’s the old way, it was whatever we said. They have a right to make an informed decision but they say no, they don’t want to be involved. Whereas the younger or more proactive patient does know what they want. Sometimes you have to be aware of the balance between involving patients in an active participation in their health care and respecting their right to not participate.

This view of patients as abrogating their decision-making responsibilities was a view that was present across most of the hospital-based nurses’ discourses, yet it was absent from the community nurses’ accounts. The difference may well lie in the fact that the nature of community nursing practice makes them more willing to question the traditional health care system principle that all roads should lead to clinical intervention.

Category 5: Assessment of patients – the nurse’s surveillance role

The nurses were generally willing to acknowledge the potential for bias in applying their own value-judgements or occupational social typifications when assessing patients and their families. This awareness is reflected in the following exchange between A&E nurses:

R8 Before you even speak to a patient you’ve made assumptions about them already.

R9 But I don’t think it’s a wrong judgement.

R8 I don’t know about that, because you can typecast people that way, which means you treat them in a different way.
No, I don’t think you treat them in a different way, I think the advice you give them is different.

I’ve seen it when nurses triage patients. If they are homeless, the way they are spoken to, and what’s written down about them is not the same as other patients.

I think it does influence care, if someone has either written down or passed on their judgements about the way a patient is when they come into the department. It will alter the way they are spoken to, if nothing else.

To a detrimental effect, you mean?

Yes, sometimes.

The ‘subjectification’ of patients through the development of surveillance methods such as the ‘nursing process’ is something that is of particular concern within Foucauldian theorisations of the relation between professionals and the public. This may, at least at a theoretical level, be borne out by the use of the ‘holistic assessment’ of patients, which involves the nurse coming to ‘know’ the patient. Patients who will not permit themselves to be ‘known’ and with whom ‘talk’ cannot be conducted are seen to represent an obstacle to such professional ‘surveillance’ practices. However valid such a conceptualisation may be at the level of governmentality, for those nurses who felt they engaged in a holistic process of assessment (and this was only a minority of the nurses in the focus group discussions), they perceived this assessment process, by generating more personal information than was strictly required for the purposes of clinical intervention, as enabling them to develop a deeper understanding of individual patients’ ‘needs’. This it was felt enhanced the care they were able to deliver to patients, for example in the following exchange between District nurses;

You are a guest in somebody’s home, and it’s easier to be holistic.

If you’re going to do a dressing for a patient you have to consider her as an individual, everybody’s needs are different.
What she is able to do, what she is not able to do at home, her psychological needs.

There was a good article in a nursing journal recently about caring for a woman who has cancer and still has a family who she has to look after. You have to think about this in assessing needs. Other things may be important as well as the cancer.

In other words, the focus is on the practical benefits for the patient of going beyond a purely biomedical understanding of patient needs. The use of this Foucauldian 'subjectification' issue within the literature does appear to be a curious concern in the context of a health service that is often unable to deliver even the basic treatment and care that people require, when they most require it. Those nurses who engaged in the holistic assessment of patient needs did tend to consciously see it as a practice that marked a progressive shift away from the biomedical reductionism (although they would not of course use such a phrase) of the traditional task orientation of nursing, which emphasised the physical needs of patients. For example:

Whether they have something going on at home, do we need to involve the police, are there children involved? It's much more than just looking after the patient, you are assessing the whole scope of the patient's social situation. So has the little old lady with a fractured hip got a cat locked up inside the house? or is there a child expected home from school? – that sort of thing.

Category 6: Intra-professional relationships

A quite distinct gap exists within the academic nursing literature in particular, but also within the wider field of health service research and the sociology of professions and professionalisation processes, concerning intra-professional relationships between different groups of nurses. In relation to the latter, this probably reflects a tendency to aggregate the work of all nurses into a single category: 'nursing'. This failure to differentiate between the range of nurse practices represents a neglect of institutional
context. In relation to the academic and professional nursing literature it could be argued that it is too closely tied to nursing’s ‘professionalising project’ and is therefore reluctant to draw attention to rivalries and tensions that exist between different groups of nurses.

The exception to the discursive gap that pertains to intra-professional relationships within nursing is the issue of de-skilling. In relation to hospital-based nurses, this question relates very much to the development of the ‘clinical nurse specialist’. This new grade of nurse was very much a product of the managerialist-driven reorganisation of nursing’s skill mix in the mid-1990s. Perhaps not surprisingly, this issue was discussed within the ward-based nurses’ focus group, for example:

R24 (ward-based nurse)  Giving health education advice to patients, this is where more specialist nurses come in, like cardiac rehab nurses or the diabetic nurse specialists. They are giving this sort of information all the time, they have the knowledge and confidence to pass that over to the patient.

R27 (ward-based nurse)  And it’s just de-skilling the ward nurses even more, because patients get referred on to a specialist nurse.

This issue of de-skilling was not discussed by the A&E nurses, probably because they represent an example of the more highly trained nurse specialist. DNs on the other hand appeared to welcome the opportunities that the developments in skill mix resulting from the reforms to community care offered them, as in the example below:

R12 (district nurse)  In the old days there was no skill mix, you were in a department of District nurses, and they did everything, and in some cases they were over-qualified for some of the work. Whereas now more of the work of the District nurse is management of a team. We have very skilled staff nurses who often have areas of expertise that everyone can draw upon. We used to have to fight for any specialist training years ago.

It was apparent from some of the themes that emerged within the focus group discussions that a distinct set of well-honed group resentments was found to exist...
between groups of nurses, in particular between A&E and ward-based nurses. The reasons why these intra-professional tensions exist appear to lie within a mutual misunderstanding of their respective (and discrete) roles; as demonstrated in the exchange below:

R3 (A&E nurse) Sometimes I think that the ward staff resent us. They think that we are just sending them more work. If you phone them up and explain that you have a patient for them, although of course they have a limited number of beds, they don’t seem to appreciate the numbers we have waiting in the department...

R4 (A&E nurse) It would be good if the ward staff could come down and work for a short time in the department to see what we are up to.

Or in another example, where the opportunities for practising 'real' nursing are said to be limited in the hospital wards:

R10 (A&E nurse) I think I can turn around at the end of the shift and feel that I've done at least 90% nursing work, compared to say 40 to 50% on the wards.

Category 7: Relevance of Nursing Theory for Practice

Within the discourse of the nurses participating in the focus groups, considerable cynicism was expressed regarding the relevance of academic nursing theory to everyday practice, and in particular the issues of documenting care and trying to theorise holistic practice; for example:

R5 (A&E nurse) In A&E sometimes patients don’t want so-called holistic care...all they want is a diagnosis. What have they come in for? they’ve come in for a service... ‘I’ve got something wrong, make it better’.

And another example:
R24 (ward nurse) We are looking at the whole situation. But there are times when you have to be an efficient nurse as against a holistic nurse… If you have got someone who is acutely ill then you are not going to have time to be nice and holistic.

One view that comes across from these accounts was that some nurses saw their practice in terms of being very much ‘hands-on’, more like some craft industry, rather than as the ‘evidence-based’ professional occupation that nurse theoreticians like to present it as being.

R9 (A&E nurse) No, I don’t think care plans work in A&E. I don’t think we have the physical time to write down, I’m not saying the wards don’t either, but they allocate time in the afternoons to write plans, we can’t do that purely because of the volume of patients we’ve got or the severity of the cases that come through, and I don’t think it’s important enough to waste time… I don’t mean waste, I mean spending our time doing things like that. I think actual hands-on patient care is far more important in the casualty department certainly.

The philosophical approach of the ‘new nursing’ that seeks to epistemologically demarcate nursing practice from its traditional focuses of concern is embraced less than enthusiastically by the nurses in the focus groups, possibly because it is seen to be imported from ‘outside’, i.e. from academia. Whilst there are differences between the hospital and community-based nurses as to the practical application of the holistic approach to delivering nursing care, there is a consensus about the value of experience over theory or an evidence-base. Here is an example of this process:

R1 (A&E nurse) Well, like in triage, you are not exactly making a diagnosis, but if you have got an idea in your head of what something might be, that will lead you to give your triage category to a patient.

And another example:
R23 (ward-based nurse) You tended to get influenced by staff nurses and the patients in practice. To a degree you get a lot of their feelings, their opinions about nursing, more than you would have from the tutors; more than theory.

Even though the majority of the community nurses recognised the value of a holistic approach, the view was very much that this came through experience rather than a theoretical model:

R16 (health visitor) When you think about nursing in the community fifteen years ago... You've always done what you are doing now. In seeing the patient as a whole person, you'd always noticed that raggedy piece of carpet in the corner, and the cat peeing all over the place or what have you. You always noticed it...

R13 (health visitor) ...but I feel that I see more now, maybe it is because I am more experienced.

The views of the nurses themselves would then appear to support those hypotheses that assert the importance of processes of occupational socialisation over formalised education in perpetuating the now notorious (in the nursing literature at least) 'theory-practice gap'. However, the reasons for these differences between what is learnt 'on the job' and what is acquired through formal nurse education is certainly more complex than would appear to be the case from the nurses’ own discourses. Some form of 'nursing culture' clearly plays a part in occupational identity formation for nurses. Whether the process is constructed around the reproduction of the organisational values of the hospital and/or the clinical priorities dictated by the requirements of the medical profession, it is difficult to say. Possible ideological mechanisms that could account for the structuring of such anti-theory views will be discussed below (in Section 4.3.1).
Category 8: Impact of Organisational change on Nursing work

It is clear from the discursive themes that emerged from all the nurse focus groups that the organisational changes to the structure and function of the NHS that occurred in the decade of the 1990s had a significant impact upon nursing work. Not all those changes, however, are regarded as negative for nurses. For DNs, there was some regret about the diminishing of the social care role, but they did recognise new opportunities for their professional development arising from the reforms to community care over the decade, although the GP Fundholding initiative (a central structure in the Conservative government’s ‘internal market’ reforms) was generally seen to have represented a backward step for the practice of nurses within the community. The following exchange between DNs demonstrates this point:

R15 (District nurse) GPs could now specify which nursing staff they wanted as well...whether they wanted a well-staffed nursing team or not.

R13 (District nurse) If there was a problem with getting a patient into hospital, they would ask you on the phone whether the practice you were based at was a fundholding one or not. What was I to say, I did say we were once, and we got the patient in.

R15 (District nurse) It was all very confusing

R12 (District nurse) Different practices offered differing services such as cancer care. Our contracts were also different, specifying what nurses were to do, such as phlebotomy. So really GPs had the power over us. I lost some autonomy.

On the other hand, the reforms to primary care introduced by the New Labour government in its ‘NHS modernisation’ programme, and in particular the creation of the Primary Care Groups (this was the first stage in the move to Primary Care Trusts or PCTs), were at the time of the focus group discussions (in 1999) generally seen to be a positive development for nurses. As for example in the following exchange:
R12 (district nurse)  GPs are now going to have to work more closely together with nurses and won’t be able to get away with so much.

R13 (district nurse)  They now have to work more closely with us. More like colleagues. It used to be once upon a time, ‘I’m the doctor, you are the nurse’, now it’s changed.

R15 (district nurse)  Oh yes.

However, the HVs were less positive about the community care reforms of the early 1990s, which had given local authority Social Service departments a much greater role in determining the health needs of the community. All this had left HVs with little scope for professional development within the NHS, given that the nature of caring and what is purchased legitimately as ‘health care’ in the community had become narrower. However, for all the groups of community nurses, whilst there were concerns about the way in which social and health care had been divided, a generally positive view was held concerning the impact of the reforms in community care for the patients themselves; for example:

R17 (health visitor)  I think what the (Community Care) Act has done is to make sure that the right people deliver the right care. Because with an acute illness it is not really social care, it is nursing care, but with a long-term chronic problem, then you can divide up the tasks far more appropriately.

The hospital-based nurses saw the greater demands that were placed upon them over the period of the 1990s (in the form of target-setting, raising patient expectations, and the increasing process of developing ‘frameworks’ for care delivery) in more negative terms; for example:

R5 (A&E nurse)  A department that is under pressure does not give the patient good care, and we are more under pressure. Complaints are increasing...litigation, there’s that sort of tension. There’s defensive practice...
in a lot of cases. There’s the public’s expectations which are higher, therefore when they come here and get worse care, relative to their expectations, because they are not seen within two hours. And that seems worse to me than when I was a student nurse at Guys A&E, I don’t remember any of this stuff happening then.

However, even here, new roles such as the ‘nurse practitioner’ have emerged (and more recently the ‘nurse consultant’). These nursing perspectives are reflected in those conceptualisations of the changing nature of nurse practice which seek to contextualise such change within an understanding of the material basis of nursing work and the wider health care division of labour. Additionally, the literature which seeks to examine the impact of the ‘new managerialism’ in the NHS and its ideology of productivity and ‘value-for-money’ would argue that the interests of all the health care professions are inevitably relegated in the drive to deliver efficient and effective patient services. This position was generally borne out in the views of the nurses themselves.

Those more ‘postmodern’ theorisations of the emergence of new non-hierarchical organisations, with an accompanying ‘reflective individualisation’ marking the end of what has traditionally been seen as a ‘service career’, are not reflected at all within the discourses of the nurses. From the nurses’ perspective, a top-down approach continues to characterise the organisation of the NHS, even though the formal hierarchy and priorities of the NHS have changed. The following exchange demonstrates the somewhat rueful manner in which these reforms have been perceived by nurses:

R27 (ward-based nurse) I think the changes have encouraged questioning. I’ve worked on the admissions ward for years, and people who have waited a long term in Casualty do complain when they finally get up to you. You know, it’s that kind of, ‘I’ve come in as an emergency, therefore I deserve treatment, and I deserve it now, and you people are stopping it’. I think it has quite bad implications for nurses in that way, but then again I think the ‘named nurse’ standard is a good thing.
R28 (ward-based nurse) Yes, there are some good things.

R23 (ward-based nurse) But the nursing staff are now being sent on aggression training courses to learn how to deal with these expressed needs of the patient.

*(general laughter)*

### 4.3.4 A note on the limitations of the deductive approach to abstraction

It is evident from the previous section that the tensions and contradictions that characterise the discourses of nurses, as they emerge from the inductive analysis of the transcripts, cannot be satisfactorily accounted for within a deductive analytical process of inference. This essentially demonstrates the contingent nature of such an approach to abstraction. At least implicitly, the analytical process of deductivism assumes a closed social system within which there exists a constant conjunction of events enabling us to move from general claims about an object or event to particular inferences; contradictions are necessarily cut out of analysis. As previously discussed *(Section 3.2.2.3)*, empirical facts rarely take the form of strict regularities; they express phenomena to be explained, but they are not the end-points of research.

Rather than attempting to grasp the research phenomena (nurses’ discourses of practice) as a whole object of knowledge consisting of interconnected parts, let us look at what emerges from a purely deductivist approach, namely a decomposition of such an object. This is an analytical method that essentially produces *"a chaotic collection of fragments...or a mere aggregate of unconnected happenings"* (Callinicos:1998, cited in Creaven:2000:13). We need to move beyond these abstracted emergent themes and deductive conceptualisations, which may only bear a contingent and tendentious relationship to the concrete research object at the level of ‘appearance’. It has been asserted above that a methodology informed by critical realism and historical materialism would move towards a dialectical (in Marxian terms) or retroductive (as understood within the philosophical framework of critical
realism) form of analysis. This requires an understanding of the dynamic interplay of the parts through a process of analytical synthesis, in order to better understand the whole.
4.3 Retroductive Analysis

As diagrammatically represented in the analytical schema presented in Figure 2 above, the process of retrodution is the next stage (vi) in the analysis. The objective is to be able to identify those generative mechanisms that underlie the discourses of nurses practising in the NHS at a time of organisational transition. This will demonstrate that these views are not some decontextualised set of ideals but are dialectically connected to social structure. To engage in the process of retroductive analysis is to postulate (Lawson terms this ‘as if’ reasoning – 1997:25) those necessary rather than contingent causal relationships or mechanisms that are the condition for the generation of the concrete object (nurses’ discourses). Before we can move towards the retrodution of generative mechanisms, the analytical process requires that the demi-regularities potentially indicative of which generative mechanisms are in play within the specific context of contemporary nurse practice should be identified. This process corresponds to stage (v) of the analytical schema presented in Figure 2.

This process is an acknowledgement of the stratified nature of reality, involving competing structures and mechanisms that operate side-by-side in the real world, often in tension with one another. The centrality of a ‘stratified reality’ for critical realism opens the possibilities for an understanding of the ways in which the activities of social agents relate not just to one but to a whole range of inter-related structures and practices. This understanding (it has been argued) necessarily requires a non-reductive and dialectical approach to analysis of the data.
4.3.1 The identification of contrastive demi-regularities in nursing work

The stratified nature of social reality may be said to be reflected in “…the dialectical complexity of the social world where competing structures and mechanisms operate side-by-side” (Joseph:2002:34). Given this position, how are the variations that consequently exist within a social context or ‘restricted regions of time-space’, namely the practice of nursing within the contemporary NHS, to be analysed?

The work of Tony Lawson (1997), discussed in detail above (in Section 3.2.2.3), recognises that the underlying generative social mechanisms come to attention through their effects at the empirical level of the contrasts that exist between two similar situations or between two similar social groups in the same situation. Something stands out, which enables ‘rough and ready generalities’ to be made about that situation. Such contrastive demi-regularities provide evidence for the occasional, but not universal, actualization of a generative mechanism.

Drawing on the outcomes of the ‘theorisation’ section of this process of data analysis, it is possible to identify a number of contrastive demi-regularities in relation to nursing work within the late modern system of health care. These exist in two forms: first, in terms of the contrasts in the nature of nursing practice as it has changed in response to the organisational restructuring within the NHS in the 1990s as well as wider social processes of change and transition (this is a period during which all the nurse participants in the focus group discussions were in practice); second, in terms of the contrasts that existed between the practices of the different groups of nurses at the time when the focus group discussions were conducted. Attempting to identify the underlying causes or mechanisms that could account for the differences or contrasts in each of the examples presented below means beginning the process of postulating an explanation for the phenomena in question – i.e. moving beyond the deductive to the causal-explanatory mode of theorisation (Fleetwood:2002:65). Three contrastive demi-regularities that emerge from the discussion of the inductively-derived themes and deductive theorisations are discussed below.
(a) The contrastive demi-regulatory existing between formal nursing theory as expounded by the academic hierarchy of nursing and the discourse of nursing found in the everyday practice of nurses within the NHS: The so-called 'theory-practice gap'

Nurses’ own conceptualisations of their practice concerned with the delivery of care to patients, as articulated in the discourses emergent from the focus group discussions, appeared to be predicated on the basis of meeting clinical need (usually determined by the medical profession) as well as the organisational needs of the hospital and of the health care system in general. It should be noted that the requirements of these two structures are not necessarily coterminous, which leads to inevitable tensions in the practice of the nurses. At the same time, the development of a more openly philosophical approach to the practice of nursing (known generically as the ‘new nursing’) which arises out of the work of nurse academics (and North American theoreticians at that) stands outside the everyday demands of the health care system. This approach has consciously attempted to epistemologically demarcate nursing practice from biomedical and organisational priorities, in favour of the holistic needs of patients. This represents an attempt to give nursing a ‘distinctive jurisdiction’ within the health care division of labour. However, such concerns, which are largely driven by a desire to achieve the ‘full’ professionalisation of nursing, do appear to be fairly low down on the priorities of practising nurses, as in this example taken from a focus group discussion:

R6 (A&E nurse) The pressures that we are under make it a lot harder than I thought it would be. I always thought that I would be the person that communicated well, and, people would say ‘what a great nurse that A&E nurse was’, and ‘it’s a great hospital, and the A&E department is brilliant’. But it does not always work out like that because there are so many pressures. Because there are never any beds, the immediacy of everything, people want things done now! That was one of the reasons I came into it, but on the other hand, after so many years working in A&E, I don’t think I actually fulfil my idea of myself as a nurse when I first came into the department.
There was only a minimal discussion by the nurses of the processes that would be necessary to apply nursing theory to practice in the NHS. This process is well recognised within the literature, where it is known as the ‘theory-practice split or gap’. This is a demi-regularity that has long existed in nursing practice but would appear to be much more marked in the 1990s, probably reflecting the shift of nurse education into the higher education sector in Britain and the subsequent development of a whole new layer of nurse academics, contrasted with ever greater demands from within the NHS for greater productivity and efficiency.

Material context is a crucial factor here, because these sets of idealisations and practical concerns associated with nurse academics and practising nurses exist within quite separate institutions, each with their own different sets of organisational demands.

\[(b)\] The contrastive demi-regulatory existing between the differing perspectives of groups of nurses (generalist, specialist, community-based) regarding the key constituents of their practice

Contrasts also emerge in relation to the perception of the key constituents of the nursing role, with hospital-based nurses generally having a much more idealised view of the ‘basic role’ of nursing (although rarely defined) than community-based nurses. The ward-based nurses generally regretted the shift towards more ‘extended roles’, whilst the ‘specialist’ A&E nurses as well as the DNs welcomed the opportunities now offered to them as a result of the organisational changes within the NHS, which have sought to widen the roles of health care professionals in general (and have been resisted by the medical profession in particular).

In relation to the notion of holistic nursing practice, definitions varied widely between groups of nurses, from seeing holism as simply a more elaborate form of patient assessment, through to the opportunities such an approach gave nurses to recognise and meet the emotional and social needs of patients. The community nurses as a group almost uniformly adopted the language if not the explicit philosophy of holism when describing the care they provided.
There were also contrasting perspectives concerning the contribution and commitment to the needs of the local community and the promotion of health by the different groups of nurses. Whilst for community nurses these areas of nursing work are central, hospital-based nurses tend to play down (occasionally with reflective regret) these aspects of nursing work in favour of clinical interventions and a concern with medical technology. This particularly applies in regard to nurses with specialist skills, such as A&E nurses; for example:

R8 (A&E nurse) I like working in a multidisciplinary team, I like the pace of the work. I like the fact that patients move on quite quickly so that you don’t have people to look after them for fifteen days, fifteen weeks, fifteen months. I enjoy the fact that there are always different things going on and things change very quickly, it made it more interesting to work in an area that was like that.

The causal factor that would appear to explain these contrasts between groups of nurses is the material and institutional context in which such nurses practice. This is certainly manifested in the relative distance (not just in physical but also in ideological terms) between the nurses in general and doctors when carrying out care. It may also be reflected in the on-going relationships that community-based nurses are able to establish with their patients, as against the brief interaction of a nurse with an attendee in the A&E department of a hospital.

(c) The contrastive demi-regulatory existing between the traditional relationship of subordination within the medical division of labour that pertained between nurses and the medical profession and that which now exists within a reorganised system of health care.

In the NHS today, there would appear to be a greater willingness by nurses to question the clinical autonomy of doctors, although just how widespread this is in practice is difficult to ascertain. This is a development that possibly reflects a number of processes that have occurred within nursing itself. These would include the greater
willingness on the part of nurses themselves to take on a 'patient advocate' role, the
acquisition of greater technical skills, and a wider academic knowledge-base for
nursing practice itself.

The patient advocate role is in part a response by nursing to the 'consumer-led'
organisational reforms within the NHS. It has now become more formalised within
the new 'clinical governance framework' introduced as a central plank of the New
Labour government's 'modernisation' programme for the NHS. Nurses' own
discourse surrounding this patient advocacy role did appear to be all about asserting
themselves as a relatively autonomous profession, rather than necessarily acting as a
conduit for patient rights. This process is demonstrated in the following exchange
between District nurses:

R1  We have become more of an advocate for patients.

R15 Yes, we now have more responsibility. I can go in and say to the GP,
'I've seen Mr X, he's got a leg ulcer, query infection, we've swabbed it and he
needs some anti-biotics, or could we try this dressing?' And they now say,
'Yeah, no problem, try it and come back to me'.

R13 Yes, we do have more responsibility. You have updated yourself, you
have done your research. You are able to negotiate with the doctors.

What emerges from the focus group discussions is a manifest confidence amongst all
the different groups of nurses to assert their knowledge and skills in clinical practice.
This may also explain why there appears to be a greater willingness by doctors to
acknowledge the contribution of nurses as colleagues (although not necessarily equal
ones). However, the relative decline and diminution of the authority of the medical
profession at the organisational level of the NHS which was discussed in detail in the
literature review (see Section 2.2 above) must also be a crucial factor in this
contrastive demi-regularity.
4.3.2 The postulation of generative mechanisms underpinning nurses’
discourses in a period of organisational transition within the NHS

The objective of the methodological process of retroduction is to arrive at a concrete
conceptualisation of the research object. This is achieved through a process of
synthesis of a range of relevant abstract categories, which in this case have been
derived both inductively from the focus group data and deductively from the
theorisations of nursing work and the organisation of health care in modernity that are
presented in the literature. The intention is to be able to infer the set of underlying
generative mechanisms which are at work in a specific social and material context,
“... which if it were to exist and act in the postulated way would account for the
phenomenon in question” (Bhaskar:1989:12).

The identified contrastive demi-regularities indicate that, when inferring the set of
generative mechanisms that could account for nurses’ practice, we need to examine
the relationship between the processes of structural and organisational change that
have occurred within the state health care system and the tensions that exist in the
contemporary practice of nurses. We have to look beyond processes that are purely
internal to the profession of nursing itself. The contemporary practice of nurses, as
articulated in the discourses of nurses themselves, would appear to be framed by a set
of reactive responses to the structural and organisational impositions upon nursing
work experienced within the NHS in the 1990s. However, the form of these responses
appears to be shaped by an ideological framework of understanding common to the
(heterogeneous) collectivity that is nursing.

(1) The material requirements of the late modern NHS, setting structural limits to the
role of the nurse within the health care division of labour

The material requirements of the NHS collectively constitute a generative mechanism
that can be identified as setting clear limits to the ideals and ambitions of nursing as a
profession. The health care delivered to patients within the NHS continues to be
structured in large part around the individualised biomedical conception of illness and
its associated clinical interventions. The NHS as an example of a modern system of
state health care, was primarily developed to provide a service which would compensate individuals for the vicissitudes of the capitalist system of production and consumption. As has been argued above, the organisational ‘reforms’ experienced by the NHS in the 1990s (from the attempt to introduce competition into a state system of provision through the back door of the ‘internal market’ introduced by the Conservative government in 1989, through to the ‘modernisation’ programme of the New Labour government) have not significantly changed this fundamental approach to health care delivery. This is despite the apparent commitment of the New Labour government to resourcing primary preventative health care programmes (DoH:1998) and the various anti-poverty initiatives that it has introduced since 1997.

Modern nursing has always been a subordinate occupation within the health care division of labour, which in turn emerged largely as a consequence of the technological changes that characterised the development of modern medicine at the end of the nineteenth century. This was a process that eventually led to the modern form and organisation of the hospital, in which nurses could be seen as workers (rather than a traditional profession with a degree of autonomy) in a system of health care production. The reforms to the NHS that have been imposed by both Conservative and New Labour governments in the 1990s, although inspired by somewhat different sets of political and ideological priorities, remain primarily driven by the need to raise productivity of all health care staff (the primary resource of all health care systems) to provide a ‘value-for-money’ service. These are a set of material processes that, together with a technologically-driven shift in clinical priorities, such as minimally invasive ‘keyhole’ surgery (allowing even greater patient ‘throughput’), clearly have had a direct impact upon what is expected of nursing and nurses.

(2) The ideological framework of nursing practice

It has been argued that the ideological framework forming the basis for the practice of modern nursing as well as shaping nurses’ responses to structural change can be seen to be constructed from a wide variety of ideas and influences, many of which are
contradictory. In this it reflects Gramsci’s observation of the ways in which an ideology contains ‘sediments’ or ‘stratified deposits’ of previously influential philosophies, with the result that we do not begin anew in conceptualising or making sense of the world with each new generation. This positive conceptualisation of ideology (rather than as a negative ‘false consciousness’), when applied to the collective understandings of nurses as a social group, can be seen as embracing the historically idealised view of the role and status of the professional within society that exists within formal nursing theory. That is, the nurse as idealised knowledgeable expert in a top-down but caring relationship with the lay patient. However, this ideological framework can also be said to incorporate elements or sediments of late modern developments in the politics of health, which place an emphasis on individuals taking responsibility for some aspects of their own health.

Whilst these positions may appear contradictory (traditional service-welfare role as opposed to the incorporation of a late modern consumerism), they are linked within nursing discourse by an essentially individualist conception of health and health care. Such individualism finds expression both within the biomedical ‘pathological body-system’ approach to clinical intervention, as well as the ‘new nursing’ theoretical framework which employs an understanding of humanistic philosophy which is very focused on ‘self-conception’ (as against collective identity), employing notions such as holism, autonomy, reflexivity, and self-empowerment. Whichever one or combination of both of these approaches is adopted by nurses in their practice, it essentially excludes the wider social structural factors that account for the social inequalities in health outcome that exist in Britain today.

The potential contradictions that exist between the different strata of the ideological framework shaping nursing practice can be accounted for by an understanding of the stratified nature of social structures as a process that produces unpredictable outcomes for social agents. In the context of the sets of meanings and ideas employed by nurses in their practice, we are not dealing with the ideological influence of just one formal structure, nurse education, but inter-related structures with multiple effects. There is also the temporal aspect, which would produce a disjuncture between the ‘official’ or formal expectations of nurses in practice, whether this comes from the Department of Health or nursing’s own professional bodies. This results in an ‘uneven’
incorporation of these formal conceptualisations of the role. These processes can serve to produce a more ‘low-level’ discourse held by nurses in practice which is quite frequently in tension with the formal position of the profession as expressed through the UKCC or Royal College of Nursing.

(3) The late modern politics of health care consumerism

From outside the organisational structures of the health care system come those emergent demands upon the health service and the staff who constitute its prime resource that are fuelled by a pervasive consumerist ideology. This is an ideology that has not simply ‘emerged’ but has been promoted by both Conservative and New Labour governments within Britain, and the process has been common to most EU countries through the 1980s and 1990s. The new politics of health care that has emerged in consequence is a curious amalgam of neo-liberalism and its sibling, consumerism, within a state-funded universal system of provision. One of the outcomes of this structural process has been to increase patient expectations of the health service within Britain. Developments such as the ‘Patient’s Charter’, introduced by the Conservative government in 1992, set specific ‘rights’ and ‘standards’ for patient care and treatment that health professionals were expected to meet for the first time, even if they do not coincide with clinical need.

This consumerist politics is also at the base of the New Labour government’s modernisation programme for the NHS. The needs of the consumer of health care have been cited in an attempt to gain more centralised control over the activities of health care professionals (and the medical profession in particular). However, this organisational process is in many ways quite different from that of the previous Conservative government, which attempted to reduce the decision-making power of the medical profession (and by extension the nursing profession) through the introduction of a new stratum of professional managers. The New Labour programme of reform (DoH:1997; DoH:2000) has introduced the clinical governance framework which is designed to get the health care professions to set their own standards of accountability – standards by which they will be held accountable not internally, by the professions themselves, but by the Chief Executive of the local health care trust in
which nurses and doctors work. This process is only possible if at least some of the ideological goals of consumerism have been absorbed into nursing’s own ideological framework of practice.
4.4 Recontextualising the concrete conceptualisation

An analytical process informed by critical realism does not end with a set of conceptualisations, however concrete. Although such conceptualisations exist at a different level from the research object (nurses’ discourses), they are potentially able to postulate the mechanisms that can explain the research object’s form and content in a particular social context. But to do so involves the second phase of the ‘double movement’ that is an essential requirement of a dialectical process of analysis. That is, the ‘abstracting-down’ process must be balanced by a reconstructing or ‘recontextualisation’ of these concrete conceptualisations so that the essential as against the inessential aspects (or the necessary as against the contingent relations) of that ‘chaotic whole’ can be distinguished (Sayer: 1992:87).

To illustrate this recontextualisation process, three examples of discourses that arose from the nurse focus group discussions will be examined. Then the necessary rather than purely contingent structural mechanisms that are determinate of the form of these discourses can be identified. The three discursive themes are presented below in the form in which they appeared in the inductive analysis (see in Section 4.1.2 above).

(a) Recognising the need to develop a relationship with patients which respects their autonomy in relation to health care decision-making...however,...nursing practice is becoming more defensive in order to avoid raising patient expectations of the service, thus reducing the number of patient complaints.

This nursing discourse demonstrates the effects of those contradictory elements that constitute the ideological framework of nursing practice. At one level there is the idealisation of the philosophical approach which has informed much of the theoretical output of nursing education since the mid-1980s. This approach is driven by the recognition (at an idealist level) that there is a need to move away from the traditional top-down nurse-patient relationship towards one which is more equal. However, there is also the practical constraint of coming up against patients who have increasingly
high expectations of the service (possibly arising out of a wider late modern politics of welfare) which can never be met by nurses, given the material curbs on health care spending.

A practical acknowledgement of patient autonomy in the delivery of nursing care, whilst meeting patient expectations, does not in principle (given unlimited health care resources) constitute a contradiction for nursing work. In practice, it has resulted in significant tensions within nurses' own discourses. This demonstrates the way in which social context is crucial to the understanding of the social structural constraints (resource limits of the NHS), which set limits on the possibilities of action for human agents (in this case the desire to provide nursing care which would meet the holistic needs of patients).

The result is a set of tensions which serve to produce increasing apprehension about patients' responses to the care they receive as nurses wonder whether they will be blamed personally and subjected to formal complaints for their failure to meet patient expectations of the service. This leads to a nursing ideology that seemingly retreats from or rejects idealisations or theorisations of the role and adopts the traditional 'nurse knows best' attitude which serves to reinforce the separation of nurse as professional and patient as lay individual. This is demonstrated by the way in which some nurses regard patients as being essentially happy to assume the 'sick role'. Their discourse sees patients as being forced into defining their own health needs, as a result of consumerist reforms to the NHS or by the 'system' generally, when all they 'really want' is to be told what to do.
(b) Doctors are dependent upon the advice and support of nurses but do not reciprocate this dependence by allowing nurses to participate in clinical decision-making processes.

This discursive theme is an example of an implicit recognition by nurses of the structural limits set to their competence within the health care division of labour. These structural limits are determined by the hegemonic practice of the medical profession and biomedical determinants of what are ‘effective’ nursing interventions within modern health care systems. This hegemony of biomedicine is a generative mechanism that serves to define the (material) basis for the practice of nursing. This hegemony is built in part upon the ideological power of scientific rationality within modern Western societies, which reflects its historical success in constructing the myth that it is able to manage the uncertainty that has always pervaded and continues to pervade the practice of medicine (of all types) in relation to its object, the sick individual. Doctors who are engaged in the practice of biomedicine have thus been able to maintain their position in defining the areas of competence of other (subordinate) health professions such as nursing. Even quite junior doctors have traditionally been able to maintain a large amount of discretion in their daily work vis-à-vis nurses and other health professionals. The modern system of health care has given doctors the legitimacy to maintain these discretionary powers over clinical decision-making, and until recently this has served to prevent encroachment upon their autonomy by other health professionals as well as by users of the health service.

The nurses’ discourses present the view that doctors are happy to implicitly acknowledge the skills and knowledge of nurses through their reliance upon nurses’ advice and support (this is certainly the case as regards junior doctors in A&E Departments and as regards GPs dependent upon a community nurse’s knowledge of the patient). However, the medical profession continues to set definite limits to nurses’ clinical decision-making powers. Here, what is being acknowledged is that, whilst an individual doctor may, from the perspective of the nurse, be lacking in the appropriate knowledge to carry out his or her role effectively, a challenge to that doctor would nevertheless be seen as a challenge to the hegemony of the medical profession as a whole within the system of health care.
Eastern Europe in the late 1980s, representing a completion of the modernist project. Second, as used within particular strands of sociological thought, ideologies are understood in the broader sense of being discursive types of social phenomena, which can include the level of everyday notions and 'experience' as well as elaborate intellectual doctrines. Thus conceptualised, ideology can be seen as operating not only at the level of the 'consciousness' of social actors but also at the level of institutionalised 'thought-systems' and discourses of a given society (Therborn:1980:2).

Therborn's (1980) own use of the concept relates to his concern with the operation of ideology in the organisation, maintenance, and transformation of power in society. This concern with power and hegemony is characteristic of the use of ideology as it has been classically conceptualised within the Marxist theoretical tradition. The Marxist theoretical lineage has frequently (but not always) embraced both a concern with the epistemological issue of ideology as distortion and a rather more sociological concern with the formation of 'action-orientated sets of beliefs' (Eagleton:1991:3). Certainly by the 1970s the Marxist conceptualisation of ideology had come to represent an 'orthodoxy' (if the term can be used) that post-structuralist theories of discourse (which were to become fashionable and influential over the following two decades) sought to 'deconstruct' (in the Derridian sense of the term). Within this latter theoretical framework, the critique of ideology has been said to be less than relevant to the self-reflexive post-modern world, which apparently we all now inhabit. In this world, the epistemological notion of a relationship between reality and representations of that reality present in forms of ideological consciousness is seen as being hopelessly outdated. From this position emerges the non-reductionist notion of discourse. This conceptualisation of discourse will be explored and challenged within this chapter, and the argument for the continuing relevance of a positive Marxist concept of ideology for an understanding of the dialectical relationship between agency and social structure will be presented. It will be argued throughout the chapter that this is of particular importance if the relationship between the practice of nurses as social agents and the transition in the structure and organisation of health care is to be understood beyond the level of idealist constructions.
2.5.1 Marx’s theory of ideology: Material practice and the formation of ideas

Whilst ideology as a historical materialist construct appears in the work of many of the key Marxist thinkers of the twentieth century, there are significant disparities in the way in which it is conceptualised. Ideology’s significance for any particular strand of Marxism is usually dependent upon the relative importance accorded to subjective class consciousness in relation to the structures of capitalist production and reproduction. Larrain argues that we can find both these concerns in Marx’s own attempt to bring together the two main elements of Enlightenment thought (the philosophy of consciousness and the new scientific rationality) by locating the historical place of the active subject in making material reality (1979:35). Although Marx never offered a dictionary-type definition of ‘ideology’ or a theoretical account of ideology per se, his conception of ideas and social consciousness was intimately bound up with his concept of determination. His contention was that all forms of consciousness were determined by material reality, that consciousness was therefore a ‘social product’. Marx rejected the idealist metaphysical conception which separated consciousness and reality, and in The German Ideology he argued that men, “…in developing their material production and their material intercourse alter, along with this, their real existence, their thinking and the products of their thinking. Life is not determined by consciousness but consciousness by life” (1970:47).

Consequently, in order to understand the relationship between consciousness and reality therefore it is necessary to understand the specific material conditions of production in particular historical periods. For Marx, the notion of ‘practice’ is central to this relationship, material practice being the human labour involved in continuously producing the means for sustaining and reproducing human life. However, practice is not some instinctual process; for Marx it is always “intentional activity, it has a goal” (Larrain:1979:41). Therefore, practice has the potential not only to ‘transform nature’ as a process of production but for men and women to transform themselves, liberating themselves by their own actions from oppressive social relationships that are their own creation. It is through the process of producing the conditions for material life that consciousness is produced, hence the unity of consciousness and reality for Marx.
Practice as an essentially collective process leads on to the historical development of production processes and a division of labour from which social relationships and social conditions emerge independently of (the majority of) men’s and women’s wills and interests. From these contradictions or unintended consequences of human practice, structures and relations (social class divisions) emerge as an ‘objective power’ over which men now lack control. Practice which is a product of an ‘incomplete reality’ results in ideology. This represents an ‘epistemological dimension’ to the concept of ideology (Higgs:1993:177), a conception of ideology as a ‘distorted solution’ to contradictions that cannot be solved in practice, such ‘restricted practices’ forming the basis of a contradictory reality (Larrain:1979:47). It should, however, be emphasised that the notion of contradiction is conceived by Marx not as the universal essence of reality but as a condition of specific social situations in which inversion (used in the Hegelian sense of an inner reality concealed and reversed by its phenomenal form) occurs; i.e. all class societies. For Marx, these are real, historical contradictions rather than the abstract ideal conceptualisation that exists within Hegel’s philosophy (Larrain:1983:132).

In the work of Marx, four principle contradictions within the capitalist mode of production can be identified. These are the contradictions that exist between the productive forces and the relations of production; within the commodity as between use-value and exchange-value; between a socialised system of production and private appropriation of profit; and between capital and labour. The latter is arguably the most fundamental contradiction since that it constitutes a basic antagonism within the capitalist mode of production; the two components each presupposing and negating the other. Certainly, the contradiction between capital and wage-labour is crucial to Marx’s own understanding of the origin and role of ideology within capitalism, as the outcome of capital being compelled to reproduce itself by reproducing its opposite, namely wage-labour. Thus, for Marx, the process of reproduction involves not only the reproduction of the material means for capital production but also the reproduction of the social conditions producing a supply of wage-labour, which in itself potentially constitutes a principle contradiction for capital. In so far as the other contradictions outlined above are dependent upon and shape this principle contradiction, they have also historically become the object of ideological contradictions:
Ideology is therefore both the result and the condition of the reproductive process of the contradictions between capital and wage-labour" (Larrain:1983:157).

Marx’s notion of ideology is thus both a critical and a negative conceptualisation in that particular sets of ideas are recognised as serving to legitimate an existing social and class structure and thus serve to reproduce that social system. The ideas of the ruling class emerging in any historical epoch are those ideas which ‘take on the form of universality’:

“For each new class which puts itself in the place of one ruling before it, is compelled, merely in order to carry through its aim, to represent its interests as the common interest of all the members of society ” (Marx and Engels:1970:60).

This new ruling class can initially present itself as the representative of the whole of society. However, contradictions soon crop up within the new mode of production, and this is the moment when ideology emerges to conceal such contradictions. Thus, for Marx, ideology arises not only as a historical phenomenon; “... its very character also changes as contradictions evolve ” (Larrain:1979:49). Central to these contradictory processes is the involvement of the individual as both subject and object in the production of ideology.

As stated above, in Marx’s generalised conception of ideas there is no single unitary theory but rather two positions. The first is that which is outlined in his early work and is concerned with the effect of material structure on consciousness. Here, ideology is seen as reflecting the interests of the dominant class, the ruling ideas as reflecting the ideas of the ruling class. This position assumes the existence of some form of ‘ideational superstructure’ which includes modes of thought, beliefs, and culture and which serves to reflect and reproduce the existing (contradictory) social formation (Larrain:1979:51). The notion of the ‘superstructure’ does appear several times in Marx and Engels’s work, but it is used ambiguously, so the meaning is open to interpretation. However, Larrain for one maintains that Marx is referring not to any objective ideological level (as in Althusser’s reading of Marx) or, indeed, the totality
of forms of consciousness (as in the positive conceptualisation of ideology that appears in the work of Lukács and Gramsci) but to a level of global consciousness or level of intellectual production of a society that would include both ideological and non-ideological forms of consciousness. The ruling ideas are the ideas of the ruling class, but this does not make all of them ideological (Larrain: 1983:171-3). Marx would separate science from ideological forms of consciousness such as the political and the legal.

The second way in which Marx conceptualised ideas is as set out in *Capital* (1976), which had as one of its prime concerns an examination of the objectified power of capital over labour. Here Marx argues that the real character of capitalist relations of production cannot be understood by subjects simply through their experiences. This is because of the particular phenomenal forms these material practices take on. Marx then emphasises the role of consciousness in creating ideology as distortion, and this introduces the notion of ‘commodity fetishism’. Here, the commodity as historical form is seen to arise out of the particular reproductive processes associated with the capitalist mode of production’, ‘dead labour’ or capital assuming greater importance than ‘living labour’. This represents Marx’s ‘essence-appearance’ dichotomy, wherein the value-relation of commodities appears as a relation between things, when its value is built upon the social relation between men. On the other hand reality, for Marx, is the unity of essence and appearance, in which phenomenal forms concealing real social relations are as real as the essence they conceal; ideology serves to ‘fetishise’ the world of appearances (Larrain: 1979:57).

If each of these two positions is viewed separately and interpreted in a purely mechanical way, then social structure and the individual’s place within it could be interpreted as determining such individuals’ understandings of the world. Yet Marx’s conception of material practice has the potential for overcoming this problematic subject-object as it mediates between consciousness and social being (Larrain: 1979:64). For Marx, the subject both shapes and is in turn shaped by ideology, whilst at any historical moment either the subjective or the objective can be a dominant influence. As Larrain goes on to argue, “(t)he proportion of each aspect may vary, but ideology is never pure invention disconnected from reality or a mere objective deception imposed by reality on the subject” (1979:49). This is a conception
of history which "... does not explain practice from the idea but explains the formation of ideas from material practice" (Marx: 1970:58).

2.5.2 The shift to a totalised conception of ideology within Western Marxism

For Marx, no forms of knowledge exist outside his 'double perspective' on ideology. This includes knowledge as forms of social consciousness, where Marx stresses the relationship between consciousness and practice, but also the recognition that knowledge or consciousness reflects the economic structure, where ideology is manifested at the level of superstructure. Essentially, Marx's position represents a critical rather than an overly negative assessment of ideology. Whilst Marx identified the negative impact of ideology as a state of inversion of consciousness and as an inversion of objectified social practice (which the early Marx termed 'alienation', although the later Marx recognised that the level of production is concealed by the level of circulation, with the wage form as equitable exchange making this inversion process more complex), he was never unequivocally committed to the existence of an objective or true knowledge ('science') as existing outside the sphere of ideology. After Marx's death, this critical conception became gradually 'displaced' by a conception of ideology as the 'totality of forms of social consciousness' and by the notion of an ideological superstructure (Larrain: 1983:46). The elements that Marx integrated to construct a notion of ideology gradually became polarised within two distinct positions emergent within this totalised conception; these position have been termed 'positivist' and 'historicist'.

The positive conceptualisation of ideology is usually associated with the work of Engels (and later of Lenin). It emphasises the primacy of the economic base over an essentially derivative superstructure in the determination of knowledge; without this being seen as a reductionist or mechanical process. Engels argued that the ideological has no independent historical development, whilst admitting that it did have an effect on history. Lenin subsequently developed a positive yet essentially epistemologically neutral concept of ideology, his early work arguing that the will or consciousness of the individual, social class, or government is very much a secondary phenomenon.
compared to the laws of historical necessity. Practice and consciousness are conceived purely as instruments of this structural determinism. All forms of social consciousness that are not merely distorted consciousness are seen as reflecting the base-superstructure relationship. Hence for Lenin there is a bourgeois ideology as much as a proletarian ideology.

In *What is to be done?* (1902), Lenin developed a political theory of class struggle which essentially jettisons Marx’s notion of ideology as the distortion or inversion of economic reality. The dominant ideas in a class society are seen as closely tied to the political interests of the ruling class, whilst the critique of these ideas is an expression of the political interests of the dominated class. Here, ideology takes on a positive connotation in that it reflects the political ideas of all social classes (Larrain:1983:64). However, whilst ideology is defined by its connection to the interests of a class, it does not follow that all the ideas produced by a class are necessarily in the interests of that class. Lenin recognises what he terms the ‘spontaneous ideology’ of the working class as essentially reflecting bourgeois ideology. Science, on the other hand, which Lenin saw as being somehow produced outside of the class struggle, offers the possibility of liberating proletarian consciousness. His conception of the process of development of a socialist consciousness was essentially a fusion of three concepts: ideology, class consciousness, and science (Larrain:1983:68). Significantly, this process had to be mediated via the revolutionary party rather than through practice. The falsity of bourgeois ideology, then, for Lenin, is a reflection not of its ideological character but rather of its bourgeois origins. Thus the concept of ideology as a tool of analysis and critique, present in the work of Marx, begins to disappear from Lenin onwards. As a positive conception, ideology ‘loses its specificity’ (Larrain:1979:74-77); it becomes neutralised.

Lenin’s positive conceptualisation of ideology is often, within the literature, contrasted with the ‘historicist’ approach (as described by both Althusser and Poulantzas) to conceptualising ideology. This is associated with the writings of Lukács and of Antonio Gramsci. In Lukács’s early work, particularly *History and Class Consciousness* (1971), there is a rejection of the Engels-Lenin view of ideology as reflection. Rather, Lukács sought the link between consciousness and reality in practice. This ‘praxis’ or unity of consciousness and existence does not result from
some form of correspondence or equivalence between them but results from both being aspects of the same historical process. For Lukács,

“Ideology appears not only as a consequence of the economic structure of society but also as the precondition of it...(however) consciousness does not depend upon the historical practice of the class; rather it is conceived as an imputed rationality which flows from class being” (Larrain:1979:79).

This distinction sets up a duality of the ‘psychological consciousness’ of a class against the ideology or ‘ascribed consciousness’ of a class (which some have compared to Lenin’s spontaneity/science dualism). The emancipation of the proletariat is no mere mechanical evolutionary process. The role of consciousness as the ‘ascribed’ world view of a class is crucial in anticipating these economic developments. Class consciousness has almost an autonomous existence for Lukács, an approach which places a central role upon the subject in the creation of class ideology.

It is important at this point to emphasis that the basis of Lukács’s theorisation of class consciousness “...is not the empirically given consciousness of individuals or of the class as a whole, but rather what the class can become” (McDonough:1978:36). The notion of ideology represents a true consciousness of reality for Lukács, as opposed to actual awareness or ‘psychological consciousness’. Here the relationship between a class and its ideology (true for both bourgeoisie and proletariat) is seen as a functional rather than as a genetic one. From this it follows that what Lukács termed ‘ideological contamination’ can arise out of the very situation and practice of the proletariat within the capitalist system, and it is precisely because the proletariat is the product of such a system that it is subjected to the typical mode of existence of that system, i.e. inhumanity and reification (Larrain:1983:75-76). Stedman Jones explains this process as follows: “…relations between men take on the appearance of relations between things; human society and human history, the products of man, appear not as the products of social activity, but as alien and impersonal forces, laws of nature which impose themselves on humanity from without” (1978:13). In marked contrast to Lukács, Lenin saw the ideological subordination of the proletariat as resulting from the fact that the ruling class posses more powerful means for the communication of ideas.
Lukács argued that it was only with the historical emergence of the proletariat that ‘social reality can become fully conscious’, that there now existed the potential for the proletariat to understand itself, developing a class consciousness in the movement from contemplation to praxis. In the production of this proletarian ideology, “...the unity of theory and practice is only the reverse side of the social and historical position of the proletariat, simultaneously subject and object of its own knowledge” (Lukács:1971:20). On the other hand, the nature of bourgeois class consciousness for Lukács is that of a state of ‘false’ or unreal consciousness, not because it is ideological per se but because of the structurally limited historical position of the bourgeoisie (Larrain:1983:73). Thus, when Lukács argues that it is ‘only ideology that stands in the way’ of the proletariat opposing capitalism, he is referring not to ideology in general but to bourgeois ideology. Concretely, that is, the impact of the economy, state, and its legal structures appear as ‘man’s natural environment’, as “…the only possible environment for [men] to exist in” (1971:262).

Nevertheless, Lukács’s work has been criticised historically, from the Leninist political perspective, as being too idealist. This was a charge acknowledged by Lukács himself in a subsequent political phase of his life, when in a new preface to History and Class Consciousness he admitted to “over-extending the concept of praxis such that it resulted in its opposite... a relapse into idealistic contemplation” (1971:xviii). He also admitted that, rather than it being practice which transforms reality, it was ‘practical consciousness’; consciousness acquiring an almost total autonomy in his early work. As summed up by Larrain, “…this reaction against the reductionist tendencies of positivist Marxism has been taken too far, to the point where the role of social determinations on ideology has almost disappeared” (1983:77). However, as Higgs argues, it is possible to utilise Lukács’s insights, particularly the connection between social consciousness and a positive conception of ideology, to develop an understanding of how ‘limited forms of class consciousness’ can emerge from the failure of bourgeois ideology to explain ‘the totality of capitalism’ (1993:184).

The work of Antonio Gramsci also represents a reaction against the positivist scientism of the Marxism of the Second International. This embraced an essentially negative conceptualisation of ideology, seeing it as an epiphenomenon operating at
the level of ‘pure appearance’. Gramsci rejected such an epistemological reading of ideology and sought to emphasise a positive (but not positivist) conceptualisation of ideology and the ways in which it operated at both the historical and the structural levels. In ‘The Philosophy of Praxis’ (in Selections from Prison Notebooks:1971), Gramsci demonstrated that, whilst ideology was visible only at the superstructural level, it was to that extent an expression of a contradictory reality. This was because superstructures were ‘objective realities’ and not mere epiphenomena, and it was through such structures that social actors gained a ‘consciousness of their positions and goals’. Ideology is thus seen by Gramsci to operate at different levels. This was in contrast to Lukács, whose analysis remained at “an undifferentiated level of high intellectual complexity” (Larrain:1983:82). Gramsci’s work was concerned more with specific ideological conceptions of the world that were bound up in the social practices and class struggle accompanying the rise of Fascism in Italy in the 1920s and 1930s, whilst Lukács was addressing questions of ideology-in-general. Ideology and hegemony were not, for Gramsci, general entities. This made it easier for him “…to ask empirical questions about the material determination of ideologies and the role they play in securing, or undermining relations of class domination in specific social formations” (Callinicos:1983:153).

Gramsci went on to distinguish between two broad types of ideology: on the one hand, those which were ‘historically organic’ or necessary to a given structure and expressed as ‘philosophy’, and on the other those which constituted arbitrary or ‘willed’ speculations of individuals. The most systematic and rigorous form of ideology was ‘philosophy’, which expressed the world view of a class or at least the intellectuals of that class. A ‘spontaneous philosophy’ of the masses was recognised as being connected to this higher level of ideology through the use of ‘language’, which was seen to consist not simply of words and grammar devoid of content but as containing structurally predetermined notions and concepts. This ‘spontaneous philosophy’ was in turn seen as consisting of three broad types: ‘common sense’, as the generally unsystematic sets of assumptions and beliefs common to any given society; ‘religion’ (much more significant in the Italy of the 1930s when Gramsci was writing than it is today); and the entire system of beliefs, superstitions, and opinions which he collectively termed ‘folklore’.
For Gramsci, acquiring a conception of the world or a set of ideas and way of acting has a social basis which contains many disparate historical prejudices together with more modern scientific ideas. Contemporary sociologists would probably recognise this conception as the process of cultural socialisation. His conceptualisation of 'common sense' as ideology has a particular significance, given its pervasiveness in society. Although such 'common sense' has a basis in popular experience, it nevertheless does not represent any unified or systematic conception of the world; as opposed to 'philosophy' (the ideology of a social group). Gramsci argued that each social group or class has its own notion of 'common sense', which draws upon what he termed the 'sedimentation' or 'stratified deposits' of previously influential philosophies. In other words, we do not begin anew in conceptualising or making sense of the world with each new generation:

"Common sense is not something rigid and immobile, but is continually enriching itself with scientific ideas and with philosophical opinions which have entered ordinary life" (Gramsci: 1971:326).

For Gramsci, then, whilst the ordinary person ('active man-in-the-mass') is daily engaged in practical activity, this does not mean that they have a clear theoretical consciousness or understanding of that practice, even though they may be engaged in transforming the social world in some way. Indeed, it is possible for the theoretical consciousness of a person to be 'historically in opposition' to his or her activity. The impact of ideology is here manifested in the form of a contradictory consciousness. To illustrate this argument, given its importance for the present thesis, it is worth quoting Gramsci at length:

"One might almost say that he (the typical working class person) has two theoretical consciousnesses (or one contradictory consciousness): one which is implicit in his activity and which in reality unites him with his fellow-workers in the practical transformation of the real world; and one, superficially explicit or verbal, which he has inherited from the past and uncritically absorbed. But this verbal conception is not without its consequences. It holds together a specific group, it influences moral conduct and the direction of will, with varying efficacy but often powerful enough to produce a situation... (that) does not permit of any action, any decision or any choice, and produces a condition of moral and political passivity" (Gramsci: 1971:333).
The superiority of the ‘philosophy of praxis’ (Marxist theoretical practice) for Gramsci therefore lies in its being the ‘most conscious’ expression of the contradictions of capitalism. It represents a collective consciousness or will to overcome these contradictions or ‘dual consciousness’. This position could be said to reflect Gramsci’s ‘historicist’ version of Marxism, in which truth or objectivity is always historically variable “...relative to the consciousness of the most progressive social class of a particular epoch” (Eagleton:1991:121). The differences from Lenin’s notion of Marxism as a scientific ideology detached from ‘class contradictions’ and carried from without by the party to the proletariat are clear (Larrain:1979:82).

In assessing the role of ideology in ‘mediating’ class consciousness or, as Larrain (1983) terms it, its ‘integrating effect’, Gramsci focuses on the existence of what he called ‘civil society’ in modern capitalist societies. Civil society is the means through which the ruling class of a political and economic formation establishes its intellectual, moral, and cultural leadership, without resorting to coercion. This is what he termed ‘ideological apparatuses’. These are not to be confused with Althusser’s notion of ‘ideological state apparatuses’ (discussed below), Gramsci’s concept maintaining the distinction between the state and civil society. In modern societies, this form of class domination is conceptualised as the ideological ‘hegemony’ of the bourgeoisie. Here, Gramsci sought to go beyond what he regarded as the ‘economism’ of the time, which identified the state only with repressive government in capitalist societies. His conception of the bourgeois state assumed a ‘wider and more organic sense’, which included the formal political structures as well as the key cultural institutions in the national society. Together, they are seen to sustain the political and cultural hegemony of the capitalist class:

“The conception of power is thus extended to include the whole complex of institutions through which power relations are mediated in society”
(Merrington:1978:151).

Gramsci recognised that, in order to maintain their power, the ruling class must establish a ‘hegemonic bloc’ involving the establishment of alliances with other class factions and social groups, in order to be able to disseminate its central ideological assumptions. For Gramsci, hegemony is the process by which consent to rule is
achieved in modern societies (although he has been criticised for overstating the
distinction between coercion and consent in his separating-out of the role of the State
from the achievement of ruling class hegemony through ‘civil society’ (Anderson:
1977). Hegemony is a central concept within Gramsci’s work, and his
conceptualisation of ideology develops from it. Gramsci’s hegemony includes
ideology but is not reducible to it. As Eagleton argues, ideology refers to the way
struggles are “...fought out at the level of signification; and though such signification
is involved in all hegemonic processes, it is not in all cases the dominant level by
which rule is sustained” (1991:113 - emphasis in original).

Eagleton sees Gramsci’s notion of hegemony as ‘extending and enriching’ ideology as
a conceptualisation. Ideology becomes transformed from a potentially static ‘system
of ideas’ into a dynamic, “ lived, habitual social practice, which encompasses
unconscious acts as well as the workings of formal institutions” (1991:115). Central
to the concept of hegemony is a non-reductionist reading of the relationship between
ideologies and material forces. An important example of this relational approach is
when Gramsci discusses how to analyse the development of ‘popular beliefs’ and
proposes the conception of the ‘historical bloc’, in which

“...material forces are the content and ideologies are the form, though this
distinction between form and content has purely didactic value, since the
material forces would be inconceivable historically without form and the
ideologies would be individual fancies without the material forces”

However, as Larrain points out, although the material content of the ideological form
cannot be separated out, there is no neat ‘mechanical correspondence’ between
ideologies and the social structure. For Gramsci, structural developmental ‘tendencies’
do not amount to absolute necessities (1983:81). Gramsci expresses this relationship
between structure and agency in the following terms:

“ What exists at any given time is a variable combination of old and new, a
momentary equilibrium of cultural relations corresponding to the equilibrium
of social relations ” (Gramsci:1971:398).

As a revolutionary, Gramsci was primarily concerned to develop an understanding of
power relations with modern society in order to further the revolutionary struggle. In
this he concluded that if the proletariat was to overthrow bourgeois class rule it must achieve ideological hegemony, which in turn required moving beyond the limitations of ‘economistic’ struggle to what he termed the ‘ethico-political moment’. The achievement of proletarian hegemony represents “…the superior elaboration of the structure into superstructure in the minds of men. (ii) also means the passage from ‘objective’ to ‘subjective’ ” (Gramsci:1971:367). However, Gramsci was fully aware that culture and/or civil society (there is some slippage in the ways in which he utilises these concepts) could not be treated in isolation from the economic structure of the system, “… for though (bourgeois) hegemony is ethico-political, it must also be economic, must necessarily be based on the decisive function exercised by the leading group in the decisive nucleus of economic activity ” (1971:161). In attempting to overcome the space between revolutionary theory and practice, Gramsci emphasises the importance of collective consciousness. In this, he identified a central role for what he terms ‘organic’ (from within the class) intellectuals in organising and educating. For Gramsci, ideology is not simply a philosophical world-view (as it is for Lukács and Lenin). As Larrain argues, it must“…necessarily entail orientations for action and must be ‘socialised’ in the masses” (1983:87). In this sense, ideology cannot remain as some pristine set of ideas but must constantly be adapted in new historical and structural situations.

To conclude this section, it will be interesting to examine briefly the ways in which Gramsci’s writings have been received and applied. Gramsci was a leading member of the Italian Communist Party, and as such his approach to building the revolutionary struggle was severely criticised at the time by the Leninist left for being too ‘voluntaristic’. In the 1970s, his work was attacked from a very different quarter, namely by structuralist academic Marxists, who criticised those aspects of Gramsci’s work they deemed to be ‘historicist’. However, at the same time such critics appropriated significant elements of that work, arguing that it led to idealism by reducing ideology to the expression of a social class (Poulantzas:1973). From a very different academic perspective, there has been an attempt to lay claim to Gramsci’s legacy in support of the post-structuralist or post-Marxist position (today, its representatives would probably describe themselves as ‘Third way’ theorists) that politics and ideology are essentially ‘autonomous’ from the economic sphere. For example, Mouffe chooses to interpret Gramsci’s work in the following way:
"Ideology as a practice producing subjects is what appears to be the real idea implicit in Gramsci's thoughts on the operative and active nature of ideology and its identification with politics" (1979:141).

It is to the theoretical origins of this structural re-interpretation of Marxism that we now turn.

2.5.3 The road from Marx to Structuralism: The gradual disappearance of the active subject

This discussion of Marxist theoretical conceptualisations of ideology is framed by the distinction drawn by Larrain (1979;1983) between a negative and critical conceptualisation (the ideological as an attribute of any thought that conceals contradictions), as utilised by Marx himself, and an emergent positive conceptualisation (the ideological being 'the quality of any thought that serves class interests') that appears in the work of Lenin, Lukács, and Gramsci. Larrain argues that this positive conception essentially changed the Marxist understanding of the relationship between ideology and class, with the recognition that all classes produce an ideology. The positive conceptualisation also changed the understanding of the connection between ideology and contradiction. Ideology came to be understood as the terrain or particular space of contradictions rather than as originating on the terrain of contradictions. In the process, however, ideology lost its critical quality as a concept. Drawing a distinction between negative and positive concepts as both 'incompatible and historically successive' (Larrain:1983:90) is of particular importance, given the frequent attempts to argue that one or other of the conceptualisations is a misinterpretation of some Marxist essentialism. On the other hand the work of Althusser, which is discussed below, is an example (it will be argued) of the theoretical ambiguities thrown up when attempting to combine both conceptualisations of ideology.
Althusserian 'structuralism' represented a particularly influential development within Marxist social theory in the late 1960s and early 1970s. The intellectual influence of French Structuralism, and in particular Saussurean linguistics, is clearly present in Althusser's attempt to develop a theoretical conception of ideology which seeks to locate its operation not within the structures of a social formation but rather as a structure in and for itself. The self-styled 'anti-historicism' of this approach saw ideology as constituting a material or structural force in its own right, conceived of as 'relatively autonomous' from the economic sphere. By arguing from within a Marxist theoretical framework that ideology acts to determine the subject, Althusser set himself the task of identifying an 'epistemological break' in Marx's own work between what was regarded as the pre-scientific idealism represented by *The German Ideology* and the scientific positivism of his later works, such as *Capital*. However, the development of Althusser's own thought in relation to the concept of ideology was also marked by a series of divergent or even contradictory emphases.

In his early work, Althusser emphasises the 'function' of ideology as a system of representations (rather than as the response to social contradictions present in Marx), operating at an objective level or 'instance' of society, independent of individual subjectivity. In other words, ideology is conceptualised as an objective level of social reality. This ideological system of representations impacts on the ways in which people live their lives through the operation of various structural institutions. For Althusser, ideology acts to 'interpellate' or direct the actions and thoughts of individuals (rather than existing purely at the level of consciousness). Ideology functions to 'secure cohesion' both amongst people (of all classes) and between people and the meeting of their social tasks: "(H)uman societies secrete ideology as the very element and atmosphere indispensable to their historical respiration and life" (Althusser:1977:232). Here, ideology is conceived as an 'objective instance'. This introduces a dualism between subject and object which is not present in Marx's work. Where for Marx the notion of practice is a 'mediation' which facilitates the unity of subject and object, in Althusser, practice acquires an objectivity that separates it from the subject (Larrain:1983:97). This objective existence for ideology within class societies means that different ideological tendencies emerge from 'within', reflecting the representations of each social class. Whilst this could potentially reflect a positive reading of the concept of ideology, Althusser nevertheless firmly believes
that there exists a cognitive truth outside of ideological representations, an essentially negative reading of ideology as distortion, as false consciousness.

This negative conceptualisation reflects the next phase or emphasis in Althusser's work. Here, ideology is contrasted to scientific practice, the latter being seen to offer the potential for a true knowledge of the social structure in which people live. Ideology is abstract knowledge, whereas science is seen as concrete and adequate knowledge. However, this position became difficult to sustain alongside his broader conceptualisation of ideology as an objective level within a social formation. How was science, if it was not ideology, to be located within such an 'organic totality' (Larrain:1983:94)?

The third emphasis appears in Althusser's later work. It follows from the distinction he draws in his essay 'Ideology and Ideological State Apparatuses' (in Lenin and Philosophy and other essays:1971) between the 'theory of ideology in general' and the 'theory of particular ideologies'. This was Althusser's attempt to reconcile both positive and negative Marxist conceptualisations of ideology (Larrain:1983:91). By 'general theory', Althusser means the 'omni-historical' function of ideology in securing social cohesion: "ideology...is endowed with a structure and a functioning such as to make it a non-historical reality" (1971:151). His theory of 'particular ideologies' refers to the assessment of the ways in which specific class divisions function in specific social formations and at specific historical periods to 'overdetermine' the general function of ideology. Here, the state is seen as playing a central role in the reproduction of relations of production within modern capitalist societies through what he terms 'Ideological State Apparatuses' (ISAs), as distinct from the openly repressive role of the state in pre-modern times. There is seen to be a 'plurality' of ISAs in existence, which Althusser refuses to identify as simply being within the 'public' or formal state sphere of influence. However, he does include education, the family, the religious, the 'cultural', trade unions, and the media amongst his list of ISAs.

As has already been indicated, a central characteristic of Althusser's theorisation of ideology, consistent across all his writings, is his recognition of three 'objective levels' of society. The 'politico-legal' and ideological structures of a social formation
(as an ‘organic totality’) are seen as both distinct and relatively independent from the economic base. This structural theorisation is underpinned by two of his central contentions concerning ‘ideology in general’. The first of these is that ideology as a representation or world outlook is essentially illusory. Yet this ideological representation is not a distortion of the existing relations of production (i.e ‘false consciousness’) but represents “...the way they (men) live the relation between them and their conditions of existence. This presupposes both a real relation and an ‘imaginary’, ‘lived’ relationship” (1977:233 – emphasis in original). The second concerns the materiality of ideology, the notion that ideas or representations have a material rather than an ideal existence. By this he means that ideology always exists within an apparatus and its associated practices and acts to ‘interpellate’ individuals as subjects. Individuals are thus seen to ‘live in ideology’, that is in “…a determinate (religious, ethical, etc.) representation of the world whose imaginary distortion depends on their imaginary relation to their conditions of existence” (Althusser: 1971:156). It is precisely because individuals believe their actions to be under their own volition that ideology has a material existence:

“(The individual’s) ideas are his material actions inserted into material practices governed by material rituals which are themselves defined by the material ideological apparatus from which derive the ideas of that subject...(thus)...there is no practice except by and in an ideology...(whilst)...there is no ideology except by the subject and for subjects” (Althusser: 1971:159).

Although hugely influential in the theoretical development of a Marxist theory of ideology, Althusser’s approach has also been subject to strong criticism. One fundamental concern relates to his methodological approach, which appears to constitute ideology “...as an immutable object of study across the various modes of production” (Larrian: 1979:160). Althusser is seen to begin from the essentially abstract contention that ideology exists only in two forms: ideology in general and the theory of particular ideologies. This essentially deductivist approach is the antithesis of Marx’s own method, which while utilising abstract concepts (such as labour power, production, social classes) when analysing different historical social formations was also clear that, as abstractions, they were the products of specific historical relations. For Marx, therefore, their efficacy as abstract concepts was valid only within the context of those relations. Within the terms of Marx’s method, Althusser is mistaken
in his contention that the theory of particular ideologies depends upon the theory of ideology in general: “There is no possible connection between the abstraction of ideology in general and concrete ideologies such that by starting from the general one can deduce the conditions of the concrete” (Larrain: 1979:160). Indeed, it could be said that the efficacy of Althusser’s approach in any detailed analysis of the impact of ideology in a specific context is undermined by his generalised conceptualisation of ideology as pertaining to all mental products, all lived practice. This lack of specificity is reflected in what is an essentially teleological or functional explanation of the ideological dimension or ‘level’ as existing only to maintain social cohesion in class societies.

A further criticism levelled at Althusser is that his insistence upon the determination or interpellation of the subject by ideology in effect transposes Marx’s conception of the determination of consciousness by material practice (Larrain: 1983:97). This produces a bleakness and pessimism in the conceptualisation of the subject. As Eagleton has observed,

“The word ‘subject’ literally means ‘that which lies beneath’, in the sense of some ultimate foundation...but it is possible by a play on words to make ‘what lies beneath’ mean ‘what is kept down’, and part of the Althusserian theory of ideology turns on this convenient verbal slide. To be ‘subjectified’ is to be ‘subjected’: we become ‘free’, ‘autonomous’ human subjects precisely by submitting ourselves obediently to the Subject” (Eagleton: 1991:146).

This ‘big’ Subject as against individual subjects is the dominant hegemonic ideological signifier with which the individual subject identifies through the process of interpellation. This form of structuralism is said (by Althusserians) to reflect Marx’s own position, when he is said to have abandoned the idea of man as a general essence, as the origin, cause, and goal, of history (in the Thesis on Feuerbach), replacing the active subject in his later work with scientific concepts concerned with the structure of social formations and productive forces. But as Rancière in La leçon d’Althusser (1974 - cited in Larrain: 1983:98) argues, Marx did not criticise Feuerbach because his conception of history had a subject but rather because his subject did not have a history.
Another central criticism of Althusser's conceptualisation of ideology relates to his assertion of its materiality, his contention that it has a material independence so far as it exists within material apparatuses and practices. Larrain (1983:100) argues that this position is based upon a misreading of Marx's view of ideology, that whilst the latter has a material base it is not ideas in themselves that constitute such a base. This follows from Marx's fundamental anti-idealism. It is precisely because ideology has to do with consciousness that it is necessary to qualify the character of its materiality. This is something which Marx does and Althusser, slipping into an overly reductionist view of ideology, fails to do. The argument for the existence of a fundamental dualism between the ideal and the material was not at all acceptable to Marx himself. In The German Ideology, he specifically argued that consciousness, whilst it is a social product, exists within us all; it is internal to human beings. This leads Larrain to conclude, in contradistinction to Althusser, that "(c)onsciousness is simultaneously social, internal to the subjects and requires physical modifications in order to exist. Consciousness is not imposed on subjects from without because it is social; rather, it is also internal to the subjects because it is social" (1983:101). Thus, in attempting to give consciousness a reality, Althusser makes the mistake of considering such a reality only in the form of the object, as an externality, rejecting its subjective qualities.

Somewhat ironically, given Althusser's statements concerning the 'imaginary' and 'distorted' effects of the interpellation of subjects through ideology, yet understandably, given his different analytical phases or emphases, later ('post-structuralist') writers have taken his conception of ideology as having a material existence independent of the subjectivity of individuals. They have then used this to criticise Marx's negative conceptualisation of ideology as falsity or false consciousness. This group includes Laclau (1977), Mouffe (1979), and Hirst (1979), who have collectively argued that because ideology is an objective level of the social totality, and because it is a 'practice producing subjects' (Mouffe:1979:171), it cannot possibly be illusory or serve to deceive subjects. Yet, as Larrain points out, when Hirst (1979) uses falsity as a synonym of illusion, he is equating falsity with non-reality and this essentially transposes "...an epistemological reality into an ontological absence" (1983:103). There is no good reason for opposing falsity to existence, since a false statement remains real and has effects, despite the fact that it is a distortion. Nevertheless, post-structuralist objections to ideology as falsity and the rejection of
the use of ideology as a critical concept clearly do have roots in aspects of Althusserian structuralism, even if Althusser himself would undoubtedly have disagreed with the conclusions of this intellectual group.

2.5.4 Re-conceptualising ideology as discursive practice

The concept of 'discourse' first gained wide academic usage as it appeared and was applied within the work of Foucault. However, Foucault was not interested in either the truth of statements or their meaning; he was interested in the rules of formation that determine objects, concepts, operations, and options of a particular discourse (Dreyfus & Rabinow:1986;49). Foucault's notion of a 'discursive formation' sees power not simply as exercised by but as pervading social structures, as evidenced in its reproduction through social practices and discourses. This analysis of the rules of discourse formation is the 'archaeological analysis' of the conditions of existence of such discursive events. Such an analysis demonstrates that the rules of discourse formation are articulated within non-discursive conditions, and here Foucault (1985) points to the particular example of the historical development of the medical discourse. The relation between the discursive and non-discursive is neither determinate nor expressive; rather, the non-discursive transforms the mode of existence of a discourse. Whilst discourse has a certain level of autonomy and specificity, it is not, for Foucault (1985:164-5), historically independent. The subject is seen as being constituted through discourse rather than having a 'prediscursive existence'. The body, for example, cannot be understood by reference to some 'naked abstraction' or 'unmediated gaze'; rather, it is historically and culturally located by reference to forms of knowledge or discourse (Peterson & Bunton:1997).

The post-structuralist critique of Foucault's somewhat all-embracing notion of power, knowledge, and discourse, in many ways mirrors that of Marxist structuralist conceptualisations of ideology. The work of Laclau and Mouffe (1985;1990) and Slavoj Zizek (1994) would reject the distinction that Foucault draws between the discursive and non-discursive as being unable to account for the existence of competing discourses. Their claim to be 'anti-essentialist' only recognises a reality constructed through discursive practice. In coming to this position, these theorists of
discourse would see themselves as the most recent manifestation of a theoretical lineage that has its beginnings within Saussurean linguistics, passes through Althusserian structuralism, embraces the 'anti-essentialist Marxism' of Gramsci, is influenced by the Derrida-inspired philosophy of deconstructionism, yet is nevertheless posited within the conceptual methodology of Lacanian psychoanalysis (Torfing:1999:4). This heady mix of influences could certainly be said to be a good example of postmodernist thinking, particularly in the way that the strategy of 'dedifferentiation' is used to present 'discourse theory' as an all-embracing account of the essential contingency of the social.

The early work of both Mouffe (1979;1981) and Laclau (1977) utilises a particular reading of Gramsci’s work on the relationship between the state and civil society, and in particular his notion of the ‘historical bloc’, in order to argue for the primacy of the political over the economic. This is an approach that essentially substitutes an over-determination of the political form for the (alleged) economic reductionism of Marxism. It presents Gramsci’s conception of ideology as being anti-essentialist. This claim is made largely on the basis of Gramsci’s rejection of the ‘vulgar Marxism’ of the Second International, which was characterised by the notion of paradigmatic class ideologies, i.e. socialism as the ideology of the working class. In Mouffe’s reading of Gramsci, the struggle for hegemony becomes a struggle for ‘moral-intellectual’ leadership within ideology rather than a class struggle fought across a number of levels.

Laclau (1977) similarly attempts to use Gramsci’s work to support his own notion of the existence of a ‘concrete ideological discourse’. This is the view that the ideological level of society is made up of different types of interpellation. Here, Laclau is concerned to avoid any class ‘reductionism’ (the claim that every ideological element necessarily belongs to a class) in the interpretation of ideologies (using the term in the positive sense as being a system of ideas). In doing so, Laclau proposes an understanding of the determination of ideas which draws a distinction between the form and content of an ideology: “...the class character of an ideology is given by its form and not by its content” (1977:160). Hence the existence of these ‘non-class interpellations’ such as fascism, liberalism, and nationalism, which are not
'pure' in the sense of being produced by classes as totalities but are somehow neutral in isolation. The content of these ideologies has no necessary class connections but derives the form of a class determination through a process of articulation (and therefore can be used by all classes). In this process of articulation, the notion of hegemony is central. This is an analysis influenced by Althusserian structuralism. It recognises that, in the struggle for hegemony against the ruling class or 'dominant bloc', particular ideological elements exist which can act to 'interpellate' individuals as the 'people' (Laclau calls them 'popular-democratic' interpellations). These popular struggles develop out of political and ideological relationships rather than the economic relations of production; hence they constitute 'non-class' rather than class interpellations. Here, Laclau is describing a struggle that is essentially concerned with discursive rather than material power. It involves what he terms the 'intermediate strata' (the middle class) in their attempt to integrate 'popularism' into the hegemonic discourse of the ruling class.

However, it is highly debatable whether Laclau's notion of popular struggle has anything at all in common, as claimed, with Gramsci's revolutionary strategy of moving the organised sections of the working class beyond purely 'economistic struggles' in order to build cross-class alliances and ultimately achieve a hegemony which could bring about the end of capitalist class rule. This is because the distinction that is drawn between form and content within post-structuralist approaches does not exist in the work of either Marx or Gramsci, both of whom conceptualise the determination of ideas as necessarily a historically specific process involving both form and content. And, since both class and ideological content are conceived of as concrete rather than abstract entities, they cannot somehow exist apart from each other and then combine arbitrarily. Laclau's conception of determination is arguably ahistorical and formalist (Mouzelis:1978:53 - cited in Larrain:1983:203).

Ultimately, however, the issue of expropriating Gramsci's notion of hegemony, on the basis of its 'anti-essentialism', for a post-structuralist politics becomes a purely academic matter. In what could be termed the 'second phase' of their work, Laclau and Mouffe (1985) began to see a Marxist 'essentialism' in Gramsci's assertion of the class character of political or hegemonic struggle as rooted within the contradictions
between the forces and relations of production. This 'essentialism' was now seen as problematic for their particular notion of indeterminacy or the 'primacy of the political'. This was because Laclau and Mouffe were now arguing for an anti-economistic understanding of the economy, one which asserts its essentially political character (1985:78-80). The evidence for this argument stems from the ways in which the labour process itself is seen to represent more than a method for the efficient production of commodities for profit; it now acts as a ‘locus of domination’. As such, it is subject to political struggles, an example being the documented resistance to the exercise of power manifested in Taylorist organisational principles of specialisation and fragmentation, which go beyond the purely economistic. This position ultimately leads to a re-conceptualisation of the ‘space’ that Marxism designates as ‘the economy’ qua discursive formation - ‘a terrain for the articulation of discourses’ (Torfing:1999:39).

The shift reflects the adoption by Laclau and Mouffe (1987) of the anti-essentialist philosophical position of Derridean deconstructionism, which asserts an absence of any notion of the ‘centre’ or ‘transcendental signified’ (e.g. God, man, consciousness, the economy, etc.). The conjecture here is that postulating a ‘centre’ of whatever form fulfils some need or desire for certainty or for overcoming anxiety; its absence simply gives rise to endless displacements and substitutions. The notion of the ‘centre’ becomes not some fixed locus but rather a non-locus in which any number of substitutions come into play: “In the absence of a centre or origin, everything becomes discourse” (Derrida:1978:280). Following this deconstruction or questioning of the idea of structure as a ‘self-contained space unified by a fixed centre’, Laclau and Mouffe’s conception of discourse is not a structure in the ‘traditional’ sense of the term, precisely because it lacks this ‘unifying principle’ or centre (1985:112). For both of them, the process of questioning the transcendental status of the economy leads directly to the concept of discourse, which is defined as a ‘de-centred’ structure in which meaning is constantly negotiated and structured (Laclau:1988;254).

Nevertheless, because discourse as a ‘relational ensemble of signifying sequences’ lacks a fixed centre it cannot be a totalizing structure. ‘Closure’ therefore becomes impossible. There will always be something that escapes the processes of signification, and this ‘surplus of meaning’ is described as the ‘discursive’. Laclau and
Mouffe draw a distinction between the discursive and discourse, which they argue enables them to move beyond the Foucauldian distinction between the ‘discursive and non-discursive’. Differentiating the ‘field of the discursive’ from discourse, enables them “… to indicate that what is not fixed as a differential identity within a concrete discourse is not necessarily the ‘non-discursive’, but is rather the discursively constructed within a terrain of unfixity” (Torfing:1999:92). What this means in practical terms is that a particular concrete discourse may undergo differential meanings or interpretations as a result of particular historical and social conditions, such that a degree of ‘unfixity’ or ‘partial fixity’ in this discourse emerges. However, always in the background are the original fixed meanings of the discourse, and these can be ‘reactivated’ at times of particular ‘disruption’ (Laclau:1990:220). Torfing uses the example of the discourse of ‘welfare’ to illustrate this point. He argues that the notion of welfare was originally associated with mercantilist theories of ever-increasing wealth linked to an expanding population, this being later developed in neo-classical economics to mean the maximization of private utility within a market economy (and subsequently applied to the intervention of the state to compensate for market failures). The term ‘welfare’ in relation to the discourse of welfarism associated with the interventionist role of postwar welfare represented a ‘de-activation’ of the original discourse under different conditions of ‘discursivity’. But with the fiscal crises of the state in the late twentieth century many of these original meanings were reactivated (1999:92-3).

However, this particular example of the distinction between ‘discourse’ and the ‘discursive’ could also be conceptualised as being a form of transcendentalism in which society is merely a backdrop (Torfing describes Laclau and Mouffe’s notion of discourse as being ‘coextensive with society’ – 1999:290). It can be argued that this theoretical distinction lacks any historical and social mechanism which could explain why a particular meaning becomes ‘unfixed’ from a concrete discourse at a particular time. To argue that this process is the result of an inevitable ‘rupture’ is theoretically inadequate. Given that these concrete discourses are seen to exist within a soup of signifiers (within the field of discursivity), each of which have many meanings, it is difficult to see why some meanings change or become ‘unfixed’ while others remain the same or ‘fixed’.
The explanation offered by Laclau and Mouffe as to why particular ‘partial fixities’ of meaning come together at particular moments (but without accounting for the process of ‘rupture’) reflects their essentially idealist reading of ‘hegemony’. For these writers, ‘social identity’ (a definitive post-modernist concern) is not seen as emerging from the material conditions of existence, as it does within a Marxist understanding; rather, “...in sharp contrast to the essentialist conception of identity, (it) emphasises the construction of social identity in and through hegemonic practices of articulation” (Torfing:1999:41). The conception of a ‘hegemonic practice’ is used not in terms of an imposition (and certainly not as reflecting the interests of a fundamental dominant class) but rather as an intention or attempt to dis- and re-articulate elements of a discourse.

Class identity thus becomes simply one form or articulation of the hegemonisation of a field of different subject positions. Thus, to be working class is no longer to recognise some common set of interests determined by a subject’s structural position within the capitalist relations of production. This is because the historical period during which the economic over-determined the political is now seen as ended. Rather, workers as subjects articulate their different positions both at the level of production and at the level of consumption, so that identity can be as much about housing, sport, or cultural concerns as about economic interests. Laclau (1985) argued that it was the fact of living in a shared deprived neighbourhood, with life centred around work in a particular industry (in a factory, for example, or a mine, or a shipyard), that caused the subject positions of workers to became strongly correlated. For such industrial workers, then (in some unspecified historical period, presumably in the early to middle years of capitalist development), material conditions were ‘discursively constructed’ in such a way as to give them a political identity in their struggle to improve their condition. With the end of this early modern stage of capitalist development and the improvement in the shared conditions of existence for the majority of workers, political struggle ceased to be centred around traditional class concerns. Thus, for Laclau, the concept of class struggle becomes “...totally insufficient as a way of accounting for social conflicts” (1985:29).

In seeking to affirm the irreducible character of ‘difference’ or differential identity, Laclau and Mouffe (1985) develop a conceptualisation of the origins of social identity
as that which emerges from a field of diverse discursive subject positions. They go on to make the claim that they have ‘radicalized’ Gramsci’s conception of hegemony in relation to the formation of social identity, yet they draw no distinction between the subject and its subjectivation. Whereas Gramsci’s notion of hegemony focused upon a transcendental autonomous (class) subject in struggle, Laclau and Mouffe adopt Althusser’s notion of subject positions. There is no attempt to theorise the subject. This is acknowledged by the authors themselves: “...whenever we use the category of ‘subject’ in this text, we will do so in the sense of ‘subject positions’ within a discursive structure” (1985:115). Thus, for Laclau and Mouffe, hegemonic practices of articulation constitute discourse. It is the very ‘unfixity’ of discourse itself that is seen to offer the possibilities for a hegemonic articulation of the subject positions (Torfing:1999:42). This approach reflects the Derridean ontological position (‘The structural undecidability of the social’), which would see a social structural basis for the formation of identities as essentially problematic, given the divided, disorganised and destabilised characteristics of social life. This represents the classic postmodernist assertion of the primacy of the political over the social, in which it becomes no longer possible to maintain the idea that politics is derived from something which is not itself political.

This ontological position, as adopted in the later work of Laclau and Mouffe (1985), is surely incompatible, philosophically, with the realist epistemological framework in which Gramsci situated his conception of hegemony? Nevertheless, Laclau and Mouffe insist on calling themselves both ‘realists’, with realism defined as the assertion of the existence of a world external to thought, and ‘materialists’, with materialism defined as the affirmation of an irreducible distance between thought and reality (1987:86). This very particular ‘constructivist’ notion of realism derives from a rejection of a (transcendental) realism which is seen as a predetermination of the experiencing subject by the experienced object, in which the subject becomes a passive recipient of an already constituted meaning. As Eagleton notes, this claim of realism “...is not entirely at one with the logic of full-blooded post-structuralist theory which would recognize no ‘given’ reality beyond the omnipotent sway of the signifier” (1991:216). Laclau and Mouffe also reject ‘idealism’ because it ‘essentializes’ the subject (rather than object), reducing the object to a mere object of thought and thus the distance between thought and object. They claim that their work represents a ‘non-
idealist constructivism' of the discursive which builds on the ontological view that the
given world and the subject that undertakes the construction of the 'object' are both
incomplete. The place of discourse is to attempt to construct or articulate forms of
meaning in this unstable world (Torfing:1999:47-48).

What is also missing from this conception is any notion of contradiction and
synthesis, a dialectic involving subjects with fundamentally divergent sets of interests.
How does history move forward in Laclau and Mouffe's firmly non-essentialist, but
apparently real world? Objects and subjects seemingly go round and round in no
particularly direction. Finally, it could be said that in such a 'disarticulated' world, the
notion of endless discursive possibilities would seem to be perfectly suited.

Zizék's (1989 & 1994) Lacanian-inspired work shares many of the assumptions and
post-structuralist concerns of Laclau and Mouffe's later work. However, he is also
concerned not to reject the Marxist critique of ideology out of hand and offers a
Lacanian psychoanalytical 'narrative reconstruction' of the concept of ideology. Zizék
first sets out to 'map' the more 'cognitive' uses of the concept within a Marxist (or at
least Marxian) tradition, using what he terms a 'synchronous' approach. He argues
that it is possible to 'dispose of the multitude of notions associated with ideology' by
locating them within three axes based upon the Hegelian 'moments' of doctrine,
belief, and ritual. Thus, we have ideology as a complex of ideas and convictions;
ideology in its externality, as material practices; and ideology as 'spontaneity', the
ways in which we see 'reality'. These axes enable Zizék to 'reconstruct' a Hegelian
triad of ideology 'in-itself', 'for-itself', and 'in-and-for-itself'.

Firstly, in relation to the notion of ideology as 'in-itself', which Zizék argues is
associated with the 'critique of ideology' (or, as understood above, constitutes a
negative conceptualisation of ideology). This is the notion of ideology as doctrine
serving powerful interests and concerned to push a particular 'truth' which distorts
'reality' for the masses. The work of Habermas is seen as an example of this
tradition, perceiving ideology to be systematically distorted communication.
Secondly, ideology conceptualised as 'for-itself' possesses a material existence within
ideological practices and institutions. Althusser's work concerning ideological state
apparatuses (ISAs) is seen as epitomising this approach. Here, people are seen to act
in a way that they see as expressing their inner beliefs, yet the very rituals they perform are but a materialisation of ideology: “...the 'regression' into ideology at the very point where we apparently step out of it” (Zizék:1994:13). Zizék argues that these ideological mechanisms or ‘interpellations’ are seen by Althusser as originating from the state. They act to ‘seize’ the individual.

The third step in Zizék’s reconstruction of ideology is to see the externalisation of ideology ‘reflected into itself’. Ideology is no longer conceived of as a ‘homogeneous mechanism guaranteeing social reproduction’: rather, it works in a much more heterogeneous and therefore localised way. To this end, Abercrombie, Hill, and Turner’s (1983) critique of the ‘dominant ideology thesis’ is cited as an example of the argument that, in late capitalism (ironically, given the perfusion of the mass media and electronic communication into every corner of our lives), ideology is now less important in the process of social reproduction than economic coercion, legislation, and state regulation. However, Zizék argues that these regulatory processes are not as extra-ideological as Abercrombie et al make out but act to ‘materialise’ beliefs and ideals which are inherently ideological. Here, he also criticises the notion of a ‘post-ideological society’ where people are somehow free to believe and choose what they want. This, he says, is itself an ideological presupposition.

Zizék is conscious of the fact that the “…very gesture of stepping out of ideology pulls us back into it” (1994:10). He argues that the problem with the Marxist conception of ideology is that the ‘extra-ideological reality’ which is seen to be distorted by ideological representations is indeed already ideological. The phenomenon that is ideology must therefore be seen as an “…elusive network of implicit, quasi-'spontaneous’ presuppositions and attitudes that form an irreducible moment of the reproduction of ‘non-ideological’ (economic, legal, political, sexual...) practices ” (1994:15). For Zizék, there is no reality existing outside of this ‘elusive spectral network’, it is all-inclusive, and requires no ideological mechanisms to maintain its consistency. A deep level of ideology is at work in everything we experience as ‘reality’; “…there is no reality without the spectre” (1994:21).

The ‘spectre’ that Zizék is referring to is the Lacanian notion of the Other. This is derived from the ‘mirror stage’ of ego development, when for a moment the child sees
no distinction between object and subject, but in the language of psycho-analysis this is then somehow 'primordially repressed'. The Other can also stand (in Lacan's work) for the whole field of language and the unconscious, an elusive fragmented terrain in which the relations between it and the individual subject are fraught and fragile. In this understanding, the Other cannot readily interpellate the subject in the Althusserian sense of functioning as an ideological signifier (Eagleton: 1991:144). Therefore, what we experience as reality is not the 'thing itself' but something already pre-symbolised, constituted, and structured by the symbolic. However, this symbolisation can never fully 'cover' the real, so the part of reality that remains non-symbolised "...returns in the guise of spectral apparitions; the spectre gives body to that which escapes (the symbolically structured) reality" (Zizek:1994:21).

Zizek utilises Lacan's notion of the Other as an expression of a pre-ideological 'kernel' of ideology, something so fundamental that it too cannot be objectified. The very constitution of social reality involves this primordial repression of an antagonism (the particular dominant form of that antagonism, which Zizek recognises as class struggle, becomes of 'secondary' importance). Thus, a critique of ideology, the 'extra-ideological point of reference' that enables the content of our immediate experience to be recognised as ideological distortion, is not 'reality' (as recognised within a Marxist understanding of ontology) but "...the repressed real of antagonism" (1994:25). Thus, in Zizek's work, ideology becomes transmuted into an essentially idealist transcendental concept. This is a highly individualised conception which, it can be argued, is less than useful for the analysis of specific social contradictions or even 'social antagonisms', to use post-structuralist discourse theory terminology.

2.5.5 Some concluding comments on the place of the active subject in the theoretical conceptualisations of ideology and discourse

Drawing together some concluding comments concerning the theoretical efficacy of a Marxist conceptualisation of ideology makes it obvious, from this review of the literature, that the question of the relation of dependence or otherwise between the subject and social structures remains fundamental. Marx always discusses the subject within the context of social and historical relations, never as an ideal nor as some pre-
determined 'bearer of structures'. In this regard, what is apparent from the historical tracing of developments within Marxist and post-Marxist conceptualisations of ideology is the way in which the active class subject becomes gradually submerged beneath 'objective structures', re-emerging as some trans-historical and undifferentiated supra-subject, with a social identity garnered from choices made between articulated discourses.

Certainly, the post-structuralist or postmodernist notion of discourse, as represented in the work of Laclau and Mouffe, for example, would appear to have little to offer an analysis of specific instances of discourse (understood as articulated sets of ideas) involving a specific set of subjects, such as nurses. Within this perspective, the notion of discourse is, as Eagleton has observed, "...inflated to the point where it imperializes the whole world, eliding the distinction between thought and material reality" (1991:219). Material interests are not recognised, only discursively constructed ideas about them. The question of where ideas come from, how they are manifested in practice and whether they can be challenged is a question that is never posed within discourse theory.

Throughout this literature review, the heuristic distinction that Larrain (1979:1983) draws between a positive (neutral), and a negative (critical) conception of ideology has been employed as a framework for analysis of the different positions. Given the centrality of historical and material contradictions in accounting for the emergence of ideology within a broad Marxist theoretical framework, it becomes possible to see that, for a negative conceptualisation, ideology is a distorted solution to such contradictions. For a positive conception of ideology, on the other hand, the principle contradictions of capitalism are seen to produce inevitable periodic crises which potentially open up the space for the ideological hegemony of the dominant class to be resisted and challenged through the emergence of a dominated class ideology. Nevertheless, whilst this positive/negative distinction is particularly useful for theoretical orientation within the very wide spectrum of Marxist thought, it is perhaps less useful for assessing the relationship between the active class subject and the operation of social structures. It is quite possible for an active class subject to be absent from both conceptualisations. In Althusser's positive conception, for example, the subject is merely the bearer of certain interpellations, whilst in certain negative
and critical readings of ideology as concealing or inverting reality the subject can appear as an alienated dupe.

Larrain maintains that if a positive conception of ideology is held, then it becomes impossible to criticise an ideology as being a distortion of reality, because in this positive reading of ideology there are no distortions only class interests. The positive conceptualisation of ideology adopted within the present thesis would argue that the identification of ideological distortions (without engaging in a debate concerning the existence of ‘false consciousness’) is less than productive for a sociological analysis of the outcome of specific material and ideological practices as they shape the understandings and rationalisations of human subjects (nurses, for example). As Raymond Williams (1977) has noted, the epistemological distinction characteristic of the negative conceptualisation of ideology, which draws a distinction between ideological and non-ideological forms of consciousness, is a tempting path but one that should not be followed too far. This is because “there is a fool’s beacon erected just a little way along it. This is the difficult concept of ‘science’” (1977:62).

Working within such a conceptualisation of ideology, the analytical temptation is to dismiss the actions of nurses in, for example, engaging in occupational boundary struggles to achieve professional status for the occupation as a manifestation of false consciousness. Whilst it is extremely doubtful that anyone operating within what might be termed a critical perspective would make the explicit claim that such actions constituted a deviation from the ‘path’ towards some form of non-distorted health care practice, the logic of Williams’ argument is apparent. Significantly, those who would make at least an implicit claim that a form of ‘true’ or undistorted nursing care was possible would be those within the hierarchy of nursing inspired by humanistic philosophy who have promoted the notion of the ‘new nursing’ (discussed in detail in Section 2.1.2).

More appropriate is an approach that is able to acknowledge the usefulness of a positive conceptualisation of ideology as material practice. This kind of conception can help us think about the ways in which hegemonic social structures such as the system of health care in late modern societies (e.g. the UK) act to produce and reproduce the medical division of labour and to shape the organisational framework through which nursing care is carried out. At the same time, it involves a recognition
that it is precisely because the ideas and understandings of social subjects are rooted in the material that contradictions emerge and are present within the practice of subjects. This enables us to focus attention upon those social processes that, within a specific context, produce change within both social structures and the practices of social agents such as nurses. A positive conceptualisation of ideology and a recognition that social subjects are 'active' (in the sense that they can effect change within social structures) means acknowledging (following Gramsci) that whilst the material content of ideologies cannot be separated out, what we are dealing with here is primarily a social rather than a 'mechanical' relationship between ideologies and practice. Essentially, what this amounts to is the need to achieve a stratified and dynamic understanding of the place of the ideological dimension within a social formation.
3. Methodology

This chapter has three distinct sections. The first, setting out the design of the research, begins with an explanation of why a qualitative research method was seen as the most appropriate approach to data collection. This is followed by an account of the social and organisational context in which the data was collected, together with a description of the participants. After a practical discussion of how access and confidentiality was achieved, this first section concludes with a detailed analysis of the advantages and disadvantages of the focus group discussion method.

The second section is primarily concerned with developing the case for the use of qualitative research methods within an analytical framework informed by the methodological principles of critical realism. The contention is that the use of qualitative data need not be limited to an ‘interpretation’ of the actions of social agents; rather, the beliefs and understandings of social agents captured in the form of qualitative data can represent a starting point for a methodological process of abstraction and retroduction or synthesis. This process has as its objective the postulation of underlying generative mechanisms that produce the specific responses of a set of social agents in a specific social context. For example, which combination of social structural processes shapes the set of discourses utilised by nurses in their practice, when interacting within a specific health care context?

The third and final section of the chapter is concerned with the author’s reflections on the conduct of the fieldwork and lessons learned for future investigations.
3.1 Research Design

3.1.1 Assumptions and rationale for choosing a qualitative research design

This study is concerned with the beliefs and meanings attached to practice by nurses as a social group (this is because the social group or nursing team is generally the structure by which nursing is practised) rather than with the attitudes of individual nurses. So it was appropriate that the research design adopted be essentially qualitative rather than quantitative. A qualitative approach befits the research problem not because this is a piece of exploratory research as such, nor because the variables are unknown. Rather, it reflects the view that the beliefs and understandings of social agents themselves, captured in the form of qualitative data, represent the starting point for any analytical process concerned with how social structures are replicated, elaborated, or transformed over time.

It should be noted that, given the critical realist methodological principles which inform the research (as discussed in detail in Section 3.2.3 below), many of the assumptions that are frequently associated with the choice of a qualitative research design are not pertinent to this study. This is particularly true as regards those methodological assumptions that are rooted in the quantitative-qualitative dualism, which seeks to split reality into an ‘objectivity’ and a ‘subjectivity’ (see Section 1.2 above). This would see the researcher as having to make a choice, vis-à-vis their research subjects, between being either independent, unbiased, and impersonal, or being interactive and biased, taking the ‘insider’ perspective. Two other assumptions that are more usually associated with the choice of a qualitative rather than quantitative research design are firstly that the research is descriptive rather than theory-driven and secondly that the data analysis process is purely inductive. Both these assumptions are challenged by the realist methodological framework for analysis set out below.
3.1.2 Justification for the choice of qualitative data collection method

Because the research concern is with the beliefs and understandings reflected in the discourse of nurses as a collectivity (but not necessarily a homogeneous group), the choice of data collection method was narrowed down to the following determinants. A method was required which could directly elicit the meanings and understandings received by nurses themselves. Attitudinal surveys, for example, were ruled out because they cannot easily accommodate the social, political, and cultural context in which attitudes and beliefs are formed and behaviour initiated. The research question also demanded that participants be given an opportunity to interact with the researcher in some way to enable ideas to be generated beyond what might be anticipated from a deductive reading of the literature. This meant that some sort of unstructured or semi-structured interview process was necessary, rather than simple observation or use of documentary material. And because individual beliefs are not discrete or isolated entities but are formed through interactivity, a method which offered the opportunity for individuals within a group setting to express and develop specific attitudes around the research issue was also required. Giving nurses an opportunity to interact with one another to stimulate debate and discussion allowed the ideas and understandings that may be implicitly understood by the nurses themselves as collective agents to be vocalised in an explicit way for the purposes of the research. The research also demanded that the authentic voice and discourse of the nurses as a collectivity be emphasised. This required a method without a formalised structure, capable of involving a group rather than a single individual participant. Given all these requirements, the focus group discussion appeared to afford the most suitable data collection method.

3.1.3 The Focus Group Discussion Method

The origins of the focus group discussion method lie within market research and political consultancy, but in more recent years there has been an increasing social scientific interest in focus groups as a main or stand-alone method of data collection. Focus groups themselves are ‘focused’ collective discussions, which rely on interaction within the group to generate data. These group discussions also offer the
potential to explore the complex social contexts and contingencies that influence people’s understandings and behaviour. It offers the researcher the opportunity to record a set of observations that would be difficult to obtain through other qualitative methods. However, this is a deceptively simple description of a method or technique that can be conducted in a variety of ways depending upon the task or aim of the research.

Drawing on the work of David Morgan (1988, 1993), a writer who has made an important contribution to the development of this technique within the social sciences, it is possible to identify a number of qualities that focus groups can offer the researcher (it also offers the potential to empower the participants themselves). First, the focus group can give the social scientist access to ‘tacit, uncodified and experimental knowledge’. Focus groups are particularly suited to the study of attitudes and experiences around specific topics and within a given cultural context. The theoretical assumption of the method as used within social research is that when people talk about an issue (describing their occupational role, for example) they do so in a highly complex way that requires careful interpretation.

Second, the focus group can give the researcher access to the opinions of the participants. A successfully run focus group will be one that does not impose the theoretical assumptions of the researcher (or the funder of the research) on the participants but will allow participants to generate their own questions and concepts. The attraction of being able to access consumer’s opinions is one of the main reasons why focus groups have achieved such a popularity within the field of market research. However, market researchers are simply concerned with uncritically summarising such opinions. This positivist emphasis on simply documenting or reporting views is potentially problematic if social scientists simply adopt this technique wholesale. As a qualitative social scientific method, the opinions that emerge from these discussion groups have to be subjected to a theoretically informed interpretative understanding (Cunningham-Burley, Kerr and Pavis: 1999:190).

The third quality of focus groups is their potential to give the researcher access to the participant’s frames of meaning or ‘world views’. Posing the question of how people come to ‘know’ their world can lead to very useful challenges to the researchers own
epistemological assumptions about the research subject. In the context of the research conducted for this thesis, a group discussion of the ways in which nurses themselves conceptualise their patient care role within the health care system would give the researcher an insight not possible from official or formal accounts of nurses responsibilities.

Fourth, the focus group offers the researcher the opportunity to study social actors not as isolated individuals but as part of a collective group. The facilitators aim is to achieve a ‘synergy’ within the focus group, that is a vibrant group discussion, producing a ‘rich and meaningful multilateral conversations’ between group members (Morgan: 1988). It is precisely because attitudes are not discrete entities but are formed partly through interactivity, that focus groups can provide the opportunity for individuals within a group setting, to express and develop specific attitudes around the research issue.

Fifth, the focus group technique can be combined with other methods, for example in designing and ensuring the validity of questionnaires or individual interview schedules. Focus groups can not only compliment other research methods, but may actually challenge how data from other sources are interpreted. For example, Kitzinger’s (1994) study of the public understandings of AIDS showed the way in which focus groups can suggest different ways of interpreting quantitative survey findings through revealing the ‘readings’ and value systems that inform respondents answers to survey questions. In this case, the influence of the media on the public understanding of AIDS.

In was the combination of all these qualities of the focus group technique that ultimately determined its choice as the data collection method most suited to achieving the thesis research objectives. And as Johnson (1996) has argued, focus groups have the ability to ‘bring back’ into sociological research, process, context and meaning.

Finally, an additional quality of the focus group discussion is its potential for transforming the researcher-researched relationship. The focus group technique as used within market research has undoubtedly been associated with an exploitation of
participants for commercial gain. Therefore, the social scientific 'appropriation' of this method requires a very different set of responsibilities on the part of the researcher (Johnson:1996). This is seen to involve a recognition that focus groups have the potential to shift the balance of power such that participants can be involved in helping to define the research questions. Barbour & Kitzinger have also expressed this same point arguing that:

"Certainly, focus group work can disrupt researchers (and commissioning bodies) assumptions and encourage research participants to explore issues, identify common problems and suggest potential solutions through sharing and comparing experiences" (1999; p.18).

Utilising the Habermasian notion of 'communicative action', conceived as a counterweight to the bureaucratic 'colonisation' of the 'lifeworld', Johnson has argued that it is possible to see the focus group as one possible form of such communicative action. However, dependent upon who initiates the focus group, either the 'communicative competence' of the participants will be appropriated to serve interests of powerful organisations, or it could "...institutionalise communicative action in support of a vibrant civic democracy, rooted in public policy formulation in the tacit everyday knowledge's carried in communicative reason " (1996:526). In the context of its use within this thesis, there was a clear intention to use the focus group discussion as a technique that could afford the nurse the opportunity to discuss and reflect upon the changes within the NHS which they had recently experienced. In particular, the ways in which the top-down re-organisation of the NHS as a public service, has impacted on patient care as well as the morale of the nurses themselves. The intention is to disseminate the research findings through the professional nursing journals and at conferences and workshops attended by nurses where appropriate. In this sense, the opinions and tacit knowledge emanating from focus groups involving health care staff have an important role in policy development and implementation, acting as potential counterweight to bureaucratic power and interests.

An example of this perspective is outlined in Jean Orr’s (1992) study of women’s health groups. In her study, Orr recognises the potential of focus group discussions to not only enable participants to express their personal experiences of ill-health and through this sharing of experience to develop a group confidence, but also to foster,
(following C.Wright Mills classic concept) the collective creation of a ‘sociological imagination’. As she explains:

“By concentrating on the commonality of women’s experiences the group encourages members to see that problems are often not caused by personal inadequacy but are based in current social structure” (Orr:1992:32).

Examples of this potential for focus group discussions to develop beyond subjective experiences in order to think about wider social processes (although this is not always a foregone conclusion) emerged in the nurse focus groups conducted for this research thesis. In the following example, Accident and Emergency nurses are discussing the degree to which individual patients should be taking personal responsibility for their health problems.

R1. The thing that I resent is your regular attenders who have alcohol problems, and come in all the time and are very abusive, and mainly come in with alcohol-withdrawal fits and they bump their heads all over the place, and come in covered with blood.

R4. I don’t think that we should resent them, they do need helping...

R1. They do need helping, but when they have been referred many times and they just don’t want to help themselves.

R2. But they can’t help it.

R4. I think you just have to keep digging away.

R2. I think its very easy for nurses to dish-out big advice and asking why do you do this? We don’t know anything about their background, they can’t help it. I’m sure they aren’t coming up to Casualty for the excitement; they have a problem.
Following this focus group discussion, whether the nurse (R1) continued to express what might be termed a 'victim-blaming' mentality towards patients is unknown. Nevertheless, this nurse would have realised that there were alternative nursing discourses which were able to 'imagine' the issue of alcohol-related health problems beyond the confines of the institutional-setting of the A&E Department.

3.1.4 Utilising focus group data

The question that arises once the focus group discussions have been completed and recorded, what social scientific value can we place on the interactivity of these participants? What is the status of the data that has been collected? The concern within this thesis is to draw upon the opinions and frames of meaning of nurses, whilst integrating these discourses within an theoretical understanding of the structural processes at work within the NHS. These organisational structures provide the context for such 'talk'. It is argued by Barbour (1999) that omitting these structural factors from the analysis of focus group discussion is an unfortunate characteristic of a good deal of the interactionist research employing this method.

Clearly, there is a range of interactionist approaches that can be adopted within sociological inquiry. The tradition of conversational analysis (C.A) would challenge the idea that opinions and attitudes can be isolated from the conversational context (in this case the focus group discussion) in which they are generated (Myers and Macnaghten:1999). This principle is rooted in the distinction that is drawn by cognitive social psychologists between an 'attitude' and a 'belief'. Within this frame of reference, an 'attitude' is conceptualised as a positive or negative uni-dimensional evaluation that does not in itself determine individual behaviour, whilst a 'belief' is a stable internalised set of ideas about how the world works so providing the basis upon which attitudes may be formed (Ajzen 1988). The point being that if the expression of an attitude within a focus group is conceived as simply a stance that can change in a different context and different time, then the implication for data analysis is that researchers have to acknowledge that the focus group context itself is central. That more attention be given to "...the transcripts as talk " (Myers and Macnaghten:1999:173).
The difficulty with this position is that it becomes difficult to say anything ultimately substantive about the opinions expressed by a group. If a more sociological understanding of the notion of belief is adhered to, then it is possible to see the attitudes expressed in a focus group discussion as reflecting and shaped by deep-seated beliefs, many of which originate within cultural, class, gendered and organisational patterns of socialisation (something akin to Bourdieu's notion of 'habitus'). The methodological approach adopted within this thesis is based on the epistemological assumption that if a collective group such as nurses are organised within a focus group which is conducted within the participants own workplace (the institutional context of nursing practice), then the opinions, tacit knowledge, attitudes and beliefs expressed by these nurses interacting together with the moderator can be seen as representing a distinct set of discourses of practice. Once interpreted, these discourses can then be analysed outside of the conversational context in which they were expressed, but located within a social structural context which is often missing from C.A. The critical realist position central to the methodology adopted within this thesis acknowledges the inherent fallibility of discourse. It would recognise that thinking and understanding are mediated through a pre-existent conceptual system which makes it becomes difficult for actors to conceive of the world in ways that diverge from these structures. However, this thesis would reject the conjecture expressed by Myers and Macnaghten, that the social sciences should treat opinions and attitudes 'rhetorically', "...as utterances produced in specific situations rather than as attributes of subjects" (1999:185). Rather, the ideas and expressed in the focus group discussions that were conducted for this research thesis would be recognised as rooted with the real material conditions in which nursing is practised.

The detailed case for the 'realist' approach to methodology adopted within this thesis is set out in section 3.2, while the process of focus group data analysis and the issue of maintaining the richness and complexity of the data collected is discussed in detail below in section 3.2.1.3.
3.1.5 Verification and generalizability of the focus group discussion method

The notions of validity and reliability that are associated with the positivist research paradigm are usually deemed an essential characteristic for the conduct of quantitative research. However, even if these 'qualities' are seen as relevant and desirable within qualitative research, there remain immense barriers to achieving the same level of verification as can be achieved in quantitative research. In relation to achieving 'reliability' within qualitative research, the uniqueness of a qualitative study in a particular setting at a particular time prevents it from replicated in another context and time. In relation to achieving 'validity', the usual intent of qualitative research is not to generalise findings but to form a 'unique interpretation of events' (Cresswell:1994:159). Many qualitative researchers consequently choose to adopt a different language in discussing quality criteria, using terms such as 'trustworthiness' and 'authenticity' (Erlandson et al:1993).

Other qualitative research theorists, notably Miles and Huberman (1984) and Denzin (1989), have argued for a form of 'triangulation' as the qualitative equivalent of a quantitative validation procedure. This involves corroborating the findings of one method (structured interviews, for example) with those from another method (say, depth interviews). However, as Bloor et al have argued:

"(t)his positivist view of triangulation is mendacious on two counts: first, it equates (wrongly) one method with another in respect of their suitability for addressing the research issue in question; and secondly, it assumes (wrongly) that the data produced by each method are directly comparable in respect of the order of the specificity of their findings" (2001:12).

The same authors (2001) go on to argue that there is no justification for rejecting the findings of the most suitable method for the research topic and the setting because they have not been confirmed by a less than appropriate method. However, as these authors acknowledge, rejecting a validating role for the triangulation approach does not imply a rejection of multiple methods.

In this study, the question of verification is approached by the use of a particular form of triangulation (although this is not the appropriate term), which involves the use not
of multi-methods but of a type of multi-analytical approach (this is described in detail in Section 3.2). Also, using a transparent 'audit trail' of the key decisions made during the research process, from the fieldwork through to the completion of the data analysis, gives a form of 'internal validity' to the research (Creswell: 1993:158).

In relation to the question of the generalisability of the research findings, there is no intention (as is the case in many qualitative studies) to present the research participants as in any way 'representative' of all nurses, as a 'population' in the way in which this term is understood within quantitative research. This is because groups of nurses practising in different institutional contexts necessarily articulate different sets of discourses. However, this is not seen as invalidating either the research method or the approach to data analysis. It reflects the importance of the retroductive approach (see Section 3.2.2 below) to analysis adopted within the present thesis. This, process of abstraction it will be asserted, allows the research to postulate the generative mechanisms that can account for the production of specific nurse discourses of practice. The purpose is to identify the causative mechanisms that underlay the social processes that produce these discourses in a particular set of social circumstances, rather than simply a list of subjective themes.

3.1.6 Practical issues involved in the management of focus group discussions

It is precisely because values and attitudes are actively formulated within the group setting that the processes involved in conducting a focus group deserve as much attention as the end-product (transcripts).

In relation to the practical concerns of setting up the focus group discussion, Barbour and Kitzinger (1999) argued that there can be no rules about group size, composition, and the desirability of achieving homogeneity or heterogeneity within the focus group, pointing out that any such advice is usually didactic. The specific decisions that were taken concerning the make up of the nurse focus groups used within this research are discussed in section 3.1.7 below.
The role of the moderator or facilitator of the group (who would usually be the researcher and was in the case of the focus groups organised for this thesis), has to be understood in the context of the key principle underpinning this technique which is that participants are encouraged to interact with one another rather than a researcher asking questions of individuals. Whilst the thought of participating in a group discussion may intimidate some people, if the group is effectively facilitated those who might not think they have much to say can be drawn in and encouraged to make a contribution. Therefore, whilst the role of the group facilitator is to draw the attention of the group to discussing a list of topics or broad questions concerning the research problem, he or she should not stifle debate and discussion. The group facilitator thus requires a range of communication skills in order to conduct the group discussion successfully, needing to flexible about the use of available venues and to be able to balance keeping quiet and letting the discussion run on with knowing when to intervene to keep the discussion focused on the research question. The facilitator needs to be aware that sensitive revelations can arise which may be painful for individual participants, as well as being alive to issues of self-presentation (and social identity) which can affect the responses of participants (Bloor et al:2001:15).

3.1.7 The Social and Political Context of the Fieldwork

The fieldwork process began in early 1997 and was completed in late 1999. The first focus group discussion was carried out during the period when the Conservative government was still in power and the NHS was subject to the ‘internal market’ purchaser-provider split and the implications of the ‘Patient’s Charter’. The last focus group discussion was carried out at a time when the New Labour government was in the early phases of implementing its ‘modernisation’ programme for the NHS. This potentially complicates the analysis of the qualitative material emerging from the focus group discussions since the discussions conducted in 1997 (with three groups of Accident and Emergency nurses) in many ways reflect the frustrations of nurses attempting to practically implement such political initiatives as the Patient’s Charter, whilst at the same time feeling devalued as professionals after years of low pay and limited opportunities to shape their practice in a organisation dominated by managerial prerogatives. On the other hand, the discussions conducted in 1998 and
In 1999 (with two groups of community nurses and one group of hospital-based general nurses) inevitably focus upon what was being done and the promises that were being made by New Labour to shift the balance in local clinical decision-making towards health care professionals; one particular example being the new (in 1998) Primary Care Groups (PCGs).

Nevertheless, conducting the fieldwork in this period of dramatic political change and organisational reform (within the NHS) should also be seen as offering a unique set of (nursing) insights into just how significant were the policy reforms occurring in two different political formations for those practising at the micro level of the NHS. Certainly the later focus group discussions (carried out after the defeat of the Conservative government and its replacement by New Labour in May 1997) were particularly reflective about the ways in which the very significant organisational changes that had occurred during the decade of the 1990s had affected nursing practice.

The focus group discussions were all carried out within the workplaces of the participant nurses. These workplaces included three separate hospitals (all three were teaching hospitals) and two local health centres; all were located within West London. It should be noted that the London location skews some of the perspectives articulated within the discussion groups, reflecting the problems of nurse recruitment because of the high cost of living within London, with the attendant problem of short staffing and heavy workloads.

3.1.8 Research Participants

In all, six focus group discussions were organised involving different groups of nursing specialisms. The intention, when recruiting nurses to participate in the focus group discussions, was not to achieve any kind of 'representative' sample of nurses. This is because it is not possible (or even desirable) to attempt to achieve such a sample using qualitative methods. However, to a certain extent the groups that were put together for the purposes of the focus group discussions could be said to be a purposive sample in that a key objective of the research was to contrast the discourses
of nurses practising within different health care settings in order to establish the importance of the context of practice. To this end, separate focus groups were organised amongst ward-based ‘generalist’ nurses; community nurses (both health visitors and district nurses); and A&E nurses as a group of ‘specialist’ nurses.

Three focus group discussions were undertaken with A&E nurses in three separate A&E departments, two focus group discussions with ‘community’ or primary care nurses (which included health visitors, district nurses, and practice nurses), and one focus group discussion with hospital ward-based generalist nurses. A total of 28 nurses participated in the six focus groups.

Given the importance of contrastive forms of explanation for the research methodology, the decision was made to combine some degree of heterogeneity (between generalist, community, and A&E) with homogeneity in the nurse focus groups. Homogeneity within the groups was determined by length of nursing experience, qualifications, and grades. The attempt was made to recruit nurses holding a middle to senior position (i.e. grades ‘F’, ‘G’, and ‘H’), since these were likely to have been qualified at least four or five years, rather than more junior nurses who by definition had less experience of past and present changes in the organisation of the health care system.

3.1.9 Access, Consent, Confidentiality, and Ethical issues

Following approval from the Faculty Ethics Committee within the university that employed me at the time, I was able to go ahead and attempt to gain access to the various groups of nurses working within the NHS that I wanted to participate in the research. The study itself was conducted more than two years before the Department of Health issued a set of guidelines for the conduct of research ethics committees (RECs) within the NHS. If the research were to be carried out now, the fact that it involved NHS staff talking about their professional responsibilities would require the consent of the local NHS REC. However, at the time (1997-99), the consent situation was much more ad hoc, and the various Directors of Nursing whom I approached saw
no difficulty in granting me access themselves, on condition that the basic principles of data confidentiality and participant anonymity were met.

Once consent had been obtained, a gate-keeper (typically the relevant senior nurse manager) needed to be found for each of the clinical areas in which I was interested in recruiting participants. Co-ordination and recruitment problems are a typical feature of setting up focus group discussions (described in Section 3.1.7 below), hence there was a heavy dependence upon such gate-keepers to give out the recruitment notice to relevant staff, book a room for the focus group on site, and most importantly grant permission for the individual nurses to take time out from their working day to participate. This dependence can potentially produce a bias in recruitment as well as raising the ethical problem of whether participants know what they are volunteering for. Therefore, in order to achieve the informed consent that ethical standards require of a research study, potential participants were given an information leaflet. This leaflet set out the main concerns and parameters of the research and outlined the confidentiality and anonymity safeguards that would be made in relation to the transcript data (the leaflet is reproduced in Appendix I).

Once the group had been recruited and had agreed to participate, on the day arranged for and directly prior to the focus group discussion, I myself, acting as the group moderator, ran through the research objectives as well as the confidentiality and anonymity principles. Participants were then given an opportunity to opt out if they were not satisfied with the research aims and confidentiality arrangements.

3.1.10 Conduct of the fieldwork

Recruitment is always a particular concern with focus groups, given the numbers required. With this in mind, following the granting of consent to interview staff in the particular hospital or community trust, the information leaflet (described above) was sent to nursing staff in the relevant clinical areas. There were then the practical problems of co-ordinating the focus group. Unlike individual interviews, where the interview is conducted at a time of the respondent’s choice, a focus group discussion requires a venue capable of seating at least eight people and needs to be held at a time
which is agreeable and convenient for all participants. Therefore, there was a need to recruit more participants than are actually required. In relation to the nurse focus groups, the aim was to recruit a minimum of five and a maximum of eight participants; the average eventually worked out at just over five participants per group.

As discussed above, the advantage of the focus group discussion over the individual or group interview is that participants are able to generate their own questions, frames, and concepts. Nevertheless, if results from one focus group discussion are to be compared with those from other similarly composed groups (as in this research), then some form of topic list needs to be devised, essentially to act as an aide-mémoire for the facilitator. This list is not an interview schedule as such, there being no fixed questions to be asked in a particular order. Rather, it acts as a prompt for the facilitator to enable subsequent comparative analysis to be conducted between the different focus groups. These topics were not raised in any particular order with the nurse focus groups, and if a group raised the issue itself, then so much the better: the point was that the key issues for the research were at some time discussed by all the groups. The prompts used by the facilitator appear in the transcripts, and it can be seen that the topics were raised in different ways and at different points in the discussion, depending upon the flow of participant exchanges (see Appendix 2).

Recording the focus group discussion can take a variety of forms, and whilst note-taking alone is broadly acceptable, audio tape-recording provides much richer access to the discussion. These focus group discussions employed audio tape-recording, using a table rather than a directional microphone, which was capable of successfully recording all participants, who were placed in a circle around the microphone. Transcribing audiotapes is a time-consuming business, and it was most helpful being both the facilitator and the transcriber in that it made the process of identifying individual speakers so much easier, particularly since in any group discussion people inevitably talk over one another and interrupt one another.
3.2 Developing a Methodological Framework for Qualitative Data Analysis informed by a Critical Realist Depth Ontology

The objective of this section of the thesis is to make the case for developing an analytical framework informed by critical realism capable of incorporating the findings of qualitative research methods. The contention is that the beliefs and understandings of social agents or subjects represented in the form of qualitative data can provide a starting point for a methodological process seeking to infer or postulate the effects of generative mechanisms operating below the surface. Such mechanisms could account for the phenomena in question (nurses’ discourses of practice) through an analytical process of abstraction and retroduction.

Qualitative research methods need not be confined to the micro-level analysis of social interactions and inter-subjective meanings; they are also particularly suited to furthering our understanding of the stratified relationship pertaining between social structures and the production and reproduction of the practices of social agents. A key assumption of the present thesis is that the discourses of nurses as social agents are an expression of an essentially collective social process (nursing care). Whilst operating at the ‘appearance’ level of social relations, they are nevertheless as ‘real’ as the social structures to which they are materially tied. This perspective reflects a realist understanding of social structures as being incapable of existing independently of the activities they govern or of existing independently of social agents’ conceptions of what they are doing in their activity. This mirrors Marx’s classic dictum that “men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past” (1973:398).

This section begins with a critical assessment of the limitations of what might be termed the ‘interpretative sociologies’, in other words, those approaches to the analysis of social processes that are influenced by hermeneutic philosophies. It will then go on to outline the case for the use of focus group transcript material within a
methodological framework informed by critical realism and by Marx's historical materialism. In particular, it will argue for the significance of shared collective discourses, not just in terms of their meanings for a social group but as reproducing wider social structural processes. Finally, an analytical schema or framework is proposed which seeks to apply the methodological principles outlined below to the analysis of focus group discussion material.

3.2.1 Non-realist methodological approaches to the analysis of qualitative data

In making the case for the use of qualitative data within a methodological framework of analysis informed by critical realism, it is impossible to ignore the fact that the use of qualitative methods within social research has traditionally reflected a commitment to a hermeneutic interpretation of the human condition (hermeneutics being philosophically rooted within an anti-naturalist ontology that seeks to distinguish between 'explanation', or causality, and 'understanding'). It is therefore necessary to begin by establishing just why the ontological assumption, implicit or otherwise, that informs a research methodology is so fundamental to the analytical outcomes of that research. As Bhaskar has argued:

"...ontology does not have as its subject matter a world apart from that investigated by science. Rather, its subject matter just is that world, considered from the point of view of what can be established about it by philosophical argument" (1978:25).

3.2.1.1 Interpretative methods within the 'hermeneutic tradition'

For those social scientists influenced by hermeneutic philosophies both new and old, Verstehen or 'understanding' is seen to be a fundamentally different activity from 'explanation'. Thus, there can be no description of social phenomena which is not interpretation. In the 'hermeneutic circle' (a term that Gadamer adopted from Heidegger), all understanding demands some degree of 'pre-understanding' (Giddens:1976:56). Hence, for sociologists working from this ontological position all
social research is ‘qualitative’ research. Essentially, the expressed knowledge or ‘practical theorising’ of subjects is taken at face value. This is because subjects are seen to be drawing upon ‘pre-understandings’ or, as Schutz (1972) calls them, ‘first order constructs’. It is on this basis that the hermeneutic tradition can be said to broadly reflect a philosophical idealism and anti-naturalism. This is not to deny the existence of important philosophical differences between phenomenology, ethnomethodology, and the anti-positivism of Winch (1970).

This philosophical background to hermeneutics is demonstrated in the way in which \textit{Verstehen} is seen to be much more than a method allowing sociologists to access the perceptions of subjects, as it is in the work of Weber for example. Within the hermeneutic tradition, language becomes ‘the medium of understanding’. Giddens argues that four distinct methodological assumptions are associated with application of the \textit{Verstehen} principle within hermeneutics. First, he points out that \textit{Verstehen} cannot be treated as a mere social research technique; it is something common to all social interaction. Second, and following the \textit{Verstehen} principle, at root social scientists are seen to utilise the same resources as lay people in analysing their own experiences. In this way, the ‘practical theorising’ of the subject cannot be ignored in a ‘scientific analysis’ of human behaviour because it is central to why that behaviour occurs. Third, knowledge drawn upon by subjects to make their social world meaningful is implicit knowledge. Fourth, the concepts (Schutz’s ‘second order constructs’) utilised by social scientists must depend upon a prior understanding of the implicit lay knowledge of their subjects (Giddens:1976:52-3).

The necessity of ‘interpreting’ social processes within the social sciences is something that both the hermeneutic tradition and the tradition of critical realism (although not positivism and empiricism) can agree upon. As the four principles identified by Giddens demonstrate, the notion of \textit{Verstehen} within the hermeneutic tradition is built upon a distinct ontological and epistemological approach to understanding that is quite distinct from that of a realist social science, which would recognise the existence of a reality outside of conscious awareness. Giddens (1976) has further demonstrated that interpretative sociologies adopting these principles of \textit{Verstehen} do in fact share some important limitations, the major one being that they deal with action as meaning, not
action as practice. Partly as a consequence of this position, any conception of power as a fundamental relationship within social interaction is absent from hermeneutics.

Whilst the focus group method is not exclusively the preserve of social investigation methods rooted within the hermeneutic tradition, the position adopted here is that the continuing influence of hermeneutics within social research tends to set epistemological limits to the analytical conclusions that can be drawn from this form of qualitative data.

3.2.1.2 Interpretative analysis, fallibilism, and the question of essence and appearance

The methodological position adopted within this thesis rejects the epistemological duality which at one extreme (anti-naturalism) would see the natural and social sciences as radically different types of enquiry, whilst at the other extreme ('physicalism') it would see the natural sciences as providing the social sciences with the conceptual framework for explaining social behaviour; reducing the human sciences to physics alone. Interpretation is seen not only asinescapable in any social or 'scientific' enquiry but also as perfectly compatible with the position of naturalism that there must be a methodological unity (which does not imply the hegemony of physics) of all the sciences in the formulation and evaluation of any theoretical proposition. For example, in the process of attempting to make sense of the words uttered by individuals, an acknowledgement that language and thought are inseparable means attributing beliefs and rationality to that individual. Therefore, the process of giving the correct sense to a sentence used by that individual must be an interpretative process. Interpretation thus represents a crucial dimension in the scientific explanation of human behaviour, given that any description of social practices makes “irreducible reference to human beliefs and intention” (Callinicos:1985:102-5).

However, the question then arises: can a process of interpretation take such intentional activity at face value? Do the things that informants tell us about their social experiences constitute knowledge of the social processes at work? In other words, are discourses fallible? Certainly, we can only ever know the world in terms of those
discourses that are available (science, for example), but that does not make the world a product of those discourses. So the power of discourses to create effects by influencing action must be seen as limited, if it is admitted that those discourses may be fallible. Critical realism, for example, places great emphasis on the potential for falsification, reflecting the distinction that it draws between what is termed the 'intransitive' (an independently existing reality, i.e. the idea that the world exists largely independently of social actors' understanding and ideas about it) and the 'transitive' (reducing the question of 'what is' to 'what is known') dimensions of science. Thus for critical realists there can never be any complacent assumptions that thought must in some way mirror the world as it is, and this is demonstrated every time our expectations are confounded in some way (Sayer:2000a). Clearly, there are inherent difficulties submitting the practical understanding of subjects to theoretical reconstruction. Writers as disparate as Winch and Bourdieu would see theoretical objectification as being antinomic to the practical logic or sense of subjects, since it short-circuits the process of analysis. However, this position (which is also present in social constructionism of both the weak and strong varieties) could be said to confuse or ignore the intransitive and transitive dimensions of science (Engholm:2000:18). The critical realist Tony Lawson has asserted that, "social objects exist intransitively at the time any social scientific analysis is initiated, whatever the eventual effect upon them induced by such an enquiry" (1997:200). This position applies just as much in cases where the object of enquiry is discursive as it does for the examination of economic structures.

Developing this issue of the inherent fallibility of discourse and the consequences for interpretative analysis, because thinking and understanding are always mediated through a pre-existent conceptual system (seen here as an ideological framework), it becomes difficult for us to conceive of the world in ways that diverge from these structures. Nevertheless, unexpected situations inevitably arise precisely because the world is not dependent upon our thinking about it. These situations or events may contradict our existing conceptual systems, yet they are registered within and through them. This can produce mistaken or false conceptualisations of phenomena (Sayer:2001:969). For practical analytical purposes, this means acknowledging that a hermeneutic understanding of individual discourse will inadvertently, but necessarily reproduce the hegemonic or dominant ideas existing within socially stratified
societies. As Mouzelis has pointed out, "... actors, because of their very unequal access to the economic, political and cultural means of production, contribute just as unequally to the construction of social reality" (1995:16). Therefore, it is not sufficient to simply acknowledge that the accounts of social agents can be mistaken; an interpretative analysis must also seek to delineate the social processes which produce this fallibility. To recognise that discrepancies exist between people's perceptions of their world and of its underlying structural mechanisms is to acknowledge the ontological position of realism that appearance and essence are not identical. Hence, the process of interpretation of human actions and ideas must recognise that

"Actors' accounts are both corrigible and limited by the existence of unacknowledged conditions, unintended consequences, tacit skills and unconscious motivations; but in opposition to the positivist view, actors' accounts form the indispensable starting point of social enquiry" (Bhaskar:1998:xvi).

Thus, the interpretation of actors' understandings should constitute not the end point of analysis but rather the 'indispensable starting point' of an interpretative realist analysis, which through the process of identifying contradictions and fallibilities is able to postulate the operation of deeper social structures. This is what Margaret Archer is referring to when she argues that: "...we do not uncover real social structures by interviewing people in depth about them" (1998:199).

3.2.1.3 Induction and the coding-categorisation problem:

A methodological issue of a rather different order concerns the validity of the results of qualitative data analysis which result from the type of inductive reasoning that is frequently found in, but is not unique to, non-realist forms of qualitative social research. This question of validity is often linked to the process of coding. Coding, understood as the indexing and then linking of those elements of the data that are conceived of as sharing some perceived commonality, is always a first step in the analytical process;
whatever the ontological standpoint of the researcher. However, as Coffey and Atkinson (1996) argue, the process of coding can become confused with the analytical work of developing conceptual schemes. Coding can then all too easily reflect the researcher’s implicit conceptualisations of the social phenomena under investigation. This occurs because transcript data is seen to be something unwieldy, as raw material that needs to be refined or reduced in some way prior to interpretation. Yet this form of ‘data reduction’ can exclude \textit{a priori} whole sections of material that do not fit easily into the emerging codes.

Problems can also emerge if the purpose in using codes is to reduce transcript data so as to identify a simplified conceptual schema. This approach usually involves the exclusive index coding of segments of data text in order to make it possible eventually to retrieve sections sharing a common code; treating the data in a ‘quasi-quantitative’ way. Thus some non-realist approaches to the analysis of qualitative data appear to begin and end with a coding process which cuts up and then reassembles the qualitative material in a manner reminiscent of some Frankensteinian project. Such approaches all too often result in the fragmentation and decontextualisation of research material and distort the richness and complexity of interactive discourse of informants (as in the case of focus group transcript material, for example). The issue then, as Coffey and Atkinson (1996) point out, is essentially one of failing to integrate fieldwork within an explicit theoretical framework. Certainly, data generated through the increasingly popular focus group method has, as Frankland and Bloor (1999) argue, all too frequently been selectively analysed. This outcome is a consequence of employing such exclusive coding procedures and using decontextualised interview quotations, ironically as a result of a desire to retain the richness of transcript data. Frankland and Bloor (1999) go on to argue that analysis, as an essentially comparative exercise, should seek to derive propositions that can be applied across all of the data transcript items, not just selected items.

To this end, the analytical technique known as analytic induction (AI) is one possible avenue that can lead away from such reductionism (discussed in Hammersley and Atkinson:1995 and Coffey and Atkinson:1996). Each section of interview transcript is not assigned a single code, in some final and arbitrary interpretative act; rather, each
segment is assigned several non-exclusive index-codes, which refer to the various analytic topics brought up in the group discussion. Index-code words or labels are attached to these emergent themes as an inductive process, which can be quite general at first but is progressively elaborated as more data is examined. Once indexing is complete, a method of making systematic comparisons within the transcript data is required, the indexing process being merely the first stage. In AI, generalizability of the final analytical propositions is achieved by specifically focusing on the 'deviant' or contradictory indexed transcript items. Here the attempt is made to modify the analytical propositions in order to embrace these deviant cases, this procedure being designed as an attempt to guard against selective attention to data and provide a more systematic means of extending analytic thinking.

There are clear merits to this deviant case approach applied to focus group data analysis, particularly in the way in which it draws attention to how participants can contradict one another. Such contradictions, it will be argued below, can be indicative of an important dynamic or dialectic at work rather than simply constituting an aberrant occurrence or utterance that cannot be fitted into a code. Nevertheless, for realist research concerned with explaining the social processes at work within the observed behaviour, texts, or group discourses under investigation, there remain considerable ontological difficulties in uncritically adopting what is still an essentially inductive approach, however sophisticated. This emphasises the need to develop a distinct framework of data analysis consistent with the methodological principles of critical realism.

3.2.2 The case for a realist approach to qualitative data analysis: What can the subject tell us about the object?

What, then, can the qualitative material generated by a focus group discussion offer a realist social science that is more usually associated with quantitative structural analysis? To put it another way, what can the subject tell us about the object? The argument presented here will assert that qualitative research material, if utilised within a broader realist framework of inquiry, has the potential to contribute to a transcendental (that is, beyond the subject-object or agency-structure divide)
understanding of the causal relations and social processes that pertain at a particular social and historical conjuncture. It will also be contended that both discourse and social action represent forms of practice rooted in the conditions of material existence and associated sets of social relationships and practices.

3.2.2.1 The ontological basis of a realist social scientific methodology

Consistent with Bhaskar's philosophy, a social scientific methodology informed by a critical realism can be said to be predicated upon three basic ontological premises concerning the nature and depth of social reality (Archer:1998:195-196). The first is a rejection of positivist ontology with its dependence upon observable events in favour of a recognition of the existence of intransitive entities which are independent of their identification. Such 'intransivity' precludes the 'epistemic fallacy' of collapsing the ontological into the epistemological (confusing what is with what we take it to be). It means that any reductionist theorising is also precluded in favour of a relational conception of social scientific research phenomena.

The second is an assertion of the 'transfactuality' of social structural generative mechanisms to the effect that “…their activities are continuous and invariant, stemming from their relatively enduring properties and powers, despite their outcomes displaying variability in open systems” (Archer:1998:195). However, whilst this means acknowledging that forms of society are historically contingent, it is not the same as assuming that all social phenomena are therefore contingent. The task of a realist explanatory methodology is to find these mechanisms and the relatively enduring tendencies that derive from them (this process is discussed below largely in relation to Lawson's (1997) work on the importance of identifying ‘demi-regularities’).

Third, the insistence that reality is 'stratified' means a rejection of any methodology that is dependent solely upon 'surface sense data' and an assertion of the necessity of achieving an 'ontological depth' in the analysis. For Bhaskar (1979) achieving such analytical depth implies a recognition of three ontological 'domains' of reality. Firstly, there is the 'empirical' level where the real is only those events that are observed
directly or indirectly; this equates to the strict form of empiricism. Secondly, the level of the ‘actual’ where events happen whether we experience them or not. ‘Actualism’ recognises the existence of the unexperienced but still experienceable events which may be produced under experimental conditions in a laboratory or less predictable ‘conjunctures’ outside of the lab. This may show us that there must be some underlying mechanism which explains the event, but it cannot tell us anything about what this mechanism is. The third domain is the ‘real’ world of causal mechanisms, powers and tendencies which have to be inferred (Benton and Craib: 2001: 124).

In terms of an explanatory methodology; this conceptualisation of ontological depth necessarily introduces a notion of "vertical causality which simultaneously entails temporality" (Archer: 1998: 196). In other words, one social structural mechanism cannot be explained in terms of another, or reduced to another; emergence and differentiation must be allowed for. Stratification thus forms the basis for a critical realist process of abstraction. But such abstractions "...are not subjective classifications of an undifferentiated empirical reality, but attempts to grasp precisely the generative mechanisms and causal structures which account...for the concrete phenomena of human history" (Bhaskar: 1998: xvi).

A central theme of Bhaskar’s realism is this assertion of the essential ‘stratified, differentiated, and dynamic’ nature of human societies. The social world is seen as differentiated in the sense of recognising the existence of multi-determinations rather than a single deterministic essence. This reflects the position that societies are by definition open rather than closed systems. It is a stratified and dynamic social world in the sense of recognising pre-existing structures which operate below the surface, these different structural layers complementing or contradicting one another. These are generative or causal social mechanisms which interplay with other objects including social agents and result in non-predictable but potentially explicable outcomes. This is because these mechanisms are seen as belonging to different layers of strata of reality. Each new stratum is formed by the powers and mechanisms of the underlying strata. When the properties of the underlying strata are combined qualitatively new objects come into existence, each with its own specific structures, forces, powers and mechanisms. This process is described by Bhaskar as ‘emergence’. It allows him to assert that an object or structure has ‘emergent powers’. Thus an
understanding of any social phenomenon involves contextualising it in terms of the operation of these hidden mechanisms.

At a substantive level, realism has the potential to be compatible with a wide range of social theory, although there will be formal differences as to the relative importance of particular mechanisms and structures. Marx's philosophical understanding of realism, for example, has been described as being an 'epistemological materialism' (Callinicos:1985). This is in terms both of Marx's conceptualisation of thought as the reflection of materiality ("...the ideal is nothing but the material world reflected in the mind of men, and translated into forms of thought" Marx:1976:102) and of his recognition of the existence of objects independently of thought; of his distinction between appearance and essence:

"Realism thus understood views the world as stratified, so that the observable behaviour of people and objects is unintelligible unless set in the context of the hidden structures of which it is a manifestation" (Callinicos:1985:115).

Critical realism's own relationship to a Marxist social science is a necessarily complex one. However, if critical realism is seen not as a theory of society in the direct sense but as a philosophy of scientific methodology and practice (second-order knowledge), and if Marxism is defined not as a philosophy but as a theory (rooted within a realist ontology) which studies the structures of society (first-order knowledge), then critical realism can be seen as complementary to Marxism. Critical realism thus conceived as a philosophy can play an 'underlabouring' role in commenting on the methods, practice, and claims of Marxism (Joseph:2002:24-6). The attempt to 'underlabour' a Marxist understanding of ideology as material practice will form the basis of the data analysis section of this thesis. This approach will assert that a realist social science informed by historical materialism recognises that underlying the rational or conscious intentions of social agents are hidden generative structural mechanisms which reflect the material basis of capitalist societies. However, in order to avoid the kind of crude reductionism that characterises some analyses of this material relationship, there is a need to acknowledge the existence of an ideological dimension to social practice. The use of such a conception of ideology can account for the existence of the 'discrepancies' or contradictions often found to exist between the 'appearance' level of the discourse of social actors (i.e. what
subjects say in interviews), and the ‘essence’ level or what we know about the influence of deeper social structures.

3.2.2.2 Critical realism, ideology and the methodological status of discourse

Putting to one side for the moment those methodological concerns regarding interviewer bias and the artificiality of the research format, what status can be placed upon the discourses of social agents as articulated within a focus group discussion? Can the knowledge of individuals and social groups represented through talk, or collectively as ‘discourse’, be accepted for research purposes as material that can inform a realist understanding of the social world?

Discourse as an expression or articulation by individuals and groups, whilst it operates at the ‘appearance’ level of social relations is nevertheless as ‘real’ as the structural interrelations to which (it will be argued) it is materially linked. Clearly, as an expression of shared meanings and beliefs discourse cannot be readily conceptualised. However, this does not imply that discourse is merely some superficial manifestation of more fundamental social structural relations. It can have real effects in the world: for example, shared discourses can be seen to be confirmed through the reproduction of social practices in the form of social institutions and processes. Discourse thus has a material existence, and because it has effects in the real world it must also be causal. In this sense, then, a realist research methodology would recognise the importance of qualitative methods in furthering an understanding of ‘discourse in general’ as an articulation of the social practices of agents which are produced and reproduced as an outcome of the interaction with social structures. Analysing discourse in this way emphasizes its ‘performative’ aspect as opposed to its representational or denotative aspect, the latter generally being the concern of social constructionist approaches (Sayer:1997:474). This is a position which would argue that social processes cannot be reduced to the level of statistical relationships alone. A research process informed by critical realism would recognise that social structures are constituted through a set of internal relations and that this in turn necessitates an understanding of intersubjective social practices. Utilising qualitative data such as transcriptions of
group discourses on the assumption that knowledge and practice are inseparable offers us the possibility of exploring such intersubjective social practices.

However, since social actors can be fallible in their common-sense understandings (as discussed above), any empirical observation of the world must inevitably be ‘theory-laden’. Sayer (1992) rejects the possibility of achieving a positivist ‘objectivity’ as a naïve belief that facts can ‘speak for themselves’ and need only be ‘collected’ as ‘data’. This, he argues, applies as much to qualitative as to quantitative research methods. However, Sayer avoids a retreat into relativism by arguing that theory does not order or structure given observations; rather, it “negotiates their conceptualisation, even as observations” (1992:84). Similarly, Andrew Collier argues that the process of theory construction in the social sciences must involve a process of ‘theoretical transformation’ of these theory-laden or ideological preconceptions of social practice (1994:165-167). This theoretical work is required precisely because the social world is an open system and therefore requires a process of theoretical abstraction before the explanatory power of any causal hypothesis can be tested. This methodological process, which is known as ‘retroduction’ is described below. The approach of transcendental or critical realism (categorised by Bhaskar [1989] as ‘a species of the retroduction genus’) to the analysis of social practice always begins with social agents’ conceptions of that practice. In this respect, it resembles hermeneutics. However, unlike the latter, it holds that social explanation must be both causal as well as interpretative.

A critical realism that is informed by historical materialism would also recognise that knowledge is primarily produced through social activity or ‘practice’. For Marx, the notion of practice refers to both the goal of transforming our environment through work or ‘labour’ and the process of communicative interaction with others through the sharing of meanings (men and women transforming themselves); both forms of knowledge are highly interdependent. At the root of this conceptualisation of the transformative power of labour is an ‘isomorphism’ of thought and the object of that thought (Brown:1999). Embracing such a isomorphism means recognising the existence of a relationship between the social form or ‘appearance’ and a hypothesised structure or ‘essence’. Nevertheless, for Marx this essence-appearance relationship in class societies reflects a contradictory reality. This arises from the historical
development of production processes and a division of labour out of which social relationships and social conditions emerge independent of (the majority of) people's wills and interests. Such contradictions or unintended consequences of human practice give rise to structures and relations (social class divisions) as an 'objective power' over which men now lack control. Practice as a product of an 'incomplete' or 'contradictory reality' results in ideology (Larrain: 1979:45). It should be said that the notion of contradiction is seen by Marx not as the universal essence of reality but as a condition of specific social situations in which inversion (used in the Hegelian sense of an inner reality concealed and reversed by its phenomenal form) occurs, i.e. within all class societies. For Marx, these are real, historical contradictions rather than the abstract ideal conceptualisation that exists within Hegel (Larrain: 1983:132).

This conception of ideology enables us situate the discourse of subjects within a conception of reality that "does not explain practice from the idea but explains the formation of ideas from material practice" (Marx: 1970:58). This essentially non-reductionist relationship between ideas and practice as well as between structure and agency acknowledges that, whilst ideological structures are built by social subjects, they also shape the ideas of those subjects. This conception of ideology (in both critical and positive variants) provides a framework for the understanding of the structural basis of contradictory realities.

3.2.2.3 Analytical dualism, demi-regularities, and synthesis of the concrete concept

The objective in a critical realist analysis of the qualitative transcript data emerging from the focus group discussion is to move beyond the interpretation and abstraction of themes or conceptual categories in order to achieve a concrete conceptualisation of underlying generative mechanisms. This attempt to analytically abstract structure from interaction, which acknowledges that social outcomes are shaped by a reciprocal relationship that changes over time between structures and social agents, reflects a commitment to what has been termed methodological or analytical 'dualism'. The dualism of structure and interaction in social systems reflects the fact of their separation in time. Structure predates the interactions which reproduce it, and since interaction predates the reproduced or elaborated structure which results from it these
must be treated as analytically separable within any process of social theorising (Creaven:2000:12). Such a process of analysis would investigate a real ‘concrete object’ (the discourses of nurses, for example) by moving from this concrete object through a systematic process of conceptually abstracting-down to the point where the constituent relations or mechanisms that generate its effects are identified. Then, in a ‘double movement’, reconstructing that concrete reality in thought (a concrete conceptualisation which combines the abstractions), the essential as against the inessential aspects (or contingent and necessary relations) of that ‘chaotic whole’ can be distinguished (Sayer:1992:87).

This approach closely follows Marx’s own dialectical ‘method of inquiry’, which went beyond the analytical induction that characterised much of ‘political economy’ in his time. The latter, characterised by such writers as Adam Smith and John Stuart Mill, assumed that by moving from presenting simple to more complex categories, the analyst was able to achieve an understanding of the phenomenal object. The problem, however, was that the historical and analytical origins of these simple analytical categories was taken as read. Marx’s approach was dialectical in that his intention was not to decompose the concrete object into a collection of fragments but to understand the dynamic interplay of the parts in order to better understand the whole. It was also dialectical in the distinction that it draws between relations which define the essence of a social object and those which are purely phenomenal aspects (the necessary and contingent relations described in Bhaskar’s work). Marx began with the concrete phenomenon and sought to find, by analysis, its simple determinants. The resulting abstract categories were then ‘presented’ in such a way as to achieve a synthetic concrete categorisation of the phenomenon. The key to this approach was to start from some pre-analytic concrete concept. Marx’s approach is empirical rather empiricist in that he recognised that, in the devising of simple abstract determinations, the analytical categories did not have to be immediately identifiable by observation or measurement. However, their emergence did require an analytical process of reasoning; as did the subsequent synthesis (‘presentation’) stage. Here, Marx was able to

" (steer) a middle ground of method by avoiding the extremes of the assumed omnipotence of reason as independent of any concrete reality found in
idealism and the crass devotion to the scope and power of the senses which limited the potential for comprehension in empiricism” (Oakley:1984;149).

Marx’s analytical process of synthesis has much in common with the mode of inference described by critical realists as ‘retroduction’. For critical realists, the retroduced concrete concept synthesises a range of relevant abstract categories to arrive at an analogous generative mechanism (or mechanisms) at work, “... which if it were to exist and act in the postulated way would account for the phenomenon in question” (Bhaskar:1989:12 - cited in Collier:1994:163). It should also be added that the analytical process of retroducing sets of causal mechanisms necessarily “draw(s) heavily on the investigator’s perspective, beliefs and experience” (Lawson:1997:165).

Lawson’s (1997) own work, which is situated within the critical realist tradition, is particularly concerned with the practical task of identifying causal or generative mechanisms through a process of contrastive explanation. For Lawson, central to the process of retroductive inference is the recognition of what he terms ‘demi-regularities’. Beginning from the perspective of the social world as open, dynamic, and constantly changing, it is possible to acknowledge that, ‘over restricted regions of time-space’, certain mechanisms may dominate others and may be reproduced continuously. The effects of these causal mechanisms may be apparent at the level of actual phenomena which give rise to partial or demi-regularities (Lawson 1997:204). Demi-regularities (or ‘demi-regs’ for short) thus provide evidence for the occasional, but not universal, actualization of a generative mechanism. The very fact of the patterning of such demi-regs “...reveals something in turn of the nature of the tendency in play” (1997:207). Lawson argues that the evidence for the pervasiveness of demi-regs in a social world where it is not possible to exercise control through some form of experimentation turns upon the existence of differences or contrasts between social groups, events, or states of affairs in particular periods of time or social contexts. As Lawson asserts:

“...we notice the effects of sets of structures through detecting relatively systematic differences in the outcomes of prima facie comparable types of activities in different space-time locations, or differences in types of position-related activities in comparable space-time locations” (1997:208).
Lawson offers the following examples of contrastive demi-regs to demonstrate their pervasiveness: the fact that women spend more time looking after children than men do; the small proportion of working class children in higher education; and changes in unemployment rates over two decades. He goes on to make the point that using the terminology ‘demi-reg’ acts to reinforce the critical realist critique of deductive inference that empirical facts rarely take the form of strict regularities; rather, “...they express phenomena to be explained, not the end-points of research or mere devices to be built into formal systems” (1997:208).

Times of social crisis and change (as in the organisational changes that have occurred within the NHS in the 1990s) may be particularly revealing. Crises are instances of what are actually a wide range of occasions when mechanisms become visible (Lawson: 1997:209). The existence of contrastive ‘demi-regs’, which Bhaskar describes as “a class of potentially epistemically significant non-random patterns or results” (in Archer et al: 1998:14), allows us to retroductively infer (at a different level from the phenomena to be explained) the effects of generative mechanisms. However, as Bhaskar also points out, this is justified only if the demi-regularity is the only relevant difference in contrasting social groups or events, i.e. if it is true “...that for epistemic purposes other things are equal” (in Archer et al: 1998:14).

For Lawson, then, the initial task is to identify those factors that are directly responsible for the identified contrastive demi-regs in one set of social circumstances but not in another comparable situation. That in turn requires an understanding of the mode of reproduction of the identified causal mechanism, what he terms ‘an explanation of an explanation’ (1997:219). This process involves two separate modes of analytical activity. First, there has to be an abstract or theoretical explanation of structures and mechanisms. A necessary condition for this activity to occur is the reproduction of enduring mechanisms discernible through the ‘shining through’ effect of demi-regularities. However, a second mode of explanation, the ‘applied’ or concrete, is also called for. Here, the extent to which the concrete phenomenon (in this research the discourses of nurses practising within the NHS) is understood to be relatively unique, as representing the conjuncture of ‘numerous countervailing tendencies’, means that any explanation of such demi-regs requires the drawing-upon
of (the researcher’s) pre-established understandings of relatively enduring structures and mechanisms. Lawson argues that neither of these modes of explanation is primarily inductive or deductive in form, but that each serves to ‘re-describe’ the concrete phenomenon under a new scheme of concepts (1997:220-221).

3.2.3 The critique of critical realist approaches to sociological inquiry

There are a number of criticisms of critical realism. Some are critiques of realist approaches to social inquiry in general, while others focus specifically on the problems perceived to arise out of critical realism’s primary concern with ontology over epistemology.

Firstly, concerning the application of a realist approach to explaining human behaviour and interaction, there is a view that the realism with its concern to identify underlying causal structures ends up reducing all phenomena to some essential core or process. So Fay (1990) for example, argues that the realist assertion that there is are causal structures at work beneath surface phenomena, “suggests an essentialism to the effect that this underlying causal structure is unitary and invariant” (1990:39). This is a critical perspective which argues that a primary concern with ontology inevitably leads to the development of an overarching theory about the social world which enables realists to simply ‘read-off’ all the facts about human nature or social structures.

Harré’s (2002) critique of realism in general within the social sciences derives from his social constructivist views, and focuses on the problems associated with attributing causal powers to social structures. For Harré it is the interactivity of people that produces or generates social structures such as institutions, norms and rules. Such structures are therefore ‘secondary formations’. It is only people who are recognised as possessing the causal powers necessary to bring about real effects in the world, this is because individuals have the capacity for ‘focused agency’. Harré argues that the only reality social structures have, “...is of the same ontological status as the activities they ‘govern’, namely discursive acts” (2002:116). In other words, social structures exist only as discursive categories. The word ‘govern’ is placed in single-
inverted commas because Harré believes that these social structures are discursively constructed by people on the basis of the rules and conventions that ‘come to them historically’. Institutions are thus the product of ‘rule-following’, but these rules can be changed through the efficacious activity of people, “...immanent in social practices” (2002:119). This view constitutes Harré’s critique of the critical realist position that structures exist in the realm of the transcendental, whereas the discourse of social agents lies within the realm of the imminent (here Harré is drawing upon the distinction Kant draws between these realms). His ‘moral objection’ to the approach of critical realism to social scientific inquiry follows from this:

“...it is easy to postpone the hard task of transforming story-lines and making face-to-face amelioration’s to the real social world by moving to the realm of the transcendental. It is easy to talk grandly of the ‘the social system’ as if it, as something over above the mess of actual social interactions, brought about all those social interactions. But the only efficacious being in the game is the person” (Harré:2002:117).

The second area of criticism focuses specifically on the consequences of critical realism’s commitment to the primacy of ontology. The argument that is made is that this apparent relegation of epistemological concerns ultimately detracts from its utility and applicability within the social sciences. Holmwood’s (2001) critique of Sayer (2000b) as an example of this form of criticism argues that the distinction that critical realists draw between the ‘real’ and the ‘actual’ does not allow for the possibility for falsification of theory. According to Holmwood, this is because retroductive abstraction (see section 3.2.2.3 above) does not allow for the possibility that ‘lower-level’ empirical analysis might indicate that there could be a mis-recognition of underlying mechanisms. He argues that only by giving more weight to the importance of empirical research would it be possible to recognise that “…the non-occurrence of necessary effects might indicate that the claimed mechanism was false” (2001:951). And, that therefore the effects of such a postulated generative mechanism could not then be ‘real’. Critical realists are thus accused of attempting to protect their substantive claims about the effects of generative mechanisms from falsification by treating them as matters of causal necessity. Holmwood anticipates that Sayer would dismiss this view as mere associational empirical thinking and would assert the
importance of abstraction in analysis. However, Holmwood sees such abstractions as ending up as ‘misleading simplicities’, when what is required in social inquiry is a greater empirical understanding of the conditions of existence of a particular social phenomena before going on to develop complex conceptual theories about contingent or necessary associations with underlying mechanisms.

Layder’s work is also critical of what he sees as the failure of critical realism to engage in grounded empirical work which would enable it to test out and develop theory. Layder (1985) has argued that what he terms ‘dogmatic’ forms of realism which privilege ontology result ironically, in a particular form of empiricism in which knowledge is seen as having to mirror these perceived structures of reality. An example of such a ‘reality’ for critical realists would be the operation of underlying generative mechanisms. For Layder, “…the nature of reality and how we come to know it are inextricably bound together and this has important implications for the manner in which we go about research” (1998:23). Knowledge of the world is thus impossible without appropriate conceptual instruments which derive from wider theoretical discourses (Layder:1985:255 cited in Cruickshank:2003:115). Layder goes on to draw a distinction between ‘ontological schemes’ (theories about reality) and ‘ontology’ (by which he means reality-in-itself). Bhaskar’s critical realism is seen to adopt the latter position which leads to it making an implicit claim that the structures of reality somehow ‘determines our knowledge of them’ (Layder:1985:268). For Layder, realism in the social sciences should be all about moving beyond such general theoretical discourses which are seen to serve as a ‘ready-made’ explanation of research findings. Rather, we should recognise the discursive relativity of ontology in order to avoid this critical realist empiricism which assumes that beliefs ought to mirror reality directly (Layder:1985:273 cited in Cruickshank:2003:115).

A general criticism of critical realism that is shared by a range of sociologists, who describe themselves as primarily engaged in realist forms of social inquiry, is that whilst it is theoretically persuasive it lacks the methodological tools necessary for application at the practical level of social research. As Pawson argues, “(r)ealist social theory has propositional precision but has been unable, in the most part, to descend from a critical domain to the empirical plane” (1999:3) That is, if and when critical realism as a form of philosophical analysis engages with social research all too
often its ontological perspective is simply appended to, rather than being synthesised with, the empirical observations. As Carter (2000:62) has argued, a privileging of ontology can occur which avoids the important question of how as sociologists we might set about identifying the ontological features of a social reality.

There is a notable dearth of sociological research which is informed by, or acknowledges the influence of critical realism. As Pawson (1989) has argued, the reasons for this may be rooted in the central construct of the ‘open society’. In principle, the objective of any social inquiry should be to explain the regularities, patterns, uniformities, and rates that are uncovered by empirical research. However, for realism these social outcomes result from the action of underlying generative mechanisms operating in a particular social context. Thus the methodological process of identifying such outcomes becomes, “...not the ‘end-point’ but the ‘collection-point’ of empirical inquiry’ (Pawson:1999:13). For critical realists, who emphasis the open nature of the social world, there are clear epistemological limits to an understanding of reality, and the occurrence of ‘regularities’ within empirical research has to be disputed. This is because in an open system where people are able to reflect upon and then change their ordered patterns of social action predicting particular outcomes in an actual social configuration is an impossibility. Therefore, social science is denied the empirical tests necessary to isolate a generative mechanism in the way in which the closed system experiment is able to achieve this within the physical sciences. The solution to this problem of epistemological limits offered by Bhaskar (1979) is a process of retroductive analysis. Pawson however, argues that this ‘side-step’ within Bhaskar’s own critical realism to a form of retroductive explanation fails to address, “...the form of empirical inquiry needed if social research is to go about collecting and analysing data on the action of contextually constrained mechanisms” (1999:15). This makes it difficult if not impossible to adjudicate between competing theoretical claims about whether a particular generative mechanism brings about a particular set of outcomes in a particular context. Pawson argues that this amounts to a form of ‘conventionalism’, where ‘master mechanisms’ are applied metaphorically as explanations of ‘a potentially limitless set of social outcomes’ (1999:16).
The engagement of the various strands of Marxism with critical realist philosophy and the application of depth ontology within social inquiry has produced a range of critical perspectives. Gunn (1988) adopts a particular Hegelian view of the dialectic as existing in all processes and structures, and that therefore no situation can be reduced to being a form of some other process. He has argued that the critical realist use of a meta-theoretical ontology as an underlabourer for research effectively constitutes a model of external relations resulting in a tautology. This is because in order to identify the operation of a generative mechanism it must be seen as explaining an observed phenomenon, but within critical realist forms of inquiry such phenomena can only be explained by reference to a generative mechanism. Gunn contrasts his perception of Marx’s approach to the analysis of capitalism which applies an ‘immanent critique’ able to engage with its critical targets, its objects of study, this Marx achieves by fusing meta-theory and theory. Cruickshank’s rejoinder to Gunn is that his Hegelian meta-theoretical assumptions about everything in the world being a moving force effectively conflates the specific findings of empirical research or micro-theory so that, “...any research will simply repeat the pantheistic ontology” (2003:121).

Whilst Gunn as a self-declared Marxist is not alone in his critique of critical realism, there are also many writers from within the Marxist tradition who recognise the potential contribution of critical realism to an advancement of an emancipatory methodology within the social sciences. Alex Callinicos for example, in a recent debate with Roy Bhaskar (Bhaskar and Callinicos:2003) emphasises the importance of the ‘underlabourer’ role played by critical realist philosophy in ‘clarifying’ what is happening in the sciences. Not only the physical sciences but also those engaged in understanding the social world. However, he is also sceptical about any claims made by critical realists that they are somehow pursing a new approach to the social sciences. Callinicos goes on to argue that:

“I think there are very strict limits to what philosophy can achieve with respect to actual scientific research...It seemed to me that what critical realism did best was to articulate best practice in critical social theory rather offer a philosophers stone that would allow us to resolve a whole series of anomalies, tensions and crises in particular disciplines” (2003:91).
Critical realists have responded to the broad critique of their 'meta-theoretical' ontological approach to social science outlined above in the following ways. The apparent paradox that Fay (1990) and Layder (1985) point to between an ontology which encapsulates some notion of truth about the nature of being and also an anti-foundationalist epistemology is one that is rejected by Cruickshank (2003). He argues that critical realism’s concern with ontology pertains to an intransitive or metaphysical conjecture about reality which exists outside discourse or our representations of it, and which does not attempt to say anything specific about the social world. That is, a conceptualisation of realism as being an ontological thesis not an epistemic thesis (Searle:1995 cited in Cruickshank:2003:119). Realism can thus be used as a guide ('an underlabourer') for empirical research without negating the outcome of such inquiry by presuming a direct understanding of reality-in-itself.

Sayer’s (2001) own response to Holmwood’s critique of his critical realist position is that far from avoiding the possibility of falsification all critical realists have to be ‘fallibilists’ because they explicitly acknowledge that “...the world can exist largely independently of our (i.e researchers’ and in many cases other actors’) understandings of it...(this) immediately puts into question any complacent assumptions about the relationship between thought and the world” (2001:969). The everyday experience of the fallibility of discourses and its implications for social research is also explicitly acknowledged in the methodology adopted within this thesis and is implicit in the notion of a ‘critical’ realism (discussed in Section 3.2.1.2 above). Sayer goes on to criticise Holmwood’s assumption that a clear distinction exists between the empirical and the conceptual in reference to critical realism’s apparent privileging of conceptual necessity, by arguing that “…this overlooks not only the conceptual mediation of empirical knowledge but the fact that the conceptual can embody results of empirical research” (Sayer:2001:970).

Harré’s (2002) more recent shift towards social constructionism is reflected in his critique of realism and the ‘myth of social structure’. This is situated within the agency-theoretical perspective which reduces the macro to the micro. One of a number of problems with this position is it can lead to refusing the argument that social structural variables have efficacious effects in producing social inequality. Rather such structural constraints would be conceived of as simply discursive ‘story-
lines'. In other words, individual excuses (Strydom:2002). Carter's (2002) response to Harré's argument that rules and conventions (Harré's own definition of social structure) cannot be causally efficacious because they cannot have intentions in and of themselves, is that in itself this would not be conceived as problematic from a realist perspective. The point however, is that this claim reflects a limited definition of social structure, it does not acknowledge that structures should also be seen as ‘sets of internally related objects and practices’ (Sayer:1994:92 cited in Carter:2002:140). Harré's view would subsume generative structures, social organisations and institutional rules under the social structural heading. This constitutes a misconstruing of the critical realist position and fails to address something that Harré himself once advocated, namely the recognition of a reality existing independently of individual consciousness. Recognising that relations and rules or institutional structures are analytically distinct components of social structures is fundamental to a realist social science, and is a distinction that underpins the analysis of nursing discourses within this thesis.

As discussed above, Layder (1985) has made some explicit criticisms of 'dogmatic' forms of realism which lead onto empiricist immediacy, and has argued that we should recognise the discursive relativity of ontology. Nevertheless, and in contradistinction to the views of Glaser and Strauss (1965) and other interpretative sociologists, Layder has argued that conceptualisations of intersubjective experiences and understanding must necessarily reflect the influence of systemic factors:

"Social activity and the subjective or lived experience are never 'free' of the social settings and contextual resources which are constitutive of social systems elements. Thus, ... a concept which may seem faithfully to depict the research subject's world does not necessarily guarantee the truth or efficacy of these concepts ... these concepts must also be concordant with knowledge of the wider social conditions in terms of which social experience is played out " (Layder:1999:87).

The validity of theoretical concepts for Layder (1998) cannot be solely subject to the criteria of subjective criteria. By default this critique would appear to acknowledge the existence of a reality-in-itself beyond what actors tell us about their worlds. Yet he
also argues that "objects are always embedded in, and in a significant sense constructed by, discursive parameters i.e that knowledge of these objects largely depends upon prior theoretical commitments" (1985:260; emphasis in original). It is therefore becomes difficult for Layder to sustain both a criticism of forms of social constructivism as well as a notion of fallibilism. Layder’s critique of the intersubjective understanding of actors is mirrored in the discussion referred to above (in Section 3.2.1.2) concerning the fallibility of social actors subjective accounts of reality. The difference is that here the possibilities for falsification draws upon the critical realist distinction between the ‘intransitive’ and the ‘transitive’ realms of existence. Yet this particular understanding of ontological depth would probably not be endorsed from the ‘broadly realist’ perspective occupied by Layder (1990,1998).

3.2.4 A proposed schema for the realist analysis of focus group discussion data

The objective of this section of the thesis is to set out in an essentially exploratory manner a critical realist framework or schema for the analysis of qualitative data drawn from focus group discussion material (in the case of the present research, this is the articulated collective beliefs and understandings of nurses). Such an approach seeks to move beyond the social research cul-de-sac which is the choice between an inductionist or deductionist (or indeed subjectivist versus objectivist) approach to theory development. Rather, it seeks to reflect the principles of historical materialism (as employed by Marx in his critique of political economy) and the methodological ontology of critical realism. In particular, the intention is to apply the two modes of activity described by Lawson as ‘abstract’ and ‘applied’. However, neither an inductive nor a deductive approach is ruled out per se, and this is because “…employing deductive logic, where it is appropriate, is not the same thing as accepting the deductivist form of analysis” (Lawson:1997:112).

This analytical framework is of necessity theoretically complex in that it requires these different levels or forms of analytical abstraction. This reflects the fact that competing structures and mechanisms operate side by side in the real world and sometimes contradict one another. And here, the critical realist notion of stratification is a particularly useful way of understanding how the activities of social agents relate,
not to one particular structure, but to this range of inter-related structures and practices. The aim is thus to develop a social theoretical explanation that acknowledges the operation of the below-the-surface mechanisms and as such is in keeping with the stratified object of analysis. Additionally, by revealing the complexity of concrete social phenomena or forms, a retroductive analysis (it will be argued) necessarily entails a critique of their immediate appearance, an acknowledgement of the importance of ideological structures in reproducing such structures (Joseph:2002:32-35).

**Note:** The schema set out in *Figure 2* below outlines an analytical process that is designed to be an open one, whereby the ‘trail’ from the data to analytical conclusions is transparent. The numbers in parenthesis represent each of the separate steps taken within the schema and correspond to the boxes in the figure.

(i) The analytical schema starts with the focus group discussion data set out in transcript form.

(ii) The next step is to engage in the process of indexing the data, and this follows the principle established in the A.I approach (include all the issues raised by the focus group participants themselves). The coding of data is thus a non-exclusive indexing process which avoids selection at this early stage in the analytical process. This means that any possible contradictions within and between the discourses are not precluded at this stage.

(iii) The indexed expressed ideas which directly correspond to the perspectives of the nurses as social agents are then collated and re-described as ‘themes’ following a process of interpretative abstraction. So far the process follows the orthodox hermeneutic approach, except that, unlike the latter, here these abstracted themes represent just the first (albeit essential) stage in the retrodution of a concrete conceptualisation of the research object. Identifying themes from the transcripts is not the end-stage of this particular process of data analysis. Whilst these themes could be said to represent a form of the real as they apparently represent the actual discourses or ‘practical logic’ of the respondents, from a critical realist perspective, we are still at this stage within
the 'domain of the actual', where reality is 'collapsed and homogenized' (following the distinction drawn by Bhaskar concerning three kinds of depth achievable in realism – discussed in Section 3.2.2.1 above). An 'actualist' analysis cannot establish the hidden dynamics of the multi-relational stratified nature of shared discourse.

(iv) The next level in this analytical schema involves employing a deductive logic in order to abstract from the literature a range of theoretical hypotheses related to the concrete object (nurses' discourses of practice within a late modern health care system). The problem with leaving the analysis at this theoretical-deductive level is that it is in essence a generalised conceptualisation of a complex social phenomenon and lacks specificity. Deductive theorising acts to homogenise the subject, so that we end up with the generic nurse as well as a universalisation of nursing practice. The analytical centrality of social context is lost, namely those necessary conditions under which actual practices emerge and are articulated. Both the interpretative induction of abstractions (iii) and the deductivist derivation of theorisations (iv) would reflect what Sayer (1992) describes as 'an ordering framework' used as a 'nominalist solution' to concept formation.

(v) Drawing upon the abstractions identified though the processes of induction and deduction, the next stage in the analysis is to attempt to identify those contrastive demi-reg (as 'a class of potentially epistemically significant non-random patterns or results' - Bhaskar:1998:14) within nursing practice. This will facilitate the process of enabling the retroduction or inference (at a different level from the phenomenon to be explained) of the effects of generative mechanisms which can explain such patterns or tendencies. As Lawson (1997) argues, the identification of contrastive demi-reg, by definition, reflects phenomena to be explained and is not the end point of research.

(vi) The next step involves the process of inference that critical realists have described as retroduction, in which the conditions for the social phenomenon under investigation are explained through the postulation of a set of generative
mechanisms. Following the stratified nature of reality, in the process of abstracting from the concrete object then back to the postulation of a concrete conceptualisation, it is essential to distinguish between those social relationships that are necessary for the social phenomenon to occur and those that are contingent.

(vii) The final step, and a fundamental one, is the process of applying or recontextualising the conceptualised generative structures in order to explain the concrete phenomenon itself.

*Note:* This analytical schema does not imply that the emerging categories are in some way reliant upon either inductive or deductive forms of analysis, which combine together in some way to constitute the retroduced concrete concept. Rather, it is a case of employing first inductive logic in order to abstract themes from the focus group discussion material, then deductive logic in order to abstract a range of competing hypotheses which can be tested for their explanatory power in relation to the identified contrastive demi-regularities associated with the concrete object of the investigation.

The representations, beliefs, and shared meanings which constitute the discourse of the nurses arise out of the collective material practices of these social actors. Thus, it is the shared understandings associated with these practices to which, through a process of interpretation, *inductive reasoning* can effectively draw attention. *Deductive reasoning*, on the other hand, can reveal the ways in which generalised social structural features may be reproduced in the discourse of such social agents. The postulation of the conditions needed for this discourse to occur, that is, the contingencies which produce a particular combination of generative structures, is the objective of the process of retroductive inference set out in this analytical schema.
Concrete Research Object
- Discourses of social actors -

(i) Transcriptions
The focus group discussions

(ii) Indexing
Non-exclusive coding of focus group discursive material

(iii) Interpretation

(iv) Theorisation: deductively-derived explanations
A range of competing deductive theorisations. Assessed according to their explanatory power in relation to the identified themes

(v) Identification of contrastive demi-regularities

(vi) Retroduction of Generative Mechanisms
A concrete conceptualisation which postulates an explanation of the emergent contrastive demi-regs. Through the identification of the necessary rather than contingent causal relationships or mechanisms, which are the condition for the generation of the concrete phenomena.

(vii) Applied explanation or recontextualisation
...of the concrete conceptualisation of the research phenomenon
3.2.5 Methodological conclusions

This methodology chapter has argued for the relevance and contribution of a realist philosophy in supporting a sociological analysis of what social actors tell us about their understandings and motivates as they interact with others in the social world. Whilst there is a broad agreement with Pawson’s (1999) argument concerning the practical applicability of Bhaskar’s notion of a metaphorical form of explanation in social scientific forms of inquiry, this thesis would emphasise the potential for critical realism, conceived as a philosophy, to play an important ‘underlabouring’ role in commenting on the methods and practice of sociological inquiry. In particular, the contribution it can make in ‘underlabouring’ a sociological understanding of ideology as material practice. When examining the range of contingencies which determine the changing demands upon social structures such as institutions of health care, and in turn the ways in which such structures shape the work of social agents such as nurses over time, a methodological approach which emphasises stratification and emergence is extremely useful in avoiding the pitfalls of empiricism and reductionism.

In acknowledging some of the criticisms made of Bhaskar’s use of analogies as a substitute for the role of the experiment in the natural sciences (experiments not being possible in the social sciences because societies are not closed systems), the methodological approach adopted within this thesis has utilised Lawson’s work on the existence of demi-regularities to demonstrate the operation of generative mechanisms. It is argued above that this approach overcomes Pawson’s criticism of critical realism as lacking a conception of empirical measurement.

In arguing for the relevance of a critical realist approach to methodology within the social science research process, a framework has been proposed which (it is contended) enables qualitative transcript material to be integrated into an analytical process. The primary objective is to achieve a concrete conceptualisation of the research object. This involves identifying the necessary rather than contingent causal relationships which are the condition for the generation of a concrete phenomenon (in this case, the practice discourses of nurses working within the contemporary NHS). This requires an analytical approach that goes beyond the interpretation of the themes drawn out from the micro-interactions of nurses as a group of social agents, and
moving towards a realist explanation of the way in which social discourses arise out of the interaction between human agents and social structures in a particular material context.

However, it should be emphasised that the analytical schema or framework (Figure 2) proposed in the thesis remains essentially exploratory, an illustration of just one possible way in which the methodological principles of critical realism may be applied to the analysis of qualitative data. Yet whilst the critical realist approach to analysing focus group discussion material that is proposed in the analytical schema is undoubtedly an unwieldy and protracted process, it is argued that social researchers should attempt to demonstrate the methodological process by which they arrive at their final analytical conclusions.
3.3 Reflections on the Fieldwork

"Researchers are themselves a powerful, and often under-recognised, influence on their research and their findings" (Blaxter et al:2001:82).

Social researchers' own interests and views are more than likely to find expression in the conduct of the fieldwork, both explicitly and implicitly. Explicitly, for example, they will determine the issues framed in the questions raised with the research participants; implicitly, they will affect the manner in which these questions are posed.

With regard to my role in the conduct of the focus group discussions, I should point out that my occupation at the time when I was engaged in the fieldwork was as a Nurse Lecturer working within a university faculty responsible for providing professional training to both pre- and post-registered nurses. I was initially concerned that my position might unduly affect the responses of the participants, i.e. that participants would tell me what they thought I (as a nurse academic) wanted to hear. However, on reflection I feel that no undue bias was introduced into the focus group discussions because of my presence. There are several reasons why I feel justified in making this point.

First, none of the nurses had met me before in a professional (or personal) capacity. Second, none of them (as far as I could ascertain) was undertaking professional development courses at my university, which could possibly have compromised some of their responses. Third, none of the groups included junior nurses. I had specifically asked for participants who had a relatively high level of experience in their respective fields, commensurate with their nursing grade ('F' grade and above). This I felt gave the nurses the confidence to participate on their own terms and not defer to me as the facilitator. Fourth, all the group discussions were lively and required only minimal input from me as the facilitator in steering them towards discussion of the research topics.
One of the well-recognised problems in conducting or ‘moderating’ focus group discussions is that of being able to control dominating participants (though without inhibiting their responses) whilst at the same time stimulating the more passive group members. This particular problem did not really manifest itself within the six focus group discussions, which on reflection was probably explained by the decision to go for a homogeneous composition in the groups, with the nurses all having approximately the same grade or occupying an equivalent position within nursing’s hierarchy. The exception was in one of the focus group discussions with community nurses, where a nurse manager did dominate the discussion, not through intimidation but through her articulacy. I had not intended this nurse manager to participate, but as she was my gate-keeper within the health centre in which the focus group discussion was to take place, I found it difficult to resist when she asked if she could participate. This individual’s ability to express her views cogently did, in my opinion, mean that the other participants tended to defer to her. On the other hand, the other participants may well have been implicitly agreeing with the individual in question. Nevertheless, it had the effect of reducing the amount of interaction within the group, which had been one of the primary reasons for choosing the method in the first place.

Overall, the ability and enthusiasm of the nurse participants to pick up on and develop the topic areas prompted by myself as the discussion facilitator were very positive aspects of the fieldwork. This willingness on the part of nurse participants to involve themselves in the group discussion may be explained by the following factors. First, the topics were of relevance to the nurses themselves. They concerned the impact of the organisational changes within the NHS upon the practice of nurses and the consequent expectations that patients, managers, and nurses themselves placed on their role, and they had all been chosen following discussions with individual nurses and impromptu meetings with groups of nurses in my role as a nurse lecturer (a variant of piloting). Second, the focus group discussions were conducted at a time of significant organisational change within the NHS which had been and was producing well-documented stresses for nurses as well as for other groups of health professionals. The focus group discussion often appeared to afford an opportunity for nurses to let off pent-up frustration with these organisational processes, as well as allowing nurses (in the later focus groups in 1998/99) to express support for the dismantling of many of the organisational structures created during the period of the
Conservative government and deemed to be oppressive to the delivery of nursing care. Third, the fact that I had direct, personal experience of nursing and therefore some understanding of the conditions in which these nurses practised enabled me, as group facilitator, to be empathetic without compromising my objectivity as a researcher.
4. Data Analysis

This data analysis chapter is concerned to implement the methodological framework that is informed by the philosophical approach of critical realism as well as by the historical materialist method of Marx. Each of the sections making up the chapter follows the order discussed in the previous chapter and diagrammatically represented in Figure 2 above. The first section (4.1) is concerned with setting out the themes that emerged from the focus group discussion. These were derived through a process of induction involving interpretation. The themes are presented in relation to each of the ‘categories’ or areas of research interest which were reflected in the topics posed to the focus groups for discussion. The second section (4.2) seeks to deductively derive from the relevant literature a set of theorisations of nursing practice and organisational change within the NHS. The third section (4.3) is concerned with the process of retroductive analysis, the identification of the generative mechanisms that underlie the discourses of nurses in practice. The fourth section (4.4) seeks to recontextualise the derived concrete conceptualisation in relation to the research object, as the second phase of the ‘double movement’ of dialectical analysis.
4.1 The Process of Interpretation:
Inductively abstracting emergent themes

As diagrammatically represented in the analytical schema presented in Figure 2 above, the interpretative process of inductively deriving themes from the qualitative focus group data represents the first major stage (i, ii, and iii) of the analysis.

4.1.1 Explanatory note on the use of the terms ‘categories’ and ‘themes’:

The terms ‘category’ and ‘theme’ are sometimes used interchangeably when applied to the essentially interpretative process of inductively drawing together commonalities emerging from the indexed transcript data. The process of data analysis adopted in this thesis uses both terms, but here each is given a distinct meaning and purpose. A key concern is to be transparent about the way in which themes are derived from the data.

The term ‘category’ is used to denote a distinct issue or area of research interest that is discussed by the focus group as a response to a direct or ‘focused’ question or prompt by the facilitator. These categories, therefore, were not necessarily generated by the group themselves. However, they appear across all the focus group discussions, enabling a comparative analysis between groups of nurses. There are eight categories, as listed below:

1. Role of nursing (ideas and ideals) in specific settings (A&E, wards, community)
2. Providing a public service
3. Relationship with medical profession - are traditional boundaries being broken down?
4. Patient expectations and responsibilities: nurses’ perspectives and responses
5. Assessment of patients - surveillance role for nurses
6. Intra-professional relationships
7. Relevance of nursing theory/nursing knowledge
8. Impact of organisational change on nursing work

The use of the term ‘theme’ here denotes a distinct (shared) understanding that arises out of the focus group discussion concerning the ‘category’ or research issue in question; that is to say, themes emerge ‘in vivo’. Those indexed statements from focus group participants sharing similar concerns drawn from the transcript are collated to produce such a ‘theme’. Differences in these group-generated themes were quite distinct across the different nurse focus groups.

It is acknowledged here that the themes which emerge from the separate focus group discussions will and do cross the research categories’ boundaries, and this is to be expected given that these are the researcher’s conceptual boundaries, not those of the research participants. It is ultimately with these themes, which reflect the shared experiences of nursing practice, that this phase of the data analysis process is primarily concerned.

Note: The initial stages of the analysis of the fieldwork data (in the form of focus group discussions transcripts), i.e. the process of indexing and coding, are demonstrated in Appendix 1. Here the analytical process that results in the emergent themes is presented in relation to the fourth of the research categories – ‘Patient expectations and responsibilities’. An excerpt is taken from one of the A&E nurse focus group discussions in order to demonstrate how the themes outlined below are derived.

4.1.2 Inductively-derived themes by research categories

The emergent themes are set out below within the research categories to which they pertain. Each emergent theme is represented below by a separate bullet point. The particular specialism of the nurses involved in the focus group out of which the theme emerged is indicated in italics. At the end of each of the categories there is a summary which brings together the positions of all three nurse specialisms - A&E, community, and ward-based generalists. The inevitable divergences and even contradictions around a particular theme pertaining to nursing practice that arose within and between
nurses with the same specialism are represented below by the word ‘however’ in italics. The reason for making this emphasis at this initial stage of the analysis is precisely that contradictions, divergences, and ‘deviations’ are especially important to the methodology adopted within this thesis. It is also central to the method known as ‘deviant case analysis’ or A.I, described above, which has influenced the early stages of this analytical process.
Emergent themes pertaining to Category 1 - ‘Role of nursing (ideas and ideals) in specific settings (A&E, wards, and community)’

- **A&E nurses**: Work is motivating because it is exciting, variable, and dramatic. It is not routinised work (characteristic of nursing in hospital wards)....however, it is also... demanding and pressured work, meaning less or insufficient time with each patient. This can mean patients are not properly assessed, resulting in important problems being sometimes overlooked and a failure to meet patient needs, with a consequent drop in professional standards.

- **A&E nurses**: Have autonomy to make treatment decisions and initiate patient care for minor injuries and problems (‘Nurse-led Department’)...however,...taking on (this) 'extended role' does carry the risk that basic nursing responsibilities are left behind.

- **A&E nurses**: Increasingly defensive and circumspect in relationship with patients, i.e. conscious of what is said and judging situations before intervening...however, it is also felt...now a more adult relationship with patients exists, which means respecting and supporting patients’ choices and not making them feel guilty; whatever one thinks personally.

- **A&E nurses**: Demoralised and demotivated, A&E work has not fulfilled ideal of nursing as building relationships with patients...however, it is also felt that...caring for patients in A&E allows nurses to be closer to the wider aspects of people’s lives - holistic approach adopted. A&E work is not all trauma; nurses are able to interact and provide support and education for patients/clients.

- **Community nurses**: Extended role under Community Care (CC) legislation means District Nurses (DNs) can no longer meet all patient needs - released from responsibility for providing basic care (undertaken by unqualified staff) now able to be involved in treatment decisions and team-management responsibilities.
• **Community nurses:** Providing medical care is most important part of role

• **Community nurses:** A more equal and open relationship with patients, able to negotiate care with patients and their families - empowering patients even if disagree with their decisions...however,...don’t always give patients full information as this raises their expectations.

• **Community nurses:** Time is available to develop long-term relationships, as well as nurses having responsibility for continuity of care with clients, so better able to achieve empathetic and holistic approach to care...however,...do find it difficult to disengage at end of working day, unlike nursing work in hospitals.

• **Community nurses:** Health promotion role is limited, haphazard, and largely informal in the community...however,...health education role is seen to be central to and implicit within nursing work.

• **Ward nurses:** Oppose the discarding of basic care role in pursuit of extended role. Basic care is seen to be practical care which ensures patients are safe and comfortable and that their psycho-social needs are met.

• **Ward nurses:** Becoming more reliant upon medical technology to the detriment of patient needs...however,...relying upon technological solutions means giving less thought to rationales for care.

• **Ward nurses:** An awareness that hospitals can be ‘de-humanising’, and that the social needs of patients in hospital have to be met.

• **Ward nurses:** Insufficient time available to properly meet patient needs and carry out health education responsibilities.

• **Ward nurses:** Opposition to integrated pathways of care (ICPs), which are seen to limit nurses’ decision-making autonomy and not allow for patient individuality.
Summary of emergent themes pertaining to nursing role

The desire for stimulating, non-routinised work, which the professional role within A&E fulfils...yet...frequently a failure to meet high standards of care because of excessive demands.

Having more autonomy (patient management responsibilities) in relation to the planning of patient care... whilst... losing basic care role (Hospital-based nurses seeing the latter as a negative outcome, whilst community nurses see this as an opportunity to develop role).

Difficult to build relationships with patients in A&E...and yet...the setting offers the potential for nurses to be closer to patients and the wider aspects of their lives.

Recognising the need to develop a relationship with patients which respects their autonomy in relation to health care decision-making...however...Nursing practice is becoming more defensive so as to avoid raising patient expectations of the service, and so reduce the number of patient complaints.

Recognising the need for a health education role with patients, such a role is largely opportunistic and haphazard because of work demands.

Greater reliance on technology... and yet...this over-technicising of the role can lead to giving less thought to the rationale for giving a particular form of care.
Emergent themes pertaining to Category 2 - 'Providing a Public service'

- **A&E nurses**: Seen to provide a safety-net to the public because of failings of primary care services...*however,...*this can lead to inappropriate use of A&E service.

- **A&E nurses**: A&E service should be closer to local communities, and provide both primary and secondary care.

- **A&E nurses**: Need to be aware that working in A&E (the 'front door' of the hospital) influences public perceptions of health service as a whole.

- **Community nurses**: Need to support the elderly within the community in order to avoid a situation where they have to be placed in institutions.

- **Community nurses**: Nurses go to the patient, they do not come to us. We ask them what they want from the service.

- **Ward nurses**: Little or no discussion of nurse responsibilities to the local community.
Summary of emergent themes pertaining to providing a public service

A&E Nurses see themselves providing a safety-net / last resort to the public because of failings of primary care services...however... this can lead to inappropriate use of A&E service.

An awareness that working in A&E (the ‘front door’ of the hospital) influences public perceptions of health service as a whole.

A rejection of an explicit aim of the Community Care legislation to separate out the social from the health care responsibilities of health professionals. Community nurses want to provide a needs-led service.

Little acknowledgement by ward-based nurses of any responsibility to the local community.
Emergent themes pertaining to Category 3 - 'Relationship with Medical Profession - are traditional boundaries being broken down?'

- **A&E nurses**: Junior doctors depend upon the advice and support of nurses, but they don't always acknowledge this dependence by allowing nurses to participate fully in treatment decisions. However, no big boundaries are seen to exist between nurses and doctors as they work together uniquely (for a hospital) in multi-disciplinary teams, although doctors do have greater theoretical knowledge.

- **A&E nurses**: Because nurses are part of a multi-disciplinary team they are involved in treatment decisions. However, being a patient advocate means sometimes disputing doctors' decisions - no unconditional acceptance of doctor's diagnosis.

- **A&E nurses**: Little respect for the clinical judgement of GPs.

- **Community nurses**: The system of GP fund-holding enabled GPs to exert greater control over the work of nurses. However, it also meant a closer working relationship with GPs as colleagues, which has given nurses greater confidence to question treatment decisions.

- **Community nurses**: Because of workload pressures, GPs tend to focus only on disease management of patients. But they have learned to value the work and skills of nurses and to appreciate that nurses can spend more time developing relationships with patients.

- **Community nurses**: Working closely with GPs gives us Health Visitors (HVs) more professional credibility.

- **Ward nurses**: Supportive of organisational developments which enable patients to challenge the mystique of doctors. This is because it opens the door to nurses being able to question medical decisions.
Summary of emergent themes pertaining to the relationship with the medical profession

Junior doctors dependent upon the advice and support of nurses but fail to reciprocate this by allowing nurses to participate in treatment decisions.... However, ... no important boundaries are seen to exist between nurses and doctors in A&E, where they work together in multi-disciplinary teams and so are involved in treatment decisions.

Being a patient advocate means no unconditional acceptance of doctor’s diagnosis and treatment.

Little respect for the clinical judgement of GPs by A&E staff ...however,... community nurses now have a closer working relationship with GPs as colleagues, which has given them more confidence to question treatment decisions.

GPs tend to focus only on disease management of patients but they have learned to value the work and skills of community nurses, and appreciate that they can spend more time developing relationships with patients.

Working more directly with GPs gives HVs more professional credibility.
Emergent themes pertaining to Category 4 – ‘Patient expectations and responsibilities: nurses’ perspectives and responses’

- **A&E nurses**: Some patients behave irresponsibly, alcohol abuse being a good example of a self-inflicted health problem; patients should take more responsibility for own health...however,...patients do lack the health knowledge of health care professionals and therefore have misconceptions about their health, they lack the capacity to manage their own health. So no blame should be apportioned.

- **A&E nurses**: Health system takes responsibility for health away from individuals, and many patients subsequently assume the ‘patient’s role’. They are happy for nurses to take responsibility for their treatment decisions...however,...patients’ expectations of A&E service have increased; they now see themselves as customers/clients.

- **A&E nurses**: Patients attend A&E inappropriately and need to be better educated about the appropriate use of the service...however,...many people with a problem use the A&E service as they have nowhere else to go - the ‘system’ has created the problem of inappropriate attendees.

- **A&E nurses**: The Patient’s Charter introduced a culture of complaint that didn’t exist prior to its introduction...however,...many of the complaints by patients concerning the A&E service are justified, but they are often misdirected against nurses, who are unfairly blamed for failures elsewhere and for underfunding of the service.

- **A&E nurses**: Have to anticipate who is going to complain in advance, by being more conscious of what advice is given to patients. Middle class patients are particularly difficult to cope with in this regard as they know their ‘rights’...however, it is said that... communication with patients in A&E has
improved at least partly as a result of the more transparent NHS complaints procedure.

- **A&E nurses**: There are many forms of health information available in society...*however,...media health scares can result in patients using the service for reassurance, because the advice of nurses is trusted.*

- **Community nurses**: Patient expectations of community care are high (‘no longer blind gratitude’), they are also more aware of their rights and better informed, although there is a social class difference in demands put upon service. This presents a challenge to nurses to be better informed and able to explain choices to patients.

- **Community nurses**: The public don’t understand the role of Health Visitors, and stigma is perceived to be attached to contact with HVs, this may reflect the way in which the media portray our work...*however,...can gain credibility if seen to be working with GP, to have a nursing background, or even to be wearing a nurse’s uniform!*

- **Ward nurses**: In the past, patients coming into hospital wards were treated as ‘packages’, but now we have to respect patient rights...*however,... patients don’t always want to be involved in treatment decisions.*
Summary of emergent themes pertaining to patient expectations and responsibilities

Patients are seen to behave irresponsibly in relation to their own health... however... some patients lack health knowledge and the capacity to help themselves.

Health system seen as taking responsibility for health away from individuals, with many patients seen as happy to assume the ‘sick role’ and not wanting to be involved in treatment decisions ... yet... patient expectations of A&E service have increased, they now see themselves as customers. This presents a challenge to nurses to be better informed, able to explain options/choices to patients, and respect their rights.

Some patients use A&E service inappropriately ...yet... many people with a problem use the A&E service as they have nowhere else to go - ‘the system' has created the problem of inappropriate attendees.

The Patients Charter has made public aware that they can complain about the service. Although many of the complaints by patients concerning the service are justified, they are often misdirected towards nurses who are unfairly blamed for failures elsewhere in the system.

Stigma attached to use of Health Visitor service by the public... but... can gain credibility if seen to be working with a G.P.
Emergent themes pertaining to Category 5 – ‘Assessment of patients, the surveillance role’

- **A&E nurses**: Can develop suspicions about certain individuals who attend the Department. More information can come from observing the way patients look and talk than by direct questioning. Every professional makes this type of value-judgement when assessing patients/clients…however, an acknowledgement that...the pre-judgements or stereotypes of nurses have a detrimental effect for patients. That nurses should not ‘over-step the mark’ when recording patients’ personal details, and that the ‘attitudes’ of some nurses only increase the tensions experienced by patients.

- **A&E nurses**: Patients are assessed holistically, looking at their whole social situation, and this can pick up on problems a clinical assessment alone may miss.

- **Community nurses**: Looking at the wider social aspects of patients has always been part of community nursing.

- **Community nurses**: Whilst patients are admitted to hospital for their medical problems, when in people’s own homes, nurses can make an assessment of their health needs, which can also include the needs of the patient’s whole family.

- **Ward nurses**: Nurses can bring their ‘middle class’ preconceptions with them when assessing patients.
Summary of emergent themes pertaining to the assessment of patients

Nurses can develop a second sense about particular individuals. More information can come from observing the way they look and talk than by direct questioning. Every professional makes these type of value-judgements when assessing patients/clients …yet also acknowledge…that the pre-judgements of nurses can have a detrimental effect upon patients.

Patients are assessed holistically, looking at their whole social situation, which can identify problems a clinical assessment alone may miss…however… nurses should not ‘over-step the mark’ when recording patient’s personal details.

Community nurses able to assess a patient’s health needs within a wider social context when visiting them in their own homes.
**Emergent themes pertaining to Category 6 - 'Intra-professional relationships'**

- **A&E nurses**: Ward staff resent us and think we don’t do enough for patients, but they should come and see what we actually do. Our work is 90% nursing work, whilst in wards the work is only 40% nursing.

- **A&E nurses**: The tension between ward and A&E nurses arises out of low morale amongst nurses generally.

- **A&E nurses**: Nursing management is too concerned with non-clinical issues and fails to support staff, ignoring their needs.

- **Community nurses**: A variable relationship exists with hospital staff because they lack an understanding of the contribution of community nurses, perceiving their own work as somehow more ‘intensive’.

- **Community nurses**: Unlike hospital staff, community nurses ‘can’t do what they like with patients’ when they are in their own homes. Also unlike hospital staff, we continue to think about our patients even when we are finished for the day.

- **Community nurses**: Whether working in a hospital or the community, all are nurses, but do different jobs.

- **Ward nurses**: Role of the clinical nurse specialist is seen as ‘de-skilling’ ward nurses.
Summary of emergent themes pertaining to intra-professional relationships

A&E nurses think that Ward staff resent them because they are perceived as not doing enough for patients...however.. The job of the A&E nurse is said to consist of 90% nursing work, whilst in wards only 40% nursing work..

The tension between ward and A&E nurses is seen to arise out of low morale amongst nurses generally.

Nursing management too concerned with non-clinical issues and fail to support staff, ignoring their needs.

Hospital-based nurses seen to lack an understanding of the contribution of community nurses, they perceive their own work as somehow more 'intensive'.

Community nurses 'can't do what they like with patients' when they are in their own homes, unlike the situation that exists in hospitals. Also unlike hospital staff, we continue to think about our patients even when we are finished for the day.

Whether working in a hospital or the community, all are nurses, but do different jobs.

The developing role of the clinical nurse specialist seen as 'deskilling' ward nurses.
**Emergent themes pertaining to Category 7 - ‘Relevance of Nursing Theory for Practice’**

- **A&E nurses**: A&E nursing skills and judgement develop with experience; hands-on care more important than documenting care.

- **A&E nurses**: Patient care is given holistically; we do not see the patient as a collection of symptoms, unlike doctors. Holism’s relevance lies in the fact that there are always issues wider than the actual medical problem involved when a patient is admitted to A&E….however,...some cynicism about over-theorisation of holistic care, as holistic practice seen to pre-date theory.

- **Community nurses**: Professional development is seen as essential.

- **Community nurses**: Holistic care integral to work of nurses i.e. the assessment, planning, and delivery of care to clients in their own homes. This is facilitated by having long-term relationships with clients.

- **Ward nurses**: The development of a nurse as being more influenced by the practice of other nurses working on the wards than by teaching theory - ‘core skills learnt in practice'.

- **Ward nurses**: Good nursing on the wards is about learning to think for yourself; you cannot teach application.

- **Ward nurses**: ‘Getting on with the job’ and ‘surviving’ are as important as an understanding of nursing theory.

- **Ward nurses**: Holistic practice is not always consistent with efficient nursing.
Summary of emergent themes pertaining to the relevance of nursing theory to practice

Nursing skills and judgement develop with experience; hands-on care more important than documenting care plans.

Nurses approach patient care holistically, it is integral to the assessment, planning and delivery of care. Its relevance lies in the fact that there are always issues wider than the actual medical problem involved when a patient is admitted to A&E …. however... some degree of cynicism about over-theorising holistic care. This is because this form of nursing practice is seen to pre-date theory.

Professional development is seen as essential for nursing practice…yet...the development of a nurse is influenced by the practice of other nurses, rather than by theory / formal teaching - ‘core skills’ learnt in practice.

Good nursing on the wards is about learning to think for yourself, you cannot teach a positive application to nursing work. Getting on with the job' and ‘surviving' are as important as an understanding of nursing theory.
Emergent themes pertaining to Category 8 – ‘Impact of Organisational change on Nursing work’

- **A&E nurses:** Hospitals have become businesses, which aim to standardise patients’ problems and needs.

- **A&E nurses:** Patient care has worsened in A&E because the workload of nurses has increased directly as a result of cuts in resources...however,...the development of the nurse practitioner extended role in A&E has brought about a reduction in waiting-times for minor injuries and has come at the insistence of the health care purchasers.

- **A&E nurses:** The 'system' has created the problem of inappropriate attenders in A&E by taking away responsibility from patients.

- **Community nurses:** The CC Act has changed the role of DNs and HVs substantially. It has relieved DNs of the burden of carrying out basic care...however,...should not divide social and health care responsibilities of nurses.

- **Community nurses:** The introduction of GP fundholding and the subsequent development of PCGs have resulted in a closer working relationship with GPs...however,...GPs now have greater day-to-day control over the work of community nurses, leading to a reduction in nurses’ autonomy.

- **Community nurses:** The CC Act has diminished the social care role of community nurses. Families are now told to take greater responsibility for themselves – rather than have an HV intervene to improve their housing, for example.

- **Community nurses:** Social Services now take on a much greater role in developing community care initiatives, which has left HVs with little scope for professional development.
• **Community nurses**: Difficult to make national targets for health relevant in day-to-day work.

• **Community nurses**: Nurses have been drawn into the new ‘political culture’ of the re-organised NHS, i.e. PCGs. However, they have only a token voice within the new structures.

• **Ward nurses**: The Patient’s was positive in that it gave patients rights and took away some of the mystique of doctors... *however,...* the public has been given unrealistic waiting-times for treatment but also encouraged to complain when there are problems, all of which has negative implications for nursing.
Summary of emergent themes pertaining to the impact of organisational change on nursing work

The system of G.P fundholding as enabling G.P’s to exert greater control over the work of community nurses... however... it also meant a closer working relationship with G.P’s as colleagues, which has given nurses greater confidence to question treatment decisions.

Hospitals have become businesses whose objective is the standardisation of patients problems and needs.

Patient care has worsened in A&E because the workload of nurses has increased directly as a result of cuts in resources... however... the development of the nurse practitioner extended role in A&E which came at the insistence of the health care purchasers, has brought about a reduction in waiting-times for minor injuries.

The ‘system' has created the problem of ‘inappropriate attenders’ in A&E, by taking away responsibility from patients.

The Community Care Act has substantially changed the role of District.Nurses (DN) and Health Visitors (HV). The D.N’s have been relieved of the burden of carrying-out basic care... however... it has also led to the diminishing of the social care role of community nurses, with Social Services taking-on a greater role in developing care initiatives. This has left H.V’s with little scope for professional development.

Difficult to make national targets for health relevant to the daily work of community nurses.

Community nurses have been drawn into new ‘political culture’ of the NHS.

The Patients Charter was positive in that it gave patients rights and took away some of the mystique of doctors... however ... The public has been given unrealistic waiting-times for treatment but also encouraged to complain when there are problems, all of which has negative implications for ward nurses.
4.1.3 What conclusions can be drawn from the inductively-derived themes?

Given the limitations of a purely inductive analysis of discursive data, as discussed in detail in Section 3.2.2 above, and given the intention to move beyond the inductive-deductive dichotomy, how might the findings at this level of analysis be presented? The more usual approach in qualitative analyses is to highlight a theme emergent from the data, and then illustrate it with statements drawn from the interviews, or in this case from the focus group discussions. Here, however, the interpreted themes which emerge from the transcriptions are treated as the initial form of abstraction from the concrete object, i.e. nursing discourses. The methodological aim is to move down from this concrete object, through a systematic process of conceptual abstraction, until the constituent relations or mechanisms that generate its effects are identified.

At this point in the analysis, the intention is not to attempt to draw any final conclusions regarding the significance of the discourses of the nurses that emerge from the focus group discussions. Rather, the themes that have been abstracted inductively will form the starting point of the retroductive analytical process of postulating the necessary rather than contingent structures that can contextualise such discourses on nursing practice. However, even at this level of abstraction, what emerges from the transcripts is a wide range of contradictory views held by and between nurses. Between the three specialist groups of nurses who participated in the focus group discussions, clear differences can be identified with regard to the impact of the organisational reforms within the NHS in relation to nursing roles. Whilst hospital-based nurses generally perceive themselves to be subjects of such organisational changes, community-based nurses generally see the changes as opportunities to develop their role in a positive direction. Community nurses also appear to have been much more proactive in re-shaping their relationships with patients and with the medical profession (GPs).
4.1.4 Concluding note on the limitations of inductive analysis

Generally speaking, those interpretative sociologies that adopt the inductive approach to data analysis do not attempt to go beyond the presentation of the collated themes that arise out of the qualitative data. The discourse of the research subjects is usually conceptualised as no more nor less than the contribution of micro-actors to the construction of (their) social reality. Within this context it can be argued that the inductive approach actually represents a distinct epistemology, but one that is more often implicit than explicit within the chosen methodology.
4.2 Theorisation

As diagrammatically represented in the analytical schema presented in Figure 2 above, the process of theorisation is the next stage (v) in the analysis. The objective of this section of the data analysis is not to engage in a process of deductive inference in order to derive a set of theories built upon the assumption of the existence of constant conjunctions or event regularities. This would be a form of deductivism which would deny the existence of sets of underlying mechanisms working in conjunction with and in contradiction to one another. As such, it cut across the methodological assumptions of this thesis that reality is dialectical, that contradictions are the basis of all movement and change, whether in the physical or in the human world. This is a position opposed to ‘empirical realism’, which would see empirical facts as taking the form of strict regularities. Rather, they should be seen as expressing phenomena that require an explanation; facts are not ‘the end-points of research’, as Lawson (1997) has argued. However, it is possible to acknowledge that, ‘over restricted regions of time-space’, certain mechanisms may come to dominate others and may be reproduced continuously, and their effects may be apparent at the level of actual phenomena which give rise to partial or demi-regularities (Lawson 1997:204).

Let us review some of the points made earlier (in Section 3.2.2.3 above) regarding the relevance of such demi-regularities for this analytical process. In a dynamic and open social world where experiments cannot be conducted, the analytical process of identifying demi-regularities turns upon the existence of differences or contrasts between social groups, events, or states of affairs in particular periods of time or social context. These assumptions are reflected in the methodological approach adopted here. This is concerned with identifying those differences or contrasts that are found to exist between the activities (as reflected in discourse) of different groups of nurses practising in different health care locations. It is also concerned with the ways in which the role of the nurse has changed over a period of time (the decade of the 1990s). Lawson cites Bhaskar (1989) in arguing that it is moments of social transformation (for example, that which has occurred within the organisation of the NHS in the 1990s) that prove to be revealing of underlying mechanisms. Identifying the existence of any contrastive demi-regularities in nursing work, where one might
reasonably have expected there to be broadly the same outcomes, requires an explanation, and as such it directs the analysis. The purpose of a realist retroductive analysis is to be able to postulate the tendency in operation in or the mechanism responsible for such contrastive demi-regularities in the context of contemporary nursing practice.

However, before this process of identifying demi-regularities can be undertaken, it is necessary to delineate the field of contemporary nursing practice within the NHS (or, to use Lawson’s terminology, the activities of human agents in a ‘space-time location’). Comprehending this field of practice, it is argued, means combining and contrasting the perspectives of the agents (nurses) themselves, as reflected in the inductively-derived emergent themes (set out in Section 4.1.2 above), with the theorisations of such practice derived deductively from the literature (this is set out in Section 4.2.1 below).

Then there follows a discussion (Section 4.2.2) which brings together the emergent themes inductively derived from the data, and the range of possible deductive theorisations derived from the literature review. These will be discussed in relation to the research categories (1 to 8), the purpose being to assess both the relative explanatory power of each analytical approach and more particularly to arrive at a set of understandings of contemporary nursing practice that would enable us to identify certain demi-regularities (which will be set out in the following Section 4.3, concerned with the analytical process of retroduction).
4.2.1 Deductively derived theoretisations (drawn from the literature) applied to the emergent themes; by research category

**Deductive theorisations pertaining to Category 1 - ‘Role of nursing (ideas and ideals) in specific settings’**

The nursing role as it is defined within the ‘new nursing’ paradigm centres upon the notions of emotion work and holistic care (Stacey:1988, James:1989) the aim of which is to establish a therapeutic relationship with clients. It is broadly recognised that from the late 1970s onwards, nursing in the U.K moved significantly away from a task-orientated role towards focusing on the needs of the individual patient. This has required an integration of the many aspects of nursing practice, which has become a unified ‘process’ (Melia:1979). This development ended the distinction that had long existed between ‘basic’ and ‘technical’ aspects of nursing care.

The role of the nurse is perceived to reflect the gendered nature of nursing as ‘women’s work’. Nursing work is still seen as calling for the ‘feminine qualities’ of intuition and caring and is practised within a health care system marked by a patriarchal division of labour (Abott:1988, Witz:1992). In other words, the traditional masculine occupations of medical science and technology are deemed as in some way more legitimate than healing/caring.

The ‘professionalisation project’ initiated by the formal representative bodies of nursing which began in the early 1980s has been largely unsuccessful because nurses as an occupational group within the health care system lack the power to independently structure and develop their own role (MacDonald:1995, Traynor:1999a). This is reflected in the inability of nursing as a profession to resist those managerialist organisational reforms which create more demands upon the role.

Historically, the role of nursing is recognised as the product of the process of change in the science and technology of medicine; in particular the development of the organisation of the modern hospital (Dingwall and Allen:2001). The development of
the 'extended role' has ended the requirement that nurses must have medical approval to undertake tasks not included in their basic training. The responsibility for taking on an 'extended role' now lies in the hands of the individual nurse, who is accountable for her or his actions (UKCC:1992b).

**Deductive theorisations pertaining to Category 2 – ‘Providing a Public service’**

From the perspective of the Weberian concept of the ‘professional-bureau’ ideal type of organisation, the primary commitment of nurses within the context of modern health care systems such as the NHS, would be to the organisation (which trains and pays them) rather than to the public and to the local community *per se* (Clarke:1998). However, the post-modernist conceptualisation of the shift in forms of health governance from one characterised by the collective provision of health care found in the traditional welfare state to a form of neo-liberalism in which there is greater individual responsibility and consumer choice in welfare provision (Bauman:1995). The consequences for the role of welfare professionals such as nurses is that will have to change their traditional ways of a working with patients (Lash:1994). The Foucauldian perspective utilises a conceptualisation of governmentality which recognise the ‘authority of expertise’ as becoming separated from the formal structures of government (Foucault:1979). This expertise is said to be now located within the market (rather than the state) and subject to competition and consumer demand (Osbourne:1979).

**Deductive theorisations pertaining to Category 3 – ‘Relationship with Medical Profession - are traditional boundaries being broken down?’**

The ‘professional dominance’ model sees the power of the medical profession as deriving from ‘autonomy’ and ‘dominance’ (Friedson:1970). The latter refers to doctors’ control over the work activities of other health professions such as nurses. This ‘power-approach’ to conceptualising the dominance of the medical profession over nurses has been absorbed into nursing’s own critiques of the general failure of doctors to respect the contribution of nurses and to support inter-professional team-
working. It is also from this perspective that nursing has been seen as traditionally occupying a subordinate or adjunct role to medicine (reflecting the health care division of labour). Nursing knowledge continues to be seen by the medical profession as being 'indeterminate' or less than valid precisely because it is a 'practice-based' knowledge (MacDonald: 1995). Whilst the role of the nurse has changed to reflect developments in medical technology and science, the relative lack of autonomy for nurses in their practice vis-à-vis the medical profession is seen by some commentators as not having changed as much as the advocates of nursing’s professionalisation project would have liked (Porter: 1992, Witz: 1992; 1994, Friedson: 1994).

The tensions that have been identified as existing in practice between doctors and nurses are generally seen as arising out of this the hierarchical division of labour. Nevertheless, it has been noted that the tensions between these professions are reduced by what is known as the 'doctor-nurse game' (Stein: 1967; Porter: 1991). This construct points to the ways in which nurse initiatives become retranslated as having come from the doctor. Other studies suggest that the old doctor and nurse stereotypes are being broken down, and that role boundaries are shifting in order to reflect such influences as work pressures, differences between clinical areas and the changing knowledge context of nursing (Svensson 1996, Allen 1997). It is argued that doctor-nurse interactions are more diverse and situation-specific than the traditional models of doctor-nurse relations, emphasizing professional dominance and subordination, allow.

Occupational socialisation processes (both formal and informal) associated with the organisation of the hospital and its medical division of labour are recognised as serving to make nurses aware of occupying a subordinate place within the health care division of labour” (Perry: 1993). It is upon an understanding of such organisational processes that Strauss (1982) described how the need to achieve medical ‘legitimation’ has shaped the nature of nurses’ work. Utilising a construct such as ‘cultural capital’ (Bourdieu: 1990) may also help to explain the professional and social distance existing between nurses and doctors as occupational groups.
From an essentially postmodernist perspective, it has been argued that the risk and uncertainty increasingly associated with the practice of science which includes medicine has had the effect of narrowing the authority gap of doctors as experts over patients (Bauman: 1991; 1995). If indeed this social development has occurred or is occurring then we should expect to see an impact on the traditional hierarchical relationship existing between doctors and nurses.

**Deductive theorisations pertaining to Category 4 – ‘Patient expectations and responsibilities’**

The work of Beck (1992) and Giddens (1991) theorises the social outcomes that they associate with the emergence of the ‘risk society’. The latter is recognised as giving rise to a social condition termed ‘ontological insecurity’ reflected in a loss of collective faith in science, state institutions, and big business. The associated notion of ‘reflexive modernity’ refers to the process whereby the ‘project of the self’ or looking for self-identity from within rather than from outside (for example, as derived from class or career). One way in which this is manifest is a shift from state to personal responsibility for health. By extension, patients or ‘users’ of the health service are seen to have a raised set of expectations about the ways in which care and treatment are to be delivered. Theorists of the postmodern, such as Bauman (1991; 1995) typically see the health and welfare of the population as becoming an individual and moral responsibility rather than a ‘social right’ of citizenship. The role of government is limited to constructing targets for health. The consequence for the health care professions, including nursing, is that their power (as knowledge) has become less as citizens or patients are increasingly seen as consumers.

The nursing literature points to conflicts existing in the nurse-patient relationship as predominately arising out of the differences in goals, interests, and knowledge between the two roles (Kelly and May: 1982). Nurses in practice are seen as continuing to utilise the notion of the ‘sick role’ (as per Parsons: 1951) in relation to the expectations they have of patient compliance with treatment. However, there is a perception held by nurses that patients are increasingly not fulfilling the obligations
implicit in the 'patient role', this is to be one consequence of the raised expectations now held by patients (Dingwall and Allen:2001).

Hence for example, those patients seeking treatment with Accident & Emergency Departments but presenting with minor problems become known as 'inappropriate attenders' in the typologies employed by medical staff (Jeffrey:1979, Sanders:1999). That is, they are perceived by staff as not using the A&E service in a responsible way, and as not taking personal responsibility for their health. In practice the increase in the numbers attending A&E departments nationally over the past decade probably reflects the limitations of the primary care services (in particular access to GPs) in the face of raised expectations, bringing about an increased workload for A&E departments.

_Deductive theorisations pertaining to Category 5 – ‘Assessment of patients, the surveillance role’_

Implicit in the notion of the 'clinical gaze' which Foucault (1973) used in relation to the rational and scientific practices of medicine is the notion of the 'subjectification' of the patients. This process is seen as manifest in the requirement of the 'nursing process' for nurses to construct personal relationships with patients that will enable them to come to 'know' the patient as more than an 'object of clinical attention' in order that the patient's needs can then be better assessed and attended to (Armstrong:1983, May:1992;1993). Associated with this perspective concerning the surveillance of patients is the increasing prominence of the discourse of health promotion within official health policy (DoH:1993, DoH:1998). This is seen to a feature of neo-liberal health care governance) and the formal requirements for nursing theory. Within this discourse, health risk is seen as arising not only from external environmental hazards but also from internal individual factors. This strategy is seen to have resulted in the identification of specific social groups as being at particular risk and so subject to interventions. These are typically working class and ethnic minority groups (Armstrong:1993, Lupton:1997).
Deductive theorisations pertaining to Category 6 – ‘Intra-professional relationships’

The conclusion drawn from a search on the CINAHL Nursing Journal database (January 1991 to January 2002) was that those few nursing research papers that do discuss intra-professional relationships primarily focus on the conflicts of interest between front-line nurses and their nurse managers, the issue of bullying by colleagues, or the related issue of the ways in which student nurses are treated by their supervisors. Although the issue of professional de-skilling of generalist nurses as an indirect outcome of the development of clinical nurse specialists is acknowledged in the literature, there is very little published material on the intra-professional relationships that exist between nurse specialisms – for example, between ward and community-based nurses (as emerges from the focus group discussions in this research).

Deductive theorisations pertaining to Category 7 – ‘The relevance of nursing theory for practice’

As per the work of Kuhn (1970), the criterion of validity within science is not the adequacy of a theory in relation to an objective reality, but rather its adequacy to an approved way of doing things, which is fixed by a paradigm. Given that nursing is has historically been practised within a medical division of labour its follows that its formal knowledge base has been constructed around the positivist biomedical scientific paradigm. The notion of the ‘new nursing’ was an attempt by academic nurses in the 1980s to construct an alternative paradigm with the aim of epistemologically demarcating nursing practice from the primary concerns of clinical medicine. This was also in part a response by academic nursing to the changing technical and demographic demands being placed on the health service by the end of the 1970s (Dingwall and Allen:2001). By emphasising the importance of holistic and emotion work, it has contributed to a view of bioscientific knowledge as being ‘external’ to the practice of nursing. The objective of such theory development was to enhance the claim to separate and autonomous professional status, so achieving a measure of ‘professional closure’ (Witz:1992).
However, there is evidence that nurses themselves tend to be suspicious of any knowledge perceived to be ‘external’ to a highly contextualised and relationship-focused set of practices (Traynor: 1999a). It is now broadly recognised that there are clear differences between the informal (hidden agenda) and formal professional socialisation processes within nursing (and most other professional groups). In nursing, this is seen as largely responsible for the ‘theory-practice gap’ that is talked about so much (Perry: 1993). The informal culture of nursing can be seen as a ‘field’ which produces a distinct ‘habitus’ (as per the work of Bourdieu: 1990), which serves to construct particular forms of individuality or ‘social dispositions’ amongst nurses. Examples are a service-orientation, deference to the medical profession, and a practical rather than academic orientation reflected in the ‘getting on with the job’ attitude. This symbolic (service-orientated) role directly associated with nursing work can be seen as an example of occupational ‘identity fetishism’; the formation of occupational identities as reflecting the wider contradictions of capitalist relations of work and production (Willmott: 1990).

In practice, the organisational structures of the NHS have de-valued the principles of holistic nursing care. This has led to an ‘alienation’ or professional demoralisation of nurses educated in accordance with such principles (Dingwall and Allen: 2001). The biomedical approach to patient care remains pervasive.

**Deductive theorisations pertaining to Category 8 - ‘The impact of organisational change on nursing work’**

A theoretical emphasis upon the material rather than the ideal in the analysis of modern nursing would recognise that a lack of relative autonomy (a traditional characteristic of the medical profession) has effectively bound nursing to organisational rather than to professional imperatives (Carpenter: 1993). In other words, the role and authority of nurses is primarily constituted by the organisational division of labour within modern health care systems. Thus, organisational reforms of the system of health care have usually brought about a changing set of requirements for nursing. An indicator of this relationship is the history of the compromises that
nursing has made in relation to its original 'professionalisation project'. Witness the ultimate failure of the attempt to uncouple nurse training from the organisational demands of the NHS through Project 2000 (UKCC:1987; Allen:2001).

The impact of the introduction of the ‘new managerialism’ upon the traditional decision-making structures of the NHS has had the effect of relegating the interests of health care professionals in general. This form of managerialism has succeeded in ‘naturalising’ the process of organisational restructuring which has occurred within the NHS since the late 1980s, with its emphasis on target setting and cost-effectiveness to the detriment (nurses’ and doctors’ professional organisations have argued) of professional standards of care (Clarke:1997,1998). For example, cost containment priorities led to the development of nursing skills substitution or ‘skill-mix’, as it is now commonly called. This resulted in many ‘basic’ hands-on patient caring activities being delegated to unqualified health care assistants, whilst ‘nurse-practitioners’ have take-on tasks and responsibilities which have traditionally been the preserve of medical professionals. Whether this has delivered the cost-effective outcomes that are government has claimed for this strategy is questionable as there are relatively few economic evaluations of nursing skill mix (Richardson:1998). There have also been very few studies of the impact of skill mix change in shaping the ‘interface’ between registered nurses and support staff and the subsequent effect on patient outcome (Spilsbury and Meyer:2001).

The Community Care Act (DoH:1991) has had a particular impact in the field of community nursing, as a consequence of the redefining of the boundaries between health care and social care, as well as between formal and informal care. The consequence for community nursing has been that the nature of what constitutes nursing care has become narrower. Many dimensions of what might be termed a traditional nursing role are now only finding expression outside the NHS (Walsh & Gough:2000).
4.2.2 Discussion: The explanatory power of deductive theorisations in relation to, and by comparison with, the emergent themes inductively derived from fieldwork data

Emergent from the analysis of the focus group discussion transcriptions are the inconsistencies, tensions, and contradictions present in the themes inductively generated from the focus group discussions. These tensions and inconsistencies are frequently mirrored in the variety of (often mutually exclusive) deductive theorisations of nursing practice found in the literature. The objective of this section is to discuss and assess both the relative explanatory power of the themes derived from both the inductive and deductive analytical approaches (as set out in Sections 4.1.2 and 4.2.1 respectively) and, more particularly, to arrive at a set of understandings of contemporary nursing practice that would enable the identification of demi-regularities and facilitate the process of retroductive analysis.

In this discussion, the emergent themes and deductive theorisations will be examined in the context of the eight research categories utilised to manage the initial stages of the data analysis. Each will be examined in turn.

Category 1: 'Nursing role (ideas of and ideals) in specific settings'

One of the first issues that arose in the attempt to theoretically conceptualise the determinants of the nursing role was the problem of reconciling the tensions that exist between the ideals of what is termed the 'basic role' (found both in the literature and in the themes emergent from the nurse focus groups) and the changing demands on nursing practice which arose from the organisational restructuring in the NHS. This is illustrated in the following quote from an A&E nurse:

R6 (A&E nurse) Based on all the nursing care that I have learnt, working in a busy A&E department, it is not a problem to take on these extended roles, but the problems begin when you start having to leave behind the basic roles that I would say are nursing. Which are, spending time with a patient and making them comfortable, you know, giving them basic nursing care. If it gets
to the point where you can’t do those any more then maybe that’s when you should be saying no.

Hence, the articulation of nursing work as a unified ‘process’, so central to formal nursing theory, is something that is not immediately apparent within the discourse of nurses themselves. A distinction can be found to exist between the ‘basic’ and technical roles of the nurse; for example:

R26 (ward-based nurse) I think these days, and I don't think it’s just restricted to nurses, we get so tied up with the science and technology we sometimes forget the basics, as you say, making patients safe and comfortable. We are so busy worrying about carrying out this or that test, or using fancy equipment that people actually sometimes forget basic patient needs. Providing physical comfort as well as you know, emotional... holistic... I don’t know why, maybe it’s because we have turned direction as nurses, or the world has turned direction, or probably a bit of both.

There a clear tendency emerges, particularly amongst hospital-based nurses, that at least at the level of the ideal, they have found the shift towards more ‘extended’ roles regrettable. However, the community-based nurses, particularly the DNs, took a very different view of their change in role as a result of the introduction of the new framework of community care which came into operation in April 1993. The DNs generally held positive views about the way in which they were now freed up from routine or even non-nursing work, for example, washing, dressing, and doing shopping for patients. These routine roles are in large part now taken on by non-professional care workers, 4which is seen to have enabled the DNs to develop their professional role; for example:

R18 (community nurse) People are coming out of hospital a lot sicker now, and therefore it’s not a question of giving simple care, it is more complex. Therefore you need to spend a lot of time sorting things out, they need to be checked regularly. So if someone can do one part of the jigsaw, it gives you more time to make sure that everything is running smoothly.
A&E nurses think that ward staff resent them because they are perceived as not doing enough for patients, yet the role of the specialist A&E nurse is said to consist of 90% ‘nursing work’, whilst the role of ward-based nurses is only ‘40% nursing work’. Whilst, from the perspective of the community-based nurses, ‘we do not do what we like with patients when they are in their own homes’, unlike the situation that they see as pertaining for hospital-based nurses.

This particular theme points to the differences that exist intra-professionally between groups of nurses as to the constituents of nursing work. But why should such differences exist, given that these nurses have all undergone essentially the same initial training programme and received the same basic professional qualification (Registered General Nurse - RGN)? This is to acknowledge that the differences that pertain between the work of psychiatric nurses, midwives and general nurses is something that is relatively well-documented. Indeed, a case can be made that these are in many ways different occupations because they have undergone different programmes of training and emerged with different professional qualifications (Registered Mental Health Nurse - RMN; Registered Midwife - RM; Registered General Nurse - RGN).

Here it is asserted that these different views concerning the ‘legitimate’ role of the nurse (and many other differences between hospital and community-based nurses also inductively-emerged from the focus group discussions, as previously discussed) necessarily reflect distinct ideological orientations. These essentially ideological understandings can be seen to reflect the differences in the institutional contexts in which these groups of nurses practise. That is, hospital-based nurses work within a much more structured environment, where the division of labour between health care occupations is quite distinct. This is borne out in the views of A&E nurses who think ward-based staff engage in too much administrative work which should be performed by other more specialist occupations. For community-based nurses, their material work environment is essentially the client’s home, and the hierarchical division of labour is much less clear.
5. Conclusion

The broad objectives of this thesis were twofold. To explore the range of discourses that nurse’s draw upon in managing the practical problems of delivering care to patients within the NHS at a time of organisational transition. And, following on from this objective to postulate the underlying causal social mechanisms that shape the relationship between these structural developments and the practice of nurses as social actors in this particular conjuncture. The process of sociological analysis following the fieldwork was concerned with situating these social processes within a theoretical framework composed of two distinct but complementary strands. The first strand involves utilising the concept of ideology to conceptualise ideas and discourse as a reflection or expression of a (contradictory) material reality. The second strand involves the application of the methodological principles of critical realism in order to inform (or ‘underlabourer’) the analysis of nurse discourses of practice.

5.1 Key Theoretical Conceptualisations

The first strand, a non-reductionist and positive conceptualisation of ideology it conceived as being able to materially connect social structural processes with the beliefs and actions of social actors. This is seen as essential in establishing the nature of the relationship between the changing demands on the state institutions of health care and the representations of reality nurses hold in relation to their role and practice within this social structure.

A key concern of the research was to seek to explain why the ideas and beliefs of nurses appear to be marked by a range of tensions, inconsistencies, and contradictory elements (these emerged at the initial inductive level of analysis of the fieldwork data). This finding stands out and requires explanation, because all nurses receive the same professional training and are all formally educated within an occupational discourse of practice (‘nursing theory’). They also all work within the same
organisational structure responsible for the delivery of health care, the NHS. Therefore, at this empirical level of reality one would expect a consistency of views, both between the nurses themselves, and in concordance with the principles of practice examined by their professional body, and consistent with the framework of objectives and goals set by the Department of Health. A positive conceptualisation of ideology it was argued would recognise that whilst these discourses are structurally mediated, nurses as social actors are able to play an important part in actively constructing their own understandings of practice. These discourses drawing upon the shared experiences and knowledge of nurses as a collective group are able to challenge ‘official’ institutional rules and policy, they therefore have the potential to effect change within these organisational structures. These discourses of practice cannot therefore be simply dismissed as distortions or false versions of reality.

When we examine the ideologies that nurse’s draw upon in their practice, we find (following Gramsci) that the material content of these perspectives is something that cannot be easily separated. This is because we are primarily dealing with what is a ‘social’ rather than a ‘mechanical’ relationship between ideologies and practice. Nursing like all social processes, cannot constitute an unchanging set of practices and relations (nurses have indeed witnessed dynamic and substantive changes in their role over the past two decades), these changes cannot simply be ‘read-off’ from the organisational developments that have occurred. This is because nurses draw upon a wide range of disparate and historical ideas concerning the nature of their work. As social actors, they do not jettison their existing values and understandings overnight because there is a shift in political and organisational priorities. Discontinuities do arise, as for example the finding within this research that community-based nurses tend to emphasise the holistic elements of their work whilst A&E nurses are generally more concerned to focus on their role in carrying out clinical interventions on behalf of doctors.

The second theoretical concern has been the application of a methodology informed by a critical realist ontology. Here, it is asserted that through a process of retroductive abstraction, the analysis is able to postulate or infer the existence of a set of causal generative mechanisms. If these causal mechanisms are understood as ‘necessary’ or ‘internal’ (Sayer:1992:119) to nursing practice within the NHS, then they could
account for the processes of change and development reflected in the nursing discourses of practice that were recorded in the focus group discussions. The operation of these mechanisms within this thesis is traced through their effects which are apparent in the existence of 'demi-regularities' or patterns occurring at the empirical level.

This approach is posited upon the notion of a 'transformational' relationship existing between social structures and the practice or action of social actors. This approach requires a methodology attuned to the existence of stratified and differentiated multi-determinations. One that is able to move beyond the interpretation of the actions and understandings of nurses as social actors in isolation from an analysis of the structural context in which they practise. Here, the concept of 'analytical dualism' is central as it recognises an analytic separation but irreducible relationship existing between structure and agency. This enables the distinction to be drawn between the structural integrity of a social system (which in this case would be the system of health care) and the integration of social actors (in this case nurses) within that social system. Drawing this distinction allows us to recognise the existence a temporal disjuncture between changes occurring within these organisational structures and the response of nurses to those changes. This disjuncture occurs because structures and social agents, 'the parts' and 'the people' to use Archer's (1995) phrase, have distinct and emergent properties reflecting their distinct internal differentiation's characteristic of the stratified nature of the world. And, it is because ideas are conceived as having a material existence that we can conceptualise nursing discourse as being 'emergent' over time, and as drawing upon an underlying strata of ideologies pre-existing within a particular conjuncture of social and institutional elements.

5.2 The Transformational Relationship existing between Nurses and the System of Health Care

Set out below (Figure 3) is a diagrammatic representation of the postulated relationship between structure and agency within the context of nursing practice. This model is based upon a reading of Bhaskar's (1979) 'transformational model of social activity' (TMSA) but makes the temporality element more prominent than in the
original model. This follows the adjustments recommended by Archer (1995:154), which argued that Bhaskar's model required a greater emphasis on emergence as a process. This is because structure and agency (as distinct) social phenomena possess different powers and properties, and that therefore the interplay between them takes place over time span.

The model that is presented also introduces a conceptualisation of ideology (absent in Bhaskar's model, although arguably implicit in his understanding of the 'reproductive' activities of agents). The model demonstrates the ways in which the understandings and knowledge of nurses are both structurally mediated by the organisational demands of the system of health care, as well as being emergent from the collective practices of these social actors. Thus conceived, ideology operates not at some undifferentiated level of complexity but at many different social levels. From the individual practices of nurses at the bedside delivering care to their patients, through to the reproduction of the macro structures of health care delivery via the institutions of the state. Whilst the pressures for change within nursing practice can be seen as reflecting the balance of material forces within the NHS in a 'restricted period of time-space' (to use Lawson's expression), it is not necessarily reducible to those forces.
Figure 3: A model of the transformational relationship between social structures and social agents, informed by Bhaskar (1979), and applied to the changing social and material basis of nursing practice

Structural & organisational basis of health care within late modernity

Stratified network of mediating generative mechanisms

Reproduction and/or transformation of relations of health care production & delivery

Material practices of nurses as health professionals within the NHS

Figure 3: Footnotes

= Left-to-right arrows indicate temporality.

[ ] = 'Stratification' denotes the existence of a multiplicity of generative mechanisms (rather than entities such as institutions). One mechanism cannot be explained in terms of, or reduced to another, in a pre-structured society.

[ ] = 'Objectively real' causal mechanisms (which can be political, economic, and ideological) having a material existence. Operating below the surface, these mechanisms interact with one another and result in non-predictable but potentially explicable outcomes, dependent upon social context.

[ ] = Whether these practices reproduce existing relations of health care delivery or challenge existing structures is dependent upon the balance of hegemonic forces operating in the NHS in a particular time and context. In late modernity, ideology operating at the level of practice is one of the most important ways (there are others) in which this hegemony is sustained.
This analysis assumes a non-reductionist reading of the relationship between structure and social agents in asserting that there is no neat 'mechanical correspondence' between the structural requirements of the system of health care and the practice of nurses (and other health care professionals). These tensions and contradictions that exist within the practice of nursing in a health care system in transition are seen to be played-out on the terrain of ideology. Applying this analytical framework to an understanding of nurses' discourses of practice within the contemporary NHS it is possible to identify the influence of what can be termed 'ideological deposits' operating at different or stratified social levels. These 'deposits' would include the following elements: A set of notions concerning the historical and cultural role of the nurse arising from within the profession itself; from medicine a biomedical understanding of disease processes; and from organising principles upon which the system of health care is predicated, notions of equity and universality. These and many other ideological influences produce a range of pre-structured conceptions which nurses draw upon when engaged in their practice. All these elements together could be said to form an ideological framework for the practical activity of delivering nursing care, rather than constituting an 'ideology of nursing' per se. This is a conceptualisation of ideology as having a particular set of effects within the discourses used by nurses, rather than as constituting a discrete set of discourses. Ongoing nursing practice which engages with the real world of systems of health care delivery, will result in the reproduction and elaboration of these structured forms.

What emerges from a retroductive abstraction of the discourses that emerged from the focus group discussions is an ideological framework that contains many diverse and contradictory elements. The formalised nursing philosophy or theory inculcated during nurse training is unsurprisingly reproduced in discussions of nurse's professional relationship with patients, but elements of the discourse of managerialism and of consumerism are also present in these nurse discourses. The latter elements have arguably achieved a hegemonic status in the organisation of the NHS over the last decade, and their inclusion within nurse's own discourse of practice is also not too surprising.
The ideological influences of other social structural factors relevant to the delivery of nursing care that were identified within the research would include the recognition (by some but not all groups of nurses) that nursing practice needs to change to accommodate the demands required of nurses as new technological developments occur in medicine. However, whilst the view of medical technology as shaping nursing practice is historically accurate, the nurses themselves framed this process in terms of it being a much more recent development i.e following the more contemporary development of key-hole surgery, new diagnostic imaging technology, patient self-administered analgesia, etc. However, this understanding is itself ideological, given its implicit regret of the loss of some idealised ‘autonomous practitioner’ role. This idealised role which was explicitly discussed in the focus group discussions involved a set of assumptions about the degree to which nurses were said to of enjoyed some degree of professional autonomy when patient care was all about labour intensive ‘hands-on’ nursing care. However, as was discussed in the literature review, the material and technological demands of medicine have always meant that such a state of autonomy has never in fact existed within modern health care systems.

A further demonstration of this process of ideological layering is that even formalised and discrete nursing theory, as it is taught within the nursing academe, includes a range of disparate, inconsistent, and often contradictory elements. At one level, this might be a surprising conclusion to draw given that the academic basis upon which nursing theory is constructed might be expected to be internally consistent. However, close inspection reveals at least three major inconsistencies that derive from the historical and structural origins of the profession. The first of these ideological elements is the continuing hegemony of a biomedical epistemology and paradigm of medical practice that reifies the disease process. This knowledge base continues to inform nursing interventions despite the more recent embracing of the discourse of ‘holism’. This latter discourse derives from humanist philosophy and is a central element of the ‘new nursing’ philosophy. Explicit to this nursing philosophy is an acknowledgement of the centrality of the psychological and social dimensions of health for effective nursing care. This paradigm informs all current nurse education curricula. The second element is more diffuse but follows from the previous point. Despite a litany of professional criticism both from within the formal and informal
strands of nursing culture, doctors remain widely seen among nurses as the bearers of a set of esoteric knowledge which legitimately determines the patient care interventions of nurses. For many of the nurses in this study, the medical profession clearly continues to occupy a referential (but not a reverential) role. The third ideological element is a set of implicitly gendered (but also essentially patriarchal) conceptions of the caring and healing role of women within society. This inverted view of ‘women’s work’ is manifest in the appeals within the ‘new nursing’ for a use of self (‘emotional work’) in attending to the psycho-social needs of patients. This position would appear to contradict the quite legitimate complaints of the professional bodies of nursing that the low remuneration that has traditionally been received by nurses is a direct consequence of the value placed on ‘women’s work’ by the state. That nursing as a predominately female occupation is somehow not worthy of the same status, pay and attention accorded to other traditionally male-dominated professions such as medicine. Finally, there continues to be an adherence by nurses to the essentially ideological notions of altruism and of the public service ethic, which would appear to fly in the face of the now well-documented disenchantment with the low levels of pay and limited prospects for promotion within the public sector that leads to thousands of nurses leaving the NHS each year. Again, the origins of what might be described as a ‘vocational’ element to nursing derive from an idealised historical image of the nurse which would appear to be out of step with the increasing technicising of the nursing role within the hospital.

The ‘new nursing’ philosophy was originally presented (by nursing academia) as a form of ‘paradigm shift’, in which holistic nursing practice would became ‘epistemologically demarcated’ from the biomedically-defined constituents of nursing work. However, the inconsistencies described above demonstrate that this discourse could not sit outside the ideological effects of the material requirements of the health care system. Formal attempts at constructing a nursing philosophy and politics can at best only ever constitute a reference point for practice, one ‘stratum’ of understanding within an ideological framework. This is because nursing, like all social processes, does not occur in a social or even institutional vacuum. It will always be subject to the ideological influence of other social and organisational processes. This is one fairly fundamental reason why claims to holistic practice within nursing have recently become much more muted. What emerges from the research is that to a greater or
lesser extent nurses are incorporating some but not all of the newer components of nursing philosophy into their practice. The degree to which this occurs is dependent on the context of nursing practice. Hospital-based nurses tend to emphasis those ideological elements that recognise and value social and caring skills but not if they also downplay the relevance of biomedical knowledge and the associated technical skills. On the other hand, community-based nurses appear to be more convinced by the arguments concerning the importance of holistic practice and a respect for the ‘autonomy’ of the patient. This is probably because their greater relative autonomy within the health care system allows them to integrate these elements within their practice.

These and many other ideological ‘deposits’ or ‘strata’ were found to be present within the nurse focus group discussions, and could together be said to constitute an ‘ideological framework for nursing’. However, the balance of these ideological elements is contingent to a specific health care context at a specific historic conjuncture. Certainly, it could be said that the disparate and contradictory discourses of the nurse articulated within the focus groups in many ways appear to mirror the political and social tensions that have characterised the state provision and delivery of health care within Britain throughout the decade of the 1990s.

Finally, a few comments concerning the possibly more esoteric issue of the ideological relationship that exists between class, consciousness and materiality. Nurses as a social collectivity have a wide range of social and material interests in common (as set out in the emergent themes inductively-derived from the focus group discussion material), but these commonalities could not be described as a limited form of ‘class consciousness’ (as in Lukács’s use of the term). The history of nursing with some notable exceptions (the 1988 industrial action by nurses in support of the NHS being one) has been marked by a lack of collective action in support of what would appear to be common material interests such as improving wages and poor working conditions, reducing the excessive workload, changing what until recently was a limited career structure, and confronting bullying by the medical profession and hospital management. This observation would appear to demonstrate the importance of recognising the key role played by ideological frameworks, not as inversions of reality (as in the negative sense of the concept) but as an expression of what Gramsci
(1971) described as a state of 'dual' or 'contradictory consciousness'. Such a contradictory consciousness, if it exists, should be seen as tied to the material structure and social context in which most nurses continue to practice in the NHS. This organisation continues to promote amongst its clinical staff a particular (ideological) view of the importance of a service ethic and the qualities of being a 'good professional', whilst at the same time delivering what is basically a commodity (health care) essential to the reproduction and maintenance of the capitalist system of production.

5.4 The relevance of the 'health risk' discourse within nursing practice

An interesting if tangential outcome of this study was the finding that the discourse of 'health risk' would appear to have little resonance within nurses' own discourses of practice. At one level this is surprising given that this notion of risk, in conjunction with an acknowledgement of professional uncertainty and the shift towards changing forms of governance, has in recent years come to dominate both academic (for example Bauman defines risk as a central 'defining motif of late modernity' - 1997) and official (as represented in government policy documents for example DoH:1997 and DoH:2000) conceptualisations of the role of the state in the provision of health and welfare services. There are two possible reasons for this. The first is that nurses themselves are so insulated from the 'real world politics' of health care delivery that they refuse to recognise the fundamental changes that have occurred in health and welfare relationships (a charge that both New Labour and Conservative governments have levelled at the medical profession over the last decade). The second possible reason is that the 'risk society' thesis constructs generalities out of sets of unrelated social processes, and this results in the epistemic fallacy of seeing 'risk' as a defining feature of the world of health and welfare provision.

However, there is an important question that flows from this more general discussion of the relevance of the risk discourse, and that is do nurses themselves now feel less certainty about their practice?. Clearly, given that this research was not a longitudinal study and given that it was retrospective only to the extent that the nurses in the focus group discussions chose themselves to look back at their previous practice in
hindsight it is not possible to provide a definitive answer. However, what did generally emerge from the discussions was that nurses felt that their practice was now more rather than less certain (‘evidence-based’, to use the current expression). Although it was acknowledged that in the past, nursing interventions were often made on the basis of a very dubious knowledge base. The primary concerns that were expressed in relation to current practice were to do with lack of resources, an increased workload, and the consequent difficulties in meeting patient expectations.

5.5 Does a critical realist retroductive analysis add anything to the empirical research findings?

A central and final issue that arises in relation to these concluding comments regarding the relationship between nursing discourses of practice and organisational change, is the question of whether a critical realist process of retroductive analysis actually adds anything of substance to the initial inductively-derived themes drawn from an interpretation of the focus group discussions? To put the question another way, if the process of retroduction is subtracted from the research analysis would the same conclusions be drawn, and what would be left?

What would be left would be largely a series of empirical inductive generalisations together with some deductive inferences drawn from theorisations of nursing practice in general and not specific to the context of organisational change within the NHS in the 1990s. Utilising the inductive mode of inference alone will always be problematic when attempting to explain social phenomena. Social reality in an open system is frequently unstable, and it is therefore difficult to predict the effects of social mechanisms because they depend upon numerous concrete circumstances. And, because of this range of potential conjunctures it becomes difficult to draw general empirical conclusions from individual (and group) observations (Danermark.B et al:2002:86). The use of inductive inference alone would also raise the question of the representativeness of the focus group samples. It would also be difficult to draw any general conclusions from the focus group material given the divergences and contradictions within the range of opinions that are expressed, not only between nurse specialisms but also within homogeneous groups of nurses. Such an analysis would be
able to draw our attention to these anomalies but it would not be able to explain systematically why and how these differences arise within what would appear to be a collective occupational group with a set of common interests.

The apparently straightforward analytical approach of inductivism would essentially take what the nurses say about the changes in their practice at face value. A critical realist depth ontology on the contrary would insist that further analytical work was required in order to overcome potentially misleading appearances such as the ‘talk’ of nurses generated within focus groups. In this sense, critical realism is fallibilist:

“...in contrast to idealist and relativist theories of knowledge which insulate themselves from the possibility of being proved wrong by doing away with the idea of a knowable independent reality” (Benton and Craib:2001:121).

The fundamental epistemological principle underpinning this thesis is that society and social processes consist of two separate but related phenomena, the action of people and social structures. Thus, for the ongoing development of sociological theory, and in order for this social scientific understanding to be efficacious for social planning and practice, the way in which this relationship is conceptualised and approached within social research is crucial. This thesis conceptualises the relationship existing between structure and agency on the basis of the critical realist principles of ontological depth and the notion of ‘analytical dualism’. If this realist philosophical ‘underlabouring’ was absent and there was no explicit theorisation of the relationship between agency and structure which embedded the action of social actors within a range of stratified social process, then it is likely that there would be a tendency within the research to emphasise either an action-orientated perspective or a structurally-deterministic ‘social fact’ perspective of the impact of the organisational changes within the NHS on the work of nurses. The former position can all too easily lead to an exclusive concern with the voluntaristic intentional response of nurses (in general) as social actors. Adopting a purely deductivist theoretical approach could potentially mean the loss of the richness of the opinions and beliefs expressed by nurses in the group discussions. This could be the case if the range of conceptions employed by these social actors could not be linked deductively to pre-existing
theoretical conceptions concerning the relationship of discourse to occupational practice.

This thesis has attempted to examine and link the interplay of health care system structures and the practice of nurses over the time frame of the decade of the 1990s. It has been asserted throughout that a sociological understanding of these practices requires an assessment of understandings and beliefs of nurses as social actors embedded within an examination of social structures and their powers and tendencies. In this way, the research has the potential to make a contribution to the reflexivity of nurses with regard to the structural influences on their practice, and the imitations or possibilities for change within nursing.
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Appendix 1: Focus group recruitment leaflet

Organisational Change and Nursing Practice Study

Call for Participants

I am conducting an independent study into the changes that have occurred in relation to the role of the nurse and nursing practice as a consequence of the organisational changes that have occurred within the NHS in the 1990s. To this end, I am interested in eliciting the views of nurses on: the relevance to practice of their professional education and theory (pre and post registration), and the challenges that nurses feel they are facing within a changing Heath Service.

I propose to use a focus group discussion method to gain the views of these nurses. A focus group being a group of 5-8 nurses discussing the issues described above for a duration of 1-1.5 hours with the support of a facilitator.

I am specifically concerned to recruit RGN's who have been qualified for 4 years or more for participation in the research.

It is fundamental to the validity of the research that you feel safe in discussing these issues. Therefore this research will be carried out in or near your clinical area. The focus group will be tape-recorded in order to enable the researchers to transcribe and analyse the discussion. All participants will be given a pseudonym to ensure anonymity. These tape-recordings will be stored in a secure environment (on University not Trust premises), and destroyed on completion of the project. Please note that participants have the right to leave the focus group discussion at any time.

The safeguarding of confidentiality is crucial for the successful outcome of the research, and thus we will ensure that this occurs.

If you are interesting in participating please contact: Sister...........

If you further information please ring me at:

Iain Crinson Senior Lecturer, TVU 0181-280-5159
Appendix 2: The process of indexing and coding the transcript data to inductively derive emergent themes

Using an excerpt taken from the transcript of an A&E nurse focus group discussion, the example demonstrates how the themes associated with research category 4 (Patient expectations and responsibilities) are derived.

Note: The numbers in parenthesis after each indexed statement demonstrate that they could be located in one or more research categories.

<table>
<thead>
<tr>
<th>Excerpt from a A&amp;E Nurse Focus Group transcript</th>
<th>Indexing</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent do you think that patients should be held personally responsible for their minor health problems and should be discouraged from using A&amp;E departments?</td>
<td>• We should not assume that patients know as much about health as a trained nurse</td>
<td>(4)</td>
</tr>
<tr>
<td>R7. You do think about it, don’t you, because you think I wouldn’t come to this hospital with something minor, but that’s judging someone by your own self. There are multiple reasons why people do come, some with really minor problems, but we forget sometimes that we’ve gone through nurse training and been doing this job for years, and what’s simple for us is not simple for someone who lives down the road. I think that people expect more nowadays; before they wouldn’t have come to this hospital with something trivial. We’ve been told this is a great health care system when it isn’t, but people still think it is. The attitude now is that you’re a customer and should demand more.</td>
<td>• Patients expect more, they have the attitude of being a customer of the service</td>
<td>(4)</td>
</tr>
<tr>
<td>R5. I think at the same time they don’t take responsibility for their own health.</td>
<td>• Patients don’t take responsibility for health</td>
<td>(4)</td>
</tr>
<tr>
<td>R6. To a certain extent the health care system takes responsibility away from the patient, it always has done.</td>
<td>• The system takes responsibility away from the patient</td>
<td>(4)(8)</td>
</tr>
<tr>
<td>R5. Often people throw it in your face when they’ve had a long wait and they’ve got a problem that perhaps they do need to see a doctor for, but their condition is not dire, they sort of throw it at you, ‘I’m sick and you’re not</td>
<td>• Patients give nurses the responsibility for</td>
<td>(4)</td>
</tr>
</tbody>
</table>
letting me see the doctor so I’m going to go home now’. So they give you the responsibility for their going home and not seeing a doctor and not having taken paracetamol when they have a temperature and not having done anything at all to help themselves.

R7. I just come back from a weekend away where you have to pay to get a doctor out to see you. There’s no way that half the people would come in if they had to pay money to use the A&E, I don’t agree with people paying for health care, but people would think more, it would put more onus on them to think: ‘What actually is wrong with me, why am I going down to casualty?’.

R6. The very fact that we are not allowed to say to someone: ‘Please leave, you do not need to be here’. The only one who would take that responsibility in this department would be one of the consultants, and they have been known to say it. But the way that it’s gone is that we have to take responsibility, we have to have the authority and accountability to rationalise anything we say or do to any patient, and the patient knows that, the client knows that, that is why people will still keep on coming back because they know we won’t send them away.

Do you resent that?

R6. You get so used to it, I used to spend my time educating people about what they should be coming here for, but you just get to the point where you don’t bother anymore, it just never seems to sink in. On the other hand. I do think that people should take responsibility for their own health, but there are certain things that might happen to them that are beyond their control. There are, though, people who do try, and I think the system does create the situation where people can’t get GPs so they come to A&E, the GPs that are there are completely pushed so people come to A&E. I don’t think it’s a case of saying these people shouldn’t be here, a lot of the reason people come here is because there is nowhere else for them to go. So it’s very hard to say: ‘I resent those people’, because you do when you’ve got sick children and adults who are waiting, and there are people who have had their problem for five weeks and haven’t been to see their GP and are grumbling about having to wait, so yes you do resent them, but, you do think that they have come up here for a reason, they’ve been told by the government that they can get emergency care, for free, so the system has created the problem.

| patients should take more responsibility for their health | (4)(8) |
| Patients know we won’t send them away | (4) |
| nurses lack authority to refuse treatment to ‘inappropriate’ attendees | (4) |
| patients should think more about the appropriate use of A&E service | (1) |
| resentment inappropriate attendees in A&E; but the system has created this problem | (4) |
To what extent do you think nurse-patient relationships have improved, in the time that you have worked in A&E?

R6. I think they have improved because from the patients' side of things we give more information, people are now informed by us because they have to be, so generally the communication is better. On the other hand, people are more likely to complain about the care that is given, because they now have a voice and can complain. Efforts are being made to make the waits less even though more and more people are using the A&E department. So I think in general it has improved.

R7. I think for the patient things have improved, no, I don't think so, because people do have to wait longer, I don't know, because some things are better, communication is better; we don't see patients as people in pyjamas doing what they are told, it's now more of an adult relationship between patients and nurses, and doctors of course. What I worry about are the waits on trolleys which have got absolutely horrendous over the past few years, people have got nowhere else to go, and it's because of the ageing population, care in the community, if you are an older person things are not good for you, whereas if you are younger, minor injury units and nurse practitioners mean you are in and out much quicker.

R5. I thought it had not improved, because the service in the community does not seem to be adequate, consequently because of the bigger demands and technology is greater, and a whole host of reasons why there is greater demands placed upon A&E departments. A department that is under pressure does not give the patient good care, and we are more under pressure. Complaints are increasing, litigation, there's that sort of tension, there's defensive practice in a lot of cases, there's the public's expectations which are higher, therefore when they come here and get worse care, relative to their expectations, because they are not seen within two hours. And that seems worse to me than when I was a student nurse at Guys A&E, I don't remember any of this stuff was not happening then.
The indexed statements pertaining to research category 4 (Patient expectations) that are identified in this particular excerpt taken from the transcript of one A&E nurse focus group are included in the list below of all the indexed statements related to this category, which are drawn from all the A&E nurse focus groups. These indexed statements are then coded or grouped together on the basis of an interpreted commonality; as demonstrated below.

<table>
<thead>
<tr>
<th>All indexed statements from all 3 A&amp;E nurse focus groups pertaining to research category 4</th>
<th>Coding/grouping</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No fault attached to patient lack of knowledge (4)</td>
<td>(a) No guilt should be attached to patients for their health behaviour</td>
</tr>
<tr>
<td>• Some patients are irresponsible (4)</td>
<td>(b) Patients should take more responsibility for their health</td>
</tr>
<tr>
<td>• Doing irresponsible things is human nature (4)</td>
<td>(a)</td>
</tr>
<tr>
<td>• We have to be more conscious of what we say to patients (4)</td>
<td>(c) Have to anticipate who is going to complain in advance, nurses need to be conscious of advice given to patients</td>
</tr>
<tr>
<td>• Health advice is everywhere (4)</td>
<td>(d) Many sources of health information in society</td>
</tr>
<tr>
<td>• Patients rely on nurses for health advice (4)</td>
<td>(e) Patients trust the advice of nurses</td>
</tr>
<tr>
<td>• Parental irresponsibility - Alcohol abuse as an example of self-inflicted health problem (4)</td>
<td>(b)</td>
</tr>
<tr>
<td>• Limited ability of certain patient groups to help themselves (4)</td>
<td>(f) Patients lack capacity to manage their own care</td>
</tr>
<tr>
<td>• Patients will use A&amp;E because they have a problem or are unable to cope (4)</td>
<td>(g) People use the A&amp;E service because they have nowhere else to go, failure of the primary care system has created the problem of ‘inappropriate attenders’</td>
</tr>
<tr>
<td>• People attend inappropriately because they have nowhere else to go (4) (2)</td>
<td>(g)</td>
</tr>
<tr>
<td>• People need to be educated to use appropriate services (4)</td>
<td>(h) People attend inappropriately and need to be better educated about the use of the A&amp;E service</td>
</tr>
<tr>
<td>Numbers</td>
<td>Statements</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>(I)</td>
<td>Many patient complaints about the service are justified, but misdirected towards nurses</td>
</tr>
<tr>
<td>(I)</td>
<td>The Patient's Charter introduced a culture of complaint that didn't exist prior to its introduction</td>
</tr>
<tr>
<td>(j)</td>
<td>Middle class patients making complaints are particularly difficult to manage as they know their 'rights'</td>
</tr>
<tr>
<td>(c)</td>
<td>Patients do lack the health knowledge of health care professionals and therefore can hold misconceptions</td>
</tr>
<tr>
<td>(j)</td>
<td>Patient expectations of the A&amp;E service have been raised, they see themselves as customers</td>
</tr>
<tr>
<td>(n)</td>
<td>The health system takes the responsibility for health away from individuals so that many assume the 'patient role'</td>
</tr>
<tr>
<td>(4)</td>
<td>Some patients' irritation with system is justified</td>
</tr>
<tr>
<td>(4)</td>
<td>Patients' justified frustrations are misdirected</td>
</tr>
<tr>
<td>(4)</td>
<td>Patient respect for nurses diminishing</td>
</tr>
<tr>
<td>(4)</td>
<td>Nurses are unfairly blamed for problems with service - where the buck stops</td>
</tr>
<tr>
<td>(4)</td>
<td>The public have an old-fashioned image of what nurses do - don't understand nurse's role</td>
</tr>
<tr>
<td>(4)</td>
<td>PC made public aware that they could complain about the service</td>
</tr>
<tr>
<td>(4)</td>
<td>M/C patients difficult to cope with as know their rights</td>
</tr>
<tr>
<td>(4)</td>
<td>Have to anticipate who is going to complain</td>
</tr>
<tr>
<td>(4)</td>
<td>Never used to think about patients complaining</td>
</tr>
<tr>
<td>(4)</td>
<td>Complaints about waiting times are justified</td>
</tr>
<tr>
<td>(4)</td>
<td>Patients don’t realise that the cuts in funding are responsible for waiting times</td>
</tr>
<tr>
<td>(4)</td>
<td>No complaints in past</td>
</tr>
<tr>
<td>(4)</td>
<td>Things have got worse for patients in A&amp;E</td>
</tr>
<tr>
<td>(4)</td>
<td>We should not assume that patients know as much about health as a trained nurse</td>
</tr>
<tr>
<td>(4)</td>
<td>Patients expect more, they have the attitude of being a customer of the service</td>
</tr>
<tr>
<td>(4)</td>
<td>The system takes responsibility away from the patient</td>
</tr>
<tr>
<td>(8)</td>
<td></td>
</tr>
<tr>
<td>Patients give nurses the responsibility for treatment decision-making (4)</td>
<td>(h)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Patients should think more about the appropriate use of A&amp;E service (4)</td>
<td>(b)</td>
</tr>
<tr>
<td>Patients should take more responsibility for their health (4)</td>
<td>(g)</td>
</tr>
<tr>
<td>Resent inappropriate attendees in A&amp;E – but system has created this problem (4) (8)</td>
<td>(o)</td>
</tr>
<tr>
<td>Communication with patients has improved; however, patients now have a voice and can complain (4) (8)</td>
<td>(g)</td>
</tr>
<tr>
<td>Now have more adult relationship with patients (1) (4)</td>
<td>(h)</td>
</tr>
<tr>
<td>Older patients are now receiving worse treatment as a result of increase in waiting-times (4) (8)</td>
<td>(e)</td>
</tr>
<tr>
<td>Educating patients about appropriate use of services (1) (4)</td>
<td>(a)</td>
</tr>
<tr>
<td>Patients have a lot of trust (4)</td>
<td>(h)</td>
</tr>
<tr>
<td>Patients have misconceptions about what is wrong with them (4) (5)</td>
<td>(i)</td>
</tr>
<tr>
<td>Have to avoid making patients feel guilty (4)</td>
<td>(n)</td>
</tr>
<tr>
<td>More patient education required, as lack knowledge regarding availability of services (4)</td>
<td>(i)</td>
</tr>
<tr>
<td>Patients don’t understand significance of symptoms (4)</td>
<td>(p)</td>
</tr>
<tr>
<td>Assuming the ‘patient role’ (4)</td>
<td>(p)</td>
</tr>
<tr>
<td>Patients are uneducated about health problems (4)</td>
<td>(e)</td>
</tr>
<tr>
<td>Media producing health panics (4)</td>
<td>(h)</td>
</tr>
<tr>
<td>Codes</td>
<td>Themes</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Patients use A&amp;E service for reassurance (4) (2)</td>
<td>(o)</td>
</tr>
<tr>
<td>One dissatisfying patient experience can mar otherwise excellent treatment (4)</td>
<td>(c)</td>
</tr>
<tr>
<td>Patients do not accept low priority status when being triaged (4) (8)</td>
<td>(m)</td>
</tr>
<tr>
<td>If communication with patients improved, then less complaints (4)</td>
<td></td>
</tr>
<tr>
<td>Defensive practice results from increase in complaints (4) (1)</td>
<td></td>
</tr>
<tr>
<td>Public expectations of the service are higher (4)</td>
<td></td>
</tr>
</tbody>
</table>

Following this interpretative coding process, the codes themselves are grouped together under themes, as they pertain to each of the eight research categories. These themes are set out in Section 4.1.2 of the thesis.