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PROFESSIONAL POWER AND SOCIOLOGICAL ANALYSIS:  
LESSONS FROM A COMPARATIVE HISTORICAL STUDY  
OF NURSING IN BRITAIN AND THE U.S.A.

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DECLARATION

The material in this thesis has been used in a number of publications by the author although none appeared in the form used here. Parts of the information and analyses in Chapters Four and Five have appeared in:

'Four Events in Nursing History: a New Look, 1 and 2' Nursing Times 2, 1977.

'A Constant Casualty: nurse education in Britain and the U.S.A. to 1939' in C. Davies (ed.) Rewriting Nursing History, London, Croom Helm, 1980.

'Past and Present in Nurse Education' Nursing Times 76, (No. 39) 1980.

In Chapter Six I have drawn extensively on:

'The Regulation of Nursing Work: an historical comparison of Britain and the U.S.A.' in J. Roth (ed.) Research in the Sociology of Health Care Vol. 2, Changing Structure of Health Care Occupations, J.A.I. Press, Greenwich, Conn. (forthcoming).

Reference to these papers and to unpublished papers is made, as appropriate, throughout.

LIST OF ABBREVIATIONS

ACSN	Association of Collegiate Schools of Nursing
AHA	American Hospitals' Association
AJN	American Journal of Nursing
AMA	American Medical Association
ANA	American Nurses' Association
ANTC	Area Nurse Training Committee
BNA	British Nurses' Association
BSA	British Sociological Association
DHSS	Department of Health and Social Security
GP	General Practitioner
GNC	General Nursing Council
GNP	Gross National Product
HMC	Hospital Management Committee
ISU	Industrial Sociology Unit, Imperial College
JBCNS	Joint Board of Clinical Nursing Studies
LPN	Licensed Practical Nurse
MO'sH	Medical Officers of Health
NAPNE	National Association for Practical Nurse Education
NHC	Neighborhood Health Center
NHS	National Health Service
NLN	National League for Nursing
NLNE	National League for Nurse Education
NNAS	National Nursing Accreditation Service
NOPHN	National Organisation for Public Health Nursing
QIDN	Queen's Institute for District Nursing

Rcn	Royal College of Nursing
RHB	Regional Hospital Board
RN	Registered Nurse (USA)
SEN	State Enrolled Nurse (U.K.)
SRN	State Registered Nurse (U.K.)
USPHS	United States Public Health Service

SUMMARY

This thesis is a comparative and historical study of nursing in Britain and the USA from 1860 to 1970. The framework for the enquiry is drawn from the sociology of occupations and professions and the material is oriented specifically to the suggestion that occupational groups 'professionalise' and that professionalisation is a quest for power. There are four parts. Part one reviews the literature on professions which was available in the early 1970s, noting the strong consensus of what are called 'sceptical theorists' around the theme of professional power. It also examines a more substantive literature on nursing, for its bearing on this theme, and outlines a research design. The design involves the specification of areas of power and of indicators of the amount of power held. It suggests ways in which empirical materials might be collected, largely from secondary sources. Part two presents data on control gained by nurses in both countries in relation to two areas of entry and training. Reasons are given why the research design needed to be modified to produce a much more exploratory and interpretative account than had been envisaged. Differences in the matrix of institutions surrounding the regulation of nursing and the ways they function in the two settings are covered, still in the context of asking questions about the locus of power. The weaknesses of this style of analysis prompt an approach in part 3 which departs further from the original specifications. Nursing is seen as engaged less in a direct quest for control and more in a struggle for meaning. Three chapters deal in turn with concepts of the nurse and her work, aspects of the formulation and presentation of nursing knowledge and some of the strategies and struggles in which nurses have collectively engaged. A deliberate effort is made to build on and use the crosscultural, comparative opportunities presented by these data. The concluding section assesses the relevance of these analyses for the sociology of occupations and professions, suggesting that although the sceptical theorists of the early 1970s performed an important service in highlighting the normative nature of the concept of profession, they did not suggest altogether satisfactory ways of coming to terms with it. Two appendices are included, one providing additional statistical material for chapters 3 and 4, the other discussing issues of theory and method which arise in an historical and sociological project such as this.

PREFACE

The work described here arises from a research project carried out with the aid of a two year research grant from the Social Science Research Council in 1977-9. The original design was a product of a long association with the Industrial Sociology Unit at Imperial College and with the traditions of research there as interest shifted from organisation structures and performance to a concern with organisational power. It was in this context that I became interested in professionals in organisations, thence moving to the whole question of professional and occupational power in a more macro sense. The air of ferment and change in the sociology of occupations and professions was attractive; it seemed to promise new questions and new insights.

The thesis is offered first as a contribution to the study of occupations and professions, a commentary on the state of the art in the 1970s and an assessment of some of the consequences of following the oft expressed injunction to 'go empirical', specifically to do cross-cultural and historical work. Following this route raised more questions than I had anticipated, some of which were too large and too fundamental to tackle within the confines of a single piece of work. In terms of an approach to the study of professions, the end result is not entirely what the writers of the 1970s were advocating, but it is an approach, I argue, that is worth pursuing further.

The thesis deals with nurses and nursing in Britain and the USA, and it is my hope that the detailed material I have acquired in

the course of addressing questions about nursing and professionalism will say something at the substantive level too. Nursing, along with other occupations such as teaching, social work and librarianship, has had a raw deal in the hands of sociologists of professions. With the so-called 'established' professions as the yardstick, these occupations are the ones that 'failed', the 'marginal cases', interesting for what did not happen rather than what did. I hope, especially in part 3 of the thesis, that I have been able to redress the balance a little, by presenting something of the world-view of nurse leaders, the dilemmas they perceive and the factors which influence them in the different settings of Britain and the USA. It is now my firm conviction that we must address the substantive and the subjective in the sociology of occupations and professions, and this is a theme which grows in momentum as the argument progresses.

The third theme of the work has to do with the research process. As the work developed, two points became clear. First, there were weaknesses in the proposed new approaches, so that the noticeable dilatoriness in delivering examples of new work became understandable. Secondly, it emerged that the original research design was strongly imbued with my own history - it was one reading of the available literature, and by no means the only one. Any claims that there were inherent weaknesses in the approach would run into the difficulty of how much was my interpretation and how much other authors' intent. Rather than trying to mask this, I have given it considerable emphasis.

The conventional sequence of theory, methods and findings is still there, but it is presented less as a logical sequence, and more as a struggle to understand, adapt and modify, a process which has to be cut off at some point if anything is to be written at all. It may be politic, especially in today's climate, to present crisp sets of sociological findings. But I am among those who believe we must continually reflect on the assumptions and procedures which generate those findings, continually try to transcend the limits of our own frameworks. I want to keep trying, in other words, to see beyond the end of my nose.

PART ONE.

BACKGROUND

CHAPTER ONENEW DIRECTIONS FOR RESEARCH? A REVIEW OF THE  
LITERATURE ON PROFESSIONS IN THE EARLY 1970s

An air of change was blowing through the sociology of occupations and professions in the 1970s. Critiques of established ways of thinking were being mounted with growing confidence and stridency (Elliott 1972; Gabriel Gyarmati K 1975; McKinlay 1973; Roth 1974) and there were at least two writers who tried to develop a new approach in some depth and to exemplify it in their own work (Freidson 1970; Johnson 1972). Not all writers, of course, consciously strove to abandon the old. Some saw the problem not as one of generating new concepts and frameworks but as one of adding system and precision so as to operationalise and test the old (see Harries-Jenkins 1970; Pavalko 1971; and in particular, Hickson and Thomas 1969; Snizeck 1972). Others continued to work in a well-established empirical tradition, exploring the attributes and commitments of professionals, studying professional socialisation or dealing with the thorny problem of professionals in bureaucracies.<sup>1</sup>

This Chapter aims to explore the new sociology of occupations and professions of the early 1970s and to review the extent to which it offered programmatic statements about research. It will become clear that much of the writing was polemical in tone, and written with more of an eye to the past than to the future. Furthermore, a close inspection suggests less consensus than is

ordinarily supposed. The literature of this period served to clear the ground for a diversity of different approaches rather than to point to a single new direction.

Scepticism was the most obvious distinguishing mark of the new sociology of professions in the early 70s. Much of what had gone before had consisted of an effort to identify those factors which marked the profession out from other occupations - be these special knowledge and skill, length of training, adherence to an ethical code or whatever. Now, the whole idea of listing attributes or traits was being called into question and doubt was being shed on the notion that there was something intrinsically different and more worthy about the professions. Scepticism extended to the claims professionals ordinarily made about themselves, about their work and about the conditions under which they ought to perform it. To Paul Halmos, observing the scene in 1973, the climate appeared "radically and bitterly antiprofessional", and full of denunciatory campaigns (Halmos 1973:6). Halmos was not slow to express his distaste. The new approach onesidedly denied the altruistic element, especially in what he called the 'personal service' professions, it generalised an American-based critique to other countries and it so far elevated the 'debunking' aspect of sociology as to transgress the limits of intellectual honesty. Yet he was swimming against the tide; it is difficult to find even one essay in the collection edited by him which lent support to his position.

Had Halmos taken a longer view, he would have had to acknowledge, however virulent the tenor of the new debate, that there had always been a tradition of scepticism. Ben-David (1963-4) had drawn upon it a decade earlier, but had been an isolated voice. Now Elliot (1972), Johnson (1972) and, drawing on Johnson, McKinlay (1973) oriented themselves in relation to that tradition, and to its exponents in Britain. One factor perhaps encouraging them to line up with the denunciators was the emergence of a radical critique from within the professions and the start of a client revolt as documented for example by Haug and Sussman (1969) for the USA and by Heraud (1973) for Britain. Sociology in a sense was following an antiprofessional movement and documenting it.<sup>2</sup> But there was more to it than this. The sociologists were not just debunking the professions, they were addressing their own colleagues. One point here was the realisation that much previous sociological work had taken the professionals' views uncritically; another was dissatisfaction with what had become, in the eyes of many, sterile and trivial debates, a third had to do with the effort to escape from structural functionalism. The writing, in other words, reflected as much the turmoil in sociology as the turmoil in the professions under scrutiny, and the sociologists were self-consciously aware of this.

But was the new work anything more than polemic? Did it represent a coherent, alternative view - a view from which new

programmes of empirical research could flow? To answer this, a number of the more prominent contributions will be surveyed briefly before considering in rather more detail the work of Freidson (1970) and Johnson (1972).

Without a doubt, some of the most lively writings were of the debunking variety. Roth (1974) devoted a large part of his article on professionalism as the 'sociologist's decoy' to contesting the utility and accuracy of conventional lists of attributes of professionalism. Gabriel Gyarmati K (1975) made a similar point in his insistence that professionalism is a doctrine not a description, and McKinlay (1973) spent a considerable time expanding on the reasons why trust in the professions might well be misplaced. To do this, as we have noted, is to mount a serious critique of past sociological work. Johnson (1972) stands out for his treatment of past sociological work and its inadequacies, and the other studies tend to reaffirm rather than add to this. What though, do they say about directions for research?

At the opening of the decade, directions for future work were by no means clear. Jackson (1970), in editing a collection of new essays, was highly tentative. He saw a pattern of dissatisfaction with the assumptions which had previously governed the field, he accepted a more sceptical view, and felt that a link had to be made with class analysis. Yet he was prepared to accept the scaling work of Hickson and Thomas (1969) and he spoke rather unclearly of a 'competitive model'.

His contributors were equally diverse - their offerings range from a typological exercise (Harries-Jenkins), to a resource/control model (Turner and Hodge) to a rich analysis of intra-professional conflict (Jamous and Peloille).<sup>3</sup> Two years later, Elliott (1972) argued strongly that a sociology of professions should take us out into a consideration of the social structure and the nature of change in it. His suggestions that professionalism was implicated in, but not a prime cause of social change and that the top echelons of society remain largely uninfluenced by professionals and professionalism were important challenges. His notion that new work needed to proceed at the level of society as a whole, the level of the occupational group and the level of the individual was promising. But these levels of analysis did not easily mesh with the aims of his book and with the substantive content of the chapters, and overall the plan seemed to be more a synthesis of old materials than a pushing forward to new. Elliott himself was already working in other fields by the time his book appeared and all in all there seems to have been little follow-up from this work.

Other writers turn out to be highly schematic in their suggestions for new questions and new directions of enquiry. McKinlay (1973) closely followed Johnson(whose work is discussed later in the Chapter), in suggesting that we study professional occupations in terms of their power relations in society. The key question in his article concerned the extent

to which such groups, having assumed a powerful position, influence social change. How strategic this question is, how it might relate to other viable questions in a sociology of occupations and professions, is not explored. For Roth (1974) too, the privileged position of established professions was a subject for scrutiny, but so also was professionalisation, understood as a negotiative process by which power is achieved. Roth specifically enjoined researchers to do more historical work, though the studies he cited in support of this were both theoretically and methodologically highly diverse. Gabriel Gyarmati K (1975) again focussed on power questions, asking about the bases of power, the mechanisms used and their effects. He was very clear that we should make specific studies of occupational groups to demonstrate exactly how a particular group managed to acquire its prerogatives. Conceptually, two foci were outlined; we would need to give attention to the way ideology is converted into power, and to the deliberate strategies of occupational groups. Though this goes rather further than the other writers, there is an unresolved tension between the use of concepts of ideology within a framework which regards professions as reflecting a dominant ideology, and the use of a concept of strategy hinting at a much more voluntaristic approach to social change.<sup>4</sup> Furthermore, it is not at all clear how studies of individual occupations could provide a base for the specific attribution of causes for which he appears to call.

It is hard to escape the conclusion thus far that there was indeed a fashionably cynical vocabulary surrounding the professions in the early 1970s, but there was no coherent set of concepts to put to use, no new theory of professions, and no guidelines as to methodological approaches. The question now arises as to whether this conclusion should be modified when attention is given to the work of Freidson (1970) and Johnson (1972).

Freidson's Profession of Medicine is a long and discursive work. We might note that it began as a planned textbook in the sociology of health and illness, that it came at a point in Freidson's career where he was not only interested in the place of professions in society and in their organisation and work practice, but was also concerned with medical knowledge and with the application of traditions in the study of deviance (especially labelling theory) to medical definitions of illness. Here he was influenced by the theme of the 'social construction of reality' as propounded by Berger and Luckman (1967). On Freidson's own admission, there are "obvious seams and awkwardnesses at various points" (Freidson 1978:124-5) and we should not perhaps be surprised if these various themes are not, in the end, tightly integrated with each other.

For Freidson, as for the other authors discussed so far, the so-called attributes of a profession, expertise, commitment, etc. are not a useful starting point. Like them, he is concerned with power. The key feature of a profession is its autonomy;

a profession has a special status in the division of labour, it has been granted "control over the determination of the substance of its own work" (Freidson 1970:xvii), and this is a recognised and institutionally legitimated form of autonomy. Freidson is quick to point out that the autonomy so granted is conditional and not absolute. Here a supportive clientele is less important than the support of the already powerful. In a much cited passage, he observes:

"a profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite which sponsors it..." (ibid:72).

The notion of conditional autonomy has now come to be a crucial conceptual prop for a very different tradition of work, and Freidson has been criticised for not exploring this theme further (for further details see Part 4). Such a criticism, however, misses the point that it was the thrust of Freidson's own analysis which persuaded him that it did not need further exploration. His cross-cultural investigation of the position of the medical profession in the USA, the UK and the USSR, and his analysis of the occupational division of labour dominated by medicine are factors drawing him towards a position arguing that technical autonomy gives a 'sturdy wedge' into other areas. Once established with professional autonomy, he sees a profession as having something of a dynamic of its own, even able at times to contradict the elite and to survive. It is because he is convinced of the salience of technical autonomy that he devotes so much

attention to the question of professional self-regulation, exploring in part two of his study what this means in the contexts of everyday practice and in part four what it means in social and political terms for society to accord status to experts. In this way, his focus is more on achieved autonomy and its consequences, than on the process of its achievement and this, as we have seen, has been an emphasis echoed by the writers examined above.

If, for the most part, Freidson's volume was concerned with professional organisation and status, there was nonetheless a second strand of his work, as indicated in the subtitle, 'A Study of the Sociology of Applied Knowledge'. In practice, the sociology of knowledge approach led Freidson into chapters dealing with illness as deviance, professional and lay constructs of illness and the social organisation of illness. Here Freidson was struggling out of medical hegemony, attempting to liberate himself, in his own words "from any reliance on medicine as the authoritative guide to the ultimate character of illness" (Freidson 1978:124). He was insisting that sociology address the body of professional knowledge as well as the social organisation of the professions. It is easy to see the intrinsic merits of these chapters and to recognise the pioneering character of their insights. But Freidson was trying to do more than this. Later he was to put it as follows:

"...I attempted to produce a book which treated medicine as an occupation with special characteristics, including a special location in the social structure, a special self-justifying ideology as well as evangelistic view of health, and an unusual amount of autonomy. The human

as well as the analytical problem lay in the extent to which the claims of the profession (through its ideology) were in fact being realised. These issues required analysis of the character of the profession's 'knowledge' as well as of its self-regulating mechanisms. By adopting the approach of the sociology of knowledge...both the knowledge and the ethicality of the profession became ideologies which were problematic and which had to be evaluated by the sociologist as one who stands outside the system. (ibid.:125) (my emphasis)

In these later comments, but even more in the original volume, the implications of the one analysis for the other and the way in which they are to be brought together as the project of the sociology of professions are unclear. In the end, the more structural approach and the sociology of knowledge approach still seem relatively self-contained, at least as presented here. It is interesting to see in this connection that an Open University course team solved the same problem in the mid 1970s by keeping separate an analysis on the one hand of what they called the politics of professional authority, and on the other professional ideology<sup>5</sup>. This links with the contemporary debates in radical analyses of health and social welfare between the political economy perspective and the culturalist one (see Ehrenreich 1978; Gough 1979; Treacher and Wright forthcoming). Some are now beginning to argue for a new conception of power which will enable us to break away from and transcend this distinction, and this is an issue which will be discussed at a later stage in this thesis (see Ch. 9).

Johnson (1972), the second author to be considered here, starts from rather different intellectual preoccupations. His work stems from a research project attempting to compare

professions in countries in the British Commonwealth and a dissatisfaction with the explanatory potential of conventional concepts for this purpose. His slim volume is one in a series aiming to analyse current controversies in sociology, intending, as he puts it, "to work within existing conventions in the field...while, at the same time, suggesting new departures in the framing of problems" (Johnson 1972:89). Curiously, he makes no reference to the work of Freidson, though as we shall see, there is much that the two have in common.

In what is arguably the best critique of the sociology of professions to date, Johnson begins at once to offer hints as to the new departures he has in mind. "Professional occupations", he states, must be understood "in terms of their power relations in society, their sources of power and the ways in which they use them" (ibid.:18). There is nothing to be gained in searching for a single process of professionalisation, instead we must proceed from the basis that "variations in the role of governments and academic organisations will substantially affect the control and institutional forms associated with similar occupational activities" (ibid.:29-30). Past work has been thoroughly ahistorical and in his view we must look comparatively across time as well as across occupations to discover variant forms of organisation and differences of structure. It is the variations which are to be observed and to be understood as "historically specific institutionalised forms of control" (ibid.:27).

On this argument a profession, or what he terms the phenomenon of professionalism, is to be seen not as a type of occupation or activity but as a form of control over work. It is a specific form in which the producer defines the needs of the consumer and the manner in which they are to be met. Professionalism and the guild are two forms of control by a collegiate producer group. There are other forms in which the producer does not dominate. Under patronage, for example, the consumer dominates and aristocratic patronage and corporate patronage are subtypes here. A further form is mediation where the state intervenes to define both the needs and manner in which they are to be met. Johnson's project then becomes to explore the antecedents - in particular of professionalism, and also to consider other factors associated with each form, for example, colleague relationships, the conditions and characteristics of recruitment, and knowledge and ideology.<sup>6</sup>

What factors conduce to the establishment of professionalism as a type of occupational control? Some factors appear to function as resources. Esoteric knowledge, for example, is one resource. Thus knowledge does not necessarily have to be complex or specialised, it does have to be such as to maintain a distance between the professional and client. The character of the occupational activity is important, insofar as it generates uncertainty for the client and a pressure towards the reduction of tension. Client characteristics are important in the sense that professional control is enhanced when clients form a large, heterogeneous and fragmented source of demand. And, almost the obverse of this, a homogeneous producer group can be helpful. On their own, however, these resources are

insufficient. Johnson puts it as follows:

"The resources of power available to any single occupational group are rarely sufficient to impose on all consumers its own definitions of the content of production and its ends, except where these resources are articulated with other and wider bases of power" (ibid:42) (my emphasis)

The meaning of this becomes clearer in the discussion of professionalism as a feature of conditions in the second half of the nineteenth century in England. What was important was the rise to power of an urban middle class which provided both a market for professional services and recruits to the ranks of the professionals. In addition, there were the scientific and technical developments of the period and the possibilities of forming colleague-controlled practice institutions which related to "the practitioners' membership of, or association with, an existing or emergent powerful social grouping" (ibid.:52). As Johnson put it, "middle-class power provided the basis from which the expanding 'professions' created their own autonomous organisations" (ibid.:52).

Johnson is clear that the specific nineteenth century conditions for professionalism no longer obtain. New occupations will face a different set of conditions and occupations which enjoyed professionalism in the past have not remained static. Tensions between professionalism and consumer choice, for example, and tendencies to 'occupational fission' are among the important trends leading to the supersession of professionalism as a form of control. While he

rejects outright the concept of professionalisation as far too much of a straightjacket on our thinking about processes of change, his main contribution is to delineate types of control and associated features rather than to respecify in any detail processes of occupation formation and change.

Despite their different origins and styles of presentations, there are striking similarities between Johnson and Freidson. Neither author is prepared to accept the old views about professional attributes as the defining characteristics of professions or as the reasons for professional status. Neither is satisfied with an analysis at the level of orientations or attitudes. For both, the point that professions are about power is a sine qua non; both claim that professions are to do with privilege and with gaining a legitimate institutionalised arena of autonomy. It is remarkable too that, though he does not use the same terms, Johnson makes observations which are entirely consistent with distinctions Freidson suggests between the scholarly and consulting professions on the one hand and between dominant and subordinate occupations in an occupational division of labour on the other. It is also of considerable interest that both are sceptical about the directions of previous theorising in the sense that the search for a universal set of resources or characteristics which will enable autonomy to be achieved is questioned by them. This is an important point which will be taken up again, particularly in the concluding section of the thesis.

The most striking difference, however, lies in Freidson's treatment of professional organisation/status as a contemporary phenomenon as against Johnson's claim that it is a rare case, found in nineteenth century England, but not today. This is in part because their definitions of the power to be observed are not strictly identical. Freidson is concerned to stress technical autonomy - control over the determination of the work, whereas Johnson stresses control over the producer-consumer relation, involving producer control of the manner of delivery as well as the definition of needs. Johnson's then is the wider definition.<sup>7</sup> But there is more to it than this, and it is clear that they evaluate technical autonomy differently. For Freidson, it is the key feature, the 'sturdy wedge', as we have seen, into other kinds of control. For Johnson, technical autonomy does not have the same salience. State mediation is a form of occupational control where medical practitioners, for example, continue to determine the manner in which needs are catered for (i.e. technical autonomy) but the State guarantees the clientele and defines who is to receive services. His discussion of mediation draws upon medicine to suggest ways in which control by the occupations is lessened under this arrangement. He speaks of 'undermining' the existing bases of recruitment, of 'incorporation' in government agencies, of the creation of divergent interests, the loss of a position as sole repository of knowledge, and the growth of a social service rather than a personal service ethic.<sup>8</sup>

In practice, one is tempted to observe that neither account is wholly satisfactory on this fundamental point of what is controlled and whether control in one arena somehow entails control in others. Certainly control does extend beyond the immediate work and work relationship, to training and recruitment, for example, and, as many of the authors cited in this chapter observe, often members of professions are treated as generalised experts. But while both Johnson and Freidson stress that we should not take the mere existence of institutions (the professional association, for example) to indicate control, in the end, criteria for recognising control are not made explicit by either. Their divergence of views must at least in part surely be attributed to this.

Another criticism which has been levelled at both writers is their failure to locate their writing in a theory of political, economic and social change. In a sense, this is less consequential with respect to Freidson, since he is prepared to see some occupations as having achieved an important degree of autonomy, suggesting a pluralistic model of political process; Johnson, however, does leave himself open with his frequent reference to wider relations of power which remain quite unspecified and unanalysed in this work. One result is that for both authors a language of strategy and tactics and negotiation lies just beneath the surface.

What is the relevance of strategic action, of the subjective perceptions of leaders and of ideologies? Neither author would appear to go along with a fullblown voluntaristic model, according primacy to social action, but neither discusses the role of such factors in an explanation.<sup>9</sup> And, interestingly, though both authors have subsequently addressed the problem of the theory of social change and done so in very different ways neither has come back to the subjective meanings of profession and the role of this in the overall analysis.<sup>10</sup>

Finally, we turn to the question of methodology and directions for further research. It should be clear by now that neither author offers a detailed guideline as to what is researchable and how. Freidson's work is a scholarly volume, in essence an interpretative essay rather than a research monograph. His methods for developing his perspective include historical and crosscultural research, together with a considerable command of and willingness to use and interpret existing materials. Johnson, on the other hand, is oriented more to the development of sociological research and offers to the attentive reader a number of directions for development. We are enjoined to consider specific institutions, in their historical specificity, to examine the role of governments and academic organisations and  
 11  
 so on. But a researcher must work out a research design for her/himself; Johnson uses the case of accountants to develop his analysis, basing his materials, as far as one can see, on two  
 12  
 extant histories. Problems, if there be such, for sociologists in doing historical work are not addressed at all.

Where, then, had the sociology of occupations and professions reached by the mid-seventies? The most obvious feature of work in this field was the growing chorus of dissent from the old approaches. This doubtless gained attractiveness from its link with sociology's debunking role, but profession-bashing was not the whole of it. In part, at least, it must be seen as a genuine effort to set new and more properly sociological parameters around the debates, parameters which had to do largely with the investigation of profession in terms of power and privilege. There remained, as one might expect, some confusion. Some aspects of previous research had been criticised but the status of others remained unclear. There was a real difference between the positions of Freidson and Johnson which had not been acknowledged or confronted. Terms such as power and control were being used with ambiguous empirical referents and although a start had been made, the question of the articulation of occupations and professions especially with the class structure of wider society had hardly begun to be explored. In terms of method and research designs, historical work was advocated, but in a very general and loose way.

My immediate concern was whether any of this writing was relevant for the case I had resolved to study, namely, nursing. Could the general framework of the new, sceptical writers be taken and used? Some insiders certainly claimed that nursing was a profession, yet nurses' rewards and privileges were not comparable with those of doctors, and the level of autonomy enjoyed in their work was clearly less. There seemed to be a real dilemma as to whether one regarded claims for professional status in this

case as legitimating a position of privilege to which nurses aspired, or whether such claims could be said in some sense to protect nurses from dominance and exploitation. On the other hand, and if we set this debate aside, questions of how much power and of what kinds could equally be asked of nursing. To help arrive at a decision, I resolved to explore materials on nurses themselves, to see whether these offered anything of an alternative.

NOTES

1. For further general discussion of this literature, see Elliott (1972); Jackson (1970); Johnson (1972). For more on the professionals and bureaucracies theme see Benson (1973); Davies (1972) and forthcoming a); Heydebrand (1973) and Larson (1977). The theme of professional socialisation is an important one, and still an active topic for research and debate in this period (for material on nurses, for example, see Oleson and Whittaker 1968, and Simpson, 1979, but it is beyond the scope of this particular discussion.
2. Gerstl and Jacobs (1976) offer the provocative suggestion that historically professionalisation and deprofessionalisation are cyclical, with the 1970s representing a *high point of advanced elitist professionalisation*.
3. It is not strictly correct to refer to the work of Jamous and Peloille (1970) as dealing with intra-professional conflict. Certainly it is about an old guard and a new guard, but there is also the question of a determinacy/indeterminacy ratio in the work itself - which is central to the analysis - and there is an important discussion of both an internal and an external dynamic of development. I return to some of these questions later.
4. The question of an occupation and its 'strategy' is a problematic and recurrent theme in this thesis. It is discussed in most detail in Chapter 8.
5. This is clear in introductory remarks by Graeme Salaman and in the two units which follow, both by Geoff Esland, entitled respectively 'Professions and Professionalism' and 'Diagnosis and Therapy'. Open University (1976a).
6. What Johnson actually says is this:

"In the following analysis of each of the types.... (of occupational control).... there will be a discussion of such factors as the nature of the consumer, the produce-consumer relationship, the conditions and characteristics of recruitment, colleague relationships, knowledge and ideology" (Johnson 1972: 47).

This is not really very satisfactory. The producer-consumer relationship defines the type of control, whereas the nature of the consumer (or facets thereof) help determine the type of control. The other factors are rather loosely regarded as 'associated'. This is a pity especially in the light of my earlier discussion of Freidson and the specific issue of exactly where professional ideology might fit into an analysis.

7. Compare this with the position of Parry and Parry who suggest nonetheless that Johnson's focus on producer-consumer is a narrow one (Parry and Parry 1976:43).
8. There appears to be some ambiguity here. Professionalism is defined as producer control of both the needs and the manner in which they are met. Mediation is defined as third party control of both, with medical practice inside the British NHS as a special and different resolution of the producer-consumer relationship. In practice, however, when Johnson comes to discuss state mediation, he draws on the example of medicine. (Parry and Parry 1976:44).
9. Freidson, on his discussion of nurses is in fact pessimistic about whether strategy makes any difference at all, (see Chapter 2).
10. Johnson's work has shifted in a Marxist direction and as such will be discussed later in the thesis. Freidson's current position is less easy to summarise. He is seeking a reorientation of the sociology of occupations and has called for an analysis linked with the class structure and with political economy (Freidson, 1980). In looking, as he does, to institutional economics, and in building on the concept of 'market shelters', however, he does seem to be led back into the strategies and institutional arrangements of the occupational group rather than led towards an explicit articulation of those with wider relations of power. Since this work is still in draft form, I shall not refer to it further.

11. Johnson 1972: esp. 29, 37-8

12. ibid.: 66-74

CHAPTER TWORELEVANT DEVELOPMENTS IN THE SOCIOLOGY OF  
NURSING

A prolific literature on the social aspects of nursing has been appearing in the postwar period.<sup>1</sup> Particularly in the USA, it had become common for sociologists to find jobs in or associated with schools of nursing and to develop their research interests accordingly. So it was conceivable that I might find a starting-point for a study of nursing as an organised occupational group elsewhere than in the sociology of professions. Certainly, some review of this material seemed relevant. I confined my attention for the most part to literature which had appeared in sociological journals and in medical sociology textbooks and readers and to the research monographs frequently cited in these sources. There were at least two kinds of approach which it was necessary for me to address. The first was the wave of writing in the 1950s and early 1960s which may be said to be on the topic of 'dilemmas of position and status'. The second had to do with the concept of 'semi-profession' and its application to the case of nursing. Beyond these two, and in the most recent period was yet more material which at the time I found difficult to assess. I will give it brief mention here in order to take it up again at a later point in the thesis.<sup>2</sup>

An early article which falls under the heading of 'dilemmas of position and status' was that of Devereux and Weiner (1950). The authors aimed to analyse the occupational role of the nurse with reference, as they put it, to the

psychological implications and professional consequences of the definition of the nurse role in society. They started with a wideranging discussion of the sexual division of labour and the way in which so-called 'natural' characteristics of women were reaffirmed in the drudgery of everyday nursing work. They offered a sensitive discussion of the place of emotion in the nurse's work and the prescription to hand out 'tender loving care', drawing on a mixture of themes from both sociology and psychiatry. It was a blend, however, which was not to become popular in sociological circles. 'Dilemmas of position and status' soon got tackled in rather different ways - ways that at first affirmed the sexual division of labour as natural and later ignored gender differences in favour of concepts of work organisation and orientation to work which took their points of reference more from within the hospital walls than from without.<sup>3</sup> We will examine these briefly and in turn.

Writing for the nursing press, Johnson and Martin (1958) set out a clear functionalist model which accorded the instrumental tasks (and the authority and status) to the doctor and the expressive tasks (and the support and caring roles) to the nurse. They urged upon the latter adjustments which would make the system operate more harmoniously. Others wrote for the sociological press in a more or less similar vein (e.g. Thorner, 1955) and ideas that women had nurturant and non-scientific values, that they were less ambitious and less aggressive, that they were committed to roles as mothers and

hence could not be expected in any large numbers to be totally committed to their work, began to be taken for granted. Even those who argued that change was likely, that the trained nurse would reject a mother surrogate role, escaping the bedside for management (Schulman, 1958, 1972) were in essence taking a basic sexual division of labour as given (cf. Mok, 1969).<sup>4</sup>

Attention seemed quickly to shift away from nursing work as women's work and nurses as women, however, and to become focussed on the organisation of work in the hospital and on the nurse as participant in this. Narrower conceptions of role and role conflict were involved, communication and hierarchy were discussed, together with different patterns of work allocation (see, for example, Bennis 1958; Berkowitz and Bennis 1961-2; Corwin 1960-1, Coser 1958; Mauksch 1966; Pearlin and Rosenberg 1962).<sup>5</sup> Added and often allied to this was a rapidly growing volume of material on the nurse herself, her self-images, her attitudes, commitments, possible alienation, authoritarianism and so forth, and the way these were distributed across different grades. Habenstein and Christ (1955) were particularly influential with their suggestion of three main types of nurse and other typologies followed (cf Meyer 1960; Reissman and Rohrer 1957). The literature on nurses also began to be cited along with that on social workers, teachers etc. - all seeming to point to groups who did not have a fully-fledged professional orientation to their work, or a professional organisation of their activities (see, e.g. Corwin 1960-1 on the former and Davies and Francis 1976 on the latter).<sup>6</sup>

Research of this kind was something nurse leaders could understand and use, for it pointed to a plan of action for changing the rank and file nurse. How such an argument worked out was especially clear in an article in the American Journal of Nursing in 1963. The authors claimed that a framework of professionalisation was available for nursing in the shape of licensure, ethical codes, etc. But responses of a sample of hospital nurses showed they were 'confused' about their functions, 'uncertain' as to who was the most appropriate judge of the quality of nursing care, and content to remain subordinate to doctors (Kurtz and Flaming 1963). The strong implication was that injecting a more 'professional attitude' would help.<sup>7</sup> But the trouble was that nothing did seem to be changing.

Fred Davis, introducing a new volume of essays on nursing in 1966, summed up well the mood of puzzlement and confusion about nursing as an occupation. He referred to a multiple set of paradoxes within it, to do, for example, with the responsibility of the nurse, yet her lack of autonomy and authority, to do with the multiplicity of grades of work covered by the term 'nurse', the varying educational requirements and so on. Betraying the state of mid-sixties American sociology, with its confident empiricism and often unacknowledged functionalist base, he went on:

"whether these paradoxes are but sub-species of 'modern woman's social role', or 'uneven rates of social change'

or 'the tension of functional and substantive rationality' in the organisation of health services is, of course, a question of paramount interest to social science and nursing alike".  
(Davis 1966:viii)

There was no hint here of a social order crosscut by major divisions of class and gender, of a health care division of labour as reflecting and sustaining these divisions and of nurses as oppressed, exploited or ideologically subordinated.

Contributions to his volume were diverse; issues of practice and contexts of practice were taken up by Mauksch and by Brown, educational matters were the concern of the group then working on the San Francisco nursing careers project (headed by Davis himself). All of the contributors were beginning to step further back from the immediate concerns of nurse leaders, though as Davis points out they all shared a desire to address practical policy questions and had developed this orientation through close contact with nursing and nurses over many years. The essay by Glaser is the one which perhaps steps back the furthest. Basing his remarks on comparative data from 16 countries and drawing on his own background in political science and institutional analysis, he began to suggest that the same institutions may have different results in different countries and that a process of 'organic social evolution' meant a lack of institutions salient for the development of nursing in some national contexts. Of particular interest for the subject-matter of this thesis was his suggestion that a professional model of nursing practice

could take better root in the U.S. than in Britain. Even so, he felt that nursing faced the twin problem of being women's work and taking place largely in hospitals - the preserve of the doctor. These factors, he argued, hindered the development of what he termed 'nursing science'. Strauss's essay was similarly pointing towards new conceptual frameworks. While focussing for much of the time on problems directly recognisable to nursing leaders as such, his analytical focus was on values and structure and the inter-relation of these in a context of a growing demand for nurses.

Overall, however, the volume was aptly named as a set of essays. Davis did not try to integrate them closely or to draw out directions for further work. Nor were the contributors especially concerned to be reflective about this sociology of nursing and its relation to the wider sociological enterprise. Had they been so concerned they might have had pause to reflect on how their work was displaying the tendencies of a 'sociology of .....

' to become a 'sociology in .....

', a service enterprise which tends to lose some of its critical flavour.<sup>8</sup> As it was, the sociology of nursing remained the interest, by and large, of a specialised group - few of whom started with specific interests in sociology which led them to nursing, more of whom found themselves in settings where nurses were calling on their sociological skills.<sup>9</sup>

Three years later, a volume was published which promised much more of a theoretical integration and worked hard to achieve it. This was a book not about nursing as such but about semi-professions; and teaching, librarianship, social work and nursing were all counted as semi-professions and presumed to display similar characteristics by virtue of their semi-professional status (Etzioni 1969).

The idea of semi-professions had been around for some while, appearing in various guises in both theoretical and empirical studies. Back in 1961, Goode, in a study of librarians, had suggested that there were certain groups unable to make a transition 'from occupation to profession'. On what he was later to elaborate for the Etzioni volume, as the two core traits of knowledge and a service ideal, librarians were said to be lacking (Goode 1961, 1969). Two years later, in the Handbook of Medical Sociology the division between the chapters suggested an interesting distinction; while Wardwell (1963) dealt with 'limited', 'marginal' or 'quasi-practitioners' - all in competition with doctors, Corwin and Taves (1963) offered an essay on occupations allied to and aiding medicine. This distinction, however, was not explored directly. A little later, Denzin (1968) bemoaned sociologists' failure to deal with occupations which do not become professions and offered the case of pharmacy as 'incomplete professionalisation'. Some clearly felt that a more rigorous operationalisation of traits would clarify matters, a position referred to in Chapter One and exemplified here by Vollmer and

Mills(1966) but it was the Etzioni volume which was to stand out and be remembered on the topic.<sup>10</sup>

Etzioni's interest had stemmed from work on formal organisations and the way knowledge was handled in them. He had concluded that there were four solutions - the fullfledged professional organisation, the semi-professional organisation, the service organisation and the non professional organisation. What distinguished them from each other was the extent to which the individual was free to operate on terms dictated by his/her presumed knowledge or skill.<sup>11</sup> What Etzioni was now doing was extending these ideas about organisations to encompass organised occupational groups. What then are the distinguishing characteristics of a semi-profession and of the semi-professionals who comprise it?<sup>12</sup>

Etzioni refers at the outset to semi-professions as a "group of new professions whose claim is to the status of doctors and lawyers is neither fully established nor fully desired" (Etzioni 1969: v) He goes on as follows:

"Their training is shorter, their status is less legitimated, their right to privileged communication less established, there is less of a specialised body of knowledge and they have less autonomy from supervision or societal control than 'the professions'."  
(ibid.:v)

Some of these points receive later restatement and elaboration. Semi-professions are seen as having qualities required for the communication rather than the creation of knowledge and, linked with this, skills and personality traits more compatible with administration. They are often to be found in an

administrative hierarchy, in a supervisory relation to each other, as well as being directly observed, instructed or corrected by full professionals. Those in supervisory positions tend to be more organisation-oriented than client-oriented (thus promoting divisions within the semi-profession). These points, as Etzioni acknowledges, are to do with the organisation of work and the nature of authority. Other differences are associated with the empirical fact that the typical semi-professional is female. It is worth quoting him in full on this point:

"Despite the effects of emancipation, women on the average are more amenable to administrative control than men. It seems that on the average, women are also less conscious of organisational status and more submissive in this context than men. They also, on the average, have fewer years of higher education than men, and their acceptance into the medical profession or university teaching is sharply limited. It is difficult to determine if the semi-professional organisations have taken the form they have because of the high percentage of female employees, or if they recruit females because of organisational reasons; in all likelihood these factors support each other". (ibid.xv)

It is important to consider the semi-professions argument in some detail. If it can be shown to be coherent and acceptable and prima facie applicable to nursing then it should be chosen, in preference to the kind of work discussed in Chapter One, as the framework for further study. It is my argument, however, first that it is not coherent, and secondly that while at first sight far removed from the apologist orientation that the writers examined in Chapter One criticise, it is, in practice,

very much an apology for the status quo and as such an unacceptable starting point.

On the point about conceptual coherence, a number of points emerge. First, in the tradition of the trait models of professions, the concept of semi-professions is unsatisfactory in several respects.<sup>13</sup> Shorter training, less specialised knowledge etc. figure both as definition and as explanation. Secondly, and again as with all trait approaches, endless debate is opened up about quantities: how much shorter is shorter, how much less specialised and so on. Thirdly, one must observe that semi-professions are being defined largely in a negative way, less by what they are, than what they are not. Such an explanatory strategy has a strong tendency to produce a derogation of a deviant case and to support existing and hegemonic ideas. Next, there is a welding together at the heart of the notion of semi-profession of two ideas probably better kept apart. The claim of the semi-profession is 'neither fully established nor fully desired'. Achievements and aspirations would be better considered separately. Indeed, the whole argument runs together aspects of the semi-profession as a group with a social position and aspects of the individual semi-professional. As will become clear in the chapters that follow, I do take the position that both of these must be studied, but to confuse them in one's initial concepts seems to me especially unfortunate. Finally, there are still further ambiguities in the 'not fully established/not fully desired' criterion. Is it that none fully desire, or that some fully desire and some do not? And what are we to suppose about those who do fully

desire, yet whose desires are unmet? Some kind of dynamic process with learning and modification in it seems called for.

Turning then to the question of the concept of semi-profession and to its status in face of scepticism that concepts of profession are apologies for the status quo, the situation at first seems more promising. One might almost want to number Etzioni among the new sceptics when he remarks firmly of the semi-professions:

"we do not accept some of the claims and self-images these professions have fostered". (ibid.:vi)

But it quickly becomes clear that this remark is to be set in the context of acceptance of the claims of the established professions and acceptance, in effect, of the position these groups accord to semi-professions. Semi-professions are thus enjoined to accept their place:

"(T)he policy recommendation which obviously emerges is for these middle-status groups to acknowledge their position, to seek to improve their status rather than to try to pass for another....Once it is recognised that there is a middle ground, inauthentic aspirations and positions are more likely to be renounced and the dysfunctional consequences of attempting to pass will tend to disappear. The semi-professions will be able to be themselves." (ibid.:vii)

One could hardly ask for a clearer example of sociology in service of the status quo, in service of prevailing ideas about expertise, and, of course, prevailing ideas about the position and status of women.<sup>14</sup>

What then of the 'sceptical theorists' as described in Chapter One - where do they stand on semi-professions? Their position, as we have seen, represented an attack on the status quo, a refusal to accept the claims of the established professions and a recasting of these claims as an ideology, buttressing positions of inequality and privilege. Conceivably, this vantage-point would offer an opportunity for comment on what Etzioni had called the semi-professions.

A clear position certainly emerged from Freidson's work (Freidson 1970:57-70, 75-6). In the sphere of health, he claimed, medicine was the dominant profession and others were in a subordinate position in a division of labour headed by the physician. These others did not possess, nor were they able to develop the crucial features which gave a position of privilege. Nurses were a case in point: all nursing work flowed from doctors' orders and nurses were unable independently to monopolise an area of work and to develop autonomy. This subordination had been facilitated by the growth of nursing work in the medically-dominated arena of the hospital and by the Nightingale interpretation of nursing work. The emergence of schools and of statutory registration did not alter the position, since it was autonomy of work which was lacking and autonomy which lay at the heart of true professional status.<sup>15</sup> Nor did professional attitudes (professionalism in Freidson's terminology) matter. Indeed the claims of para-professionals to status of their own or to status in association with medicine served to underscore their subordinate position and make it more stable.

Nor, again, did strategies count; drawing from the case of nursing, Freidson argued firmly:

"(T)hose paramedical occupations which are ranged round the physician cannot fail to be subordinate in authority and responsibility and, so long as their work remains medical in character, cannot gain occupational autonomy no matter how intelligent or aggressive its (sic) leadership" (Freidson 1970:69).

Freidson, indeed, saw the elaboration of management roles in recent years as a strategy to cope with blocked mobility, but a strategy, as the above quotation implies, with little likelihood of success.

Krause (1977), relying on a Freidsonian perspective, took the argument about strategies a step further. He isolated six strategies on the part of American nurses, of which the managerialism noted by Freidson was one. Each strategy, it seemed, had failed and this prompted him to question whether any occupations essentially based in the hospital setting and oriented towards medical technology can hope to gain independence. Both the hospital setting and the nature of the legal rights and obligations built into the statutes were factors, he felt, in the subordination of nursing. Such a perspective, however, is a deeply deterministic one, and others have accorded more place to leader strategy in determining outcomes. This is an issue alluded to already in Chapter One, and one to which we shall later return.

Turning to Johnson (1972) whom we also classed as a sceptical theorist, his position on an occupation such as nursing

is more difficult to penetrate. This is because, as we have already seen in the last chapter, he is not persuaded of the contemporary dominance of the established professions. Mediation, rather than professionalism is the mode of control over occupations in the modern period and mediation by the State, altering the terms and conditions of the provision of health care, importantly affects the medical profession. What, then, of nursing? Is it that control is 'secondhand' (via medicine) as Freidson suggests; is it that State mediation more severely curtails nursing as an occupation; or is it both of these? Johnson offers few clues.

The difference between Freidson and Johnson on the degree of dominance of the established professions was to be reiterated and to gain added significance as more radical writings emerged. What is now referred to as the Illich/Navarro debate is in essence a major theoretical difference between those (with Illich) who see professional dominance as crucial and those (with Navarro) who see professions as pushed and pulled by the wider forces of a capitalist society and so enjoying only conditional autonomy.<sup>16</sup> But none of this was very clear at the time, especially to one whose primary interest lay not with medicine but with nursing. What was apparent was that while the semi-professions literature was not altogether compatible with the power approach of the sceptical theorists, there was no really clear alternative on the horizon.

In addition to all this, there were, what seemed at the time, isolated radical analyses of nursing to consider. Ehrenreich and English (1974), for example, had written an historical pamphlet arguing that the current subordination of nurses must be understood in terms of the cultural subordination of women reinforced by nurse training. This subordination was in turn to be located in the class and sex struggles which had already taken place before the rise of scientific and clinical medicine. It was not, then, just that nurses were subordinated to doctors, but that women were subordinated to men and women of one class were subordinated to women of another. Jo Ann Ashley (1976) provided another feminist orientation with her work on American hospitals and her arguments about the exploitation of women as nurses in them. Cannings and Lazonick (1975), on the other hand, were inclined to see a logic of capitalist development and a long-term deskilling of the nursing labour force - presenting a Marxist, but not a feminist view.

Much, much later I was to begin to see how important it was to come to terms with these kinds of analyses, and to allow them to penetrate the apparently new, but in some ways still solidly conventional sociology of professions. At the time, however, all seemed buzzing confusion. Some seemed to feel that nurses were subordinated to medicine; others that they were subordinated to hospitals and still others that they were, as women, subordinated to men. Whether the strategies leaders adopted

were consequential or not seemed in doubt, and the true meaning of the institutional arrangements - the schools, registration schemes etc. was unclear.

The following Chapter recounts how I resolved all this - a resolution which involved sticking closely to the new sociology of professions, as represented by the writers discussed in Chapter One, attempting empirically to measure power and abandoning, for the time being at least, the rather confusing literature on the sociology of nursing. But it was not a lasting solution. I had to return, especially to the radical writing, and to come to terms with it. By the time I did so, it had developed further, necessitating the reconsiderations which are the subject-matter of part four.

NOTES

1. Some idea of the vast amount of work can be gained from consulting the Nursing Studies Index (Henderson 1963, 1966). The years 1900-1929 were covered by a single volume whereas two large volumes were necessary to cover the 1950s alone.
2. It is perhaps worth emphasising that this is not a review of the sociology of nursing as such, but of those aspects relevant to a sociology of occupations and professions and, within that, to questions about the status and power of occupations. Thus work on professional socialisation, for example, is omitted altogether. There is a heavy emphasis also in this chapter on American literature, a correct reflection, I would argue, of material which has been produced. Sociology of nursing is a very recent phenomenon in Britain and one which is beyond my brief to investigate here.
3. A tendency, I have argued elsewhere, which gave rise to a particularly barren form of organisational analysis (Davies 1979a).
4. A growing caution in relation to what today would be seen as sexist themes in the study of nursing is revealed if one compares the review essays on nursing commissioned for two editions of the Handbook of Medical Sociology (Corwin and Taves 1963, Mauksch 1972).
5. Mauksch (1966) is particularly interesting in respect of this narrow organisational issues focus. For the most part his long article follows the tradition, but at the end there is a brief acknowledgement of wider issues of sex and gender, viz:
 

"Cultural traditions and expectations that are closely linked to the sex role have obviously laid the groundwork upon which many of the hospital's institutional practices have taken their departure" (Mauksch 1966:131).
6. It should be noted at this point that the direction of work - the focus on attitudes and orientations - is something writers have noted as a more general feature of the sociology of the professions in this period (cf Johnson 1972:9). The flavour of the ANA's programme of research on nursing functions is well captured in Hughes et al. (1958).
7. For a discussion of the theme of professionalism as taken up in British nursing see Anderson (1973:Ch.12). Anderson also provides a review of much of the literature cited here from the different point of view of a nurse researcher anxious to build upon existing work.

8. The distinction between a 'sociology of ....' and 'sociology in .....' was first drawn in relation to medicine by Straus (1957). It continues to be a distinction found valuable by reviewers of the field today.
9. It is interesting to note how many of the writers in this field are husband and wife teams, where the husband is a sociologist/historian/psychologist and the wife a nurse. For a fascinating and revealing personal account, relevant to the themes of this chapter, see Mauksch (1978).
10. The concept of semi-profession has received recurrent treatment since Etzioni's classic work. Leggatt (1970) reviews the literature and makes the case for teaching as a 'bureaucratic' profession (cf. Gold, 1976). Larkin (1978) pleads, in my view rightly, for a historical sociology of para-medical occupations, linking the ascendancy of medicine with the broader division of labour, but interestingly, finally brings in a concept of a sub-profession. His hints as to the comparisons available between occupations in his work in process, however, seem most promising.
11. Etzioni reprinted the relevant section of his earlier work on organisations (Etzioni 1964) as a guiding memorandum for contributors to the 1969 book.
12. Etzioni's exposition runs together features of the profession and of the professional.
13. Johnson (1972:23-7) discusses the weaknesses of trait models and I am building on this here.
14. I would not extend this harsh judgement equally to all the contributors in Etzioni's volume. Simpson and Simpson, who deal with nursing along with other occupations and the relevance of their female composition, are at pains repeatedly to point out that it is cultural norms which subordinate women and that change will not come without an alteration both in attitudes and in institutions of the family. On the other hand, they are cautious about claiming that women are actually discriminated against; they state at one point their belief in basic personality differences between men and women and they do not provide anything by way of a critique of the concepts suggested to them by Etzioni. A present-day feminist would be likely, in the end, I suspect, to treat them unsympathetically (Simpson and Simpson 1969).

15. In relation to schools, registration etc. Freidson claimed of nurses: "Their autonomy is only partial, being secondhand and limited by a dominant profession (Freidson 1970:76). It will be the purpose of part 2 to explore these institutions and what they say about the power of nurses. Whether the 'partialness' comes from domination by the medical profession or domination by the State is an important question. If the latter, it also becomes relevant to explore these institutions for the case of medicine itself - something Freidson does not do, and something beyond the brief of this immediate study.
  
16. There are different versions of the two arguments. For the most recent, see Navarro (1976) and Illich (1976). For more on 'conditional autonomy' see part 4.

CHAPTER THREEDEVELOPING A RESEARCH DESIGN1. The Context

The research process, the textbooks tell us, consists of a review of the literature from which derives at best a hypothesis to be tested, and at the very least an identification of gaps in our knowledge, areas covered less than adequately and so on. It is not often remarked that we come to the literature with a mind already set in a particular groove, with commitments, often not made explicit, at the levels of theory and of practice, and with a predilection to recognise what is already familiar to us.

The intellectual environment in which I came to a reading of the literature on the professions in the early 1970s was one with a strong emphasis on empirical work. The Industrial Sociology Unit at Imperial College (ISU) had been theoretically eclectic, drawing more from writers on management than from sociologists. Joan Woodward had attracted in the 1960s a group of people with diverse backgrounds in engineering and in industry, few of whom had had a formal training in sociology and to an important extent the ISU had remained protected from the turmoils faced by those in sociology departments coming to terms with ethnomethodology and with successive variants of Marxian analysis. There were debates, of course, about how managerially-oriented the research programme was but there was little doubt that fieldwork, whether in the shape of observation, or more usually, an interview programme, was crucial. There were more reports back to the various firms studied than there were

contributions to the literature (but see Woodward 1965, 1970). But there had been an important change; to what was already a fairly numerate tradition carried along by graduates in engineering was added a commitment to systematic model-building and rigorous theory development. Mathematics and statistics seemed to offer powerful tools, path analysis in particular suggested a way of coping more precisely with the interrelationships of variables, and the work of econometricians began to be held up as something to emulate (see Abell and Mathew 1973, Abell 1975).

A much-respected survey of the literature on organisations pointed up an orientation shared by probably most of the ISU staff at the time (March and Simon 1958). Vague, repetitive, unfounded generalisations, the authors felt, comprised much of what passed for organisational knowledge; the task was to work towards a common language, to sort out what had and had not been subjected to the rigorous scrutiny of scientific method, and above all to review and restate with the aim of taking things forward towards empirical testing. Lists of key variables were to be made, ways of operationalisation discussed so as to impose an order showing what had been achieved and what was still to be accomplished. A complete volume which described itself, quite accurately, as an 'inventory of propositions' followed in this tradition (Price 1967). Formalisation with its attendant neat and parsimonious logic was admired and books on theory construction were much discussed (Hage 1972; Stinchcombe 1968).

In substantive terms interest had begun to focus around power, and a renewed concern with what sociologists had had to say about power and how far this was serviceable for empirical work, was evident. There was considerable tension between those stressing the formal requirements for testing the proposition that A has power over B and those who felt that, with all the requirements met, the whole issue became trivialised, losing the essence of the insights in the original sociological writing. What all this concern with power also heralded, however, was a determination to bring human agency in, to leave space for what John Child was to dub 'strategic choice' and to regard organisational outcomes as in some measure a product of the beliefs of powerful participants (Child, 1972).

This general climate influenced my reading of the professions literature and the initial research design in two main ways. First, in the manner of March and Simon (1958) it seemed highly desirable to introduce more system into the existing literature, to explore the range of dependent and independent variables in it, to make clear which relationships were known and supported by empirical data and which were still under dispute. Built into this kind of goal is an assumption that the framework one imposes for the purposes of coming to terms with the literature is a matter of convenience, and does not itself involve any major theoretical and methodological commitments. This assumption, part and parcel of an empiricist approach, was something I was later to challenge, both in this context as will be seen below, and in others

(Davies 1980b; Davies and Roche 1980). Also involved in this approach is a willingness to draw from all writings, old and new, which seem to have a bearing on the problem. Treating eclecticism as a positive value in this way, the research design thus was to draw, albeit for use in a power model, from the conventional approaches so heavily criticised by the power theorists as well as from those theorists themselves.

The second clear influence exerted by the ISU tradition lay with the approach to data and data collection. Though this was to be a historical study, for the growing chorus of voices in favour of this had been duly noted, I took the view that historical data was data like any other for the sociologist - it was relevant in service of a sociological interest in building and testing models of social change (for further discussion, see Appendix II). In this context I was impressed by the work of Somers who had, from a background in statistics and survey analysis, reanalysed Barrington Moore's work, taking us forward I felt, towards the goal of generalising from history. "I believe" Somers had said "there is merit in considering whether historical analysis ... cannot be made a basis for the development of knowledge that is more reliable, consensual and systematic than artistic insights ordinarily are" (Somers 1971:358). There was also, of course, a growing body of work in a tradition of quantitative social history, which seemed to underline the viability of the approach (for an interesting empirical example see van Tijn 1976).

While the new literature on professions did not emerge from traditions at all comparable with these, it was compatible with them. For one thing the units of analysis in the sociology of professions were not individuals and the battle to shift the level of study away from the individual was something entirely familiar to students of organisations. For another thing, there was, overtly at any rate, no general theoretical stance within which professions and occupations had to be viewed, and which might have interfered with adopting them as a set of reasonably coherent and autonomous entities, actors in rather than agents of a system. Of course, one had to 'understand wider society' for the purpose of understanding occupations, but it was that way round; few were proposing to understand occupations for the purposes of understanding wider society. For one schooled in organisational analysis, the idea of a focal occupation, like a focal organisation, was entirely congenial.

The aim of my project thus became to take the literature as described in Chapter One and to render it empirically testable. If professionalism was indeed about power, how was this power achieved? Could we begin to specify more precisely both the kinds of control achieved and the variables which were relevant to that achievement? My interest in nurses led me to focus more on the process of achievement of power than on the maintenance of it, and from this point of view, Johnson rather than Freidson seemed an appropriate starting point. Initially,

efforts were made to render his work in terms of a model of the determinants of professionalism, the mechanisms for its maintenance and the strains within it. What I was not to observe until much later was that the kinds of questions generated by this exercise and the form which the search for specification took, led in directions somewhat removed from the thrust of Johnson's argument, a point I shall return to later.

## 2. The focus of research

The first task in research design seemed obvious; it was to clarify what was to be explained. As we have seen, Johnson had focussed on the producer-consumer relationship and the power of the producer over the consumer. Freidson, on the other hand, had concentrated on control over work, and each, it seemed, took a different view as to whether this power 'spilled over' into other arenas. Influenced by the then current discussion in the field of industrial relations (cf Walker, 1975) and convinced that power was a relation concerning which we should always ask 'over whom?' and 'with respect to what?', I began to work towards a number of apparently logical distinctions.

First, there was the question of direction; occupational groups attempted to control their own members as well as to gain a position of privilege in wider society. (The relationship between these two would, of course, be of interest). Next, control attempts would occur in different spheres, with respect to coherent types of issue. The immediate practice of work was

only one of these spheres and I experimented with various ways of clustering issues into spheres.

Having come to some decision on these conceptual matters, the next task was to devise operational indices and to ensure that the conceptual ideas had some referents in the realm of observation and measurement. Table One shows the results of such a line of thinking. The details of the table were modified on several occasions, but the approach remained the same.

It is clear from a glance at that table how the old literature as well as the new was used. Items which in the conventional writings were seen as part of the definition of professionalism and part of the legitimation of professional privilege (length of training for example) were here seen as mechanisms through which control was gained, their values serving as indicators of the extent of control achieved. The potential pay-off to the empirically-minded was considerable. The approach added precision and moved us towards the stage of testing. With this guide to data-collection, one could, at the very least, see the order in which controls were achieved and review the vexed question already noted in relation to Freidson's work (see Chapter Two, p35) of how far institution-creation (the professional association, the training school etc.) actually involved increments of control. Of course, it was clear that there was room for argument about indicators and how far they 'really' indicated control gain and loss. But it was felt that without a language of increase and decrease of control no advance could be made. It was for those who criticised the operational

TABLE ONE OCCUPATIONAL DEVELOPMENT-CONTROL COMPONENTS

Control Issues	Direction of Control	Indicators
Beliefs	of members	<ul style="list-style-type: none"> <li>- length of training.</li> <li>- length of special training of teachers.</li> <li>- degree of standardisation of the curriculum.</li> </ul>
	of Societal resources	<ul style="list-style-type: none"> <li>- extent of professional membership on governing bodies of work organisations.</li> <li>- proportion of professionals in knowledge-creation tasks (research posts).</li> <li>- locus of initiation of enquiries into the profession.</li> </ul>
Work Practices	of members	<ul style="list-style-type: none"> <li>- ratio of supervisors to practitioners.</li> <li>- level of legal responsibility of occupational members.</li> <li>- comprehensiveness of code of ethics.</li> </ul>
	of Societal resources	<ul style="list-style-type: none"> <li>- exclusiveness of jurisdiction over duties.</li> <li>- control over a 2nd grade.</li> </ul>
Rewards	of members	<ul style="list-style-type: none"> <li>- number of standard pay grades.</li> <li>- frequency of pay reviews.</li> <li>- regularity of pay reviews.</li> <li>- level of specificity in contract.</li> <li>- percent covered by pay reviews.</li> </ul>
	of Societal resources	<ul style="list-style-type: none"> <li>- relative position of occupation to pay of doctors/all health staff.</li> <li>- proportion of occupational members on pay review bodies.</li> </ul>

Continued .....



indicators to suggest better ones. My task was to make clear how I had defined my terms and operationalised them, and then to get on with the job.

Following this, the next interest was in exploring the circumstances in which power was or was not gained. Influenced by organisational analysis, I referred here to the 'environmental determinants of control'. Johnson had argued that several resources aided in the establishment of professionalism, including client heterogeneity, producer homogeneity, esoteric knowledge and so on. He had also stressed some very specific conditions to do with the rise of the middle-class in the last century. Guided, however, more by the argument that factors at a lower level of generality were more likely to show associations with occupational development (cf Millerson 1964:51), and after reviewing briefly some of the themes regarded as important in nursing history, the list of dimensions shown in Table Two was devised. Choice was governed by my knowledge of the availability and comparability of materials as well as by suggestions as set out in the literature. To generate this 'environmental variance', as it were, I opted for both a crosscultural and an historical comparison; nursing was to be studied in Britain and the USA from 1860 forward. This design was suggested in part by my existing knowledge of American nursing and the known availability of some materials in Britain. It was also, I assumed, a conservative strategy, for I had explored and rejected the idea of studying several different occupations in a single country. (In the event, the conservatism was called into question,

TABLE TWO      ENVIRONMENTAL VARIABLES AFFECTING OCCUPATIONAL CONTROL

Type	Dimension	Indicator
Immediate environment	level of health provision	<ul style="list-style-type: none"> <li>- Proportion of GNP on health.</li> <li>- Level of State expenditure on health.</li> <li>- Level of expenditure on medical insurance.</li> <li>- Ratio of hospital beds to named population groups.</li> <li>- Ratio of staff to population group.</li> </ul>
	level of governmental regulation of health	<ul style="list-style-type: none"> <li>- Proportion of hospitals State run.</li> <li>- Proportion of doctors in State employment.</li> </ul>
	bureaucratisation of health care delivery	<ul style="list-style-type: none"> <li>- Proportion of resources devoted to home vs. hospital care.</li> <li>- Ratio of administrative to other staff.</li> </ul>
Remote environment	level of economic growth	<ul style="list-style-type: none"> <li>- GNP per capita.</li> <li>- Growth of GNP per capita.</li> </ul>
	degree of equal opportunity for women	<ul style="list-style-type: none"> <li>- Proportion of women in named occupational groups.</li> <li>- Relative educational achievement of the sexes.</li> </ul>
	degree of emphasis on academic achievement	<ul style="list-style-type: none"> <li>- Proportion of GNP devoted to education.</li> <li>- Level of qualifications achieved.</li> </ul>
	prevalence of welfare-statism	<ul style="list-style-type: none"> <li>- Relative contribution of voluntary bodies to research/welfare provision.</li> <li>- Proportion of labour force in State welfare employment.</li> </ul>

for studying two countries was more of a commitment than I at first realised.)

In practice, the emphasis on specification of variables and their measurement was associated with a distinct lack of clarity as to the overall model which was to be put to the test. In a general way the data would lend themselves to addressing a sequential hypothesis such as had been developed by Wilensky (1964) and Caplow (1954) on the one hand, versus a notion of environmental factors affecting control on the other. But the way in which occupations might be affected by their environment remained unspecified. Whether one could meaningfully search for a set of resources which favoured the establishment of control was not discussed (compare Turner and Hodge 1970 and Johnson 1972 on this). Where and how the idea of an occupational strategy fitted in was unclear - indeed the whole notion of the occupation, in the shape of its leadership, acting upon its environment was left in the air at this point. It was consistent with the basic orientation of the research to argue that these questions could be left to one side for the time being and indeed should be addressed as far as possible as empirical issues rather than theoretical ones. It was felt to be enough to aim to provide a much more comprehensive set of indicators concerning what was controlled and who was controlled than had hitherto been available. That in itself would lead to a more adequate understanding of the kind of institutional control achieved at any point in time and the direction of change in this.

### 3. Research Procedure

The first step in the research was seen to be a clarification and development of the list of concepts and indicators already devised. A more detailed and wideranging literature search would doubtless throw up more variables and would suggest hypotheses as to the relationships between variables. This work could partly overlap with a second step of reading the available historical accounts of nursing in both countries. This would provide essential background knowledge, would serve as a corrective to errors of interpretation in using some of the indicator variables and would help locate sources for collecting the required material on indicators. Step three would then comprise the mapping of elements of control for a period of 100 plus years in the two countries. Given the kinds of hypotheses which were beginning to emerge, the appropriate design seemed to be some form of time-series analysis. Values of dependent and independent variables could be ascertained within each 2-5 year period and associations between them explored. Unless time units were used, no serious test of hypotheses could be undertaken, given that only one occupation and two countries were involved.

It was considered that the sources for this work would largely be secondary. There were a considerable number of histories of nursing written in different periods and from different perspectives, and it was felt that between them they would supply a great deal of the relevant information or at least give

indications of where it might be found. These sources could be supplemented, where necessary, by recourse to professional journals, Annual Reports of Associations and so on. The strategy was later modified (see Appendix II for further discussion). As far as the environmental variables were concerned, they had in part been constructed with an eye to existing official statistics and comparative studies of health care systems. But difficulties and modifications were expected. The first two steps in particular were designed to allow for modification as a result of a growing knowledge of the field; and throughout it was felt that the biggest challenge of the project was not going to be data analysis, but the achievement of sufficiently good quality data to allow the use, albeit a tentative and exploratory use, of statistical techniques.

In the event, however, the biggest challenge of the project was found to lie in a different direction. Much more important than questions of availability and reliability of sources were questions of conceptualisation and theory. As I began work on plotting changes over time in the spheres of control outlined in the initial research design giving, as planned, critical attention to the indicators chosen so questions rapidly surfaced. At length, I came to see that at the back of the whole enterprise were several key assumptions: that the occupational group was a single and coherent entity, that its members shared a predictable and already understood interest in advancing the position of the occupation as such, and that the mechanisms to pursue this interest were recognisable and indeed invariant over time and place. And

it was these assumptions which were the real source of difficulty.

Had I cared to look, I would have seen, of course, that writers in the field had already challenged the coherence assumption; work on 'professions in process', and the concept of professional 'segments' was available (see Bucher 1962; Bucher and Strauss 1961 and more recently see Ross 1976, Marsden 1977). And, as I shall discuss later, acceptance of the coherence assumption probably remains as a key weakness of the present study. The historical and cross-cultural features of the research design, however, meant that I was constantly brought into doubt concerning the other assumptions. If the expressed goals and overt interests of American and British nurses were to be taken seriously they could not easily be reduced to a claim that their interest was always in enhancing the position of the occupation as such; and even if this were the case, they went about it in very different ways. Indeed, it began to seem to me that the very matrix of institutions which regulates nursing, itself a product, in part, of struggles by nurses, was in its turn, shaping consciousness and aspirations. In whatever sphere in which I looked, initial similarities between forms of organisations in the two countries rapidly turned to differences and these differences in their turn had much, it seemed, to do with subsequent patterns of development.

Thus, in what follows the reader will not find a detailed following through of the research design spelled out in this Chapter. The initial design is still important insofar as it

dictated the kinds of sources to be used, the overall period to be investigated, and the time constraints. It was not practicable in the circumstances to tamper with these much. Moreover, the interest expressed in that design in occupational power, how it is achieved, increased, lost, etc. remains intact, although I am now convinced that a much more subtle approach is vital if understanding is to advance. The analysis in part two bears the most overt traces of the original research design, and in it I quite deliberately address the questions posed by that design and the difficulties those questions presented. As one researcher who faced strikingly similar problems in his own research has recently put it:

"Attempts to work naively within a particular paradigm can be just as convincing and satisfying a way of discovering strengths and weaknesses as purely theoretical exegesis" (J. Maxwell Atkinson 1978:xi).

Yet the problems were too great to allow me to work totally within the initial paradigm. What I have done is to retain the initial questions: Did nurses ever gain occupational control and if so, in respect of what? Can their history be seen as a progressive increase of control in one or more spheres, or were there periods of stalemate and reversals, even in the collective institutionalised power they enjoyed? I have accepted as legitimate the quest for precision in answering these questions, but I have sought to show that that quest can be premature. Further it is misleading to demand data on increases and decreases of the phenomenon of power when our understanding of that phenomenon is insecure.

Again and again, the logic of my doubts forced me to explore the matrix of institutions surrounding nursing and the way in which this matrix shaped social action. The next two Chapters explore the matrix of institutions surrounding entry to nursing and nurse training in the British and American context. In the process of this it should emerge just how much the initial framework and indeed the very goals of the study were called into question by a research activity which demanded that I examine patterns of change in occupational control.

PART TWO.      OCCUPATIONS:

A QUEST FOR CONTROL?

CHAPTER FOUR  
CONTROLLING ENTRY TO NURSING

The idea that existing members of an occupational group specify restrictive criteria for recruitment and thereby control entry to that occupation has long been a commonplace of sociological writings on professions. It is an emphatic point, for example, in the early writings of Caplow who sees entry control as a distinguishing feature of professions and limitation of the numbers of recruits as a consequence (Caplow 1954:102, 170). Among more recent writers, Johnson has claimed that the regulation of entry is a feature of professionalism and seems to suggest that both greater homogeneity and greater exclusiveness are the outcome of successful control in this area (Johnson 1972:54,79). Parry and Parry in positing professionalisation as a process of collective social mobility, also stress homogeneity, enhanced social origins and limitation of numbers as features of occupational control (Parry and Parry 1976:77,82-3).

It is a short step from material such as this to begin to spell out potential indicators for the purposes of exploring how far, and indeed whether, nurses have achieved control in this arena. Four indicators were chosen at the outset of this empirical work. These were years of education required, proportion of the relevant population qualified for entry, proportion of the qualified rejected at interview and age of entry.<sup>1</sup> Each of these, it was felt, bore upon the issue of degree of exclusiveness achieved though, in practice, it did not seem possible to find separate indicators of each, so closely were they linked. No-one seemed to have attempted to explore the processes of entry control empirically, in a sustained and systematic way.

The problems encountered appeared first as operational difficulties. Take age and education, for example: how were we to proceed if there was no single, agreed rule, or if the existing 'rule' was widely ignored? Would it then be meaningful (let alone practical) to try to compare an average practice statistic? What too was to be done where there were two or more routes of entry, the one, rigorously controlled, the other(s) less so? And what, similarly, of direct recruitment to practice - for the original thinking had presumed that entry was, in fact, always entry to training. Should multiple routes be counted as no control or as partial control? If the latter, would this not confuse matters by bringing different dimensions into what was first conceived as a simple scale?

To add to these problems, there was the issue of the agent(s) of control. Written into the existing literature was an assumption that when numerical limitation etc. occurred, this meant control by 'the profession' itself. But it rapidly became clear that specific agencies were involved, agencies which could not necessarily be equated with 'the profession'. A statutory body might be composed largely of nurses but be at odds with a professional association. Individual schools might decide on entry criteria, but it would take a full project in its own right to establish whether this meant nurse control. Such local nurse control was not organised or concerted and could not be used to achieve an overall pattern of entry.

A third area of concern emerged rather more slowly as a result of the initial reading of secondary sources. It is best exemplified by the case of American nursing in the 1930s; here was a moment when numbers went down and requirements for entry went up - classically what is supposed to happen as the profession gains control. In this instance, however, as will become clear later in the Chapter, the changes were a feature not of occupational control, but of the economic circumstances of the period. It would be quite erroneous thus to infer from trends in numbers, qualifications etc. to the degree of control by the occupation itself. The trends, I suspect, were influenced very much by factors such as the availability of education and job opportunities for women, and the demographic balance between men and women - so that wars, booms and slumps and technological change are key factors altering the supply of labour for nursing and as such are outside the control of any occupational group.

These observations, particularly these last ones, called for a reassessment of the research plan. It was not my brief to try to account for changes in numbers, entry requirements etc. as such. Mapping these changes had been seen, after all, as a means to the end of understanding occupational control. I elected, therefore, to concentrate on the changing institutional framework which surrounded entry to nursing and, from this vantage point, to explore questions of control. What I had already begun to find, and what my subsequent analyses bore out, was that the theorists of professions did not have a detailed acquaintance with

empirical materials; and concepts which were plausible in theoretical terms, proved less than workable in the face of empirical data. The institutional focus of this and the following Chapter offered the more flexible and explanatory focus I needed.

The Chapter deals with the institutions of entry control first in relation to British nursing then in relation to American nursing. I have selected points of change and points of contrast for close examination. What is lost is a comprehensive chronological coverage; what is gained, I hope, is greater analytical depth and a step on the road to a more satisfactory approach to occupational power.<sup>2</sup>

1.a) Schools for Nurses in Britain 1860-1900

The year 1860 is a conventional landmark in the history of British nursing. It was the year in which the Nightingale Training School for Nurses, based at St. Thomas' Hospital in London opened. Funded by monies provided by grateful citizens following Florence Nightingale's successes in nursing in the Crimean War, it was influenced very much by Miss Nightingale's ideas, although she was not herself its formal head (Seymer 1960).<sup>3</sup> It is an appropriate starting point for this Chapter since it marks the point at which the idea of entry to nursing through a training began to take hold. By 1898, one estimate suggested that there were as many as 114 establishments in England and Wales with over

100 beds offering a training and a further 296 smaller hospitals doing likewise (Burdett 1898). Furthermore, nursing institutions, that is, nursing homes or nursing agencies run on a commercial or philanthropic basis, employing perhaps six or eight nurses would be likely also to take a trainee, or 'probationer' in the terminology of the time (ibid.).

What, if any, were the distinctive characteristics of these new entrants to nursing? Did they supersede and outnumber previous nurses - did the school as an institutional innovation thus control and transform entry to nursing? To answer these questions we need to examine who became a nurse in 1860, and how; we need to explore the recruitment practices of the schools and to estimate how far the new group replaced the old.

The term 'nurse' in 1860 covered quite a range of persons.<sup>4</sup> For some, it meant a relatively stable post in an affluent household with responsibility for children; family size was considerable and the (children's) nurse ranked quite high in the hierarchy of servants (Burnett 1974). For others, it meant becoming a more transient employee hired to care for the sick members of the family on a temporary basis. For still others, it meant a domestic servant post as nurse-maid. It could further refer to workers in institutions, voluntary hospitals, workhouse wards and mental asylums. The point to note is that entry to all of these kinds of nursing was a matter of supply and demand in the market place. No doubt, these nurses were very varied in their quality and character, but largely they were doing work as servants, in either a domestic

or an institutional setting. Middle class families, not usually wont to entertain the idea of paid work for their women, would certainly not have regarded nursing, in any of these senses, as a real option.

The Nightingale School sought deliberately to change this. The aim was to recruit not the high born, not the daughters of the leading families in town and county, but the daughters of small farmers, artisans and tradespeople - respectable young women, god-fearing, healthy and not afraid of hard work. Probationers were to be recruited not on the basis of paper qualifications - an impossible demand for women in the period and an anachronistic one<sup>5</sup> - but after a personal interview and an assessment of character and reliability. In some schools this was achieved - in the Nightingale School and in certain of the others modelled on it, and in well-known and respected voluntary hospitals in the main centres of population. Elsewhere, however, in many of the smaller, provincial schools and in the schools which grew up associated with Poor Law Institutions, fewer candidates came forward and there was less choice.

What evidence is there for this? First, there is material indicating that high born women did come forward. A division grew up between 'lady-pupils' and 'ordinary probationers' and the former were subject to a somewhat different regime (Abel-Smith 1960: ch.2). Personal sponsorship of women from respected families occurred, and certain schools also had waiting lists, and could afford to be very selective about whom they would train. We

know less, inevitably, about the less prestigious schools, the nursing institutions and so on, but given the speed at which schools were opened and probationers were becoming the mainstay of hospital staff, it is unlikely that strict selection was always in operation. A rare insight into the situation outside the metropolis has recently been contributed by Maggs (1980), who stresses the variety of local labour markets in producing candidates for training.

In addition to these diverse new entrants to nursing via the schools, the old pattern of direct employment remained both in hospitals without schools and in hospitals with them. The Poor Law hospitals continued to recruit pauper nurses throughout the nineteenth century and it is unlikely that the voluntary hospitals discontinued direct recruitment (Abel-Smith 1960; White 1978). Outside the hospitals, trained and untrained nurses competed for work with no protection for the former. This, of course, was one of the factors which led certain trained nurses to organise and agitate for statutory recognition and protection.

To sum up then, some control over entry to nursing was exercised in this period; but it was an arbitrary, varied and local affair. Indeed, in the St. Thomas' case, it was a highly personalised control by Miss Nightingale herself. But the schools did represent an institutional innovation and their selection of trainees a potential mechanism of control. The result was added diversity - the addition, broadly speaking, of middle and even upper class women to the existing ranks from whom nurses were drawn. We should not look in this period for exclusivity as

specified in our model of occupational control, there were no organisational devices through which it could have been effectively achieved, and further, as I shall discuss in part 3, no-one really aspired to achieving control of this sort.

1. b) Statutory Basis for Nursing - 1919

The 1919 Nurses' Act set up the General Nursing Council (GNC). Its membership reflected the changes which had taken place, taking account, as it did, of the different organised groups of nurses which had come on the scene in the preceding thirty years or so, and the different types of nurse and places of practice which were available.<sup>6</sup> What we need to consider here, however, is the power this legislation gave to the GNC in respect of regulating and influencing patterns of entry to nursing.

It was to be the responsibility of the GNC under the Act to create and maintain a Register of nurses. To this end, it was to set conditions of admission to the Register and to regulate the conduct of an examination. Anyone not on the Register who described him/herself as registered was liable to prosecution and a fine. The GNC was to make rules (known as the Nurses' Rules) but these were to be subject, however, to approval by the Minister of Health and to ratification by Parliament.

When we inspect it closely, this legislation was remarkably limited as far as control over entry to nursing was

concerned. First, there is the question of entry to employment as a nurse. Provided that the title 'registered nurse' was not used, matters remained as before. It was entirely legitimate for a private individual or for a hospital to employ untrained nurses. Nothing then, was done to regulate the direct entry channel. Secondly, there is the question of entry to training. For the GNC to approve individual candidates would have meant a massive central expenditure, and this was not countenanced. But nor, however, was the GNC given powers to set an entrance requirement (be it years of education received, examinations passed or a specific test). Instead the GNC was to approve the schools and the schools, in turn, were to choose their candidates. We shall see in Chapter Five just how limited this approval process turned out to be, and how often the Ministerial veto was used. There was no way in which approval of schools could be used as a route to entry control. In any case, there was nothing to prevent unapproved schools, or schools approved by other bodies<sup>7</sup> from continuing in existence.

How did this new institutional framework affect recruitment? It is hard to claim that it made any difference at all. Certainly there was no contraction in the total pool of new entrants. Numbers of new entrants to the State examination rose steadily in the late 1920s and 1930s (see Appendix I, Table one), and Abel-Smith, after making certain adjustments in the Census figures, suggests that there was a fairly even expansion of nurses over the first three decades of the Century

(Abel-Smith 1960:256). Furthermore, what direct evidence there is, tends to cast doubt on greater exclusiveness in entry. A survey in 1931, carried out for the Lancet's enquiry into nursing, showed hospitals for the most part facing a shortage of trainees, and over half those in the sample were prepared to accept probationers with an elementary education only. Many of the teaching hospitals no longer had waiting-lists for would-be nurses and one in five claimed to have difficulty in recruitment (Lancet Ltd. 1932; Appendix XVIII). Very many hospitals were also recruiting untrained nurses to supplement their staffs (Abel-Smith 1960; Appendix II). As to the paying probationers, the 'ladies' of the earlier era, it is clear that they were still being taken on into the 1930s, though probably in fewer and fewer numbers.<sup>8</sup> The trends, then, were towards more nurses, and, if anything, less discrimination as far as entry requirements were concerned; trends, in short, which were the obverse of what a theory of occupational control would predict.

As we have seen, the explanation for these trends was not to be sought in the new institutional framework represented by the GNC. That body had gained control over an examination, held at the end of a training process, but it had not gained control over entry to training. Nor, indeed, did it have any say over entry to employment. In some ways, as I show elsewhere, this was a debilitating mix of powers (Davies 1978). In this context, however, we need only note that the powers of the GNC were of little moment as far as entry control was concerned. If we are to explain the trends in entry we must, it seems, turn to an appreciation of the factors underlying the growing demand for

nurses and the expansion of hospitals in this period, and we must set this against an understanding of the extent to which alternative job opportunities were opening up for women. Supply and demand were still important, and occupationally-controlled institutions had not superseded the market in this instance.<sup>9</sup>

1. c) Hesitant moves by the State

The supply question came to a head in the 1930s, with a growing consensus that there was a nursing shortage in the hospitals. Doctors carried out an enquiry of their own (Lancet 1932), and in 1937 the shortage of nurses was so far acknowledged as to merit an official enquiry. An interdepartmental committee was set up to carry out an investigation of both recruitment and training. Potentially at least, entry to nursing was being acknowledged as too important to be left to the play of market forces.

Under the Chairmanship of Lord Athlone, the committee issued an interim report in 1939. The direction of its thinking on entry control is made evident in the following excerpt:

"(I)t is abundantly clear that some means must be found to replace the existing haphazard system of recruitment. At present each training hospital secures for itself such probationers as it can or as are necessary to satisfy the needs of the hospital, and irrespective of the national demand for trained nurses, provides a training for them. What is required is a regularised and ordered system of recruitment in which the national needs receive equal consideration with the needs of the individual training hospital". (Ministry of Health, 1939; para. 29) (my emphasis)

The report went on to emphasise the difficulties which would have to be faced, but it also spoke of the possibility of a central authority with wider powers than the GNC to control recruitment although it felt that such a step could be delayed for a few years in favour of an all out effort to increase recruitment.<sup>10</sup>

What amounted to an unambiguous pointer to manpower (or rather womanpower) planning was not taken up. The report itself was shelved with the outbreak of war, and yet, even with a national health service imminent, there was no serious return to these ideas. State planning was not being set aside in favour of occupational control, but in favour, rather, of a continued belief in market forces as the best providers of a nursing labour force.<sup>11</sup> I shall attempt to justify this interpretation by reference to an event which at first sight runs counter to it, namely the Nurses' Act of 1943.<sup>12</sup>

The Nurses' Act of 1943 gave recognition to a second grade - the Assistant Nurse.<sup>13</sup> The GNC was to maintain, in addition to its Registers of Nurses, a Roll and it was to have powers in relation to the Roll analogous to those for the Registers. The idea of an assistant grade had been debated in the 1930s. The GNC had remained aloof, taking the position that the question was beyond its statutory brief. The College of Nursing, by now the strongest nursing association, was coming around. A report published in 1942 marked a conversion - from a position of doubt it had moved to support. A second grade could be commended, if state registered nurses (SRNs) controlled it and if it posed no threat (Rcn 1946).

This might have been a moment for the State or the GNC to specify entry requirements for both Register and Roll, to offer guidance to schools as to which form of preparation they should undertake and by these entry controls to start to influence the size and shape of the nursing labour force. In practice no such agency was involved. The Minister of Health was adamant that no formal entrance test should be applied to nursing. First and foremost the hospitals must be staffed and an entrance test might put this at risk. In the schools, there was opposition to converting from Register to Roll, given the reduction in status and salaries involved. And the College of Nursing did not make any moves at this stage to amend its own rules to allow nurses on the Roll to become members.

Such, then, was the position at the commencement of the National Health Service (NHS), and the subsequent trends in recruitment are not surprising. In the first decade of NHS operations, the numbers of student nurses grew rapidly. By 1960, indeed, the annual intake figures were almost double those of the prewar period.<sup>14</sup> The assistant grade, however, as we might predict from the preceding discussion, grew more slowly. By 1960 they still represented only 16% of the new training intake (see Appendix I, table 2). With such a small proportion of entrants for the Roll and with no entry requirements, it was unlikely that there would be a clear demarcation between the two groups in terms of social and educational origins. There is not a great deal of data on this, but a study in 1957, showing that 38% of recruits for the

Register had had a Grammar School education, and 29% a Secondary Modern School education lends support to the notion that diversity was still the keynote (GNC 1966). Added diversity came from recruiting nurses from overseas. Fully 88% of new student nurses came from overseas as the same 1957 Study was to show. Others, already trained, were investigated on a case by case basis and admitted to the Register.

Even more diversity came via employment policies in the NHS. The hospital statistics reveal that older, married women were an increasingly important component of the hospital labour force - hence that re-entry was being encouraged. (These women, of course, often worked on a part-time basis). Untrained nurses also continued to be an important segment of the nursing labour force. Employers were once again looking to who-ever they could find to make up the shortage of nurses, and drawing now from a pool, not previously acceptable, of married women.

To summarise, it seems that no real case can be made for an increase of occupational control over entry to nursing. This period opens with the suggestion that the State arrogate to itself more entry control over nursing, but this idea neither gained acceptance nor galvanised nurses into a bid to restructure institutions and take more control of them. Formal acceptance of a second grade, one might be inclined to say, was something that organised nurses blocked - and this would be consistent at least with some theories of profession.<sup>15</sup> But examined closely the 1943 legislation would

seem better seen as a somewhat half-hearted measure, built on the model of the 1919 Act and giving no positive powers to shape the mix of entrants. Certainly the outcomes were not what any intended, for shortages continued to be felt and employers were once again taking initiatives in recruitment policies. The GNC remained perturbed about levels of recruitment as well as about quality.

1. d) A Select Few?

The 1960s saw two changes which it will be important to assess in the context of this Chapter; first the entrance test for candidates for training as a registered nurse, and secondly, the arrival of degree courses and of candidates with degrees. At last, one might be inclined to say, the GNC was behaving like, and succeeding in behaving like, the sociologists' model of a professional body! It was improving the social origins of recruits and managing (given what we know about GNC powers) to get State sanction for this. Such, however, would be an incautious conclusion, as we shall see.

The GNC had long been concerned about wastage figures for student nurses and it was convinced that better initial selection would reduce student wastage. On the other hand, it had also accepted the Ministry position that recruitment must not be allowed to drop. A way out of this impasse began to emerge. With formal recognition of the Assistant Nurse grade, the GNC felt it could step up its campaign for an entrance test for students for the Register (see GNC Annual Reports, 1949, et.seq.).

It then became apparent that some schools were voluntarily applying an entrance test of their own, and the GNC looked on with interest and amassed data. These data showed that a test could indeed reduce wastage, and furthermore, (an argument likely to carry more sway at the Ministry) even with a test, numbers seemed to remain buoyant.<sup>16</sup> The Ministry formally capitulated and in 1962 a test was allowed, although it was not to apply in respect of entrance to training in mental illness and mental handicap hospitals where recruitment problems were most severe.

What happened to recruitment? Numbers of new entrants to training for the Register fluctuated around the 22,000 mark in the mid-sixties, fell in 1967/8 and dropped even further thereafter. At the same time, numbers of new entrants for the Roll increased, with the net effect that the ratio of SRN to SEN entrants shifted markedly from 4:1 in 1961 to 3:2 in 1971 (see Appendix I, table two). Without doubt then, the trend was towards a smaller and more exclusive category of registered nurses and a growing lower grade. But we cannot, with any confidence, attribute these trends to the new testing powers of the GNC.

First, the level of the test was set very low. Tests which had previously been applied by the individual schools were more taxing and indeed in 1968 over half of the applicants had educational qualifications in excess of the test (GNC Annual Report 1968/9). Secondly, not only does a close look reveal that numbers of entrants for the Register were already fluctuating by 1962, but the sharp drop comes some five years after the introduction of the test, precisely at the moment one would expect it in demographic terms - the end of the postwar 'baby bulge' (see

Appendix I, table 2 ). Thirdly, there were other moves directly to encourage numbers coming forward as potential nurses in the lower grade. The College had already described the assistant nurse as 'pivotal' (Rcn 1956). Legislation in 1961 removed the term 'assistant' so that the grade was now State Enrolled Nurse (SEN) and discussions began on the idea of a senior grade and of developing SEN functions in specialist areas in children's nursing, public health nursing etc. In 1963 SENs were admitted as full members of the College. It is important also to point out in this connection that the GNC in no way intended to reduce the one grade and enhance the other. GNC Annual Reports in the period express continuing alarm and concern over the drop in recruitment for the Register. And neither the GNC nor the College, now Royal College of Nursing (Rcn)<sup>17</sup> had an articulated policy about the size of the two grades.<sup>18</sup> In short, it is doubtful both that the test in its 1962 form could have affected the pattern of entry, and that anyone was actually trying to use it in this way.

The other issue to consider in this period, however, is whether a new elite was being formed by another means, for this is the period in which nurses with university entrance requirements entered new degree courses in nursing and existing graduates were provided with opportunities to train for nursing on special accelerated training schemes.

The 1949 Nurses' Act had made it possible for the GNC to approve experimental courses and slowly, a number of initiatives were taken. It had always been possible, of course, for a graduate

to decide to train as a nurse, or for a nurse to decide to read for a degree, but the personal considerations of time and finance did not make such moves attractive to many. GNC Annual Reports reveal that new opportunities came first in the shape of schemes which gave an SRN qualification together with a university diploma; next came shortened SRN courses for those with degrees, and in 1965 the first degree in nursing was unveiled. By the 1970s it has been estimated that around 100 candidates per annum were entering nursing degree courses of one sort or another; (Scott Wright 1973) some linked with biological sciences, some with social sciences and so on (see Emblin and Hill 1976).

Clearly then, a new route of entry to nursing was opening up - but at whose instigation and under whose control? The GNC did not and could not control it. Its powers were to approve, but not to initiate new developments. It could and did encourage, but to provide policy guidance or financial resources was beyond its remit. There has been, to date, little detailed study of the experimental schemes linked as they were with universities and polytechnics, but what material there is suggests that degree courses have been (and probably still are) an uphill struggle, where enthusiasm tends to substitute for resources and where nursing is likely to become a pawn in faculty politics. Scott Wright points out how dismissive the Robbins Committee on Higher Education had been of nursing as a university subject in 1965, and she speaks from her own experience of:

"...striving from day to day to find adequate means of financing integrated degree and nursing programmes often on an ad hoc basis, where grants have somehow to be found from educational and/or service agencies to cover 12 months rather than the traditional academic years...." (Scott Wright 1973:225)

A detailed study in the field of health visiting courses at Universities paints a vividly similar picture (O'Connell 1978). When for all kinds of reasons, some of which are discussed in Chapter Five, the government of the day was moved to set up an enquiry into nursing in 1970, it made for the first time a policy recommendation that between 2 and 5% of nurses should be graduates. But no swift action was taken on the Report (Committee on Nursing 1972) and developments continued to be reliant on local initiative and support.

Before turning to the American data on entry control it is as well to make at least a few summary observations. First, in no period that we have examined has there been an indisputable allocation of control over entry to nurses. Changes which on the face of it qualify as this, do not do so on closer inspection, and supply and demand factors appear to be much more important. Governments of the day have, for most of the period considered, remained interested in who becomes a nurse, if only to try to ensure a continued high recruitment. Where the GNC fits as between government and profession is a vexed question - for though we have not addressed issues of policy and strategy directly, it has become clear that the GNC's loyalties can lie closer to those of the government of the day than to the professional association. And yet

there have been changes; there has been a massive increase in numbers, a second grade and an elite segment in terms of educational background. Before analysing these trends any further we shall examine a case where the institutions and patterns of entry have been different, that of the USA.

2. a) Early American Schools 1870-1900

As far as can be generally ascertained, the title 'nurse' covered as varied a set of workers in nineteenth century America as in Britain. There were hired nurses in homes and institutions; there were institutional inmates forced to do 'nursing' by virtue of their inmate status. There were also children's nurses - Census commentaries made clear that particularly in the South the term 'nurse' often referred to a low status, black household servant (Davies 1980b) - and there was nursing done under the aegis of religious orders. Some have claimed that there was less call for the home nurse, in a society of mobile, westward-moving, small, nuclear families, with their independent 'frontier-women'; this is an intriguing question for which no hard evidence is available.<sup>19</sup> Entry to nursing work, however, was not controlled by any group (bar some religious orders) and market relations held sway.

In 1873 three important training schools for nurses opened their doors. They were at Bellevue Hospital in New York, at Massachusetts General Hospital, and at New Haven Hospital (Connecticut) (Nutting and Dock 1907:Ch.IX). Other schools rapidly followed, and although some, as we shall see in Chapter Five, borrowed much of the curriculum from St. Thomas', there is some controversy, if

the contemporary sources are to be believed, about how far they also borrowed ideas about appropriate recruits. A report of the Hospitals Committee of the New York State Charities Aid Association in 1872 had this to say:

"...the nurses trained in England are chiefly recruited from the class of upper servants. In this country that class of women find plenty of employment at high wages; we propose, therefore, to offer the advantage of our school to women of a higher grade. In this country we have a large class of conscientious and laborious women, whose education and early associations would lead them to aspire to some higher and more thoughtful labor than household service or work in shops: such as daughters and widows of clergymen, professional men and farmers throughout New England and the Northern States, who have received the good education of our common schools and academies and are dependent on their own exertions for support" (cited in ibid.:1907:385-6)

Ten years later, a commentator on Bellevue school made the additional claim that the distinction between the 'ladies' and the ordinary probationers was absent in the USA, all nurses being drawn from a middle and educated stratum (North 1882).<sup>20</sup>

Evidence from the early history of certain schools lends some support to the claim of obtaining recruits 'above the servant class'. For the cautious response of the hospitals, handing over only a few wards at a time, meant that Superintendents could afford to be selective in filling the few places available to them. Whether this could be sustained, given the rapid growth of the schools, was another matter. On the question of rejecting ladies, the position is even more doubtful. Some ladies trained as nurses "wanting a life of usefulness among the sick poor" (North 1882:40); others trained with a view to becoming Superintendents, and some clearly also worked on the wards (see Giles 1949). Nor is it entirely certain that specific educational requirements were given any greater

emphasis than in Britain. Women of high moral character and religious commitment were welcomed. The prospectus of the Washington School captures the tone as late as 1905:

"Applicants are also reminded that women of superior education and cultivation will be preferred, provided they meet the requirements in other particulars"  
(cited in Youtz 1975:38)

This material must be set in a wider context. It relates to a small number of schools and, as a sample is biased towards the more prestigious and more selective. The period from 1870 to 1890 saw the setting up of many schools, some at first independently<sup>21</sup> financed and administered but most rapidly taken over by hospitals often with a loss of independence for the Superintendent. Furthermore, there were training schools run by doctors and others on a correspondence basis for the purposes of profit. We know next to nothing about these and about the entry criteria operating here. And, of course, there were no controls over entry to employment. Anyone could call herself a nurse and set up in practice.

Hence, as far as we can ascertain, the position was similar to that in Britain. Nurses were able to control entry to a small number of schools and to demonstrate what could be done with recruits of a 'better character'. It may be that educational qualifications were emphasised more and that a split between the ladies and the rest was less marked, but these are difficult points to establish and await more work on local records in both countries (but compare e.g. Tomes (1978) and Maggs (1980)). Be that as it may, the period was as in Britain, not one of entry control but of a new route of entry. And as the hospitals saw advantages, they took more control

setting up their own schools and applying their own criteria (cf. Ashley, 1976).

2. b) Collective Action: the Impact of Legal Regulation

The 1890s saw the beginnings of organised action among nurses. Starting in 1893 with the formation of the Superintendents' Society, alumnae associations were then encouraged and eventually the American Nurses' Association (ANA) was set up (see Chapter Eight). What is important here is the legislative activity upon which nurses embarked and the extent to which it placed control over entry in the hands of nurses themselves. From 1903 onwards, Nurse Practice Acts were passed in the various States. By 1913, as many as 38 out of the 49 States had legislation giving recognition to nurses in the shape of a State licence for registered practitioners (Roberts 1954: 72-106). But what did such legislation actually achieve?

The same criteria must be applied here as we applied in the case of entry control in Britain. If the States set up bodies entirely comprised of nurses, gave them powers to regulate numbers of entrants and entry qualifications, to train and examine and to exclude from nursing work all who did not meet the stipulations, then we would be prepared to say that entry control had shifted out of the marketplace and into the hands of the occupational group. Yet practice was far from this.

Dock (1912:142-187) has recorded in detail the way in which State nursing associations were formed and fought for legislation. She has shown the tremendous variability in legislative achievement and has attributed it not just to different levels of organisation of

nurses in each State, but to the very great contrasts in the type and extent of health care and the levels of economic development in the different States. Bodies usually called Nurse Examiners Boards were set up, but were not always composed of nurses, indeed, sometimes they consisted solely of medical men. The relation of the Boards to other State Authorities varied considerably; sometimes they were largely autonomous, sometimes they were subordinate to a medical Authority. Boards did not necessarily examine, except in ascertaining that schools met requirements (numbers of beds, specialties etc.); nor did they always specify educational requirements for entry. Just six acts out of the 37 in 1912 did so. And in the majority of States, as Dock pointed out, the legislation was permissive and not mandatory. Studies of nursing organisation in individual States bear out this picture (e.g. Christ 1957, Rodabaugh and Rodabaugh 1951, West 1932). Legislation, in short, cannot be equated with control, and the variability of organisational practice bears witness to the uncertainty surrounding legitimate occupational control in this era in the USA.

What happened was that more and more nursing schools opened; schools remained a cheap way of getting the work done. The legislation in no way hindered the supply of recruits and indeed the number of schools and the number of recruits increased so rapidly that 'trained' nurses actually began to replace untrained in employment (Appendix I table 7). What is particularly revealing is that educational standards of entry declined; where in 1911 40.6% of schools required a high school education, in 1918 only 28% did so (Cited in Stewart 1944:153).

Occupational licensing may have served to eliminate the commercial schools and diploma mills; indeed the frequent specification of a hospital-based training was often designed with this in mind. In no way, however, did it limit numbers of schools or numbers and qualifications of entrants. The patterns here were emphatically not under nurse control, and numbers and diversity were both on the increase.

2. c) The Depression - a contrasting interlude

The Depression marked a trend to fewer trained nurses and better initial qualifications. The number of schools which had continued to grow from the start of the century steadied and began to drop in the mid-twenties. The number of students reached an all-time high in 1931 but thereafter dropped for each of the ensuing five years. And the proportion with high school backgrounds by the early 1930s was very high indeed. Further, baccalaureate programmes were on the increase, and at the other end of the scale, the untrained seemed to be kept in check, at around one third of the total of active nurses (see Appendix I, tables 6, 7 & 9; see also Committee on the Grading of Nursing Schools 1934). All of these trends might be construed as consistent with a professionalisation thesis. They are in marked contrast with the previous period of unlimited expansion and lowered entry standards. So was there then a new and stronger level of institutionalised control by nurses over entry to their work?

First let us consider the nurse practice acts. Could it be these, in amended form, which now led effectively to the closure of schools and to the removal from practice of unrecognised nurses? What evidence there is suggests that this is very unlikely. It was still the case in the 1930s that no state law gave a mandatory closure to nursing. Nurses, in other words, were nowhere required to gain licenses in order to practice. In a few cases to be sure the term 'graduate nurse' or 'trained nurse' was protected but that was all. An act was passed in Missouri in 1929 which purported to regulate entry both to trained and untrained nursing but it was not effective (Stewart 1944:272). Following a five year crusade for safer nursing in New York, a law was passed in 1938 making licenses mandatory. Interestingly, a succession of waivers actually deferred implementation of this until 1950 (Roberts 1954:407). A committee investigating the situation in the early 30s commented specifically on the weakness of legislation and on the need for revision in face of very low standards in some schools. It observed, regarding nurse practice acts, that "some of these laws placed their approval on requirements so low that they become a menace" (Committee on the Grading of Nursing Schools 1934:151-2).<sup>22</sup> In presenting evidence collected for its report, researchers for the same Committee, commenting on raised educational standards, deliberately disabused readers of any idea that legislation could be responsible for the improvement. Standards of education in the population as a whole could, they felt, more plausibly account for the pattern. There is then little of a case to be made for more restrictive legislation as a factor accounting for entry trends.

What then of the trends towards degree programmes? Earlier on, nursing leaders had made strenuous efforts to promote associations with universities at graduate and particularly postgraduate level. Could it be then that collegiate entry was something being shaped by organised nursing? Later research was to reveal the implausibility of this idea. It would show that courses were set up for a diversity of reasons and were often of doubtful educational worth (Bridgman 1952). The setting up in 1932 of the Association of Collegiate Schools of Nursing at first glance seems a regulator of matters such as entry to courses, but its standards applied only to those schools which applied for membership - an entirely voluntary matter. The trend of growth in collegiate education is thus, as we have seen with the question of entry standards, equally inexplicable in terms of new or more powerful institutional controls.

The most obvious explanation for the changes is an economic one. Already in 1926 the unchecked expansion of schools and the use of student labour to staff the hospitals was flooding the market with trained nurses and destroying their chances in the labour market. Trained nurses, it became clear, were replacing untrained ones, being on offer at similar prices, but more than this many of them were unemployed (Committee on the Grading of Nursing Schools 1934:22). Unemployment was severe in the following years and worsened as the depression then took its toll. The various nursing organisations got together in 1932 and distributed a letter to hospitals urging that they use graduate nurses instead of students in the hospitals. This at least would stem the flow of new entrants to the labour market. The evidence suggests that it worked, and trained nurses for the first time in the U.S. staffed the hospitals.<sup>23</sup> They did so for very low pay, desperate as they were for employment. And at

such low pay and board they were an attractive proposition to the hospitals in a way they could not have been in previous years. Hospitals slowly found that it made economic sense to close schools (and also to slow their activities) - just as previously it had been economic to open them. This seems by far the most plausible suggestion for the halt in school growth and in student numbers. Nursing was not somehow apart from its market and in control of it, it was being shaped by supply and demand. In short, the institutional framework of the occupation, established in the first decade of the Century, was as powerless in a period of contraction as it had been in one of expansion.

2. d) New entrants, new grades

The postwar period saw the full emergence of two new grades, the licensed practical nurse (LPN) and the associate degree nurse to add complexity to a pattern of hospital diploma nurse, full degree nurses and untrained nurses. It was also a period which saw, after much debate, some amalgamation and reorganisation of national nursing organisations so that it was now the National League for Nursing (NLN) which was primarily concerned with matters of nurse education.<sup>24</sup> The question, then, is whether these trends had anything to do with each other - whether the NLN was taking any active control over entry to the various grades. The short answer is no - the NLN, as we shall see in Chapter Five, was concerned to improve the programmes of the schools, and a range of other agencies and factors were involved in the growth of these new grades and in the changing mix of entrants to nursing.

Let us deal first with the practical nurse. The question of a shorter training and a lower grade had long been discussed - by doctors and by nurses themselves.<sup>25</sup> Some States had set up schools in the 1920s, though, according to one observer, there were only 12 worthy of the name in 1938 (Torrop 1951). By 1951, 32 States had licensing legislation though less than half a dozen of these made it mandatory. A National Association of Practical Nurse Education (NAPNE), comprising both registered nurses and practical nurses had been set up in 1940; and a membership organisation, the National Federation of Licensed Practical Nurses began in 1949. Where was the impetus for all this coming from?

The immediate postwar period saw the national nursing organisations as apparently prepared to co-ordinate on questions of qualifications, functions, licensing and so on. In 1951 a joint statement was published involving as many as six interested parties as well as the ANA and NLNE (Joint Committee 1951). But other groups had already been pressing harder. NAPNE had secured funds for a study in 1943; in 1945 the U.S. Office of Education had mounted a job analysis and in 1950 published a Curriculum. Recognition of courses showed that multiple initiatives had been taken. NAPNE recognised some courses, State boards of nursing education, the licensing authorities for registered nurses, recognised others. In some States courses were approved by a Board of Vocational Education. As late as 1956 'Facts about Nursing' was still counting separately the programmes approved by the NLN and ones approved by the U.S. Office of Education. Strong institutional controls were nowhere present,

and the growth of practical nursing was consequent on diverse initiatives, not all of them stemming from within nursing.

Something similar might be said of the associate degree route into nursing. In 1953, there were around 600 junior colleges, a figure which, with a national education policy encouraging such an educational channel, had increased to 890 in 1968 (National Commission for the Study of Nursing and Nurse Education 1970). Nursing was one of the subjects covered in two year junior college programmes which typically mixed general and vocational education and which counted as credits in the overall system of American higher education. There were 35 programmes in 1958 and 325 ten years later (*ibid.*). Nursing organisations tended to follow behind and endorse rather than lead and shape this development. Funds, quite unsolicited, were offered to Teachers College for an evaluation study (Montag 1951). The NLN soon followed up with guidelines for such programmes (1955), conferences (1956, 1957) and an Associate Degree Board (1957).

The new developments of practical nurse and associate degree nurse were taking place in the context of a general encouragement by the NLN of the full degree route into nursing and of the hospital programmes (see Chapter Five). In practice, however, a marked restructuring of entry routes was under way, with the popularity and availability of the associate degree programmes growing at the expense of the diploma programmes. The time-honoured hospital route of entry to nursing by 1970 accounted for less than a quarter of new entrants (21%);

the associate degree for 22%, the baccalaureate for 15% and practical nurses for fully 43% (see Appendix I, table 8). Patterns and possibilities were becoming hard to explain, for the potential recruit could now choose from a bewildering variety of courses (for further details, see Chapter Five).

What, then, did this mean in terms of numbers, social origins and educational background of recruits? Overall, the number of practising nurses increased between 1950 and 1960 as rapidly as it had done in the war decade, and by 1970, the rate of increase was becoming more rapid (see Appendix I, table 9). More interesting, however, is the information available on the social character of entrants to the different programmes. A special study mounted by the NLN is informative here and yields a not altogether surprising pattern (Knopf 1972).

It seemed that hospital schools and full degree programmes pursued most rigidly the policy of recruiting white, single women. The trend data suggest that the universities and colleges were shifting somewhat but the hospitals were not. The associate degree programmes, which are two year courses in community colleges and can count as credits in the system of American higher education, recruited more broadly. A very substantial proportion were older than the usual nurse trainees, were married, separated or divorced. Not many were men or non-white, but still there was a higher proportion of men in this group than in any other training mode. The practical nurse entrants were diverse too but what was distinct about them was that non-whites form a fifth of the total. Figures for the other groups nowhere near approach this.

Further information is available in the same study about the fathers' occupation of nurses in different programmes. In the main the picture is not unexpected, with the baccalaureate students being drawn most from the professional and semi-professional groups, and the practical nurses least. Associate degree students were closer to baccalaureate ones in their social origins than to diploma students but the differences between these two groups were not marked. What is intriguing is that for most of the entrants nursing in the 1960s meant upward mobility. Even among baccalaureate nurses only a quarter came from professional and semiprofessional homes; over 30% of the associate degree students and closer to 40% of the diploma students came from manual backgrounds, the trend if anything suggesting an increase not a decrease in the proportion from these groups.

Admitting at once that this information is sparse and lacks comparability, it is still such as to represent a strong challenge to a professionalisation thesis in the predictions that thesis makes for entry control. Numbers of entrants did not hold steady or decline, they grew. Nurses as a whole did not become more homogeneous, instead new grades emerged to play a significant part in the overall entry mix; and the social origins of nurses were very mixed with a continuing and substantial portion from manual backgrounds, though this was less true for the full degree nurses. Instead of facing a set of professionally controlled institutions, would-be nurses were by and large left to find their places in the context of varied and overlapping educational opportunities.

When junior college education gained in popularity, a formal College route to an associate degree in nursing quickly opened up. The postwar period saw an increase in federal and state aid to nursing education; it is interesting and entirely consistent that where that aid was directed to basic programmes it was not channelled strongly to any particular type; degrees, baccalaureate and associate, diplomas and practical programmes all received about equal support.<sup>26</sup> Each educational institution remained largely in control of its own development - its independence respected.

Just as the depression period and the period preceding that generated distinctive patterns of entry to nursing, so the postwar period was different again. It was a period of renewed rising demand and of rising supply. But the demand this time was not filled by a growing army of 'trained' nurses, all of varying abilities but all with hospital diplomas. It was increasingly met by a recognised and growing diversity of grades of nursing worker whose different routes of entry were ever more closely articulated with patterns of American higher education.

### Conclusion

Nursing, almost regardless of the national context to be surveyed, is a mass occupation once medicine is established on a broad scale. Nurses represent by far the largest group in the health labour force and, in the labour force in general,

nurses are a large and significant group also. On the face of it, it seems implausible to expect that professionalisation theory, with its assumptions about control of entry, maintenance of a small homogeneous and socially exclusive occupational membership could have anything to offer. Yet, in both countries studied, the institutional trappings are there; the examination and legislative recognition, the sanctions against anyone describing herself as a registered nurse. I have sought to analyse how these institutions have worked in the two settings and what part they have played in influencing patterns of entry to nursing.

But what have these patterns been? The social heterogeneity of nursing has certainly remained. At the beginning of the period studied nurses were drawn from across class boundaries - there were the ladies, the ordinary probationers and the old style nurses in Britain and the USA (though each of these categories meant something somewhat different in the two countries). The swift imposition of an educational test would have created a homogeneous elite and a sharp distinction between those included and those excluded - but this was not to be. Educational requirements, as far as we can see, followed rather than preceded widening educational opportunities for women and did not act as a novel and potent stratifier in the first four or five decades of this Century. The trend was there, however, earlier and more powerfully in the U.S., to legitimate the different types of nurse by reference to educational achievement. As we have seen, in the post war period in the U.S.A. distinct grades of nurse had emerged,

more or less labelled according to their educational status ('practical', 'associate degree', 'baccalaureate') and the race was on to shift training out of the hospitals altogether. But as we also saw, the educational sector itself reproduced social divisions - between black and white, between classes of origin and so on. I suspect, though we would need local studies to confirm it, that the prestigious hospitals in Britain (viz. the London teaching hospitals) continued to recruit young women of higher social origin and better educational qualifications than did the other hospitals, so that 'where did you train?' remained a significant question in 'placing' a nurse socially. Only very recently indeed, as we saw in the course of the Chapter, have degree courses come to take on any importance in identifying the elite in British nursing. What we can see here is less a change in the heterogeneity of nurses, more a relabelling of categories in more socially acceptable terms.

In two senses, however, heterogeneity has actually increased. First, there are the distinctive grades, the enrolled nurse in Britain, the associate degree nurses and so on in the U.S., together with all kinds of distinctions for 'aides and maids' grades. Social divisions from outside the hospital stand in a close but nonetheless complex relation both to this occupational hierarchy and to the hierarchies of the employing organisation (categories of head nurse, sister, etc. etc.). Then there is greater social diversity in the sense that many women who are nurses now are no longer single women filling in time before marriage

or making a full career in nursing but are married women, are mothers and so on. In short, patterns of entry have so changed as to add an even greater heterogeneity and intra-occupational stratification between nurses and a greater fragmentation.<sup>27</sup> To this, of course, we must add the phenomenon of ever-rising numbers.

Have these patterns, however far from the dynamic of entry control specified by the theory of professions, been influenced by occupational institutions of entry control - and if not, what are the groups and interests behind these changes? At first, in both countries, the notion of restricting entry by imposing selection criteria at school level was important. It did not reshape nursing altogether, but it did succeed in introducing a new contingent of nurses. Thereafter, the institutional patterns diverged, but neither, as I have been at pains repeatedly to point out, significantly shaped entry to nursing. Nor is it true, on the other hand, to say that control was wrested from nurses or located in the hands of the State. There was a moment when State control seemed imminent in Britain, but that moment passed. Perhaps organised nurses did have more say in shaping the grades available - but supply and demand constantly set limits on what could be done.

Two sources of difficulty have emerged in the production of this account. The first, linked with the problems of operationalisation and measurement alluded to at the outset of this Chapter, has to do with the poverty of existing concepts. Control over entry can be maintained by restrictive criteria on entry to

training for the occupation. It can also be achieved through specifying different grades of entry, and by limiting employment as well as training. How to juggle all three of these is not a problem so far addressed in the literature. In addition, a detailed account such as this raises the question of whose control is to count as occupational control. This is seen most starkly at the point of dispute and disagreement in Britain between the GNC and the Rcn. But it is also apparent when the national nursing organisations in the U.S.A. condone local level control. Even if this control were undeniably and exclusively in the hands of nurses in the schools or in the State nurses associations (which it is not) we would have lost the underlying feature of occupational control which is the unitary action of an occupational collectivity giving shape to an overall pattern.

The second problem highlighted by this study concerns the strategies and aspirations of an organised occupational group. Again and again there have been strong hints that the various occupational organisations involved have not been in hot pursuit of entry control. Nor indeed has any other body firmly and sustainedly articulated a case for implementing such control (though in Britain we have come closer to it). This points to the need for a study not simply of power and mechanisms of power but of the ideological texture which surrounds it. Ideologies of professions and occupations and ideologies about professions and occupations are involved here. Similar conclusions will emerge

from our investigations of control over training in Chapter Five. They are an important factor in the decision to pursue not the conceptual refinements suggested above, but questions of action, ideology and consciousness and the place these have in a study of occupational power.

NOTES

1. This represents a slight departure from the indicators listed in Chapter 3. Reasons for this need not detain us here, since the whole exercise, as will shortly become clear, was called into question.
2. The shift of focus described in the preceding paragraph raises questions of the extent to which a shift of method is indicated - in particular, more attention to primary sources. For a discussion of the mix of source materials eventually used, see Appendix II.
3. The Nightingale Training School is discussed by many writers. Seymer (1960) provides the fullest account. It was not the first school in Britain, for nursing reforms of various sorts were under way already (cf Tooley 1906); the point about the Nightingale school is that it was highly influential (Seymer 1960, esp. Ch.5).
4. It is revealing in this connection to consider the debates in the Census and the changing classification of nurses. For a UK/US comparison, see Davies (1980b).
5. Perkin (1969:Ch.7) has discussed the rise of the examination system and the new stress on the professional ideal of expertise. Women were excluded from this, as W. Reader's aptly titled volume Professional Men (1966) implies. The mid-century was the high point of the cult of domesticity (see e.g. Davidoff et al. 1976) and it is worth noting that although the campaign for women's education was under way little advance has been made (Bryant 1979).
6. The Council, as set out in the Schedule to the 1919 Act, was to consist of 25 members. Two were to be lay people (neither nurses nor doctors) appointed by the Privy Council; two were to be appointed by the Board of Education. Five persons were to be appointed by the Minister of Health "after consultation with persons and bodies having special knowledge and experience of training schools for nurses, of the work of matrons of hospitals, of general and special nursing services and of general and special medical practice". The other 16 were to be or to have been nurses, their names chosen after consultation with nursing organisations. The Minister was to have regard to the desirability of including those from the various different forms of nursing. It is important to understand the rival groups of nurses and the interests they espoused. These included not only the Royal British Nurses' Association and the Nurses' Group of the Hospitals Association, but other interest groups including matrons of poor law hospitals, cottage hospitals etc. (see Abel-Smith 1960: esp. Ch.4-7).

7. There is data on unapproved schools available in the Lancet enquiry (Lancet 1932: Appendix XVIII). On alternative bodies approving nurse training the Wood Report produced data. Numerically the most important were 196 hospitals approved for mental nurse training by the Royal Medico-Psychological Association, and 107 hospitals approved by the Tuberculosis Association for its nursing certificate, and 21 for Orthopaedic Nursing (Ministry of Health 1947: Appendix XV).
8. "Even when nursing was fashionable among girls with private means, we have no information that any big hospital was ever staffed entirely by paying probationers. Some hospitals accepted, and still accept a proportion of paying probationers as a favour, and the mixture of paying and non-paying does not always have happy results" (Lancet 1932: para. 110).  
  
Burdett's Directory of hospitals schools for 1933 carried advertisements showing that St. Thomas' and Guy's Hospital accepted paying probationers (Burdett 1933: 403, 411).
9. An important exception is the Nursing Homes Act of 1926 specifying that only registered nurses should be employed at the head of such homes.
10. One measure felt to be relevant to this was a change in the examination procedure, known as "splitting the Prelim." (Ministry of Health 1939: Ch.IV).
11. Such a remark cries out for a comparison with medicine and, for example, the various but indirect measures to control medical manpower in the early years of the NHS. Such, however, is beyond my brief here.
12. I have left the period of the war out of consideration here, concentrating attention on the evolution of 'normal' procedures of entry control. This omission is less serious here perhaps than in relation to questions of aspirations and strategies which were affected by wartime experience. Chapter six, which deals with such matters is meant to be illustrative only, and again I have not elected to deal with war experiences.
13. The 1943 Act and the 1949 Act deserve more consideration than I am able to give them here. As yet, no-one has subjected them to the valuable kind of scrutiny which Abel-Smith (1960), for example, provides for the 1919 Act.
14. The GNC published annual reports from 1949 and I have drawn on these as well as on NHS statistics for this period forward. See Appendix I, tables 2, 4 and 5. It will be clear that it is not strictly correct to say intake had doubled, since the published figures for the 1930s were not of intake but of entry examinations.

15. Sociologists of professions have different views as to reactions to a second grade. There is an argument deriving from Hughes points about off-loading dirty work to suggest that a second grade will be welcomed. On the other hand there is a 'trade union perspective' suggesting that workers in related grades are an imposition from outside and must be resisted for fear of 'dilution' and lowering the price. On 'dirty work', see Hughes 1971:306, 340ff).
16. We might also note, (see GNC Annual Reports) that an entrance test had been applied as a result of GNC pressure for it for a brief period in 1938. The Athlone Committee reported that witnesses from hospitals felt it was a deterrent to recruitment in that young women were reluctant to take a general, school-like examination and found it difficult given the gap between school leaving age and age of starting nursing. Furthermore, since the examination could be taken up to three month after entry, matrons, anxious to keep recruits, were offering tuition in arithmetic and other subjects to ensure passes. (Ministry of Health, 1939: 42-7). The test was discontinued with the onset of war.
17. The College had petitioned for and been granted a Royal Charter in 1928. In 1939 it made successful application to use the title Royal College of Nursing (Rcn).
18. The GNC would doubtless have seen it as beyond its statutory brief. The Rcn had published a policy document in 1956 but it was nowhere near so precise as to spell out proportions required in each grade (Rcn 1956).
19. Consider, for example, the following:
- "Every woman worth her salt could turn out a poultice, clean and dress a wound, massage a lame back, cup to relieve pleurisy and pneumonia. Otherwise, how could she expect to take proper care of her husband and bring up her family in a country that was still primitive?" (Giles 1949:32).
20. The relevant extract is as follows:
- "... Another necessity in an American training school is the abolition of caste. In England the 'ward sister' (who has received thorough training) is expected to be a lady, superior in social position and intelligence to the nurses, who are drawn from the class of domestic servants. At Bellevue, the preliminary examination, and the high standard subsequently exacted, exclude, and are meant to exclude them. But among those who enter there is no distinction. All submit to the same discipline and perform the same duties, none of which, being connected with the sick, is considered menial" (North 1882:47).

21. The Bureau of Education lists just 15 schools in 1880, with an output of 157 graduates; by 1900 the figures are 432 schools and 3,456 graduates. See Appendix I, table 5.
22. We can note also that some schools, possibly around 250 operated outside the laws of the States (Committee on the Grading of Nursing Schools, 1933).
23. In the 1930s the number of (trained) general duty nurses in the hospitals shot up from 48,000 to over 100,000. Where in 1927 as many as 77% of hospitals with training schools employed no graduate nurses for floor duties, ten years later the figure was a mere 10%. (figures cited in Roberts 1954:286).
24. Reorganisation was agreed finally in 1952. There was to be the ANA, the membership organisation, its functions including the definition of functions and qualifications of nurses, the promotion of standards and of the welfare of nurses, the representation of nurses to other groups and the promotion of legislation. The NLN was to incorporate a number of previous organisations, including NLNE, NNAS, NOPHN and ACSN. It took over the principle from NOPHN that a lay membership was relevant and three groups of non-nurses were able to join, members of professional groups who worked with nurses, members of boards and committees associated with nursing services and nursing education units and administrative and instructional staff working directly with nurses.
25. A Committee of the American Hospitals Association in 1916 had recommended formal teaching of the practical nurse; the Winslow-Goldmark Report in 1922 had endorsed it, the President's Committee on the Costs of Medical Care in 1932 was in favour, as were the Brown Report in 1948 and the Ginzburg Report of the same year. For a discussion of these see Roberts (1954, esp. Ch.44).
26. Federal funds for nurse training were made available under various wartime provisions and legislation in the 1950s further supported diverse programmes. The 1964 Nurse Training Act also covered a very wide-ranging set of provisions.
27. Cannings and Lazonick (1975) argue that there has been deskilling within nursing. In my view fragmentation is a more accurate term. This will be discussed further in Part Four.

CHAPTER FIVE  
CONTROLLING NURSE TRAINING

The second area of occupational control selected for scrutiny here relates to training. For the sake of simplicity, I shall refer here only to training for first level positions and shall concentrate largely on training for the status of registered nurse. I shall be concerned, as in the previous Chapter, with institutional devices and the extent to which they can be said to place control collectively in hands of nurses. Just as the received wisdom suggests that occupational control over entry will be associated with certain clear outcomes (numerical limitation etc.), so too is there a received wisdom about training control. And it is this which will be subject to examination, along with the specific mechanisms in use to regulate training in the two countries. Training control did not figure in the original list of four areas (see Chapter Three); it is treated in an analogous way, however, and is selected because it raises fewer conceptual difficulties than the notions of 'belief control' and 'work practice control' as specified in the original research design.

The approach of the sceptical theorists of professions (discussed in Chapter One), to the question of training is brought out well in the following quotation:

"The content and length of training of an occupation, including abstract knowledge or theory, is frequently a product of a deliberate action of those who are trying to show that their occupation is a profession and should therefore be given autonomy. If there is no systematic body of theory, it is created for the purpose of being able to say that there is"  
(Freidson 1970: 79-80 quoted in Roth 1974:7).

The outcome, in other words, of a process of occupational control over training is thought to be the maintenance and development of an esoteric knowledge base. This is likely to promote the independence of the practitioners, and both of these, in turn, serve to confirm the status and worth of the occupation, distancing its members from the untrained on the one hand and from practitioners of other occupations on the other.

In principle, it would be possible to proceed, as in the case of entry control, to devise indicators for presumed outcomes, and to investigate how far there has been an esoteric and independent knowledge base in the training of a nurse. But difficulties, analogous to those discussed in Chapter Four, arise. There is the question of devising acceptable and meaningful indicators; there is the problem that even with such indicators and their movement in the direction presumed by the professionalisation thesis, we cannot necessarily infer with confidence that there has been an increase in occupational control (see Chapter Four, p.83-6). Once again, therefore, I have elected to examine the institutional framework, examining this time those institutions which might be thought to confer control over the curriculum, over the forms of pedagogy and over the modes of evaluation of trainees. (These terms are drawn from Bernstein (1971, 1975) and are taken up again in Chapter Seven).

Such an approach is not entirely new; writers such as Caplow (1954) and Wilensky (1964) focussed attention on the creation of the training school, seeing this as a major step on the road to

professionalisation of an occupation. A thorough institutional analysis, however, cannot stop with the mere creation of a school; it must look to the administration of the schools, their employment practices, funding procedures and so on, in order to ascertain whether they facilitate control over curriculum, pedagogy and evaluation. And it must consider too, the part played by others - statutory bodies and professional associations, for example. This approach is not inconsistent with Freidson's reluctance to equate institutional frameworks with control, and his injunction that we study not the length and character of training but rather the control of it, as embodied in legal, political, occupational and educational institutions (Freidson 1970:78-80).

One conclusion which will emerge strongly from this analysis is that the establishment of schools in places of learning (the educational sector) rather than in places of practice (the health sector) does not always carry with it a concomitant occupational control. It does, however, facilitate the emergence of a secure relatively independent and respected segment of the occupation concerned with educational issues and this can be influential in promoting esoteric and independent knowledge. Johnson (1972:29) has already drawn attention to the emphasis in the USA on training in the educational sector and in GB on training in the practice sector, and has considered some of its historical origins. Teasing out its implications for control, however, is another matter and one on which he remained somewhat ambivalent. (ibid., 54-5, 79).

This Chapter then, like the previous one, explores institutional devices and examines their implications for control. The format is as before, dealing in sequence with the two countries and selecting relevant periods for detailed scrutiny. I shall be interested in mechanisms of control, the implications of their functioning and the degree to which nurses themselves control them. There is less reliance here than in Chapter Four on available and tabulated data to back up the argument. Some relevant material on numbers and types of schools, however, will be found in Appendix One.

a) Early schools and their training<sup>1</sup>

The term 'school' with all the connotations it has to the modern ear, is a profoundly misleading one if we seek to understand control over nurse training in the latter part of the 19th Century. To be sure there were nurse training schools; and as we have seen in the previous Chapter their numbers increased rapidly. But there were no schools in the sense of independent entities with staff and pupils, both groups seeing formal learning as their major life commitment. There was no generalised acceptance that teaching and learning roles were so self-evidently legitimate that they should command resources. There was no developed body of knowledge available and waiting to be transmitted. What was called the 'nurse training school' was in practice an on-the-job training for persons seen primarily as hospital employees. And it is only when we see it in this light that its key features become apparent.

It was assumed, first, that much of the learning of the new nurse would be gained in the practical setting of the ward. She would carry out her tasks under the watchful supervision of the ward sister and would learn from her. Secondly, where formal teaching was called for, it was assumed that this could often be done in the off-duty hours of the probationer (facilitated, of course, by the fact that she lived in at the hospital). Arrangements for teaching consisted of lectures by the hospital matron and of programmes of formal teaching by those members of the medical staff who were willing to participate.

It is important to underline the very limited extent to which the 'nursing school' represented a real annexation of resources and control by nurses themselves. There were no full-time teaching posts at first. Matron, ward sister and medical staffs extended their duties to cover instruction for probationers. The Home Sister, since probationers lived in, also came to have a role. Interestingly, when teaching posts did begin to appear, they came not in the form of nursing lecturers or teachers of nursing but of 'nurse tutors'. The terminology is apt, for the tutor did not introduce new material, instead she coached probationers on material presented by others. We find references to the tutor attending the lectures, correcting the students' notes on them and reworking difficult points. Later, she was to become involved in encouraging rote learning to get the probationers through the examinations. There was no educational segment, collectively shaping the knowledge to be transmitted.

Those women who did have the facilities to write, as nurses, about nursing gained such facilities not via posts as educators, but by virtue of their own social positions. Miss Nightingale wrote what was to become a key textbook<sup>2</sup> from a position as an independently wealthy semi-invalid who thus had the leisure to reflect upon and consolidate her experiences. Mrs. Bedford-Fenwick, who had been a matron, was able to use the leisure created for her as the wife of a doctor to add to the store of nurse writings on nursing and to edit the British Journal of Nursing (see Hector 1973). Interestingly, she elected to publish articles on nursing by her husband.

When we come then to examine the content of the Syllabi and the subject-matter of the textbooks, it should come as no surprise that these reflect the existing social relations of the hospitals. They build a picture of medical knowledge as paramount and of nurses as requiring a certain familiarity with this knowledge in order to carry out the more practical tasks and activities which are their lot. (cf Jarman 1980). We shall explore this question in more detail in Part Three, but should note here that it was not just that doctors were brought in to help with nurse training in the early years before nurses were themselves qualified to do this work. There was an explanatory rationale which justified the absence of a specialised nurse education segment and legitimated the practical experience of work on the wards as a learning experience. And there was virtually nothing in the institutional arrangements of 'the school' which offered a vantage point from which to develop

a critique (cf Chapter Seven). Nurse training was a system which suited well - it suited the doctors who could inculcate their own ideas of medical etiquette and proper doctor-nurse relations, and it suited administrators, as a system of cheap labour. It is hard to see where funds and support for so many schools would have come from had 'the school' been a school in the modern sense.<sup>3</sup>

The knowledge base of nursing, its curriculum, was being created and codified simultaneously with its transmission. The people involved in curriculum, pedagogy and evaluation were in no small measure doctors, not nurses. To understand who controlled training we must look to the hospitals and the set of social relations in them, for control was a local and hospital-based affair. How much then, was this altered by the setting up of the GNC in 1919? Did this hail a transfer of resources to nurses and the emergence of nurse educators and learners and schools under secure nurse control?

1. b) The GNC and Nurse Training

The 1919 Nurses Act, as we have seen in the last Chapter, gave recognition to the trained nurses by admitting only those who had followed the approved training and passed a GNC examination. But we must proceed with care, for the Act itself made no mention as such of the training schools or their curricula. It referred throughout, somewhat ambiguously to an 'approved training' and to 'institutions approved by the council'. It will become apparent later how open to restricted and restricting interpretation these

terms were. A reasonably detailed examination syllabus was, however, published as a schedule to the Act; this meant that change was a cumbersome process requiring legislation. There were in fact, no major amendments to the general nursing syllabus until 1952 (see Chapter Seven).<sup>4</sup>

The first few years of the GNC revealed how limited legislation was - not just in relation to entry, as we have already seen, but in relation to training too (Abel-Smith 1960:esp. Chapter 7). On curriculum matters, a bid to set out a syllabus for the Schools to follow during training caused alarm in several quarters and was vetoed by the Minister of Health. On factors to do with pedagogy, a proposal for minimal criteria for a hospital to be recognised as a school (number of beds, specialties, etc.) was similarly rejected. There were no funds for the GNC to inspect schools, but probably most important of all, the GNC was not pay-master. It controlled neither payments to probationers nor payments to tutors. Both were hospital employees and subject to hospital terms and conditions of work. There was strong pressure for the GNC simply to approve all hospitals which applied to be recognised as training schools; even so, some remained outside the scheme and other bodies continued to put their approval to schemes of training (see Abel-Smith (1960); see also Chapter 4, note 7).

Whether or not the GNC could have excluded doctors from its examination procedures is a moot point. It did not attempt to do so. The Syllabus remained medically oriented and the contributions of doctors to the setting and marking of the new national examinations

were considerable. Indeed the questions on section one of the new preliminary examination were set and marked entirely by doctors and the question format and titles of papers in the final examination suggest heavy medical influence here too (Lancet 1932: paras. 231ff). Medical involvement had carried over from the earlier era, not surprisingly, since, as we have seen, the earlier pattern provided almost no space for the growth of a specialised group of nurses poised to develop nursing knowledge and nurse training.

All of this begins to suggest that the formation of the GNC did not alter the pattern of control of training in any marked way. In practice, numbers of schools continued to increase, a teacher segment began to develop but was by no means fully established and the nursing student continued to be treated primarily as a hospital worker. On numbers of schools, the figures show a continued increase in the 1930s and 40s, and in practice small hospitals were approved as suitable for training. (see Appendix 1, table 3 ). On the growth of an educational segment, figures made available in the 1940s suggest that there was less than one tutor still for every school. (Ministry of Health 1947). This is a dismal picture indeed, though against it we must set certain developments in the College of Nursing. A course for sister tutors had been organised in 1918 (before the GNC was established). In 1920, two annual scholarships were made available for the course. By the mid 1920s, the College had a sister tutor section, providing something of a forum for an emerging educational segment as was witnessed by the contribution made by that section to the College's evidence in 1938 to an official inter-departmental inquiry into nursing. (College of Nursing 1938). In

1939 the College established its own Roll of Sister Tutors.

As far as trainees themselves were concerned, all the evidence pointed to a continuing and heavy load of routine ward work for the probationer and to lectures and classes being squeezed in as secondary to this. The routine work of a probationer, it was calculated in the 1930s, could occupy some nine to ten hours per day.<sup>5</sup> A governmental enquiry in the 1940s came up with similar results and commented caustically:

"It has to be recognised that at present the nurse is almost invariably 'a student' in name only. First and foremost she is an employee of the hospital with which she signs a contract, and her training is largely incidental to her daily duties" (Ministry of Health 1947: para. 119)

We have already seen in Chapter Four that the growing demand for nurses rendered entry control too important to be left to nurses and what is now becoming clear is that concerns over costs and shortages had their effects on training too. The GNC could take no action which might interrupt the flow of student labour into the hospitals. More than this, local authorities began to implement assistant nurse courses (Abel-Smith 1960:156) and the Board of Education approved pre-nursing courses to bridge the gap between school-leaving and nursing work and perhaps ease the burden of training. And, one after another, outside groups came up with suggestions as to the conduct of training, curriculum, pedagogy and evaluation (Lancet, 1932; National Association of Local Government Officers 1937; Ministry of Health 1939).

The GNC had been created with a particularly debilitating mix of powers as far as training was concerned. It could examine, but it could not control the pedagogical framework within which students learned. It could neither close schools, nor specify the resource base required. It could not aid in creating and sustaining a teacher labour force. It had no means totally to revamp the curriculum. All of this meant that despite a considerable formal difference with the creation of the GNC, nurse training was still a matter largely negotiated in the hospitals with each matron organising her school as she could.

1. c) Nurse Training in the NHS

The 1946 National Health Service Act was silent on the subject of nurse training and its place in the newly nationalised hospitals - indeed, it was more or less silent on the whole question of nurses and nursing (cf. Davies 1978). But there were two other pieces of legislation which were important. First, there was the Nurses' Act of 1943. We have seen in the previous Chapter that this marked the emergence of the Assistant Nurse grade, but what it also did was to grant the GNC powers to recognise nurse tutors and to prescribe a statutory training for them.<sup>6</sup> Then there was the 1949 Nurses' Act which brought a reconstitution of GNC membership,<sup>7</sup> and the creation of a nurse training budget separate from the service budget of the hospitals. It also made funds available for the inspection of training schools and empowered the GNC to initiate closure of

supplementary registers and, with Ministerial approval, to approve experimental courses. In theory these two Acts might have meant substantial changes, but in practice they did not do so and controversy broke out - first on the tutor question then on the whole institutional framework. First, however, let us examine these new powers.

To have a separate budget was perhaps the most radical-looking change. The GNC was to make an annual bid to the Ministry and to channel funds received through a set of new Area Nurse Training Committees (ANTCs). Salaries of staff directly concerned with nurse education were paid through the training budget, as were equipment monies. Allowances for students, however, were not covered and nurses in training remained employees of the Regional Hospital Boards (RHBs). Nor were the ANTCs clearly allowed separate capital expenditure.<sup>8</sup> And when we add to this the recurrent battle between the GNC and the Ministry over the total sum to be made available - a battle which despite anticipatory paring down by the GNC of ANTC estimates the GNC invariably lost - we get some idea of the limited nature of this fund. To take one example, we find the GNC Finance Committee pleading unsuccessfully for two years running that a nurse granted leave on full pay to take a tutor course in London have the London weighting added to her salary (a matter finally resolved via the Whitley Council machinery). To take another example, throughout the 1950s, the chronic shortage of tutors meant vacant budgetted posts and the ANTCs lost the unspent money and were unable to spend it on "sorely needed teaching equipment", as Annual Reports of the GNC bemoan. Nor were other innovations necessarily a big extension of powers. Inspection monies, for

example, were small, so small that the number of inspectors had not moved into double figures in the early sixties and by 1968, the interval between inspections was still as much as five years (National Board for Prices and Incomes, 1968).

But even with limited powers, choice is exercised and it does seem, notwithstanding its greater educational component,<sup>9</sup> that the GNC remained cautious in many respects. Schools were only gently encouraged on the question of standards; on the matter of closing supplementary registers, very slow moves finally resulted in the closure of the fever register, and the new Curriculum of 1952. When it was unveiled it was not found to be greatly different from the old. The GNC's policy on tutors, as we shall see below, was regarded by some as oriented more to the Ministry than to the requirements of nurse education. The strongest line the GNC took was over the entrance test, finally achieving a low standard of test in 1962 (see Ch.4: 72ff). What of pressure from organised nursing on the GNC? The Rcn had stood back somewhat after the creation of the GNC, regarding a watching brief as appropriate (Davies 1978; Simpson 1977). The wartime Nursing Reconstruction Committee had endorsed an essentially ambivalent policy, stressing that nurses should receive an 'education' rather than a 'training' yet regarding the practical apprenticeship on the wards as appropriate and manageable if part of a block system with intensive alternating periods of work and schooling. (Rcn 1943). While this might relieve the strain somewhat for the student nurse, it left the student labour system unchallenged. When we add to this viewpoint the point that the new ANTCs were unlikely to be an educational force, dominated as

they were by service staff, it is difficult to see where a basis for pursuing a different policy could emerge.

But emerge it did, at first from the Sister Tutor section of the Rcn and later from the College itself. In 1953 a memorandum set out criticisms of problems in operating the current system and made suggestions (Rcn 1953). The GNC, together, interestingly, with the Ministry, was in process of working on this and issued a statement soon after (Ministry of Health, et al., 1954)<sup>10</sup>. The joint policy emphasised the importance of a sound educational base for nurse tutors and applauded the link which had been established with universities. Yet in the end (and in view of shortages of tutors), it came down in favour of a shorter course than the two years accepted by others. And it also stressed the importance both of medical lectures and lecturers for nurses and of instruction on the wards by the ward sister. Again, it seemed, immediate service concerns were taking priority, despite a rhetoric of education. A strong note of dissent was registered, interestingly, by the Professor and Reader in Education on the Committee. They saw the shortened course (five, not six academic terms) as "educationally retrograde", they insisted that at least some nurse teachers should be on a par with other branches of education and recommended trying to establish at least one full-time internal university course as an alternative to the existing London extra-mural diploma. (Ministry of Health, et al., 1954: 21). But their pleas were ignored. Further criticisms emerged from the College (Rcn 1961) and finally, the Rcn decided to set up its own enquiry into the whole basis for nurse education.

To what extent had the legislative changes of the 1940s facilitated institutional change in nurse training in the first twelve years or so of the NHS? The GNC could point to a series of changes. There was the entrance test; there was a new Syllabus; there were new guidelines for approval of hospitals as training schools and there were also growing numbers of experimental courses (see later). Critics, however, could claim that these were small gains and were hampered by the continuation of the student labour system and the associated imperative of getting staff for the hospitals as cheaply as possible. They could claim that basic weaknesses would remain until these fundamental issues were tackled. And this, in essence, is what the Platt Report, emanating from the Rcn, said (Rcn 1964).

1. d) Recent Trends: a stalemate?

The Rcn's interpretation of events, as embodied in the Platt Report, was uncomprising. After reviewing current arrangements, the Report stated firmly:

"This system of nurse training can no longer be justified. It is wasteful of students and of educational resources, it discourages many good students from entering nursing and it fails to produce adequate numbers of registered nurses of the type required, who wish to continue in the practice of nursing" (Rcn 1964:5)

Implicitly or explicitly it criticised progress on just about all the reforms of the 1940s legislation. Enrolled nurses as a grade had not grown sufficiently; untrained nurses were still being employed; students and pupils were doing ward work; the ANTCs had reflected the tension between service and educational needs.

The lessons of experimental programmes of training now needed to be followed through, and urgently in the context of more and new demands on the nurse.

The set of arrangements Platt proposed for nurse training was quite new; the powers of schools, of area committees and of GNC were redefined. The 1962 Syllabus was one of the few things which remained relatively unscathed. This, it was felt, would be capable of interpretation within a curriculum based on sound educational principles. But, even here the Committee felt that extensions "to cover more adequately aspects of public health nursing" (Rcn 1964:22) were required.

In trying to strengthen the chronically weak training schools, however, the Platt Report had trodden on GNC toes. It was advocating powers for the schools which had previously been in the hands of the GNC; and it had tended to play down the changes of the 1950s and 1960s with which the GNC had been firmly associated. Not surprisingly, then, the reaction of the GNC was a cool one. It set out a list of what it felt were real achievements of the first 15 years or so of the NHS. A reform such as that envisaged by the Rcn Committee was it felt "neither necessary nor desirable" (GNC 1965:1). The Platt Report thus represented a moment of sharp divergence of views and conflict between nursing bodies.

But the debate did not deepen at this point, nor was there a clearcut governmental initiative in support of one or other of these two positions. Instead attention was deflected to other matters; the setting up of a committee on the structure of senior management

in nursing and the report (the 'Salmon Report') produced by that Committee was a new and continuing source of controversy, so that what had appeared as if it would be a major turning point in the institutions surrounding nurse training turned out to be more of a stalemate. In the eyes of many too, the Salmon structure failed in nurse education terms, for education's subordination to service was reflected in the more junior grading of the school head as compared with the head of the nursing service. (For further perspectives on Salmon see Austin 1976; Carpenter 1977; Davies 1978).

None of this is to say that change was absent in this period, but what changes there were tended simply to sweep the GNC along. One such set of changes had to do with the reorganisation of the health services, changes which, oddly perhaps, swept the GNC along in directions favourable to its greater influence on the schools. The main reason for this greater influence was the reduction in the numbers of single hospital schools and the reconstitution of schools on a group basis.<sup>11</sup> This gave a number of opportunities to realise a reconceptualisation of 'school' as apart from 'hospital' and as comprising possibly around 1,000 'learners' on courses of different types; to do more frequent inspections and actively to guide schools on questions of internal structure and resource requirements. The GNC could now, for example, reasonably claim a role in appointing the head of the school and could manage to find the resources to get involved. Yet these moves towards closer relations with the schools were achieved within an essentially unchanged legislative framework. GNC powers were not increased and funds remained subject

to Ministerial agreement. Still the GNC could not initiate new trainings, it could not impose conditions on schools, it could do little to shape the educational segment. Where the GNC had introduced change in the curriculum sphere, for example, its new ideas met up with cost and organisational obstacles resulting in a protracted struggle with the DHSS.<sup>12</sup>

Change also came 'from below', i.e. from the schools. The late sixties saw the development of some specialisation within nurse training with new grades of clinical instructor and the teacher of pupil nurse. The idea of a clinical instructor on the wards had not come from the GNC at all, and at first in the mid-sixties the GNC was inclined simply to note what were local developments, and to be rather pessimistic that any special funds could be made available for this new grade. Some funds were given in 1965 and the GNC tended to attribute this to the publicity surrounding the Platt Report; certainly it was not easy to establish the grading and a blow by blow account of the negotiations is given in annual reports. By 1969, however, the Ministry had agreed to register both these grades. When these moves are taken together with the growth of degree courses and the similarly local and ad hoc way provision was being made for teachers at this level, it is tempting to say that the GNC was failing to take a lead in shaping the educational segment and career possibilities within it. But that would be to ignore its shrewd appreciation of the role of the Ministry (or rather now the DHSS<sup>13</sup>). It was a Ministerial initiative that set up a Joint Board of Clinical Nursing Studies (JBCNS) in 1969 to be concerned with post-basic training and the

GNC was made firmly aware that its role was not to extend to this - precisely the sphere in which teachers, tutors, etc. would be concerned.<sup>14</sup>

The GNC's position had become an unenviable one by the end of the 60s. There was the JBCNS, there were the arrangements for training in management, organised by a separate National Nursing Staff Committee, there were interesting new degree courses which the GNC could applaud but do little to help or influence. The Rcn too had become more active in bringing pressure to bear. We find the GNC reacting cautiously to Rcn proposals, irritated with the National Board for Prices and Incomes, which had taken a broad view of its remit on pay and seen fit to comment on other matters, education included (NBPI 1968), and ~~cross~~ with its own new members for failing to understand the limits of its powers and its special responsibilities. In 1969 a working party of its members seriously countenanced the idea of the GNC being a wholly appointed body,<sup>15</sup> and in 1970 we find it trying to articulate its especial position of responsibility not just to nursing but to the Health Service and to the community.<sup>16</sup> All this was a long way, not only from an institutional but also from an ideological expression of occupational control over nurse training. Widespread doubt and demoralisation within nursing was the background to the government-sponsored Committee on Nursing set up in 1968. And when the Committee reported, two years later (DHSS 1970), few realised that another ten years would elapse before changes to the statutory framework were enacted.

2. a) Early Schools and their training in the USA

There are striking similarities between the late nineteenth century nursing schools in Britain and America. It was not just that American nurses faced the same problems of developing a knowledge base and annexing resources for training in the face of reluctant hospital authorities who had to be persuaded that a nursing school was an economic proposition; American nurses also borrowed ideas and institutions quite deliberately and directly from Britain. Visits to Miss Nightingale, correspondence with her and/or periods of observation at the St. Thomas' school figure in the setting up of at least five important early schools in the USA. Indeed, the list of items to be learned was all but identical to that at St. Thomas' (see e.g. Giles 1949; Youtz 1975).

The precise impetus for nursing schools had varied, and had involved medical and lay initiatives. But the pattern of provision was similar. One or two wards would be released for staffing by students. They would be given some practical teaching, lectures by the medical staff and by the school superintendant. When this was shown to be acceptable, other wards would also be opened to students and a pattern of rotation through the hospital's departments would begin. The school was thus a device which emerged in close conjunction with the provision of a hospital service and its activities were elaborated in relation to that service. As in Britain, the term 'school' tends to mislead as a description in this period. And the Superintendant too had responsibilities closer to a British matron than to a Superintendant of a school. The matters can be studied through the many school and hospital histories (e.g. Johns and Pfefferkorn 1954; Giles 1949; Youtz 1975).

From quite early on, however, there was a certain change of direction. It can be traced in particular to the work of Isabel Hampton<sup>17</sup> as Superintendant at the new Johns Hopkins Hospital in Baltimore. Miss Hampton had previously worked as a teacher in Canada and her interest in pedagogy bore fruit at Illinois where she introduced a graded system of instruction and class work and had pioneered a system of affiliation whereby students gained experience in types of nursing not available at the main school. The founder of Hopkins had laid down that a school was to be established, and the Medical Superintendant, Dr. Hurd, had displayed interest, touring other nursing schools already open in the US, and stressing, among other things, that careful attention should be paid to the intellectual part of the training of a nurse.

Favourable as these omens seem to be for an educational emphasis in the nursing school, the historians of that school conclude that Miss Hampton was constrained to follow the prevailing pattern more than she would have wished (Johns and Pfefferkorn 1954). In four years she managed to secure a substantial number of lectures from the medical staff, she strengthened this with classes in diet cookery, she appointed an Assistant Superintendant to concern herself with first year instruction, brought in outside lecturers on social questions and started a Nurses Journal Club to study the emerging periodicals literature. Yet her first annual report talks of changes in the pupils' programme according to the needs of the hospital; their day was a full twelve hours, and they would be expected, inexperienced as they were, often to assume full responsibility for a ward. A two year course had been implemented, with pupils spending the first

year as ward assistants and the second as head nurses and as nurses in private homes. Miss Hampton worked for a three year programme so that nurses could familiarise themselves with teaching and administration. She admitted that the contemporary arrangement severely taxed the time, capacity and strength of pupils, leaving them no opportunity for collateral reading. But to persuade of the change it was necessary also to promise the services of these pupils for at least some of their time as special duty nurses - nurses for patients on private wards. In short, the welding of service and training was still intact. No-one questioned that the school was to provide the nursing service and that its other aims should be subordinate to this. Superintendents were fighting a gallant battle to provide what was stipulated; even under the most favourable conditions they were finding that they had to accede, as in Britain, in the exploitation of student labour. A special study of over 300 schools in 1896 found the students worked a range of eight to fifteen hours a day with an average of  $10\frac{1}{2}$  hours. This excluded classes held in the evenings (see Johns & Pfefferkorn 1954:112-4).

Nurse training then faced problems in the USA similar to those in Britain. Under the Bellevue system in particular it was quite directly conceived as a solution to staffing and management problems in the hospital, and even at Johns Hopkins the conditions were not such as to help the formation of a different model. There were both similarities and differences when compared with the Nightingale pattern. In both countries the idea of a separate nursing administration was advanced. In both it gained acceptance on the condition that all aspects of nursing service be encompassed by the head of nursing whatever her precise title. In both the notion of

a training and a nurses home caught on. This meant the proliferation of unendowed schools in both countries, schools which did not have the independence of St. Thomas'. Nurses were well aware of this by the 1890s in the USA. Schools were often under the same management as the hospitals and it was a pattern which "seems to be growing in favour" (Hampton . 1893:90). It was not a pattern, however, which created new institutions under the unambiguous control of the nurses themselves.

## 2. b) Organised Nurses Intervene

In the British case, after 1919, the GNC, as a statutory body, figured recurrently in the analysis, for even though its powers were limited, all looked to the GNC on training matters. In the US case, we shall pay less attention to legislation as such, and more to the institution-creating activities of organised nurses themselves. For this was a sphere in which American nurses were more active than British ones and their activities, while not increasing control over training in any global sense, did have important effects upon the availability of an educational segment, and ultimately, as I shall argue in Part Three, on the consciousness of nurses themselves.

The institutional devices to be considered here are the American Society of Superintendents of Training Schools (later to become the National League for Nursing Education (NLNE), the establishment of the base for nurse education at Teachers College, Columbia, and the appearance of the Curriculum Guides. It was the Superintendents Society, however, which got activity under way.

The Superintendent Society started in 1893 with just eighteen members (see Roberts (1954) and, for an early account, Munson (1936)). It aimed to promote fellowship among school superintendents to enable them to discuss educational ideas, exchange information and support each other in the difficult business of promoting nurse education in hospitals. Conditions in the schools were studied; the feasibility of an eight-hour day was explored; the notion of a preliminary course, separate from the hospital, was considered. Without doubt, this Society was important as a resource group for generating and publicising ideas and as a support group for fostering and developing a critique of contemporary arrangements. But it was also the starting point for the work at Teachers College and eventually for influencing school curricula through the Curriculum Guides.

Over the first years of the Society, we find Miss Hampton, now Mrs. Robb, advocating further training for Superintendents. Training in practical household economy was vital, and to this in 1898 she added a plea for training to teach (Christy 1969). An Education Committee of the Society was set up and the Dean of Teachers College was interviewed and a course started. The course was in Hospital Economics in the Department of Domestic Science. The early history of the course, however, makes abundantly clear that it was the efforts of this group of nurses themselves more than the altogether ready availability of university support which got a programme off the ground. Existing courses in the University were open to the students but the Superintendents Society itself found funds, approved

candidates, outlined the hospital economics course, provided the lecturers from its own ranks, paid them a very low stipend, relying on their enthusiasm and devotion to the cause. Not until 1906, seven years after the course started with two students, was funding from the college made available and the first lecturers appointed, and in 1907 a Chair was created in a full department (of 'Household Administration') and M. Adelaide Nutting<sup>18</sup> became a full nursing professor. Still the Society worked, this time for an endowment to support a Chair in nursing. It solicited gifts from individuals and from the newly organised nursing groups. Income from the endowment fund was handed over to the College and in 1921 the fund itself was transferred. By 1910, a course for instructors in nursing had begun and courses in public health nursing had also started.

The significance of Teachers College is not that it provided undergraduate courses for nurses (though it did do this, starting in 1916); for other educational establishments were doing this at the time also. In 1897, for example, the University of Texas had integrated the nursing school of the John Sealy Hospital into its medical department (though it was not required to meet university standards in its courses). In 1910 the University of Minnesota began a full course in nursing and put the school of the University Hospital on the same basis as other departments. In 1916 not only Teachers College but also the University of Cincinnati began the first basic programmes in nursing education leading to a degree (Dock and Stewart 1938). The significance of Teachers College is rather that it

brought together nurses interested in nurse education and gave them a space to develop and articulate their ideas, in association with others interested in educational matters. Teachers College was the natural place to turn when the Rockefeller Foundation first mooted the idea of an enquiry into nurse education. Under the influence of Professor Nutting, the eventual enquiry took a very different shape from that originally envisaged and played an important part in securing the independent endowment of three schools of nursing.<sup>19</sup> Teachers College was also the natural place to turn for Curriculum ideas. And Teachers College staff were prominent in the NLNE's efforts to specify the fundamentals of a sound nursing curriculum.

Three Curriculum Guides were published (NLNE 1917, 1927, 1937). Each emerged after much publicity and discussion in the nursing journals, and each was a substantial document, with lecture outlines, reading lists, aims and objectives of each section of the course, etc. These Guides made available, to any who would listen, the product of a great deal of thinking and debate in the forum of the NLNE and in the pages of the American Journal of Nursing. They represented the most progressive thinking of the time as to how a nurse should be trained and hence, what she should be. In an important sense, they were an ideal maximum, compared with the statutory minimum laid down in Britain. (see Chapter 8 ). But how much difference did they make in the overall practice of nurse training?

The answer is, very little. In few schools was there the base, in terms of staff and facilities to mount so ambitious a programme

and the guides offered no clues as to how a pedagogical infra-structure might be built. The guides were a storehouse of ideas and energetic leaders put exemplary schemes into practice when and where they could. The NLNE remained interested in the schools, trying to shame them into improvement by research and publicity. Studies in 1929, 1931 and again in 1949 showed just what a distance there was to travel for the vast majority of the schools.<sup>20</sup> They were part, as in Britain, of a cheap health care system, based on student labour. Some American nurses appreciated this only too well (see Ch. 8 ), but they were powerless to change it.

c) New Institutions to Promote 'Improvement'

In the period after the Second World War, some new mechanisms emerged for directing attention to training and they embodied somewhat different aims from those found earlier. It will be important to look into this, and also to examine the information which had begun to come to light about the growing number of college or university schools, and to bear in mind, as we saw in Chapter Four, the growing diversity of routes of entry to nursing in this period.

After considerable initial uncertainty,<sup>21</sup> two important measures were taken. The first was a plan for the accreditation of nursing schools, the second a programme for the improvement of the schools. The accreditation exercise got under way in 1949, under the auspices of a National Nursing Accreditation Service (NNAS), a body which was merged in 1952 with the newly formed NLN (see Chapter Four, note 24). The school improvement programme, as it began to be called, was an initiative of the NLN itself. I shall deal with these in turn.

The NNAS was to set criteria for the approval of programmes of basic and advanced education in collegiate and non-collegiate schools and it was finally to publish a list of approved programmes. It went about this, however, in a strongly conciliatory way. Schools were not to be closed and certainly there was no question, say, of phasing out diploma programmes in favour of collegiate ones. Every effort was in fact made to get the schools approved; criteria were flexible in the sense that a school did not have to reach a set standard on each one, but instead it was the total mix which was judged. Overtures were made to encourage the schools, the hospitals, administrators, teaching staffs etc. to participate in the setting of criteria, and the NNAS found that when those in the schools were asked for opinions as to criteria, their criteria were more stringent than the ones the NNAS was taking. Temporary accreditation was a device which enabled many schools to come under the umbrella and overall the accreditation exercise meant little in terms of real training control.<sup>22</sup>

The NLN's school improvement programme dovetailed neatly with this. A document set out 'Objectives of Educational Programs' emphasising that each school should set them itself (NLN 1955). The NLN would help by providing an analysis of actual objectives in use by some schools, it was prepared to provide consultation, tests, bibliographies, etc. and to point to research which might be relevant. And much energy went into this 'resource-centre' role (Cunningham 1963; Freeman 1972).

Furthermore, the understandable career interests of individual nurses were creating patterns where there was no policy. Nursing leaders had not really foreseen that it made good sense to the student to take an associate degree course and to build up credits in the educational system. The baccalaureate degree course was used by these and especially by diploma nurses as their route to advancement - something that made a nonsense of the NLN's policy that the baccalaureate should introduce principles of teaching administration and public health, but not prepare for these functions. And where there were such specialised first degrees they also threw into confusion the aims and purposes of masters programmes.<sup>23</sup>

d) Nurse Education - new plans, new problems

It is clear, then, that changing patterns of recruit availability and of educational provision had caught nursing unawares. Types of recruit, types of programme and indeed types of eventual employment were not well aligned. In 1961 a group was appointed to report to the Surgeon General of the Public Health Service on nursing needs and in particular to identify what the federal government's role should be. It reported two years later condemning the education structure in nursing as one which "lacks system, order and coherence". (U.S. Public Health Service 1963:33). It recommended to the nursing profession that a large-scale study be undertaken of the pattern of nursing education. The need for professionally qualified leaders, for a pattern of recruitment which kept up with increasing care needs, and with the staffing requirements for different health

settings - all of these were issues on which, the report strongly implied, nursing had failed to meet requirements. Overall the tone of the report was friendly, especially so in that it recommended more federal funds and was sympathetic to the idea of a contingent of highly trained nurses, but nursing must do more, taking the initiative on assessing needs and planning programmes.

Subsequent events were to show just how difficult it was to respond to the apparently rational plan of action as set out in the Surgeon General's report. For one thing a patchwork of public funding support had grown up over the years, and the Report had remained silent on how to tackle this (see Chapter Four, note 26). For another thing, nurse leaders had to carry their membership with them on any longterm plan. And it is worth, however briefly, dipping into some of the events of the sixties to demonstrate how important and how impossible this latter requirement was. Institutional change, after all, does require a certain level of consensus before it becomes possible, and this consensus was lacking.

It was the ANA which sparked off the controversy. In 1960, it had already, through its Committee on Longterm Goals, argued for a slow and cautious shift to baccalaureate education as the basis for professional nursing. The constantly rising general education of the population and the need to meet other professionals as equals were factors pointing towards this. If nursing was to hold its own it should have an educationally well prepared component. Just how many such nurses there would be and what functions they would perform was left open. General principles were sketched - the transition would

take 20 or 30 years, the matter needed much study and debate. A resolution in favour of baccalaureate degrees as basic preparation for professional nursing was passed. A detailed position paper was now issued (ANA 1965). Here the rationale of each of three nursing grades, professional, technical and assistant, was set out, together with the requisite educational preparation. The professional nurse, in the longterm, was to have a baccalaureate degree.

The position paper provoked fierce debate at the 1966 biennial Convention of the ANA. It was supported but only with the proviso that it would be slowly implemented and that change would involve full consultation and would be carefully planned. Most practising nurses after all were graduates of diploma programmes which were to be phased out under the new arrangements. They were uncertain as to what this meant for their own career prospects. The NLN was more cautious. Support was given for the ANA position paper at the 1965 meeting but provisos were built in. In 1966 the NLN and the ANA issued a joint statement on community planning for nurse education. This placed the onus firmly on local groups to assess nursing need and to evaluate their local resources to see how best such needs could be met (see American Journal of Nursing 1966:1697-8).

The idea of community-based planning got further endorsement in the National Commission for Nursing and Nurse Education (1970). Nursing, the Report claimed, should develop within a framework of higher education but it should be left neither to higher education organisations nor to nurses alone. Instead, there should be 'state master planning committees' with representatives of nurses, educators, other health personnel and the public. Furthermore, there should be

a unified form of regional accreditation. (National Commission for Nursing and Nurse Education 1970:107ff).

By 1970 then, the position on control of nurse training had shifted considerably. Nurses were being swept up in an enthusiasm not for occupational control but for local control in which an occupational interest was represented. There were shades here, perhaps of the national nursing organisations' earlier retreat from setting guidelines and standards, but whether this community planning and local lay involvement was to extend into the interior of the teaching programme - into curriculum, pedagogy and evaluation - was unclear.

### Conclusion

Training control, we might think, should present fewer problems as a claim on the part of an occupational group than control over entry - for surely it is self-evidently acceptable that those who have practised and are experienced in the occupational skill should have a predominant say in how the neophyte is to be prepared for practice? In the event, however, we have found that this is not the case and we have repeatedly shown how limited are the institutional powers granted to and taken by organised occupational collectivities.

Control over training, however, seems to be a topic which has engaged occupational members more than has entry control. We have dealt with more purposive actions in this chapter than in Chapter Four and with more controversy. And, perhaps for this reason,

differences between the two countries have emerged more sharply. In the British case debates have centred around the activities of a single, statutory body, the GNC. Membership organisations have felt constrained to address themselves to the GNC, and, until recently have been taking something of a back seat in face of GNC statutory powers. And yet, as we have seen these powers were incomplete and perhaps even damaging as far as training control was concerned. In the American case, by contrast, the state boards have been concerned with minimal requirements while the nursing organisations have been active in setting model Curricula and encouraging the growth of a specialised educational segment, which, in its turn, would be in a position to insert new ideas. The British pattern meant much pleading for change and a slow response; the American pattern meant much action and highly variable results.

In both settings, a key consideration has been resources. Pedagogical control in particular has been hampered by the lack of specialised teaching staff and by the fact that students are used as the labour force of the hospital. We should not let the image of the college-trained American nurse mislead us here. In the first place, as we have seen, hospital schools were still the primary producers of trained nurses until the mid-sixties; in the second place, college courses did not necessarily mean the establishment of a full nursing faculty and full nursing control over what was taught and how. The training of nurses has been entangled with other interests - with the interests of hospitals as service-providers and with college and university politics.

But it is more complex than this. Questions of ideology intrude - and do so in several ways. First, we have seen, particularly in the U.S. case, that decentralisation or localism is a value of increasing importance as time goes on. The NLNE abandoned its Curriculum guides, and by the time the NLN was formed, it seemed appropriate to act as a resource centre, encouraging those in the local schools to devise their own programmes. In the most recent period, there has been another shift, to state master plans bringing local nurses together with other local interests to plan nurse education. Related to this, there has been an acceptance of the autonomy of the educational sector and the legitimacy of local action there. The 1970s community plans and regional accreditation reflect the ideological tensions. Localism has been less of an issue in Britain where professional control of training has taken the form of a statutory body answerable to Parliament - but there are contradictions again, especially with the experimental courses and the question, left unanswered at the end of our period as to whether 'the profession' in some collective sense should have oversight of the somewhat haphazard developments in the further and higher education sectors.

We should note too that ideological issues intrude not just at the level of what is a tenable control claim for an occupational group in general but also at the specific level of nursing and nursing work. Educational programmes embody an answer to the question: 'what is nursing?' and this answer differs at different times and in different places. At the outset in Britain, it was thus not self-evident that nursing was or could sensibly claim

to be independent of medicine and the institutional framework - with its medical lecturers and examiners and its practical ward work - reflected thus. Given the institutional basis of certain American nurses at Teachers College and elsewhere the seed of something more of an independent practice could be nourished and other kinds of specialist knowledge (from education and from the social sciences, for example) could become candidates for inclusion. These issues are explored and developed much further in Part Three; what we need to note here is only that the study of control has pushed us towards considerations of ideology and aspirations and the way these relate to institutional frameworks. The study of occupational control has raised more questions than it has answered, and the moment is ripe to search for new vantage points on the vexed question of occupational power. One important point that those new vantage points should illuminate in relation to training is the sharp contrast between the two countries in the more recent era. Where in Britain the threat to training control was from 'above' - in the U.S. it was a threat from 'below' - on the one hand the issues seemed to be all to do with professions and the state, on the other, they were to do with professions and the public.

FOOTNOTES

1. The information in the following paragraphs is drawn from a variety of sources including texts on nursing history, notably, of course, Abel-Smith (1960), accounts of nursing in hospitals (e.g. Hector 1974; Anning 1976), nursing schools (e.g. Seymer 1963; and contemporary writings (e.g. Tooley 1906).
2. I refer, of course, to her Notes on Nursing first published in 1859. Another latest edition has been published together with a contemporary commentary (Skeet, 1980).
3. This leaves out of account, of course, the real differences between large and small, metropolitan and provincial, voluntary and poor law hospitals. For a rare piece of information on curricula in the last of these see White (1978).
4. It should be noted, in addition to the general register, and a general nursing syllabus, supplementary registers were set up for mental nurses, children's nurses and male nurses. This, too, confirmed a pre-existing pattern and the GNC, even had it wanted to establish a single basic course, had no choice but to devise examinations for the categories as given.
5. This calculation came from the survey work carried out for the Lancet enquiry (Lancet 1932). In a sample of hospitals taken for that enquiry in 1930, 23% reported that they held lectures mostly or all in off-duty time, 48% said half and half and only 29% arranged lectures largely in probationers time on duty.
6. The relevant section is very short, stating simply that the power of the GNC was to be extended to allow them to make rules for the granting of certificates to persons who had undergone a prescribed training in an approved institution. If the rules so provide, it went on, they may also be required to pass an examination in the teaching of nursing.
7. The reconstituted GNC consisted of 34 members. As detailed in the First Schedule to the 1949 Nurses Act these included 17 elected and 17 appointed members. The elected members were to be drawn from both the general and supplementary registers and in the case of the general nurses were to be from different geographical regions. Ministry of Health Appointees comprised two community nurses, two tutors, one male nurse and one nurse in charge of a ward in a training hospital, together with three appointees who were to have had "experience of the control and management of the hospital". Two further persons were appointed by the Ministry of Education and the remaining two by the Privy Council (these to represent Universities). Details of the previous arrangement are given in Chapter Four (note 6).

8. There is reference in the Annual Report of the GNC to this lack of power over capital expenditure as a "drafting error", but the matter was still in dispute as late as 1960. Furthermore, the Act included a broad clause concerning expenditures "of such description as the Minister may specify". Perhaps this had something to do with the dispute over a sum for wages of domestic and other staff which for the first few years was found out of the nurse training budget!
9. See note 7 above. The GNC now had to have two nurse tutors as members together with two Privy Council members specifically representing the Universities.
10. This Committee to consider nurse tutors had been set up in May 1951. The introduction to their report makes clear that it was largely the evident shortage of tutors and in face of this the alarm in the Ministry over the University of London's proposals to lengthen the course from one to two years which had prompted a Ministry initiative in which the GNC had agreed to participate.
11. While some anxieties had been expressed earlier than this, a special subcommittee was set up in May 1968 to consider criteria for grouping schools (GNC Annual Report 1968/9).
12. I am referring here to the new 1962 Curriculum and its revision in 1969. An innovation here was for students to cover experience of community nursing, and for three years from 1969 negotiations continued with the DHSS over this.
13. There was a major reorganisation of Whitehall departments in 1968 which included the abolition of the Ministry of Health and the creation of a single Department for Health and Social Services (DHSS).
14. Much later, in 1975, the GNC was involved in a survey of teachers of nursing which revealed shortages of basic grade teachers, surges of outmobility especially of registered nurse tutors to colleges of education, and also that many clinical tutors went on to train as registered tutors (GNC, 1975). In career terms these shifts are not surprising but the GNC had not anticipated them. This is directly comparable with the way American nursing organisations were taken by surprise by the use diploma nurses made of the degree courses, discussed later in this chapter.
15. An internal working party preceded legislative reconstitution of the GNC in 1969. The difficulty of conducting elections with so massive a constituency was a reason put forward for shifting to a system of appointment. Consultation with the nursing organisations yielded so negative a view that the idea was dropped.

16. Consider the following comment, drawn from the GNC's evidence to the Committee on Nursing:
 

"the Council's position, as the one body responsible under statute for the training of student or pupil nurse, is unique in relation to the Committee on Nursing, in that those responsibilities demand that the standard of nursing care, and the standards of nursing education, shall both be safeguarded; at the same time, nurses must be provided, of the right calibre and in adequate numbers, to meet the needs of the Health Service and the Community. It follows that the Council's approach to all problems must be realistic ....." (GNC Annual Report 1970/1:17)
17. Isabel Robb (nee Hampton), 1859-1910 was the first Superintendent of Nurses at Johns Hopkins Hospital. She chaired the influential nursing section of the 1893 World Fair in Chicago (see Chapter Eight) and was first President of the Association which was later to be renamed the American Nurses' Association. She married Dr. Hunter Robb in 1894 and died in an accident in 1916. Her textbook Nursing: its principles and practice ran to many editions.
18. M. Adelaide Nutting (1858-1948) joined the first class in the Johns Hopkins Training School in 1889, and four years later was head of the school. She was the first nurse to hold a full professorship and was active in professional activities. She was co-author of A History of Nursing (1907-1912) and author of a collection in 1926 under the title A Sound Economic Basis for Nursing Education. A full length biography of her is available. (Marshall 1972)
19. The enquiry became known as the Winslow-Goldmark report. It is discussed further in Chapter Eight.
20. Two studies were carried out in connection with the nurses own 'Grading Committee' (Committee on the Grading of Nursing Schools 1930, 1933); a further study again organised by nurses themselves was conducted in 1949 (West and Hawkins 1950). For a comment on all this nurse sponsored enquiry see Chapter Eight.
21. For a discussion of the various moves involved see Roberts (1954: section x). The 'Midcentury' Study of Schools produced valuable data as part of this activity, but what caused a great deal of controversy was the tough line taken by E. L. Brown in the study commissioned from her. (Brown 1948).
22. Temporary accreditation was introduced in 1952, giving the considerable number of schools still outside the system five years to come up to full accreditation status. Many were covered in this way. In 1951-2 18% of the 1,103 programmes evaluated were given full status, another 57% were given temporary accreditation and in this way, fully 85% of all students were covered (see Roberts 1954:516ff).

23. Yet another complication concerned entrants with degrees in subjects other than nursing. An accelerated course rather than any of those so far mentioned seemed indicated here. We should note that some, later, did see what had been occurring (National Commission for the Study of Nursing and Nurse Education 1970:104-5).

PART THREE.      OCCUPATIONS;  
A STRUGGLE FOR MEANING?

CHAPTER SIXNURSING WORK: CONCEPTS AND CONTEXTS

Nurses spend a great deal of time in hospitals, training there, and teaching, managing or practising in a hospital setting. We must not underestimate the impact of the hospital on the nurse and the way her position in it affects her patterns of thought and behaviour. In this chapter I shall argue that although the hospital is of central importance to the health care system in both countries, historically it has been a more important determinant of nurses' concepts of themselves and their work in Britain than in the USA. This, in turn, helps us make sense of the contrasting patterns of behaviour of nurses in the two countries.

What does it mean to speak of the domination of the hospital? I refer not so much to the problems of large-scale, people-processing organisations with their hierarchical staff relations and tendencies to dehumanised care, but more to hospital-centredness as a form of definition and mode of delivery of health care. Hospital-centred health care in this sense is associated with a curative rather than a preventive orientation, with an individualistic and one-to-one service bias rather than an environmental or population-changing one, with a technological approach and a devaluing of personal skills, a focus on acute and episodic rather than chronic illness, and fragmented treatment rather than holistic care (Davies 1979a). Hospital-centredness in this sense, of course, is closely associated with the development of modern medicine; the hospital has provided the locale for specialisation in medical practice and for the technical interventions

of modern medicine and surgery. Where nurses are oriented to the hospital then, they are caught up in a medical concept of health and in views of their own work which are closely allied to those of doctors. The hospital is not just an organisational form, but the embodiment of particular concepts of disease and treatment (cf. Davies 1979a and b). With this in mind we turn to a comparison of the relation between nurse and hospital in Britain and the USA.

### 1. Hospitals and Health Care in the Early Twentieth Century

Both Britain and the USA in the nineteenth century had their old, established 'hospitals'. These were charitable institutions founded for the aid, relief and disciplining of the poor; institutions where the distinction between sickness and poverty or dependency was blurred. For this reason, and because of the real fears of hospital diseases, hospitals were shunned as places of last resort for the poor and for those without roots in the locality (Abel-Smith 1964; Rosenberg 1971, 1977; Woodward 1974). Viewed through the rather blinkered eyes of contemporary nurses and of many nurse historians, the hospitals tended to be somewhat sordid establishments; patients gained little nursing care and little medical attention. Viewed in a less emotive way, however, it is clear that much that we take for granted in modern organisational life was absent. Work commitment was not of a modern kind mediated by the cash nexus or by a belief in the value of the work activity per se. Staffs had a diffuse obligation to the hospital expressed in Britain in the terminology 'house servants' and 'officers' rather than 'employees'.

Much payment was in kind, rations were issued which nurses cooked in situ for themselves. There were no set hours of work, living in was expected. Nurses had long been engaged in physical labours in the upkeep of the hospital and the deployment of its resources. . That they engaged in reciprocal exchanges with the patients for whom little or no specific medical treatments were prescribed is not surprising given that the social distance between nurse and patient was not great. In Britain and in the US nurse and patient were subject to regulation in a paternalistic social order which gave passes to leave the hospital, for example, and required Church attendance and so forth (Abel-Smith 1964; Rosenberg 1971, 1977; Vogel 1978).

All of this was in the throes of change. For the case of Britain Abel-Smith (1964) has shown how hospitals were becoming linked with the development of the medical profession, and for the case of the USA, Vogel (1978), for example, has shown strikingly similar pecuniary, status and specialist work advantages to be found in the hospital for the medical elite. Nursing reform was built on this process. It related to the doctors' need for an aide and the trustees'/governors' need for a need for a cheap, disciplined staff. What did it mean in terms of daily work?

In practice, much remained as before. The domestic and housekeeping work which had previously been the lot of the nurse was not removed, but included as part of the learning experience for the probationer. Rules and procedures came to surround such work, and principles of hygiene legitimated its practice by the nurse. Acceptable procedures for bedside care of the patient were established and routinised under the

direct tutelage of the medical staff. There is an important paradox here, namely that the nursing work of the hospital in both its domestic and bedside aspects was largely being portrayed as work for learners. The hospital, at this point, was not the site of complex nursing technique - much of its work could be done by those still in training. And the nurse's authority to act matched this; her activity was legitimate because of the orders she received - from the doctor and from nursing superiors - not because of her own special expertise. Nursing work in hospitals was hence the work of the young, the ignorant and inexperienced women. The nurse was a lowly employee in the hospital, directed by doctors and by other nurses.

What then, was the work of the trained nurse? The answer was somewhat different in the two countries. In Britain, positions were available for the trained nurse in the hospitals, but these positions were essentially managerial and supervisory ones. Miss Nightingale stressed the importance of ward sisters: trained nurses were the "keystone under the matron", "lieutenants", one of the key influences on staff nurses, probationers, ward maids and patients (Seymer 1960:33). Their influence was both technical and moral, and it seems quite clear that the trained nurse was trained first and foremost to a position of command over other women. In the US, by contrast, a role as head nurse in a ward was more likely to be adopted by a senior probationer rather than a trained nurse, and the usual expectation was that, on qualifying, the trained nurse would work, not in the hospital at all, but in the community. For American nurses, the hospital was more of an interlude, a necessary preliminary to working elsewhere. For British nurses, especially Nightingale

nurses, but others too, hospital work was much more important - for it fell to the trained nurses to take up hospital posts, to set a new example for nursing in the hospitals from positions as sisters and matrons and in this way to spread the message of reformed nursing.

In practice, however, private nursing was the activity of the numerical majority in both countries. The private nurse faced a precarious living with periods of isolation and unemployment. Because she lived with a patient's family during illness she had to adapt to conceptions in that family of the domestic division of labour and to the servant hierarchy if there was one (Geister 1926). Her hours and duties were subject to the whim of her employer, tempered by the instructions of the visiting medical practitioner. There is no reason to think that the differences between the countries were especially marked. Charitably-funded nursing work, however, was rather different.

In Britain, a single agency came to have predominant importance and that agency was the Queen Victoria Jubilee Institute for District Nursing. (Stocks 1960).<sup>1</sup> Queen's Nurses, as they were called, worked to principles very much echoing those at work in the hospital. They had had a further six months of training; they lived in a Nurses' Home, working under the supervision of a nursing superintendent and working only at the instructions of a medical practitioner. Domestic labour was not ruled out, a key activity was keeping the home 'in good nursing order'.<sup>2</sup> In the US, by contrast, charitable

developments were much more varied, with local visiting nurse associations taking different forms and raising money in different ways (Brainard 1922; West 1932). It was an insecure living, posts came and went and one writer suggested that a three month guarantee of work was a reasonable one to accept (Brainard 1919). After the turn of the century, it is important to notice how some of the visiting nurse associations became associated with other voluntary bodies, such as the Anti-Tubercular Leagues, the Red Cross and various Industrial and Child Health Programmes. Such bodies had an educational and preventive remit and could involve nurses in a wider set of duties than nursing of the sick alone. Beyond this, some municipal posts were emerging - earlier in Britain at first than in the US - all of these developments are discussed further in the next section.

The crucial point to note in this era is the divergent directions of development for the British and American hospitals. In Britain the new work of hospitals came in the context of a fair number of established charitable institutions and an acceptance of the idea of charitable funding for the voluntary hospitals. When, soon after the turn of the century, debates began to escalate on whether and how paying patients should be accommodated, a considerable uncertainty surrounded this issue in the face of established traditions. Rather than attempting to transform themselves into self-sufficient commercial enterprises the voluntary hospitals limped on, taking some paying patients but turning finally to the State for support in their difficulties (Abel-Smith 1964, Pinker 1966). In the US, by contrast, the rapid increase in the number of hospitals around the

turn of the century was a growth of new commercially-oriented ventures. Places for paying patients were made available earlier than in Britain (Rosenberg 1971, 1977), hospital proprietors organised themselves and debated principles of business efficiency at their meetings (see Ashley 1976; Reverby 1979; Rosner 1979). One commentator has gone so far as to suggest that the American hospital system was one which "sprang almost de novo out of the private enterprise, commercial middle class" (Anderson 1972:50).<sup>3</sup> Although there is little hard evidence on it, we should not neglect the likelihood that these two different hospital systems were already influencing social relations between doctors and nurses. The American hospital was a more permeable institution; a large number of local doctors came to have hospital privileges, bringing their patients to the hospital and performing specialised treatments there (Stevens 1971:145). In addition, paying patients brought their own private nursing 'specials' who were attached to a single patient in the hospital for the length of his/her stay. In the British case the boundary between hospital and community was stronger. We have already seen that trained nurses were hospital employees (usually living on the premises too). While doctors were not employed in the same sense,<sup>4</sup> still there was a small group of consultants attached and doctors and nurses would have got to know each other well. There is some basis here, perhaps, for greater deference and acceptance of the status quo on the part of the British nurses, for the undisturbed continuation of social relations of an earlier era. This is important since, as we shall see in the next section, British hospitals were much less transformed by the Depression than American ones. In the section which follows, I shall take these hospital

differences, add to them a growing difference in public health programmes and begin to link both with the hints in nursing and other publications of a divergent image of the nurse and her work. Two different health care systems then, were already taking root at the turn of the century and different notions of nursing were already dimly visible. We pick up the story again in the 1920s and 1930s.

## 2. Hospitals and Public Health - the Interwar Mix

Let us start with developments in public health in the US, for the interest, which had already been apparent early in the century, broadened and deepened in the 1920s. The Red Cross redirected its wartime funds and facilities towards public health and the formation of a National Health Council in 1921 was designed to facilitate co-ordination among a growing number of voluntary agencies. The National Tuberculosis Association appointed the first nurse to its staff in 1920; the American Public Health Association became convinced of deficiencies in the availability of public health nurses in large cities and set up its own nursing section. Important demonstration projects were funded by bodies such as the Metropolitan Life Insurance Company, the Red Cross, the Mil bank Fund etc. Added to voluntary activities were certain federal initiatives. In 1919 a nursing division was set up in the US Public Health Service (USPHS) and in 1921 with the setting up of the Veterans Bureau, this division inherited 400 public health nurses. The Sheppard-Towner Act (1921) inaugurated an eight year maternity and infant care programme based on grants to individual states; this resulted in the first public health nursing consultants appointed in peacetime to work under government auspices.

All of these are indications of the strong public health movement. Growing out of Progressivism early in the twentieth century (Wiebe 1967), and backed by the new philanthropy of the Foundations, public health was presenting a challenge to established private medical practitioners. Within the public health movement there were arguments for rationalisation of health care and for health insurance as well as support for all kinds of practical experiments to bring health services and health education to urban areas and to deprived immigrant groups (see Brown 1979). What this meant for nurses as Fitzpatrick (1975) shows in her history of the National Organisation for Public Health Nursing (NOPHN) was an opportunity for extending their work.

The depression, of course, hit at public health work. Temporary relief programmes for unemployed nurses present a varied picture. Some certainly helped nurses to increase their skills and implanted new ideas about services, but others used non-nurses as supervisors and assigned work to trained and untrained nurses on an arbitrary basis (see Woodward 1937; Swope 1934). More important was the shift from voluntary provisions towards officially sponsored schemes. Already under way in the 1920s, it was a trend which accelerated in the 1930s (Roberts 1954:277). And, in some important ways this also contributed to an expanded role for the nurse.

For one thing, by the late 1930s every State had some kind of central advisory service and there was a nurse consultant too at federal level in the USPHS. Nurses in these positions were promoters and facilitators - they were able to put a nursing point of view, to help plan and run educational programmes and to push for an extended

scope of nursing work. For another thing, the entry of nurses coincided with a broader move to lessen the impact of political factors in public appointments and to work to a 'merit system'. Since this meant spelling out qualifications, rationalising job titles, promoting inservice training and career paths (Belsey 1937; Hilbert 1941), it was a set of guidelines which supported rather than stifled initiative and the building of skills (cf. Davies forthcoming a).

How does this compare with Britain? Britain is conventionally seen as the home of the public health movement and often held up today as the country in which community public health care workers in the shape of health visitors, midwives and district nurses - have a long and honourable history. All of this is true enough, but what I want to suggest is that there was very little impetus to development in this later era; there was no strong voluntary public health movement as in the US and public health issues were intertwined with, and deleteriously affected by already established interests.

In the first place it is crucial to note that the era of voluntary bodies taking up campaigns for specific groups or specific diseases was in decline. Not only environmental health but also personal health services were coming under the administrative oversight of the Local Authorities and of local officials - the Medical Officers of Health (MOsH). The services which were available depended on the zeal and interests of these medically qualified officials and their skill in persuading elected members of the authority of the value (economic and political as well as social) of any extensions and additions to

existing services. This was a point of particular importance given the permissive status of much of the legislation. The Maternity and Child Welfare Act of 1918 is a case in point where it is clear that fears of costs, in the absence of really developed local pressure groups, could lead to inaction (Lodge 1981). Furthermore, it has been suggested that MOsH in the 1920s lost interest in extending health services, since in 1921 they achieved greater security and established rights of tenure in their posts (Honigsbaum 1979: 85 ). All in all, it does not look as if this structure encouraged initiative.

Next, certain areas of work which might be considered part of public health nursing work had developed separately from each other and had come under medical supervision. For example, a separate occupation of health visiting had grown up, in important part at the instigation of MOsH who regarded female visitors as an important extension of their own work - a way in which their health message could be taken into the homes of working-class mothers and infant mortality thereby reduced. Though duties and qualifications of health visitors came to be specified by statute, the health visitor worked as a subordinate officer and often a closely supervised one. Midwifery too was separate, with legal stipulations surrounding it (Donnison 1977), but regulation of midwives was again a matter for the MOH Department and supervision often one of the many and varied jobs delegated to health visitors - which could cause friction. A variety of other workers whose activity was made possible under the various permissive powers of the Public Health Acts was also supervised by the MOsH. These workers included school nurses, infant life

protection visitors and TB visitors. As far as can be seen, these workers were separated from each other in different divisions, they held varied qualifications (and sometimes none) and worked to a variety of different job definitions (Eastwood 1955).

Home nursing was something of an exception to this. It was not until 1936 that a Public Health Act made possible the direct employment by local authorities of home nurses. By this time, the Queens Institute had spread its service widely. By 1934 nursing in 51 out of 62 counties was provided under its auspices (QIDN 1934). The pattern of provision as far as can be seen was little different from before; it still echoed the hospitals in its requirement that nurses live in a nurses home, be subject to the close supervision of a nursing supervisor and do nothing to challenge the treatment regime of the local medical practitioner.

Sketchy as the account is, it suffices to suggest that there was nothing comparable to the experimental approach and the diverse interest groups involved in the American public health movement of the time. Public debate in the U.K. centred very much around the hospitals as the focus of the problems and the solutions in health care. What then was happening in the hospital sector, both in Britain and in the USA?

By this time, the hospital had become the 'workshop of the doctor' in both countries. New developments in technology and new treatment regimes required more expensive equipment and more and more diverse grades of auxiliary staff. The search was on to find new ways of funding health care and, however reluctantly, the independent private practitioner was becoming aware that his days

were numbered. This is not the place to go into much detail about the different types of hospital and their problems during the Depression era, but certain broad contrasts between developments in the two hospital systems especially as they affected nurses are important for our story.

American hospitals were hit hard by economic recession. In their search for economies vital to their survival they looked to a cheaper pattern of staffing. With the support of the national nursing organisations many closed their training schools and began instead to employ trained nurses (Kalisch and Kalisch 1978). These latter, as was explained in Chapter Four, facing high levels of unemployment were glad enough to gain board and lodging and a small salary. Economic pressures forced them back into the hospitals - it was emphatically not that there was some new and more responsible work to do there.<sup>5</sup>

In practice the new trained nurses in hospitals began by working on flexible job assignments, going wherever they were needed in the hospital (AJN 1931:689-92). Objectives and duties were unclear and ratios of trained to untrained and of nurses to patients were highly varied (Burgess 1932). A study of graduate nurse positions in small hospitals at the end of the 1930s showed that the turnover was high among trained nurses in hospitals and there was no clear rationale in the work assigned to them (AJN 1941:422). American nurses had been catapulted back into the work they associated with their student days and they were likely to be critical of it. Their positions were too insecure for this to show straightaway, but later, as it

became clear that private work was not going to pick up again, and that the hospital was going to be the centrepiece of medical care, they were going to take a hard look at that institution and to ask just what was the place for the 'professional nurse' within it..

In Britain, matters were otherwise. To be sure the voluntary hospitals were in financial difficulties; we have already noted that Abel-Smith (1960) has documented the various moves made and the recourse to the idea of state grants to aid them. But the demand for hospital care remained bouyant, more beds were created and a major problem was finding enough nursing staff.<sup>6</sup> We have seen too that a contingent of trained nurses had always remained in the hospital, doing both managerial and bedside work. Now, what with slow growth in public health work and less and less private work, hospital nursing occupied many. A GNC survey in 1937 found that 45% of active nurses held hospital appointments (Abel-Smith 1960:154-5). But this did not mean that they constituted the majority of nurses in hospitals. Trainees, and also now untrained assistant nurses were doing bedside nursing work. A ward typically might have two trained nurses - a ward sister and a staff nurse. The rest were probationers and assistants. Proportions of each varied, for while the wellknown teaching hospitals could attract probationers easily, other hospitals could not and they recruited whomsoever they could to get the work done.<sup>7</sup> This affected the work in a number of ways.

For one thing it was impractical to work with rigid job boundaries for different grades. Where probationers were being rotated between wards, where auxiliary staff may or may not be available, sister and staff nurse (if there was one) needed to fill the gaps in whatever way they could, including doing domestic and clerical as well as bedside nursing tasks themselves. Jobs therefore overlapped.

For another thing, with an inexperienced ward staff routinisation and/or close supervision made sense. In different hospitals and at different times within the same hospital workers with very different competences were being asked to do the same jobs. Double-check and supervision in detail made sense. The staff nurse came to be sister's deputy, with no special responsibilities of her own; the sister's job became taken up significantly with administrative and supervisory work along with such teaching as could be arranged for probationers. The sister in practice was the pivot with authority which stemmed at this point from several sources - a status as registered in relation to the unregistered and would-be registered; an implicit pact much like that of the Matron to 'fix-it' - co-ordinating whatever resources were available and, in a trouble-shooting capacity, pushing herself and her staff to the utmost if necessary. British nurses were thus caught up again in a different set of social relationships from their American counterparts. There were more continuities with the past and fewer opportunities to develop a questioning stance. We should remember too that most still lived in the hospital as well as working there. These different experiences and the different context which produced them help make sense of the then contemporary ideas about the nurse's work and her position in the division of labour.

Ideas of the period about the proper work of the nurse can be found in two reports of the time, one conducted under the auspices of the medical journal, the *Lancet* (*Lancet* 1932), the other an official Inter-departmental enquiry (Ministry of Health 1939). Of these, it is the former, the doctors' report, which is particularly informative. The doctors saw the role of ward sister as

manager, suggesting indeed that she be provided with further courses in topics such as economical marketing, catering, supervision of laundry arrangements and other sundry matters (Lancet 1932: para. 277). As for the staff nurse, hers, in their view was a training grade for the position of sister. There was no hint of a responsible bedside role for the trained nurse, and a strong implication that nurses when they were not doing managerial work were simply following the instructions of the doctor. Here the doctors' comments on the Syllabus are instructive, for they were critical on the grounds that it had too many medical questions, "it is no part of the nurse's duty to supplement reasons why a doctor orders certain treatments" they stated firmly (ibid: para.236).

These remarks must be seen in the context of trends we have already noted, towards a growing use of hospitals and an extension of medical techniques. The doctors increasingly needed eyes and ears on the spot and specialised auxiliary workers were increasing too. From this point of view perhaps it was an important moment for them to affirm medical authority as well as to express frustration over shortages. At one stage it looked as if the official enquiry might develop a more far-reaching analysis (see p.69-70) but it had managed to issue only an interim report when war broke out and this confirmed that the most pressing issue was not the proper work of the nurse but the staffing of the hospitals.

There is little in the nurses' own writings which contests this hospital-orientation, and in this regard the College of Nursing's stance is an interesting one. In 1938, it submitted evidence to the

Interdepartmental Committee; a long initial section largely reproduced the familiar argument about hospital nursing and accepted the need to increase staffs. A much shorter section appeared on public health; it sat uneasily in the overall document and one gets the sense of a small group fighting a losing battle against dominant and well-entrenched ideas (College of Nursing 1938). Above all, it was difficult to contest that the hospitals were in urgent need of more staff. Nurses had to defend the GNC and registration, pointing out that they had not themselves generated the shortage by these measures, but that demand was increasing. We will pick up this story of how nurses were on the defensive again in Chapter Eight. Suffice it to say here that new ideas about nursing work were not emerging (cf. Davies 1976).

All this stands in some contrast to available publications of the same era in the USA. First, the public health movement interest in nurses had led to a Foundation-funded enquiry and the production of the Winslow-Goldmark report in 1923. This thoroughly vindicated the work of public health nurses giving them important legitimacy and publicity. (Committee for the Study of Nursing Education, 1923). Other public health movement initiatives also had a bearing on nursing as something essentially outside the hospital. The Committee on the Costs of Medical Care (1952) argued that the nursing Curriculum should produce 'socially rounded nurses', and stated firmly that a hospital-based preparation was not sufficient for this. The White House Conference on Child Health and Protection (1930) called for more nurses better prepared in paediatrics and obstetrics, knowledgeable on child development, care of the well child, mental

hygiene etc. (Stewart 1944:217-221). In short, the climate was favourable to extending ideas about nursing practice beyond the hospital and the bedside.

It is particularly interesting to examine the definition of the work of a nurse produced by two nurses and incorporated in the important nurse-sponsored study by nursing schools in 1934. The full list, drawn from the report, reads as follows:

"What should a Professional Nurse know and be able to do?"

1. All professional nurses, irrespective of the special field in which they have elected to practice, should be able to give expert bedside care. They should also have such knowledge of the household arts as will enable them to deal effectively with the domestic emergencies arising out of illness.
2. All professional nurses, irrespective of the special field in which they have chosen to practice, should be able to observe and to interpret the physical manifestations of the patient's condition and also the social and environmental factors which may hasten or delay his recovery.
3. All professional nurses should possess the special knowledge and skill required in dealing effectively with situations peculiar to certain common types of illness.
4. All professional nurses should be able to apply, in nursing situations, those principles of mental hygiene which make for a better understanding of the psychological factor in illness.
5. All professional nurses should be capable of taking part in the promotion of health and the prevention of disease.
6. All professional nurses should possess the essential knowledge and the ability to teach measures to conserve health and to restore health.
7. All professional nurses should be able to cooperate effectively with the family, hospital personnel, and health and social agencies in the interests of patient and community.

8. Every nurse should be able, by means of the practice of her profession to attain a measure of economic security and to provide for sickness and old age. It should be possible for her to conserve her physical resources, to seek mental stimulus by further study and experience, and to follow that way of life in which she finds those spiritual and cultural values which enrich and liberate human personality."  
(Committee on the Grading of Nursing Schools, 1934:Ch.3).

The concept of expert (almost independent) bedside care, of promotive and preventive work, of linking social and psychological factors to illness are striking and can only derive from the community role in which nurses were involved. No definition of the scope of work is available for British nurses in this period, but if it were, it is doubtful that it would cover such aspects.

3. Postwar health care: nurse as managers or practitioners?

By 1950, the health care systems of Britain and the USA had moved in visibly different directions. Britain had opted for a nationalised system with services free at the point of delivery and over 80% of expenditure channelled in ways involving accountability to local or central government. In the USA, pressures for compulsory health insurance had come to nought; public funding of health care amounted to 28% in 1950 and forms of private insurance and of pre-paid group practice began to develop. There was an important similarity in the shape of support for hospitals and the high technology medicine they involve. Britain's Nationalised Health Service (NHS) was a state takeover of hospitals - leaving GP and local authority services more or less intact. In the US too, there was attention to and even economic support for hospitals via the Hill-Burton Programme. But it is differences which will concern us most and the implications of those differences for nursing practice.

The NHS was implemented after protracted negotiations with doctors (for discussion see e.g. Abel-Smith 1960; Eckstein 1959; Willcocks 1967); assurances were given about clinical autonomy and representation was assured at all levels of the new and complex structure. Doctors had probably mellowed more than their American counterparts as a result of experience in the wartime Emergency Medical Service, but Britain too was a country in which state intervention was looked on with much less disdain and in which an organised labour movement had more say. Nurses, however, were treated very differently from the doctors. To be sure there was considerable concern over staffing; action was taken to improve pay and a ministerial publication urged nurses to come forward to meet the nation's peacetime need and set out a code of practice as far as conditions were concerned (Ministry of Health 1945). But almost nothing was said about the kind of work to be done, the types of nurse or non-nurse to do it and the organisation structure required. In the White Paper prior to the NHS, it was as if nursing was an afterthought: the aim was to provide medical services for the population along, of course, with the allied services and facilities that required. Nursing was very definitely an appendage to medical care (cf Davies 1978).

Yet, though there was no conscious planning the NHS did alter nursing in a number of discernible ways. First the powers of the hospital matron were altered. Hospitals were no longer autonomous but grouped under the administrative control of a Hospital Management Committee (HMC). This reported to a regional hospital board (RHB) and thence to the Ministry of Health. The matron now had other nurses above her and faced something of a lacuna at HMC level. All kinds of ad hoc Committees and special arrangements to give nurses

a voice were devised (Central Health Services Council 1954).

The practice of appointing functional heads to departments such as catering and laundry meant that matron's span of control was narrowed and the job of co-ordination made more complex.<sup>8</sup> And given too that terms of conditions of work were changing - more part-timers, shorter hours and different systems, these presented additional headaches in allocating staff. When these trends are set in a context of growing specialisation of tasks in the hospital and a more intensive use of hospital beds it is not surprising that the traditional unitary and personal control of the matron began to be under strain.

At ward sister level much remained as before. In 1953 the Nuffield Provincial Hospitals Trust provided a particularly vivid picture of the sister's job (NPHT 1953). Only three wards out of 26 studied in 12 hospitals had more than one sister and one other fully trained nurse. Seven sisters were single handed. The variation in staffing patterns was tremendous. Domestics in one ward were 20% of the total staff. In another they were 60%. Transient student nurses were usually the majority of the available labour force. Fully half of the sister's day was spent on administrative tasks. There was not, the researchers felt, a clear division of labour between doctors and nurses, between nurses and domestics and between ward staff and external staff. The function of the trained nurse they found "is not, in the main to nurse the patient herself, but to see that he is nursed" (ibid., 1953:134). And with staff shortages, differential availability of workers of different grades and the constant passing through the ward of trainees who constituted

an important part of the labour force, this job was an extremely complex and wearing one. Much of this account applied equally to the staff nurse. As the only other trained nurse on the ward she would deputise for the sister, and as such had no work of her own. The job would seem to offer, as the Nuffield Study put it "neither the satisfaction of bedside nursing, nor executive responsibility" (ibid., 1953:138, see also Dan Mason Nursing Research Committee, 1960). In a sense this was the pattern of the 1930s writ large. The administrative role for the sister was expanding and the staff nurse position remained the unsatisfactory staging post it had been before. Shortages still abounded and untrained nurses were still prominent, for the workload of the hospital was intensifying. Nurses still had overlapping and routinised work roles, despite the change of employer. What was new was the pressure on the matron and the felt need to develop consultation machinery at all levels.

What did the NHS mean for nursing outside the hospitals? In a word - not much. The NHS structure had skirted around the local authorities and the medical and nursing services which had grown up in them. While the 1946 Act had provided a clear channel of accountability upwards to the Ministry from the hospitals, respecting the autonomy both of GPs and of local authorities, it had left these two sectors of the health service very much to themselves. It had envisaged, for example, that the local authorities would continue as before with their medically supervised services for schoolchildren, mothers and infants etc. Though a ministerial circular in 1947

recommended the appointment of a Chief Nursing Officer, there is no evidence of widespread reorganisation of services. And though local authorities were now authorised to employ their own home nurses, there was no mass abandonment of the services of Queens nurses either.

In practice a great deal of variation continued. Staffing ratios, for example, differed in different authorities, and the degree to which nurses were trained for the various kinds of work they did was variable also. The old residential pattern for Queens nurses was at last breaking down and various ad hoc new solutions were tried (Davis 1955; Leeson 1957). There was considerable debate about new directions of work for the health visitor in the late 1950s, but efforts to link her with the social worker had mixed results and eventually, the idea of attachment to a GP caught on. At least one study highlighted the deleterious consequences of this for preventive work (Gilmore et al., 1974). In the eyes of various commentators, community nursing services, especially in the context of high technology medicine, had become a backwater, bereft of leadership and ideas (Baly 1965; Jefferys 1965; Morton 1978).

What happened in this context to concepts of nursing work and of the nurse in the division of labour? The 1950s and early 1960s were a time when the energies of nurse leaders were directed towards establishing themselves in the hierarchical and hospital oriented framework of the NHS and ensuring that a nursing voice was heard. This meant that the existing tendency to think of nursing work as staffing the hospitals became even more firmly entrenched. The

Rcn is a case in point. In the 1920s and 30s it had gained some representation on various bodies and sometimes succeeded in getting a nursing viewpoint heard. The war experience, however, and particularly the setting up of the NHS revealed that consultation rights were by no means fully established, and restructurings within the Rcn can be seen as efforts to secure influence in the NHS. Its previous exclusiveness altered and it began to embrace more grades and types of nurse.<sup>9</sup> It also took steps to strengthen its administrator component, setting up a new section in 1959. Whether it was still elitist, whether the changes incorporated the Rcn, making it impossible to raise real challenges to the directions of development are interesting questions; the point here, however, is that, by trying to meet the Ministry on its own ground and to find a place in the echelons of decision-making, it was confirming the equation of nursing work with hospital staffing, and underlining the notion of the trained nurse as a manager and administrator rather than as a practitioner.

The early years of the NHS were perhaps inevitably quiescent, with no groups prepared to give it a hard and critical look.<sup>10</sup> When the Rcn did turn its attention to the organisation of nursing work in 1964 its recommendations were for an extended hierarchy and the specification not of nursing practice roles but of managerial ones. It is sometimes not appreciated that the so-called Salmon structure in nursing was not, in its first manifestation, a state initiative but a set of ideas advocated by nurses in the Rcn. (Rcn 1964; Ministry of Health 1966). In 1964 the Rcn had a two-pronged policy-reform of nurse management and reform of nurse education, but it was the former that the government took up. Having produced an extended hierarchy in the hospitals, rather predictably perhaps this was then applied to the community setting

via the Mayston Report (DHSS 1969). In neither case did the enquiry extend below what was seen as the first level of management, so in neither case was the work of the trained nurse as such discussed (Davies, forthcoming, b).

Nurse leaders it seemed had judged that the urgent problem was to integrate themselves more securely in the NHS. The government of the day was ready to accept this in the 1960s and it became part of a general management emphasis which permeated the health service and beyond (Carpenter 1977; Heywood and Alasewski 1980). Later some nurses were to question what had happened. It was to become apparent how one-sided the emphasis was, especially when changes in nurse education were postponed. Nurses turned to the US for ideas to counter or at least to balance managerialism. They found all kinds of notions about expanded and extended roles and about independent practitioners. We now turn to the development of these ideas and to exploring the context in which they arose.

By the 1930s and 1940s in the US, with the public health base we have described earlier, ideas about a more independent nursing practice were beginning to become apparent in the nursing organisations. There were new ideas in fields such as mental nursing, orthopaedic nursing and public health nursing (Roberts 1954: sections 6 and 7). In 1945 the NLNE embarked on preparing documents on 'clinical nursing' for graduate nurses. It argued that there was a distinct body of advanced clinical nursing knowledge and that it was appropriate to create clinical nursing specialists (AJN 1951:392). In the public health sphere the NOPHN in 1949 had reviewed and deleted terms such as 'help' and 'assist' from its definitions of public health nursing

arguing that the nurse was a "provider of nursing care and health guidance", a "collaborator in studying, planning and putting community health programs into action" and a "participator in educational programs" for various groups (Fitzpatrick 1975:185-6).

But the time was not ripe in the 1950s to pursue this. A major restructuring of nursing organisations was under way. Much research activity began to be started both in the hospitals and in public health, yet in terms of action, it was a quiescent period rather than one in which new programmes were tried with vigour and zeal.

The hospitals, of course, had no centralised administrative machinery to compare with Britain, so issues of representation did not detain nurses in the same way. But the situation of nurses was not a happy one and it bore unmistakable signs of its unfortunate and precipitous birth circumstances. The overwhelming impression gained by Esther Brown for her study in 1948 was of so many "who had become tired and frustrated because they had been little more than hands and feet in constant motion" (Brown 1948:53). She found that the nursing service was often being run on authoritarian lines with little scope for, as well as little time for initiatives in patient care. But nurse administrator authoritarianism was not the whole of it. The nursing service was caught between medical authority and hospital authority and was still trying to satisfy both (ibid.:46). Later, in the 1950s, when a considerable number of research studies became available, they revealed a picture similar to that in Britain. Nurses were being used for clerical work and for domestic work (Abdellah and Levine 1954); hospitals showed dramatic differences in staffing for apparently similar work, thus suggesting that job boundaries overlapped (Levine 1961, 1969).

Work allocation was carried out according to fragmented principles and differential attitudes among nurses were still prevalent (Burling et al., 1956; Hughes 1958; Habenstein and Christ 1955).

It seems, in short, that the majority of hospital nurses were still working in a hierarchical and routinised structure with little scope for the expression of autonomy. And the focus too was on hospitals rather than public health. It was the hospital sector with its promise of high technology innovations and of course its more stable funding base<sup>11</sup> which was drawing most public attention.

It was not until around 1962 that the pace of new ideas really began to quicken. At the ANA convention of that year, a resolution was passed concerning the development of nursing skills which faced the need to work with doctors in effecting a readjustment. This was the first step in a process which was to culminate in a series of successful joint conferences between nurses and doctors - renegotiating boundaries.<sup>12</sup> At the same convention some 21 clinical sessions were held. The papers were explained as ones which derived directly from the practice of a professional nurse, and presented findings from nursing research. Clinical nursing was thus being promoted via the discussion of specific examples. In 1966 books were published covering explorations in clinical practice in each of six clinical nursing areas (namely community health, geriatrics, maternal, and child health, medicine and surgery, psychiatry and mental health).

A parallel set of clinical divisions in the ANA was established to forward certification and the recognition of clinical skills. The NLN moved in similar directions. In 1960, it had set up a committee to review future developments. Reporting in 1965, it referred to a growing conviction that nursing was no longer the handmaiden of medicine when the needs of patients are considered (NLN 1965: 7) and noted a number of

trends strengthening and developing a greater nursing independence. One of these was growing patient power; therapies were less debilitating, active patient co-operation was required and nurses needed to develop skills of working 'with' not 'for' patients . Another was the development of new health care facilities and the opportunities these gave for involvement, planning and for the introduction of new expanded health care roles for nurses. The report referred to nurses now being comfortable with the idea of a 'nursing diagnosis' and with a range of tasks which 25 years previously had been the doctor's prerogative. (A list of 24 was compiled). It foresaw a constant realignment of boundaries in the future and argued that this necessitated the learning of skills for independent action for nurses, the development of the concept of patient care as opposed to medical care and, so that discussions and boundary alterations with doctors could more easily occur, some closer links and some joint courses for students in the two professions.

Writing in 1971 Brown was able to cite a whole range of examples of more independent nursing practice, even in the older setting of the hospital. She argued that the release of nurses from non-nursing duties was one of the "most vigorous and successful trends" (1971:65); she was able to observe instances in which new work was being assigned to the practical nurse (e.g. as a medication technician), and where the head nurse role had been eliminated in favour of smaller teams with stable patient group assignment under the direction of a clinical nurse specialist, who formulated a care plan for the patients in her group and acted as a consultant and teacher. A generic professional nurse role, she felt, was here replacing the older technical/managerial

and administrative/supervisory ones. She found other new roles too - there were liaison nurses, sometimes trained public health nurses forming a link between hospital and community. Hospitals, she argued, still had too few nurses with other than a technical preparation, and requirements for narrow technical skills (e.g. in an intensive care setting) were still detracting from an effort to develop professional nursing. Even so, examples of new roles were there to be described.

In the community field there were new programmes too. Public health nurses were increasingly involved especially in the paediatric and obstetric fields as nurse practitioners. (Andrews and Yankover 1973; Mereness 1973). At the end of the 1960s in California there were ten Local Health Departments, and one county department with extended nurse roles in child health. Such work was also sometimes found in private practice, and in prepaid insurance scheme agencies too (Browning and Lewis 1973). And there are some papers showing that nurses had set up in independent practice either singly or in groups (Kinlein 1973, Agree 1973; Greenidge 1973). Furthermore, writers have suggested that nurses could sometimes find scope in commercially-run nursing homes, with 'social' rather than 'medical' facilities. This was a sector which had expanded at a rate of about 10% p.a. in the 1960s (Bonnet 1972:122, see also Brown 1971).

Events of the late '60s and early 70s were to show how tenuous and unestablished the basis for this new work was. Some doctors in private practice had extended the work of the nurse, but others had given her clerical and/or technical duties to do. Either way, she was in the position of employee. Public health and hospital nurses remained employees whose employers tacitly recognised the new work they were doing or gave it some minimal recognition by issuing medical and

nursing joint practice statements and an AMA/ANA Commission on this has been set up (Notter & Spalding 1976:61). But nurses were brought to court by doctors for practising medicine (see Kelly 1974), and opposition from the medical profession also resulted in the creation and implementation of a new health role under direct medical control - the physician's assistant. Nurses were not consulted about this. We should note that it was especially when nurses tried to legitimise their newfound autonomy via legal institutions that opposition mounted. The end of our period saw them engaged in battles to get independent nursing practice recognised in a less grace and favour way. By and large, they failed in this; they became angry as a result of these experiences (see Driscoll 1973; Kelly 1974; Bullough 1975). No comparable anger, and no comparable aspirations were to be found in Britain.

What was the basis for all this activity and why does it provide so striking a contrast with Britain? The answer or at least part of it, lies in the vagaries of an essentially market-based health care system, the twists and turns it has taken in the context of economic, political and social changes in the USA, and the opportunities this offers for varied work experience for nurses.

In the immediate sense, the pattern of short-life health programmes, made available in the 1960s was probably a galvanising factor. Why the 'Great Society' welfare programme was introduced at that point, what impact it had on unrest amongst blacks and the poor are not matters for discussion here (see Piven and Cloward 1972; Marris and Rein 1967; Levitan 1969). What is important is that the various measures did represent efforts to create new kinds of services and a new division of labour. Neighborhood Health Centers (NHCs)

made possible by funding under the 1964 Economic Opportunity Act, drew inspiration from developing countries where the unavailability of highly trained doctors prompted innovative solutions - though in practice results were mixed.<sup>13</sup> The Social Security Amendments of 1965, introducing Medicare and Medicaid, together with the Comprehensive Health Planning and Public Health Service Amendments of 1966 gave scope too for certain expansions and extensions of nurse roles - especially in settings outside the hospital for care of the elderly (see Wilson and Neuhauser 1974).

Yet clearly these programmes of the 1960s were part of a health care system oriented overall in a different way from the British one. Looking back over this Chapter, we have seen how, in the American case, the hospitals, under one set of economic circumstances, welcomed student nurses and ejected trained nurses, and, under other circumstances offered the latter a place. No such sudden and new influx of trained nurses occurred in British hospitals and there was no comparable base for dissatisfaction to grow. We have also seen how the organisation of public health work took on a very different form. Doctors were involved to a greater extent in Britain, and ratepayers kept a wary eye on expenditures whereas in the US a variety of interests came together in a vigorous inter-war voluntary movement. Whether this gave better service is a moot point, what it did do was to allow new ideas to be tried, on a temporary and highly local basis. American nurses did not have a centralised and hierarchical structure to face if they wanted to effect changes; what they had to do instead was to harness support for an experiment, try it out and hope thence to persuade. The pressure to create a managerial hierarchy was absent, and in its absence ideas about nursing work went in a different direction.

British nurses have been more hospital-centred than their American counterparts in two senses. First, they have been more continuously encapsulated in the hospitals as places of work; secondly, they have had to adapt to the NHS, itself largely a programme for hospital care. Undoubtedly, there is more to it than this. Although the hospital, for example, implies a particular set of relations with doctors, nonetheless it would be useful to consider the interests of the doctors in nursing and nursing work and to compare this over time in the two countries. Enough has been said, however, to suggest that the concepts of the nurse and her work do vary in ways worthy of study, and do seem to be related to their context. This is a dimension until now little studied in the research tradition of the sociology of professions with which we started.

NOTES

1. This organisation was set up in 1890 and made possible by the Queen's decision to devote a large part of the Women's Jubilee Offering to this cause. Later its name was changed to the Queen's Institute of District Nursing (QIDN). For details, see Stocks (1960). I refer to it throughout as the Queen's Institute.
2. Florence Lees (Mrs. Dacre Craven) wrote a textbook for District Nurses (Lees 1890); later she was to describe the work for an audience of American nurses thus: "the nurse clearly dusts the room, arranges for its proper ventilation and temperature, washes all utensils, dirty glasses, etc., and when necessary disinfects utensils and drains, sweeps up the fireplace, fetches fresh water and fills the kettle, and, if there is no-one else to do it, prepares and makes what nourishment is required for her patient" (Dacre Craven 1893).
3. I am somewhat glossing over here the different financial bases of hospitals - be they charity funded, commercial etc. The argument does seem to be that commercial principles were strong whatever the exact funding base (see e.g. Rosner 1979), but the whole matter needs more investigation.
4. The position on payment of medical staff in the 20s and 30s was varied, confused and a matter of considerable debate. In the original poor law infirmaries (and the isolation hospitals and mental hospitals) full-time medical officers were employed. By around 1930, payment (sometimes substantial) was being given to consultants from the voluntary hospitals to offer a few hours specialist work per week (Abel-Smith 1960: 375-6). In the voluntary hospitals, the tradition of paying small honoraria to medical staff was meeting with difficulty. Traditionally, these doctors had made their money in private practice and the hospital was for the poor. Now, however, with paying patients, the whole system was in disarray (Abel-Smith 1960:309ff). The important point to note for this argument, however, is that suggestions that GPs had open access to bring their patients into the hospitals were rarely taken up and the concept of a limited hospital medical staff as such (albeit with private work too) seemed secure in Britain.
5. An argument is emerging, however, that, despite hardships, there was a considerable expansion of hospitals in the depression, more than in Britain (D. Fox personal communication). The general argument that economic forces led nurses back to the hospitals would still stand, of course, whatever the precise comparative position of American hospitals in this period.

6. Abel-Smith summarises as follows: "the remarkable growth of the voluntary hospitals during the interwar years gave confidence to all those associated with them. By introducing contributory schemes, provident schemes and paybeds, the movement appeared to have taken on a new lease of life" (Abel-Smith 1964:405). Some of the poor law hospitals now taken over by the local authorities, expanded their acute medical care work.
7. Differential rates of pay in voluntary and local authority hospital reflected problems of recruitment (Abel-Smith 1960:121); staff composition also differed as between the types of hospitals (ibid:Appendix 2).
8. These issues emerged rapidly with the implementation of the NHS. For early case studies of the matron's power and a discussion of specialised functional managers, see Acton Society Trust (1955-9), especially pamphlet No.2. See also the report by the Central Health Services Council (1954).
9. A number of developments are relevant here. They include the amalgamation of the Rcn with the National Council of Nurses, and the amendments to the Charter of the College in 1958 - which meant that for the first time nurses on other than the general part of the register became eligible for full membership. Further changes in the Charter in 1966 allowed the possibility for enrolled nurses and student nurses to become full members, and the whole pattern of communication with the membership became a matter for study and review.
10. Early concern in fact centred around costs and a committee of enquiry was set up in 1951. The Guillebaud Committee rejected the idea of radical reform, arguing that it was too early (Ministry of Health 1956).
11. The development of hospital insurance schemes especially Blue Cross, by the hospital associations and Blue Shield by the doctors began in the 1940s. For discussion see Stevens (1971:268ff) and compare Ehrenreich and Ehrenreich (1970).
12. Detailed reports of these conferences arranged between the ANA and AMA in 1964, 1965 and 1967 are available, see American Nurses' Association and American Medical Association (1964, 1965); American Medical Association and American Nurses' Association (1967).
13. For a good discussion of the socio-political environment of NHC see May et al. (1980). For interest displayed by organisational analysts see Wise et al. (1974), and Tichy (1977).

CHAPTER SEVENNURSING KNOWLEDGE: COMPARING CURRICULA<sup>1</sup>

New ideas about nursing work are taken up and developed when the setting is conducive to them. This was the argument of the last chapter. But people must be ready to take up new ideas too. I want to argue in this chapter that there have been differences in the socialisation of the nurse in Britain and the USA which are likely to have played a part. What I cannot do, given the kinds of materials collected in this project, is to trace the rich interplay of individual and situational factors which make up the process of identity-creation for the nurse. This is the strength of the empirical studies of student cohorts so admirably analysed by writers such as Oleson and Whitaker (1968) and Simpson (1979), and of the work by Bucher and Stelling (1977), which, while not about nurses specifically, synthesises and takes forward theoretically the interactionist framework which informs these studies. What I can do is to make some observations at a more global level.<sup>2</sup> I shall focus on the structure and content of the Curriculum in Britain and the USA. Taking some of its implications for individuals as given, I shall attend to wider factors which might be said to conduce to a different pattern of Curriculum development.

The analysis will remain at a rather formal level. No attempt will be made to study the actual operation of a specific school curriculum, or to link individuals to their experiences of different Curricula. The focus is on nationwide, formal Curricula in the period of the 1920s and 1930s. The choice is dictated by the material in the sense that this is the only time when there were two, nationwide Curricula to be compared. In the British case, the GNC's statutory Curriculum came into effect in 1926 and remained unaltered until 1952. In the American case, the NLNE published a Curriculum Guide in 1917 (with revisions in 1927 and 1937). This latter had an advisory status only.

It was probably beyond the means and the resources of most schools to implement the American Curriculum Guide, and estimates suggest that around a quarter of schools were able to approach it.<sup>3</sup> Strictly speaking, then, the two are not comparable; the one is a compulsory Curriculum, the other something to which schools might aspire. But for our purpose it is justified to compare them, for they can be seen as representing taken-for-granted ways of thinking about nursing. In the American case, to be sure, these ways were only taken for granted by a few - but they were the influential few.

There are surprisingly few models of how to proceed with a Curriculum analysis, and I have opted to use some part of the ideas of Bernstein (1971, 1975) on the 'classification' of educational knowledge as the analytical basis for this Chapter. The attraction of Bernstein's work lies in his insistence that there are certain structuring principles embedded in the presentation of educational knowledge which relate on the one hand to the social context of its production and on the other to forms of consciousness and self-images of participants. The choice, however, is not without its difficulties. In the first place, few empirical applications of his ideas are available (King 1976; Milsom et al., 1976), to my knowledge, his framework has only once been used in a sustained way in relation to professional knowledge (Musgrove 1973, but see also Armstrong 1977). In the second place, the analysis has provoked considerable theoretical criticism (see, e.g. Gibson 1977; Pring 1975) and perhaps retains a number of crucial ambiguities. It is not the aim here, however, to attempt an evaluation of Bernstein as such, rather to use some of his ideas to illuminate the problem at hand. No such evaluation then should be inferred from this Chapter, in important part because I have used only one of his two key ideas - 'classification' but not 'framing'.<sup>4</sup> A brief exposition of this part of Bernstein's approach is necessary before we proceed.

### Bernstein on the Curriculum

Bernstein deals with the form of the Curriculum, of pedagogy and of evaluation. Underlying his conceptual language is the key organising idea of boundary. First, the boundaries between various contents to be transmitted may be strong - each set of content discrete, closed and well insulated from others. This, as a way of encoding education, is referred to as strong classification, and gives rise to a Curriculum of a collection sort. Further distinctions are built upon this basic idea. The strongly classified Curriculum (collection code) may itself be of several types. It may be more or less specialised, according to the number of discrete contents covered. And these discrete contents may be drawn from a common universe of knowledge or from different ones, thus yielding a pure or impure collection. Where the collection is non-specialised, it may be discipline-based or course-based depending on whether subject or course is the basic unit. There are certain difficulties associated with these distinctions which one cannot altogether ignore for the purposes of empirical work (see Davies 1980a), nonetheless the major point to grasp is that all of these variations represent points at one end of a spectrum from collection Curricula to integrated Curricula. Integration Bernstein defines as the subordination of previously insulated subjects or courses, to some relational idea which blurs the boundary between the subjects (Bernstein, 1971:53).

Of crucial importance for this Chapter are features of the identity, commitment and social relations of teachers and learners, which Bernstein regards as associated respectively with collection and integrated codes and the types of knowledge they produce. The strongly bounded classification of a collection code means that the

learning experience is rigorously structured, with an emphasis at each stage on a state of knowledge not a way of knowing. It separates teacher and taught. The knowledge gained is property and learners stand in a competitive relation to each other in respect of it; it is alien knowledge from which the learner is distanced as a person. Furthermore, such a structure reveals its 'ultimate mystery' late in the socialisation process; few come to experience the provisional quality of knowledge and few are in a position to create new knowledge or transcend its terms of reference. Teachers can be heterogeneous, and they can be mediocre; they do not need to co-operate with each other or to enter into a consideration of the knowledge to be transmitted in a deeply challenging but rather a ritual way. An integrated code by contrast requires teachers of an exceptional ability to transcend their own socialisation and subordinate it to the new relational idea. It requires a strong moral consensus on the worth of that relational idea and flexible and participatory organisational forms and social relations. It is more involving and more challenging for all. Propositions such as these are designed to make good Bernstein's claim that "principles of power and control are realised through codes and via codes shape consciousness". (Bernstein 1971:54).

The next part of this Chapter will be concerned with the application of these ideas to the case of nursing, its Curriculum and pedagogy in Britain and the USA. Thereafter we shall consider the context for different Curriculum structures and some of the features associated with this. For convenience, the GNC Syllabus

of 1926 and the 1917 American Curriculum Guide are printed in full at the end of this Chapter pp.190-94) since reference will need to be made to them throughout. The 1926 GNC Syllabus (see p.189ff) is represented as covering eight core subject areas. A preliminary examination covered anatomy, physiology and hygiene; it also dealt with first aid and with the first part of a course entitled 'Theory and Practice of Nursing'. The final examination comprised the more advanced part of the nursing course, together with materia medica, medical nursing, surgical nursing and gynaecology.

Bernstein's classification terminology can be immediately applied in reference to these course headings. The Syllabus is clearly more of a collection type than an integrated one. Knowledge, that is to say, is not subordinated to a relational idea, instead boundaries between subject-matters seem firm. Furthermore, it has the appearance of a relatively pure collection, drawing apparently from medicine and related basic disciplines. It is also almost, one might say, a collection from other collections since the various sets of contents (nursing excepted) each represents a specialist area of enquiry for others. But we can also explore the form of the Curriculum in rather more depth.

At first sight, it might seem that courses entitled 'medical nursing' and 'surgical nursing' represent an integration (albeit an intra-boundary one) subordinating disciplinary knowledge to a relational idea of nursing. In practice they do not do so at all. The topic-headings make this clear, dealing as they do with 'diseases of' various organs, with 'common surgical affections'

etc. Additional information provided for a special enquiry in 1932 (Lancet, 1932) revealed that the examination papers at that time were actually entitled 'Medicine and Medical Nursing' and 'Surgery and Surgical Nursing', and a perusal of some of the questions set served to eliminate any further doubt. Nurses were being taught medicine; the questions were often indistinguishable from those put to a medical student. The difference was that the nurse had far fewer learning resources, and she was being taught elementary medicine.

Comments such as these, we might note, are not strictly permissible on Bernstein's definition of classification, since they are intra-boundary observations. They nonetheless serve to uphold the argument that the overall form of this Curriculum is a collection one. We can make certain other intra-boundary observations which refer to form rather than content, however, and these suggest not just that intra-boundary data are necessary but that some conceptual expansion might be in order.

Consider the course entitled 'Theory and Practice of Nursing'. In the first place, there is a strong practical bias, as the title implies. A brief examination of the content reveals 'doing' verbs, not 'understanding' verbs, an emphasis on procedures and skills rather than on rationales and explanations - not 'why?' but 'how?' In the second place, the items seem neither to be drawn from the same universe nor very smoothly to progress (from simple to complex, from basic knowledge to knowledge for which the basics are a prerequisite), although there are some elements of such a sequential logic involved.

This course reads as the residuum it is, the jobs which the doctors will not handle and which at this point have not been parcelled out to other groups. We are dealing here more with a socially prescribed universe of practice than a socially prescribed universe of knowledge. And this practice is hospital work.

On a rather different point we may ask about the nature of the universe of knowledge from which nursing here draws. This universe is medicine. Taking from anatomy, for example, is just as much taking 'from medicine' as is taking from surgery, since both are part of the medical curriculum. David Armstrong (1977) has made the important and valuable suggestion that the medical curriculum in Bernstein's sense is a collection code in its preclinical years and an integrated code in the clinical ones, with clinical medicine integrated around the idea of disease. Once we appreciate this we are in a position to observe not just that nursing knowledge has an elementary form, but that it has a derivative form; it is here aping the overall form of the medical curriculum and dominated by the medical integrating idea of disease. These observations stem from a further 'stretching' of Bernstein's argument this time in order to subject the notion of 'universes of knowledge' to scrutiny. In the nursing case the universe of knowledge has already been redrawn in an integrated form and nursing is collecting not from collections but from an integration.

Let us turn now to material from the USA, and consider the principles of classification, understood in this now broadened sense, as embedded in the 1917 NLNE Curriculum Guide. We must remember, of course, as noted earlier, that this is not an enforceable Curriculum, but a guide to good practice.

A glance at the course headings here suggests again a collection Curriculum but an impure collection. The overall Curriculum, that is to say, draws from a wider range of subjects. As in Britain, general sciences are represented, but household sciences and disease prevention are additional features. Furthermore, the amalgam of social science topics and fields of nursing practice has no counterpart in the British version. Most interesting of all is the point that the clinical subjects do not have space of their own. They have been assimilated to a heading of 'Nursing and Disease', a course treated, as we shall see, very differently from the 'Theory and Practice of Nursing' discussed above.

One of the essential differences here seems to be that the universes of knowledge from which nursing has drawn are themselves conceived differently from in Britain. Household science and disease prevention are regarded in the USA as established disciplines providing a distinct stream of learning for the nurse; in the British case elements of each are to be found, but found under the more practical heading of nursing and taught as skills or procedures not as bodies of knowledge. The heading of social and professional subjects represents a less certain identification of other relevant subject-matters; it is interesting that by 1937 this has become the contribution from social sciences, identifying much more clearly sociological and historical components. American nurses were much less reliant, it would seem from these data, on the particular collections and integrations which represented medical knowledge, they were casting the net more widely and not treating medicine per se as the only salient universe.

This, of course, necessarily has implications for what is conceived as the core nursing element of the Curriculum. Two points are worthy of note. First, since much of what is included in the British Curriculum is seen in the U.S. one as deriving from distinct disciplines there is much less of a practical and residual air about the whole U.S. Curriculum. Secondly, as the very title of the course itself implies, the integrating idea of disease is explicit rather than implicit - it is nursing 'and' disease, not nursing 'in' disease. This point is surely relevant to the shifts apparent in the later versions, where we find the disease emphasis being challenged and a stress, for example on the normal growth and development of the child under the heading of paediatric nursing and a stronger emphasis on elements of public health as a part of the basic programme for every nurse (NLNE 1927, 1937).

A glance at the more detailed recommendations for the various specialised nursing courses, reveals that the authors of the Curriculum were clearly avoiding the elementary medicine format. They aimed to provide an integrated nursing view within disease specialisations. Thus, for each class of courses, be they surgery, obstetrics or whatever, the material is arranged to provide coverage of three aspects - the medical, the nursing and the social. The physical causes of disease, they explained, had been stressed at the expense of the social and economic conditions which so often lie at the heart of the presenting disease problem. The intra-content classification was not presented as a strictly sequential programme of learning nor did it have a residual and practical bias. In relation to each topic what was advocated was a relativist approach, setting out

competing or complementary paradigms, rather than allowing the dominance of any one. The course 'nursing in disease' then was neither discipline-dependent nor strictly integrated around a substantive relational idea. It was designed to show the contributions of different approaches and apparently was to make the nurse eclectic in her use of all of them. This seems to be a possibility Bernstein has ignored in his analysis.

If then, the structuring of material in the nursing curriculum differed in the ways suggested above, what implications was this likely to have for the characteristic modes of thinking and acting of the nurse? This, it will be recalled, was a key feature of Bernstein's analysis. The British nursing curriculum, which we have characterised as a collection, will distance the teachers from the taught rather than involving them together in a learning process. Teaching will be formal and ritualistic with learners experiencing the knowledge to be gained as alienated from them. They will emerge from the learning process with knowledge as an acquisition but without the sense that they themselves could begin to add to knowledge in a creative way, challenge it or transcend it. Such observations seem to fit well with a situation where nurse teachers have an uneasy place in mediating medically based knowledge to nurse learners and perhaps personally feel something of the alienation of the learners themselves. Setting these relations of training inscribed in the structure of the learning process inside the hierarchical relations of the hospital itself, we can begin to understand how an essentially humble and deferential nurse is produced. It is not just that she is subject to hierarchical behaviour on the part of doctors and other

nurses - she also learns that her competence is insecure and inferior and learns this by the very way in which her own special knowledge is transmitted to her.

If this is one example of how "codes shape consciousness", what of the codes and consciousness in the NLNE Curriculum? A fully integrated code, we have noted, is linked with a more participatory form of learning, and requires exceptional abilities on the part of teachers who are required to transcend their own socialisation and work to a new relational idea. But the argument above has suggested that the NLNE Curricula although moving that way, were not fully integrated. Instead of subordinating different types of knowledge to an integrating idea, they appeared deliberately to juxtapose knowledge from within different paradigms. It is perhaps plausible to suggest that the effect of such a code will be to provoke greater confidence in the nurse that knowledge is there to be selected and used as appropriate, that she should be instrumental in her attitude to it, challenging it where a challenge appears justified and perhaps even taking the view that available knowledge and techniques are deficient in some areas and need developing. It seems that there is more of a basis here than under the collection code, for nurses to come in the long run to feel that none of the existing paradigms is sufficient, that they must do more than juxtapose them and they must, in the end, build an integration of their own. Again, we can see how principles of power and control, different ones this time, are written into the learning process. And we can begin to see too that in addition to the 'space provided' by the health care system itself for implementing differential ideas about nursing (discussed in Chapter Six) there are aspects of the training of a nurse which are important too.

The British pattern described here is consistent with material in earlier chapters. We have seen that, with the opening of the schools, minimal resources were devoted to nurse education, nursing education was an on-the-job training and there was no contingent of teachers and researchers developing nursing knowledge as such. It was at hospital level that questions of what was taught, how and by whom were determined. Small wonder, then, that the Curriculum took the form and indeed the content that it did. The universe of discourse from which the Curriculum drew was that immediately available in the hospital - clinical medicine. Medical staffs could hardly be expected to provide other than an elementary rendering of their own specialisms, together with details of the practical nursing care which they required nurses to perform. The so-called 'school' borrowed from what was already there - in no way did it provide a space within which an integrated code of nursing knowledge could grow. And the arrival of the GNC, as we have argued in detail in Chapter Five, did not herald a major change. Nurse training remained in the hospitals, no resources were allocated to allow a contingent of educators to grow, and the Syllabus, not surprisingly, drew on what was already being practised. The creation of the GNC crystallised, ossified even, a pattern of nurse training which was already a tradition in British hospitals.

What, then, was the basis for the NLNE nursing curriculum? Again, the link can be drawn with material in Chapter Five. American nursing schools, like British ones, began with few resources to devote to developing nursing knowledge as such. But a group of superintendents of schools was formed and became not only a forum for discussing

ideas but also the basis from which, as described in Chapter Five, pressure was put on Teachers College to establish first some courses and later a Department of Nursing. The NLNE (which grew out of the Superintendents Society) together with the Teachers College group provided enough of a stimulus to get curriculum discussions going. The Curriculum guide was just that - it was implemented, as we have noted, in probably less than a quarter of schools in the 1930s and 1940s - but it set the pace, and its ideas were widely publicised. But, if American nursing could not boast an entirely different system of schools, or the annexation of considerably more resources and control over nurse education, what was it that enabled these developments to take place? Two factors need discussion, both to do with the context in which nurses operated, and the choices they made within that context.

First, the American educational system has always operated in a more 'open' way than the British. Rigid selection and segregation of different streams of learning is much less important. Routes for learning are many and varied; the individual is encouraged to build a mixture of courses suitable for her own advancement and flexible entry and multiple course choices reflects this. In the higher echelons of learning, rigid distinctions between what is 'pure' and what is 'applied' are not drawn, the vocational and the practical are not terms which isolate some kinds of subject matter as less respectable and as unfit for the curriculum of elite educational organisations. The universities have seen more merit in being responsive to community needs than in maintaining a specific level of educational standard. American universities in the interwar period put on courses for journalists, social workers and so on; they

covered skills in hotel management, librarianship, gymnastics and even clogdancing. They had as one commentator put it "excessively catered to fleeting, transient and immediate needs" (Flexner, 1930:44)

It was this that made it thinkable in the U.S., in a way it was not thinkable in the U.K., for nurses to knock on the doors of universities and to establish courses within their walls. This was not achieved without difficulty, but it meant, especially in the department at Teachers College, an embryonic educational segment, something not matched in the U.K. at all. The Teachers College base not only provided a key resource for Curriculum development in terms of nursing personnel - much of the Curriculum work for the handbooks was done by the staff and students - it provided too, a fund of other advisors and helpers from fields of education, psychology, philosophy, etc.<sup>5</sup> We can already begin to see how it was that the NLNE Curriculum could draw from such diverse educational discourses and could begin to emancipate itself from medical dominance.

Another set of reasons why such novel ideas could be propagated has to do with the strategies of nurse leaders. They were not concerned as were their British counterparts, to implement a standard Curriculum nationwide. They remained content with smallscale and piecemeal change and tolerated variability. Here we must look to political institutions and their distinctive character; for a suspicion of federal intervention and a respect for local autonomy had led nurses, like many other occupational groups at the same time (Gilb, 1966) to seek recognition on a state by state, not a nationwide basis.

National nursing organisations endorsed a strategy of improvement little by little. Instead of seeking to impose a minimum (the British strategy) they brought together the 'best' experience, published a Curriculum handbook as a target at which groups of nurses could aim. The professional organisations, in other words, tried to set the pace.

Now both the presence of variability of practice and the acceptance of variability aided the nurses in their cause in the NLNE. The first was a help because new ideas could emerge from or be tried out in contexts favourable and supportive to nurses. What they suggested was thus a Curriculum which was workable given maximum support. At the same time, everyone was clear that it was not feasible everywhere and in this it was a spur not a criticism. It did not have the threatening implications of a standard Curriculum and it did not cause bitter controversy. In this sense too then the American context was a more amenable one for developing new ideas.

We have now considered two sets of ideas of the nurse - the way in which nursing work is conceptualised and the way in which nursing knowledge is put to the novitiate. In each case I have tried to link those ideas to their social context, arguing that the way nurses see themselves in the division of labour will be affected by the institutions and values to which they relate. I now turn to the final empirical Chapter - looking more directly at the worldviews of the nurse leadership, the way these have been constituted and some of the implications which have followed.

FOOTNOTES

1. An earlier version of this Chapter was presented at the BSA Medical Sociology Section Conference, Warwick, 1980. Some of the material is also to be found in Davies (1980a);
2. Though it is not a major purpose of this chapter to address it, I am responding here to the argument that studies of socialisation (being interactionist) fail to situate themselves in a wider social structure. My work does not challenge these studies, but rather draws on them and tries to develop them in ways that might help face this criticism.
3. Information is available for around 1930 (Committee on the Grading of Nursing Schools 1930, 1933) and again for 1949 (West and Hawkins 1950).
4. For rather more exposition of Bernstein's idea and some direct discussion of the concepts as such see Davies (1980a).
5. Isla Stewart, for many years at Teachers College has commented specifically on the opportunity it afforded for contacts with figures such as Dewey, and the influence he and others had on the 1937 Curriculum (Christy 1969:91n).

THE 1926 CURRICULUM (England and Wales)

I. ELEMENTARY ANATOMY AND PHYSIOLOGY:

the human body; the skeleton; joints and muscles; blood and circulatory system; respiratory system; digestive system; metabolism; excretory system; endocrine system; nervous system; reproductive system.

II. HYGIENE:

air; water; milk; disposal of refuse; personal hygiene; infection; heating; lighting; hygiene of the ward and sick room.

III. FIRST AID:

haemorrhage - pressure points; fractures; sprains; burns and scalds; poisons - general principles of treatment; loss of consciousness and convulsions; asphyxia - by drowning, by choking, by gas.

IV. THEORY AND PRACTICE OF NURSING:

Part One: ethical aspects; hospital etiquette; domestic ward management (methods of cleaning, care of furniture, care of bedding, linen, blankets, waterproofs, care of kitchen, bathroom, lavatory, sanitary methods of cleaning utensils, baths, lavatories, crockery, mackintoshes, disposal and disinfection of soiled linen, and dressings, etc.); general care of the patient (lifting and turning, bathing, in bed in bathroom, care of backs, hands, feet, head, hair, mouth, teeth); bed making (general, special, for operation, fracture, plaster, amputation, rheumatic, renal and cardiac cases); bed sores; filling of water beds, water and air pillows, hot water bottles; charting, temperature, pulse, respiration; common abbreviations in prescriptions; measuring of lotions and simple drugs; inhalations by steam kettle, inhaler, oxygen apparatus; fomentations, surgical and medical; ice bags; enemas, cleansing and stimulative; excreta, preservation of specimens; requirements for simple ward dressings; cleaning and sterilizing instruments; care and sterilization of catheters; preparing and serving meals; feeding, helpless patients and children; bandaging, splints in common use.

Part Two: extensions, plasters; preparation for rectal and vaginal examination; artificial feeding, test meals; irrigation of bowel, stomach, throat, nose ears and eyes; weights and measures, lotions in ward use; technical terms and abbreviations in common

use; administration of drugs; hypodermic injections; preparation for intravenous and subcutaneous infusions, blood transfusion and venesection; instruments in common use; local applications, hot and cold; counter irritation by poultices, mustard leaves, blisters, cupping, leeches; aspiration, drainage by Southey's tubes, tapping, lumbar puncture; catheterisation, bladder irrigation; baths, sponging, packs, radiant heat, hot air and vapour baths; last offices.

#### V. MATERIA MEDICA AND THERAPEUTICS:

Laxatives, purgatives, anathelmintics, expectorants, emetics, cardiac drugs, antipyretics, diuretics, diaphoretics, sedatives, hyponotics, narcotics, anaesthetics, nerve stimulants; weights and measures; poisons; hypodermic injections; value of the cubic-centimetre, the litre, the gramme.

Dietetics: chemical constituents of foods, and value of special articles of food, such as milk, butter, cheese, eggs, fish, meat, vegetables and fruits, farinaceous foods, alcohol, beverages, condiments; proprietary preparations, their values and dangers; the feeding of infants and children; diet in general disease; diet in special diseases, deficiency diseases, diseases of the blood, stomach, intestines, kidneys, diabetes mellitus, methods of cooking; practical sick-room cookery; beef tea, soup, jelly, junket, whey, albumin water, barley water, egg dishes.

#### VI. MEDICAL NURSING:

Diseases of the blood and organs of circulation; diseases of organs of respiration; diseases of organs of digestion; diseases of urinary organs; diseases of the nervous system; constitutional diseases; diseases of the endocrine system; diseases of the joints; infectious diseases; diseases of the skin.

#### VII. SURGICAL NURSING:

Inflammation; haemorrhage; burns and ulcers; injuries, fractures and dislocations; infection; surgical technique; operating theatre; anaesthetics; common surgical affections; affections of eye, ear, nose, and throat; venereal diseases.

#### VIII. GYNAECOLOGY:

Structure and functions of the ovaries, fallopian tubes, uterus, vagina; disorders of menstruation and menopause; vaginal discharges; inflammation of the genital tract; displacements;

toxaemias of pregnancy; abortion; new growths of ovaries and uterus; preparation of patients for examination; vaginal douche, tampons, plugs, pessaries; instruments in common use; nursing after major and minor operations; antenatal and postnatal care.

Source: General Nursing Council for England and Wales:  
Rules and Schedules to the Rules Framed under the  
Nurses Registration Act, 1919. General Nursing  
Council, 1926 (reprinted 1947).

TABLE 2THE 1917 U.S. CURRICULUMGENERAL SCIENCE:

anatomy and physiology  
 elementary bacteriology  
 applied chemistry  
 elementary pathology

HOUSEHOLD SCIENCE:

nutrition and cookery  
 diet in disease  
 hospital housekeeping  
 home problems of the  
 industrial family\*

DISEASE PREVENTION:

personal hygiene  
 public sanitation

THERAPEUTICS:

drugs and solutions  
 materia medica and  
 therapeutics  
 massage  
 special therapeutics (incl.  
 occupational therapy)

NURSING AND DISEASE:

elementary nursing principles and methods  
 elementary bandaging  
 nursing in medical disease  
 nursing in surgical diseases  
 nursing in communicable diseases  
 nursing in diseases of infants and children (incl. infant feeding)  
 gynaecological nursing  
 orthopedic nursing  
 obstetrical nursing  
 nursing in diseases of the eye, ear, nose and throat  
 nursing in mental and nervous diseases  
 nursing in occupational, venereal and skin diseases  
 operating-room technic  
 emergency nursing and first aid  
 special disease problems (advanced work in any special forms of disease studied  
 above)\*

SOCIAL AND PROFESSIONAL SUBJECTS:

historical, ethical and social basis of nursing  
 elements of psychology  
 principles of ethics  
 survey of the nursing field  
 professional problems  
 modern social conditions

SPECIAL BRANCHES OF NURSING:

Introduction to public health nursing and social service\*  
 Introduction to private nursing\*  
 Introduction to institutional work\*  
 Laboratory technic\*

\*These subjects are elective. Each student to cover at least three.

Source: NLNE Committee on Education: Standard Curriculum for Schools of Nursing (1917).

CHAPTER EIGHTCONTRASTS IN STRATEGIES AND STRUGGLES

In the last two Chapters I have explored how concepts of nursing work and knowledge have developed, relating them to the different settings of Britain and the USA. I have portrayed each country as making available a different set of opportunities for the development of nursing as an occupation and regarded nurses as responding to this by elaborating different understandings of their own position in the division of labour. But in the course of this I have said little about individual leaders or their policies. I have only indirectly alluded to the different ways nurses have organised and the targets of their organised efforts, even though these too were themes which were starting to break through at the end of Part Two. This Chapter attempts to rectify this.

At the outset the concept of strategy appeared to provide an appropriate organising frame. The sceptical theorists had said much that was consistent with a view that occupational groups engage in strategic behaviour. Parry and Parry went so far as to define professionalism as:

"a strategy for controlling an occupation in which colleagues set up a system of self-government and restrict recruitment through control of education, training and the process of qualification" (Parry and Parry 1977:112).

The material of earlier Chapters, however, has cast some doubt on the usefulness of such a definition for the cases of nurses. It became clear in Part Two that nurses did not always strive after the kinds of control listed, and in Part Three we have seen some clear

differences in how nurses have interpreted their position in Britain and the USA. If a concept of strategy was to be of use, it seemed that it would need to be content-free.

I defined occupational strategies as follows: they were to be seen as sets of intentions and actions, purposely designed by leaders and or representatives with a view to institutionalising change in activities and relationships pertaining to the occupation as a whole. There would be a rationale specifying why the change was advantageous and necessary, but no assumption was made that the strategy was always the same. Indeed, shifts in strategy and strategy contrasts would be, no doubt, the very stuff of the analysis.

Two periods have been selected to be compared and contrasted as case studies of occupational strategy in this Chapter. In the first, the early period of nursing reform, the strategy approach seemed to work well. Later, things were less clear. It almost seemed that American nurses had a strategy while British nurses did not. But then doubts emerged as to whether strategy was a helpful concept or a misleading one.

#### 1. Separate Strategies

Nursing reforms in a single hospital, or the separate introduction of a programme of training in one or more settings does not constitute an occupational strategy. A strategy, as I have defined it, only emerges when one or more nurses tries deliberately to transcend the limits of reform in a single setting and to shape the

development of nursing as a whole. This point came earlier in Britain than in the USA, and we have to deal in the British case with not one, but two strategies, associated respectively with the names of Florence Nightingale and Ethel Bedford Fenwick.

Miss Nightingale's strategy can be stated briefly. It was to train a corps of new nurses, to send them out in teams to staff other hospitals and to teach in them, thereby setting an example, proving their worth and hence transforming nursing itself. The key to this was not an immediate transformation of the work to be done but of the character of the women who did it; this was to be achieved by a close specification of the terms and conditions under which they lived and worked. The training school and the nurses' home were the two new devices designed for this. As we shall see below, together they were a solution to the problem of prising women from the home and giving them an acceptable and disciplined place outside it; they were also set up in such a way as minimally to disturb existing social relations in the hospitals in which they were located.

We have had cause to consider the details of the training school at St. Thomas' Hospital in earlier Chapters in the context of exploring the types of nurse recruited and the degree to which resources were allocated to training. It is only necessary then briefly to recapitulate. The recruits to the school were probationers under the watchful eye and rule-making genius of the matron. Their conduct and character was subject to her scrutiny; not only were they supervised in learning procedures for observation and treatment of patients, their appearance, deportment and manners

were attended to also. The remit of their duties was wide; they were to do whatever was necessary for the wellbeing of the patients and the smooth running of the hospital. Their training was essentially practical and they learned on the job. They were to obey doctors' orders and in all else be responsible to a nursing supervisor. The out-of-work life of the probationer was circumscribed by the rules of the nurses' home and the surveillance of the home sister. The plan, in short, was to staff hospitals with a strictly disciplined nurse labour force. The stress in training was on practicalities and character-building. The nurses were to be loyal and obedient to sisters and matron and they were to follow doctors' orders. They were self-denying and hardworking, and Miss Nightingale's close personal interest kept them that way. She invited her nurses to call on her, had long conversations with them and wrote and received an endless stream of letters. She had set the first example, they, under her eye, were to follow.

Let us turn then, to the question of the context in which this strategy was espoused and implemented and the resources Miss Nightingale had at her disposal. At the outset, the situation was not a favourable one, either for Miss Nightingale personally, or for the women she hoped to transform into nurses. The position of bourgeois women in the late 19th century, as is well-known, was firmly contained in the domestic sphere. Some see domestic life in this era as representing a haven of order and humanitarian values in a world characterised by the exploitative relations of laissez-faire capitalism (Zaretsky 1976). Whether or not women had this ideological place, they were certainly economically and politically subordinated to men and largely

confined to the institutional sphere of the family. Modern writers speak of the 'cult of domesticity', 'separate spheres' etc. (Harris 1978; Branca 1974; Davidoff 1978; Vicinus 1972). Women's property rights were severely curtailed, they had little access to education, opportunities in the labour market were few, always assuming that women could leave home, which for any purpose but marriage was exceedingly difficult. Florence Nightingale's own experience bears witness to this; an extraordinarily strongwilled and determined personality, she did not succeed in leaving home until over the age of thirty, and even then was subject to constant reproaches and was strongly enough tied to her family to return at intervals when duty called her to do so (Woodham Smith 1950). To prise women from the home was thus a major problem; even where the values which retained them in a domestic sphere were less secure, in the middle or lower ranks of society, there would be a problem of accommodating and financing persons with the status of dependent. There would be a problem too of investing their activities with legitimacy - legitimacy for the purposes of walking the streets unaccosted, as much as legitimacy for the purposes of obtaining patient compliance and doctor consent to do the work of nursing.

Miss Nightingale's achievements rested, of course, on her ability, but they rested too, on other resources. Financial support from her father and a class position which gave her entree to the best homes in the land and which gave her the ear of prominent political men were crucial. Her work in the Crimea gave her personal status in her own right, and also importantly, the funds to start a school. Yet it is striking how much she still worked through

others and behind the scenes, feeding information and advice through her friends to policy-making settings, both in respect of the voluntary hospitals and in respect of the Poor Law Institutions. Undoubtedly she built a vast knowledge of matters to do with hospitals and nursing, and undoubtedly many came to respect her for this knowledge. But she could not display it openly, and certainly could not hope for recognition in any public position. She received in her home some of the most powerful in the land: there were shades of the 'salon' or even the courtesan in the tactics of manipulation she employed.

The strategy then, arose from and was intimately linked to its context. Yet it still posed problems. It rested on the charismatic properties of a single woman and her close personal association with 'her' nurses. It proceeded in parallel with reforms of varying types in other hospitals (cf Tooley 1906), but it paid no attention to these. It totally ignored the private nurse, practising in the community and the competition she faced from the disreputable and from the untrained. Nightingale nurses undoubtedly had an influence beyond what would be suggested by their numbers, but they were not transforming the whole of nursing or building any kind of a base so to do (see Chapter Four). For these kinds of reasons, the Nightingale strategy was a limited one, and dissatisfaction grew.

Mrs. Bedford Fenwick's activities can be seen in some ways as a direct response to these tensions. She recognised that without a clearly recognised qualification, the trained nurse outside the hospital was in an unhappy position. She could be undercut by the untrained nurse and her reputation could be diminished by the

unsavoury behaviour of some of those who posed as nurses. Even in the hospital, trained nurses often suffered when hospital authorities chose to appoint an untrained matron over them. Furthermore, the standards of some hospitals were appallingly low as far as nurse training was concerned. Mrs. Bedford Fenwick's twin aims of distinguishing firmly between the trained and untrained and of upgrading nurses flowed from these concerns. She came to recommend closure of nursing to the untrained, strict educational requirements for entry and regulation of programmes of training. These were much more ambitious goals to pursue - they involved not demonstration but regularisation, not influence over the few but authoritative control over the many.

In practice, she took different views of how this authority might be lent to the nurses' cause. Through the British Nurses' Association (BNA), a body she was instrumental in creating, she tried, without success, to interest hospitals in forming boards to organise nurse education on a more regular basis; she succeeded in achieving a Royal Charter for the BNA but was thwarted in the aim of enabling it to recognise and register all bona fide nurses. Increasingly she pinned her hopes on Parliament, on statutory recognition for nurses and she looked, with varying results, to doctors to support her in this course.

There were elements of her approach not so far removed from Miss Nightingale's. There was a similar deference to doctors, a similar concern to bring pressure to bear - this time a little more overtly - on the powerful and a similar attention to an elite group of nurses

(though a rather differently constituted one). But her willingness to create organisations was new, and her regard for Parliament as the source of protective legislation for nurses was a new strand too. On the latter point, it is important to point out that there had been a precedent in the Medical Act of 1858, and now teachers, dentists and midwives were among the groups beginning to press for legislation. What was emerging too by the early twentieth century was a new view of the State as justifiably concerned with social issues and as hesitantly taking over some of the tasks of social enquiry and ameliorative social action which had previously lain almost entirely in the voluntary sphere. All this, as we shall see, stands in sharp contrast to the situation in the USA, where both strategy and context were different.

From around the 1870s as we have seen in Chapters Four and Five, nursing schools had begun to spring up in connection with American hospitals. Doctors, nurses and local philanthropists, singly and in combination, were behind them. And, as we noted particularly in Chapters 4 & 5, a pattern quickly became established whereby hospital trustees, attracted by the cheapness of the schools and the tractability of student labour had often taken over the running and financing of the schools. By 1890, then, the problem was no longer of demonstrating the worth of reformed nursing, but of coping with runaway development - and this is where an occupational strategy comes in.

The year 1893 marks the point at which a group of American nurses came together for the purpose of designing organisational

devices which, hopefully, were to alter their collective fate. The personnel included Miss Hampton, Miss Dock and Miss Nutting, who were all to become important leaders of American nursing (see Roberts, 1964). These three had already had ample opportunity to explore issues of nursing organisation, since they were all working at the same hospital at the time. Different sources suggest that they had done much advance planning (Marshall 1972:57, Dock 1912:125-7) and a later associate of these leaders assures us that all of them "knew quite well that important events were in the making" (Hampton 1893:xix). The occasion for unveiling the plans was the nursing section of the Chicago World Fair, 1893, and it was there that an analysis of the situation and the problems slowly unfolded.

Miss Hampton stated what seemed to be the kernel of the problem in her keynote address:

"Each school is a law unto itself. Nothing in the way of unity of ideas or of general principles to govern all exists, and no effort towards establishing and maintaining a general standard for all has ever been attempted" (Hampton 1893:4).

A plan was put forward which involved two organisations. One was worked out in detail immediately. The other, clearly a more innovative step, was unveiled as an idea and left more slowly to penetrate the minds of those present. The first organisation was the Society of Superintendents of Training Schools for Nurses, later to be renamed the National League for Nursing Education (NLNE). The other was the National Associated Alumnae, set up in 1896 and was later to become the American Nurses Association (ANA). Speaking from the chair, Miss Hampton gave a rationale, which is worth setting out in detail:

"Superintendents being the heads of schools have a great deal of influence, not only among their pupils, but over graduate nurses, and until we can get Superintendents united regarding the fundamental principles of the work, we cannot expect the nurses to work and to unite and to be as successful as they must be later when we hold ideas in common. The next thing we can take steps towards accomplishing is to organise a Superintendents' society and also alumnae associations in connection with every good school in the country. The alumnae associations should be as nearly alike as possible ... I do not think superintendents should take too active a part ... Until these alumnae associations are in good working order it will be impossible to organise a national association because in that we must have schools and hospitals and nurses represented ..."  
 (ibid.: 158).

In a particularly interesting paper, Miss Darche gave added point to the idea of Society by reference to how improvement had been made in the nursing care in British hospitals, and to the distinctiveness of the American pattern which rendered a similar strategy inappropriate. She noted that at St. Thomas' a nurse trained for one year and was pledged to remain in service of the training committee for a further three years, never getting a certificate and full independence. This was particularly puzzling to an American:

"... it would seem that the nurse is never graduated in the sense of being placed on her own responsibility, but must always remain under the supervising control and authority of the training committee" (ibid.: 98).

Such a system, Miss Darche argued, was unthinkable in the U.S. "where the idea of pledging oneself to a corporation or society for a period of four years, not to say indefinitely, would have been regarded as impossible" (ibid.:98). But its viability in Britain had enabled Miss Nightingale to send teams of nurses from the School to make improvements in the hospitals. It was justifiable, it had results, but

could not be accomplished in the U.S.A. The strong implication was that some other arrangement had to be found. The Superintendents Society was the answer.

Miss Darche's comparative perspective also shed light on the plan for setting up a wider membership organisation. By drawing out the precise ways in which a system of nurse training at first borrowed from Miss Nightingale "began to assume proportions and a bearing distinctly American" (*ibid*:96), she was able strongly to imply that the need for such a body was particularly marked. In the U.S., the nurse trained for two years, the second spent in a post of responsibility in the hospital; she then went into independent practice in the community as a graduate nurse. She stressed that the Registries of graduate nurses run by the schools were distinct devices to help meet these situations. They were a way of aiding the independent graduate nurse. It is a short step to link this picture geared to isolated independent practitioners (not the trained hospital nurses who figured so prominently in Miss Nightingale's thinking) with a device again for association and support. Further addresses developed this theme and were reported in the same volume.

We have already seen some of the ways in which the American strategy was tied to its context, for the participants themselves made conscious efforts, particularly in drawing upon British experience, to adapt to their own local circumstances. But it is worth pursuing this comparison a little further, emphasising, rather more than the participants did, the 'adaptedness' of their strategy to the context. Historians have put forward a number of reasons for the conscious adaptation and creation of institutional forms in the U.S.A.; these have ranged from suggestions about unique values stemming from colonial and revolutionary origins, to suggestions about the necessary transformation of ideas and

institutions in their transportation from diverse European settings to the U.S.A. (cf Boorstin 1946; Hartz 1964; Lipset 1963; Bailyn 1960). Furthermore these events appear in a period of organisation creation and recreation by occupational groups which writers have linked to the social and economic changes of the time and particularly to the optimism about rational social change associated with the Progressive Era (cf Wiebe 1967; O'Neill 1971, Gilb 1966).

It is of interest too, to note how the plans for the Superintendents' Society accorded with what are often taken to be distinctive American values - an emphasis on individualism, achievement, a belief in equality and the openness of mobility prospects. The Society upheld the independence of individual Superintendents and schools and in no way aimed to judge or regulate. It was predicated too, not just on notions of freedom but of individual perfectibility; self-improvement required self-help and motivation and support were the keys to this. There is no notion here of a deep difference of interests or of structural impediments to change and of confrontation with these. At the same time, the Superintendents were afraid of being considered elitist. The development of a democratic body of associated alumnae was a necessary part of the plan. It was stressed, not just that this was democratic, but once again that it was consistent with individual independence and self-fulfilment, and not in any sense imposing measures from a privileged group. This is a long way from the indirect and manipulative approach to change pursued by Miss Nightingale and the respect for established institutions shown both by her and by Mrs. Bedford Fenwick. The remarkable feature of all these strategies is just how time and culture-bound they were.

## 2. Divergent Developments

By the mid 1920s nurses in both countries had established their own membership organisations and had engaged with some success in fighting for statutory recognition. But the differences in the direction of their organised effort by then far outweighed the similarities.

To take Britain first, the predominant issue had become legislation - the aim was a nationally recognised and state-regulated standard of nursing practice. From 1904 to 1914 Bills were introduced annually to Parliament (Abel-Smith 1960:81) and when the College of Nursing was formed in 1916, its line on legislation was the most pressing and urgent issue. With the passing of the Nurses' Act in 1919, hopes were pinned on the new statutory body, the GNC. And the GNC, as a State body, stayed very much in the political limelight in the 1920s. We have argued at length in earlier Chapters how the GNC's powers were limited and how its composition gave rise to difficulty; on the face of it, however, it appeared that this 'self-regulation' by nurses was not working. There were as many as six debates in the House of Commons on nursing in 1922-3, and in 1924 a Parliamentary Select Committee was set up to investigate questions the GNC had failed to settle (Abel-Smith 1960: Ch.7). Members of Parliament, championing the underdog, could present the GNC as elitist and irresponsible; even Abel-Smith refers at one point to events on the GNC as an "undignified squabble" (Abel-Smith 1960:105). The various nursing organisations put pressure on the GNC to recognise the interests of their members but beyond this they kept their distance, the College in particular finding a role in developing post-basic courses which was attractive to its membership and distancing itself from issues of concern to the GNC.

Nurses it seems were paying dearly at this point for their faith in State regulation and protection.

Matters were quite different in the U.S. for there was no such faith in legislation as the cornerstone of change. We have just seen how the Superintendents' Society had taken educational matters into its own hands by studying different possibilities, acting as a resource and a publiciser. The Curriculum Guides of the NLNE discussed in detail in Chapter Seven represented fuller extensions of this activity. Nurses saw themselves as engaged in a voluntary movement concerned with educational improvement. There were the State-wide nurse practice acts, of course, and the ANA provided help and guidance. Experience from some States was brought to bear in others, efforts were made to amend Acts, events in more 'progressive' States having a galvanising effect elsewhere. Nurses expected less of legislation; they began to learn the arts of lobbying and to grow in confidence rather than to be diminished by their legislative activities. Above all, they were doing the right American thing - working for self-improvement. These then are the different backgrounds against which to set the events of the period.

Let us start with the American case, where the strategy seems much more clearcut. The striking feature of the period is the continued effort on the part of nurses to research their own position and to develop an analysis of how they might advance their cause. A basis was already there in the NLNE with its vigorous programme of research and enquiry. This was a forum in which some nurses, notably Adelaide Nutting, were able to develop their interpretations of events, and to become critical and to challenge the status quo. Let us look at the detail of their interpretation.

Consider Miss Nutting's arguments about hospital-based institutions of training. In 1901, we find her already casting around for models in other occupational groups of how to organise training; in 1905 she was pointing out that a training does cost money and it should; by 1908 she was arguing that not all hospitals were fit to provide a training. Her researches into hours and pay persuaded her that hospitals were closing their eyes to the true costs of nurse training and using students as labour. In a setting where charity was much less of a virtue, running training schools as 'charitable institutions' smacked of dependency and failure to help oneself, rather than being an obligation which the more fortunate should extend to those less so (Nutting 1926). A further strand in Nutting's thinking concerned the growing educational and preventive work of nurses and the need to include these themes in the basic syllabus. Yet another idea was for college based training, not for all but for some nurse recruits. All of these themes had emerged in her lectures and addresses before 1916 (ibid.). And she was arguing too around this point that a full-scale study of nursing and nurse education along the lines of the Flexner Report on medicine, needed to be mounted.

Her position in Teachers College made Adelaide Nutting an obvious choice for consultation when the Rockefeller Foundation was considering how to deal with the issue of creating a new kind of public health worker. No doubt with her strong encouragement, the group set up to consider this question transformed its terms of reference. Instead of studying the public health nurse and public health education for non-nurses, it chose to concern itself with the entire field occupied by nurses and other workers of a related type. Its studies ranged over health work and sick nursing in the community, over

the hospital-based system of training, over problems of financing and of subsidiary workers. 'Nursing and Nurse Education in the United States' was the title of the final publication which has come to be known as the Winslow-Goldmark Report (Committee for the Study of Nursing Education, 1923).

The Committee comprised 19 members, of whom 6 were RN (3 directly associated with Teachers College) and 10 were MDs. It was chaired by C.E.A. Winslow, a professor of Public Health. Members were for the most part in education and public health, not in pure hospital service positions. The report which they produced was a vindication of the nurse in the public health field. It was argued that care of the sick and health education and prevention went hand in hand; they were more effective when seen as one job than two. For this job a trained nurse was essential, but she needed a broad general education whose standards were safeguarded if the public was to receive full benefit and protection. A detailed study was mounted of the duties public health nurses undertook and the organisational arrangements to provide them were evaluated. It was a lack of knowledge and training which sometimes meant nurses were not using their full potential. Basic nurse education was thus also given intensive study; for each of 23 hospitals a nurse and an educationalist conducted a review. It was shown that the hospitals failed to conform to standards in other educational fields. And from the point of view of public health their training programmes, strong on symptoms and care and weak on prevention, were unbalanced. Endowments were essential the report argued so that the school could serve the needs of the community not just the needs of the hospital. University schools as well as hospital schools, and a defined role for a subsidiary grade were further recommendations.

There rapidly followed a new study set up, this time, by the nursing organisations themselves (Committee on the Grading of Nursing Schools 1934). It spanned an eight year period and it resonated with self-confidence. The Winslow-Goldmark committee had argued that progress had been handicapped by the system whereby schools were not run primarily as educational institutions. Further studies, it was felt, would make the evils of this arrangement so clear that the need for radical reform would be obvious even to the most conservative. The findings of the new study were directed inward as much as outward, with 81 of the 94 issues of the American Journal of Nursing in the period of study carrying material on the work of the Committee. Furthermore, the findings of its first report were published in a 25 ¢ brief summary and sold as widely as possible.

The study took the analysis further. It was not just that nurses had a restricted education in hospital schools; the schools, in their own interests, turned out far too many graduates. The final report referred to the "twin evils of overproduction and undereducation" (Committee on the Grading of Nursing Schools 1934:Ch.1). The advance pamphlets in 1930 and 1933 had shown that even in 1926 nurses had been unemployed; 1920 was the crossover year in which there were more (so-called) trained nurses than untrained on the market, and from a total nurse population ratio of 1:6389 in 1900 the position had moved to 1:416 in 1930. This was one nurse to every 65 families. "We have no need of any more nurses with mediocre training and background" the report insisted, instead quality was the problem (ibid.:42). Essentials of a basic school were listed, a chapter dealt with how hospitals could provide a nursing service without schools, and a chapter on nursing schools was firmly

entitled 'Conditions which should not be tolerated'. Added to all of this, work was commissioned from the Teachers College Department on the proper role of the nurse, something we have already noted in Chapter Six.

Many commentators are quick to point out the limits of influence of these two reports. It is questionable whether the actual grading of schools done in this enquiry directly affected the schools; the plans which the Committee had for a broadly based Permanent Advisory Council on Nursing Education never actually materialised; the whole Report still had the old aim of exhortation to self-improvement rather than suggesting clear sanctions to be employed. None of this can be denied, but the striking point in the context of this Chapter is that nurses were no longer only encouraging each other to improve, they were developing their own understanding of the obstacles to improvement and locating these obstacles in the world outside rather than in their own personal shortcomings. It is this which provides a startling contrast with events in Britain.

British nurses, as we have noted, were concerned about the GNC and no doubt somewhat demoralised by the train of events in the 1920s. Added to the considerable skills needed to find a set of rules for admitting nurses to the Register which would be acceptable to all parties was the growing demand for nurses in the hospitals. Increasing as they were, annual numbers of new probationers were not keeping up with escalating demand. This was the context in which the proprietors of the old established medical journal, the Lancet, encouraged, it seems by one or more prominent nurses, decided in 1930 to mount their own enquiry. The Lancet had mounted enquiries into topics of concern before, so it was not an unusual occurrence.

But why did a report not come from nurses themselves? It would have been beyond the resources and its statutory powers for the GNC to mount an enquiry, and indeed, given its earlier and unwelcome publicity, it seemed that it was determined, now with a nurse in the chair, to play a low-key role (Musson 1932). The College of Nursing (formed in 1916) was trying both to win a greater membership and to gain respect with outside bodies. The first it pursued by offering various advanced courses, the second by winning quiet battles for behind the scenes consultation (Davies 1978). An enquiry would have been an unprecedented public step. Furthermore, divisions between nurses were only just below the surface, what with the disinterest of the College in any other than general trained nurses, the continued presence of the RBNA, and of Mrs. Fenwick's activities, and, increasingly, the interest of the trade unions in the terms and conditions of employment of nurses (Abel-Smith 1960: Ch.9).

Shortage of nurses was the burning issue and the Lancet Commission terms of reference directly reflected this. How to recruit more nurses was the question uppermost in the minds of those conducting the enquiry as well as where to allocate the blame for the current state of affairs. The Commission came to an unequivocal conclusion. The root of the problem, they decided, lay in the hospitals with the trained nurses themselves. The solution would come via a modernisation of attitudes. Trained nurses erected a system of work organisation which placed value on routine, which stressed a strict discipline, which gave responsibility on the wards without trust in the

Nurses' Home, which demanded obedience, punctuality and loyalty. This, the Lancet Commissioners felt, had been a value in the past, but was anathema to the modern girl. The following excerpt perhaps shows the investigators at their most patronising:

"It is only the exceptional nurse, that is the one who has maintained close touch with the social and educational tendencies of the day, who is able to discern which of the peculiarities of hospital life are essential to its structure, and which are mere survivals from a different age and could safely be jettisoned. Fortunately, many matrons of important institutions now belong to this category, and they are doing much to bring hospital training into line with other forms of training, but their efforts are then hampered by the conservative attitude of valued members of their senior staffs. Ward sisters, especially those who have given their lives to hospital service without seeking administrative promotion, may be intolerant of attempts to induce them to allow others a discipline less severe than that which they willingly impose on themselves..." (Lancet 1932: para.37).

The report touched on other matters too of course, (see Chapter Six) but it is the element of victim-blaming which is of interest here. It was the nurses' own fault for being traditional and as individuals they should mend their ways.

When an official committee later considered the problem, when the onset of war brought the deliberations to an end, its interim report covered a lot of the same kind of ground. Shortage of nurses was again seen to be the major public issue. It was now accepted that nurses were overworked and underpaid, a salary negotiation machinery was recommended, along with grants to nurse training schools.

Beyond this, while there were hints that a more fundamental analysis was coming, the theme of traditionalism and authoritarianism amongst trained nurses was still important. The Report was cautious about how widespread such attitudes were, and about the reliability of witnesses, but it remained convinced that there was something in this criticism. Thus, for example, in discussing conditions of service, discipline got a longer coverage than any other item and the committee pronounced itself particularly astonished that attitudes remained amongst nurses which restricted social intercourse between different grades of staff. Once again, nursing problems were being laid at the door of the nurses themselves.

Nursing reaction to these reports was muted. The College of Nursing had offered a very short memorandum of evidence to the Lancet Commission and when the results were published the Nursing Times admonished its readers to accept them "with humility". It editorialised: "Here were our own personal convictions expressed infinitely better than it has hitherto been in our power to do" (Nursing Times, 1932:178). And indeed, far from setting up an inquiry by nurses, the College in the 1930s itself at least twice pressed the Ministry for an official enquiry. When that enquiry was set up, the College had a long submission of evidence and of opinion. But as we have had cause to note already in the course of Chapter Six, the College's Memorandum was a document which did not fit together well. The list of new ideas was a long one; it included a shorter and more comprehensive basic training, a statutory base for private, domiciliary and school nursing, and an enquiry into the requirements for a public health service. But all of these

were hidden away in specialised sections and not alluded to in the opening part of the evidence. There was a fair amount of stress on short-term solutions, such as more orderlies and attendants and possibly more married women working part-time to allay the shortage. There was no fundamental analysis of the problem of the nurse in relation to doctors, to hospitals and to the health system as a whole.

The contrast between the two groups of nurses in this period is a striking one. American nurses developed an analysis of their own position which gave them confidence in themselves and challenged the status quo. At the heart of this analysis was a perception of the hospitals as pursuing narrow and sectional interests, irresponsibly training too many nurses and limiting the Syllabus and making them less than fit for the work which was to be done. Yet, as before, the nurses were still convinced that voluntary reform was possible - that once the true position had been revealed, the various parties would be persuaded by the argument and would change. British nurses acceded in an analysis which criticised them and their behaviour, which equated the hospital interest with the public interest and argued that nurses were themselves responsible for shortages of staff. Again, as before, these nurses were looking to the State (and to some extent to the doctors) to protect them while still enabling health care goals to be met.

How are we to make sense of this? Now is the moment to step back a little, to consider not just this one difference but the whole range of differences which have emerged in the chapters of part 3. I have drawn attention to different concepts of nursing work and different educational arrangements, and now to different analyses of

of 'the nursing problem' and different directions for collective action. Can the threads of this not be woven together a little more to reveal the contrasting parameters within which nurses have attempted collectively to make sense of themselves and to act?

Let us start with aspects of the two health care systems. A consistent theme in American health provision has been demonstration and improvement. Enthusiastic groups have raised funds and provided short-term, small-scale programmes of service. This was especially true in the 1920s and again in the 1960s. Since each programme is negotiated anew in a particular setting with its specific balance of forces, some at least will provide a fertile soil for the expression of new ideas and a space to try them without involving a large and continuing commitment. Continuity, however, and extension cannot be guaranteed; indeed pressures for largescale innovation can be defused. This is what Alford has described in the memorable phrase 'dynamics without change' (Alford 1979). In Britain, by contrast, the emphasis has been less on demonstration and more on delivery. Health matters have long been a concern of governments, both central and local, and the notion of State responsibility for health is more developed. The trend has thus been towards a growing concern with the availability of services, and with common standards of provision, and with the central planning this involves. The NHS was the culmination of this in the sense that it represented a structure geared more towards standardisation and coverage than towards flexibility and innovation. There are value choices here, between minima and maxima, between basic 'floors' of service and exemplary 'ceilings', between standardisation as a good versus

innovation. And what we have seen in these chapters is the way in which nurses are oriented not only and necessarily to the institutional arrangements of the two societies, but to the basic values too. Organised nurses in America found a ready and acceptable role as pacesetters, something not so easily conceivable in Britain.

Turning to the two educational systems, again we can see different values given expression in different specific institutional arrangements. As we saw in Chapter Seven, the American university has fulfilled a different function from the British; it has been more open and in particular has welcomed vocational education in a way long disdained in Britain. The maxima/minima values intrude again, with the British preference to protect standards and the American way to open institutions more broadly and to allow for divergent practice - some especially good and some very poor. It is the education system of course which also most clearly reflects in the American case, beliefs in individual opportunity, achievement, mobility, equality and the breaking down of privilege and autonomy, while in the British, it responds to more traditional and elitist themes. These notions have been captured well by Turner in his concepts of 'contest' and 'sponsored' mobility (Turner 1960). Again we have seen nurses espousing the values and acting accordingly in each of the two societies.

There is also, at the risk of oversimplification, a British way and an American way in political activity. What has been most striking here is the localism of American politics, the willingness

of groups to organise and lobby and the expectation that legislation will be amended. In Britain lawmaking has been a more central, more important and yet more remote affair; nurses have pinned their hopes on it and have regarded it as a framework for activity; once enacted, they have treated the statutes with respect in the expectation that change is a weighty affair and not to be embarked upon lightly.

The orientations described here link back, as we have noted, to the revolutionary origins of the USA, its absence of a feudal past and its lack of an aristocratic tradition. They relate, in the British case to a society which changed more slowly, bending old traditions rather than breaking them, forming something of an 'open aristocracy' where old notions of hierarchy and position remained influential and continued to shape political and educational institutions and work practices. The point is not to say something new about these values and institutions as such, but to emphasise that occupational groups, though from time to time bringing new and challenging principles to bear, mostly work within the parameters rather than outside them.

What then are the implications of all this for the concept with which this chapter was initially concerned - occupational strategy? Initially the strategy concept was useful. It aided in contrasting the two programmes for change and enabled us to draw out features of the social context which seemed to relate to these differences. Later, specific strategies were more difficult to discern. There had been no overall strategy change by the 1920s in the sense that British nurses continued to look to the State for salvation and American nurses continued to look to themselves. But their respective understandings of their

own position were diverging markedly. The lesson seems to be, at the very least, that we must examine the production of strategies as well as their results. And we must see both production and results as deeply influenced by the setting in which they occur.

Perhaps there is a more fundamental question at issue here. We started from the conviction that occupational groups were engaged in a quest for power, and that there were resources (including strategies) of those groups which would lead to success or failure. These chapters have been not about the quest for power but about the struggle for meaning. They have focussed not on the interior of the occupational group but its relation with the wider context. Just how much of a challenge is this to the sociology of occupations? Was my earlier reading of it justified? What is the next step in this field? These are some of the questions to be tackled in the next and final section of this thesis.

PART FOUR.

CONCLUSION

CHAPTER NINETOWARDS A SOCIOLOGY OF OCCUPATIONAL POWER

There was tremendous optimism among sociologists of professions in the early 1970s. Trait theory, with its stress on expertise and its apologist character had been abandoned; a new and more sceptical era had opened. All were enjoined to do work, especially historical work in the new paradigm. This was the starting point for this thesis and for its historical enquiries into the development of nursing in Britain and the U.S.A. No single study, of course, can provide a decisive evaluation of an approach, but it can raise serious doubts and questions.

It is now my belief that sceptical theory was not the decisive break with the past that it purported to be; indeed, its very continuities with previous traditions can help to explain some of the problems faced in this research. This case to be made here is not just a criticism of writing now around ten years old. I shall try to show that what I call the 'resource model' of power lies at the heart of present-day writing and contributes to difficulties in making any significant advance. The agenda which emerged for the sociology of professions in the early 1970s was limited, and a new one remains to be constructed. One sign that we have achieved this will be when an analysis is produced which gives dignity to occupations such as nursing, social work, teaching etc., instead of forever damning them at worst as failures and at best as cases of marginal theoretical interest.

One further word of explanation is necessary before the argument proceeds. I shall not attempt in this chapter to review in any detailed way the historical studies of professions which have emerged since this study began. There have been a number of these, with an especial concentration on medicine. Parry and Parry (1976), as sociologists, have provided a review of the professions literature and some empirical data on the medical profession in Britain; Peterson (1978), as an historian, has provided important new material on nineteenth century medical careers. Honigsbaum (1979) has discussed divisions in medicine, Berlant (1975) has compared British and American medicine from an avowedly Weberian perspective, whereas Larson (1977) has carried out a similarly comparative exercise for medicine, the church and law from a Marxist starting point. E. Richard Brown's (1979) recent work is also in the Marxist mould. This is not the place to focus on the interior detail of these and other works; review essays, to which I shall refer, are available (Klegon, 1978; Dussault, n.d.).<sup>1</sup> What I shall want to do, however, is to address broad questions of the overall thrust and direction of work.

The procedure for this chapter is as follows. First, the different stages of this study will be reviewed together with the findings which emerged from each and the questions which were left outstanding. Next, we turn to the initial framework which guided the work and to an effort to demonstrate that the empirical work exposes important weaknesses in that framework which still go unrecognised today. These weaknesses, I shall argue, have to do with a 'resource model' of power, an approach which is now being challenged particularly by feminists. New Marxist writing on the topic of professions is considered in the light of this critique. I shall argue that while this work deserves

much more attention that it has received, there are nonetheless serious problems with the directions of study it proposes. In all, and despite the widespread agreement that we should 'locate professions in the wider social, economic and political structure', the frameworks and procedures of a sociology of professions continue to militate against this. The thesis closes with some suggestions for directions for further work.

### 1. An Overview of Findings

The initial plan for the research was to apply new developments in the sociology of occupations and professions to the case of nursing. The plan was developed into a detailed research design, noting in passing that the sceptical theorists themselves had not proceeded far in this direction and noting too that nursing still remained a marginal case in this new approach, holding much the same place as it had held in previous theorising. But the research design underwent at least two metamorphoses, so that the detailed indices of power and the hypotheses about resources giving rise to power were not investigated. Instead, much more exploratory styles of work were adopted. At first these continued to address the question of power directly, later they dealt with it in a more oblique fashion. What emerged from this?

The first set of analyses were concerned quite directly with the matrix of institutions which surrounded nursing in each country and which might be thought to regulate its conduct. Focussing in turn on control of entry and control of training, formal arrangements which might be thought to bear on these were assessed in detail. We found, unsurprisingly, that the institutional paraphernalia of control was there, but, equally unsurprisingly, it was not easily

equated with the acquisition of control.

The changing pattern of entry to nursing was 'wrong' from a professionalisation point of view. There was increasing heterogeneity and a rise in numbers - just the reverse of what one would expect. But this did not mean that the operation of professional associations and statutory bodies was an irrelevance. Far from it. A real understanding of what was happening in patterns of entry to nursing demanded that we understood the way in which bodies such as boards of examiners functioned, the limits of their powers, the influence of employers, the pressures of the professional associations and so on. And all of these had to be located in relation to broader trends in supply and demand. The comparative perspective was helpful here and it began to become clear not just that the formal structures were different, but that the aspirations expressed through them were also distinct.

On training too, a detailed examination of institutional arrangements paid dividends. It is often supposed that the American pattern of establishing nurse training in institutions of learning rather than places of practice means more nurse control. We were able to show that this has not necessarily been so and that nurse training could be starved of resources in a college setting as well as in a hospital one. It was also in the training arena that differences between the countries came out even more starkly. Both in Britain and in the U.S. there has been debate and dissension about nurse training, but we were able to see that American nurses tried to set the pace through their professional associations, whereas British nurses looked (often with very critical eyes) to a statutory body, the G.N.C., for action.

By the end of this exercise we had learned a lot about the dynamics of development of nursing in Britain and the U.S.A. But rather than being in a position to say that control had been gained or lost over time or was more or less in one country than the other, I was beginning to question the idea of seeing the development of an occupation as a quest for control. On the one hand, we needed more studies of professional associations, statutory bodies and the like. Few sociologists of professions had a good grasp of how these functioned and where they fitted in the social structure. On the other hand, it was also necessary to try more firmly to break with a concern with amounts and locations of power. Professionalisation, understood as a process of accruing legitimate and institutional control, was too narrow a model for encompassing the dynamics of occupational development which were emerging. Because nursing did not fit the proposed pattern of acquiring power, we were left with no terminology to describe in any positive way what did occur. And, it was not clear how to take further the kinds of cross-cultural differences which had begun to emerge. The demands to quantify power, or at least the continuing pressure to address it as some kind of abstract phenomenon seemed to raise more questions than it answered. Above all, it seemed in some ways to be deflecting attention from differences in conceptions of the place of the nurse in the division of labour and of the nature of her work. There was little in sceptical theory as such to suggest how these sorts of themes might be pursued.

Underlying the analysis of part three was the theme not of

a quest for power, but of a quest for meaning. Chapter six focussed on different sets of ideas about the practice of nursing and the role of the nurse in the two countries, making clear that there was more of an argument (and an earlier one) about independent practice in the U.S. than in Britain. Ideas about practice were then linked to context. Differences in the development of the health care system in the two settings were explored, and more specifically, the contrasting histories of hospital services and of the organisation of public health programmes were examined. A further set of ideas, this time, to do with the content of nurse education, were explored in chapter seven. Although this dealt with a more restricted time period than chapter six, a similar pattern nonetheless emerged. Given the different pattern of educational arrangements in the two countries, there was a space available in the U.S. to develop a more integrated conception of nursing knowledge, and, in a limited way, to put this into practice. The hospital-based conception of the nurse as carrying out doctors' orders was more firmly entrenched in Britain, and the curriculum for the nurse reflected this. Both chapters, then, were seeking to situate nurses in their social context, showing that the aspirations they collectively entertained were, in important ways, specific to that context and made sense in terms of it. Chapter eight carried a similar message. The early leaders of nursing in both countries evolved a strategy for reform. These strategies were not identical - even though there was sharing of information. Instead, strategies were time- and culture-bound. Following developments through to a later period, we were able to see that American nurses developed

an analysis of their position involving a critique of the hospitals and the opportunities they offered for nurse training. British nurses, however, looked, as they had done at the outset, to the state and to the doctors for support. The analyses provided by these outsiders were critical and nurses were in a weak position to counter them. The material in this chapter suggested that nurses were not forever engaged in strategies to marshal resources and to obtain power; they were trying to place a meaning on events and to derive lines of action from that meaning. Sometimes they failed to attach a meaning that gave them a belief in themselves and the confidence to act.

The material of part 3 presented something of a paradox. For one thing, these chapters had gone into much more depth about the substantive problems nurses face than is usual in the sociology of professions. For another thing, the argument constantly linked developments in nursing with social context, and in doing so seemed almost to deny the usual project of focussing on occupational groups as such and on the factors which may facilitate or impede their acquisition of power. I want to argue that this represents not a retreat into ethnography, but the start of a critique of the 'new directions' in the study of occupations and professions.

Let us backtrack for a moment. The one thing that had characterised the new writers on professions in the early 1970s was their insistence on power. Professional power was thought to entail control over the work itself, this linking to control over matters such as entry, training, and working conditions, including perhaps pay.<sup>2</sup> It was no longer sufficient for the sociologist to

try to identify the hallmarks of a true profession; what was at issue instead was a struggle to establish the institutions of professional self-regulation. And it was self-interest on the part of members of the occupational group which rendered this process sociologically comprehensible. A lot was taken for granted in this approach. We knew what occupational groups would do and how they would do it. What we did not know was whether, and under what circumstances, they would be, or could be, successful. This was why there was so concerted a plea for historical work. The interest lay in strategies and tactics, the alliances formed, the resources brought to bear in trying to achieve professional power.

This line of argument was, of course, part of a more general period of paradigm reconsideration which affected work in a whole range of fields of sociological enquiry; the sceptical theorists were part of the "sudden attack of self-consciousness that gripped general sociology in the late 1960s" (Strong, 1979: 203). For sociologists of professions, it meant a debunking of professional claims, including an assertion that whatever leaders of an occupational group said or did, self-interest lay behind it. What I now wish to suggest is that this approach has given rise to difficulties in the study of nursing reported here, because of the 'resource model' of power it adopts and the assumptions which are involved in and associated with it.<sup>3</sup>

## 2. The Resource Model

The first feature of a resource model of power is that it treats power in the abstract. Groups (or individuals) strive for power and gain more or less of it. The specific nature of their

demands at any particular point is not made problematic. The demands are treated as known and self-evident - not a matter for analysis in their own right. The second feature of a resource model is its considerable emphasis on the properties of the group concerned as explaining their power. Occupational groups are said to be more likely to gain power if they are homogeneous, for example, if comprised of higher status individuals or if they adopt particular ways of organising themselves. While breaches are frequently made in this - by arguing for example that resources may only operate as such in some conditions, and/or by pointing to the need to make strategic alliances with outside parties, the idea of group properties as a power resource remains.

Closely allied with these two features of the resource model is its focus on power-play rather than on content. I am referring here to the marked tendency to focus on processes of bargaining and/or arenas of legitimate control by the professional group without ever being concerned with the substance of their activity. Somehow, because we 'know' that control over entry will mean restricting numbers and because we 'know' that occupational groups strive for autonomy, actual activities can be ignored. We therefore learn almost nothing from theorists of professions about the kind of knowledge which is being purveyed, the concepts of the division of labour which are built in and the nature and consequences of everyday practice as viewed by the various participants.

Certain other features also attach to the resource model. For one thing, interest centres on success and failure and in practice success is of more interest than failure. The theoretical

project comes to involve an explanation of the transition from occupation to profession - those who do not make the transition are grouped separately and rarely figure as a challenge to the theory. For another thing, the kinds of generalisation sought take on a rather mechanical character. The aim is to specify which resources, strategies etc., give rise to control. There is little room for subjective experience and social action in this perspective. An additional feature of the approach lies in its emphasis on the essential unity of an occupational group and the single direction of its struggles. There is no room for segments with different missions and no rationale either for developing an understanding of the diversity of organisational devices and the precise mechanisms and channels through which action is taken.

The net result of these features is a model which sees a world of competing interest groups, freely selecting goals and self-consciously pursuing them in given directions with the resources at their disposal. It is a voluntaristic and rationalistic model, with a pluralist, perhaps Weberian approach to power.<sup>4</sup> The emphasis on successes and failures gives a normative flavour to writings, and one which strikingly parallels that in the trait theory, said to be superceded.

Inevitably, this sketch is something of a caricature. But the resource model does have a considerable hold over those who, orienting themselves to writers such as Johnson and Freidson, have wished to do empirical work.<sup>5</sup> Two examples will serve to exemplify the continued hold of the resource model in the contemporary sociology

of professions. The first is an empirical study, the second a literature review.

Carol Kronus (1976) provides the example of the first. Her historical study of the relations between physicians and pharmacists is oriented directly to the sceptical theorists and she asks immediately what the bases of occupational power are, and what resources are crucial to its achievement. "The more resources a system controls", she argues, "the greater its potential power to influence other units" (ibid.:5). For Kronus, a power analysis, by definition, involves studying what resources are important and how they are used. The aim, she explains, is not to specify types of resources in advance, but to specify them empirically. Kronus, in short, cannot conceive of a power approach other than via a resource model. She treats the link between these as self-evident and inevitable.

Much more recently, Dussault (n.d.) has utilised the resource model both to describe and analyse the work of contemporary scholars and to advocate directions of future work. On the latter he has this to say:

"A first problem is how to assess the relative importance of the specific sources of the power of an occupational group, that is the characteristics of the group itself, such as its membership and its economic resources, its capacity to produce supportive ideologies and to develop appropriate professionalising strategies; the kind of service it offers, and its cognitive base; its clientele or the support it gets from powerful sponsors; the level and type of competition it encounters from other occupations or the support it can obtain from the state.

The extent to which each of these is necessary for the process of professionalisation to succeed is a fundamental question."

(ibid.:27)

Dussault certainly makes a number of salient criticisms of past work from within this perspective. He also sees that it gives rise to certain difficulties.<sup>6</sup> But, in the main, it is striking how a resource model has taken hold. Professionalisation is the process to be studied and it is seen as the acquisition of power. The nature of this power and the means of its recognition get little discussion, attention centres instead on the resources which enable professionalisation to succeed. Dussault is no isolated example. Klegon's (1978) much cited review essay can similarly be seen as being influenced by an underlying resource model.

It is perhaps not altogether surprising that the resource model has proved popular. It offers the hope of generalisations about occupations and their differential privileges. It allows us to begin to order a large amount of detailed historical material in a plausible way.<sup>7</sup> It appears to follow the sceptical theorists' injunction that we distance ourselves from the ideological pronouncements of the leaders of the professions themselves. But, with hindsight, we can also see that the very assumptions the resource model makes led to difficulties in the present research.

First, because power could only be treated in the abstract, and only be seen to be gained by a recognised route (of 'professionalisation'), we were forced to conclude that nurses, sometimes at least, had either reached an impasse or did not want

power. And because power was abstract and to be quantified, we were faced with operational problems. Often it seemed much more appropriate to argue that there were qualitative changes in what occurred, or qualitative differences between countries rather than working always to answer a question 'how much?'. The framework also led us continually to try to answer the question of where the power lay - and responding to this was not easy. Indeed, before even turning to the question of the nature of the resources themselves, questions were beginning to surface about whether nurses could be seen as a unitary and goal-oriented group making voluntaristic choices in the way the model demanded.

What is now clear is that the resource model involves a highly restricted set of questions. Working within it we could explore few of the facets of the situation nurses faced, little of the way they interpreted their situation, and almost nothing of the varying courses of action - at different times and in different places - available to them. And, having abandoned the resource model, and turned to the forms of organisation and institution associated with occupational activity, and the way in which nurses collectively saw their work and their problems, there was nothing in the sociology of professions to prepare for this. Of course, the sceptical theorists were right to warn against the danger of reiterating professional ideology, but in doing so, it seemed they could offer no ways of linking the real experiences of an occupational group and the detailed forms of organisation it employed to their general theorising. They had almost become too sceptical about professional ideology to study it!

### 3. New Approaches?

It is important to bear in mind that the sceptical approach to professions, with its emphasis on power, had taken hold before new writing on the concept of power itself was available. There are at least two important developments which could have had, but to date have had almost no influence on the sociology of professions. I refer to the work of Lukes on the one hand, and a number of French writers, most notably Foucault, on the other.

Lukes (1974) offered an argument that it was possible both to work with an extended concept of power and to do empirical work. Although his focus of attention was a different one, and his argument not altogether comparable with that produced here, his dissatisfaction with attention to surface appearances, his insistence on somehow bringing in issues which have not come onto an overt agenda, and exploring how preferences are shaped, are common themes. For Lukes, an adequate and 'three-dimensional' view of power is one which deals with the "sheer weight of institutions" (*ibid.*:38) and their bases, with inactivity as well as with activity, and with power as something more than the visible assertion of the will of one individual or group over others. It is interesting to see that Lukes advocates use of comparative studies in a similar methodological strategy to that used here. Comparison allows us to see that issues can be hidden in some contexts, or raised and understood in contrasting ways. And, in all this, of course, a detailed attention to substantive issues is necessitated.

The theme of the importance of the substantive finds an echo in the very different tradition exemplified by the work of Foucault (see, esp. 1977 & 1978).<sup>8</sup> This too may be seen as an

attack on a resource model, since it is an approach which refuses to give privileged place to the actor, or group of actors or to see power as given in a judicial system with its sanctions and prohibitions. For Foucault, power is enacted and inscribed in daily practice and in the definitions of the instruments, techniques and targets used. Power, he insists is something which produces; it produces "domains of objects and rituals of truth" (Foucault, 1977:194). He goes on to explain:

"Power has its principle not so much in a person as in a certain concerted distribution of bodies, surfaces, lights, gazes; in an arrangement where internal mechanisms produce the relation in which individuals are caught up".  
(ibid.:203)

Those schooled in the studies of power in organisations, power in politics etc. which have abounded in Britain and the U.S.A., may find this fusing of concepts of power, action and knowledge disturbingly inaccessible. But it may well be that accepting the weaknesses of a resource model points in this direction. Certainly, a resource approach is no longer the self-evident way of tackling power that it once was. Sociologists of professions need to take a stand on how they view power, and how they propose to incorporate it in their analyses.

Confronting the question of power more directly would bring sociologists of professions face to face with a third approach - one which was in principle becoming more available in the early 1970s, but was in practice quite ignored by sociologists of professions. I refer to feminist research and feminist theory. While it would divert us too far to try to consider the different perspectives within feminist theory per se, it is important to

underline the seriousness of the challenge which has emerged from this quarter - especially, but by no means exclusively, for those who would wish to study nursing as an occupation. For feminists, though they may not always see it this way, also have an 'approach to power'. Their focus is not so much on overt power struggles and differential resources, but once again on the practices of social institutions. Where they differ, of course, is in their insistence on the gender-bias of social institutions, and on the pattern of male domination which is taken-for-granted in them, and their critique of mainstream sociology for its long neglect of this crucially important theme (Stacey 1981).

In the realm of paid work, marked differences in opportunities and experience for men and women has already been well-documented. An increasing number of writers have drawn attention to the heavily skewed distribution of women across occupations and grades in the labour force, and to the normatively strong sex-typing of the job market. It is clear that women are in low status and low-paying jobs and that their mobility is blocked. They form the vast majority of the part-time labour force and experience the poor conditions and limited rights associated with this (for British data see, e.g. Mackie & Patullo 1977; Wainwright 1978). All this is nowhere more evident than in the health care sector as both British and American studies show (e.g. Leeson & Gray 1978; Navarro 1976). Not only are there strong divisions between occupations (male medicine and female nursing), but sex-typing goes on within occupations too, so that there are typical women's specialties in medicine, and in American and British nursing it is men who are found disproportionately represented in top administrative posts (Carpenter 1977; Grimm & Stern 1974).

It is striking, in the face of this, how gender-blind the sociology of occupations and professions has remained although some of the themes of chapter two, where we traced the recent development of a sociology of nursing did begin to suggest how this came about in relation to the specific field of enquiry under investigation here.

Hopes for a reconciliation between feminist approaches and the sociology of professions would seem to be misplaced - for feminists are asking for, and beginning to provide theoretical developments which fundamentally challenge the starting points of a sociology of professions. Here I refer to the growing insistence that we stop examining the sphere of work as if it were separate from the domestic sphere and consider instead the interrelations of paid and unpaid, 'public' and 'private' work at different historical moments. There is a recognition that older accounts which refer to the separation of family and work with the rise of industrialism, and the forms of specialisation in sociology which followed this, can only mislead. From this follows the view that we can only understand the sexual division of labour in the sphere of work and the particular ways in which it structures options for women and men, as part of a total process of the development of unpaid, domestic as well as paid labour under capitalism; the transformation of housework and the allocation of responsibility for childrearing must be considered too. This perspective informs Wainwright's (1978) recent review; it is the basic premise of Barrett's (1980) extended theoretical discussion; for Stacey and Price (1981) it is an insistent thread also. (c.f. Carpenter & Fairclough 1977).

Eva Gamarnikow (1978), in an article which is theoretically as well as empirically important, has explored some of these themes

for the case of nursing around the turn of the century in Britain. The sexual division of labour, she argues, "treats all women as potential wives-mothers" (*ibid.*:100), and as such it both divides work processes into male and female ones and allocates women to the subordinate places in the division of labour. It is an ideology specific to patriarchy.<sup>9</sup> Using material from the professional journals and from the writings of Florence Nightingale, she shows that many of the aspects of nursing work became identifiable with domestic labour, and many of the qualities required for a nurse were the qualities of a 'good woman'. She highlights a double legitimization of the subordinate position of the nurse; her inferiority is justified both as technically required for the new scientific medicine, and as natural for her sex. On this latter point, references in the journals to doctor/nurse/patient relations as analogous to those in the family of husband/wife/child, are cited. Though the point is not developed, she further argues that nursing organisation itself "supervised and taught a form of nursing care which established and maintained the hierarchical division between nursing and medicine" (*ibid.*:107). And given the variable class positions of the women entering nursing (something which we documented in chapter four), Gamarnikow argues that nursing offers a particularly pristine example of male domination in the division of labour.

Gamarnikow does touch upon criticisms of professionalisation as a theory (*ibid.*:101ff) and it is not hard to push this further.<sup>10</sup> Professionalisation we might argue, is part of an ideology which directs attention away from gender. And the extent to which nurses subscribe to professionalisation is something, I would also want to suggest, which becomes increasingly important over time, and which must be increasingly

salient for us if we are to understand how nurses participate in reproducing their position of inferiority. This is where some of the recent radical writings produced by nurses themselves fit. The Boston Nurses Group (1978) has considered the 'false promise' of professionalism, and the Radical Nurses Newsletter in Britain in its first two or three issues again and again sees fit to take issue with professionalism, to try to explore the social relations it masks and legitimates and to mount a challenge to them. The evident difficulty its members (and some of its sociologist friends) have in trying to achieve this bears eloquent witness to the ideological entrenchment of concepts such as professionalism and professionalisation.

To sum up, there are then certain strands of work potentially relevant to a sociology of professions but not incorporated in it. Especially important here is feminist writing, for this, along with other work, suggests alternatives to the resource model of power. Thus far at any rate, the sociology of professions has failed to face the problem of power and to see the relevance of writers new perspectives. These writers, in their turn, have largely neglected to address the question of professions and occupations. But there is an exception to this which deserves some brief discussion, and this is the new Marxist-influenced material on professions. A consideration of this, and of its limitations in the light of the kind of data produced in the study and of feminist writings, will aid in moving towards a conclusion on the kinds of work which remain to be done.

A sustained interest on the part of Marxist writers in professions is of relatively recent origin. It arises in particular in renewed

discussions about class fractions, about the relations between productive and unproductive labour in the Marxist sense of those terms and about the significance of groups 'between capital and labour' (see e.g. Poulantzas 1975; Gough 1972; Walker 1978). Much of this writing is of a formalistic kind, concerned with conceptual elaboration. Olin Wright (1980) provides a particularly lucid example where he tries to relate occupational categories to class categories and to focus on contradictory class positions as ones sharing features of both capital and labour. He insists that this conceptual clarification must precede empirical or historical work if that work is to have any coherent character. Another discernible strand emerges from those concerned with empirical work on the labour process. While many of these draw inspiration from Braverman (1974) whose work is perhaps at its weakest in dealing with the 'middle layers', nonetheless there have been important studies of those in professional, scientific and technical positions in industry. Writers such as Gorz (1972, 1978) and Friedmann (1977) for example, have addressed the problem of technical expertise, using concepts such as 'conditional' or 'responsible' autonomy to try to capture the contradictory location of these relatively privileged workers within the capitalist mode of production, and stressing also the ideological role such workers play.

This kind of thinking has begun to be applied in the sphere of health care. Carol A. Brown (1973) and perhaps more particularly Navarro (1976) have pioneered with arguments that the dynamic of the division of labour in health care reflects that in capitalist production, (though there are some, e.g. Carpenter (1980) who are more cautious in this latter respect). Nor has nursing been entirely

neglected. Cannings and Lazonick(1975) speak of the position of nursing in a health industry, stressing a cost-cutting dynamic and deskilling. Bellaby and Oribabor (1977, 1980) refer to the proletarianisation of nurses and to the activities, in the long run, of individual capitalists in shaping the health industry and setting the constraints within which there is an occupational response.

The important thread in all this work for our purposes is its challenge to the resource model and to its pluralistic, voluntaristic bias. These writers are all starting from the position that occupational groups - be they labelled professions or no - are more controlled than controlling. In the last analysis 'professions' must be seen as serving the interests of capital or at the least as occupying a contradictory position in regard to capital and labour. This, of course, is the kernel of Navarro's critique of Illich and MacKinlay's doubts about Freidson - issues already noted in chapter one. From these perspectives, those who would look for professional power are perpetuating an ideology which masks the material dynamic of capitalist accumulation.

Johnson's work is interesting in this regard. We have seen how in his Professions and Power (1972), he had taken the view that professionalism as a form of occupational control was a late nineteenth rather than a late twentieth century phenomenon and that we should relate professions to wider power relations in society. In a series of later and overlapping publications (Johnson 1976; 1977a; 1977b), he was to turn to an exploration of Marxist analysis, and particularly of the work of Carchedi, in an effort to theorise the position of professions in the class structure. This led him to affirm the

mode of production as the crucial starting point for analysis, and to argue that professions both serve the requirements of capital (generating mechanisms of social control) and perform the function of labour (being subject to hierarchy, routinisation and fragmentation of work). Rather than treat professions as homogeneous, he now insists we must see the different locations in which they are to be found, both as between the spheres of appropriation, realisation and reproduction and within them. Accountancy is the example he takes, pointing to the material differences of position between the 'housed' accountant working as an employee, the partners of an independent firm and so on.

Three things emerge relatively clearly from this. First, a point also stressed by Larson (1977), the idea that resources can directly predict or explain power is rejected. Johnson, puts it as follows:

"It is not suggested ... that the forms and content of knowledge are without influence ... it is claimed that the influence of such factors can only be evaluated within the context of capitalist relations of production." (Johnson 1976:39).

Next, the profession as a unitary phenomenon and an acceptable unit of analysis is doubted. Repeatedly, Johnson stresses the heterogeneity of locations of employment of professionals, a heterogeneity which is important theoretically. While he does not call outright for the dissolution of the concept of profession, the term itself starts regularly to appear in inverted commas. Thirdly, there is the question of heteronomy. Heteronomy is the concept Johnson employs to refer to State intervention in defining the needs, the content and the manner of professional practice.<sup>11</sup> But occupationally-defined work no less than state-defined work can coincide with the

requirements of capital and in the former case the occupation, as he puts it "autonomously carries out the functions of capital". (Johnson 1976:54). What this means, of course, is that power and interest must be construed in more subtle ways than is possible in an overt bargaining and resource-wielding model.

A few brief observations on this material are in order.<sup>12</sup> First, as we have seen, much of it to date has had a formalistic bias, being concerned with conceptual clarification and bent on locating apparently privileged groups in relation to capital and labour. The result is often a close interpretation of existing texts with few clues as to implications for empirical work or the consequences of such work for existing theoretical exigeses. Second, there is an economic, and rather mechanical, determinist emphasis. Whether the political forms associated with occupational activity can give rise to real autonomy and/or sustain privilege against the interests of capital is unclear, and there is little and often no mention of the kinds of struggle in which occupationally organised groups engage and where we fit matters of consciousness and action into the analysis. Thirdly, while there does seem to be growing consensus that professionalism and professionalisation are ideological categories, there is less certainty about how one should hence proceed. Larson (1977) has provided what is undeniably the most important empirical and Marxist study to date,<sup>13</sup> and her chapter on professionalism as an ideology is perhaps the most provocative and stimulating in the book. Yet it is couched in highly abstract terms, and offers few clues as to how we might proceed with an historical analysis of a specific group. These emphases in current work are particularly frustrating from the point of view of the

material presented in this thesis. It is hard to see how either the institutional analyses of part two or the substantive concerns with action and struggle in part three could find a place in the alternative framework for the study of professions adumbrated by the Marxist authors discussed here.

Especially noticeable in the Marxist work, however, is its lack of attention to the themes raised by feminists. This is an issue, of course, which is subject of intensive debate in a much wider arena than the one under discussion here, and there are very different views of whether the two could or indeed should be reconciled (see, e.g. Sargent 1981). Yet with their strict separation, neither alone would seem to offer an adequate, overarching, alternative theoretical framework within which the material of this thesis could be presented. I have argued, for example, that there was a different 'space' for nurses to act in Britain and the U.S.A. in terms of the political and social arrangements open to them. I have noted that these differences amount to a different mode of social integration, to be associated perhaps with the development of the one country as an 'achieving society' and the other as an 'open aristocracy'. Marxist analysis has the potential here for a comparative discussion of the stages of capitalism and its distinct character in particular societies; it offers suggestions as to the different forms of the State and can begin to link these theoretically to the characteristically different welfare systems to which I referred especially in part three. But I also tried to relate these structural features to the forms of consciousness and action of nurses; I gave attention to the substance of their work and to some of their efforts to make sense of their subjective experience and to act. Marxist analyses,

at least in the forms they have taken in relation to professions, offer little to help develop this, and it is the feminists who have encouraged attention to the content of work such as nursing, drawing attention to the links between the paid and unpaid spheres and insisting further that we set the debates in the context of an often unacknowledged male domination. The constraints of gender, certainly no less than the constraints of class, must figure in our efforts to follow the way in which a group makes sense of its predicament and attempts to act.

It would be idle to pretend that either a Marxist or a feminist perspective formed the theoretical starting point for the material presented here. It has been made very clear that the concepts of the sceptical theorists of professions, and indeed, a particularly empiricist rendering of their work informed most of the data collection. The process of data collection and the struggle to make sense of it has given new insights into the weaknesses of the sceptical approach, but it has also served to raise questions about some of the alternatives currently on offer and their incompleteness.

What then remains to be done? First, the work of criticism needs to be taken forward. Whether the resource approach is entirely bankrupt as a model of power or whether it remains useful are questions which need to be considered. Whether it is still too early to evaluate the Marxist writings on professions, is also a legitimate question. For myself, I would like to see the development of a feminist critique of the concept of professionalisation, and it seems to me that we are already very close to this. It would then be an open question how much the Marxists and feminists had in common and how far a Marxist-Feminist approach could be developed. There

are shared starting points certainly - in the insistence that professionalisation is a category which mystifies, for example, and in the conviction that professions are more controlled than controlling.

Next, theoretical perspectives, concepts, methodological strategies and data-collection need to be more explicitly linked. While case studies of occupations and chronologically-ordered material on their histories will still find a place, it is incumbent on us to use more comparative designs and to make clear the thinking which underpins our research strategies. We saw in chapter one that the sceptical theorists were somewhat deficient in this respect, and I would accept the criticism that the cross-cultural design for this study was one which almost unwittingly oriented me in the end more towards Marxist themes than to feminist ones. Historical comparisons (I am thinking particularly of the nineteenth century) are probably particularly strategic for feminists because there was more reliance on the gender order as a legitimate base for structuring social relations, because it was spoken of more freely, and because the overlay of scientific and technical justifications for the division of labour was in its infancy. Gamarnikow (1978) was certainly building on all of these. But cross-cultural comparisons could yield tremendous dividends, too, especially as we grow to understand more about the nature, pace and timing of the women's movement in different countries and the degree to which it permeates an occupation like nursing. Some of these remarks clearly touch on much wider themes to do with the nature of historical sociology, its relation to its parent disciplines and its problems, be they distinctive or not, of study design, question formulation and so on, and I discuss this

a little further in Appendix II.

In more detailed terms, and arising from the work presented here, there are two kinds of study which I would like to see. One has to do with the forms of collective action which get established in the sphere of professions and occupations, and the nature and limits of the issues which can be taken up in them. I am thinking, for example, of the very different regulatory mechanisms surrounding nurse education in Britain and the U.S., and of a potential extension and development of the institutional analyses of part two of this thesis. Sociologists might need to look to the fields of law and of political science to help develop their understanding here. The other, and perhaps more crucial contribution, concerns the ideas professionals bring to a policy-making process and the nature and source of those ideas. This would extend and develop some of the analyses of part three and it would bring sociologists of occupations and professions into a partnership with those concerned in policy analysis in various ways. It would involve consideration of a substantive area and a critical appraisal of contributions of professionals to the formulation and solution of problems in that area. Above all, it seems to me, the sociology of professions has to come out of its isolation. For the clearest message of this thesis is the narrow and restrictive nature of the questions which have been asked in this particular area. Admittedly, the analyses presented in the course of this study have travelled only a short distance along a new road. This bears witness to the limited and limiting nature of the field and the difficulty of breaking out.

What, finally, is the status of concepts of professionalism and professionalisation, and what use are they in relation to nursing?

Let us take these questions in order. Patently, professionalism and its associated concepts cannot be barred from sociological vocabulary; neither should they be, given the importance such notions have for participants. Professionalism, I would argue, must be seen as an ideology, not as a form of organisation and certainly not as a set of organisational devices which automatically grant control to occupational members. And we need to be open to the idea that espousing a professional ideology can, under certain circumstances, actually be damaging for a group too. As far as nurses are concerned, professionalism has been a yardstick against which they have been assessed, by their own members, by others and by sociologists. And they have not come out of that comparison well. Our job, as sociologists, is to explain the frustrations nurses have felt, to recapture their history for them and to set it in a wider context. It is unlikely, in this task, that we will end up using concepts in the exact same way as participants. Perhaps, in the end, it is our all too similar fate, as insecure and marginal 'professionals' which has led us to swing back and forth, from accepting to deriding professionalism. Perhaps, if we recognise that, we will be able to move towards a better understanding of the practice of 'professionals' and perhaps even towards seeing some alternatives to it.

NOTES

1. A theme that would be worth pursuing by means of a detailed attention to individual studies is that of cross-cultural work on professions (see, e.g. Rueschemeyer 1973; Berlant 1975; Stone 1976; Larson 1977). I accept that this would provide one way of developing the arguments so far advanced, but it is not the route I have chosen here.
2. While sociologists have shown some interest in questions of monetary rewards of professionals, (the Monopolies Commission report (1970) has been a focus for sceptical theorists for example), they have tended to leave the field to economists (see, e.g. Lees 1966; Siebert 1977; Pfeffer 1974; Stigler 1971).
3. What follows is an argument in outline only; I make no claim to completeness or to a tight logic - hence the reference to assumptions as both 'involved in' and 'associated with'.
4. Johnson's later critique of the sociology of professions makes much of its 'Weberian' character (Johnson 1976, 36ff). Dussault (n.d.) also traces a Weberian influence in much recent work. There is some debate, however, about what a Weberian perspective truly entails (Ritzer 1975); with at least two writers calling on Weber for justification of cross-cultural comparisons (Rueschemeyer 1973; Berlant 1975). It is worth asking if here, as elsewhere, we have not been guilty of too narrow a reading of Weber.
5. The question arises of how far either Johnson or Friedson subscribe to a resource model. Detailed attention to their work suggests that strictly neither do so, but many have put this interpretation on them. I certainly did this at the outset, a number of the writers cited in chapter one did so, and the following paragraph in the text shows a particularly clear example of this line of thought in the work of Carol Kronus.
6. One such difficulty emerges when the interests of the profession and the elite coincide; another emerges from the tendency to treat professions as homogeneous, Dussault (n.d.:27-8).
7. Dussault (n.d.:28-9) puts forward some cogently expressed criticisms concerning the lack of historical evidence amongst sceptical theorists.
8. Other work which might be considered here is that of Bourdieu and Passeron (1977) on symbolic power and that of Donzelot (1979).
9. Gamarnikow (1978:99) defines patriarchy as "an autonomous system of social relations between men and women in which men are dominant". Others, however, have defined it differently and by and large I have deliberately avoided the use of the term here so as not to get embroiled in these debates at this stage.

10. While in no way trying to associate Eva Gamarnikow with the arguments which follow, with which she may or may not argue, I suspect that my comments owe something to a discussion we once had on this matter, and I would like to thank her.
11. For a comment on his change of terminology from 'mediation' to 'heteronomy', see Johnson (1976:53 and note 16).
12. Clearly, these comments are schematic. To my knowledge there is as yet no serious evaluation of the Marxist writing. Dussault (n.d.) is somewhat disappointing in this regard.
13. It would be unfair to comment briefly on so important a study in the span of this chapter. I would claim, however, that there is little in it which would directly controvert the line of argument developed here. I should also point out that the formulation being criticised here is very much a feature of the recent generation of writers and does not apply to those trained in an earlier, perhaps pre-Althusserian, era.

A P P E N D I X O N E:

STATISTICAL TABLES

TABLE ONE: ENTRY TO EXAMINATIONS FOR THE REGISTER (England and Wales)\*

For the year ending October	Entry to preliminary examination	Entry to final examination
1926	5,984	4,269
1927	6,988	5,275
1928	6,061	5,652
1929	7,109	6,132
1930	7,751	6,768
1931	8,688	7,323
1932	9,271	7,379
1933	9,813	7,834
1934	9,445	8,144
1935	8,930	8,941
1936	9,116	8,998
1937	9,624	9,516

\*Admissions to the Register include General and Supplementary Registers.

Source: Interdepartmental Committee on Nursing Services (1939:14).

TABLE TWO: ENTRY TO TRAINING FOR NURSING 1951-1971\* (England and Wales)

	Admissions to training for the Register	Admissions to training for the Roll	Total
1951/2	21,340 (91%)	2,119 (9%)	23,459
1952/3	20,059 (89%)	2,497 (11%)	22,556
1953/4	20,879 (89%)	2,534 (11%)	23,413
1954/5	21,847 (89%)	2,729 (12%)	24,576
1955/6	21,712 (89%)	2,655 (11%)	24,367
1956/7	23,044 (88%)	3,047 (12%)	26,091
1957/8	22,599 (88%)	3,165 (12%)	25,764
1958/9	22,849 (86%)	3,847 (14%)	26,696
1959/60	22,808 (85%)	4,191 (16%)	26,999
1960/1	21,838 (84%)	4,236 (16%)	26,074
1961/2	22,584 (83%)	4,498 (17%)	27,082
1962/3	23,386 (80%)	5,893 (20%)	29,279
1963/4	21,068 (78%)	5,884 (22%)	26,952
1964/5	22,152 (76%)	7,131 (24%)	29,283
1965/6	22,716 (72%)	8,787 (28%)	31,503
1966/7	22,087 (68%)	10,487 (32%)	32,574
1967/8	20,882 (64%)	11,756 (36%)	32,638
1968/9	19,417 (62%)	12,067 (38%)	31,484
1969/70	18,218 (60%)	12,274 (40%)	30,492
1970/71	18,464 (57%)	13,759 (43%)	32,223

\*Admissions to the Register include General and Supplementary.

Source: GNC. Annual Reports 1951-1971.

TABLE THREE: HOSPITALS APPROVED AS TRAINING SCHOOLS FOR THE REGISTER  
(Great Britain)<sup>1</sup>

	<u>1930</u>	<u>1946</u>
<u>General training:</u>		
Complete schools	348	389
Affiliated	85	167
Associated	25	5
Reciprocal	34	-
<u>Special training:</u> <sup>2</sup>		
Children	27	31
Fever	96	147
Mental	147	163

Notes:

1. Definitions used have been explained as follows:

"Complete Training Schools are those which have satisfied the General Nursing Council that medical, surgical, gynaecological, and children's diseases services are provided. At least one resident medical officer must be kept, the period of training must be not less than three years, and the ratio of medical to surgical beds must not exceed 2:1, or be less than 1:2.

Affiliated Hospitals are not considered sufficiently large to give a complete training, but may be affiliated to a complete training school. Four years' training is here compulsory, two years being spent in the affiliated hospital, at the end of which the Preliminary State examination is taken. Having passed this examination, the probationer goes to the larger hospital for two years.

Associated Hospitals - (1) Hospitals deficient in one branch of training may, in order to supply that branch, associate themselves with another hospital which must have a resident medical officer. The combined period of training must extend over three and a half years.

(2) A hospital for men only may associate itself in this way with a hospital for women only and one for children only, when the course may extend over four years.

Reciprocal Hospitals - Reciprocity between special and general hospitals involves two years in an approved special hospital and two years in a general hospital. Training in the special hospital must include the subjects of the Preliminary State examination.

(TABLE THREE (Continued))

2. These data are drawn from separate sources for the two years shown and should be treated with caution. Specifically on special training it is unclear whether the 1930s information covers all schools or only complete schools. In 1946 there were 126 complete fever schools and 21 affiliated fever schools; there were 29 complete sick children's schools and two affiliated; mental schools are shown as 137 together with 26 mental deficiency schools (one of which was affiliated).

Sources: Lancet Commission on Nursing (1932: Appendix XVII); Ministry of Health Recruitment and Training of Nurses (Wood Report) HMSO 1947).

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TABLE FOUR: NUMBER OF HOSPITALS APPROVED AS TRAINING SCHOOLS FOR ALL PARTS OF THE REGISTER (England and Wales)

					Sick	Fever	Mental	Mental Sub- normality
					Children's			
At November 1949	878							
At March 1951	941							
1951-1952	989							
1952-1953	990							
1953-1954	984							
1954-1955	657	incl. 357	complete training schools within one hospital	25	60	125	48	
1955-1956	658	" 357	"	25	54	125	48	
1956-1957	643	" 349	"	25	38	127	49	
1957-1958	624	" 296	"	25	34	127	48	
1958-1959	611	" 293	"	25	33	126	49	
1959-1960	600	" 289	"	25	29	126	51	
1960-1961	590	" 280	"	24	23	126	51	
1961-1962	580	" 272	"	24	23	127	51	
1962-1963	564	" 267	"	24	21	127	52	
1963-1964	467	" 100	"	23	17	126	57	
1964-1965	456	" 95	"	23	14	126	57	
1965-1966	428	" 95	"	22	12	127	57	
1966-1967	425	" 96	"	22	-	121	57	

N.B. (i) These figures are as shown in the annual reports of the General Nursing Council.

(ii) The 1967/68 figures are not given since, due to the grouping of many training schools, the "Council's analysis has been presented in a different form and details cannot be compared with those in previous annual reports".

Source: E. Bendall and E. Raybould, A History of the General Nursing Council, London: Lewis (1969).

TABLE FIVE:    NUMBER OF HOSPITALS APPROVED AS TRAINING SCHOOLS  
FOR THE ROLL OF NURSES (England and Wales)

At November 1949	128
At March 31st, 1951	210
1951-1952	285
1952-1953	335
1953-1954	371
1954-1955	400
1955-1956	426
1956-1957	459
1957-1958	479
1958-1959	513
1959-1960	515
1960-1961	526
1961-1962	552
1962-1963	586
1963-1964	625
1964-1965	641
1965-1966	785
(including 138 Mental and Mental Subnormality Hospitals)	
1966-1967	903
(including 182 Mental and Mental Subnormality Hospitals)	

Source: Bendall and Raybould op.cit.

TABLE SIX: U.S. NUMBERS OF PROFESSIONAL NURSING SCHOOLS,  
ENROLLMENTS AND GRADUATIONS, 1880-1970

	No. of schools	Students	Graduates
1880	15	323	157
1890	35	1,552	471
1900	432	11,164	3,456
1910	1,129	32,636	8,140
1920	1,755	54,953	14,980
1931	1,844	100,419	25,971
1940	1,311	85,156	23,600
1950	1,203	98,712	25,790
1960	1,123	118,849	30,267
1970	1,343	164,545	47,001

- Notes:
1. Figures for 1890-1910 are usually said to underestimate the total number of schools and should be taken as a probable underestimate.
  2. Although there are more detailed statistics in the sources, it is hazardous precisely to date the drop in the number of schools, since accreditation of schools starts in the 1920s and from 1929 the figures are accredited schools only. The falling trend in the 1930s, however, is quite unmistakable.
  3. Figures from 1950 include Hawai and Puerto Rico. The 1970 figure includes schools in the Virgin Islands and Guam.

Sources: U.S. Bureau of the Census. Historical Statistics of the United States, Washington 1960. American Nurses Association, Facts about Nurses, (Various editions).

**TABLE SEVEN: U.S. NUMBERS OF ACTIVE NURSES, TRAINED AND UNTRAINED  
1900-1950 ('000s)**

	1900	1910	1920	1930	1940	1950
Nurses, professional )	12	82	149	294	377	491
Nurses, student professional )						
Practical Nurses, )						
Midwives )	109	133	157	198	115	151
Attendants, Hospital and )					102	216
other institutions )						

**Notes:** Census classifications of 'active' 'employed' 'gainful' workers etc. change over time. For details see source cited. In addition, nurses have proved difficult to classify. There is an extended discussion of this in Davies (1980a).

**Source:** U.S. Bureau of the Census. Historical Statistics of the U.S. Washington 1960.

**TABLE EIGHT: ADMISSIONS TO DIFFERENT TYPES OF NURSE TRAINING,  
SELECTED YEARS 1962-70 (USA)**

Type of Programme	1962/3	1964/5	1966/7	1968/9	1970/1
Baccalaureate	9,597 (12%)	11,835 (13%)	14,070 (14%)	15,983 (14%)	20,413 (15%)
Diploma	36,434 (46%)	39,609 (42%)	33,283 (33%)	29,267 (26%)	28,980 (21%)
Associate Degree	3,490 (4%)	6,160 (7%)	11,347 (11%)	18,907 (17%)	29,889 (22%)
LPN	30,585 (38%)	36,489 (39%)	41,269 (41%)	49,107 (43%)	60,057 (43%)
Totals	80,106	94,093	99,969	113,264	139,339

**Source:** ANA Facts about Nursing (Various editions)

TABLE NINE: ESTIMATED NUMBER OF ACTIVE GRADUATE NURSES IN THE U.S., 1910-1970<sup>1</sup>.

<u>Year</u>	<u>Number</u>	<u>% Increase per Decade</u>
1910	50,476	
		+105.8%
1920	103,879	
		+106.3%
1930	214,292	
		+ 32.7%
1940	284,159	
		+ 31.8%
1950	374,584	
		+ 34.6%
1960	504,000	
		+ 38.9%
1970	700,000	

1. Data for 1910-30 are for nurses gainfully employed; for 1940 they include nurses seeking work, and service nurses. For 1950, 1960 and 1970 figures are for employed nurses. (The original base for these figures is census data, thus see also note to table 7.)

Sources: ANA Facts About Nursing, 1961, 1971.

A P P E N D I X T W O:

NOTES ON SOURCES AND METHODS

## INTRODUCTION

As the main text makes clear, this project did not start out as an exercise in historical sociology. The research design had assumed that an historical approach was going to give no special problems for a sociologist, and that established theory could be confronted with new data in the ordinary way. Historical material would simply represent an extension of the usual comparative net in a world where opportunities for experimental manipulation were limited. In the event, these assumptions proved problematic and certain shifts in the research strategy took place. It is important therefore to give an account of the types of data collected and the source materials used to generate the findings of the study. It is also important to reflect on any lessons which might emerge concerning the conduct of historical sociology and the special problems, if any, that it faces. These are the two topics discussed below.

### a) Sources Used

The initial plan for this study was to consult available volumes concerned with the history of nursing and to supplement the secondary materials with information from professional and official enquiries and reports concerned with nursing. The apparently large number of general nursing histories however, was found on inspection to be of restricted usefulness. They were written with a general audience (often a nurse audience) in mind; they covered an enormous span of time and space, inevitably in a rather superficial way and they tended to lack adequate footnoting and referencing. The large number of such books turned out to be a smaller number running to multiple editions which changed titles and authors somewhat en route. Some of these books drew from each other and were not the result of original scholarship. Many rested on a common interpretative foundation stressing great figures and giving an impression of an inevitable march of progress.

There was, though restricted, a useful variety in the histories available. Certain volumes were helpful for their detailed chronicling of information (e.g. Pavey 1959, Seymer 1956, Jamieson et al. 1966, Dolan 1978); others were refreshing because they were outside the usual mould, being written by doctors, or by social scientists rather than by nurse authors (Shryock 1959, Robinson 1946, Sellev and Nuesse 1946, Holcombe 1973). There were also some doctor/nurse, husband/wife teams (Bullough and Bullough 1978, Kalisch and Kalisch 1978). I was fortunate enough to find that there was one outstanding volume for each country and I came to rely heavily on Abel-Smith's (1960) work on British nursing and Roberts' (1954) volume on nursing in the USA. While trying always to avoid it, I have probably to some extent reflected the biases of these works, though the fact that they were such different biases helped draw my attention to them.<sup>1</sup> Among the older nursing histories, Nutting and Dock (1907, 1912) provided a classic study which illuminated many points, and Tooley (1906) was an interesting counterweight to volumes focussing heavily on Nightingale nursing reform.

Beyond this, there were more specialised secondary materials. First, there were the histories of specialised fields of nursing, public health, and nurse education for example. The variety in method and depth of work and in dates of publication is considerable - see, e.g. Brainard (1922); Gardner (1937); Chayer (1931); Stewart (1944); Charley (1954); Dewitt (1917); Stocks (1960); White (1978). Secondly, there were histories of nurse training schools, together with histories of hospitals which frequently included chapters on nursing and/or nurse training at the hospital. Of the former, the following were helpful: Seymer (1960); Johns and Pfefferkorn (1954); Dunbar (1936); Schryver (1930); Gray (1960); Giles (1949); Faddis (1973); Youtz (1975). Among the hospital studies, I consulted Cope (1955); Brockbank (1970); Anning (1966); Waddy (1974) and Medvei and Thornton (1974). The overall result was necessarily uneven since there are many more school studies in the U.S. A third type of specialised historical work was found in the histories of various professional associations and statutory bodies. In Britain, there is a history of the GNC (Bendall and Raybould 1969) and of the

Rcn (Bowman 1967); in the USA there are works on the NLNE (Munson 1936), on the NOPHN (Fitzpatrick 1975) and on the ANA (Flanagan 1976). Furthermore, in the US most of the individual States of the USA have by now prepared or commissioned work on the local history of nursing and of the State nursing association. Amongst these I was able to consult the following: Bond (1957); Allen (1950); West (1932); Christ (1957); Rodabaugh and Rodabaugh (1931).

In these various ways then, the review of secondary sources was extended, so that the range of material consulted was quite broad. To it I also added a certain amount of reading of biographies and autobiographies, although it was never my intention to utilise biographical materials and career histories of individual nurses in a systematic way in the project.<sup>2</sup> Two biographies I found particularly useful were those on Mrs. Bedford Fenwick (Hector 1973) and on Professor Nutting (Marshall 1972). For the most part, I kept away from the veritable Nightingale industry, reading Woodham Smith (1950), perhaps unwisely, instead of Cook (1913).

I had elected to cover enquiries into nursing as conducted by nurses themselves or as sponsored by governments or charitable foundations. In retrospect, my procedures were not entirely consistent here, for I covered and indeed have used quite extensively the Lancet Commission on Nursing in Britain, while failing to compile a list and to read the various enquiries into nursing set up by American doctors at various points. With the British enquiries I was also able, working from the library of the Rcn, to consult evidence to the enquiry and comments on its report. But since the American enquiries did not take the same form, direct comparability was impossible. The idea of reconstructing the whole of a body of evidence to an official enquiry was an attractive one but it would have been highly time-consuming simply to explore the possibility of this as a line of investigation, and in this project it was discarded. What I did do was to try to cover all discussion documents and policy statements emanating from the Rcn, the ANA, the

NLN and NLNE and the NOPHN. I was fortunate in that the Rcn library held much of the American documentation, but in retrospect I should have considered its biases as a collection of materials perhaps representing only one (albeit a powerful) view within British nursing.

As the research design took on a different shape it became an issue as to how much further I could and should delve into primary sources. Time, and the need to produce some comparability of effort for nursing in each country set severe limits. I read annual reports of the GNC (1940-) and also those of the Rcn (1916-). I read the reports of the Biennial Conventions of the ANA as reported in the American Journal of Nursing. I allowed these, and some of the secondary source material to direct me to articles in the professional nursing journals, but no systematic perusal of those journals was undertaken. Nor were any unpublished materials consulted either in the form of the records of groups or the papers of individuals.

There was one group of materials which I came only very late to see as primary sources, namely research studies of nursing conducted at different times by social scientists and others. In retrospect, it would have been useful to compile a list of such materials and to consider how far they might serve as a sample of what practice meant at a particular period. I did attempt to read such materials as they came to my notice, but they are used illustratively and perhaps to less effect than they might have been had I treated them as a direct source in my data collection strategy.

In addition to reading primary and secondary sources I also needed a strategy for adding to my general understanding of the social, economic and political background to the period under consideration. The sociologist faces in particularly acute form the problem of building up a depth of knowledge of the period or periods to be studied. She/he is unlikely to start with the stock of knowledge of the historian and has to find ways of enhancing not only source-based knowledge but also contextual non-source-based knowledge (Topolski 1976). In this context,

the amount of historical material relating directly to professions and professionalism is small and what there is I have relied upon quite heavily (Perkin 1969; Gilb 1966 ; Wiebe 1967). Beyond this I generated bibliographies under various headings of social and economic history of the two countries, of cultural differences, of welfare policy and more specifically on the topics of health policy, education policy, legal regulation and position of women. I could read only a small fraction of this and obviously would like to have read more and assimilated better what I had read. In retrospect, the lack of a clear plan for covering this kind of material was an important weakness in the new research strategy. I decided to leave concentrated non-source-based reading until I had some felt mastery of the sources themselves, and as I began to appreciate the range of these latter, so less time was left for the non-source-based material. My reading on the topics of law and women was almost non-existent. I wonder too whether it was the wrong decision to eliminate systematic reading about the medical profession in both countries. My reason for this was that the debates were too similar to my main project and too confused to have a clear payoff in the time available to me. What I did cover, and this was reflected very much in the interpretations developed, was material on crosscultural differences. It was important too, I felt, to read on the topic of crosscultural research design and on historical method. Much of my preliminary reading on crosscultural research turned out to be less than relevant as the research design became more qualitative but certain items remained helpful (Marsh 1967; Vallier 1971; Przeworski and Teune 1970). It was particularly stimulating to read both on the topic of sociology and history and the interface between them, for example, Leff (1969); Holloway (1963); Allcock (1975); Stedman Jones (1976); Thompson (1976) and on the topic of historical method - Todd (1972); Lipset and Hofstadter (1968) and Topolski (1976). I found that introductory essays to recent collections of readings illuminated very helpfully for a sociologist some of the choices between different historical approaches (Hartmann and Banner 1974; Woodward and Richards 1977; Briggs 1972) and one can only wish for more essays deliberately designed to bring developments in history to the attention of sociologists such as that of Lankford (1973).

Some of the decisions on sources concern well-known and well-understood problems of historical research. To the extent that I familiarised myself with historical methods texts, I gained a vocabulary in which to address these problems and criteria which would guide me towards solutions. Thus, for example, Topolski's (1976) point about source and non-source based knowledge was helpful and Todd (1972) clarified that my situation was one where the selection of sources, and the balance of primary and secondary sources was a more crucial problem than testing for the accuracy of sources as such. Some decisions too, were ones familiar in sociological methods texts, and here material on working with documentary sources was relevant, a point recently explored by Platt (1979). What I felt I lacked was access to materials framed specifically for the sociologist wishing to do historical work, discussing the extent to which one might expect the methods of each discipline to have relevance. There had certainly been discussions of the boundary between sociology and history, and much urging that these two come closer together (see below) but this kind of argument had not been followed through to guidelines as to the nature and mix of sources which workers from sociology were likely to use and the adequacy of these for the purposes in hand. To some extent, I had escaped from the criticism that sociologists did poor history, and relied merely on those few secondary sources which came to hand. But were the goals of the sociologist doing historical work so similar to those of the historian, that the historians' rules should apply? This theme is taken up below.

#### b) Problems of Historical Sociology

The initial research design took an unquestionably cavalier stance in relation to history. Historical material was seen almost as a data bank. In practice, this is not at all an uncommon approach amongst sociologists. Stedman Jones (1976) suggests that in the contemporary togetherness of sociology and history the influence has been one way with sociology influencing history but not vice versa; Allcock (1975) has claimed that sociologists have embraced the idea but not the practice of history and Thompson (1976) has declared himself willing to bet that historians are more familiar with the sociological journals than sociologists with the historical ones. Thompson has gone further to

point out three distinct problems - faults if you will - in sociologists who try to use history. There is an anxiety to generalise which leads the sociologist to be too ready to translate questions into inappropriate contexts. There is plain ignorance concerning historical method, and this defies Thompson's canon that when the materials are historical, historical procedures must be followed. There is a neglect of the problem of controls in hypothesis-testing, a satisfaction, in other words with illustrating arguments rather than trying to subject them to the rigours of testing. These problems identified by Thompson provide a convenient framework in which to raise a number of issues concerning the conduct of research in historical sociology, and to reflect on them in the light of the research carried out for this thesis.

i) Anxiety to generalise ...

Let us first note that anxiety to generalise can be seen in a positive light. It gives criteria for the selection and study of materials and offers some protection against total immersion in the data ('going native'). It directs the researcher towards an explicit statement of the theoretical framework and this helps avoid both the use of arbitrary or implicit theory and the resort to chronology as the main structuring device in the final report. Immersion, arbitrary theory and chronological structuring are, after all, some of the charges that the sociologist levels at the historian.

The real issue here, however, is that the sociologist is frequently concerned to situate materials in terms of some existing theoretical ideas. Whether these take the form of a well-developed theory, or are more of a loose and incomplete conceptual framework, the difficulty is the same. This has to do with relevance of theoretical ideas from sociology to the historical phenomena under investigation. The really important charge against sociologists is that their theories are not general but modern. The argument goes that in their anxiety to generalise, sociologists behave rather like the Whig historians; they engage in 'retrospective modernism', they are not just 'present-minded' but 'present-centred'.<sup>3</sup>

A gross example of error in this regard is the 'Stages' theory of professions. This actually specifies particular institutional forms (training schools, professional associations etc.) and an order in which they will emerge for any occupational group en route to professionalisation. Quite clearly such forms are not always available or available as 'the same' phenomena in different time periods. I did not make this mistake, but I did assume a) that the mechanisms by which an occupational group achieved power were going to be invariant across the period of study and b) that the idea of occupational group power was available to actors over the whole time. Both of these were called into question, but both had seemed at the outset reasonably serviceable assumptions to make.

One question at issue here is whether the theory is sufficiently general to cope with historical materials. Historians are probably right when they argue that much of what passes for sociological generalisation is unlikely to hold for different times and places. It is worth noting in this regard that the plea for middle-range sociological theory - often enthusiastically taken up by empirically-minded sociologists - is not a plea for theory which is less general (and hence less relevant in history). Merton, proponent of the term, sees fit to emphasise that "actual theories of the middle-range - dissonance theory, the theory of social differentiation, or the theory of reference groups - have great generality, extending beyond a particular epoch or culture" (Merton 1968:64). But he offers little to guide us in recognising levels of generality. Would a theory of professions be middle-range? Perhaps instead we should search for a theory of occupational action or a theory even of collective behaviour?

Given a sufficiently general theory, there are the further problems of specifying equivalent indices of concepts in diverse historical epochs and devising decision criteria to show what would call for modification of the theory and what would not. Merton has also been criticised for too rigid a separation between theory and research and for failing to deal with the 'riddles of experience' - the everyday issues which first prompt a researcher's curiosity (Dahrendorf, 1958). None of these is a new problem or one entirely specific to historical work. But all of them

need special consideration when the materials are historical - if only to justify at times a conclusion that the usual rules apply.

It is undeniable then, that the sociologist's anxiety to generalise gives rise to difficulties. Where students of the contemporary scene often manage to get away with a limited exercise in generalisation, and with little thought on questions of levels of generality and problems of theory construction, the historical sociologist must face the issues more directly. We need to look afresh at available writings, for example, on the question of middle-range theory, and take the opportunity to comment on it and perhaps reshape it with historical examples in mind.

ii) Ignorance of historical method ...

For the most part historians do not append chapters on method to their monographs and it is only obliquely that one learns about their research procedures. But there is a growing body of material of particular relevance to the sociologist which deals with historical sources, their character and their selection (e.g. Renier 1950, Dovring 1960, Topolski 1976, Platt 1979). Reading this highlights the importance of a good knowledge of the range of potential source materials available, their likely location, the reasons for their construction and hence their utility for the problem in hand. The study reported here can legitimately be criticised for weaknesses on this score, for, as the earlier section on sources makes clear, understanding of the range of sources evolved as the project progressed and as it shifted out of the 'data-bank' mould more towards historical sociology.

Yet the material on historical method does not altogether solve the sociologists' problems. Take, for example, the question of the balance between primary and secondary sources. In my observation, historians are much less reliant on secondary sources than are sociologists. Is this because they have better knowledge of their period to begin with? Is it because their goals are quite different? Should we try to make general statements about the balance between different types of sources or

consider the issues only within a substantive context? (cf Platt 1979). Whatever the resolution of these questions, it is clear that a good understanding of the population of potential sources, primary and secondary, is an early step in the research process and one which sociologists must not neglect.

iii) The research design

Historians have recently produced some stimulating new work which incorporated explicit hypothesis-testing designs. Some, for example, have used local comparisons within a country and a period to subject hypotheses to test. Others, especially those interested in quantification, have been instrumental in developing larger scale, cross-national, comparative hypothesis-testing projects.<sup>4</sup> Since sociologists are prone to claim that their own discipline is theory-based and needs more historical work, one might expect to find them especially interested in this kind of enterprise. My project, with its focus on measurement of variables and time comparisons, was an example of this. It assumed that immediate operationalisation of variables was possible and indeed that this was the major challenge at this particular time.

It is worth considering why hypothesis-testing using numerical analysis was abandoned. Part of the answer lies in the theory, and in the problem of abstractness referred to earlier. It is crucial to ask whether the state of knowledge is such that work at the hypothesis-testing level is appropriate. We must consider where the proposed research activity fits in an overall cycle of the research process, and give exploration, concept-forming and hypothesis-developing its due weight.

Another part of the reason for abandoning hypothesis-testing in my study was the problem of the requirements for quantification of variables and the logical assumptions necessary for building causal models. Again, this is something which would bear

much more discussion than has been given to it, particularly in the specific context of historical studies. Some of the restrictive assumptions which can render this mode of analysis inappropriate are as follows:

- a constancy of definition of the key concepts over the whole period of investigation;
- a constancy in the applicability of the operationalisation and scaling of variables;
- units of analysis which are essentially stable/ the same;
- data sources with no major discontinuities of information structuring or information availability.

The building of a causal model, in short, assumes that the only variability which occurs is that in the relationship between the variables themselves; units, concepts and measurement all remain the same.

It may be helpful to give a specific example from the field of professions. Consider the proposition: *the greater the expertise of a profession, the higher its social status*. Is this a plausible topic for consideration in, say, early 18th century England? In the first place it is questionable whether any group had a coherent identity as a profession and acted as a collectivity in the same sort of way as today. (I leave aside the reasonable objection to present day usage as an illicit reification). In the second place, massive changes in political, economic and social structure rule out any directly comparable measure of status, and there is scope for considerable disagreement as to how to proceed to ensure equivalence. In the third place, as recent historical work has been making clear, the concept of functional expertise is, at the earliest, probably a late 19th century idea (see Johnson 1972; Peterson 1978; Jewson 1974, 1976). Is it at all justified to try to impose it on an earlier period? And in the fourth place, if the number of cases, operating within a national context, is too small for statistical analysis, what is the point of refined measurement scales?

It might be countered that some of these difficulties are overcome by giving explicit attention to 'periodisation', i.e. the formulation of meaningful time-spans within which to search for and investigate particular forms of social relationship. I tend to agree with this. But it highlights questions about the object of historical enquiry for the sociologist. Are we in the business of setting the limits/conditions of sociological generalisations? If the historians are right about the 'modernness' of so-called abstract sociological theory, then we must expect much historical sociology to take the form of showing its time-boundedness. Or are we in the business of trying to transcend limits by still more general theory? On this argument we should not confine our remarks to specific periods but tease out the variables which underlie the periodisation.<sup>5</sup> In all this we need to consider too whether the hypothetico-deductive method is perhaps entirely inappropriate in historical work. Platt (1979) cites writers who incline to this view and does so herself on grounds which include the unavailability of appropriate documents and their ambiguity in relation to given theoretical categories.

In the field of historical sociology, we should, as always, be sceptical about hypothesis-testing designs. *We should be on* the lookout for contemporary theories masquerading as abstract ones, for insensitive use of sources and for questionable assumptions built into the methods of analysis. Sociologists still have much to learn from historians, but they need to face problems directly within their own discipline too. If the plea for more links between sociology and history is in principle a worthwhile one, it is only through encouraging reflection on methodology that we will learn whether there is a division of labour between the disciplines, and how far the problems are truly similar. This appendix has tried to take a step in that direction.<sup>6</sup>

FOOTNOTES

1. Abel-Smith's main concerns were with the legislative struggles in which nurses engaged and with the availability of nursing manpower(sic). His is a social scientist's account which draws on a range of sources including nursing and other occupational groups' journals and general press comments and House of Commons Debates. He chooses a focus on general nursing, on the hospital setting and on England and Wales. Roberts, by contrast, writes from the perspective of a nurse who had editorship for a long period of the American Journal of Nursing. That journal, together with reports and statements from the national nursing organisation, provided her major source materials. Her interests cover a wider spectrum of settings for nursing work and she engages in questioning about changes in nursing skill and in nursing education. Her evaluations tend to be positive ones, placing rather more emphasis on the achievements of nurses than on the constraints surrounding them.
2. An excellent recent example of a historian drawing on the careers and biographies of doctors is Peterson (1978).
3. For a discussion of 'retrospective modernism' see Sanazaro (1971). The distinction between present-mindedness (focussing on the present) and present-centredness (viewing the past exclusively from the point of view of the present) I owe to Wilson (1980).
4. For some examples see Foster (1974), Somers (1971) van Tijn (1976).
5. The arguments of Przeworski and Teune (1970) on not specifying arguments to countries may be directly comparable. They claim that we should not say 'in Britain ... but in the USA ...'. Instead we should specify the variable for which the two countries represent different values. In this context then we might arrive at a general statement beginning, for example, 'the greater the perceived openness of the class system ...'.
6. All of these remarks should be seen as indicating the nature of a problem which requires discussion, rather than as coming to a considered view on it. It may be, for example, that the problem of periodisation is covered quite adequately in the hypothetico-deductive mode by discussions of the contingent character of propositions and about the validity of indicators and that these offer all that is needed for the historical sociologist. Since the eventual study reported here was not a quantitative one, I did not pursue these questions in any depth. It would be interesting, however, to take some standard methodological texts not especially concerned with historical data and to read them with these problems in mind (e.g Zetterberg 1965).

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