CHAPTER 16

Nursing and Sociology
An Uneasy Relationship

Deidre Wicks

Overview

- Why is nursing often depicted in a negative light?
- What is the ‘New Nursing’?
- What are some of the new developments in nursing in Australia and overseas?

This chapter examines some of the more recent sociological writings on nursing and discusses them in relation to the practical insights they have to offer for nursing. Recent nursing reforms in Australia and the United Kingdom are analysed to see how these might be interpreted through a sociological lens. Implicit in this analysis will be a focus on the tension between the structure of the health system (particularly the influence of medicine) and the agency of nurses in these different accounts of nurses and nursing work.

Key terms

- agency
- biological determinism
- biomedical model
- class
- discourse
- doctor/nurse game
- empirical
- essentialism
- ethnography
- feminism/feminist
- gender
- horizontal violence
- materialist analysis
- medical dominance
- meta-narratives
- nurse practitioner
- patriarchy
- phenomenology
- post-structuralism
- primary health care
- professional project
- racism
- sexual division of labour (SDL)
- social institutions
- social structure
- structure–agency debate
- theory
Introduction

In the period following World War II, nursing training in Australia was broadened to include both the technological and clinical advances that had occurred as a result of nursing experiences in war. Further expansion of nursing curricula occurred during the 1960s and 1970s to include input from the social sciences, namely psychology and sociology. This was based on a view of nursing that held that nurses needed an understanding of the social context of health care delivery as well as the individual, psychological needs and perceptions of their patients. The sociology introduced at that time, with few exceptions, revolved around the concept of 'roles' and role relationships, such as 'the role of the doctor and nurse in health care delivery' and 'the role of the patient in hospital care'. As such, it encouraged an acceptance of existing social relationships and their hierarchies of power and authority. It did, nevertheless, encourage nursing students to think about social relationships and the impact of these relationships on nursing work and on patient care. As the 1970s progressed, the popularity of more radical approaches within sociology began to be taken up and applied to sociology courses within nursing education. New interpretations of nursing history and practice, based on feminist theory in particular, began to appear, especially in the new diploma and later degree courses within universities. These courses encouraged a more critical examination of nursing history and practice, as well as a more critical interpretation of the relationship of nursing to other health occupations, especially medicine.

See chapter 2 for an overview of feminist theories

At the same time as broadening the ways of understanding nursing, these more radical approaches had the unintended effect of presenting nursing in a much more negative light; so much so that in recent years, sociological writings about nursing have presented an almost uniformly negative picture. Repeatedly, nursing has been presented as a 'subordinated' occupation, and nurses themselves as passive victims of medical power. While there have been differences in the way that various sociological perspectives view nursing, it is also possible to see a consistent theme running through all the interpretations, from social histories of nursing through to more radical feminist accounts. In the historical accounts, it is argued that many of the enduring characteristics of nursing have their roots in nineteenth-century gender relations and associated ideas regarding the appropriate behaviour for women in Victorian society. This argument has become the 'holy grail' of nursing history and is trotted out whenever a potted history of nursing is required as an introduction to current trends in nursing. For instance, it has been argued that '[r]these [strategies] replicated within the hospital the existing gender relationships of Victorian society, and did not challenge prevailing male notions of womanly behaviour. Difference to doctors and acceptance of the “handmaiden role” was a cornerstone of this

theory
A system of ideas that uses researched evidence to explain certain events and to show why certain facts are related.

gender
This term refers to the socially constructed categories of feminine and masculine (the cultural values that dictate how men and women should behave), as opposed to the categories of biological sex (female or male).
strategy’ (Beauchamp & Robinson 1990). And in an Australian version, it is explained that ‘[s]ince 1868, when the first Nightingale graduate arrived in Australia, nursing as an occupation has tended to attract relatively passive and subordinate women from middle and lower class backgrounds who have accepted that their occupation was inferior and subordinate to male-dominated medicine’ (Short & Sharman 1995, p. 236).

In all of these potted historical overviews, and in the analyses that follow, there is a theoretical and logical flaw. It is assumed that the political strategy of those in charge and the real-life behaviour of the nurses in question were one and the same. Victorian doctors and administrators may well have desired the nurse to be ‘restrained, disciplined and obedient, [carrying] out the orders of doctors in a suitably humble and deferential way’ (Davies 1977). But this did not mean that matrons, nurses, and sisters always cooperated in this way. There is ample evidence to show that they frequently did not. For instance, in the earliest era of modern nursing in London, there was an important dispute at Guy’s Hospital between Mrs But (the matron) and the doctors (Abel-Smith 1960), and there were also the disputes at St Thomas’s Hospital over the timing of medical rounds (‘The Doctors versus the Nurses’ 1962, pp. 783–4). In Australia, the disputes between Lucy Osborn, the doctors, and the lay administrators at the Sydney Infirmary were so intractable that the government of the day had to resort to a Royal Commission to settle (in the matron’s favour) the struggle for authority (Wicks 1995b). In addition, labour history has documented various forms of industrial action taken collectively by nurses over the past century. Finally, ethnographic studies have revealed numerous examples of negotiation, disagreement, subversions, and open conflict as constant elements of nurse–doctor interactions within hospital settings (Game & Pringle 1983; Hughes 1988; Porter 1995; Svensson 1996; Wicks 1999). Against this evidence, an orthodoxy has developed within both mainstream and more radical approaches that has focused on the power of doctors, hospitals, and medicine more generally. Nurses were thought to have inherited a tradition of passivity and powerlessness, and worse, a tendency to engage in horizontal violence (Roberts 1983). Indeed, given these characteristics and the twin edifices of class and gender, the position of nurses was considered to be all but hopeless (Short & Sharman 1995). The common thread running through these accounts has been an emphasis on the power of social structure to shape and control nurses’ work, identity, and behaviour.

More recently, theoretical developments in feminist theory, and within sociology more generally, have promoted a re-examination of the debate concerning individual choice versus determination by outside forces (structure–agency debate), and of the need to understand an issue that has such important implications for politics and social life.
Through the influence of **post-structuralism**, there has been a re-emphasis on individual choice and action in the making and re-making of **social institutions**. While some authors think that this trend has gone ‘too far’ (Walby 1992), others see it as liberating, challenging the ‘grand narratives’ that characterised groups such as women as being oppressed by strong and unchanging social structures (Barrett 1991). I shall begin with a brief review of some earlier feminist approaches to nursing, of what they had to offer, and of what they missed. I will then examine nursing responses to these, discuss new sociological approaches to nursing, and look at recent developments and directions for nursing practice in Australia and Great Britain. Finally, I will address the question of how nursing and sociology might have a more mutually productive relationship in the future.

**Earlier feminist approaches**

In the early 1970s, two writers from the USA—Barbara Ehrenreich and Deirdre English—turned conventional theories on their head with their pamphlet *Witches, Midwives and Nurses: A History of Women Healers* (1973). Their work, with its strong feminist perspective, was a breath of fresh air in a field dominated by conventional histories of medicine. And yet its widespread influence in the decades since its publication has also had a detrimental effect on feminist sociological analyses of nursing. This stems from the way that Ehrenreich and English view the struggle within health care as something that took place in an earlier period between traditional women healers and formal male practitioners. According to their analysis, the defeat of the women healers ushered in an epoch of widespread subordination to organised, scientific male medicine. For instance, they are critical of middle-class reformers, such as Florence Nightingale, and of nineteenth-century feminists who ‘did not challenge nursing as an oppressive female role’ (1973, p. 38). This analysis overlooks much that is crucial to a dynamic analysis of the historical relationship between nursing and medicine. By viewing the nineteenth-century formation of modern nursing only in terms of capitulation and defeat, the work has had the unintended effect of devaluing contemporary nurses and nursing work.

The most influential piece of writing on nursing and its relationship to medicine is Eve Gamarnikow’s ‘Sexual Division of Labour: The Case of Nursing’ (1978). In this important paper, Gamarnikow challenges accounts of the **sexual division of labour** (SDL) that are based on ‘naturalism’ or **biological determinism**—that is, the idea that it is ‘natural’ for women to be nurses in the same way that women are ‘naturally’ maternal. She argues, rather, for a **materialist analysis**, which locates the SDL as a social relationship that is not inevitable or natural

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**post-structuralism/postmodernism**

Often used interchangeably, these terms refer to a broad perspective that is opposed to the view that social structure determines human action, and instead emphasises a pluralistic worldview that explores the local, the specific, and the contingent in social life.

**social institutions**

Formal structures within society—such as health care, government, education, religion, and the media—that are organised to address identified social needs.

**sexual division of labour**

This refers to the nature of work performed as a result of gender roles. The stereotype is that of the male breadwinner and the female home-maker.

**biological determinism**

An unproven belief that individual and group behaviour and social status is an inevitable result of biology.

**materialist analysis**

An analysis that is embedded in the real, actual, material reality of everyday life.
but that has been socially constructed. This was such a significant breakthrough, in an area typified by naturalist explanations, that sociological analysis to this day continues to refer to it to establish a position that runs counter to biological or naturalist accounts of the nurse–doctor relationship (see, for example, Game & Pringle 1983; Hazleton 1990; Russell & Schofield 1986; Short & Sharman 1995; Willis 1983). It is still widely regarded as the necessary foundation on which any critical sociological account of nurse–doctor relations must be built.

However, upon closer examination, it is evident that Gărnănikow’s account is located squarely within a ‘modernist’ feminist theoretical model, with its attendant problems of overgeneralising and universalising. In this case, Gărnănikow generalises the structural oppression of all nurses by all doctors through a patriarchal ideological structure. While Gărnănikow’s approach provides a crucial sense of the strength and pervasiveness of social structure in explanations of the SDL, it does so at a price. Both Robert W. Connell (1987) and, more recently, Anne Witz (1992) make the point that this approach ignores or at least minimises the importance of patriarchal practices within the labour market and the workplace itself. What is the point of resistance in the workplace if gender (and/or class) relations are determined elsewhere? The effect of this emphasis on patriarchal ideology and structure in Gărnănikow’s account, and other accounts derived from this analysis, has been the representation of nurses as an undifferentiated bloc of subordinated women. Individual or collective acts of resistance have either been ignored or minimised, being characterised as insignificant or as yet another variant of ‘complaint’ among nurses (see Turner 1986b). The emphasis on an all-pervasive ideological structure has also had the effect of denying nurses subjectivity (their own identity), for in accounts based on the power and pervasiveness of structure, the voices of nurses were rarely heard. (There are some exceptions, however: notably the work of Game & Pringle 1983.)

Gărnănikow’s contribution was pivotal for a critical reassessment of the conventional literature on nurse–doctor relations. Indeed, the emphasis on power relationships in general, and patriarchy in particular, opened up the traditional nurse–doctor relationship to a sophisticated and long overdue sociological critique. Nevertheless, an emphasis on structural oppression, and on an inferred passivity on the part of nurses, also runs the danger of indirectly contributing to the status quo by emphasising the inevitability and hopelessness of the situation.

**Nursing backlash?**

Given these theoretical directions and assumptions, there was certainly potential for academics, students, and intellectual leaders in nursing to develop an ambivalent attitude towards sociology and towards feminist sociology in particular. Why are sociology lecturers so surprised when student nurses appear hostile to their lectures on medical dominance?
and begin, in their postgraduate work, a mass exodus towards phenomenology? Why, indeed, are academics surprised that students do not enthusiastically embrace the notion that, on graduation, they are to be dominated and oppressed as both women and nurses? Is it any wonder that they prefer to believe their nursing mentors, who make use of the more comforting language of professionalism, with its associated characterisation of nurses as authoritative, autonomous practitioners? Interestingly, this is not the case with those working, clinical nurses who enter universities on a part-time basis as mature-age students. They have neither an investment in an idealised future career nor an investment in the practical and political realities of a professional project. They have, rather, the direct experience of both the restrictions and the rewards of the complicated work process of nursing. They generally enjoy feminist analyses of medical dominance, which give a name to many of their own discontents, and yet at the same time they are also quick to point out the contradictions and the reversals of power that arise in specific work situations. In other words, they frequently feel that both Marxist and feminist analyses (defined in chapter 2) of nursing work are ‘good’ but make things out to be ‘too black and white’. At the same time, these working nurses have little time for nurse academics whom they see as ‘feathering their own nests’ and ignoring the concerns of working nurses in their preoccupation with developing nursing theory.

It can be seen that feminist sociology has had both a beneficial and also a less positive effect on nursing. At the same time, these particular views of nursing have had a less than beneficial effect on sociology. The assumed realities of the daily oppression of nurses by doctors that are implicit in the accounts discussed above have served to reinforce certain tendencies within sociology—in particular, within Marxist sociology and radical feminist theory. Specifically they have reinforced the notion that social structure is set in concrete, rather than being the continually constructed outcome of human practice (Connell 1987). As a result, and despite the goodwill on the part of individual sociologists and nurse academics, the relationship between academic nursing and sociology has, on the whole, been a troubled one (see also Allen 2001a,b). While health sociologists continue to research and write on nursing, in other more central areas of sociology (class and gender analyses, cultural studies, theory construction) nursing rarely rates a mention; what could nursing possibly contribute to the development of sociological theory? At the same time, nursing has, for some time, been losing interest in sociology and has turned towards various forms of interpretive sociology or philosophy, which appear more sympathetic to the quest of nursing for a rationale and an underpinning for professional authority and autonomy. In the second part of this chapter, I discuss some recent developments within sociology that could provide a basis for a useful bridge between nursing and sociology. Finally, I discuss some recent developments within nursing in Australia and the United Kingdom that may have the potential to contribute to developments within sociology.

phenomenology
Its main aim is the analysis and description of everyday life. It is the study of the ways in which individuals construct the daily realities of their social world through interaction with others.

professionalisation/professional project
The process of becoming a profession, whereby an occupational group attains publicly recognised and government-legitimated monopoly and autonomy over its area of work. See trait approach
Paradigm shift in feminist theory

A broad social and political movement based on a belief in equality of the sexes and the removal of all forms of discrimination against women. A feminist is one who makes use of, and may act upon, a body of theory that seeks to explain the subordinate position of women in society.

Over the last two decades there has been what some writers have referred to as a ‘paradigm shift’ within the founding theoretical principles of modern feminism (Barrett & Phillips 1992). Central to this ‘shift’ has been a questioning of at least three of the basic assumptions of ‘1970s feminism’. These are:

1. the notion of women’s oppression
2. the assumption that it is possible to specify a cause for the oppression
3. consensus that the cause lies at the level of social structure, be it patriarchy, class, ethnicity, or a combination of any or all of the above (Barrett & Phillips 1992).

This is not to say that these authors (and others like them) are arguing that women do not experience oppression. Rather they are attempting to acknowledge that different women experience different types and degrees of oppression in specific circumstances. It allows for the possibility of resistance to the operation of power and for the emergence of counter-power. It also allows for the possibility that some women may experience oppression at the hands of other women. It recognises the uneven nature of human experience, the fact that individuals and groups can shift from being oppressed to inflicting oppression over others, the fact that even the most dominated and powerless groups work away at clawing back whatever autonomy and freedom they can. In the end it recognises the ‘contingent’ and ‘fluid’ nature of power itself (Barrett 1991).

This approach (or, more correctly, collection of approaches) has been heavily influenced by the work of the French philosopher and social theorist Michel Foucault, through what Rosemary Pringle (1995) has called ‘the Foucault effect’. Pringle argues that Foucault’s emphasis on power as productive (and not merely coercive) has opened up the space for a view of women as active agents rather than the passive recipients of orders from above: ‘Women actively produce the forms of femininity through which they are also controlled: they are never merely victims’ (Pringle 1995, p. 207). Pringle also clearly states that, in her view, the use of the term ‘patriarchy’ is more of an obstacle than an aid to understanding specific operations of power. Rather than treating patriarchy as a social system, Pringle—in her work on secretaries (1988), and more recently on women doctors—has emphasised the more fluid and local contexts in which gender and power operate (Pringle 1995).

See chapter 2 for further discussion of post-structuralism.

This and other similar approaches have not been without their critics. Feminist theorist Sylvia Walby has argued that the shift away from ‘structure’ and towards discourse has resulted in a conceptualisation of power as highly dispersed rather than as concentrated in identifiable places and groups. She argues further that the concepts of ‘woman’ and ‘patriarchy’ are, in fact, essential if we are not to lose sight of the power...
relations involved and if we are to understand the gendered nature of the social world. In particular, she points out that an analysis of the new international division of labour shows clearly the need to maintain the use of the structural concepts of patriarchy, class, and racism (Walby 1992). While Walby agrees that there were problems with ‘the old meta-narratives’ based solely on class, she holds that the answer is not to discard the concept of social structure. Rather, the answer is to develop better, theoretically richer concepts that are more capable of ‘catching’ and explaining the theoretical and practical complexities of the operation of power in the social world. In fact, she argues that a solution to this problem is to develop a theory of patriarchy that is based on six structures rather than one. She sees the six main structures that make up a system of patriarchy as:

1. paid work
2. housework
3. sexuality
4. culture
5. violence
6. the state.

It is the interrelationships between these that create different forms of patriarchy (Walby 1992).

In his work on gender and power, Connell has grappled with the same issues; he has kept hold of the concept of social structure and has developed a theoretical concept of gender relations that is based on three sub-structures: labour, power, and cathexis (or emotional attachment) (Connell 1987). The important point about these theoretical developments and debates is not that there are disagreements, but that feminist theory in the twenty-first century is

**The doctor/nurse game**
marked not by orthodoxy and homogeneity but rather by debate and openness. Directly or indirectly, these developments have encouraged a revival in sociological analyses of nursing and of the division of labour with medicine. Rather than accept old-style assumptions about the patriarchal oppression and medical dominance that are implicit in the doctor/nurse game, recent writers, working from a variety of sociological perspectives, have re-examined nurses’ and doctors’ working relationships and come up with some fascinating and important findings.

New sociological approaches to nursing

Many of the more interesting contributions to the sociological literature on nursing have resulted from small-scale empirical studies. In his study of a casualty ward in a British hospital, David Hughes (1988) demonstrates that there are many specific circumstances in which the nurse’s influence is strengthened in relation to the doctor’s. More recently, Christopher Tye and Fiona Ross (2000) have also looked at nurse–doctor relations in an accident and emergency department, in this case to examine (among other themes) the blurring boundaries between doctors and the new staff category of emergency nurse practitioner. Sam Porter (1992) reached similar conclusions to Hughes in a study of nurse–doctor interactions in an Irish hospital. He reported that neither doctors nor nurses behaved in the ways that Leonard Stein (1967) predicted (in the ‘doctor/nurse game’), but that nurses often openly directed doctors to particular actions and decisions, and that doctors frequently appeared to welcome their suggestions. These results have gained further support from a large study of the relations between nurses and doctors in British hospitals, which supplied numerous instances of nurses having direct influence over patient care (Mackay 1993; Walby & Greenwell 1994). In another study, based on interviews—this time from Sweden—Ränd Svensson reported that:

nurses’ position on their wards has been altered in a significant manner. The nurses have increased their influence over decisions which affect the patient, and they can influence the norms for interaction and work performance to a greater extent than previously. On the wards covered by this study, the voice of nursing clearly makes itself heard in more areas and with greater strength than it did before (Svensson 1996, p. 396).

This author further developed the approach outlined above by drawing on extended observations and one-to-one interviews in a hospital setting to explore incidents that reveal both cooperation and contestation with doctors and their medical goals and priorities. In Nurses and Doctors at Work: Rethinking Professional Boundaries, an examination is made of the ways that
nurses call on their knowledge and formal/informal authority to influence healing outcomes in the areas of pain relief, wound healing, and care of the dying patient (Wicks 1999).

Finally, Gjerberg and Kjolsrud (2001) focus on the dynamics of the relationship between doctors and nurses when both nurses and doctors are female. The authors conducted interviews with both doctors and nurses that covered three main areas: (1) the extent of assistance in practical situations, (2) respect and confidence, and (3) female doctors’ experience of being ‘different’. They found that female physicians feel that their relationships with female nurses differ from those of their male colleagues in all of these areas (2001, p. 200). They conclude that this is a sign of ‘status-convergence’ between medicine and nursing, where male doctors are given extra attention to reduce the risk of conflict. None of these studies attempt to ignore or gloss over the impediments to nursing authority and action. Svensson (1996) points out that one area in which it is difficult, and sometimes impossible, for nurses to negotiate change is the actual division of work: much of the traditional service work remains with nurses. However, what all of these studies have in common is an openness to the practical and theoretical possibility of nurses exercising various degrees of direct authority and power.

The second sociological approach, which has developed the theme of ‘active nursing’, has come from an unlikely quarter. It has come from the sociology of the professions. This has been an area that has historically provided little joy for nurses. In its traditional form, the sociology of professions set up an (ever-changing) ‘checklist’ of criteria for what constituted a profession. It will come as no surprise to the reader to learn that nursing (like every other female-dominated occupation) never made it to the ‘A list and, therefore, was relegated to the nether world of the ‘semi-professions’ as a ‘stunted occupational subspecies’ (Salvage 1988, p. 517). The response of many nursing theorists was to develop yet another set of criteria or ‘traits’, which could then be used to demonstrate that nursing did, in fact, meet the criteria and should, therefore, be recognised as a true profession (see, for example, Smith 1981). It was clearly an uncomfortable position for nursing, whose spokespeople were constantly on the defensive in a theoretical world seemingly dominated by ‘gatekeeping’ sociologists.

Recent work by Ann Witz has broken with this mould. She has grappled with the issue of gender and the professions directly, and has developed a very different approach to interpretations both of the past and of analyses of the present and future (Witz 1992, 1994). She puts the case for a theory of professionalisation ‘that can cope with the fact that women as well as men have engaged in professional projects’ (Witz 1992, p. 37). In terms of the history of modern nursing, she has analysed the various political strategies of nursing leaders as strategies of ‘dual closure’. This term refers to the double focus of the strategy: on the one hand, members of the group resist domination from above and seek to extend their territory; on the other, they seek simultaneously to close off the occupation and to restrict entry to its ranks (Witz 1992, p. 201). She goes on to argue that, while there are elements of historical continuity in nursing’s occupational strategy, there is also an important new element. This is the emphasis on the content of nursing work, which, she argues, represents a bid to establish practitioner autonomy in the daily practice of nursing work (Witz 1994). This strategy, and the type of practice that is envisaged for nursing, has come, at least in the United Kingdom, to be called ‘the New Nursing’.
New Nursing

The origins of New Nursing can be found in the United Kingdom in the 1970s, as new departments of nursing in universities and polytechnics generated interest in nursing theory (Salvage 1992). In the publications that emerged from these academic environments, several clear themes were evident. Salvage expresses these succinctly when she notes that:

[in these publications, the key to the New Nursing is held to be its clinical base. The bureaucratic occupational model must be replaced by a professional one, with the practitioner as its linchpin; preparation for this demanding role is to be achieved via education. This 'new animal' should have greater autonomy at the centre of a new division of labour; no longer should a position of seniority mean leaving direct patient care (Salvage 1992, p. 11).

The other central point about the New Nursing is that the theoretical base for its practice moves away from the biomedical model towards a holistic approach that enables, indeed, requires, the patient's active participation in their own care. The advocates of the New Nursing have met with a significant, though uneven, degree of success so far. There are at least three outcomes in the United Kingdom, which can be traced to successful lobbying on the part of New Nursing advocates. First, there were the proposals contained in the Project 2000 Report (Macleod et al. 1996) and the subsequent reforms implemented as a consequence of the Report. At the time the Project 2000 report was published, it was hailed as an important reform that would give nurse education priority over the needs of health service delivery systems. The aim of Project 2000 was to change the 'learning on the job' system to one in which nurses became full-time students in either diploma or degree courses at universities. It was hoped that this would make nursing a more attractive option for those of a more reflective and academic bent. As well as the older universities, such as Manchester, Edinburgh, and Nottingham, which had been offering nursing degrees since the mid-1960s, degree courses proliferated among the newer universities. Unfortunately, this important reform has seemingly been sabotaged in its implementation. Student nurses have found themselves in a difficult position in having to maintain a heavy work schedule while keeping up with their academic program. They also have to survive on a bursary (state allowance), which most students consider inadequate. In addition, arguments that the Project 2000 reforms protected students from being exploited as 'an extra pair of hands' were contradicted when it emerged that 45 per cent of nursing students were regularly left unsupervised on wards. Is it any wonder then that, when surveyed, 78 per cent of students thought that students should be employed (and thus properly paid) by the National Health Service (NHS) (quoted in Har 2004, p. 240)? While the problems are real enough and need urgent rectification, the move to education in the tertiary sector does represent an important advance for nursing.

Second, professional nursing bodies and unions have made successful efforts to encourage the government to introduce a new clinical career structure for nurses. This proposal gained impetus in 1988, when a campaign and industrial disputation developed around this issue.
These initiatives resulted in only a partial victory. While ‘nursing’ achieved success and gained a clinical career structure, many individual nurses did not do as well. The problem, once again, can be found in the implementation of the reform, in particular the allocation of individual nurses to the new grades. Hart (2004, p. 78) gives the example of two ward sisters who had worked side by side and managed the ward between them. Only one could be allocated to the highest grade and receive the 28 per cent pay increase, while the other nurse was left on the same grade with a meagre 4 per cent increase. This and other anomalies occurred because the emphasis was very much on managerial responsibilities rather than real clinical work. It left many nurses bitter and disillusioned. Nevertheless, it was an important achievement and one that delivered an overall pay increase of 15.6 per cent to nurses.

Third, there have been reforms and changes leading to enhanced autonomy of practice for nurses, and, in particular, innovations regarding the nurse practitioner role in primary health care. While many are employed by GPs, their greater level of autonomy allows them to see their own patients and be involved, for example, in chronic disease management. Many have also become experts in their own specialities, with management responsibilities in infection control, family planning, asthma clinics, and crisis work in mental health. In addition, the United Kingdom Central Council announced in March 2000 that the number of nurses recorded as having nurse prescribing qualifications on the register, rose from 2177 to 10,293 during that one year (Hart 2004, p. 17).

Nurse prescribing has indeed been another important initiative in expanding the role of nurses. First piloted in the United Kingdom in 1994, it was not until 2000 that the Government announced an allocation of £10 million to train up to 10,000 nurses and vest them with new prescribing powers (Hart 2004, p. 140). This can be seen as a key part of the Blair Government’s health policy, which places emphasis on the need to examine the existing mix of skills in the NHS, develop enhanced roles for nurses, and break down existing demarcations between medical and nursing roles (Lewis 2001). None of these initiatives have occurred without suspicion and opposition from at least some sections of the medical profession. The development of ‘Walk in Centres’ is a good illustration of the difficulties that beset advances in nurses autonomy.

Walk in Centres are funded by the NHS, are nurse led and staffed, and provide primary care services without an appointment. Most offer assessment and treatment for minor illness and injuries and information about other services (Mountford & Rosen 2001). While they have existed in both Canada and the USA for many years (and have been more doctor-led in both places), the impetus in the United Kingdom came in 1999 with an announcement by Prime Minister Blair that thirty-six pilot sites had been approved for establishment across the nation. Up to £30 million was made available in the first year to fund the initiative. Walk in Centres provide many of the opportunities for extending the nursing role, which advocates of New Nursing have lobbied for. Nurses are required to diagnose and treat patients and to manage a varied case mix. Nurses at the Walk in Centres use protocols called ‘patient group directions’ to prescribe and supply medications to patients. In one specific development, associated with the Swanage Community Hospital, nurses combined running a minor injuries unit with taking over GPs’ out-of-hours calls, using computer-generated prompts for taking clinical histories and protocols for
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randomised control trials (RCTs)
A biomedical research procedure used to evaluate the effectiveness of particular medications and therapeutic interventions. ‘Random’ refers to the equal chance of participants being in the experimental or control group (the group to which nothing is done and is used for comparison), and ‘trial’ refers to the experimental nature of the method. It is often mistakenly viewed as the best way to demonstrate causal links between factors under investigation, but privileges biomedical over social responses to illness.

In evaluating the success of New Nursing thus far, it is important to note the gains, as well as the limitations and retreats. There is now evidence through randomised controlled trials (RCTs) that indicates that care by nurse practitioners is similar in quality and cost to that provided by doctors. Also, there is evidence showing that patient satisfaction with nurse practitioners’ care is comparable, if not higher, than the care provided by a doctor (Lewis 2001, p. 5). Initiatives such as Walk in Centres, NHS Direct, and nurse-led primary care are now part of nursing experience and the history of public policy. Much will clearly depend on proof in the longer term of their cost effectiveness, as initiatives arising from a nursing agenda historically have been successful only when they have coincided with wider political and administrative concerns (Dingwall et al. 1988). As we shall see, this qualification also applies in Australia. For example, in an environment of increasing cost pressures, there are indications that concerns about impediments to efficiency and productivity in health care delivery may provide sections of the state with reasons to support nursing goals in certain areas. These areas include changes to work organisation, skill development, and occupational demarcations, especially the removal of restrictive work practices on the part of doctors, which have been identified as a barrier to efficiency in health care settings. This could well be pivotal for the long-term success or failure of New Nursing.

Another area where there is potential congruence between the aspirations of nurses and the economic interests of the state is in the opening up of portals of entry into medicine. An ‘access to medicine’ course, started in 1993 in Britain, which aims to encourage mature students to enter medical training, reports that most of its intake are nurses and that numbers applying are on the increase. The one-year, full-time course at West Anglia College, King’s Lynn, consists of physics, chemistry, and biology up to A level standard. The director of the course has stated that while the course is ‘very tough’ and that students have to get a distinction in all subjects, they have had ‘an amazing response’ from nurses (Snell 2000). In the year 2000, there were seven nurses and two midwives out of a class of sixteen, who, between them, won twenty-three
offers from medical schools. Snell argues that the popularity of this course among nurses is a further development in the process of the two professions of nursing and medicine moving closer together. Wicks (1999) offers a different perspective on the same theme when arguing for a three-year generic course for all health workers before students undertake specialist, graduate courses in medicine, specialist nursing, or other health professions.

New directions for nursing in Australia

While it can be said that New Nursing is making uneven advances in Australia (though the term itself does not appear to have wide usage in Australia), it can also be said that, overall, the advances here are actually more substantial than in the United Kingdom. There are at least five areas in which it is possible to see changes—where the philosophy of New Nursing has provided the theoretical or ideological impetus behind political pressure contributing to change. This is especially apparent in areas in which there has been congruence between nursing and state or administrative agendas. The first area of change has been the transfer of nurse education to the university sector. The move began in New South Wales in 1985, and is now complete across Australia. While the courses began as diploma qualifications, they have now all been upgraded to degree level, and so the damaging split between graduates with diplomas and those with degree qualifications has been avoided here. It is true to say that a major factor in the transition from ‘on the job’ training to university education was economic considerations. In an inspired move, the New South Wales Nurses Education Board (NEB) changed its arguments concerning the need for change, moving away from the perceived advantages for nurses and towards its cost-cutting potential. In a carefully argued piece of research, the NEB argued that, once established, it would be ‘cheaper and more efficient to staff hospitals with fully trained nurses’ (NEB 1980, p. 70). The change in nurse education was announced within three years of the release of this document.

It is a widely held view, and one held by many sociologists, that economic considerations were the sole reason for the transfer. Elizabeth Herdman, for instance, states that ‘it is difficult to perceive the decision in other than economic terms’ (1995, p. 65). While economic considerations were clearly central to the decision, theoretical insights from within sociology, concerning the nature of the state, can further enrich this analysis. Over the last two decades there has been some important work published on what might be summarised as the dynamic and contradictory nature of the state in terms of gender and other relations. Susan Franzway and others make the point that: ‘the state is culturally marked as masculine and functions largely as an institutionalisation of the power of men, especially heterosexual men. In that sense it is patriarchal…Yet this institutionalisation is uneven and generates paradoxical reversals, in which the state participates in constituting antagonistic interests in sexual politics and can become a vehicle for advancing those interests’ (1989, p. 41).

This view can be seen as one in which the state is regarded less as a monolith of class or patriarchal power than as a constellation of competing interests, with outcomes that are historically and nationally variable (Witz 1992). In this light, it is possible to see this and other
achievements of the New Nursing, partly as the result of the changing nature of the state, which can no longer ignore the interests of a large group of working women. It also acknowledges the central role of nurse leaders, who successfully harnessed the appropriate arguments at the right time. This, surely, is the nature of effective political action. Rather than detracting from their achievement, the successful linking of nursing interests with the interests of sections of the state might also be seen as evidence of clever political acumen. It is also true that these advances can be reversed through contradictory pressures acting on and through the state. One such reversal can be found in the bombshell announcement of June 2004, that the University of Sydney would cease to accept nursing students from the following year (Sydney Morning Herald, 9 June 2004). The reasons for this can be found in the cutbacks in funding for the university sector from the federal government over several years, which has meant that universities are under pressure to raise their own revenue, mainly through student fees. Given that universities are not permitted to charge fees for nursing courses, it made economic sense for this university (and perhaps others) to focus on their more lucrative courses. Is this the first step towards the stated preference of Dr Brendon Nelson, Federal Minister for Education, to move nurse education from universities to TAFE? If so, it would be a significant reversal of hard-won gains for nursing.

Second, the implementation of the New Nursing in Australia has also created a clinical career path for nurses, as part of the Public Hospital Nurses (State) Award (1986), which includes the creation of ‘specialist’ and ‘consultant’ positions. These positions carry not only enhanced status but also financial recognition. Third, the category of ‘women’s health nurse’ has been created. In 1987, the New South Wales Department of Health decided to prepare family planning health practitioners (who had received a very positive response from consumers) for a broader primary health care role. In addition to providing a wide range of services—including Pap smear collection, vaginal and pelvic examination, the fitting of diaphragms, pregnancy testing, and the issuing of oral contraceptives (under authorisation)—women’s health nurses would receive additional training, which would allow them to provide services in the fields of counselling and health education. As a result of vociferous opposition from some sections of the medical profession, the autonomy of these nurses was encroached upon, but not removed.

The fourth area of achievement that can be related to New Nursing has been the establishment of conjoint chairs of clinical nursing at teaching hospitals and universities. At the time of writing there were sixty-seven chairs of clinical nursing in Australian universities, and a significant number of these are associated with teaching hospitals. One of the earliest of these appointments was that of Professor Judy Lumby to the E. M. Lane Chair of Surgical Nursing, Faculty of Nursing, at the University of Sydney, Concord Repatriation Hospital. Lumby comments:

my work with surgeons to develop an interdisciplinary skills laboratory in which nurses, doctors and allied health professionals can learn together is evidence of a joint commitment to a paradigm shift regarding individual and joint roles. This reconceptualisation places the patient in the centre of a web of professional care coordinated for the best possible outcomes. When the focus moves from the needs of a professional group to the needs of patients then we will know that the shift is beginning (Lumby 1996, p. 5).
While Lumby also talks about opposition to role changes, even in areas that have been assessed and have been found to be successful in terms of health outcomes, the fact that surgeons are sitting down with nurses and talking about joint learning opportunities is a huge achievement, and one that would have been unimaginable 25 years ago.

Finally, the establishment of an independent nurse practitioner role is advancing space in Australia. The National Nursing Organisations define the nurse practitioner as ‘a registered nurse who has been authorised by the State or Territory regulatory authority to use the title. The authorisation process should ensure that the registered nurse applying has: (a) undertaken appropriate postgraduate education or equivalent to support their practice; and (b) provided evidence of their ability to consistently practise autonomously and at an advanced level within an extended role’ (National Nursing Organisations 2003).

The nurse practitioner program provides specialist nurses with greater clinical powers, including the power to prescribe certain medications, order diagnostic tests, and refer patients to other health care providers without the approval of a doctor. Despite extensive consultation, and in New South Wales the requirement for ‘a local agreed need’ to be present from all relevant stakeholders (including GPs) before a nurse practitioner can be appointed to an area, medical organisations continue to complain about the role and the placement of nurse practitioners. In a joint statement, the New South Wales AMA, the New South Wales faculty of the Royal Australian College of General Practitioners, and the Australian College of Rural and Remote Medicine have called on the New South Wales government to allow nurse practitioners only where there is a locally agreed need and only where a doctor cannot be found. This is clearly an attempt to limit the allocation of nurse practitioners to those areas where doctors do not wish to be located. How this situation develops in future years will depend on the ability of nurse practitioners to deliver high quality, cost-effective care in a way that brings them significant public support. Whatever happens in the future, the establishment, in law, of this expanded role for the nurse is a highly significant achievement for nursing in Australia.

Conclusion: towards a more productive relationship?

For nursing, recent developments in sociology—notably the concern with agency and practice in connection with the formation of social structure, the incorporation of ideas from post-structuralism into feminist theory, and the integration of theories of gender into analyses of occupational strategies such as professionalisation—have created the potential and rationale for some theoretical bridge-building across the two disciplines. But it is important to note that this need not be a one-way relationship. In the same way that nursing stands to gain greater clarity and understanding by looking at various aspects of nursing through a sociological lens, sociology has much to learn from nursing. Nursing is a complex and fascinating occupation, which is at an exhilarating

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and yet dangerous moment in its history. For sociologists, nursing exemplifies several significant social issues of the early twenty-first century: the issue of human agency, the role of gender in occupational strategies, the role of the state in constructing gender relations, the issue of the uses and dangers of essentialism (which in nursing is inherent in the attempt to value care at the expense of cure), and the nature of power. These are only some of the central issues that are encapsulated by nursing and its problematic relationship with medicine, with other health occupations, and with patients. Nurses are at the cutting edge of gender relations in health care. As they will tell you, it is not a comfortable position in which to be. In practice, nurses are working out political solutions to many of the theoretical conundrums facing sociology. Given the potential for mutual enlightenment, it might be worth working a little harder on this relationship.

### Summary of main points

- Historical developments in sociological theory have affected sociological views of nursing.
- ‘Classic’ sociological and feminist interpretations of nursing have emphasised the overwhelming power of social structure at the expense of an account of nursing agency. This has led to an uneasy relationship between nursing and sociology.
- Recent developments within sociology in general, and feminist theory in particular, have led to a refocus, away from structure and towards nursing agency and resistance.
- At the same time, there has been a shift within nursing to focus on the content of nursing work in order to establish a case for practitioner autonomy.
- These developments illustrate that the time could not be better for both disciplines to reassess what they might fruitfully learn from each other.

### Sociological reflection: The doctor/nurse game

The term ‘doctor/nurse game’ was coined by Stein (1967) to suggest that nurses have long influenced health care and patient treatment in significant yet indirect ways.

- What are some examples of the ‘doctor/nurse game’?
- Why was it necessary? Do you think it still exists?
Discussion questions

1. How do you understand the term ‘agency’ in the context of nursing work?
2. Describe the rules of the doctor/nurse game.
3. What is ‘dual closure’, and how does it relate to nursing?
4. What is new about ‘New Nursing’? How far has it come in Australia?
5. In what ways do nurse practitioners represent a challenge to medical dominance?
6. Is autonomy for nursing practice a good thing for patients as well as nurses? Illustrate your answer with examples.

Further investigation

1. Outline two different approaches to nursing history and analyse their implications for a sociological understanding of nursing today.
2. Discuss and apply the sociological theory or theories that best enable us to understand the current position of nurse practitioners in Australia.

Further reading and web resources


Web sites

Australian Nursing Federation (ANF): <http://www.anf.org.au>
New South Wales Nurses’ Association: <http://www.nswnurses.asn.au>
United Kingdom Royal College of Nursing: <http://www.rcn.org.uk>
United Kingdom Department of Health: <http://www.doh.gov.uk>