The deskilling of registered nurses: the social transformation of nursing work in a New South Wales hospital, 1970-1990

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ABSTRACT

This study tests the validity of the enskilling thesis as it applies to registered nurses in a major New South Wales public hospital from 1970 to 1990. From a critical sociological perspective it examines the social transformation of nursing work during this period.

A major problem in nursing literature, past and present, is the fact that the experiences of the practising nurse have been obscured by the dominance of the idealised image of nursing which focusses on the 'ideal' rather than the experiences of the practising nurse.

As a case study of nursing work this thesis builds upon feminist analyses of sex-based occupational segregation and Braverman's 1974 analysis of the transformation of the labour process under monopoly capital to examine how patriarchy and deskilling operate within the workplace. By examining the transformation of nursing work within the context of professionalisation and rationalisation the study reveals how both internal and external forces influence the nature of change within an occupation.
Using the methods of ethnography, which include participant observation, in-depth interviews and analysis of nursing discourses this study enables registered nurses to describe their reality of nursing work.

By examining the nature of nursing work from the perspectives of nurses' experiences in an organizational setting within the wider social context the study provides an alternative to the enskilling thesis. Instead it provides evidence that registered nurses have been deskill in the following ways:

Registered nurses now carry out the work previously carried out by student nurses.

Registered nurses are increasingly engaged in work that is also carried out by workers without formal qualifications.

Work previously carried out by registered nurses has been taken over by other health workers such as occupational therapists, physiotherapists, dieticians and specialist nurses.
There is a separation between conception and execution in nursing work that prevents registered nurses from attaining autonomy or control over their work.

Moreover, this study reveals the fact that the rhetoric of the dominant groups in nursing does not reflect the reality of nursing experience as it affects the majority of practising nurses. The idealised image of nursing reflected by the dominant nursing discourse obscures the conflict and power struggles that are constantly play within nursing.
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CHAPTER ONE

INTRODUCTION: The Enskilling Thesis

This study is an historically grounded sociological analysis of the transformation of nursing work in a New South Wales hospital. It examines the proposition that nursing work has become enskilled due to advances in medical technology.

The study emerged at a time of crisis and contradiction within the New South Wales health care system in general and nursing in particular. When this study began in 1989 the crisis was one of a severe and prolonged shortage of registered nurses prepared to work in the New South Wales health system (Lockwood, 1982; Burns, 1985; Ridgeway, 1987; Dewsbury, 1990). In 1992, at the completion of the study, there exists in New South Wales a serious problem of unemployment for trained nurses as thousands of nurses graduate from New South Wales universities to work in a health system which has few vacancies. At the time of the shortage specific work conditions existed for registered nurses. Policy changes that were designed to alleviate the shortage had proved futile (Battersby et al, 1990:7). The proposals were largely based on the dominant assumptions in nursing rather than the experiences of practising nurses. At the beginning of 1992 state government rationalisation of the health system, which
resulted in cutbacks and bed closures, created unemployment for registered nurses and a low turnover rate for the hospitals that formerly could not attract sufficient nurses to staff their wards. In other words, the same or worse conditions exist at an organisational level in 1992 as those which created the crisis characterised by high turnover and staff shortage in 1989. The combination of low job satisfaction and low vacancy rates may have important ramifications for the quality of care provided by nurses. Mackay suggests, "the policy makers and planners may want to know why nurses leave, but a more realistic perspective is why do they stay?" (1988:132). Preliminary analysis suggests that it may be necessary to look beyond the dominant assumptions of nurse leaders and to the experiences of nursing work itself in order to examine the current crisis in nursing more adequately.

This study is primarily concerned with the meaning and experience of work carried out by registered nurses in a New South Wales hospital between 1970-1990. Theoretically it focuses on power and knowledge, occupational subordination and deskilling within the context of nursing in New South Wales. It will examine the locus of power within nursing, strategies of professionalisation and the attempts by dominant groups within nursing to define what is to be taken as 'nursing knowledge'.
Using a case study of nursing work the study builds upon feminist analyses of sex-based occupational segregation (Hartmann, 1976; Gamarnikow, 1978; Beechey, 1978) and Braverman's 1974 analysis of the transformation of the labour process under monopoly capital to examine how patriarchy and deskilling operate within the workplace.

The main theoretical impetus for this study is the work of Braverman (1974) on deskilling. Braverman observed major contradictions in the popular notion that modern work requires an increasingly skilled workforce. His own experience, and a subsequent review of the relevant literature, convinced Braverman that the reverse was the case. He perceived that workers were increasingly alienated by work that was routine and fragmented.

"The apparent increase in active dissatisfaction has been attributed to a number of causes, some having to do with the characteristics of the workers—younger, more years of schooling, "infected" by the new-generational restlessness—and others having to do with the changing nature of the work itself."

(1974:35)

The labour process failed to sustain the interest of workers as management took greater control of the labour process.

My own work experience as a registered nurse parallels that of Braverman. It has suggested that nursing work is failing to sustain the interest of registered nurses in New South Wales.
They were leaving the public hospital system at a rate unprecedented in New South Wales history (Lockwood, 1982; Burns, 1985; Ridgeway, 1987; Dewsbury, 1990). A review of the literature on nursing reveals similar assumptions to those encountered by Braverman. Many presume that higher levels of education are required by nurses in order to cope with increasingly complex work. In 1970 the Truskett Committee released a report recommending changes to nurse education in New South Wales. Amongst other recommendations the committee called for educational entry standards to be raised (Truskett Report, 1970:10). Assumptions based on the enskilling thesis are evident in a number of nursing reports. The 1975 Australian Health Manpower report claimed that the role of the nurse in the future would be greatly expanded as "more nurses will need to develop specialist skills in the face of ever advancing technology" (1975:153). The Sax Report of 1978 also suggested that nurses must keep abreast of expanding knowledge and technology.

In 1980 the Nurses Education Board claimed that

"The literature on the role of the nurse is unanimous in proclaiming an increasingly complex, responsible and expanding future role, both within the traditional hospital setting and in newly developing areas of health care."

(1980:5)

The terms of reference of the Marles Report of 1988 includes an analysis of
"the changing role and nature of the nursing profession to which advances in medical science and the increasing application of technology in patient care have contributed."

(1988:vii)

The question this study seeks to answer is whether this 'enskilling thesis' is supported by the 'reality' of nursing work as experienced by registered nurses in a major Sydney teaching hospital from 1970-1990.

Nursing work has been chosen to extend the Braverman deskilling thesis for several reasons. Firstly, it will examine how the insights of Braverman can be extended beyond blue collar and clerical work to include service occupations in the public sector. Secondly, the focus on nurses will examine how gender ideology and notions of professionalism can contribute to the deskilling of women. Thirdly, the focus on nursing will determine whether deskilling affects women in different ways to men in the same occupation. This case study aims to make a contribution to the mounting studies of work and occupations in the Australian context. Game and Pringle (1984) considered the applicability of deskilling in all their case studies about women in the labour force since World War II. Butler (1988) examined the implications of technological change in white collar office work in terms of skill and Williams (1988) explored a range of themes, including
deskilling, for a variety of service workers including technicians, technical workers, clerical workers and flight attendants.

Nursing is traditionally regarded as women's work. It is numerically dominated by women but totally subordinate to men in the form of the male dominated medical profession and increasingly in the form of male nurses who dominate positions of power and autonomy (Herdman, 1982; Hearn, 1982). New South Wales nursing is undergoing a transformation between the balance of men and women and so provides an opportunity to examine this process in action.

Nursing involves emotional labour with 'humans' as the 'raw materials' who are transformed in the labour process into human outputs (Dressel, 1987:294). This is a relatively new area of research and must be taken into account by allowing nurses to express their feelings based on their experiences of nursing work.

This study will present an historically grounded sociological analysis of the transformation of nursing work in a New South Wales hospital from 1970 to 1990. It is a feminist labour history that works within the perspective of critical sociology. This will not be an overview of nursing history as such but rather a 'critique of ideology' which examines the nature of nursing historiography and current nursing research. It will
determine whether they have taken into account the experiences of nursing work for the majority of nurses.

This study will test the validity of the 'enskilling thesis' as it applies to nursing. In order to do this the effects on nurses of 'professionalisation' and 'rationalisation' will be examined. Professionalisation must be examined in terms of its effects on the labour process as a whole. The traditional approach to professionalisation overlooks issues of power and conflict (Johnson, 1974). Following the traditional professions such as medicine, nursing has pursued professionalisation using educational strategies and a career structure based largely on the medical model (Short and Sharman, 1989). The result is an increase in specialisation of nursing with the creation of a small group of elite nurses with specialist and consultant status. This study focuses instead on the majority of registered nurses who do not form part of this elite.

The rationalisation of the health system based on the need to control costs has resulted in an increased exploitation of registered nurses who work alongside health workers without formal qualifications to carry out the same unskilled work. The study also examines the fragmentation of nursing work within the context of rationalisation. "Specialisation" and "fragmentation" are known to have a major impact on deskilling which is in turn a factor in reduced job satisfaction (Littler, 1982).
An essential component of this study is the nature of nursing work. To determine whether there is any evidence to support the 'enskilling thesis' in the workplace it is necessary to adequately conceptualise and measure 'skill'. Phillips and Taylor suggest that,

"Far from being an objective economic fact, skill is often an ideological category imposed on certain types of work by virtue of the sex and power of the workers who perform it". (1986:54)

"Skill' appears to be based more on the relative power of competing groups including unions, employers, governments and workers and in the case of nursing it is important to identify where power resides. Beechey (1982) defined 'skill' as comprising objectively defined competences, control over conception and execution and socially defined occupational status. Using ethnographic methods including participant observation an examination of the nature of nursing skills will be carried out. Tasks performed by nurses as part of their daily work experience will be observed. The means by which these tasks are learned, who performs them apart from registered nurses and who decides how they will be performed will be examined. The use of in-depth interviews will determine whether nursing work has changed over time. In order to determine whether nurses require greater skills to perform
nursing work today compared to in the past the following questions will be asked.

(1) What changes have occurred in the nature of the work carried out by registered nurses? Who performs the work previously carried out by student nurses?

(2) Is there a clear demarcation between the work carried out by registered nurses and workers without formal qualifications?

(3) Have other health workers such as physiotherapists, occupational therapists, dieticians and specialist nurses taken over the work formerly carried out by registered nurses?

(4) Do registered nurses have any autonomy over their work?

In building on the work of Braverman this study introduces the subjective dimension by concentrating on the nature of nursing work as experienced by 'bedside' nurses. Braverman emphasised 'management control' and paid little attention to opposition from the worker. By examining the concept of hegemony as conceived by Gramsci (1972) I will explore the extent to which nurses consent to their own exploitation as well
as the ways nurses resist exploitation. Burawoy (1979) revealed the nature of active participation in the production process which he claimed could not be explained purely in terms of economic instrumentalism or socialisation. Burawoy's work does not suggest resistance but a means by which workers create a meaningful existence within exploitative relations which are obscured. Turner's 'vocabulary of complaints' serves a similar purpose for nurses (1986: 368-86).

Burawoy's work is important because it reveals how control by management can be relaxed with the development of a system of consent. In the case of nursing, control was traditionally in the form of consent based on altruism and dedication. The professional model of control is based on 'commitment'. Nurses are socialised into a professional ideology which forms the basis of their exploitation (Reverby, 1987).

If this professional ideology is in conflict with the work experiences of registered nurses nurse leaders may perceive a problem of 'commitment' which requires different mechanisms of control. This study will examine the changes in the award structures and employment conditions of registered nurses to examine whether there has been an increase in the level of bureaucratic control over registered nurses in a New South Wales hospital.
An important element of this research is the experience of nursing work as described by registered nurses. The attention to nurses and job satisfaction is due to the link between nursing numbers and standards of care. Staff shortages and high turnover rates can affect the quality of care that is provided. More important however, and perhaps more difficult to quantify is the effect on patient care of adequate numbers of nurses who are dissatisfied with nursing work. If the turnover rate is low because of low vacancy rates caused by government cutbacks nurses are 'trapped' in positions that may cause them extreme dissatisfaction. An extensive review of the literature on job satisfaction and nursing reveals many demographic variables that impact on levels of job satisfaction. These include age, marital status, level of education, length of time employed by an organization, position in the organization and type of work performed (Braito and Caston, 1983; Battersby et al, 1990). In contrast to most of these studies which use quantitative research methods, and taking these variables into account, this study will use in-depth interviews and participant observation in order to enable nurses to express in their own terms their attitudes to nursing work. This data will be triangulated with a discourse analysis of nursing journals, research articles and nursing reports in order to examine the validity of the enskilling thesis identified here.

The next chapter presents the theoretical background to the study which operates within the framework of critical
sociology. This perspective draws on and incorporates a number of perspectives including feminism, Marxism, Weberian theory and phenomenology.

Chapter Three presents a literature review in which nursing historiography is examined to reveal the assumptions on which the dominant nursing groups base their notions of what nursing was and is. Current nursing literature and research are also examined in order to determine the scope and nature of the enskilling ideology in contemporary nursing.

Chapter Four outlines the methods used to gather the data. Participant observation, in-depth interviews and discourse analysis are the principal research methods utilised in this study. This is in line with the methodological approach outlined in chapter two.

Chapter Five describes the results based on the data collected during a twelve month period of participant observation in a ward of a major Sydney hospital. It also outlines the results of the in-depth interviews with twenty-three registered nurses, the analysis of relevant policy and procedure documents and the discourse analysis of nursing literature.

Chapter Six analyses the data collected in order to test the proposition that nursing work became increasingly complex in the hospital under examination between 1970 and 1990.
Chapter Seven presents the conclusion in which all the evidence for and against the 'enskilling' proposition in nursing is examined.

We now turn to the theoretical background to the study.
CHAPTER TWO

A CRITICAL SOCIOLOGICAL PERSPECTIVE

Introduction

This chapter sets out the theoretical background to the study as a whole. The framework for this study is critical sociology, an approach to the study of sociology which incorporates a plurality of perspectives including feminism, Marxism, Weberian theory and phenomenology. A basic assumption of this approach is that the events of life cannot be fully understood unless related to the historical and social context. It is an historical social theory that aims to analyse cultural constraints, organisations and structures in order to transform them into those that are emancipatory. (Fay, 1987:4).

Critical Sociology

Brian Fay suggested the use of the term 'critical social science' to distinguish it from the critical theory of the Frankfurt School as a form of contemporary social theory. In his examination of the foundations of critical social science he described it as....

"...an attempt to understand in a rationally responsible manner the oppressive features of a society such that this understanding stimulates its audience to transform their society and thereby liberate themselves." (1987:4)
Critical sociology was inspired largely by the Frankfurt School and the call for a more practical, relevant approach to the study of society by scholars from a variety of traditions of thought. These include hermeneuticians such as Dilthey and Gadamer, reflexive sociologists such as Weber and Gouldner and phenomenologists and ethnomethodologists such as Schutz and Garfinkel (Sabia et al, 1983:4).

The 'critical theory' of the Frankfurt School is a substantive, neo-Marxist theory of advanced capitalism which was developed in Germany from the Institute for Social Research at the University of Frankfurt in the 1920s and 1930s. This group called themselves 'critical theorists' to distinguish themselves from the positions that dominated European intellectual thought and the marxists of Stalinist Russia. The 'critical theorists' opposed all forms of positivism which they said made three main claims. First, that natural-scientific knowledge is the only form of valid knowledge. Second, that natural-scientific knowledge is 'objective', independent of choices, norms and values. Third, that the realm of choices, norms and values is therefore intrinsically distinct from science and from rationality itself. 'Critical theorists' aimed to refute the above knowledge claims. (Fay, 1987) Positivists believe that there is no rational or 'scientific' justification of values. 'Critical theorists', on the other hand, aimed to create a critical theory of society that was opposed to the claims of positivism by showing the
connection between rationality and values rather than the impassible logical gap.

Critical sociology, as a form of contemporary social theory, has its most sustained expression in the works of the Frankfurt theorists, however, it must not be confused with 'critical theory' as such. Critical sociology opposes much traditional social theory because it believes they are largely a justification for existing institutions and practices in capitalist society. It sees its task as one of 'unmasking' the discrepancy between the formal values and aims of contemporary institutions and actual practices. It aims to expose those institutions that do not live up to the promises of their formal principles. It is clearly possible to subscribe to the tenets of critical sociology as metatheory but to reject the ideas of specific critical theorists.

Fay suggests that "critical social science wishes to understand society in order to alter it, and it wishes to do this in a scientifically respectable way" (1987:4). He believes that the theories of critical sociology are scientific in the sense of providing comprehensive explanations, subject to empirical evidence, in terms of a few basic principles. Theories of critical sociology are critical in the sense of offering a negative evaluation of the existing social order, and practical in the sense of stimulating members of a society to change their situation by raising their awareness of the conditions that can form the basis of
Critical Theory was the search for a "third road" rejecting both positivism and idealism (Van den Berg, 1980:449-50). In a similar way critical sociology tries to steer a middle road between idealism and the "epiphenomenalism of traditional sociological materialism" (Fay, 1987:25). Critical sociology aims to synthesize these positions with the claim that ideas are a function of social conditions that also play a causal role in creating and sustaining specific social structures. In other words there is a dialectical relationship between ideas and social structures.

A critical sociology incorporates a theory of false consciousness to demonstrate how the self-understanding of a group may be false in that it may fail to account adequately for the experiences of its members. The dominant groups in nursing have historically presented an internally contradictory account of what nursing was and is. A critical sociology can undertake a critique of this ideology using insights from discourse analysis by examining the nature of nursing historiography and contemporary nursing discourse. Macdonell (1986:2) claims that "in any institution, there is a distribution and a hierarchy of discourses". The dominant nursing discourse will be compared with accounts of the experiences of practising nurses in order to examine whether there is a gap between the rhetoric of dominant groups and the reality of nursing for a group of registered nurses.
A critical sociology also incorporates a theory of crisis which reveals both the nature of the crisis and the dissatisfactions that emanate from it. When the crisis threatens the cohesion of the group as is the case in nursing, and when it cannot be eased given the basic organisation of the system and the self-understanding of the members the need for major structural change is clearly demonstrated. The majority of registered nurses are employed in the public hospital system and it is in this system that the highest rate of turnover exists. (Battersby et al, 1990). If the basic organisation of this system fails to sustain the interest of its largest workforce then clearly a crisis exists. This thesis will present an historical account of the development of the existing crisis in nursing in terms of both false consciousness and the structural bases of society.

A theory of education which offers an account of the conditions necessary for the enlightenment of the group is the third component of the critical sociology used here. In-depth interviews with nurses will reveal any reasons for their dissatisfaction and an analysis of these reasons will be linked to the organisation of the system itself.

Finally, a critical sociology incorporates a theory of transformative action which isolates the structural changes that must be made in order to resolve the crisis and the dissatisfaction of its members. It will detail a plan of action that identifies those who will be the agents of change and
how they may achieve this.

Anne Edwards has stated that...

"Common to all state institutional forms and modes of operation in modern capitalism are rationalisation, bureaucratisation and professionalisation and the application of scientific knowledge and technology. (1988:41)

These processes are relevant to an analysis of the form and methods of social control in modern industrial society. To address the issue of rationalisation of the modern world it is necessary to examine contemporary forms to determine the extent to which they exhibit features of rationalisation. The rationalisation of the health system in New South Wales is seen as a major form of bureaucratic control that directly impacts on the working conditions of nurses. Littler (1978:192-3) claims that Taylorism is part of a wider 'rationalisation movement' and that in this context represents the bureaucratisation of the structure of control. He relates Taylorism to the Weberian concept of bureaucracy conceived as the ultimate form of rationalisation. Using the theories of Max Weber this thesis will examine the effects of rationalisation on the hospital system in which the majority of nurses work.

Max Weber (1968) saw the modern world as a product of a long process of rationalisation and intellectualisation. He used rationalisation as a major component of his developmental history claiming that purposive-rational
action had become the dominant mode in modern industrial society. This was expressed in a variety of areas including state administration. The increasing dominance of rational action was referred to as the process of rationalisation. For Weber bureaucracy was the most pervasive expression of institutionalised rationality. Bureaucracy is also a system of control so rationality can be seen as a mechanism of increased control.

Weber (1968) distinguished between 'formal' rationality and 'substantive' rationality. 'Formal' rationality deals with questions answerable by science by an appeal to the facts while 'substantive' rationality deals with questions which science can clarify but not finally decide because they include values. This thesis will examine how the principles of 'formal' rationality guide the actions of hospital management and therefore contribute to the exploitation of nurses who because of both gender and class factors are least able to resist or control the conditions of their employment.

Feminist Analyses of Work

Albrow (1987:170) states that rationality inheres in both practical action and symbolic systems. This includes both professional systems of knowledge and the systematisation of beliefs about the world. This suggests that professionalisation is a dimension of the rationalisation process and therefore also a form of control. As a strategy of
self-interest professionalisation improves the power and status of an occupational group. Domination by experts obscures the self-interest aspect and the attempts by an occupational group to legitimise its power. The process of professionalisation will be examined separately from that of rationalisation, while recognising the link between the two, because of the effects of gender on the professionalisation process. The occupations that have professionalised successfully are male dominated revealing the fact that professionalisation is experienced differently by predominantly female occupations. (Hearn, 1982).

Professionalisation, which is a masculine occupational strategy, may have contributed to the deskilling of nurses in New South Wales by creating a small group of 'specialists' labelled as 'skilled'. The majority of nurses are subsequently prevented from exercising such 'specialist skills' and are labelled 'generalists'. This polarisation of skills is the result of the development of a 'career structure' which is a component of the strategy of professionalisation. In other words it is the result of the power struggle between dominant groups in nursing and employers rather than the existence of concrete specialist skills. It is a clear example of the social construction of skills based on power and conflict. (Daly et al, 1988).

The sexual division of labour has facilitated the deskilling of female nurses as specialisation and commitment to a career tends to advantage male nurses. Professionalisation involves
a 'masculinisation' of values with male nurses tending to veer towards positions of power and autonomy (Hearn, 1982).

Feminist analyses of work are increasingly focusing on the role of ideology and processes of social construction (Beechey, 1987:14). Game and Pringle state that 'gender is not just about difference but about power: the domination of men and the subordination of women.' (1984:16) The development of distinctions between areas that are considered appropriate for males and females sustains this power relation, for example areas associated with technology are considered more appropriate for males. Game and Pringle consider the gender dimension in the struggle between capital and labour and suggest that:

"...an analysis which focuses on deskilling is also likely to represent the interests of the most privileged sections of the workforce to the exclusion of others."

(1984: 17-18)

In the case of nurses, males are emerging as the privileged group with increased career opportunities, and therefore increased power and autonomy. (Herdman, 1982). In their study of nursing work in New South Wales hospitals Game and Pringle claim ....

"Nursing....is in a shifting and constantly renegotiated relationship with domestic and clerical work, and with the work of medical and paramedical staff."

(1984:94)
They suggest that there was a high degree of fragmentation and specialisation within nursing and hospital work in general by the 1960s and that the occupational status of nurses is highly ambiguous. (1984:94-97). Game and Pringle classify nursing work into four categories which remain appropriate for nursing work today. The categories include:

(1) "Housework" which consists of cleaning, bedmaking and work that is generally an extension of the woman's domestic role into the workplace.

(2) General nursing care which involves patient comfort, sponging, showers, bedpans, turns, back rubs, oral and eye toilets and feeds.

(3) Healing functions which include dressings, injections, medications and care of intravenous therapy.

(4) Tests and observations such as the monitoring of blood pressure, temperature, pulse, respirations, urinalysis, electrocardiographs and reports.

Game and Pringle see the separation of specialist skilled areas from the general ward areas as a cause of the polarisation of skills with "basic nursing duties" devolving to lesser qualified occupational categories (1984:99). They also suggest that the transfer of nurse education to the tertiary education sector is a move that is "quite compatible with and is likely to compound the tendency towards deskilling/hyperskilling." (1984:113). Game and Pringle clearly suggest that rationalisation and professionalisation are linked to the deskilling of nurses in New South Wales.
A major flaw in the "Braverman thesis" is the tendency to objectify workers to automatons. His emphasis on total control ignores subjectivity and issues of consent. An examination of the work of Gramsci will help reintegrate the subjective dimension. There is a close link between the theories of Gramsci and the themes integral to the development of "critical theory" and the critical sociology that subsequently developed. There is also a close link between Gramsci's conceptualisation of rationalisation and that of Weber. Gramsci was critical of the objectivist theory of orthodox Marxism. He was anti-positivist, claiming that the 'cult of scientific analysis' had dulled 'the critical edge of theory by rendering it abstract, divorced from action' and that 'the undialectical relationship between subject and object and thought and action ......was the enemy of revolutionary Marxism.' He emphasised the importance of consciousness, opposing 'reified theory' for ignoring the 'subjective side of praxis' (Boggs, 1976:22).

For this study the most important part of Gramsci's work is his notion of 'hegemony'. Gramsci (1971) claimed that domination operates through ideology. He used the term hegemony which means ideological control with the consent of the people. In introducing the notion of consent, as conceived by Gramsci, this study will transcend the objectivist tendency of Braverman and examine whether nurses contribute to their own exploitation. Burawoy
(1985) following Gramsci, revived agency in his analysis of the labour process by revealing the conditions under which consent may emerge. He argued that hegemonic control has replaced earlier forms of control such as despotism. Edwards (1975) demonstrated how new work arrangements have the potential for new strategies of control and that the evolution of bureaucratic control constitutes a major development.

In nursing, the hegemonic model based on commitment to professionalism may be facing a crisis as the gap between the rhetoric and reality regarding nursing work becomes more visible, principally due to deskilling. Are nurses increasingly subject to more direct forms of control, more bureaucratic in form, as it becomes clear to the dominant groups that nursing provides less intrinsic satisfaction than in the past?

Job satisfaction studies attempt to reveal the nature of dissatisfaction in nursing. Using concepts based on the Herzberg (1959) intrinsic/extrinsic theory of job satisfaction this study also examines the attitudes of nurses towards the conditions of their work. An account of how nurses experience nursing will provide the link between their attitudes and their actions. This approach is lacking in 'official' nursing histories and current nursing literature and therefore will provide a fresh analysis of the crisis facing nursing in New South Wales.
Theories of Nursing Work

Models of nursing work are based on modes of work organisation that can be seen to range along a continuum from task allocation to patient allocation, with a variety of combinations of the features of each in between. Task allocation was the primary mode of work organisation associated with the hospital training system. Student nurses were assigned tasks that were in line with their training and experience. Task assignment was based on the perception that a hierarchy of skills existed in the care of patients. Melia (1987) suggests that there is some organisational logic to task allocation as it is a rational response to economic pressures. Early studies of nursing work revealed that it comprised 'affective/psycho-social', 'technical' and 'basic/physical' components. (Goddard, 1953). Grant suggested a dichotomy between 'basic nursing' and 'technical nursing', (1973:83) "basic nursing' involves general nursing care and housekeeping tasks and 'technical nursing' involves tasks that require a higher level of skill. These categories are rejected by nurse academics who claim that they undervalue the basic and affective components of nursing work by giving priority to 'technical care' (McFarlane 1976).

Patient allocation is the mode of work organisation most desired by the dominant groups in nursing such as the educators and administrators. It is based on the assumption
that a private relationship between the patient and nurse along similar lines to the relationship between patient and doctor is the most desirable in terms of quality of patient care and nursing status. In New South Wales the Nurses Education Board (1980:47) has argued that hospitals staffed entirely by registered nurses would provide a higher standard of health care. Patient allocation is based on the 'nursing process', a 'work method' which prescribes, 'assessment, planning, implementation and evaluation.' (Smith, 1988:3).

An examination of the development of the nursing process will more clearly delineate the theoretical bases for both forms of work organisation. De la Cuesta (1983) analysed the history of the nursing process which she claims developed during the 1960s in America principally for teaching purposes. She states that the 'nursing process' is not just 'a theoretical concept but an ideology in the technical sense as well'. (1983:365). In the American context the 'nursing process' acted as 'a coping mechanism' for the discontent felt by nurses. In other words it involved both nursing practice and professional strategy (1983:367).

The 'nursing process' emerged in Britain in the 1970s also at a time of discontent in nursing. It was seen as a solution to the many problems that existed in British nursing. In the British context, however, the 'nursing process' had a different meaning from the American experience. The American focus on intellectual skills and individual
accountability was minimised as the 'nursing process' was seen as a means of solving nurses' problems rather than a process that addressed the needs of the patients (De la Cuesta, 1983:368).

The organisation of nursing work in Britain at this time was based on task allocation. Patient care was based on the relationship between specific tasks and nurse experience rather than nurse and patient. The 'nursing process' is claimed to increase job satisfaction for nurses (Bowman et al., 1983:125-9). Dingwall et al. suggest that empirical evidence for this assumption is questionable because it comes from pilot schemes and may in fact be the result of a 'Hawthorne affect' (1988:216). As a method of practice the 'nursing process' has not been fully implemented in America, Britain or Australia and Dingwall et al. believe that the reason for this is the fact that the nursing elites have failed to consider the 'real conditions of nursing work' (1988:216).

The 'nursing process' must be seen as an ideology that is contextual rather than spontaneously generated. It is necessary to examine the question of job satisfaction from the perspective of the nursing elites whose aim is 'professionalisation'. It is also important to question the reasons for the rejection of the task based system of work organisation in the 1960s. Dingwall et al. suggest two reasons for this rejection. Firstly, they claim that it is a reflection of a wider social movement based on the call for a
more holistic approach to relationships. Secondly, it is a reflection of the 'status anxieties' of the traditional nursing elite which formed the basis of the development of the 'nursing process' as an educational experiment (1988:217).

The traditional nursing elites reconstructed the notion of 'professionalism' in nursing terms utilising concepts derived from the medical model. The assumption of a private relationship between the client and the doctor is expressed in nursing terms along similar lines with the ideal relationship in nursing being best realised through the patient allocation system of work organisation. Proposals for 'primary nursing' ...'represent the most logical extreme of this movement' (Dingwall et al, 1988:220). Task allocation is therefore rejected along 'professional' lines.

"Having captured the language of professionalism it could be used to impose an ideological hegemony on other sections of the occupation".

(Dingwall et al, 1988:217)

Little is known about patients' reactions to the change in mode of work organisation and for this reason Dingwall et al suggest that the 'nursing process' has 'been driven by a desire to solve nurses' problems rather than to respond to those of the patient' (1988:218). They also claim that it is important to note that the most significant advances of 'process nursing' is in the care of specific client groups such as the elderly 'who are least well placed to resist its
There are cost implications associated with the professionalisation of nursing which indicate that it is unlikely to succeed. The 'nursing process' is therefore unlikely to make much progress as a work method. As an ideology, however, the process has some advantages for employers of nurses (Freidson, 1970:22). The individualisation of relationships is a means of disciplining both the patient and the nurse. The 'nursing process' can divide nurses from each other resulting in a reduction in commitment to industrial goals.

The 'nursing process' is also seen as an important tool in quality assurance programmes (Pearson, 1983:82-96; Hayward, 1986:25; Dickson, 1987:25-8). It is seen as devaluing knowledge derived from experience because it denies non-logistic forms of knowledge (Henderson, 1982). It also has great potential for accounting control of nursing (De la Cuesta, 1983) and can be used as an instrument of authority (Donnelly, 1987). Lawler suggests that the irony of the nursing process is the fact that although it is promoted as a tool for the advancement of 'holistic and humanistic practice' it is in fact 'positivist, reductive and mechanistic' (1991:36-7). The significance of the 'nursing process' as a management tool has escaped the notice of nurse academics but the reluctance of nurses to embrace it in practice may indicate that it has not escaped the notice of these practitioners.
Theories of Discourse Analysis

"The kind of speech proper to the shop-floor of a factory conflicts with that of the boardroom."

(McDonnell, 1986:2)

There is a hierarchy of different discourses within nursing. 'Discourse' is defined as the verbal and non-verbal construction of meanings that occur in the wider sphere of ideological practices (Macdonell, 1986:4). This thesis focusses on the plurality of discourses that exist in nursing. The dominant nursing discourse will be contrasted with the 'bedside' discourse which has been largely excluded from nursing literature.

The discourse analysis will examine the effects that different discourses have, the political relations in which they have evolved, the positions held by those who use them and the links between discourses and various institutions. An unmasking of the dominant nursing discourse which claims to speak for all nurses will highlight the inequalities and power relations that exist in nursing.

Thompson lists three features that are common to most approaches to discourse analysis (1984:98). First, most forms of discourse analysis are concerned with 'naturally occurring instances of expression' such as everyday conversation or written texts.
"...it is the actual organisation of the expressions which matters and not the extent to which they concur with some grammatical ideal."

(1984:99)

Second, discourse analysis is concerned with linguistic units that exceed the limits of a single sentence. Third, it is interested in the relationship between linguistic and non-linguistic activity (1984:98-9). In other words, it concerns the social context within which language is used to serve as a medium of control. It is this third feature of discourse analysis that Thompson sees as a 'sociological turn' that makes discourse analysis vital to the study of ideology.

"For if the language of everyday life is regarded as the very locus of ideology, then it is of the utmost importance to examine the methods which have been elaborated for the analysis of ordinary discourse."

(1984:99)

Thompson outlined the development of three approaches to the analysis of discourse from the perspective of linguistics. The first approach centres on the work of Sinclair and Coulthard at the University of Birmingham who formulated a model for the study of verbal interaction. The second approach can be found in the work of Sacks, Schegloff and Jefferson who, influenced by Garfinkel, examined everyday conversation. The third approach is the 'critical linguistics' of Fowler, Hodge, Kress and Trew whose work took into account the "ways linguistic forms reflect and reproduce the social organization of power" (1984:99-100).
The term 'discourse' is also prominent in the work of influential French theorists, in particular, Michel Foucault whose *The Order of Things* (1966) focussed on 'fields' such as natural history or economics rather than on texts or authors. Foucault was interested in the conventions that determined the nature of specific 'fields' and the shifts in these conventions. He rejected the continuities of official histories and the notion that knowledge is a reflection of the essence of things. He outlined his position in relation to language in *The Archaeology of Knowledge* (1972). He conceptualized the way in which certain linguistic elements are linked by a coherence to form and define a distinct field of objects such as madness. These coherent formations are particular repertoires of concepts, specific 'regimes of truth' or definite sets of subject positions. He defines these as discursive practices. Weedon et al. (1986:213) claim that Foucault's theory of discourse analysis presents major difficulties that have important implications for an adequate theory of the role of language and subjectivity in ideologies. In particular it is unclear how the boundaries of a discourse are delimited and how a specific body of statements are assigned a place within a particular discursive practice. They suggest that discourse analysis is most useful in examining tightly defined bodies of knowledge such as medicine where there is less chance of statements remaining ambiguous in relation to their discursive location. (ibid)
Thompson outlines a three phase procedure for the interpretation of ideology which constitutes a form of depth hermeneutics (1984:11). Discourse analysis is the second phase of this process. The first phase is a social analysis that takes into account the social and historical circumstances in which interaction occurs. This is consistent with the approach of critical sociology. In this thesis these conditions are analysed in terms of the institutional features of the hospital in which the study takes place and the historically specific conditions under which the professionalisation and rationalisation of nursing have occurred.

The second phase Thompson refers to as 'discourse analysis' which he describes as 'the study of a sequence of expressions as both a socially and historically situated occurrence and as a linguistic construction". (ibid:11). The third phase is 'interpretation' which he maintains involves transcending the study of discursive structure to construct a meaning which reveals how discourses sustain unequal power relations.

Fraser theorizes a model of social discourse that outlines

"the historically and culturally specific ensemble of discursive resources available to members of a given social collectivity in pressing claims against one another." (1989:164)
These resources include:

(1) The officially recognized idioms in which claims can be made, such as needs, rights or interests talk.

(2) The vocabularies that are available to make claims in the officially recognized idioms such as therapeutic vocabularies, administrative vocabularies, feminist vocabularies.

(3) The paradigms of argumentation that are accepted as legitimate in judging conflicting claims. In other words are conflicts resolved by appeals to scientific experts or by democratic means?

(4) The narrative conventions that are available to construct stories that make up people's social identities.

(5) Modes of subjectification or the ways in which discourses position the people to whom they are addressed as subjects.

(1989:164-5)

In nursing there is a struggle between groups with unequal discursive resources. These groups compete to establish as hegemonic their respective interpretations of their social needs. The dominant groups define a reality that expresses specific needs for all nurses. Their interpretation excludes or obscures any counterinterpretation made by sub-ordinate groups. The dominance of certain groups within nursing is possible not only because of historical and social events but also because of the 'myths' that have evolved about nursing 'reality'. These myths draw on the language of 'professionalism', 'Nightingaleism', 'science' and 'reform'. The dominant groups in nursing which include educators, administrators, unionists and bureaucrats have seized
'power by a dominant tongue within a political multiplicity'. (Deleuze et al, 1976:8). These dominant groups may not be aware of the needs of the majority of practising nurses.

Fraser identifies three kinds of 'needs discourse' which are useful for this study.

(1) "Oppositional" discourses emerge when needs are politicized from below. This helps the formation of new social identities on the part of subordinate social groups.

(2) "Reprivatization" discourses emerge in response to oppositional discourses and articulate the entrenched interpretations or dominant assumptions.

(3) "Expert" discourses link popular movements to the state. These can be seen in the context of institution building and professional class formation.

(1989:171)

This study will examine the means used by nurses to politicise their needs with oppositional discourses. The high turnover rates for registered nurses can be seen as a means of contesting their subordinate positions. The traditional interpretations by dominant groups are clearly in question. By their actions these nurses are contesting the traditional interpretations. They are challenging the hegemony and creating a new form of discourse for the interpretation of their needs. In other words the high turnover is a form of resistance.

Discourse analysis is a vital part of the study of ideology. It reveals how meanings serve to sustain relations of
domination. The methodological procedure presented by Thompson will be elaborated further in the methodology chapter. It combines social analysis and discourse analysis in order to undertake a depth interpretation of ideological discourse (1984:141).

In Summary

In summary this study operates within the theoretical framework of critical sociology. It is an historically grounded sociological analysis of the transformation of the nursing labour process in a New South Wales hospital between 1970 to 1990. The study will examine the dominant assumptions based on the 'enskilling thesis'. It builds upon feminist analyses of sex-based occupational segregation and Braverman's analysis of the transformation of the labour process under monopoly capitalism to demonstrate how patriarchy and the bureaucratisation of control operate within the workplace.

Theoretically, the study examines the transformation of the nursing labour process from three levels. A broad historical contextual analysis will situate the development of nursing in New South Wales within a wider social framework to reveal the structures and processes of domination. This macro-analysis will reveal the power structures that impact on nursing taking into account both class and gender as important components of oppression.
At the second level of analysis, an organisational analysis will reveal the nature of bureaucratic control and the implications for nurses of 'rationalisation' and 'professionalisation'. The majority of nurses are employed by large bureaucratic institutions and it is within such institutions that the effects of 'rationalisation' and 'professionalisation' are felt most. It is also within these institutions that the crisis is most profoundly revealed as nurses are demonstrate their dissatisfaction by abandoning nursing at an unprecedented rate. (Battersby et al, 1990)

Finally, an examination of the nature of nursing work at the micro-level, as described by nurses themselves will bring to light or expose the contradictions that contribute to the crisis. This micro-analysis will form the basis of the critique of the enskilling ideology as the experiences of practising nurses are contrasted with accounts presented by the dominant groups in nursing.

I turn now to review the literature relevant to this investigation of the rhetoric and reality of nursing work.
CHAPTER THREE

THE RHETORIC AND REALITY OF NURSING WORK

Introduction

Critical sociology incorporates a theory of false consciousness in order to demonstrate how the self understanding of a group may be false in the sense that it fails to account adequately for the experiences of its members. This study will undertake a critique of ideology using insights derived from discourse analysis in order to reveal how the dominant groups in nursing have historically presented a contradictory account of what nursing was and is. The 'official histories' will be demystified also as there is considerable power in defining reality historically. The social power of professional groups is legitimised by the construction of historical accounts that justify their emergence. These accounts emphasize certain aspects and obscure others. As this study is an historically grounded sociological analysis of the transformation of the nursing labour process in New South Wales from 1970 to 1990 it takes into account the fact that both women and work are neglected areas of sociological enquiry. This presents a challenge of both substance and method. It will be necessary to counteract the exclusion of women in labour history and organisation theory and to challenge the emphasis on quantitative research methods in favour of a more
exploratory and qualitative approach.

In this study the traditional first step posed a major problem. Just as Braverman's interest in occupational change led him to review the literature on occupations my interest in nursing work led me to search the nursing literature for work related articles, books and reports. Braverman's literature review revealed the need for 'more substantial historical description and analysis of the process of occupational change' (1974:3). My review of the nursing literature revealed a paucity of critical historical or sociological analyses. There are major gaps in nursing historiography and contemporary nursing research. Both present almost a single unified view of what nursing involves for all nurses. A dominant perspective forms the basis of all research, government policy statements, nursing journals and educational curricula (Royal Australian Nursing Federation, 1962; Nurses Registration Board, 1966; The Institute of Hospital Matrons of NSW, 1967, 1969; Chittick, R, 1968; The Truskett Report, 1970; The Sax Report, 1978; Nurses Education Board of NSW, 1980, 1984; The Marles Report, 1988). The assumptions of this dominant perspective include those associated with technological determinism and an adherence to the 'enskilling thesis'. The experiences of the vast majority of practising nurses are largely ignored.

The deskilling of labour and the bureaucratisation of control are essential features of class control. An examination of the
changes in nursing work may reveal the extent to which nursing has followed these general trends. It will also examine whether strategies of professionalisation have facilitated both processes to effectively destroy any possibility of autonomy for the majority of registered general nurses in New South Wales.

While this work is an historically based analysis it is not intended to be a nursing history as such. Instead an analysis of traditional historical perspectives can be compared with recent 'reconstructed' nursing histories (Davies, 1980; Maggs, 1987; Dingwall, et al. 1988). This comparison highlights the problems posed by the traditional internalist approach to the study of nursing both historically and in the contemporary context. The wide gap between the assumptions of the dominant groups and the reality for most practising nurses has close parallels in modern nursing research which will be examined in detail (Marles Report, 1988).

This chapter will examine the scope of the gap between the two realities in nursing and ask whether there is a need for research based on the experiences of nurses who 'nurse' rather than on the ideas and assumptions of the dominant groups who make claims on their behalf. These dominant groups are the educators, nursing administrators, public servants and unionists who define the reality for all practising nurses while not practising as nurses. It would appear that these groups absorb nursing studies from
overseas, in particular from America, and selectively apply these to the Australian scene.

In America nurse academics have a very high profile. They are prolific producers of nursing theories that provide the basis of nursing processes and discourses world wide. The most graphic example of this is the dissemination of the idea of the 'nursing process'. The term emerged in America in the 1950s primarily for teaching purposes (de la Cuesta, 1983). Later it became part of the strategy to impose professional ideals on nurses in both England and Australia. The importance of the 'nursing process' as a method of practice is limited as it has not been fully implemented in America, England or Australia. While it has been imposed on syllabi for most areas of nurse education the impact on nursing practice has been 'almost universally disappointing' (Dingwall, 1988:215).

In Australia the 'nursing process' was promoted in the 1970s as both a philosophy and a work method to improve the quality of nursing care (Smith, P.1988:2). Although the idea became widespread it has not been accepted as standard practice in nursing.'...as a method of practice, it has been hardly implemented at all' (de la Cuesta, 1988:370). Lawler suggests 'that although the 'nursing process' is promoted as a tool to enhance holistic and humanistic practice, it is positivist, reductive and mechanistic...' (1991:37).
The most impact that nurse academics have had is clearly on other academics who subsequently filter the ideas through to nursing administrators, educators, public servants and unionists throughout America and other countries. There may be, however, an absolute chasm between these ideas and the reality for practising nurses, even in America where the registered nurse is the lowest paid professional in the country. (Turner, 1987: 151).

The gap between the assumptions of these dominant groups and the practising nurse is tolerated in Australia and America because a narrowing of the gap would be experienced in terms of economics and power. The employers of nurses both private and public accept in principle the ideas of the nursing elites as long as the practising nurse is kept at the bedside for as little expense as possible. The experiences of the working bedside nurse must be examined in order to find out whether there is a gap between the reality and rhetoric of nursing.

An examination of the conventional nursing histories also reveals a neglect of the majority of nurses. Dominant groups defined the "reality" for all nurses in the past in the same way the contemporary elites do. This study begins by rejecting the canons of traditional nursing history and the contemporary definitions by regarding their assumptions as discourse. That is, a set of beliefs and values which express the views of a particular social group. In the case of this study the dominant groups within nursing. These dominant
assumptions, past and present, must be seen in terms of social control and institution building rather than as an accurate representation of what nursing was and is in terms of experience for the majority of nurses.

This thesis will be examining the hypothesis that nursing work has become progressively more complex due to advances in medical science and technology. This assumption forms the basis of the transfer of nurse education to the tertiary education sector. A tertiary education is a major component of the process of professionalisation and is seen as a prerequisite for nursing autonomy and increased job satisfaction. This does not appear to be the case however, as increasing levels of job dissatisfaction are manifested in severe staff shortages and high rates of turnover in all major hospitals in New South Wales (Battersby et al 1990).

The structural changes which have contributed to the high turnover rates in nursing can be characterised in terms of the processes of 'rationalisation' and 'professionalisation'. Rationalisation is taken to mean the increasing dominance of rational action. Bureaucratisation being the principle example of this process as conceptualised by Weber. It involves precise calculation of the means to an end. Management strategies to contain costs and control the work involve the use of technology, routinization and deskilling. The professionalisation process has promoted this trend through demands for higher levels of education and a
career structure that further fragments nursing by rewarding all but clinical career choices.

This intellectual interest in the transformation of nursing work has emanated from two sources. During the course of earlier research into professionalisation in nursing I became aware of an apparent divergence between the nursing 'reality' presented by certain groups in nursing and the nursing 'reality' for the bedside nurse. This discrepancy was the source of major methodological problems during the early stages of this research. Structured interviews with registered nurses proved inadequate as many nurses answered in terms of the rhetoric of the dominant groups. The actions of the nurses when observed during participant observation contradicted the interview responses. This contradiction required a change of research strategy in order to incorporate in-depth interviews which resulted in a closer link between the statements and actions of nurses. It is essential to examine the gap between the rhetoric and reality in nursing because major policy decisions are made on the basis of the rhetoric of the dominant groups. Policy decisions which are based on the dominant assumptions of one group affect the working lives of the majority of nurses.

The second source of my interest in nursing work is personal experience. I am still a practising nurse and after twenty years of nursing experience in a variety of areas my experience tells me a story quite different from that presented by the people in powerful 'nursing' positions.
After an absence from public hospital nursing for several years to complete my undergraduate degree I was shocked to find that the nature of the work had changed dramatically. In 1985 I found myself performing largely what I considered to be the work of very junior student nurses. Work that was menial, routine and unstimulating formed the bulk of my duties as a registered general nurse in a large teaching hospital. My feelings about the nature of the work appeared to be consistent with the feelings of many of my nursing colleagues. Since my return to public hospital nursing I have observed increasing dissatisfaction with the nature of nursing. When examined structurally it appears that there is in New South Wales hospitals insufficient numbers of trained nurses willing to work in the public hospital system. Some New South Wales hospitals reported an annual turnover of over 100 percent of their nurses (Sydney Morning Herald, 11/5/89, 6). In essence, both my experience and my research informs me of the fact that issues that affect nurses have not been researched adequately.

Braverman (1974) became aware of the major contradictions in the enskilling literature. My review of the literature revealed contradictions that required systematic and rigorous investigation also. Most of the literature was based on the assumption of the need for ever higher levels of education and training because of advances in science and technology. This skilling thesis forms the basis of the conventional view of nursing and the major rationale for the
strategy of professionalisation. Braverman's experience of work in the modern world revealed a progressive deskilling of work with increasing dissatisfaction with the conditions of 'mindlessness', 'bureaucratization' and 'alienation' (1974:4). My own experience of changes in nursing work revealed a similar process of deskilling.

A review of nursing journals including The Lamp, The Australian Nurses' Journal, Nursing Outlook and the Journal of Advanced Nursing revealed major deficiencies in terms of the quality and quantity of the research. Most of the literature on nursing was produced by nurses with little regard for social, contextual or historical issues. An internalist approach takes no account of social, economic or political issues. In addition work produced by academics from other disciplines reveals little understanding of the complexities of issues as they affect nurses. The reason for this is the fact that they tend to accept the dominant assumptions at face value. Daly and Willis, for example, claim that

"The creation of the occupation of State-Enrolled nurse is a good example of (differentiation), as the more mundane manual tasks of nursing (such as emptying bedpans) have been delegated to subordinate occupations.: (1988:116)

In States of Health Davis and George suggest that after the transfer to the tertiary sector of nurse education in 1985 'at the lowest levels, nurses in training must be replaced by
aids to maintain services' (1988:113).

These are examples of recent externalist accounts of nursing work from the sociological literature that reflect uncritically the dominant assumptions. Registered general nurses carry out the 'more mundane manual tasks' at the 'lowest level' rather than 'subordinate occupations' or 'aids'. It is interesting to note that both Daly and Willis, and Davis and George recognise the existence of 'mundane manual tasks' and 'low level' services in nursing. The dominant groups in nursing reject the concept of menial work in nursing preferring to relabel basic nursing care as 'very important nursing care'......'menial work in nursing does not exist.' (Rickard, 1988:4).

Nursing Historiography

I turn now to undertake an analysis of nursing historiography, rather than a condensed history of nursing. By outlining the nature of the changes in nursing historiography I will show how dominant groups in nursing have historically defined what nursing is. It is in this authority to define the reality in nursing that power resides.

Conventional nursing history focuses on leaders and achievements. It is 'congratulatory' in that it presents the history of nursing as an advance from out of the dark ages to the present modern times. (Davies, 1980:11). Butterfield
named this the Whig view of history, a view in which the historical process reveals a chronology based on a principle of progress almost without conflict. He criticized this view to declare history morally neutral in that it is 'all things to all men'. In other words the facts support a variety of interpretations (1973:93).

Many of the early nursing histories that have appeared from the middle of the nineteenth century on were written by nurse advocates involved in the reform movements. They were mainly accounts of reforms or reformers and were basically narrow celebratory histories devoid of critical questions of power, class, conflict or change.

Brian Abel-Smith's *A History of the Nursing Profession* was published in 1960. This major transitional work pointed to the fact that early nurse historians largely ignored the working class women who provided the nursing care. He saw nursing as a problem of social policy in a specific historical context rather than inevitable progress from drudgery to professionalism. He acknowledged that it was not unusual for reformers to overstate the evils they were hoping to correct (1960:5).

Nursing historiography has undergone major changes since the 1960s for a number of reasons. First, nurses' experience presents a compelling case study of the relationship between gender and work in the Twentieth Century. It provides new insights into women's history and labour
history. The aspirations of labour history to speak for history from below fall short when the representation of women in history is considered. The traditional accounts of nursing history inform us about nurse elites but little about working nurses. These high profile elites have in effect obscured the experiences and consciousness of working nurses.

As the rhetoric of reform set the boundaries of discussion historically the rhetoric of professionalism is shaping the future for practising nurses today. Nursing history has moved beyond the limited framework of reform to locate nurses as women and workers. In the recent work of Davies (1980) and Maggs (1987) nursing history has become absorbed by the growing interest in women's history. Questions of women's labour history are now guiding research into nurses' experiences.

New views on nursing are also guided by recent work on the professions. Professional development and professional activities have become specialty areas in sociology. Nursing is an occupation that is attempting to obtain professional status to varying degrees of success depending on which theoretical perspective guides the study. Recent studies of professionalization have rejected the traditional approach in favour of a more critical sociological analysis. (Friedson, 1970; Johnson, 1972; Larson, 1977; Boreham, 1978.)
The general interest in social history is another factor that has influenced the change in focus of nursing history. Traditional nursing history as noted above, failed to present an accurate picture of its past and therefore had little place for the great majority of nurses or their work. Contemporary nursing history challenges the dominant historical perspective. Academics from diverse backgrounds are now showing an interest in the new nursing histories (Davies, 1980; Castle, 1987).

**Nursing History Reconstructed.**

The most important influence on the new nursing histories is clearly the women's movement. Until the 1960s women's history and nursing history were similar in approach. Women of achievement were retrieved from historical obscurity and promoted in the context of progress, advancement, events and movements. The Nightingale Chronicles provided a myth of origin from which nursing discourse developed. This Whig interpretation was the dominant historical view of the development of nursing as well as women's history until the influence of feminism in the 1970s.

Celia Davies edited a collection of essays in 1980 that presented a clear challenge to conventional nursing history. This influential collection was motivated by a 'collective rejection of the accepted canons of nursing history' (1980:9). Instead of focusing on notable people as agents of change
each article addressed specific questions, such as power, class, conflict and gender, using a variety of approaches and interpretations. *Rewriting Nursing History* was compiled by nurses, historians and sociologists who questioned the liberal-democratic view of change to suggest that ruling ideas are more hegemonic and in fact resistant to change. Reforms from this perspective are not always progressive but reflect in part the views and interests of the dominant groups.

An article by Williams (Davies, 1980) shows that accounts given by nurses and doctors of the same past diverged markedly. History does not speak for itself. She showed that disparate views of the same history must be seen in terms of the different discourses of the two occupational groups. She accepts neither account but looks for an alternative view in a variety of source material, in particular, in accounts of the everyday practice of nursing work. While it is clear that even this alternative evidence is subject to bias it is the extent of the divergence that is of importance.

The specific historical events that Williams examined were the founding of the Institute of Nursing Sisters in 1840 and St John's House in 1848 by Elizabeth Fry and the work of Florence Nightingale including the formation of her training school attached to St Thomas's Hospital in 1861. She examined these from the perspective of doctors and nurses. In particular Williams was interested in the source of the evil reputation of the hospital nurses at this time. The
character of the hospital nurse was the focus of much attention at the time as attempts were made to stamp out 'Gamp' in order to replace her with educated women. Williams suggested that the reasons are to be found in the philanthropic movement that was attempting to reform hospital nursing. Sarah Gamp was created to support claims for change based on different ideals. In other words: '...it is a reputation rather than a set of facts that has become incorporated into popular nursing history' (1980:58).

New metaphors were created for nursing such as the 'lady with a lamp' and 'angel of mercy'. (Kalisch and Kalisch, 1987:17) The 'doctor's handmaiden is a metaphor that modern nurse 'reformers' continue to stress as they attempt to professionalize nursing. The transfer of nurse education to the tertiary sector is the means by which nursing transcends the status of 'doctors handmaiden' to become an equal partner in science and technology. The 'doctors handmaiden' is the Twentieth Century Sarah Gamp. Just as the two Nineteenth Century visions of the development of nursing are shaped by specific group discourses, modern visions of nursing development are shaped by the interests of divergent groups such as educators, administrators, unionists and bureaucrats.

Maggs also questions the conventional image of the early nurse basing his enquiries on hospital records. He concludes 'it appears that the nurse recruit was much more like her fellow woman worker than we might have gathered from
Maggs produced a sequel to the Davies volume in 1987 in which he claims 'there is more to nursing history than labour history has so far demonstrated itself able to discuss, not least in that nursing involves women as skilled workers' (1987:7). The Maggs volume contains at least four articles that relate to professionalization from an historical perspective. The article by Josephine Castle examines the development of nursing in New South Wales. She claims that nursing skills failed to keep pace with the higher educational standards of the community at large and that the 'on the job' system of training reduced the professional status and pay of nurses resulting in militancy, amongst other things (1987:9-10). She further states that the transfer of nurse education to the tertiary sector had increased substantially the standard of nurse education. These statements are clear expressions of the dominant assumptions in nursing. In fact there was no evidence to support either of these assumptions.

**Contemporary Nursing Research**

Contemporary nursing research is often based on similar assumptions. The Marles Report is a typical example. The *Study of Professional Issues in Nursing* (Marles Report) was commissioned to examine the changing role and nature of nursing under the impact of 'advances in medical science and the increasing application of technology in patient care'
The study was commissioned in response to industrial action by Victorian nurses in 1986. It found that the causes of dissatisfaction did not include pay and work conditions but were political and organizational in nature. The terms of reference revealed predetermined notions about the impact of technology and the direction of changes in clinical and management roles of registered nurses. The report ignored evidence that disproved any of the assumptions on which the researchers based their findings and accepted at face value assumptions by dominant nursing groups about the differences between college and hospital trained nurses (1988:224). Excessive weight was given to the opinions of researchers, administrators, educators, doctors and nursing associations. Finally, the use of data obtained from group discussions raises questions about the overall validity of the study. The study clearly showed how preconceived notions combined with methodological deficiencies produced a research report that largely legitimated the position of the government without recommending any substantial changes to the status quo.

All the contributors to the reconstructed nursing history view nurses as a work defined group rather than in professional terms. They concentrate on issues of power, control, class and gender to present a more critical analysis in a richer social context. They highlight the need to evaluate nursing in terms of the practical realities rather than the idealized versions of nurse leaders as presented by the Marles Report. This new approach is well depicted in the
recent study by Dingwall et al. In *An Introduction to the Social History of Nursing* (1988) the authors point out, as did Abel-Smith, that nursing care in the nineteenth century was provided by working class women. Historians of nursing have largely ignored this fact. Dingwall et al claimed that

'\nthe forerunners of modern nurses were more like domestic servants because the precursors of modern doctors were performing what would now be regarded as relatively low level technical procedures and routine treatments.' (1988:18)

They also examine the 'social construction of an occupation and its imagery ' by pointing to the gap between the 'mythologies of nursing and the historical record.' (1988:48, 52).

**Feminist Analyses of Nursing Work.**

Literature from a specifically feminist perspective argues that nurses are an 'oppressed group'. (Speedy, 1987:23). Nursing is an illustration of the subordination of women in patriarchy. Nursing is seen as a natural extension of the female personality and this 'ideology of naturalism' ...'represents labour processes'...'as specifically 'feminine' or 'masculine'. (Gamarnikow, 1978:98). In other words, women are exploited as nurses because nursing is equated with mothering and the hospital is merely an extension of the domestic sphere of labour.
Ehrenreich and English, (1976) and Game and Pringle, (1983) also represent this trend. The nurse is the living embodiment of the problem of patriarchy, female subordination and the sexual division of labour. Gamarnikow presented a critique of the Nightingale tradition arguing that the use of the family analogy as the major theme in nursing literature is a patriarchal ideology that legitimates the nurse/doctor/patient triad in a way that blocks any further analysis. The historical connection between nursing and service is linked to the subordination of nursing and the notion that management and leadership are masculine traits. In early nursing studies Schulman (1972) drew attention to the parallel between mothering and nursing. More recently Reverby highlighted the dilemma of nursing as 'a profession 'ordered to care in a society that refuses to value caring' (1987). Nursing is 'almost wholly a woman's province' associated with 'mundane bedside drudgery' (Strauss, 1966:61).

Dimensions of Skill

The sexual division of labour and the gendered nature of the labour process are major dimensions of 'skill' so the concept is important for discussions on women's work. The importance of the concept lies in the focus of the study on changes in the quality of nurse employment. The quality of employment refers to the skill content of jobs and the control workers have over their work practice. (Forester, 1985:419). Willis suggests that the concept 'skill' is difficult
to define because it is a 'relativist concept' that is socially constructed and varies historically and culturally. He suggests that it is necessary to consider the acknowledgement of skill as a political process and to consider who defines 'skill' in specific situations (1989:218). Perceptions of skill are sex-linked and this study will examine the changes in the sexual division of labour within the context of nursing. It will reveal the establishment of new dichotomies within nursing of technical versus non-technical, machines versus people and worker versus manager. These new dichotomies are also sexual as more men enter nursing and tend toward the administrative, technological or status positions.

The notion of 'tacit skill' and the social construction of skill both point to the perception of skill as sex-linked. Most work on deskilling has involved industrial or office workers but clearly the idea is not limited to these areas. Braverman and Edwards both argue that deskilling is a major component of worker control. (Braverman, 1974; Edwards, 1979). This study does not seek to examine generalised deskilling but rather the relevance of the notion of deskilling within a single occupation, nursing. Before examining the concept 'deskilling' it is necessary to look more closely at the nature of the concept 'skill' which is rarely explicitly defined.

Skill is a multidimensional concept that is characteristic of both people and jobs. Kalleberg claimed that there are two
major components of skill, substantive complexity and autonomy (1987:176). Beechey in 1982 outlined three elements of skill including objectively defined competences, control over conception and execution and socially defined occupational status which may or may not be independent of the level of objectively defined competences (1982:63-64). Crompton and Jones in *White-Collar Proletariat: Deskilling and Gender in Clerical Work* point to the considerable importance of the social definition of skill. They claim the

"Social, as well as technical, definition of skill contribute to the complex structuring of occupations within the 'non-manual' category, even at relatively low levels of the bureaucratic hierarchy.: (1984:2)

The authors studied clerical work in three large bureaucracies both public and private. They concluded that computerisation had significant effects on clerical tasks and that downgrading had occurred. They pointed out, however, that the deskilling element was reduced for the men because of the presence of women with limited promotional prospects.

Cockburn (1983) argued that in the printing industry male workers were able to have their semi-skilled work defined as skilled and were motivated by sexist ideology in excluding women from the trade. She examined technological change in the printing industry and suggested
that there was a greater complexity to deskilling than writings inspired by Braverman allow. She claimed that loss of skill can be separated from degradation of work and that deskilling for one group need not entail an overall deskilling in the enterprise.

Manwaring and Wood (1985) argue that the absolute separation of conception and execution is impossible even at the level of 'unskilled' worker. They introduce the notion of tacit skills which they maintain are especially important in the context of the Braverman deskilling debate. Wood suggests that the notion of 'tacit' skills is important for women's work (1987:9). Tacit knowledge is purportedly learned through individual experience. It is situation specific and difficult to articulate in formalised language. Tacit knowledge is essential for skill acquisition.

There are three dimensions of 'tacit' skills. First, the performance of routine tasks which involve a learning process by which skills are acquired through experience. Second the fact that there are different degrees of awareness needed to perform certain activities ranging from little awareness for routine tacit skills to a much higher level of awareness for coping with unfamiliar situations. The third dimension relates to the collective nature of the labour process and suggests that a cooperative attitude is important because of the informal way tacit skills are learned.

The notion of tacit skills means that workers cannot be
reduced to automatons as implied by the deskilling thesis. Some level of skill is involved in all work. Wood suggests however that 'there is also the danger of romanticizing what in many cases is essentially routine and stressful work'. (1987:10). The nursing redefinition of menial work to 'very important nursing work' is a clear example of this (Rickard, 1988:4). This shows that work cannot be judged only by its label or even its superficial characteristics. Neither do formal training times reveal the full picture since 'much of the acquisition of knowledge is done on the job' (Wood, 1987:10). Berg (1970) after a four year study concluded that vocational skills are learned mainly on the job and not in educational institutions. He claimed that there was no evidence to support the idea that better education means more productivity, and that there was a continual upgrading of educational requirements for jobs that was unrelated to the actual work performed.

Observations about women's work have stimulated discussion on skill both in the context of tacit skills and the social construction of skill as mentioned earlier. The sexual division of labour is seen to be a facilitating factor in the deskilling process. Blackburn and Mann showed how women were excluded from many jobs reinforcing the argument that skills are not socially neutral. (1979). Skills performed by women at a higher level of productivity than men are undervalued. (Wood, 1987:10). Exclusion tactics by men against women were also revealed by Cockburn in her study of print workers (1983). Braverman ignored the
importance of job definitions in his effort to demystify the labels attached to them but feminist writers have shown that job definitions are as important as the job. (Phillips and Taylor, 1980). They argue that to label jobs as 'womens' is an important aspect of discrimination. This is important in the nursing context as certain tasks performed by doctors are labelled as complex therapeutic or diagnostic procedures but become routine tasks when performed by nurses. Examples include undertaking an electrocardiograph or inserting an indwelling urinary catheter.

The Braverman Thesis

Labor and Monopoly Capital was published in 1974 and stimulated widespread debate that continues today. Braverman was concerned by the contradictions in the literature on the nature of work. The assumption that modern work requires ever increasing levels of education because of the 'scientific-technical revolution' was contradicted by what he perceived as increasing dissatisfaction with the conditions of labour. Braverman saw work as increasingly divided into petty operations that 'fail to sustain the interest or engage the capacities of humans with current levels of education'. He suggested that modern work requires less skill because of the modern trend towards 'mindlessness', 'bureaucratisation' and 'alienation' for ever increasing sections of the population. (1974:4).

Braverman argued that the logic of capitalist production was
such that it inevitably 'deskilled' the labour process. He claimed that work in capitalist society becomes increasingly routine and fragmented requiring very little skill on the part of the workers. The central argument in Braverman for the deskilling process was based on Taylorist management strategies such as the separation of conception and execution, increasing fragmentation of work into simple constituent parts and the separation of 'direct' and 'indirect' labour.

Braverman's thesis hinges on the nature of the concept 'average skill' which he admits is vague and difficult to quantify (1974:425). He suggests that the question is 'whether the scientific and "educated" content of labor tends toward averaging, or, on the contrary, toward polarization'. (1974:425).

There are many arguments against the simple deskilling thesis, in particular, the fact that skilled work clearly still exists (Thompson, 1983:97). Social constructionist theories provide a solution to this by suggesting that the term 'skilled' may reflect a labelling process (Wood, 1987:8). Management attaches labels to specific jobs in order to segment and reduce the power and unity of workers. In nursing, the New South Wales Nurses Association push for a career structure for nurses resulted in the creation of Clinical Nurse Specialists and Clinical Nurse Consultants. The result is the creation of new positions that do not necessarily reflect the skills of those who hold them but have
contributed to a further reduction in cohesion in nursing.

Job labels may be the direct consequence of worker resistance or union initiatives to control wages and conditions. More (1982) argued against the social constructionist theory claiming that in the Nineteenth Century and probably today, those whose work was labelled skilled did in fact exercise some level of skill. The social constructionist approach to skill assumes an objective deskilling and that present craft labels are the result of distributive struggles in the market place, and management ability to gain control.

There are clearly many conceptual problems involved with research on skills. The Braverman stance treats the reduction of workers to automatons as a capitalist imperative. Management control and the degradation of workers are basic preconditions for efficient production. The notion of 'tacit' skills introduces the role of subjectivity revealing a basic flaw in the Braverman thesis, the reduction of the worker to total passivity. The only resistance Braverman perceives is through the development of an economic consciousness through unionism.

Other sociologists have suggested widespread deprofessionalisation or proletarianisation. (Haug, 1973; Oppenheimer, 1973). Turner claims that there are three ways that 'deprofessionalisation' might take place. The first is during the growth of bureaucracy where most professions
are employed. The professional working within a bureaucracy loses some degree of autonomy. The second way that deprofessionalisation occurs is due to the process of socialization and the development of knowledge that fragments a profession into distinct groups. The third way is with pressure from new professions and para-professions who encroach on the domain of established professions. (1987:137).

Oppenheimer (1973:213) defines the process of proletarianisation as an extensive division of labour in which workers perform a limited number of tasks. The process includes loss of control over the conception and execution of the work, a wage determined by the market rather than by individual negotiation, as the primary source of income and the use of associations or unions to bargain for improvements.

Wagner provides historical evidence for the proletarianisation of nursing in the United States from 1932-1946. He suggests that when nurses were forced to work within institutional settings they lost the traditional autonomy of private practice (1980:271). Gray (1989) examined militancy and gender ideology in hospital nurses and claimed that there was no evidence of proletarianisation. He claimed that the proletarianisation thesis draws on Braverman's (1974) work and as such suffers from the same analytical problems. In particular, no adequate definition of skill and an idealised notion of

Game and Pringle (1984) presented a feminist analysis of women in the labour force since World War II in which all their case studies took into account the notion of deskilling. In her study of office workers Butler concluded that the majority of secretarial workers in word processing centres and administrative support centres were being deskilled by changes in the labour process (1988:31). Williams (1988) considered technicians, technical workers, clerical workers and other bank workers and flight attendants in relation to a range of themes which included deskilling and proletarianisation. She concluded that for some workers, such as technicians in Telecom, upgrading and enskilling was the result of changes in the labour process despite management intentions of mass deskilling. She also found that some upgrading and skill maintenance had occurred in the banking industry with the advent of computer technology but that male bank employees were proletarianised due to the changing structure of the industry (1988:177). Hill suggests that computer technology has created a polarisation of skills with a small group of elite specialists at one end and a large group of relatively unskilled keyboard operators at the other (1988:275). Williams claims that the deskilling thesis has greater credibility in the computer industry in Australia. (1992:30). She states that

"...even though skill is based on some
notion of a critical competency as well as control over the labour process and occupational status, all three dimensions cause the definition of skill to constantly change with resistance to managerial control."

(1992:33)

Worker Resistance

It is important to recognize worker resistance and to examine the transformation of nursing work in relation to different forms of resistance. Burawoy (1979) points to the active participation of labour in the production process which cannot be explained in terms of labour instrumentalism or socialisation. He argues…..

"Within the labour process the basis of consent lies in the organization of activities as though they presented the worker with real choices, however narrowly confined those choices might be. It is participation in choosing that generates consent". (1979:27)

Burawoy's analysis does not suggest resistance but the creation of a meaningful existence within the relations of exploitation which are obscured. He shows that given the appropriate framework of incentives linked to production targets there can be a relaxation of control by management associated with the development of a system of consent.

In the nursing context Turner outlined a 'vocabulary of complaints' that functions in a similar way. He suggested that nurses as subordinates have a pragmatic acceptance of
authority rather than a normative commitment to it. (1986:383). In other words, nurses are aware of their subordinate position within the health system but create a 'meaningful existence' by informally asserting their value and autonomy through a 'vocabulary of complaints'. They are 'symbolic gestures' against the authority and dominance of doctors and administrators but do not lead to any organized form of political engagement that threatens to change the situation of nurses.

Worker Control

The perception of a trend in certain industries towards a reduction of workers' opportunity to use skills or exercise control over their work is clearly applicable to all areas of work. Oppenheimer even suggested that professionals are experiencing an erosion of their quality of employment (1973). Many professionals are employed in large bureaucracies where they are subject to managerial efficiency and rationalisation drives caused by cost cutting. Technology is seen as an important instrument in the deskilling of work (Cooley, 1980; Willis, 1988). Application of new technology by management is seen as an attempt to win control over the work process from the workers (Feickert, 1979). Even in service occupations workers of lower skills are substituted for professionals (Haug, 1977). In nursing much of the work of registered nurses may be interchangeable with cleaners, wardsmen, ward assistants, ward clerks, enrolled nurses, porters and couriers.
There is considerable variation in the ability of different service providers to influence the way new technology impinges on the content of their jobs. Forester (1985) showed how laboratory technicians and bank workers were observed to have lost elements of skill and control as a result of the application of new technology. Jamous and Peloille (1970) examined professional deskilling and touched on the idea of tacit skills with their notion of 'indetermination'. They claimed that skill involved elements of technicality and indetermination. (I/T) Technicality refers to those aspects of skill that can be observed and described. Aspects of skill that cannot be described are labelled indeterminate. Issues of power and control are raised when we consider the ability of an occupation to claim indetermination in reference to the skills they possess.

The I/T ratio provides a theoretical answer to the problems posed by various contradictory perspectives on deskilling such as Bell versus Oppenheimer. Turner suggests that all professions are characterized by a duality, the opposition between technical and routine knowledge and an ideology of interpretation. (1987:138). Professions are occupations that are subject to contradictory forces that tend to both professionalize them and proletarianize them. One significant result is a polarisation within professions as suggested by Braverman. Clearly, there are both internal and external forces acting on all occupations that serve to transform many of their basic features. The ability of an
occupation to oppose changes that reduce the quality of employment for its workers is related to aspects of power. The ability of workers within an occupation to move towards the professionalised segment is related to issues of class and gender. Nursing leaders who insist on scientific bases for nursing practice and reject tacit skill concepts or indetermination may be unwittingly undermining the power of nursing to claim professional status.

This study aims to transcend the objectivist and technicist views of work organization in order to stress the importance of the sexual division of labour, the important role played by organizational change rather than technological change, though this is also important in the transformation of nursing work. I acknowledge the contribution made by Braverman to the deskilling debate but recognize the 'dangers of Bravermania' (Littler and Salaman, 1982).

The level of skill of an occupation is relative to other occupations and the same occupation over time. Deskilling is also a relative process. Littler (1982) distinguished between specialisation where the range of skills required is narrowed but the skill status may be increased and fragmentation where the level of skill required is reduced. These concepts have some value in the nursing context. An examination of the nature of nursing work will reveal the skill content of that work.
Job Satisfaction

Many studies have indicated that the use of skills is associated with job satisfaction and the psychological well-being of workers. (O'Brien, 1980). Job satisfaction is therefore a major component of this study. Braverman claimed that he perceived a 'mounting dissatisfaction with the conditions of industrial and office labor' which contradicted the dominant view of work as requiring ever increasing skills (1974:4). A major component of this study is the increasing level of dissatisfaction in nursing. It is necessary therefore to examine the literature on job satisfaction in general and those that relate to nursing in particular. There is no single, accepted theory of job satisfaction despite many years of study and a mass of research on the subject. There have been many distinct conceptual approaches, within a variety of occupational settings and as a result many contradictory research findings reported in the literature.

Job satisfaction is a complex phenomenon that is difficult to measure. Larson et al (1984) considered 'timing' as a major difficulty in the measurement of job satisfaction. In other words the fact that we usually measure it retrospectively. Before 1975 approximately 38 percent of the student nurses who left before they completed their training did so because they 'disliked nursing' (Donehue, 1978:44). Since 1975 the category 'dislikes nursing' is no longer used. Instead terms like 'dissatisfaction with salary' or 'rosters' or 'shiftwork'
are used. "Dislikes nursing" has been absorbed by these other categories. The National Nursing Survey in 1979 and a study by Refshauge (1982) showed that very few nurses left nursing for work related reasons. By 1985, 67.5 percent of registered nurses who responded to the NSW Department of Health phone-in gave work related reasons for leaving nursing. The Battersby et al. (1990) report also revealed work related reasons as the most important determinants of decisions to stay in nursing or to leave. These findings could indicate a change in the conditions experienced by registered nurses or they could be an artefact of the research process. Larson et al. (1984) also point to the fact that it is difficult to obtain truthful information about job satisfaction because the workers believe that criticism will reflect badly upon them. In the case of nursing it is well documented that nurses rarely give accurate reasons for terminating employment for this very reason.

Most studies of job satisfaction have involved male workers and since women's labour force participation patterns differ from men's we cannot generalise from these studies. A literature review of job satisfaction must focus on those studies that can be generalised to the wider workplace or on studies that relate specifically to women's work.

Early studies related the concept job satisfaction to a variety of single dimensions. This unidimensional approach was contested by Herzberg with his dual factor theory. (1959, 1966). Other studies tended to consider job satisfaction along
a continuum from satisfaction to either dissatisfaction or no satisfaction. Herzberg's work showed that satisfaction and dissatisfaction were not the obverse of one another. This was the most important finding of his research. Satisfaction is not measured by the absence of dissatisfaction and dissatisfaction is not lack of satisfaction. The two seem to stem from different sources. Herzberg believes that 'satisfiers' stem from the work itself and are the fulfilment of 'higher order needs'. (Maslow, 1954). 'Dissatisfiers' stem from conditions surrounding work.

A review of the literature reveals many studies of job satisfaction in nursing in the last ten years. Much attention to nurses and job satisfaction are related to the cost of turnover and absenteeism in health care organizations, the fact that hospitals cannot function without nurses, and the link between nursing numbers and standards of care. MacPhail suggested it was most likely nurses have been studied more often than other health care workers because they comprise the largest proportion of workers in the health field and they provide round the clock service (1988:100). Baito and Caston also suggest that job satisfaction is relevant to the productivity of care providers and that 'it may have a direct impact on the quality of care" (1982:346).

Analysis of the literature on job satisfaction in nursing reveals serious inadequacies in methods of investigation.
Redfern reviewed the literature on absence and wastage in British nurses and found that it was not possible to make comparisons because of 'inconsistent definitions and measurement techniques'. (1978:232). Hinshaw and Atwood (1983) reviewed research on turnover and discussed the link between job satisfaction and stress as they relate to job turnover. They also identified many inadequacies in the research, in particular, methodological inadequacies.

In an extensive review of the literature in nursing Braito and Caston identified a number of issues that created job dissatisfaction. (1982:349). They claimed that the conflict between the ideal and real situations, in particular, in relation to staffing, nursing roles, autonomy and decision-making, was a major source of dissatisfaction. They also suggest that promotional opportunities were a source of conflict and that a closer examination of turnover is needed to exclude other reasons for dissatisfaction.

Kramer (1974) claimed that nurses leave nursing because of 'reality shock', the discrepancy between ideal images and the reality of nursing. Other studies list a variety of factors that contribute to job dissatisfaction including salary, rosters, long-hours, relations with doctors, lack of child support, lack of autonomy, lack of administrative support, stress, lack of recognition and so on. (Wandelt et al, 1981; Sigardson, 1982; Ginzberg et al, 1982; Moore et al, 1981).

Stamp et al (1978) undertook a three year longitudinal
study to investigate occupational satisfaction of health professionals in order to discover improved ways to measure it. They claim that job satisfaction increases with age, a fact supported by other studies. (Braito and Caston, 1982). They also claim that it increases with length of time spent on the job and perception of occupational status. Other factors associated with job satisfaction include security, perceived promotional opportunities, recognition of achievement, salary, interpersonal relations, type of work, rosters and type of task. Overall they found autonomy was the most important factor in job satisfaction.

Curry et al (1985) in an investigation of turnover among nurses concluded that job satisfaction was an important determinant of turnover and that task repetitiveness, autonomy, promotional opportunities and adequate rewards were the most important determinants of job satisfaction. Dear et al (1982) found that the strongest determinant of job satisfaction was a sense of autonomy and a sense of internal control. The strongest determinants of turnover were younger age, lower perceived autonomy and lower educational level. Everly and Falcioni (1976) suggested that an intrinsic/extrinsic dichotomy clearly exists in relation to job satisfaction and that intrinsic orientations relate most with the motivation of professionals. They suggest that nurses perceive job satisfaction in more complex terms so further study is needed.

The best method is one that takes account of the
demographic and contextual variables known to impact on levels of jobs satisfaction. In this study registered nurses will be given the opportunity to express their views on the nature of nursing work. They will also be given the opportunity to comment on the changes that they perceive in nursing in general and in nursing work in particular. The experiences, beliefs and attitudes of these registered nurses and the findings obtained during participant observation of a hospital ward will be the principle source of data for this study.

In summary

This chapter examined the rhetoric and reality of nursing work as presented in the available literature. Traditional nursing historiography and contemporary nursing research were analysed in order to reveal the dominant assumptions. Feminist analyses of nursing work were examined and the central concept skill analysed. The Braverman thesis was reviewed and its major drawbacks outlined. Worker resistance and control were examined in relation to nursing work and finally a review of the literature on job satisfaction revealed major methodological flaws as these studies relate to nurses work. The rhetoric of nursing work was well documented both in traditional nursing histories and contemporary studies. The reality of nursing work was however not adequately represented in any contemporary nursing studies. Feminist studies present theoretical analyses of nursing work in terms of 'subordination' and
'exploitation'. However, it is important to note that this examination of the literature found no accounts of nursing work as experienced by nurses. This study intends to fill this major gap in the literature.
CHAPTER FOUR

METHODOLOGY: Participant Observation, In-Depth Interviews and Discourse Analysis

Introduction

Nursing is one of the '...ultimate female ghettos from which women should be encouraged to escape' (Vance et al, 1985:281). When this study began in 1989 women were 'escaping' from nursing in New South Wales hospitals at an unprecedented rate (Lockwood, 1982; Burns, 1985; Ridgeway, 1987; Woodley and Allender, 1989; ). This study began with attempts to determine why this situation existed. The loss of nurses from the hospital system had reached the point of crisis in New South Wales as more nurses left the system than the hospitals could recruit. As a registered general nurse working in a major metropolitan teaching hospital I became accustomed to working under conditions of extreme staff shortages. All proposed solutions to the problem of recruitment, retention and turnover had failed. The transfer of nurse education to the tertiary sector was supposed to provide a large supply of qualified nurses when the first graduates entered the system in 1988. Child care facilities were provided, although these were more suited to workers not involved in shiftwork ( Short et al, 1989). Major recruitment campaigns also failed as did the importation of large numbers of overseas nurses, increased rates of pay and the provision of a career structure.
These solutions were proposed by the leaders of nursing, the dominant groups which include public servants, hospital administrators, educators and unionists. The New South Wales government acted upon the advice of these groups but the high turnover rates and staff shortages persisted.

My own perceptions and experiences as a registered nurse and a researcher suggest that the problems may lie elsewhere. My undergraduate thesis involved an analysis of the 'professionalization process' in nursing. (Herdman, 1985). I interviewed, in depth, over one hundred registered nurses and one of the most frequently emerging themes was the high level of discontent that registered nurses felt about the system within which they were working. There was a discrepancy between the reality of the nursing experience and the picture presented by the dominant groups within nursing and there was a consistent and deeply felt unhappiness about the nature of nursing work. Neither of these themes has been addressed by nursing leaders, despite the fact that neither is new. There has always existed a wide gap between the ideals and the reality in nursing, and the experiences of practising nurses have consistently created a situation of high attrition (Kramer, 1974).

Policy problems emerge from the discrepancy between the ideal and the actual and they signal covert conflict between them. This study aims to compare and contrast the dominant view of nursing with the experiences of practising nurses.
The study will examine also whether many of the major contradictions and conflicts in nursing today originate in this conflict between ideology and the experience of nursing.

This study began with the existing situation of crisis. The fact that registered nurses were leaving the public hospitals of NSW faster than they could be replaced. My question as to why this was happening elicited responses from the nurses themselves that contradicted the claims of the dominant groups. These groups claim to know the answer without asking questions of practising nurses. The answers to my questions lead me to the conclusion that it is the nature of nurses' experiences that required closer examination. The picture that emerged as a result of my early questions was one of serious disillusionment with the structural changes in nursing. Recurring themes revealed discontentment with aspects of nursing work expressed in terms such as the fact that it is "boring", "menial", "routine" and not stimulating enough to hold the interest of registered nurses. Further, nurses claimed to see "no future in nursing" that they were all at the 'bottom of the ladder'. Nurses appeared to perceive a lowering of their status as professionals in terms of their relations with other hospital workers and patients. They even saw a lowering of their status in relation to the new career structure with the creation of clinical nurse specialists and clinical nurse consultants.
Research Design

I have explained that this study aims to examine the nature of nursing work as experienced by practising registered nurses. I will use ethnographic research methods including participant observation, in-depth interviews and discourse analysis, in order to examine the situation as it exists for working nurses in a large Sydney teaching hospital. Most qualitative research involves what Glaser and Strauss termed "grounded theory" (1967). This means the research is concerned with the discovery of substantive theory which emanates from the data. This study will test the validity of the 'enskilling thesis' which proposes that nurses require a higher level of education to keep pace with the advances in medical science and technology.

The notion that experimentation leads to hypothesis verification and ethnography to hypothesis generation is a simplification that can be challenged. Dimensions such as generation-verification and induction-deduction are continuous processes of research. Most researchers move along these continua as they carry out the research process.

While there is no neat correspondence between epistemological position and associated methods of sociological research, there is substantial agreement about the fundamental differences and the practical implications for research. The choice of a certain epistemological stance leads to a preference for a certain method on the grounds of
its greater appropriateness. However, this does not rule out other methods. Denzin introduced the term "sophisticated rigor" to describe the use of multiple methods, to "seek out diverse data sources" in the research process (1978: 41-2). Trow suggested that "the problem under investigation properly dictates the method of investigation" (1957:33). He was suggesting that it is impossible to argue for the absolute superiority of a particular method.

In this study I use "methodology" to refer to an epistemological position and "method" to refer to means of gathering data. In other words, method and methodology are different levels of analysis. I am operating within the framework of critical sociology which holds the assumption that the phenomena of life can only be understood within the historical and social context.

The literature review focused on an analysis of nursing historiography to reveal the dominance of the traditional view of nursing. This study also recognizes that sociological research takes place within a political context both at the level of micropolitics (interpersonal relationships) and the wider political context of both organizations and the state.

A feminist analysis of nursing is based on the assumption that nurses are an oppressed group (Muff, 1982; Speedy, 1989). Traditionally, nursing was dominated by women even at the higher eschelons of the 'profession'. Historically it has been a case of middle to upper class women
dominating working class women. There has, however, been a well documented trend towards male dominance in nursing as men enter the profession and veer towards areas of power, status and authority. In many cases today it is a case of men largely from working class backgrounds dominating women (Hearn: 1982). The gender factor is a major dimension of the problems that face nurses today and will not be excluded from this analysis. Cook and Fonow (1986) suggest that there is a need to continuously and reflexively take account of the significance of gender and gender asymmetry as a basic feature of all social life. In nursing in NSW this gender asymmetry is only now being recognized as nurses who at one stage welcomed the influx of male nurses believing that they would assist nursing in the professionalization process, are becoming aware of how male nurses career prospects are greater than theirs.

Feminist principles also challenge the norms of objectivity that assume a separation of subject and object in social research and that personal experience is unscientific (Speedy, 1988). They stress the centrality of consciousness-raising as a specific methodological tool as well as a general orientation. In other words, feminist principles, like critical sociology, stress an emancipatory interest, with the emphasis on the empowerment of women and the transformation of patriarchal structures.

The dominant mode of analysis in this study focuses on an understanding of nurses' experiences. Oakley (1981)
revealed how textbooks are pervaded by masculine imagery especially in descriptions of the interview process which is meant to be detached and controlled. The division between qualitative and quantitative research mirrors the theoretical divisions between public and private, instrumental and expressive and the wider social structure of the social divisions between men and women.

Feminist inquiry begins with a broad unmasking of the attitudes that legitimize and hide women's status. A critical reconstruction of the meaning of nurses' experiences is the major focus of this study which uses a methodological pluralism as propounded by Bell and Newby. They claim this approach

"emerged out of the ruins of the former positivistic hegemony in sociology. No longer can there be only one style of social research with one method that is the method. Rather there are many." (1977:10)

Sandra Speedy examined the nursing literature to determine the contribution that feminism has made on nursing. She claims that there is a long standing debate about the role of feminism in nursing. (1987:25). A feminist analysis of nursing suggests that "it is not and never can be, while presently structured and ideologically governed, a profession" (Speedy, 1987:25). The adherence to the male model of professionalism in nursing is a major component of this ideological dominance.

This study is a critical empirical analysis of the transformation of nursing work in a New South Wales hospital from 1970 - 1990. This time frame was chosen because most of the major changes in New South Wales nursing have occurred within this period. I start by testing the dominant proposition that there has been a historical trend towards enskilling of registered general nurses in NSW. With the use of ethnographic methods I intend to test the validity of this proposition.

I suggest that the area of nursing work has largely been ignored by the dominant groups in nursing as they focused primarily on issues of professionalization. My own experiences and previous research have given me the impression that registered nurses are dissatisfied with the structural changes in nursing. The only means by which nurses can express this dissatisfaction is by leaving nursing because their expressions of discontentment are generally
ignored by the dominant groups. Many registered nurses working in the major public hospitals may perceive a general lack of understanding of the skills they possess, as they have been assigned tasks that were previously performed by junior nurses and are at present also performed by workers with no formal qualifications. I intend to examine the effects that the processes of professionalisation and rationalisation have had on the nature of nursing work. These processes have resulted in an increase in specialisation and fragmentation which may contribute directly to the deskilling of nursing work rather than to an enskilling. Deskilling is linked to reduced levels of job satisfaction and an increase in nursing turnover.

I intend to test the validity of the enskilling thesis by examining the nature of nursing work, the effects of professionalisation and rationalisation and the level of job satisfaction experienced by registered nurses working in a large metropolitan teaching hospital in Sydney.

The professionalisation process will be determined by examining the strategies of professionalisation used by New South Wales nurse leaders, including the transfer of nurse education to the tertiary sector and the implications of this for nursing work. It will include an examination of the development of a career structure for nurses which has resulted in specialisation within nursing and a polarization of nursing skills. Specialisation in nursing takes the form of the medical model of specialisation along the lines of specific
diseases, periods in lifespan and parts of the human body. Apart from the traditional segmentation in nursing along administrative, clinical and educational lines this specialisation has resulted in a polarization of nursing skills with the production of a small group of specialists and a majority of generalists.

The rationalisation of health services includes the departmentalisation of health care within hospitals. An increased number of health care workers have systematically stripped the registered general nurse of many former roles. Cost-cutting and efficiency drives based on instrumental rationality have resulted in a fragmentation of nursing. Increasingly, policy and procedure are dictated entirely from above as control over the nursing workforce is effected by the separation of conception and execution.

Skills and deskilling

Specialisation and fragmentation as defined are both linked to deskilling (Littler: 1982). An analysis of skill involves an assessment of the objective competence of a task, the level of autonomy and the social construction of skills (Beechey:1987). Skill is the product of struggle in the workplace. It has more to do with the relative strength of the opposing groups and their competition to control their work. The effects of gender compound the workforce struggle as “skill definitions are saturated with sexual bias.”
For the purpose of this study skill will be measured from objective and subjective perspectives. The objective measure of skill will involve task complexity as perceived by the researcher and as perceived by the nurses themselves. It will also involve diversity of knowledge, technology and autonomy. Subjective measures of skill include the social construction of skill, length and type of training, entry requirements, educational standards and political struggles which involve the ability to claim 'skill'.

In order to assess the nature of nursing skills I will carry out participant observation in a variety of wards in a large Sydney teaching hospital. I will examine the tasks performed by nurses as part of their daily work experience. I will also examine the tasks performed by registered nurses that are interchangeable with workers without formal qualifications such as wardsmen, ward assistants and ward clerks.

Using in-depth interviews I will determine how nurses perceive their work and the nature of the skills they possess or use. Many of the skills once used by nurses are now the function of other workers. By interviewing registered nurses who have worked for up to twenty years I will be able to ascertain the changes in the types of skills used. Content analysis of policy and procedure manuals and job descriptions will also reveal changes in skill levels or requirements. A comparison of the skill level of college
graduates with those of hospital trained nurses will reveal the dynamics of socially constructed skills. Berg in *The Great Training Robbery*, (1973) claims that work skills are mostly learned on the job. The dominant groups in nursing are constantly making the claim that college training produces a 'superior' nurse yet the practical capabilities of college nurses are such that when they enter the workforce as registered nurses they are 'not ready to practice alone' (Englert:1989). They have not experienced many of the simple or complex nursing procedures before they graduate. The question of the quality of the skills of the college graduate will be examined in the context of constantly reduced entry requirements to maintain numbers as nursing departments in tertiary institutions fight to expand their roles.

Deskilling involves a reduction in the skill content of a job, loss of autonomy or the loss of the skills of specific workers. It also involves a reduction in the status of a job relative to other jobs and loss of control over the execution of skills in a job. I will examine the notion of 'tacit' skills and 'indeterminate' skills (Jamous and Peloille:1969). Nursing leaders have always denied the existence of both as being 'intuition' and therefore unscientific. In the search for a knowledge base they have denied the very aspects of skill that have helped to enable the medical profession to gain dominance.
Job satisfaction - Method

Job satisfaction and dissatisfaction are concepts that have been studied at length even in the nursing context. Using the intrinsic/extrinsic dichotomy (Herzberg:1959) I will determine the factors that have the most impact on job satisfaction and dissatisfaction in nursing. I will examine whether there is a link between the intrinsic factors and job satisfaction as previous studies reveal clearly that skill utilization and autonomy are major concerns of most workers. I will use in-depth interviews to determine this but will include some of the variables known to impact on job satisfaction levels. Age, education, length of service and position in the organization are all known to influence job satisfaction so must be taken into account. I turn now to describe the research methods used in this study.

Participant observation

Participant observation is the principal method of data collection in this study. It is the research method where the researcher becomes as much as possible a member of the group being studied. This involves continuous social interaction between the subjects and the researcher. Bogdan recommends choosing a research site in which the subjects are strangers because in observing subjects who are friends the researcher may become too personally involved to be effective (1972:12). He also suggests an observer should not observe in situations in which he or she has some
knowledge (1972:13). He claims that it is difficult for the observer to detach his/herself from personal feelings. On the relationship between researcher and subject Friedrichs also noted that

"The very process of observation changes, to a greater or lesser extent in the shorter or longer run, the action it seeks to register."

(1968:9)

I do not take the position of Bogdan as I believe my expertise in nursing will enable me to understand interactions between nurses that would be difficult for a non-nurse to recognize. I do, however, acknowledge that the process of observation can change the action it seeks to observe, and further that as a full participant in the nursing scene I am subject to the same emotional and physical strains that are at present affecting the nurses I am observing. Added to this are the ethical problems involved with this form of research. Many of the nurses are aware that I am involved in research but do not know the exact nature of my research. Some nurses are aware that I am studying nursing but not that they may be the subject of my research. When do I cease to be a colleague or friend to become a researcher? Many nurses have revealed their sadness over specific aspects of nursing during the course of casual conversations without being aware that their comments may be documented to be used at a later date. Conversations that I overhear are relevant to my study. Am I justified in recording private conversations? To solve this ethical dilemma I will not permit any account to reveal the
identity of the subject quoted. Neither the name of the hospital nor the identity of any subjects will be documented, even in field notes. I always reveal the nature of my study to interview respondents. I inform them that I am examining the nature of nursing work as perceived by nurses. I assure them of the confidential nature of their responses and that any information that may identify them will altered. The substance of their comments will be maintained however.

Many techniques for data collection are used during participant observation including the recording of conversation. I will use 'situational conversation', informants and when available check records. In this way data from one source can be checked against that from another using the principle of triangulation (Denzin, 1970). I will elaborate on this principle later.

Participant observation is particularly appropriate for the study of social organizations or groups where direct social interaction occurs between the researcher and the organization or group and where fieldwork evolves over a period of time. Gold distinguished between the following roles for the researcher. (1958). Complete observer, observer as participant, participant as observer and complete participant. These roles incorporate the distinction between covert and overt participant observation. All researchers move from one role to the other depending on the situation.
Verbal interaction ranges from casual conversations to unstructured interviews. Schatzman and Strauss (1977) listed "strategies for listening" as eavesdropping, situational conversations to interviewing. (pp70-73) They also recommended the following note-taking strategy. (1973 ch 6) 'Observational notes' which are descriptive,(p100) 'theoretical notes' from which meaning is derived (p101) and 'methodological notes' which contain instructions. They recommend that field notes are kept sequentially and indexed as ON, TN, MN to monitor the problematic aspects of an unstructured project. Theoretical notes show how data analysis should be an ongoing process. (Lofland, 1971:117-118).

Bottomly carried out participant observation of coalminers who were also members of the Communist Party (1978:217-8). He was surprised by their conventional - conformist attitudes which appeared to contradict their socio-political convictions. This discrepancy became the focus of his research. He claimed that it is in the realm of data collection that discrepancies are most apparent between the ideal and the real. He suggested that 'methods books' tend to underestimate the amount of compromise, in research techniques, that arise from social constraints in the research context itself. He found his questions elicited different responses in different contexts leading him to question which response is true. Context is clearly an important mediating factor. My own experience interviewing nurses support this view. Interviews l
conducted with nurses in 1984 as part of my undergraduate thesis were initially very difficult (Herdman, 1985). Most responses were reflections of the dominant ideology in nursing. Nurses responded in rhetorical terms that expressed the ideals of nursing while their behaviour revealed quite different attitudes. It was only after I developed a rapport with them that they began to express themselves in their own terms and their expressions were in accord with their behaviour.

Responses were more likely to express the dominant themes in nursing if nurses were in groups, especially if some members of the group were strangers or more senior staff. If nurses were interviewed alone, or in small groups of close colleagues they were more open and critical in their responses. Pilot studies for the present analysis revealed a very different attitude amongst nurses than that in 1984. I have interviewed a sample of nurses about the present nursing situation using situational conversations to in-depth interviews and none have expressed their views in terms of the dominant themes. Nurses are much more open about their dissatisfaction with their situation in nursing. They express their discontentment whether in groups or alone, without hesitation, and often without any initial questioning on my part. It appears that the dissatisfaction in nursing is so strong and widespread that there is a need for it to be expressed. This will facilitate my research as previous studies have proven very time-consuming as I have attempted to develop a rapport with those I interview.
In-depth interviews

In-depth interviewing techniques provide the researcher with the opportunity to probe extensively for sensitive information from potentially evasive subjects. Each interview is adjusted to each subject to encourage candid responses. (Williamson et al, 1977:165-6). The interviews are unstructured, flexible, lengthy and dependent on the interaction between the researcher and the subject. Some questions will be standardized but basically the individuality of the subject determines the course of the interview. The technique has been used in studies of deviance, (Becker, 1955, 1963; Denzin, 1970) the research of elites, (Zuckerman, 1972) unions, (Lipset et al, 1956) and victims of rape. (Burgess and Holmstron, 1974). Clearly the technique has a variety of applications.

There are a number of considerations that influence the ultimate utility of this approach. These include the intensity of interest between the respondent and the researcher in making the interaction mutually beneficial. The ability of each to understand the true intent of the others' statements and the ways in which each interprets the content of the interaction (Williamson et al, 1977:168).

Interviews are usually characterized by the degree of structure, from highly structured or standardized to unstructured. In between these two extremes are a variety
of combinations. Semi-structured interviews include certain questions asked of all subjects and unstructured questions. This enables the researcher to obtain demographic variables as well as responses regarding unique experiences and perspectives of the subject. In studies of job satisfaction for example, variables such as age and level of education are known to influence responses so these variables must be included in all interviews.

The strengths of the indepth interview technique is also the source of its most vital weakness. There is a reduced chance of the interviewer and the subject misunderstanding one another since questions can be restated in terms clearer to the subject if confusion occurs. Inconsistencies and contradictions can be clarified. More accurate responses can be elicited with this method than with survey research because of the closer interaction between researcher and subject. There is less chance of imposing a set of categories on the subject and a more complete picture is obtained than would be possible with more structured surveys. It is possible to explore underlying motives and personal experiences that can be linked to attitudes and behaviour.

The limitations of indepth interviews include the fact that they are difficult to generalise and the generalisations we make cannot be tested. Sampling procedures also pose problems as the interviews are usually conducted using small non-probability samples. The data do not lend themselves to quantitative statistical analyses, and the lack
of standardisation in the collection of data makes replication difficult. The method is also highly vulnerable to interviewer bias because of the informal nature of the process. The interviewer may convey a great deal, unintentionally, about his or her personal values and attitudes. This has an impact on the response, as does the desire of the subject to give socially desirable answers or answers to please the interviewer. It is essential that the interviewer avoids asking leading or loaded questions.

The data that emanate from in-depth interviews are subject to interpretation problems which pose a further source of bias. The effectiveness of the technique is clearly related to the ability of the researcher who must be aware of the potential for bias at all stages.

Life histories will be used in this study to expand on the data collected from in-depth interviews. Minichiello et al claim that there are two basic approaches to the life history research. The first is the nomothetic approach which is based on the notion that theoretical generalisations can be drawn from systematic experimentation using statistical validation and that these generalisations can apply to many people. The second is the ideographic approach which claims that it is both scientifically valid and methodologically correct to examine behaviour and perceptions of a single individual as an independent whole (1990:155).

Denzin (1989) believes that there are variations of these two
approaches that can be found in three types of life history practice. These are the complete life history which incorporates the full range of life experiences. The topical life history which focusses on one phase only and the edited life history which incorporates both the complete and the topical life histories. In this study the life histories are extended in-depth interviews. They focus mainly on the career histories of the respondents and are intended to provide more comprehensive illustrations of their experiences of nursing work. They focus on the 'relationship between biography, structure and history' (Minichiello, 1990:164).

Discourse Analysis

Thompson outlined three levels of discourse analysis. (1984:136) First, forms of discourse analysis may be studied narratives "because ideology, in so far as it seeks to sustain relations of domination by representing them as legitimate, tends to assume a narrative form". (ibid) Stories that justify the status quo glorify the dominant groups, the power base. These are the 'myths' of official discourse. The 'narratives' of the everyday working life of the practising nurse comprises much of the social interaction to be studied in this thesis.

The second level of discourse analysis outlined by Thompson involves 'the argumentative structure of discourse' (1984: 136). In other words explanations and reasonings that can be reconstructed to highlight the ideological features of
discourse by revealing their function of legitimation and dissimulation. When relations of domination are concealed and the actual concealment is also concealed conflict and contradiction emerge. (1984:137). Thompson suggests that an analysis of 'argumentative structure' reveals the contradictions contained in the discourse.

The third level of analysis focuses on syntactic structure, the syntactic devices which play a role in discourse. Thompson refers to 'nominalisation, passivization, the use of pronouns and the structure of tense', that enables the researcher to reveal processes of reification within language (1984:137). Processes that are represented as things lose agency. Syntactic methods are used to remove history from society.

Thompson suggests that discourse analysis is a vital part of the study of ideology (1984:141) It is the way meanings serve to sustain relations of domination. The methodological procedure he presents combines social analysis and discourse analysis to study ideological discourse.

Nurses are not an homogeneous group. In nursing there is a plurality of roles, aims and needs. There is also a plurality of discourses based on these roles, aims and needs. Nursing is not only pluralist it is also stratified. The different groups within nursing are unequal in terms of status, power and access to resources as well as unequal in terms of gender, class, ethnicity and age. For the purpose of this study nursing will be divided into two main groups. The first is the
dominant group that includes the educators, administrators, unionists, public servants, specialists and consultants. This group can be seen as hegemonic, authorised or officially sanctioned. The second group that comprises the bulk of practising bedside nurses is non-hegemonic, disqualified and alienated.

In summary

This study is characterized by a methodological pluralism that uses a triangulation of methods (Denzin 1970). Triangulation is a term used by Denzin to describe a methodological principle that means the use of more than one research technique in studying the same phenomenon. It is based on the idea that no one method is infallible so the use of several gives more conclusive results. It can involve using quantitative and qualitative methods as complementary. The position of nurses within a large bureaucracy can best be understood through a multidimensional approach that focuses on participant observation, indepth interviews, life histories and discourse analysis. This way it will be possible to observe at first hand the nursing experience, and compare this with the nurses' descriptions of their experiences and the images of nursing presented by the dominant groups.

Triangulation is considered an appropriate feminist strategy because it ensures that qualitative approaches are included, increasing the researchers ability to gather information. It
also allows feminist researchers to refute the biased and distorted results of earlier methods by comparing these results with findings on the same topic using other methods (Cook 1983). Feedback from the subjects perspective is incorporated into the findings, thus resolving the dichotomous subject-object problem.

We turn now to the next chapter which presents the results of the fieldwork conducted into the nature of nursing work.
RESULTS: "If I'm going to serve teas I'd rather be doing it at 30,000 feet to people who don't shit all over my uniform"

"If the profession's perspective of nursing is shared by the members of that profession, then any investigation of nursing practice should reveal a consistency between the behaviours manifested by the practice and those implied by the image projected by the profession." (Buckenham et al, 1983:42)

Introduction

This study is primarily concerned with the meaning and experience of work carried out by registered nurses in a large metropolitan teaching hospital in New South Wales. Nursing historiography and current nursing research have failed to take into account the experience of nursing work for the majority of nurses. This study is examining the proposition that nursing work in New South Wales has been progressively enskilled due to the effects of advances in medical science and technology. It is necessary to examine the nature of nursing work in order to test this proposition.

This chapter will outline the results of the fieldwork conducted into the nature of nursing work. Using participant observation I examined the tasks performed by registered nurses as part of their daily work experience. I conducted
in-depth interviews to determine how nurses perceive their work and the nature of the skills they utilise. Finally, I examined policy and procedure manuals to determine the extent to which registered nurses have control over their work.

Participant observation in the ward: "Can't she see I'm busy?"

I worked for twelve months on an orthopaedic ward in a large metropolitan teaching hospital. The hospital was classified as a high turnover hospital by Battersby et al., being a schedule two hospital with more than 350 beds (1990: 26). The ward catered for male and female patients who required elective orthopaedic surgery. Occasionally acute or urgent admissions were accepted when there were no beds available in the acute orthopaedic ward. The focus of my attention whilst working in this ward was the nature of nursing work. An examination of the work carried out by registered nurses, enrolled nurse aides, ward assistants and wardsmen reveals the nature of the skills used in the daily running of this ward.

Using Game and Pringle's classification of nursing work I categorised the work carried out on this ward to determine whether it was routinised and repetitive or highly skilled. Game and Pringle classified nursing work into the following categories (1983:97):
1 'housework'- cleaning up and making beds.

2 general nursing care-patient comfort, sponges and showers, emptying bed pans, turns, rubbing backs, oral hygiene.

3 healing functions-dressings, medications, intravenous therapy.

4 tests and observations-temperatures, pulses, blood-pressures, urine tests, ECGs, reports.

There are two principal forms of work assignment in nursing. With task assignment, a hierarchy of tasks is allocated on the basis of qualifications and level of training. In other words junior nurses carried out the 'housework' and general nursing care functions of the above classification while more technical procedures were carried out by senior nurses or registered nurses. With patient assignment the nurse is assigned a number of patients whom he or she cares for totally. In this ward patient assignment was the mode of work organisation.

There were twenty-two beds in the ward, arranged into six three bed cubicles and four single rooms. Sometimes the male and female patients were at opposite ends of the ward which meant nurses were assigned the 'male end' or the 'female end'. The 'male end' was considered by most nurses to be the better end to work in as male patients are
generally easier to nurse. Cowan, (1981) found that 34% of nurses preferred to nurse men while only 10% preferred to nurse women. At other times men and women were situated throughout the ward so that it was possible to have both male and female patients on a single shift.

The type of surgery most often carried out on the patients in this ward included hip replacements, total knee replacements, spinal fusions, insertion or removal of pins, screws and plates, removal of hip prostheses (artificial hip joints) and the application of external fixatures which are a type of external scaffolding or traction. Emergency patients often had broken limbs that required surgery or plaster application, fractured pelvis, skull or other or multiple injuries usually from motor vehicle accidents.

Most of the elective patients were elderly which meant that as well as orthopaedic problems they had medical problems that required attention. In fact the ward could be said to cater for male and female, elective and acute patients with both medical and surgical problems.

To describe the work carried out on this ward on a typical shift would be difficult because of the constant interruptions to the daily routine. It would be more useful to describe the work that is expected to be carried out on each shift. That is, the work that would be carried out under 'ideal' circumstances. Using the Weberian notion of 'ideal type' the
usual features of a typical morning shift will be described (Weber, 1968).

The morning shift started at 7am. All the registered nurses assemble in the staff room to receive a report from the night staff. There are usually four registered nurses plus the Nursing Unit Manager on duty on a morning shift during week days. It was usual for each registered nurse to be assigned six patients on a morning shift. The night staff report on the patients' condition, treatment and plans for the day such as planned operations or tests. The following is a typical list of patients that I nursed whilst on a day shift in this ward.

1 Mrs H. age 75, admitted with a crush fracture of her lumbar spine. She also suffered from Parkinson's disease and dementia. She was incontinent of urine and faeces and required full general nursing care.

2 Mrs M. age 58, admitted for a left total hip replacement. She was one day post operative so required full nursing care.

3 Mrs J.M. age 74, admitted for the removal of a left hip prosthesis. She was twenty five stone, was in traction and required full nursing care. She also suffered from bronchopneumonia.

4 Miss E.H. age 15, admitted with an external fixature on her leg that required adjustment. She also required control of pain. An external fixature is like scaffolding attached to the outside of the leg with pins inserted through the major bones. It is used to lengthen and straighten the limb.
Mrs T, age 72, admitted for a left total knee replacement. She suffered from rheumatoid arthritis and this was the second knee replacement she had had. She required full nursing care.

Mrs S, age 72, admitted for the removal of a wire from her left ankle. She came to the ward from a nursing home and required full nursing care including care of an indwelling catheter.

After receiving a report on each patient the first task for the nurse is the administration of medications due at 8am. The patients are served breakfast at 7.15am and are usually finished by 7.45am. The 8am medications includes the first of two calciparine injections administered to most bedridden patients to prevent the development of blood clots. The medications are administered from a mobile trolley that is shared between nurses at each end of the ward. The nurse who is able to grab the trolley first in the morning can get a head start on the work. While the nurse is giving out the 8am medications it is possible for her/him to be interrupted many times by calls from patients for bedpans, telephone calls, calls by other nurses for assistance with lifts or even to escort a patient to theatre or x-ray.

Many registered nurses commented on the difficulty of balancing the administration of medications with other duties. Wolf reported the difficulty nurses had in setting priorities, referring to a registered nurse who was late giving medications because she was giving pans at the same time and was ignoring a patient with chest pain (1988:145).
Nurses on this ward often complained about having to lock up the medication trolley to answer a call for a bedpan. Patients know if they have been kept waiting for a bedpan. They are not usually aware that medications are due at certain times or that they may have missed out. One registered nurse commented:

"Can't she see I'm busy? I'm standing there with syringes and needles in my hands and she asks for a pan...she can't wait a few minutes until I've finished? That's how mistakes made."

Nurses must work to a schedule set out by hospital policy yet they are constantly interrupted. If patients are due to go to theatre at 8am they must be washed, gowned and pre-medicated before 8am. A nurse may have two or more patients due for theatre by 8am. As well as preparing these patients, the nurse must answer requests by her/his other patients, administer routine medications and record routine observations at times determined by hospital policy. As well as this, other workers such as physiotherapists, occupational therapists, diet aides, doctors and social workers may arrive on the ward and require access to the patient at any time. The patient may be booked in for tests such as x-rays or ECGs and the nurse may be required to escort the patient to the departments where these tests are carried out. Nursing work is therefore carried out under the pressure of established routine, spontaneous diversions and incessant patient demands.
Once the morning medications have been given out the patients must be washed. Those who are bedridden are sponged, those who can shower are assisted to the shower either on a wheel chair or with a walking frame with the nurse walking alongside. All the beds must be made and the dirty linen collected and bagged. The dishes used to sponge patients, tooth mugs, pans and urinals are all washed.

It can take up to half an hour to sponge a bedridden patient who is unable to help by lifting and turning. Dentures have to be cleaned, hair combed, nightwear changed and the patient positioned comfortably. Those in traction must have their traction bandages reapplied, and the traction must be checked.

At 10am all the patients must have observations taken. This involves checking bloodpressures, temperatures, pulses and respirations. Some patients also require 10am medications. At 11am visitors begin to arrive. This means flowers must be arranged and all other requests dealt with. Patients also require other treatments such as dressings, physiotherapy, pressure area care, care of drains, indwelling catheters, intravenous therapy and whatever else the doctor has ordered.

After lunch more medications are administered, more observations are taken, reports are written and patient requests are dealt with. While routine tasks are carried out
as close as possible to the allotted times nurses are also called upon to do rounds with doctors, arrange tests, give out pain relief, ensure all medication charts and intravenous therapy charts are up to date, escort patients and carry out any change of treatment ordered by doctors, such as removal of drains or sutures.

The difficulty of trying to balance routine tasks with the many spontaneous demands from patients, doctors or others is the source of much stress for nurses. Medications, charts, reports and various other forms must be kept up to date. Documentation has legal ramifications that is impressed upon all nurses when they commence employment. Medications are ordered by doctors on medication charts. They are to be administered at specific times, in this ward these times are, 6am, 8am, 10am, 12md, 2pm, 6pm, 8pm, 9pm, 10pm and 12mn. Observations are recorded routinely at 6am, 10am, 2pm, 6pm, 10pm and 2am. Patients returning from theatre are routinely put on hourly observations. Reports are written at the end of each shift and all other charts including, diabetic charts, coagulation charts, circulation charts and fluid balance charts are brought up to date.

The evening and night shifts also involved a combination of routine duties carried out at specified times interrupted by a multitude of demands for other services by patients, doctors, visitors and other hospital workers.
The following is a list of tasks that were carried out while conducting participant observation on this ward. The tasks are listed according to Game and Pringle's classification (1983:97).

Table 5.1 

<table>
<thead>
<tr>
<th>Task observed during participant observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 'Housekeeping'</td>
</tr>
<tr>
<td>bagging of dirty linen</td>
</tr>
<tr>
<td>bedmaking</td>
</tr>
<tr>
<td>cleaning of comodes</td>
</tr>
<tr>
<td>mopping of floors</td>
</tr>
<tr>
<td>terminal cleaning of beds, lockers and bedtables</td>
</tr>
<tr>
<td>washing of pans, urinals, bowls and tooth mugs</td>
</tr>
<tr>
<td>2 General Nursing Care</td>
</tr>
<tr>
<td>admission of patients</td>
</tr>
<tr>
<td>application of TED stockings</td>
</tr>
<tr>
<td>diet sheets</td>
</tr>
<tr>
<td>discharge of patients</td>
</tr>
<tr>
<td>escorting patients</td>
</tr>
<tr>
<td>eye toilets</td>
</tr>
<tr>
<td>hair washing</td>
</tr>
<tr>
<td>lifting and positioning of patients</td>
</tr>
<tr>
<td>oral toilets</td>
</tr>
<tr>
<td>pressure area care</td>
</tr>
<tr>
<td>shaves</td>
</tr>
<tr>
<td>showering of patients</td>
</tr>
<tr>
<td>sponging of patients</td>
</tr>
<tr>
<td>skin preparation for surgery</td>
</tr>
<tr>
<td>toileting patients</td>
</tr>
<tr>
<td>walking patients</td>
</tr>
<tr>
<td>3 Healing Functions</td>
</tr>
<tr>
<td>dressings</td>
</tr>
<tr>
<td>intravenous therapy</td>
</tr>
<tr>
<td>insertion of indwelling catheter</td>
</tr>
</tbody>
</table>
medications, including enemas, injections
operation of tilt table
operation of fitch bed
operation of CPA machine
removal of drains
removal of intravenous cannulae
removal of sutures
spraying of wounds
traction care

4 Tests and Observations

blood pressures
charts
collection of specimens
ECG
making of appointments
pulses
reports
respirations
temperatures

Many of these tasks are also carried out by other workers such as ward assistants, enrolled nurse aides, wardsmen and ward clerks. The following table shows who carries out which task.
Table 5.2  Tasks carried out by occupation.

**Task**

**Occupation**

(1) 'Housekeeping'

<table>
<thead>
<tr>
<th>Task</th>
<th>RN</th>
<th>ENA</th>
<th>WA</th>
<th>WC</th>
<th>WM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedmaking</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Cleaning commodes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Mopping floors</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Cleaning lockers</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Cleaning beds</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Cleaning bedtables</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washing urinals</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Washing toothmugs</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Washing bowls</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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</table>

(2) General Nursing Care

<table>
<thead>
<tr>
<th>Task</th>
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<th>WA</th>
<th>WC</th>
<th>WM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission of patient</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Application of TED stockings</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Diet sheets</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Discharge of patient</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Clean dentures</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Escorting patients</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Eye toilets</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
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<tr>
<td>Hairwashing</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Lifting/positioning</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Oral toilets</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Pressure area care</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Shaves</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Showering patients</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Skin preparation for surgery</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
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<tr>
<td>Sponging patients</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
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</tr>
<tr>
<td>Toileting patients</td>
<td>yes</td>
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<td>no</td>
<td>no</td>
<td>no</td>
</tr>
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<td>Walking patients</td>
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</tr>
</tbody>
</table>
### (3) Healing Functions

<table>
<thead>
<tr>
<th>Activity</th>
<th>RN</th>
<th>ENA</th>
<th>WA</th>
<th>WC</th>
<th>WM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressings</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Intravenous therapy</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Insertion of catheters</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Medications, including</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>enemas and injections.</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>Operation CPA machine</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Operation fitch bed</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Operation tilt bed</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Removal of sutures</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Removal of drains</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Removal of IV cannulae</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Spraying wounds</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Traction care</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
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</tr>
</tbody>
</table>

### (4) Tests and Observations

<table>
<thead>
<tr>
<th>Activity</th>
<th>RN</th>
<th>ENA</th>
<th>WA</th>
<th>WC</th>
<th>WM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointments</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Bloodpressures</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Collection of specimens</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Charts</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Electrocardiograph</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Filing</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Pulses</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Respiration</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Reports</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Temperatures</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
</tbody>
</table>

**Abbreviations:**
- RN = Registered Nurse
- ENA = Enrolled Nurse Aid
- WA = Ward Assistant
- WC = Ward Clerk
- WM = Wardsman
In-depth interviews: "Too much work...not enough help!"

The registered nurses interviewed for this study all work in a large metropolitan teaching hospital. While conducting participant observation informal discussions were held with approximately eighty registered nurses over the period of one year. These discussions were recorded in field notes and were subsequently used as a guide for the construction of an interview schedule. In-depth interviews based on this interview schedule were then conducted with twenty-three registered nurses and the results of these interviews will be described in this section.

The registered nurses interviewed were from a variety of areas within the hospital and held a variety of positions ranging from ward nurse to Assistant Director of Nursing. Their ages ranged from 21 to 56 years with an average age of 33 years. Two of those interviewed were male nurses. Six were married, sixteen were single and one divorced. The following table indicates the position in the organisation, the specialty and the work status of the respondents.

Table 5.3 Work profile of respondents

<table>
<thead>
<tr>
<th>Position in organisation</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Director of Nursing</td>
<td>2</td>
</tr>
<tr>
<td>Nursing Unit Manager</td>
<td>3</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>18</td>
</tr>
<tr>
<td><strong>n = 23</strong></td>
<td></td>
</tr>
</tbody>
</table>
The original aim was to focus on registered nurses who worked in the same area in which participant observation was carried out. However, this ward was seriously understaffed with only five full-time registered nurses on the roster. The ward was therefore staffed mainly by relief nurses. In-depth interviews were conducted with the relief staff as well as the permanent ward staff, registered nurses who were transferred temporarily from less busy wards and administrators who were in charge of large areas of the hospital.
The interview schedule was divided into (1) demographic variables, (2) organisational variables, (3) contextual variables and (4) an unstructured component. (see Appendix A) As the focus of the thesis is the nature of nursing work and registered nurses' perceptions of this work, the responses to those questions that specifically relate to these factors will be described.

The registered nurses were asked to describe the work they carried out on each shift, (Q4.10, Q4.11, Q4.12) to discuss the nature of the work itself, (Q2.6, Q3.2) and to describe any changes in nursing and nursing work since they first began to nursing. (Q4.9, Q 4.14) Registered nurses who trained in the hospital system were asked to recall their student days to describe the work they carried out as first, second and third year nurses. (Q4.13) The respondents were also asked what they enjoy most and least about their present position. (Q4.7, Q4.8) To examine the nature of nursing skills the respondents were asked to comment on their perceptions of their decision-making ability and nursing autonomy in general. (Q3.1, Q3.5)

**Questions related to nursing work and stress. (Q2.6)**

When asked whether they believed that they were overworked the majority of nurses interviewed clearly believed that they were and that this caused them stress.
When asked about overwork one RN said:

"That is a problem, I try not to let it stress me, like I just take a sickie if its too bad... but christ the work is hard, its shitty, its too much."

Another RN said she was overworked and stressed with only....

"...two on for a heavy orthopaedic ward which involves heavy lifting. Sometimes you have twenty stone patients with only two women to do the lifts."

She felt stress because of the 'patients' attitudes' and because she 'hated the work."

A college trained RN commented:

"Yes I get very stressed, I don't think I'm ready to cope with such workloads."

Another agreed:

"I think we are overworked, and I get pretty stressed when I'm in charge and we're busy...especially if we have real sickies. I'm not experienced enough."

A college trained RN with several years experience also admitted to being stressed because of staff shortages and too much responsibility, 'especially being senior on with new grads!'
A relief sister, trained in the hospital system, claimed that

"In some wards the stress is overwhelming. I refuse to go to certain areas because you never have enough staff.

Rosters added to the stress experienced by some RNs because when working at weekends or on night duty less staff were employed making the workload even heavier.

"I'm very overworked...I rarely get a weekend off...in fact I'm nearly always rostered on lates Friday and Saturday and early Sunday. Working with relief staff doesn't help. Whenever I'm in charge I'm given less staff so I have to take patients. Yes I reckon we are all overworked."

Some RNs said they were overworked but that they were passed worrying about it.

"Yes, we are overworked, I used to worry about it but I've come to the conclusion you can only do your best."

Another RN agreed, saying,

"There's only two on at night in a busy thirty bed ward. That's the minimum allowed and we are flat out that's all we get. It's bad now we have the neuro patients because they're heavy and usually confused. I try not to let it stress me though...not any more. I used to get really upset if I didn't get time to do everything, or even do what I can properly...but not any more. It's not good enough by far...but admin doesn't give a damn...why should I?"
Nursing Unit Managers also claim to be overworked and stressed.

"I'm a NUM and I still always take patients. Most NUMs don't and we aren't supposed to but who else is going to do it? I never have enough staff. I have to do a lot of my own work, like rosters, at home.

He claimed that the overwork caused him a great deal of stress causing him to "have a few 'mental health days' (sickies) Sometimes I just can't face it."

Another Nursing Unit Manager also claimed to take home much of his work. "I do get very stressed...I was put into admin. for a bit of time out."

An Assistant Director of Nursing claimed that she was not personally overworked but 'on the wards it's bad. I feel the stress that way. When I can't safely cover the wards." Another senior ADN agreed that the ward staff were overworked. She claimed to have an ongoing argument with other nurse administrators over staffing because she believed that the low staff levels were dangerous.

The nature of nursing work. (Q3.2)

In response to the question on the nature of nursing work the majority of registered nurses claimed that it was routine and repetetive.
"The work I do is basic. I do half-hourly eyedrops for up to ten hours, that’s pretty routine and basic."

One registered nurse who often worked overtime in the ward claimed:

"In the wards the work is just plain housework. Cleaning this and that, making beds, doing obs. It was boring. I think if I hadn’t transferred to ICU I’d have quit by now."

She had tried twice to join Qantas and was working overtime to save enough money to take a year off nursing. She hoped in that time to find work outside nursing.

Another registered nurse commented on orthopaedic nursing:

"I hate it, orthopaedics I’m talking about. Basic... routine...boring. You don't need a lot of RNs to manage patients in orthopaedics...ward assistants could do it."

Another claimed that the work was "mostly general nursing care, ....pans, backs, cups of tea, fluff up pillows...."

Some registered nurses described their work in harsher terms as they found patient contact increasingly more difficult.
"The work is disgusting. The patients think you are their personal slave. Personally I'd rather not touch another patient. Whoever said nurses want to maintain patient contact must have been crazy. I never heard anyone say it who actually has to do it."

A registered nurse with twenty years experience claimed that the work was:

"Dirty, yuckie, pooey....it's got no satisfaction. As a student you knew you would get away from it. You can't get away from the menial tasks. I hate touching shit, I don't care what anyone says, no-one enjoys it. Shit is shit!"

Another senior registered nurse agreed saying:

"I hate it, it's the worst, it's demeaning, menial, thankless, unrewarding, heavy, dirty....I could go on and on...boring, routine..."

Finally one registered summed up her feeling about the nature of nursing work:

"Dirty, hard, menial, boring, soul-destroying."

What nurses enjoy least about their work. (Q4.6)

When asked to describe what they enjoy least about their present position most registered nurses focussed on the work and the patients.
"Having to touch patients" commented one Nursing Unit Manager.

A senior ward sister claimed that ..."all the patients want you for is bedpans and pain relief." A common response was that the patients were demanding.

"The patients drive me mad...always wanting. You never get a second to yourself. You never get the chance to even finish a cuppa."

"The patients, they're so demanding. There's too much work...too little staff...no thanks."

What the registered nurses enjoyed least about their work was

"The menial tasks...giving out pans...lifting people."

Some complained that the work was "too heavy and not stimulating enough..." and that it was "dirty...backs, washes, pans, it seems you never really escape them."

Perceived changes in nursing. (Q4.9)

When asked what major changes they perceived since they first began nursing the majority of registered nurses claimed that the work was basically 'junior'.

"The fact that RNs now do all the junior menial work. We are all back to the training days."
A senior ADN commented that:

"Nurses have become drudges again. We were drudges as students but we knew it was only temporary. Now RNs are drudges again. They do the work students did. There's too much specialisation now."

A senior registered nurse suggested that it was:

"The team nursing bit..you just don't get out of the menial tasks. You've got nothing to look forward to, unless you get into admin."

Another said she saw "increasing rules and regulations, more administration, specialisation and bureaucracy."

Some registered nurses claimed that the standard of nursing care had dropped because there are so many people involved with the care of the patient now.

"We used to do the physio, O.T., diet stuff, etc. Now others do it all. We are left with just basic nursing. Also we're doing junior nurses work, alongside ENAs and wardsmen."

A senior registered nurse summed up her feeling by saying "basically we are all just nurses with nowhere to go".

Changes in nursing work. (Q4.14)

When asked to comment on the changes in nursing work specifically many registered nurses claimed that the work was exactly the same as the work they did when they first
"Basically today I'm doing the stuff I did as a student. Most of the junior nurses' work...but I also have to do the other stuff...be responsible for the ward...any emergencies. It's first, second and third years all rolled into one, but no more teaching, no more managing. That's specialist stuff now. I'm back where I started with all the rotten work and none of the interesting stuff."

Most of the registered nurses interviewed agreed that the work they now carry out is junior and menial but that they now also have to take responsibility for the ward as well.

"I still do washes, sponges, backs and pans. I still run the ward because I'm a NUM but the other RNs are like junior nurses. I'm like a third year I suppose. I'm still just a nurse."

Many complained that the work was more interesting when they were students.

"I do the same things now that I did as a junior nurse. I had more interesting work as a third year nurse. RNs have been pushed down the scale in the work they do and in status."

Another commented that the work was more specialised now.

"A lot of the stuff I did as a third year nurse they now have specialists to do, such as TPN, Stomal Therapy, plastics. Today I do the work of student nurses...junior ones at that. If I did the work I did as a third year student I'd be happy...but I don't its all junior work now."
One senior RN claimed that

"Since all the students have gone it's been pretty rough for RNs, they have to go back to their training days and do all the shit stuff. It's pretty humiliating. You think you've left all that behind now you find you've got it for good."

A senior ADN claimed that

"Sisters ran wards, they were teachers, supervisors, managers. They were in charge. They were respected by patients and doctors. They were in complete charge...sisters taught nurses...now sisters are nurses. They do all the work nurses did. They do the pans, temps, sponges. It's a hell of a comedown isn't it?"

Student Nurses' work. (Q4.13)

The registered nurses who were trained in the hospital system were asked to describe the work they did as student nurses in order to determine whether the nature of the work had changed over time. Most claimed that as first year nurses their work mainly involved cleaning duties.

"In first year I spent most of my time hiding in the panroom. Sponges, showers, pressure area care, temperatures, pulses and respirations, sometimes blood pressures, pans, pans, pans, cleaning wards, cleaning panrooms, testing wees...thought that was great at first...fluid balance charts."

One RN summarised her first year as a student nurse as "beds, backs, bums and pans."
In second year student nurses progressed to do dressings, intravenous therapy, naso-gastric feeds, indwelling catheters, medications and drains as well as the general nursing care carried out in first year.

All the RNs interviewed enjoyed their third year as student nurses.

"We were in charge, rounds, reports, IVs, medications, supervised juniors."

They took pride in the fact that once they were in third year they were "running the ward...teaching and supervising."

"You were usually in charge from late second year to early third year. RNs were not always on so you did the stuff RNs do today."

The following duties were carried out by hospital trained registered nurses during their student days.

Table 5.4 Work carried out as a student nurse.

<table>
<thead>
<tr>
<th>First year of training</th>
<th>(1) Housework</th>
<th>(2) General nursing care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>cleaning panrooms, wards.</td>
<td>toileting patients</td>
</tr>
<tr>
<td></td>
<td>pans, toothmugs, bowls</td>
<td>sponges, showers</td>
</tr>
<tr>
<td></td>
<td>teas</td>
<td>pressure area care</td>
</tr>
<tr>
<td></td>
<td>bedmaking</td>
<td>feeding of patients</td>
</tr>
<tr>
<td></td>
<td>flower arranging</td>
<td>back washes</td>
</tr>
<tr>
<td></td>
<td>running messages</td>
<td></td>
</tr>
<tr>
<td>(3) Healing functions</td>
<td>(4) Tests and observations</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>simple dressings</td>
<td>fluid balance charts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>temperatures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>pulses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>urinalyses</td>
<td></td>
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</tbody>
</table>

Second year of training

<table>
<thead>
<tr>
<th>(1) Housework</th>
<th>(2) General nursing care</th>
</tr>
</thead>
<tbody>
<tr>
<td>As for first year</td>
<td>As for first year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(3) Healing functions</th>
<th>(4) Tests and observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>As for first year</td>
<td>As for first year</td>
</tr>
<tr>
<td>Complex dressings</td>
<td>bloodpressures</td>
</tr>
<tr>
<td>Insertion of catheters</td>
<td>in charge</td>
</tr>
<tr>
<td>Medications</td>
<td></td>
</tr>
<tr>
<td>Care of drains</td>
<td></td>
</tr>
<tr>
<td>Naso-gastric feeds</td>
<td></td>
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</table>

Third year of training

<table>
<thead>
<tr>
<th>(1) Housework</th>
<th>(2) General nursing care</th>
</tr>
</thead>
<tbody>
<tr>
<td>None listed</td>
<td>None listed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(3) Healing functions</th>
<th>(4) Tests and observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intravenous injections</td>
<td>In charge</td>
</tr>
<tr>
<td>Loading IV flasks</td>
<td>Ward management</td>
</tr>
<tr>
<td>Medications</td>
<td>Rounds/reports</td>
</tr>
<tr>
<td>Insertion of catheters</td>
<td>Supervision of juniors</td>
</tr>
<tr>
<td>Complex dressings</td>
<td>Teaching of juniors</td>
</tr>
<tr>
<td></td>
<td>Ordering stock/drugs</td>
</tr>
<tr>
<td></td>
<td>Rostering</td>
</tr>
</tbody>
</table>
The tasks described by registered nurses require a closer examination because they present an oversimplification of nursing work. Dressings, for example, are described as either simple or complex. There are many different types of dressings used for many different purposes. A simple dressing could involve the application of an antiseptic solution and a gauze covering over a small clean wound while a complex dressing could involve the irrigation and packing of a major abdominal wound. All dressings are carried out using an aseptic technique and the care of a wound that is already contaminated requires a knowledge of infection control.

Dressings are also carried out to prevent the entry into the body of microorganisms. Patients who have central and peripheral intravenous lines are vulnerable to infection at the site of entry so special care is taken to protect these sites with sterile dressings. Intercostal drains, nephrostomy tubes, suprapubic urinary catheters and a variety of other drains provide a portal of entry for infection and therefore require dressings.

Bedmaking may appear to be a simple enough task but nurses must also learn how to make a bed for a patient returning from theatre, a traction bed and an occupied bed. The nurse must know how to make a bed with an unconscious patient in it, or a patient with spinal injuries, multiple fractures or a patient connected to a variety of monitors, drains and intravenous lines.
Most hospitals provide a procedure manual for nurses. The hospital in which I carried out participant observation produced a 265 page manual of nursing procedures. The manual was compiled by staff of the hospital working in the areas where the procedures are most commonly performed. It was reviewed by a Nursing Procedure Committee who approved the procedures.

The following list describes the tasks approved by the committee for registered nurses to perform.

Table 5.5  Tasks approved by the Procedure Committee

Admitting a patient
Arrest cardiac-management
Assisting with
  Bone marrow Biopsy
  Intercostal Catheter Insertion
  Intravenous Line Insertion
  Liver Biopsy
  Lumbar Puncture
  Pleural Aspiration
  Renal Biopsy
  Stick Catheter Insertion
  Tenckhoff Catheter Insertion
Bandaging
Barium-preparation for
  enema
  meal
  swallow
Bedmaking
  basic
  occupied
  operation
Bladder Irrigation
Blood Pressure
Care of body after death
Catheter
  Intercostal
  Removal of Indwelling
Catheterisation
Cleaning
  bed unit
  sluice
Continuous Ambulatory Peritoneal Dialysis
C.T. Scans preparation for
Deep breathing and coughing
Diagnostic radiology-preparation for
Discharge of patient
Douche vaginal
Drainage tube
  removal of
  shortening of
Dressing
  basic
  central line
  contaminated
  eye
  moist or packing wound
  nephrostomy tube
  penile
  peripheral line
  shunt external
  suprapubic catheter
  Tenckhoff catheter
Drops
  ear
  eye
  nasal
Drugs - Administration of drugs of addiction and restricted drugs
Enema
  disposable
  evacuation
  retention
Evacuation
  bowel lavage
  enema
  flatus tube
rectal suppositories

Eye

drops and ointment
lashes cutting
toilet

Hair-removal of vermin, shampoo

Handwashing

Heparin lock

Hickman catheter-changing and dressing of

Injection

intramuscular/subcutaneous
intravenous into cannula or infusion
intravenous using metriset
loading medications into solupacks
piggy backing
scalp vein needles

Inhalations

Lifting, turning and posturing a patient

Mouth toilets

Nasogastric tubes

feeding via
insertion of
removal of

Operation

preoperative preparations
postoperative care
transport from recovery

Oxygen

Perineal swabbing

Pessaries-insertion of

Plaster check

Postural drainage

Pressure area care

Pulse, temperature and respirations

Radioactive-nursing care of patients

Ray lamp application

Removal of clips and sutures

Respiratory physiology

Shaving

Slings

Specimen collection

sputum
stoold
swab
urine

Stoma-changing and emptying a bag
Many registered nurses are ambivalent about the procedure manual. While they recognise the utility of the manual when it comes to complex procedures such as setting up for and assisting with a liver biopsy they consider instruction in handwashing unnecessary. Such instruction is not considered necessary for the doctors who often show extreme disregard for aseptic technique.

The section on handwashing in the procedure manual contains sixteen points including how far to pull the paper towel out of the dispenser, to discard the paper into a tidy bin and at the conclusion of the procedure to replace the lid of the tidy bin.

The instillation of eye drops involves seventeen steps two of which are instructions to 'wash hands'. It is difficult to understand why 'professional' nurses should require such minutely explicit instruction for such basic procedures.

Many registered nurses complained that 'specialisation' had taken away their skills. None of the registered nurses interviewed specified any of the complex procedures mentioned in the procedure manual as being part of their work experience. The following table reveals the many
specialty areas that registered nurses are now employed in.

Table 5.6 Nursing Specialties

<table>
<thead>
<tr>
<th>Specialty Area</th>
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<tbody>
<tr>
<td>Allergy and Immunology Sisters</td>
</tr>
<tr>
<td>Weight Control Programme Sister</td>
</tr>
<tr>
<td>Preparation for Parenthood Sister</td>
</tr>
<tr>
<td>Lactation Sister</td>
</tr>
<tr>
<td>Haemophilia Sister</td>
</tr>
<tr>
<td>Gastroenterology Unit Sister</td>
</tr>
<tr>
<td>Admission Sister</td>
</tr>
<tr>
<td>Discharge Liaison Nurse</td>
</tr>
<tr>
<td>Policy/procedure Co-ordinator</td>
</tr>
<tr>
<td>Quality Assurance C0-ordinator</td>
</tr>
<tr>
<td>Senior Liaison Nurse-Drug and Alcohol Services</td>
</tr>
<tr>
<td>Amputee Sister</td>
</tr>
<tr>
<td>Diabetic Education Sister</td>
</tr>
<tr>
<td>Infection Control Sister</td>
</tr>
<tr>
<td>Mental Health Consultation Nursing Service Sister</td>
</tr>
<tr>
<td>Oncology Sister</td>
</tr>
<tr>
<td>Pain Sister</td>
</tr>
<tr>
<td>Plastic Surgery Unit Sister</td>
</tr>
<tr>
<td>Stomal Therapist</td>
</tr>
<tr>
<td>Total Parenteral Nutrition Sister</td>
</tr>
<tr>
<td>Transfer Factor Sister</td>
</tr>
<tr>
<td>Palliative Care Sister</td>
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<tr>
<td>Continence Sister</td>
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</tbody>
</table>

The Nursing Report

In this section the dominant nursing discourse will be contrasted with the 'bedside' discourse. This will be done by firstly describing the 'nursing report', which is a major nursing ritual that occurs at the change of each shift. Secondly, by examining the way registered nurses talk about their reality of nursing work compared to the language of the dominant discourse.
The 'nursing report' is a practice that takes place when registered nurses on one shift hand over to registered nurses on another. It is also referred to as 'the changeover' or 'the handover'. The purpose of the report is to provide information on patient management. The specific details include bed number, name, date of admission, age, diagnosis, treatment and condition. The degree of formality in which the report is carried out is variable. It ranges from highly formal to almost casual. The level of formality depends upon who is present, the time of the week or the time of the day. A report carried out on a Monday morning with the Nursing Unit Manager present is highly formal and detailed. A report carried out on a Saturday night is casual and brief. The following is an example of two verbatim transcriptions of reports given by the same registered nurse at different times.

Wednesday morning report by the registered nurse on night duty to the Nursing Unit Manager and four registered nurses.

"In bed one we have Mrs. T. a sixty-eight year old Italian lady who speaks very little English. She was admitted two days ago with a fractured left femur after falling over in her back yard. She went to theatre on Monday so she's two days post-op. This woman needs a lot of assistance because she gets quite confused and is very obese. She is very restless at night and requires frequent analgesia because she has a very low pain threshold. She was incontinent of faeces overnight and has urinary frequency so will need an MSU (urine test for bacteria) because she may have a UTI (urinary tract infection). She's on IV antibiotics but the six AM dose hasn't been given yet because her cannula has to be resited."
Saturday evening report to the night staff by the registered nurse on evening duty.

"Bed one is a sixty-eight year old fractured left femur. She's an Italian who can't speak a word of English even though she's been here for twenty-five years. She's six days post-op but still wants pethidine every five minutes. She's always on the pan but won't help lift herself an inch and she's absolutely huge...must be all that pasta. You really have to push her to do anything for herself. Last night she shit the bed and you wouldn't believe the state she got herself in. She is constantly calling out. She's just so demanding. Best thing is to bomb her out with pethidine and some sleepers or you won't get a minutes peace. She's on oral antibiotics but it takes ages to get her to swallow the bloody things. She's just a pain".

The language of the first report is formal. The patient is referred to sympathetically as a person who has been injured in an accident. She requires assistance because she is obese and elderly and encouragement because she gets confused and speaks little English. She is provided with analgesia because her pain is acknowledged. Medical terminology is used to describe her condition of faecal and urinary incontinence and recommendations are made to treat the problem for the benefit of the patient.

The language of the second report is casual. The patient is objectified by being referred to as a bed number and a disease. Her lack of English is criticized as is her need for frequent pain relief. Her urinary frequency, which is a painfull condition, is seen as troublesome to the nurse but
not the patient and her faecal incontinence is seen as disgusting. Recommendations made to solve these problems are for the benefit of the nurse rather than the patient.

The language of the dominant nursing discourse is formal and authorised while the language of the 'bedside' discourse is casual and unauthorised. A patient who is 'incontinent of faeces' is said to 'have shit the bed'. A patient who is obese is fat or huge. Restlessness becomes troublesome. A nervous patient is demanding and a patient in pain 'likes the pethidine'.

The registered nurses who were interviewed in-depth also used the language of this 'bedside' discourse.

Life histories

The following life histories describe the careers of four registered nurses working at the hospital in which the study was conducted. The first describes the career path of an Assistant Director of Nursing who graduated in 1970, the second, a male Nursing Unit Manager who graduated in 1984, the third, a college graduate who began her nursing career in 1988 and the fourth, a part-time relief sister who graduated in 1975.
"I'd leave tomorrow if I had to work on the wards!"

Sister A.B. graduated from the same large metropolitan teaching hospital in which she is now employed as an Assistant Director of Nursing. She is married with three teenage children. S.B. has never worked in any other hospital, has no postgraduate qualifications nor any formal management qualifications but worked her way through the system to the senior position she now holds. While her children were young she worked part-time night-duty. She has now worked full-time for ten years. Her husband has had long periods of unemployment due to illness so A.B. has had to work to support her family. While A.B. often is in conflict with nursing administration, in particular over staff shortages, she is generally held in high regard by the nursing staff because of her sympathetic approach and her willingness to 'roll up her sleeves' when necessary. Unlike most nurse administrators A.B. has kept abreast of nursing practice and is highly respected for her knowledge and ability.

When asked about her training A.B. claimed that she began nursing in 1967 after obtaining her Intermediate certificate. She chose nursing because 'there were very few options when I left school. It meant I could get paid while I trained...that was really important." She enjoyed her student days and had no regrets about her choice of nursing as a career. "I loved the work...the patients...it was so long ago... the friends...living in. It was fun."
Her first year as a student nurse was "pans, panroom, washes, sponges, teas...you could do a urinalysis if you were good. Temps and pulses...fluid balance charts." In second year "you got to do the same as first year but you could also give out pills and do dressings and obs." When asked about her third year as a student nurse she said "...the big third year. I enjoyed third year most. You were in charge. You did teaching, IVs, medications, rounds. You did complicated dressings, reports...it was great."

A.B. perceives great changes since her training days.

"Sisters ran wards, they were teachers, supervisors, managers. They were in charge. They were respected by patients and doctors. Sisters taught nurses...now sisters are nurses. They do all the work nurses did. They do the pans, temps, sponges, its a hell of a come down isn't it?"

A.B. believes that the hospital system produced a high standard of nursing care.

"I've worked in this hospital for fifteen odd years and I've seen a huge decline in the standard of nursing care especially since college grads. came on the scene. They expect an RN to do the work of two students. It's impossible even if their hearts were in it."

She claimed that hospital trained nurses "were capable, skilled nurses when they graduated... in fact even as third years." College graduates "hit the wards and are totally
useless...they know nothing...there is no comparison."

The major changes A.B. perceives since she began nursing are the fact that

"The standard of care has dropped dramatically... nurses don't care anymore. The work is menial... its an insult to trained nurses with years of experience to expect them to now run around with pans. Some of my RNs used to run wards, now they clean bums."

When asked why nurses are leaving she claimed

"Because they are just lackies, they have no respect, the work is hard...they have nowhere to go...its the same in every ward now. Sisters have become hands-on workers. No-one can sustain such a high level of stress and hard work for more than a few years."

A.B. recognises the stress felt by the majority of registered nurses but claimed that she enjoyed her own job because it gave her the freedom to move around.

'...to be my own boss. I'm not at the beck and call of the patients...I don't have to give out pans...left... none of that crap.'

She sees a return to the 'old system' or the employment of 'more ENs to take the pressure off' as the only solution to the problem of nurses leaving the system. Of her own future in nursing she believes that she will probably go no further, however,

"I'll stick it out as long as I have this job...
I'd leave tomorrow if I had to work in the wards."
"If I'm going to serve teas I'd rather be doing it at 30,000 feet to people who don't shit all over my uniform."

D.B. is a twenty-six year old male nurse who graduated in 1984. He was one of the last of the hospital trained registered nurses. He is unmarried and at the time of this study was working full-time as a Nursing Unit Manager in a busy surgical unit. His career in nursing reveals a rapid rise to a position of management and he readily admits that this is because he is a man and "knows the right people". Prior to working as a Nursing Unit Manager he was working on a medical ward where the NUM was also male. He was second in charge in this ward for two years.

D.B. has not completed any post-graduate studies since he graduated in 1984 and claims that he has no intention of doing so.

"I seem to do OK without. You just have to play it cool with admin, and they'll give you anything...they like to think you are loyal... they love to see you grovel. I let them think they're always right...but sometimes they're so stupid and petty. I hate them sometimes... and myself for playing their games, but there is no other way of getting ahead".

D.B. believes he has a limited future in nursing despite his rapid promotion. "You really have to sell yourself to get this far and I think I've sold enough of myself". He regretted his decision to go nursing especially since both his brothers and
sisters had reached senior positions in other more prestigious professions and were far better off financially than he. He had tried several times to join Qantas as a flight attendant but has been unsuccessful. "If I'm going to serve teas I'd rather do it at 30,000 feet to people who don't shit all over my uniform!"

As a first year nurse D.B.,

"spent most of my time hiding in the panroom. Sponges, showers, pressure area care, TPRs, sometimes BPs, pans, pans, pans, cleaning wards, cleaning panrooms, testing wees...thought that was great at first. Fluid balance charts."

As a second year nurse D.B. went on to do dressings, charts, IVs ..."sometimes NG feeds and stuff like that." In third year,

"You were the boss. You did what the charge does now. Run a ward. You did doctor's rounds, organised junior nurses, some teaching, especially is the juniors couldn't do things like IDCs. You gave out medications, IVs, wrote reports."

When asked if the work he does has changed since he first began to nurse D.B. said,

"Not really when you come to think of it, I still do washes, sponges, backs and pans. I still run the ward because I'm a NUM but the other RNs are like junior nurses. I'm like a third year I suppose. I'm still just a nurse...I used to be a sister once."

When asked to comment on why nurses were leaving nursing D.B. said,
"They're just so fed up. They are unhappy. They can't practice their skills, they can't make decisions, they aren't even allowed to do things they did as students. Everyone has taken something off the RN, the OT, the physio, there's only the domestic stuff left. You are treated like naughty children by admin., like incompetent fools by doctors, like shit by other workers, and like slaves by patients. Who wants that?"

He could see no solution to the problem of high turn-over rates in nursing.

"It's too late. They'll get non-nursing unit managers in eventually, they'll pull people off the streets to do the shit work, and a few RN specialists will do the rest. Nurses will be obsolete and maybe that will be a good thing...they obviously aren't needed in the same way they were. Their skills are gone, soon they will be gone too."

D.B. resigned from his position as NUM after eighteen months to work as an Assistant Director of Nursing in a smaller regional hospital. He spent a year in this position before moving to another large teaching hospital to work in a special unit where he gained valuable experience in the care of AIDS patients. He recently tried to return to the large metropolitan teaching hospital in which he trained and worked as a NUM. He was rejected.

"They said I would have to work in ..... ward so they could assess my clinical skills. In other words I'd be on probation! Christ, they trained me, I have a long record of employment
"You're always tired when you get home."

I.H. is a twenty-four year old college graduate who graduated in 1988. She has worked in an orthopaedic ward for eighteen months and claims to like nursing but "I just don't like this ward."

Of her training she commented,

"I really hated college, I was homesick most of the time...I couldn't wait to finish...I liked the practicals...but really it was boring. It's nothing like they said it would be and even the prac's didn't prepare you."

She enjoys being in-charge because "its really the only time I find it interesting. I get to do more interesting stuff." Of the work in general I.H. said, "I'm fed up with the work, it's heavy...pans and pills. It's really very dull sort of work."

She described the morning shifts as being,

"Really heavy because you have all the washes...showers and getting people out of bed. Pills, IVs, pans, it's mostly nursing care. Rounds with doctors sometimes...more pills and pans."

I.H. claimed that it was obvious that hospital trained nurses resented college graduates.

"Most of them seem pretty burned out. They know what they're doing but they don't have much time for the patients"
I.H. believes that nurses are leaving because of stress, too much work and no thanks. "You're always tired when you get home... all you friends are out enjoying themselves... you can only go on for so long." Her aim is to return to the country to find work in a small local hospital. She plans to marry and give up nursing for good.

"If you have to just do the shitwork it's too much."

G.M. is a thirty-seven year old registered nurse who works permanent part-time on the relief roster of a major teaching hospital. She graduated in 1975 and has held her present position for three years. She is married with two children aged three and twelve. Since graduating she has worked on general medical and surgical wards, gastroenterology, oncology and intensive care units. She has also qualified in obstetrics and obtained a Bachelor of Arts degree with honours.

G.M. hated her general training because it was "too strict and
such hard work." In her first year as a student she carried out,

"Basic nursing duties, pans, panroom, washes, showers, sponges, temps and pulses, teas, fluid balance charts."

By second year she was still doing basic nursing care but also took more responsibility by doing bloodpressures, dressings and pills. "You even got to clean the pill trolley!" In third year she was "more or less in charge, rounds, dressings, checking others work, reports, medications, IVs, peritoneal dialysis."

G.M. sees no great changes since she first began nursing. "I do pretty much the same work now as I did then...but I have got more responsibility now."

"Since all the students have gone it's been pretty rough for RNs they have to go back to their training days and do all the shit stuff...it's pretty humiliating. You think you've left all that behind now you find you've got it for good."

She believes that nurses are leaving mainly because of the work. "There's too much of it and it's boring and dirty. If you have to just do the shitwork it's too much." She sees no future in nursing but will continue as long as she needs to supplement her husband's income.

In the next chapter the data collected using the methods of
participant observation, in-depth interviews, life histories and relevant nursing discourses will be analysed to test the proposition that nursing has been enskilled in New South Wales.
CHAPTER SIX

DISCUSSION: Downgrading, Fragmentation, Specialisation and Reduced Autonomy.

Introduction

This study has enabled registered nurses to discuss their views on the nature of nursing work. They have described the work they performed as students, the work they carry out in their present positions and the changes that they perceive in nursing and nursing work since they first began to nurse. The suggestion that there is no such thing as menial work in nursing (Rickard, 1988:4) is clearly refuted by the registered nurses who were interviewed in this study. In this chapter the term 'skill' is defined as comprising objectively defined competences, control over conception and execution and socially defined occupational status. 'Deskilling' occurs with the loss of skill content of work, loss of autonomy, loss of skills of specific workers and the loss of status relatives to other workers.

Registered nurses perform the work of student nurses.

"I do the same things now that I did as a junior nurse".

The results of this study indicate that registered nurses are now carrying out the work that was previously carried out by student nurses. In other words there has been a loss of
skill content of the work they do. To examine this registered nurses were asked to outline the work that they carried out as students. They were also asked to describe the work that they carry out in their present positions. The nature of the work carried out by registered nurses in a surgical ward of a large metropolitan hospital was examined during a period of twelve months participant observation. I will first look at the work that registered nurses claimed they carried out as first, second and third year student nurses.

The first year of training clearly involved mainly 'housework' and 'general nursing care'. A senior registered nurse who graduated in 1971 said,

"First year was mainly washes, beds, pans, fluid balance charts, ward tidies, flowers".

Another who graduated in 1980 also described mainly 'housekeeping' and 'general nursing care' as she described her first year as a student nurse as,

"Mainly bedmaking, pans, panroom, temps, urinalysis, simple dressings, cleaning, sponges".

A twenty six year old Nursing Unit Manager who graduated in 1984 claimed,

"In first year I spent most of my time hiding in the pan room. Sponges, showers, pressure care care, TPRs, sometimes BPs, pans, pans, pans, cleaning wards, cleaning panrooms, testing wees...thought that was great at first. Fluid balance charts".
Second year involved a similar emphasis on 'housework' and 'general nursing care' but with added responsibility of occasionally being 'in charge'. The registered nurses who graduated in the early 70s described being 'in charge' more often in their second year than those who graduated from 1980 on.

"Half the time you were in charge...obs...dressings, drugs. Organisation...rounds with doctors".

A male Nursing Unit Manager who graduated in 1982 claimed that second year was the same as first year,

"...but we also did medications, dressings, obs, in charge sometimes".

There were more registered nurses employed in the hospitals in the 1980s because there had been a large decrease in the numbers of students employed as a part of the N.S.W. governmental rationalisation of the health system. Second year of training was a major transitional phase for student nurses however as their position on the roster appeared to determine whether they were 'senior' or 'junior' nurses.

Third year was a time that most registered nurses claimed to enjoy greatly. They were 'in charge' most of the time and were responsible for teaching and supervision of junior nurses. Table 5.4 reveals an emphasis on 'healing functions' and 'tests and observations'. None of the registered nurses
interviewed listed 'housekeeping' and 'general nursing care' as part of their third year duties. It seems unreasonable to assume that as third year nurses they escaped all of these tasks but they did not consider them as their work. If they carried them out it was while they were 'teaching' or 'assisting' the junior nurses whose responsibility they were. When asked about her third year of training a senior registered nurse who now works as an Assistant Director of Nursing fondly recalled,

"The big third year...I enjoyed third year the most. You were in charge. You did teaching, IVs, medications, rounds. You did complicated dressings, reports...it was great".

A Nursing Unit Manager who graduated in 1984 claimed that in third year,

"You were the boss. you did what the charge does now...run a ward. You did doctor's rounds, organised junior nurses, some teaching, especially if the juniors couldn't do things like IDCs. You gave out medications, IVs, wrote reports".

Mackay's study of student nurses in England revealed a similar focus on tasks as many claimed to dislike bedpans, observations, back-rounds and teats. The initial enthusiasm for basic nursing tasks wore off as the students gained experience and developed their skills. (1989:32). For students ....

"bedpans are something they can effectively rise above once qualified. Thus a distaste for bedpans can be expressed in the sure knowledge that
they are not a long-term hazard." (1989:19)

The registered nurses were asked to comment on the nature of the work that they carry out in their present positions. Although the registered nurses in management positions responded by describing their work in terms Specialty, the ward sisters described the work itself.

"For me its entirely admin..."

"Largely managerial..."

"My work is to staff the wards...for me this is exciting work. I wouldn't go back to being a ward sister for anything".

The respondents graduated between 1960 and 1988 but regardless of this their views on nursing work were similar. The registered nurse who graduated in 1960 claimed that her work was 'shithouse, heavy and thankless'. Despite many years of experience at ward and management level, which included Intensive Care Nursing, Peritoneal Dialysis, Medical and Surgical specialties and finally seven years of agency nursing, she was still hopeful at the age of fifty-six of finding work outside nursing. She turned to private agency nursing to enable her to work flexible hours in order to study at University. She graduated from the University of New South Wales in 1984 with a Bachelor of Arts and at the time of the interview was undertaking postgraduate studies. She was doing this not for promotion but for change. She commented that many agency nurses were undertaking tertiary studies but that they were largely denigrated by nursing administration.
"Instead of looking at them as a valuable resource to be used, they treat them like shit. I know sisters who are almost through law degrees, accounting, health admin. You know... there really is a lot of very smart, highly motivated RNs who have worked their dates off to get ahead who are not even considered".

She further commented.

"There are RNs running around the wards with bedpans with higher qualifications than the people running admin. I think admin. is threatened by anyone with a degree. They like to keep them down".

It must be pointed out that there is no evidence to support the statements made by this registered nurse. There has been no research to determine how many registered nurses who work for agencies are undertaking tertiary studies. It is clear, however, that agency work does provide the flexibility of rostering that is required for anyone undertaking further studies and it is the perception of registered nurses that nursing administrators are not sympathetic to these needs. There is also no recent research into the comparative levels of education of administrators and ward nurses. It is only the perception of many registered nurses that nurse administrators attain their positions of power prior to undertaking further study.

Eight of the registered nurses interviewed graduated between 1970 and 1988. Two were employed in administrative positions: An Assistant Director of Nursing who graduated in 1970 and a Nursing Unit Manager who
graduated in 1980. They were the only ones who did not comment negatively about their work.

Of the other six registered nurses one had a university degree and was undertaking post-graduate studies, one had an undergraduate degree, one was in third year at university and three had only nursing qualifications. All spoke harshly of their work describing it as 'demeaning', 'menial', 'dirty', 'thankless', 'boring' and 'routine'. Three of the registered nurses described the work itself.

"Pretty basic really...just general nursing".

"The work is basic...its all just general nursing care... pretty simple and routine stuff".

"Its mostly general nursing care. You know pans, backs, cups of tea, fluff up pillows".

The other three registered nurses described their work in terms of what they thought of it.

"Its the worst. I hate it, its dirty. The patients make me sick. I won't lift any more or do anything I don't have to do".

"You can't get away from the menial tasks. I hate touching shit...I don't care what anyone says...no-one enjoys it. Shit is shit!".

"I hate it, its the worst, its demeaning, menial, thankless, heavy, dirty...I could go on and on... boring, routine."

The rest of the registered nurses (N=13) graduated between 1981 and 1988. Three were employed in managerial
positions and the rest were working on the wards. One registered nurse who graduated in 1983 described her work as, "Exciting in A&E...fast and hard". Since she began nursing she believed the work had become harder, "that's why I went to A&E. I hated the wards...the work on the wards was boring". Another registered nurse expressed similar sentiments. She graduated in 1984 and was working in ICU.

"In the ward the work was just plain housework. Cleaning this and that, making beds...It was boring. I think if I hadn't transferred to ICU I'd have quit by now".

The rest of the registered nurses described their work as menial, boring and dirty. Two college trained nurses agreed adding that it was "OK when they were in charge". The registered nurses clearly did not perceive their work as 'skilled' Table 5.1 outlines the tasks carried out by registered nurses in the orthopaedic ward in which participant observation was carried out. The list simply outlines every task. It does not reflect the emphasis on each one. An electrocardiograph was taken by a registered nurse on two occasions during participant observation which was carried out over a period of twelve months. It was not the official duty of registered nurses to take electrocardiographs because there was an ECG technician on duty during official hours. Out of hours was classified as urgent and was therefore the duty of resident medical officers. It was on the 'out of hours' occasions that I observed registered nurses
taking ECGs. On the other hand bedmaking, sponging of patients and in fact the bulk of 'housekeeping' and 'general nursing' tasks were carried out numerous times a shift. The above comments made by registered nurses about their work is the best indication of the priority that specific tasks had.

As the registered nurses are now performing the work that was formerly carried out by student nurses then it can be said that they have been deskilled.

Registered nurses perform the same work as lesser qualified or unqualified workers.

".....we're doing junior nurses' work alongside ENAs and wardsmen".

If the bulk of the work registered nurses perform is also carried out by less qualified or unqualified workers then there has been a loss of skill content of their work. Littler (1982) distinguished between specialisation and fragmentation. In specialisation the range of skills required is narrowed but the skilled status of the job may be increased. In fragmentation the level of skill required is reduced. Deskilling through fragmentation limits the boundaries of what registered nurses carry out as part of their daily work. Table 5.2 lists the work carried out by various categories of worker in the orthopaedic ward in which participant observation was carried out. It can be seen from the table that with the exception of intravenous therapy, the administration of medications, insertion of
catheters and the recording of ECGs which can only be carried out by registered nurses all other tasks can be carried out by some other category of worker.

One registered nurse commented that

"you don't need a lot of RNs to manage patients in ortho....ward assistants could do it".

Another senior registered nurse commented that she resented the fact that she ran around making beds most of the morning alongside the ward assistant and occasionally the wardsman.

"It seems absurd that they're paying me to make beds when they can pay an assistant a third of the money".

One Clinical Nurse Specialist who was called out of her area of specialty to help make beds in a ward angrily expressed her resentment also,

"What do they think they are doing? A sister with twenty years experience expected to run around all morning making beds...because the ward assistant is off sick!".

The hospital in which participant observation was carried out employs a variety of workers without formal qualifications to assist with the care of the patients. These include wardsmen, ward assistants, ward clerks, couriers and porters. The Policy Manual contains details about the roles of these workers and on one page it contains a short paragraph on the respective roles of wardsmen and ward
assistants. It is interesting to compare the two.

Surgical Dressers and wardsmen (the distinction was not apparent) the policy manual states, are employed within the Division of Nursing to undertake limited duties associated with the care of patients. They complement nursing practice with their duties and are most valuable members of staff. The range of duties of a wardsman include:

- Assistance with heavy, difficult or confused patients.
- Assistance with hygiene needs of patients.
- Assistance with pre-operative shaves and other pre-operative care for male patients.

Ward assistants come under the Division of Nursing and they perform the invaluable service of freeing the nursing staff from unskilled routine tasks. These include:

- Running messages.
- Cleaning sluice rooms.
- Carbolising beds.
- Flower arrangements.
- Cleaning storage cupboards.

It is the practice of the hospital to employ men as wardsmen and women as ward assistants. The wardsman is paid at a higher rate than the ward assistant. A ward assistant with many years of service informed me that her eighteen year old grandson who had just left High School started work as a wardsman before starting university and he was earning more money than she. In the past wardmen came under the authority of registered nurses but as the above description
indicates they work 'within' the Division of Nursing' rather than 'under' it as the ward assistant does. There is a Head Wardsman and they are responsible to the Assistant Director of Nursing rather than all registered nurses. The 'routine unskilled tasks' that the ward assistant carries out are also a major component of registered nurses work as can be seen from the list of tasks carried out by occupation in Table 5.2.

The important thing to note about ward assistants and wardsmen is the fact that they work set rosters. Most wards have a ward assistant who works a morning shift from Monday to Friday. They do not work weekends or public holidays. During the evening there is a ward assistant for an entire area which includes many wards and at night there is one ward assistant for the entire nursing division. On these occasions which accounts for two thirds of the working time, registered nurses carry out these 'unskilled routine tasks'. On weekends and public holidays registered nurses carry them out around the clock.

Not all wards have a wardsman. The orthopaedic ward in which participant observation was carried out shared a wardsman with the acute orthopaedic ward during the week. During the evenings and at night a wardsman was on call for the area and during weekends and public holidays one wardman covered the entire hospital.

We will now examine the list of duties of wardmen and
ward assistants more closely. Most registered nurses would agree that wardsmen are a valuable aid when it comes to dealing with difficult or confused patients. If a patient becomes violent and is a threat to either the nurses or other patients the wardsmen are usually the first on the scene to offer assistance. The security officers and the doctors more often than not arrive after the patient has been subdued. Violent patients are, however, rare in most areas of the hospital. It is far more likely that a registered nurse would need assistance with a heavy patient. In every ward, at any one time, there would be heavy patients but there are not enough wardsmen to be of any real assistance in this area. In the orthopaedic ward it was not unusual for registered nurses to regularly have to lift and turn patients that weighed over fifteen stone. One woman, in fact, weighed twenty-five stone and it was acknowledged on her nursing care plan that it took a minimum of four people to lift her. She required turning at least every four hours and panning approximately every two hours. On night duty there were only two registered nurses covering the ward. With only one wardsman on for the entire area the nurses had to manage the majority of this woman's lifting needs.

The 'assistance with hygiene needs of the patient' means that the wardsman is able to assist a mobile patient to the shower. The wardsman does not sponge a patient in bed nor does he carry out mouth or eye toilets or backwashes. In other words the wardsman is of very little assistance in the area of patient hygiene. The wardsmen do carry out some
pre-operative shaves on male patients but I was unable to discover what 'other pre-operative care' they carried out.

The list of tasks carried out by the ward assistant also requires a closer examination. They do run messages when they are on duty but a courier is usually responsible for this. If the courier is busy the registered nurse can ask the ward assistant to run a message because he or she is unable to leave the ward. The ward assistant who works a day shift in a particular ward will clean the sluice room but not the bedpans or urinals. Only nursing staff are permitted to clean dirty bedpans and urinals. The sluice room in any ward is in constant use and requires cleaning a number of times a shift. Registered nurses clean sluice rooms several times a shift even when there is a ward assistant on duty. "Carbolising beds" is an outmoded term for terminal cleaning of beds. If a patient is discharged from hospital during the day from Monday to Friday then it is possible that a ward assistant will terminally clean the bed. Many patients are discharged at other times, however, and on these occasions registered nurses will perform the task. The same applies to the arranging of flowers and cleaning of storage cupboards. When there is no ward assistant, which is most of the time, registered nurses carry out these tasks.

It can be seen from Table 5.2 in which the tasks carried out by occupation are listed, that Enrolled Nurse Aids can carry out the majority of tasks that the registered nurses can carry out. With the exception of the administration of
medications, IV therapy, electrocardiographs and the insertion of catheters some other category of worker can carry out the task observed in the orthopaedic ward. One registered nurse commented

"I do the same as M...(FNA) except I get to hold the keys. I can do her IVs and pills fo her...but that just gives me more work...she won't do my pans for me while I'm doing her work".

Mackay suggests that the use of a skilled workforce to carry out the tasks usually designated to formally unqualified workers is a false economy.

"In simple terms understaffing leads to the deskilling of nursing. Thus most nurses are increasingly engaged in carrying out menial tasks. For a select few, highly qualified or specialized, nursing will continue to be challenging and rewarding. For the rest, however, understaffing means unrewarding and unchallenging work.

(1989:65)

The impact of specialisation in nursing.

"A lot of the stuff I did as a third year nurse they now have specialists to do...".

Many registered nurses complained that 'specialists' had taken away their skills. The complex procedures listed in Table 5.5 were not mentioned by any of the registered nurses as being part of their regular work. Most of the
complex procedures are in fact now carried out in specialist areas by clinical nurse specialists or clinical nurse consultants. These new clinical career positions were created by the Public Hospitals Nurses (State) Award in 1986 and were seen by the New South Wales Nurses' Association as leading to 'advancement, status and monetary recognition for clinical nursing' (Staunton, 1986). The position Clinical Nurse Specialist was open to all registered nurses who specialised in a specific clinical field in either a hospital or the community. Registered nurses had to fulfill certain criteria to be classified as Clinical Nurse Specialists but there was no limitation on the number of registered nurses who could attain this position. Appendix C lists all the potential clinical nurse specialist fields.

The definition of Clinical Nurse Specialist is as follows:

In hospitals of 250 ADA (adjusted daily average) and above and country based hospitals:

"A registered nurse with specific post-basic qualifications and twelve months experience working in the clinical area of his/her specified post-basic qualification.

or

"A minimum of four years post-basic registration experience including three years experience in the relevant specialist field".

In other hospitals:

"A registered nurse with specific post-basic qualifications and twelve months experience working in the clinical area of his/her specified post-basic qualification". (Department of Health, N.S.W., 1987)
Registered nurses who work in these smaller hospitals who do not have the post-basic qualifications but who believe that they qualify for Clinical Nurse Specialist status on the basis of their experience are able to be assessed by a Grading Committee.

There is, however, another step in the attainment of Clinical Nurse Specialist. The above definitions appear unambiguous and would appear to qualify many registered nurses to become Clinical Nurse Specialists. The application of 'environmental criteria which have been formulated in conjunction with the definition' is a part of the selection process (ibid p.2).

These 'environmental criteria' include:

1. There has to be a discrete unit in the hospital or health service that is dedicated to the field of specialty.

2. There has to be medical specialist input on an ongoing basis, such as visiting medical specialist.

3. Some nursing staff including the candidate must be rostered full time to the unit on an individual basis.

There is a third and final step after considering the definition and the criteria for selection to Clinical Nurse Specialist. The 'overriding principle' allows the nursing administration to have the final say. The nursing administration must see the registered nurse as 'a clinical resource for the area' and 'a source of expert nursing knowledge'. (ibid. p.3). The Health Department Guideline
goes on to state that 'not all or even the majority of nurses' can be classified as CNS. This would 'defeat the whole purpose of the introduction of clinical career opportunities for nurses'. It is not sufficient to practice in a specialised field, to practice 'highly technical skills' or to 'undertake and perform some tasks better than other nurses'. (ibid) The registered nurse must be 'systematically rostered as 'senior' nurse on duty, apart from the Nursing Unit Manager'. The Clinical Nurse Specialist 'is to be regarded as a 'core' person of the unit'. He or she must be involved in the orientation of new staff, must be 'an active, regular and a significant contributor in determining hospital policies, protocols and developing procedure manuals'. He or she must also take an active formal role in the education of other staff which includes giving formal lectures and must demonstrate a commitment to professional development. They must provide evidence of this by attending regular courses, being a member of relevant professional and or special interest groups and subscribe to relevant professional journals.

It is clear that a registered nurse who fulfills the definitional criteria may not attain CNS status because of the 'overriding principle' of the classification. In fact it is surprising that any registered nurses are able to attain the status. One registered nurse interviewed who had completed the Intensive Care Course and had worked in the Intensive Care Unit for four years was unable to become a CNS because the Nursing Unit Manager refused to allow her to take a 'senior' role in the unit claiming she had 'an attitude problem'. It
seems that attainment of CNS depends upon a value judgement by nursing administration as to whether the registered nurse is a 'core' person or not.

Clinical Nurse Consultant positions are those positions that 'carry out an across hospital or regional or area role primarily involved with consulting, researching, assessing and reviewing the delivery of clinical nursing services'.

(Staunton et al 1986)

A Clinical Nurse Consultants is

"A registered nurse appointed as such to a position approved by the department and who has had at least five years post-basic registration experience and who has in addition approved post-basic nursing qualifications relevant to the field in which they are appointed or such other qualifications or experience deemed appropriate by the department". (Staunton et al 1986)

The appointment of CNCs are dealt with by a Grading Committee and theoretically no area of nursing is excluded. Appendix D lists the areas that the Health Department in fact agreed to include as areas for potential CNC positions.

It is evident that nurses specialise along the same lines as the medical profession. These include units designed for specific diseases such as the Melanoma Unit, Oncology Unit, AIDS Ward and Transplant Units. Specialisation also involves specific medical and surgical specialties such as orthopaedics, gastroenterology, coronary care units, accident and emergency units; and specialisation of body parts such
as Head and Neck surgery and the eye ward. There is also specialisation according to age with paediatrics and geriatrics. Nurses also specialise in administration and education. Although registered nurses specialise in much the same way as the medical profession they also specialise in ways that many registered nurses consider unnecessary.

Some specialist areas in fact brought howls of derision from registered nurses. One such example was the 'lactation sister' whose introduction raised the question "left or right tit?" These registered nurses considered the matter with more seriousness however when they realised that it meant that they had lost the ability to decide feeding regimes of newborns in the area in which they worked. The 'lactation sister' worked out all the feeding regimes in advance making no allowance for individual differences. The registered nurses were not permitted to veer from her feeding regime regardless of circumstances. "We just have to let the babies cry... we can't top them up... nothing".

Many registered nurses complained that specialists had taken away their skills.

"At one time all RNs practised infection control, now you have to call the infection control sister".

"You can't even decide what to put on a bedsore, you have to consult the plastic sister".

Stomal therapy, continence and palliative care are all areas that registered nurses considered their responsibility that
they now must consult specialists. One registered nurse suggested that the 'continence sister' was, in fact, the 'physiotherapist's handmaiden'.

Once the 'specialists' are created they demarcate areas in which they alone are able to claim expertise. Registered nurses now have to consult specialists to dress specific wounds, attend colostomies, change dressings on specific intravenous lines, give advice on incontinent or infectious patients, discuss pain control and discharge plans.

Apart from losing skills to CNSs and CNCs registered nurses have lost skills to other health workers such as physiotherapists, occupational therapists and dieticians (Game and Pringle, 1984). When new graduate nurses enter the system they may never use the skills once the part of every trained nurses repertoire. This means that the registered nurse has lost the skills he or she once had and the work itself has become deskilled.

The separation of conception and execution of nursing work.

"I don't see nurses ever getting autonomy. We'll always have someone giving us orders...doctors, physios. You get used to it. Even the cleaners tell us what to do!"

Every registered nurse was asked to comment on nursing autonomy and decision-making ability. All except one Nursing Unit Manager claimed that nurses had no autonomy. A senior Assistant Director of Nursing stated that:
"Nurses have no autonomy...they are totally dominated by the medical profession and by the bureaucracy. They just follow orders".

A Nursing Unit Manager claimed that:

"Autonomy doesn't exist in nursing. It's just a word they like to use a lot...makes them feel good. I can't make any decisions even as a NUM I have to get everything with Admin".

A registered nurse who graduated in 1981 believes:

"No-one has autonomy. We follow orders from everyone and there are more people giving orders now".

The Nursing Unit Manager who said that nurses had autonomy claimed that it was:

"Within limits...only as far as running the ward ... nursingwise is concerned".

The registered nurses were also asked to comment on their decision-making ability and only four out of twenty-three claimed that they had any. Two of these were Nursing Unit Managers who believed that their senior positions enabled them to make some decisions on ward policy but that they could make 'no major deviations from administrative structures' or they would 'cop the flak from admin'. A registered nurse who graduated in 1975 claimed that on night duty she made decisions because there were few doctors around while a college graduate claimed that 'nurses have more decision-making ability than before'. When asked to give examples she said, 'I can't think off-hand'. A senior
Assistant Director of Nursing said that nurses have no decision-making ability because, 'policy and procedure are mapped out...deviate at your peril'. A senior registered nurse who was interviewed for a senior management position stated that during the interview she was asked to explain the difference between management and administration. She was informed that administration constructed policy and procedure while management implemented it. This clear separation between conception and execution of nursing policy and procedure is the basis of nurses' powerlessness. If nurse managers have no autonomy it is difficult to see how registered nurses have any. It is clear from the interviews that they do not believe that they have any.

**Nursing Discourses**

In the previous chapter a description of both a formal and casual 'nursing report' was given. In this section the 'nursing report' will be analysed and interpreted. The report is carried out most typically at the change of shifts when the departing registered nurse reports on the condition of the patient and any other relevant matters. It has been criticized for being repetitive and time-consuming and to some extent irrelevant (Walker, 1967:39). Walker reported that because of the repetitive nature of hospital reports only about ten percent of information is retained (1967:40). Wolf suggests that the report 'holds moral significance for nurses' who are unable to begin work without it. (1988:231).
Walker believes that the report has both 'intended functions' of communication and 'unintended and unrecognized' functions of social cohesion. (1967:40) Wolf claims that the report has both explicit and implicit functions (1988:231). The intended or explicit function of the report is the transfer of information. The implicit or unintended and unrecognized function of the report is social cohesion (Walker, 1967: 48), the 'imposition of order on uncertainty' and the provision of a forum for complaints (Wolf, 1988: 231).

The intended or explicit function of the report is the communication of information about the patients in the ward. The registered nurses who are commencing duty will not start work without a report. If a patient asks an oncoming nurse for assistance the typical response is "I haven't had a report yet" or "ring for the other nurse I'm not on yet".

The implicit or unintended and unrecognized function of the report outlined by Walker (1967) and Wolf (1988) appears to have greater significance for registered nurses. It is the only time that registered nurses form part of a group. During a formal report these implicit functions include the socialisation of new nurses into their role, the upholding of nursing standards and the maintenance of the nurses' responsibility for the care of the patients (Wolf, 1988:231). A casual report provides registered nurses with a 'safe
forum' for complaints about the patients, other hospital staff, each other and their work. "Thus their anger, hostility, powerlessness, and frustration was diverted from seemingly fruitless and possibly harmful confrontations" (Wolf, 1988:232-3).

The two reports described in the previous chapter illustrate the difference between the formal and the casual report. The same registered nurse was reporting on the same patient at different times. The first example was a week-day morning report attended by the Nursing Unit Manager and four registered nurses. The language of this report is formal and is clearly intended to communicate specific information about the patient. The information is precise, detailed and sympathetic. This report is held in the language of the dominant nursing discourse.

The second example is a casual report on a Saturday evening. The same registered nurse is handing over to the week-end night staff. Most of the evening registered nurses were anxious to get off duty early and there was no Nursing Unit Manager present. This report still conveyed specific information about the patient but in the language of 'bedside discourse'. In other words informal, casual, unsympathetic, and brief. The patient is criticized for speaking no English, for feeling pain, for being confused and for being incontinent of faeces and urine. The patient's medical problems are seen as nursing problems. The recommendations made by the registered nurse are for the
solution of these problems as they affect the nurses rather than the patient. "Best thing is to bomb her out...or you won’t get a minutes peace."

The registered nurses who were interviewed in-depth also used the language of 'bedside discourse'. The area of nursing practice that is broadly described as 'general nursing care' was referred to by the registered nurses who were interviewed as, 'menial', 'demeaning', 'dirty', 'thankless', 'heavy', 'shitty', 'boring' 'basic' and 'boring'. It is interesting to make a comparison between the language used at the level of practice and the language taught by proponents of the 'Nursing Process'. The following examples are taken from the Nursing Diagnosis Pocketbook which is an appendix to Understanding the Nursing Process by Atkinson and Murray. (1990)

**Nursing Diagnosis**

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<thead>
<tr>
<th>Fluid volume excess</th>
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<td>Fluid volume deficit</td>
<td>dry</td>
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<td>Altered nutrition potential for more than body requirements</td>
<td>fat</td>
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<td>Altered tissue perfusion</td>
<td>cyanosed or blue</td>
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<td>Impaired gas exchange</td>
<td>hypoxic</td>
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<tr>
<td>Ineffective breathing pattern</td>
<td>short of breath</td>
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<tr>
<td>Ineffective thermoregulation</td>
<td>febrile or hot</td>
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<tr>
<td>Knowledge deficit</td>
<td>ignorant</td>
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<tr>
<td>Impaired adjustment</td>
<td>still drinking</td>
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This study recognizes the plurality of competing ways that registered nurses talk about their needs, their work and the patients. It reveals the hierarchy of different discourses within nursing and how these are grounded in the material conditions of their work.

**Summary and Discussion**

"I didn’t spend three years at university to empty bedpans. I want to do proper nursing".

This comment was made by a third year tertiary student who was working on the ward in which participant observation was being carried out. She was disillusioned by the fact that she was expected to carry out basic nursing tasks for which she believed she was overskilled.

When asked what could be done to keep nurses in the system a Nursing Unit Manager claimed that nothing could be done.

"It’s too late. They will get non-nursing unit managers in eventually, they’ll pull people off the streets to do the shit work, and a few RN specialists will do the rest. Nurses will be obsolete and maybe that will be a good thing...they obviously aren’t needed in the same way they were. Their skills are gone, soon they will be gone too".
He was commenting on the nature of nursing work which he believed had changed so much that it actually deterred nurses from nursing. Many registered nurses believed that as students they could look forward to leaving the menial, routine work behind when they registered. They believed that they would gain respect as registered nurses and that the work would be stimulating and challenging.

"The heavy, dirty stuff you did as a student was ok because it was only for a few years. No-one was stuck with it permanently, you just sort of moved through that stage. Now we are doing mainly the same heavy, dirty work we did then and so we burn out. You just can't do the hands-on routine, boring, dirty work for any length of time. Its soul destroying".

The majority of registered nurses interviewed believed that the major changes they perceived since they first began nursing was the nature of the work they carry out. Since the nursing students left the hospitals registered nurses have 'stepped into their shoes'. The result of this, they believe, is a loss of status and a lowering of the level of skill they are able to use. When asked what they enjoy least about their present position the majority of registered nurses described the work. When asked what the major changes were since they first began to nurse the majority focussed on the 'junior' nature of the work. When asked how their work had changed since they began to nurse the majority of registered nurses claimed that they have reverted to 'student nurses' work. When asked why nurses are leaving the system the majority suggested that the work and loss of status were the
main reasons. When asked what could be done to keep nurses in the system the majority of registered nurses claimed that nothing could be done except perhaps a return to the hospital training system.

The registered nurses interviewed clearly perceive major structural changes in the health system. These changes, they believe, have resulted in major changes in the nature of the work they perform. In general they believe that the work is routine, menial and unrewarding. It is also difficult for many registered nurses to understand why a tertiary education is necessary when the work has been deskillled. This is a serious contradiction in the 'enskilling thesis' on which the transfer of nurse education to the tertiary sector was based.

The analysis of the data collected during participant observation, in-depth interviews and from procedure manuals clearly do not support the proposition that enskilling has occurred, rather, the findings support an alternative proposition. Registered nurses now perform the work previously carried out by students. The bulk of the work they do can be performed by workers with less or no formal qualifications and much of the work they formerly carried out has been taken over by other health workers or nurse specialists.

These findings suggest that in the case of registered nurses deskillling has occurred in the following ways.
Firstly, registered nurses now perform the work previously carried out by students nurses.

Secondly, registered nurses are increasingly engaged in work that is also carried out by workers without formal qualifications.

Thirdly, work previously carried out by registered nurses has been taken over by other health workers such as occupational therapists, physiotherapists, dietitians and specialists nurses.

Fourthly, there is a separation between conception and execution of nursing work. Contemporary registered nurses have less autonomy and decision-making ability.

If registered nurses are carrying out junior nurses' work along side workers without formal qualifications then it can be said that there has been a loss of skill content of the work. If other workers now carry out what was formerly the work of registered nurses then there has been a loss of skills of these registered nurses. If a tertiary education is required for work that can also be carried out by lesser trained or unqualified workers then the socially defined occupational status of registered nurses has been reduced relative to these workers. Loss of autonomy for registered nurses is incorporated within all four of the above processes that have contributed to the deskilling of registered nurses in the hospital under examination.
CONCLUSION: The Deskilling of Nursing Work

Introduction

This study aimed to test the proposition that nursing work has been progressively deskilled in New South Wales. The experiences of practising 'bedside' registered nurses are the primary source of data for this study as historically the dominant groups within nursing have defined 'nursing reality' and 'nursing knowledge'. We have examined how the rhetoric of these dominant groups has obscured the 'reality' of nursing work as it is experienced by the majority of nurses who work at the bedside. This study has provided the opportunity for these nurses to define their own 'reality', that is, their experiences of nursing work.

The ethnographic methods utilised in this study, which included participant observation, in-depth interviews, life histories and analysis of nursing discourses, were chosen to focus on the perceptions and experiences of the working 'bedside' nurses rather than those of the powerful 'leaders' of nursing.

The theoretical background is one of critical sociology which incorporates a historical, social and biographical perspective. Crisis, contradiction, conflict and power are all major aspects of this critical analysis.
This chapter presents the overall conclusions of the study. First, a micro-analysis will focus on the experiential aspects of skill, deskilling, job satisfaction and nursing turn-over.

Second, an organisational analysis will reveal how the processes of 'professionalisation' and 'rationalisation' are experienced by registered nurses in terms of 'specialisation' and 'fragmentation'. This analysis is located within the context of the authority structure in nursing in light of issues of control and consent.

Third, a macro-analysis will focus on the wider societal issues of 'professionalisation' and 'rationalisation' and how these processes are influenced by gender and economic factors.

Micro-analysis: Enskilling or Deskilling?

The central argument of the 'enskilling thesis' is that advanced industrial societies need increasingly skilled workforces (Bell, 1973). The 'enskilling thesis' is the basis of the assumptions of dominant groups within nursing in N.S.W. It has been argued that increased levels of formal education do not support a thesis of increasing levels of skill amongst workers (Willis, 1977; Corrigan, 1979). To examine whether registered nurses have been 'enskilled' it is first necessary to examine the nature of nursing skills.

Beechey (1982) suggested that there were three components
of skill. These are objectively defined competences, control over conception and execution and socially defined occupational status. These three elements will be examined in relation to nursing skills.

Nursing work has been classified in several ways. Early studies suggest that nursing work comprised 'affective/psychosocial', 'technical' and 'basic/physical' components (Goddard, 1953). Grant claimed nursing work could be divided between 'basic/physical' and 'technical' components (1973). Game and Pringle extended the classification to 'housework', 'general nursing care', 'healing functions' and 'tests and observations'. (1984). This study utilises Game and Pringle's classification which recognises the reality of nursing work by including the 'housework' component.

Early nursing curricula focussed on the study of anatomy and physiology, micro-biology, pharmacy, psychology, general nursing care, medicine, surgery and legal aspects of nursing. Nurses were taught these subjects in 'blocks' of four to six weeks throughout the year. The rest of the time they were working on the hospital wards where they put into practice what they had been taught in 'block'. Wood states that 'much of the acquisition of knowledge is done on the job' (1987:10). Tacit knowledge is essential for the acquisition of skill so it is necessary to examine the nature of tacit knowledge as it relates to nursing skills.

Wood states that tacit knowledge is learned through
experience. It is situation specific and difficult to articulate in an explicit and formalised language (1987:9).

"Simply absorbing a set of detached instructions will not be enough to accomplish the differing elements and degrees of tacit knowledge". (ibid)

Manwaring and Wood (1985) claim that there are three dimensions to tacit skills. Firstly, the performance of routine tasks involves a learning process by which skills are acquired through individual experience. Secondly, different degrees of awareness are required to perform certain activities. This ranges from very little awareness when undertaking routine activities to a heightened awareness when coping with unfamiliar situations. Thirdly, tacit skills are related to the collective nature of the labour process.

Wood believes that the importance of the concept tacit skills lies in the fact that it refutes the implication of the deskill thesis that the worker is objectified (1987:10). It does not, however, invalidate the deskill thesis. The nurses interviewed for this study believe that experience is the primary means by which they acquired their skills. They also believe that the experience they possess is undervalued by nurse administrators. The college graduates interviewed stated that their education did not prepare them for the practice of nursing and that the aspect of their training that they most enjoyed was the 'practicals'.
The level of awareness required for nursing work varies. Most registered nurses claimed that their work was routine and boring requiring very little thought. They also, however, commented that they were expected to deal with unfamiliar situations such as emergencies as if they were routine. In a general ward the work carried out by nurses is largely routine. In an intensive care unit, accident and emergency unit or any high dependency area the 'unfamiliar situations' that require a heightened awareness in a general ward would be routine.

At the Nursing Targets National Workshop in 1989 Englert stated that New South Wales was "desperate for experienced skilled nurses" (1989:2). She claimed that "the new graduate is not ready to practice alone or to be accountable for a group of patients". Support programmes are costly, however, and she questions whether future budget constraints will permit such programmes (1989:4). Garcia stated that nearly half of the nurses in N.S.W. have limited experience (1989:8).

Englert asks an important question in her address to the workshop. "Do nurses really want to do basic nursing care such as showers, bathe, padding, feedings or do they see this as someone else's job?" The results of the interviews with registered nurses in this study clearly reveal the fact that most believe that they are over-educated for the basic nursing tasks that comprise the bulk of their work. They also believe that it is a more efficient use of resources to
utilise their skills based on years of experience for more 'hi-tech activities'. The registered nurses who were trained in the hospital system recall the tasks they carried out when student nurses were employed and believe that they have been delegated a much devalued role.

Early studies of the role of the registered nurse in New South Wales public hospitals reveal that 5.3% of a registered nurses' time was spent on general nursing care, 6.1% on 'domestic' tasks, 27% on 'technical nursing' and 56% on administration (Hearn and Cable, 1967). The role of the registered nurse can be seen to have undergone a complete reversal as this study reveals that general nursing care and domestic tasks now comprise the bulk of their work.

The most comprehensive study of nursing turnover in New South Wales reveals the importance of the work itself as a factor in nursing turnover. (Battersby et al, 1990). Battersby et al isolated thirty factors that influenced registered nurses decisions to stay or leave. The most important factor in influencing registered nurses decisions to stay or leave was whether they liked the work they carried out at the hospital. For 83.7 percent of registered nurses this was the most important factor. The second most important factor (81.2%) named by registered nurses was whether they had the opportunity to work in their preferred area. The third most important factor (75.3%) was whether there was a high standard of patient care. The fourth (73.7%) was whether they were able to use their skills and experience at the
hospital and the fifth (73.4%) was whether there were friendly nursing staff at the hospital (1990:70).

Battersby et al found that four out of every five registered nurses who had decided to remain at the hospital in which they were employed did so because they liked the work. More than sixty percent of the registered nurses who had decided to leave nursing for other work were influenced by whether they had the opportunity to work in their preferred area and whether they liked the work. (1990:94-5). While there were many other factors that influenced the decisions of registered nurses to stay or leave a particular hospital or nursing in general, the work itself was the most important factor overall.

Many registered nurses interviewed complained that nurse administrators did not appreciate their level of experience. New graduate nurses with less than a year of practice were often put in charge of senior registered nurses with many years of experience. Some senior registered nurses claimed that they suspected that nursing administration was trying to phase them out of the system in favour of the junior college graduates whom they could employ more cheaply. At the time of this study nursing administration had embarked upon a strategy of changing the 'permanent' rosters of senior registered nurses without any consideration of the difficulties it caused these nurses. Some worked permanent night-duty or week-ends to fit in with family or study commitments. Some of these nurses had to leave the
hospital while others had to give up their courses. One senior registered nurse who was forced to leave because of roster changes found work in a private clinic. She claimed that she was informed by a NUM working in a Coronary Care Unit of another major teaching hospital that the employment of junior registered nurses was an economic policy. The NUM had been instructed by nursing administration that as all senior registered nurses and Clinical Nurse Specialists left they were to be replaced by first and second year college graduates. The evidence for this is only impressionistic however, and further studies would have to be carried out to determine whether such a practice is being carried out.

Nursing administrators are generally oblivious to the hardships they create for registered nurses who have family or study commitments. Registered nurses view the strategies of nursing administrators as provocative. If for financial or other reasons these nurses are unable to change jobs they become unwilling and disgruntled workers. The implications of this for the quality of patient care are an important factor that requires closer analysis. Provocative management strategies and preferential treatment for junior graduates over experienced senior nurses could prove counterproductive in terms of the quality of patient care and the economic use of resources.

Organisational Analysis: Nursing Authority and Control.
The majority of registered nurses are employed in large public hospitals (Shoebridge, 1989:117). An organisational analysis examines how the processes of 'professionalisation' and 'rationalisation' are experienced by registered nurses in terms of 'specialisation' and 'fragmentation'. Englert suggested that nursing management systems would need to "accommodate the autonomy of the registered nurse" (1988:180). She was referring to the fact that registered nurses had replaced the student workforce as the numerically dominant worker at the 'operating level'. Englert believes that with registered nurses providing direct patient care the 'bureaucratic structure' would not be appropriate. Autonomy is considered to be an important dimension of professionalisation with nurse leaders claiming that a tertiary education for all nurses would automatically lead to autonomy in practice.

The majority of nurses interviewed in this study, including nurse administrators, believed that registered nurses have very little or negligible autonomy. There was no evidence of nursing autonomy at the level of practice either. In fact, there is evidence that registered nurses have less autonomy than in the past, with many claiming that they had more control over their work as third year nurses.

The bureaucratic nature of the hospital organisation limits the level of autonomy of most of the professional workers within it with the exception of the medical profession. Ferguson suggests that the power structures of bureaucratic
capitalist societies are a primary source of oppression of both men and women and that "bureaucracies have a tremendous capacity to hurt people, to manipulate, twist, and damage human possibility" (1984:xii). This study supports this contention as registered nurses have been reduced to the level of student nurse within the hospital. A loss of status and skill has occurred with the change, revealing the fact that the 'bureaucratic structure' referred to by Englert has remained the same while the nursing workforce has changed.

Turner found that nurses were well aware of their "subordinate and limited social status within the hospital system and of their inability to utilise their skills in a fully professional way" (1986:369). Davies also suggested that in the hospital context it is difficult for nurses to exercise initiative and decision-making ability (1983:94).

The dynamics of professionalisation have resulted in an increased specialisation within nursing with specific segments establishing dominance at the expense of the majority of registered nurses. The process of professionalisation has resulted in a re-arrangement of the power structure with registered nurses becoming the lower status practitioners whose place in the system has been diminished. Registered nurses now perform tasks previously the work of students and therefore have less contact with the power structures within the occupation. Educators, specialists, administrators and consultants have succeeded
in expanding their power and social significance at the expense of the practising registered nurse.

Oppenheimer (1973:223) states that

"There are strong indications that the income position, employment picture, and job condition of the increasingly bureaucratically-located professional is helping to create 'proletarian' conditions."

Even though nursing appears to be undergoing professionalisation, and the dominant groups have adopted an ideology of professionalism, the majority of registered nurses' experiences are more consistent with 'proletarianisation' with the increasing bureaucratisation and rationalisation of occupational knowledge that has reduced their ability to control their own work.

Wagner claims that there is an 'unwritten history of nursing' that has been 'obscured by professional nursing leaders who are still suppressing revolts of rank-and-file nurses against the conditions of hospital work.' (1980:271). He believes that in America nursing was proletarianised by institutionalisation in hospitals.

"Nursing history has been characterised not by a rise in professional autonomy, responsibility, and prestige-as it is sometimes portrayed by professional leaders- but by a diminution of independence, increasing stratification and division of labor, and growing revolt against assembly-line conditions." (1980:272)
There is a clear parallel between the early American scene in nursing and the present Australian scene. Australian nurse leaders have taken on the American model as a guide for their strategy of 'professionalisation'. They have ignored the fact that professional nursing associations in America have failed to improve working conditions or salaries for nurses. Professional nurses in America are, in fact, the lowest paid college graduates in the country (Turner, 1986:373). The dominant groups in both America and Australia have had more success in implementing the idea of "in-service education and staff conferences to inculcate loyalty, proper morality, health, and professionalism in registered nurses" (Wagner, 1980:280).

In America

"...the creation of dozens of specialty occupations such as social workers, anesthesiologists, X-ray technicians, respiratory therapy technicians, nutritionists, operating room technicians, and physical therapists led to a diminution of traditional skilled tasks handled by RNs."

(Wagner, 1980:282)

Game and Pringle noted that in Australia 'nurses took X-rays and did the work later allocated to dieticians and physiotherapists." Many new occupational groups have emerged to take over the tasks previously the domain of registered nurses. (1983:94).

Gray claimed that there is no evidence for proletarianization of nursing in Australia. (1989:138). He suggests that the proletarianization debate is based on the work of Braverman
and subsequently suffers from the same analytical problems. These are, an inadequate definition of nursing skill and an idealized, ahistorical concept of nursing as a craft. (ibid) If nursing is examined from its establishment in the Nineteenth Century it would be difficult to argue against an overall increase in skill level for all nurses as suggested by Melosh (1982). This thesis overcomes these problems by examining nursing skills as they exist today and by permitting registered nurses to describe their experiences of nursing work over time. By focusing on the specific time frame of 1970 to 1990 it is possible to detect changes in nursing work that suggest a polarisation of nursing skills based on specialisation and credentialism.

Wagner suggests that nursing leaders in America hid the facts of proletarianisation in the past and that "they hide the current similarities of nursing with other underpaid women workers-in order to retain control over their ranks" (1980:289). This study suggests that a similar situation exists in New South Wales nursing as dominant groups in nursing attempt to control the rank-and-file nurses as they rebel against the conditions of nursing work.

**Macro-analysis: Professionalisation and Rationalisation.**

Numerically nursing is the largest health occupation which provides a wide variety of health services. In 1986
registered nurses and enrolled nurses made up 67.3 percent of the entire health workforce (Grant and Lapsley, 1988). Nurses are concentrated mainly in general and psychiatric hospitals and nursing homes with 88 percent working in these areas and less than 2 percent working in community health centres (Shoebridge, 1989:119). The result is the fact that the vast majority of nurses are employed by the state. This has important ramifications for nurses in terms of 'professionalisation' and 'rationalisation'.

The professionalisation of nursing has been the aim of nursing leaders for at least half a century (Short and Sharman, 1989). Nursing leaders have traditionally attempted to emulate the established professions such as medicine to achieve this goal. They have focussed on the visible characteristics of 'profession' such as a service ethic, unique body of knowledge, a professional association, institutional education and autonomy. The dominant groups in nursing have neglected to acknowledge the constraints against professionalisation. The constraints have emerged from both within nursing and from general social factors. The external constraints against professionalisation include the dependence of nursing on the medical profession, the fact that nursing is predominantly carried out by women and that nurses work mainly in large bureaucratic organisations.

Nurse leaders have failed to recognize that the ability of an occupation to attain professional status is closely linked to
the strategies it employs and the wider social forces and power arrangements. While the term 'profession' has the appearance of a natural concept, it is fraught with ideology and is linked implicitly with features such as privilege and autonomy. Larson suggests that the 'ideal type constructs do not tell us what a profession is, but only what it pretends to be' (1977:xii). The idealised notion of 'profession' forms the basis of the traditional trait approach to the study of professionalisation. The historical development of nursing reveals an adherence to the traditional approach as nursing has taken on more and more of the traits of the professional model to justify claims to professional status.

Many sociologists claim that nursing has not yet attained professional status. (Etzioni, 1969; Freidson, 1970). Nursing researchers have supported this claim for a variety of reasons. Ashley suggests that economic exploitation, inadequate education and social discrimination are the source of nursing's lack of success. (Ashley, 1972:93). Chapman focussed on lack of autonomy, control, community support, unique knowledge and a professional sub-culture (Chapman, 1977). Melosh, (1982) blames male dominance in the medical profession for the failure of nursing to become a profession.

Maresh, (1986) claims that there are four barriers to professionalisation for nurses. These are feminization, learned helplessness due to powerlessness, hierarchical structures that reinforce male power and patriarchal
dominance. Speedy also presents a feminist analysis which claims that nurses are an oppressed group. (1987:23). She claims that,

"The only conclusion one can reach from a feminist analysis of nursing is that it is not and never can be, while presently structured and ideologically governed, a profession". (1987:25)

Nursing developed as a passive and subordinate occupation and despite major structural changes has remained so. Despite their numerical dominance in the health care system nurses continue to be dominated economically, politically and socially by the medical profession (Willis, 1983). Short and Sharman (1989) claim that professionalisation is a masculine strategy that is inappropriate for nursing. They suggest that 'both gender and class have been crucial determining factors in the history of nursing and in the current nursing struggle' (1989:233).

"The capacity of nurses to work effectively with people in need is a product of structured power relations - social, economic and political - as much as it is a function of individual attributes such as an affinity for nursing, technical knowledge, skills and ethics". (Shoebridge, 1989:115)

It is necessary to examine the nature of these power relations in order to determine the position of nursing within them. Turner claims that in most industrial societies in the 1960s there was a 'period of extended hospital reform and reconstruction'. (1987:167). This process began to decline by the end of the 1970s and the 'contemporary
period has been one of containment and management'. (ibid)
This study focussed on this period of containment and it is
within this context that the professionalisation of nursing
has largely taken place. It is necessary to examine the
professionalisation of nursing within the context of the
rationalisation of the health system.

Turner believes that 'in many respects, the hospital is a
crucial illustration of Weber's analysis of rationalisation...' 
(1987:157). The hospital 'industry' is large and increasingly
complex with a high labour intensity.

"...it consumes enormous amounts of goods
and services, constituting a huge market from
which, in the capitalist part of the world,
huge commercial and personal profits can be
made".

(Shoebridge, 1989:119)

The organisation of public hospitals is in fact a 'large-scale
and serious business' despite the fact that their function is
one of public service. (ibid) This contrasts with the priority
of the private health sector which is profit. Both sectors,
however, are subject to the same economic imperatives and
this has an impact on the internal structure of both sectors.

The features of the modern hospital do conform to Weber's
ideal type to some extent but as Turner points out there are
important divergences that must be considered in an
analysis of power structures within these bureaucratic
structures.
"In fact, bureaucracies are political arenas in which struggles for power, status, personal values, and/or survival are endemic. They are oligarchical and recruitment is at least partly done by co-optation".

(Ferguson, 198:7)

Although the hospital structure is bureaucratic the medical profession has maintained professional power within this structure. The hospital can be seen to have a dual system of authority. One that flows from the professional administrative structure and the other that flows from the professional medical structure. Nurses, however, are less resistant to bureaucratic management. They are subject to both systems of authority.

If state hospitals are subject to similar economic imperatives to those of big business as suggested by Shoebridge (1989) it is necessary to examine the strategies of big business in organisational terms to determine whether the hospital system conforms to such strategies.

Shoebridge claims that the first step is to impose a general managerial elite with loyalties to the funders. In the case of the hospital this means 'lay' administrators who may not be in sympathy with the nurses, doctors or other occupational groups within the hospital. In 1989 the hospital in which this study took place appointed a new general manager who outlined his credentials as follows.

"So here I am! Having taught in a subject I have never studied and headed a legal section without
being a lawyer, run a state-wide health program without any experience in health, I became the first head of Veteran's Affairs in N.S.W. without a service background and now I'm a non-doctor running a hospital”.

The second step outlined by Shoebridge is to diversify and decentralise into computer linked subsidiaries, satellites and quasi-independent units run by people with discretionary powers. In the hospital system at the level that affects nurses this has been introduced by making individual nursing sections, wards and units responsible for their own budgets. The Commission of Inquiry into the Efficiency and Administration of Hospitals (1980) concluded that.

"...the first step in strengthening managerial control practices is to develop a standard system of functional accounting, reporting, and budgeting in hospitals". (1980:11)

The Commission determined that the topic of budgeting was central to many of the issues of managerial control, (1980:68) and that there was substantial scope for strengthening managerial control functions in Australian hospitals (ibid:73).

The final step is to ‘adjust’ the workforce to the changed ‘environment’. In other words, in response to the restructuring and in line with corporate dictates the objective is to increase workloads at a lower cost to the organisation. The more powerful end of the various occupational groups take on higher discretionary skills at the expense of the less powerful who lose discretiona
Low discretion work requires more routine and conformity to rules and procedures while high discretion work involves problem solving.

In the hospital system this process results in both 'enskilling' and 'deskilling' of various occupational groups. Nurses are least able to resist this process. The internal structure of nursing is inevitably the result of the complex power structures within the system and despite being the largest hospital department.

"...nursing care is not the most expensive service. Despite this the nursing department has been the most vulnerable to cost cutting measures". (Walker, 1982:204)

The strengthening of managerial control has benefitted nurse administrators at the expense of the majority of registered nurses. This process reveals the fact that professionalisation generates its own contradictions. McManamny (1986) examined nursing relationships with the state and medicine. She saw the Victorian Nurses' strike of 1986 as a reaction to the state having used the new career structure for nurses as a means to downgrade nursing jobs in both the private and public sectors.

In New South Wales, the 1986 Nurses' Wages Decision which provided large wage increases for senior nurse administrators, educators and unionists at the expense of lower paid nurses resulted in a similar polarisation within nursing. Poorly paid assistants in nursing, enrolled nurses,
students, registered nurses up to fifth year and community nurses who comprised 80 percent of the nursing workforce received wage increases that ranged from 2 to 10 percent. The senior nurses including administrators, educators and unionists received large increases in excess of 25 percent. J. Haines of the Nurses Reform claimed that the Commissioner was under pressure from the Health Department and the government but that there was also pressure from the nursing hierarchy and the New South Wales Nurses' Association to find in favour of a graded wage increase instead of a more equitable across the board increase (Haines, 1986). The Nurses Association presented twenty witnesses to the commissioner. Eighteen were senior administrators or educators, one was a senior association official and one was a practising registered nurse. The evidence provided by these witnesses focussed on the needs of senior nurses but ignored the needs of the majority of practising nurses. The commissioner, in fact, gave what he was asked to give.

The Nurses Reform group were critical of the NSWNA because they convinced the rank and file to accept the offer of a graded wage increase.

"The pattern is emerging throughout the whole public hospital system of powerful nursing administrators attempting to mobilise all those who clearly benefit the most from the decision, to try to persuade the whole nursing workforce including the 80 percent who benefit least, to accept the whole package". (Nurses' Reform, 1986:2)
The irony for the militant nurse leaders in both Victoria and N.S.W. is the fact that the nursing factions controlled by the dominant nursing leaders won elections in both states and despite fighting for equitable conditions for all nurses the militant factions were not re-elected. In both states the conservative factions who fought for and gained improved wages and conditions for an elite few senior nurses gained power.

Conclusion

The registered nurses interviewed in this study expressed themselves in the language of 'bedside' discourse. This highly distinctive rhetoric gives expression to facets of their work experiences and the empirical evidence suggests that they are not satisfied with nursing work. Battersby et al (1990) revealed that the conditions of nursing work were the most important determinants of nurses' decisions to remain in nursing. Previous job satisfaction studies in nursing support this and also suggest that the conditions of nursing work are the most important factors that determine the standard of nursing care (Braitto and Caston, 1983). There is clear evidence that nursing work has been deskillled over the past twenty years and that there is a link between deskillling, job satisfaction, fragmentation and specialisation (Littler, 1982).

The modern hospital is larger and more bureaucratic than in
the past and nurses are less able than other professions to retain a level of autonomy within this bureaucratic setting. The fragmentation of nursing into specialities along the lines of the medical model and the increased pressure from other professional groups who encroach onto the registered nurses' domain has contributed to the process 'deprofessionalization'.

The evidence provided by registered nurses in this study contradicts the notion that nursing has been enskilled. An alternative thesis is therefore proposed. This alternative thesis proposes that registered nurses in the hospital under study have been deskilled in the following four ways. They now perform the work that was previously carried out by student nurses. They perform the same work that lesser qualified or unqualified workers carry out. There has been a polarisation of nursing skills due to specialisation and there is a wide gap between the conception and execution of nursing work.

There is no research available to reveal the impact that this deskilling has had on the quality of nursing care that is provided. The nurses interviewed in this study believe that the quality of nursing care has greatly declined and they may be in the best position to make such a judgement. There is evidence to show that there is a link between job satisfaction and the quality of nursing care provided (Braitho and Caston, 1983).
What is clear from this study is the fact that the rhetoric of the dominant groups in nursing does not reflect the reality of nursing experience as it affects the majority of practising nurses. In fact, the dominant discourse reflects the views of a small number of elite nurses. It masks the sectional interests of the few by presenting an idealised image of nursing that appeals to the broader group. This idealised image obscures the conflict and the power struggles that are constantly in play within nursing.
APPENDIX A: INTERVIEW SCHEDULE

DEMOGRAPHIC VARIABLES

(1) Age  
(2) Sex  
(3) Education on entry to nursing  
(4) Training hospital or college  
(5) Year of graduation  
(6) Marital status  
(7) Children no. age

ORGANISATIONAL VARIABLES

(1) Roster  
(2) Position in organisation  
(3) Specialty  
(4) Length of time on job  
(5) Salary  
(6) Technology  
(7) Nature of the work  
(8) Communication with Nursing admin, medical staff, others

CONTEXTUAL VARIABLES

(1) Decision-making ability  
(2) Autonomy  
(3) Promotional opportunities  
(4) Experience  
(5) Skills
UNSTRUCTURED COMPONENT

(1) Why did you choose nursing?
(2) Do you regret your choice?
(3) Would you do the same again?
(4) If not, why not?
(5) What did you enjoy most about your training?
(6) What did you enjoy least about your training?
(7) What do you enjoy most about your present position?
(8) What do you enjoy least about your present position?
(9) What are the major changes that you see since you began nursing?
(10) Describe an average morning shift
(11) Describe an average afternoon shift
(12) Describe an average night shift
(13) If you are hospital trained can you recall the work you carried out as a student nurse? First, second and third year?
(14) Has the work you do changed since you first began to nurse? If yes, describe the changes
(15) The NSWNA claims that the hospital training system did not give the standard of nursing that the community deserves. Would you comment on this.
(16) What do you perceive to be the differences if any between the nurses trained in the hospital system and those trained in colleges?
(17) Why do you think that nurses are leaving nursing?
(18) What can be done to keep nurses in the system?
(19) What are your expectations for your future in nursing?
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<th>C</th>
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<td>Hosp.</td>
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<td>RN Relief</td>
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<td>f</td>
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<td>Hosp.</td>
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A= Age  B= Sex  C= Educ.  D= Training  E= Graduation  F= Position  
G= Specialty  H= Length of time on the job.  I= Part-time or Full-time.

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APPENDIX C: Potential Clinical Nurse Specialist fields.

Accident and Emergency
Intensive Care
Operating Theatres
Anaesthetics
Recovery
Coronary Care
Neo-natal Intensive Care
Oncology
Orthopaedics
Neurosurgery/neurology
Renal Medicine and/or Haemodialysis
Xray
Rheumatology
Dermatology
Endocrine/surgical
Endocrinology
Haematology
Respiratory Medicine
Gastroenterology
Cardiology
Bone Marrow/Plasmapheresis
Spinal Injuries
Gynaecology
E.N.T.
Urology
Vascular Surgery
G.I.T./Colo-rectal Surgery
Head and Neck Surgery
Burns and Plastic Surgery
Organ Transplant Surgery
Cardio Thoracic Surgery
Infertility
Ophthalmology
Pain management
Paediatrics/Child Psychiatry/Behavioural Disturbance Units
Assessment and Rehabilitation (Geriatrics)
Obstetrics/Gynaecology/Urology/Oncology
Delivery Suite/ANTE-Natal/POST-Natal/NEONATOLOGY
Foetal-maternal medicine/Reproductive Endocrinology
In-vitro Fertilisation/Artificial Insemination by donor
Mothercraft/Psychiatry and Developmental Disability
Acute Admissions/Crisis Intervention
Drug and Alcohol Detoxification
APPENDIX D : Potential Clinical Nurse Consultant Positions.

Infection Control
Palliative Care
Oncology
Total Parenteral Nutrition
Cardiac Rehabilitation
Stomal Therapy
Haemophilia
Vascular Surgery
Quality Assurance
Nursing Audit
Diabetic Education
Area/regional Tuberculosis Consultant
Pain Management
Head and Neck
Plastic Surgery
Mental Health
Spina Bifida
Cystic Fibrosis
Spinal Injuries
Discharge Liaison
Drug and Alcohol Liaison
Programme Officer
Welfare Officer
Recreation Officer
Drug and Alcohol Councillors
Nurse Councillors/Mental Health Consultants
Occupational Health Nurse
Family Planning
Womens Health
Lactation Consultant
Prosthesis Nurse
Infertility Consultant
Continuous Ambulatory Peritoneal Dialysis

Source: Briefing Notes on New Public Hospital Nurses (State) Award Operative from 27th June, 1986.
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